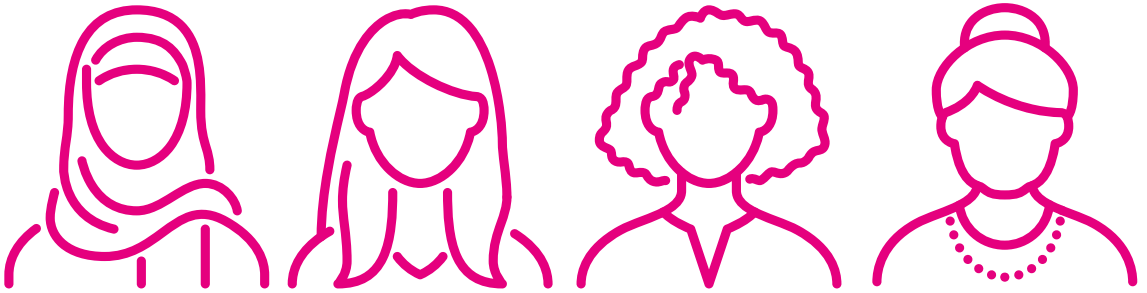
BIRMINGHAM WOMEN'S HEALTH NEEDS

REPORT WITH RECOMMENDATIONS

APRIL 2024



A BOLDER HEALTHIER BIRMINGHAM

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FOREWORD

There is clear evidence that there are inequalities in health outcomes for different people that link to their gender. The link to gender can be because of specific parts of the body such as cervical cancer or can link to the wider social position of different genders and how this impacts on health and access to support. It is important that we consider these inequalities as they affect women, men and non-binary people and this report is the start of this journey.

Evidence suggests that many women and girls in Birmingham are affected by health inequalities and face challenges in accessing the support they need to maintain good health. This report is an important step towards highlighting the key issues in women's health and taking action to address them. It has been developed in partnership with a partnership women's steering group and draws on other reports such as the community health profiles as well as key data sources. It highlights that where there are inequalities affecting women these gaps are in general worse for women from marginalised and vulnerable groups such as those from ethnic communities, women affected by homelessness, domestic abuse, and disabled women.

Women and girls face many barriers to good health, and these can be multiple and layered in their lives and change across the life course. Across the report there are common issues identified about women facing specific issues in physically getting to services, often due to caring responsibilities, limitations on individual decision-making and lower literacy rates as well as biased attitudes from providers and professionals.

Whilst it is important to acknowledge the effort that has already been made to address health inequalities in the city, there is more that must be done. This report makes the case clear: to improve overall population health in Birmingham, it is important to recognise the role of gender in this approach and underlying risk factors in determining health outcomes.

Responding to the challenge of this report will require us to work together as a city with women and communities to build a better future for our citizens.

Dr Justin Varney
Director of Public Health
Birmingham City Council

1. INTRODUCTION

Gender is recognised as one of the most relevant determinants of health inequalities.[1] A report on health equity in England found that improvements in life expectancy have stalled, and declined for women in the 10% most deprived areas.[2] Whilst sex affects the health of an individual level through anatomy, i.e., cervical cancer is exclusive to females and prostate cancer for males, gender affects health at a social level through differences in roles, responsibilities and through the social determinants of health such as lower income, poorer working conditions and employment, and housing.[3] These are influenced by gender-based discrimination. Gender inequality may be experienced by women in relation to the pay gap, primary caring responsibilities for children and family, gender-based violence and less economic and political power, all of which can contribute to poor health.[4]

1.1 BIRMINGHAM GENDER HEALTH INEQUALITIES PROJECT

In 2022, the Inclusion Health Team (Public Health, Birmingham City Council) developed a gender-related health inequalities project, which aims to influence and support the delivery of local action to reduce those inequalities in Birmingham, recognising inequalities exist for women, men, trans and non-binary communities, and these are often larger where there is intersectionality between identities.

The development of the project coincided with the publication of the National Women's Health Strategy by the Department of Health and Social Care[5], which has helped to frame phase 1 of the local gender health inequalities project focussing on women's health.

The content of the report is a product of the first phase of the gender health inequalities project, which started to be developed in September 2022 and focused on women's health inequalities in Birmingham.

It has been compiled through a consolidation of published data and local evidence, including various stakeholder insight.

The report aims to highlight challenges for women's health in Birmingham, with a focus on intersectional aspects of different female populations and inclusion health groups. The recommendations identify local opportunities for action against the national priorities highlighted in the Women's Health Strategy and focus on the following public health outcomes and inequalities:

- Under 75 premature mortality
- Cancer and cardiovascular disease
- Sexual health
- Menstrual health
- Maternal health
- Reproductive health
- Mental health
- Health impacts of violence against women and girls.

The report also highlights 'what works' to address many of those inequalities.

The overarching aim of this project and the report is to influence change in the local health system through focused work streams and strengthen existing work and community assets to reduce health inequalities for women in Birmingham.

This work is overseen by a multi-agency women's health working group, the terms of reference for which can be found in Appendix 1. The working group aims to influence and drive change in the broader health and care system to improve women's health and outcomes and reduce health inequalities. The group also aims to identify and develop initiatives and research where there are gaps and ensure women's voices feed into the work and longer term - into the health system.

1.2 NATIONAL PRIORITIES FOR WOMEN'S HEALTH

The DHSC National Women's Health Strategy for England is a 10-year strategy that aims to address gender-specific health inequalities through transformational system change. The strategy is based on a 6-point plan:

1. Ensuring women's voices are heard
2. Improving access to services
3. Addressing disparities in outcomes among women
4. Better information and education
5. Greater understanding of how women's health affects their experience in the workplace
6. Supporting more research, improving the evidence base and spearheading the drive for better data.

The following key priority areas are identified in the strategy, taking a life course approach:

- Menstrual Health and Gynaecological Conditions
- Fertility, Pregnancy, Pregnancy Loss, and Postnatal support
- Menopause
- Mental Health and Wellbeing
- Cancers
- The Health Impacts of Violence against Women and Girls
- Healthy ageing and long-term conditions.

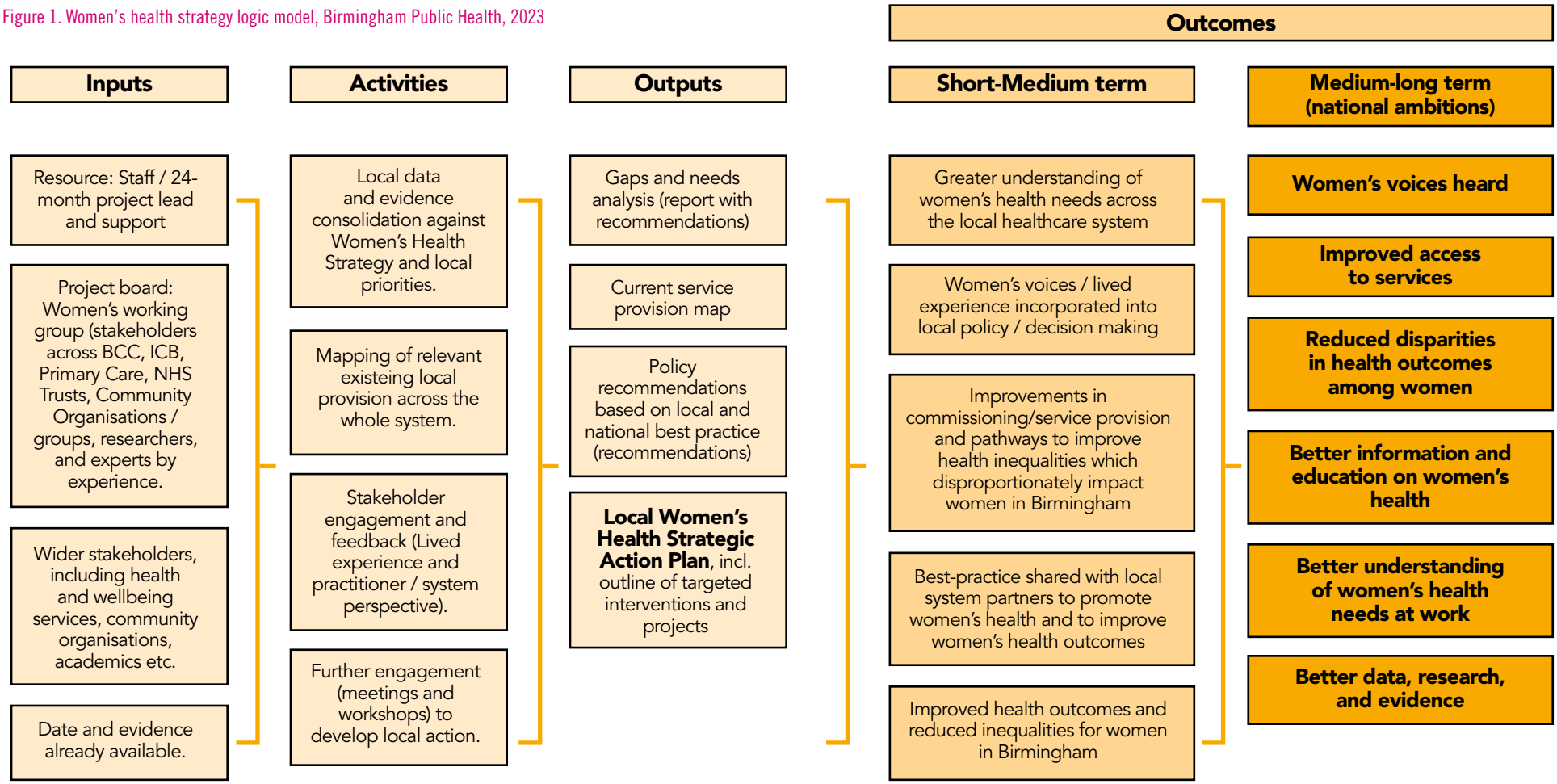
The Gender Health Inequalities Project led by Birmingham Public Health has used the national priorities as a framework for addressing inequalities in women's health locally.

2. OUR APPROACH TO DEVELOPING ACTION TO IMPROVE WOMEN'S HEALTH IN BIRMINGHAM

2.1 THE LOGIC MODEL

Based on the national framework and ambitions, the following diagram presents the logic model that has been used to deliver Phase 1 of the Gender Health Inequalities project, starting from local evidence reviews, gaps and needs analysis, and identifying priority areas for action through the recommendations within this report. The project activities involved collaboration with stakeholders, including local women experiencing health inequalities.

Figure 1. Women's health strategy logic model, Birmingham Public Health, 2023

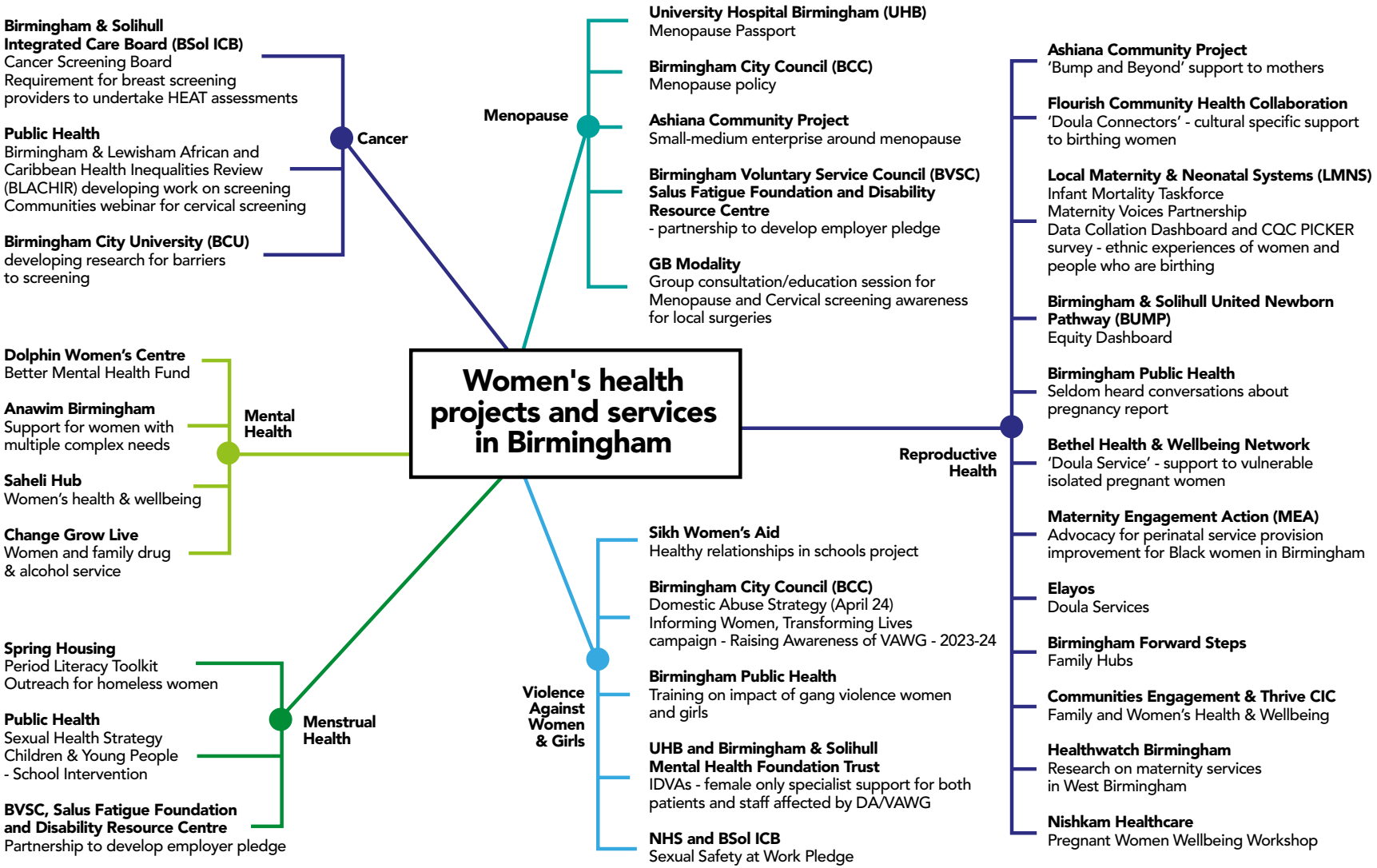


2.2 MAPPING OF LOCAL PROVISION AGAINST NATIONAL PRIORITIES

To identify gaps in local policy and service provision, the Inclusion Health Team conducted a mapping exercise to establish existing and planned service provision and projects against the national ambitions and priorities (see p.5).

Below is a map of key existing local services and initiatives that focus specifically on improving women's health and wellbeing and addressing health inequalities affecting women in Birmingham

Figure 2. Map of women's health projects and services in Birmingham, Birmingham Public Health, 2023



2.3 RAPID REVIEW OF LOCAL DATA AND EVIDENCE - METHODOLOGY

The following approach was used to collate and review available evidence and data on women's health and disparities in Birmingham, using the 6-point plan and ambitions within the Women's Health Strategy for England as a framework.

To narrow the focus of the evidence, search and review, the following categories were identified for gathering issues and ideas in the initial stages of the evidence review.

Young people and inequalities related to ethnicity are included as categories in themselves to reflect two key groups of the population of Birmingham.

Figure 3. Birmingham women's health needs and gaps analysis approach, Birmingham Public Health, 2023

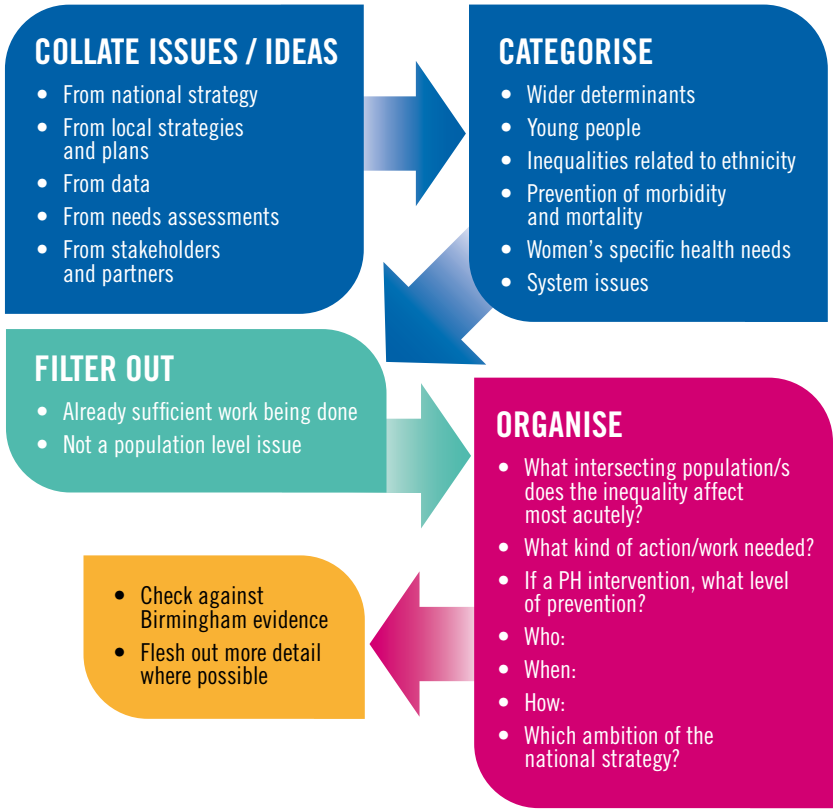


Table 1: Women's health issue categories, Birmingham Public Health, 2023

CATEGORY	EXAMPLES OF WHAT WOULD BE INCLUDED:
Wider determinants	Housing, income, poverty, education, VAWG, workplace health, caring responsibilities
Young people	Sex and relationships education, period literacy, body image and social media, eating disorders
Inequalities related to Ethnicity	Maternal mortality rates for Black women, cancer screening rates in Pakistani community
System changes	Data, research, training for healthcare professionals, co-production, mechanisms to bring women's voices into health system e.g., women's networks, piloting of women's health hubs.
Prevention of morbidity and mortality	Breast screening, cervical screening and HPV vaccine. Avoidable deaths, disabling illnesses, and look at drivers of poor outcomes to ascertain intervention needed. Including general (e.g., CVD, diabetes) and women's specific illnesses (e.g., endometriosis, fibroids) Pain management; depression and anxiety
Women specific Health Needs (not related to illness)	Menstruation, menopause - increasing awareness, reducing stigma, increasing literacy. Pregnancy, fertility, contraception - addressing inequalities in access to healthcare. Ensure including issues from across life course.

This review comprised of five main components:

1. systematic review of evidence on gender related health inequalities (delivered through a commissioned external provider)
2. supplementary rapid desktop review of relevant published research and literature
3. review and assessment of routinely collected local health data
4. consolidation of qualitative local evidence obtained through stakeholder engagement
5. gaps and needs analysis.

2.3.1 REVIEW OF PUBLISHED EVIDENCE

At the initiation stage of the overall gender health inequalities project, a separate systematic review of evidence was commissioned to explore gender-specific health inequalities experienced by the male, female and non-binary populations in Birmingham, UK. A systematic search of Medline, Embase, Science Direct, Web of Science, Cochrane Library, Google Scholar, and other relevant grey literature was conducted to find and retrieve relevant studies.

Ninety-three empirical studies were included that reported at least one outcome of interest. From the ninety-three studies, three studies were conducted in Birmingham; all three reported evidence-based interventions to address gender-specific health inequalities. One study conducted in the West Midlands reported gender-specific health inequalities experienced by the homeless population.

Since the commissioned review of evidence did not provide sufficiently conclusive outcomes, a supplementary desktop review of local and national publications, including research papers, policies and grey literature was also conducted by the project lead.

2.3.2 LOCAL DATA REVIEW

Data sources accessed for the review included:

- Birmingham Joint Strategic Needs Assessment – Local Area Health Profiles
- End of Life in Birmingham JSNA Deep Dive, 2021 - 2022
- Director of Public Health Annual Report 2019 to 2020 – Complex Lives, Fulfilling Futures
- Director of Public Health Annual Report 2021 – COVID-2019: 'The Year I Stopped Dancing'
- Birmingham Community Health Profiles
- Office for Health Improvement and Disparities (OHID)
- Fingertips/ Public Health Outcomes Framework
- Birmingham City Observatory/ Census 2021 data.

2.3.3 QUALITATIVE EVIDENCE REVIEW

The project has also collated qualitative evidence and intelligence from across the wider stakeholder group and local publications, which included:

- 'Seldom Heard conversations about pregnancy', a series of targeted focus group conversations about pregnancy which engaged stakeholders from Children Centres, voluntary sector organisations focused on supporting families and specific ethnic groups and Birmingham First Steps to collect anecdotal evidence from Birmingham's female population and their experience of maternal services.
- 'Maternity Services in Birmingham: The experiences of Black African and Black Caribbean women', a report which explores the experiences of 26 women from Black African and Black Caribbean backgrounds told us about variability and inequality in maternity services in West Birmingham.
- 'The Labyrinth Project', which maps service provision and builds local capacity for service providers who support victims of gender-based violence in Birmingham.
- Commissioners and providers of relevant public health and health services.

Their views and experiences within the local healthcare system were factored in to extract key issues of concern where there are clear gaps in the data.

2.4 STAKEHOLDER ENGAGEMENT

The evidence gathered during the rapid evidence assessment was consolidated into a briefing report to summarise priority areas to address women's health inequalities in Birmingham.

Following on from the stakeholder mapping and engagement as part of the evidence collation and analysis, a working group was established to review and consider the findings from the data and evidence reviews and identify opportunities for action to address the key issues and gaps for women's health in Birmingham.

The group invited stakeholders with a special interest in women's health and health inequalities from the following organisations:

- Birmingham Public Health Adult Services (incl. sexual health)
- Third sector partners delivering women's health and wellbeing interventions, including Ashiana Community Project, She Beasts, Flourish
- Office for Health Improvement & Disparities (OHID)
- Primary Care, including the GP Modality Partnership
- Birmingham and Solihull Integrated Care Board
- University Hospital Birmingham NHS Trust
- Birmingham Women's & Children's NHS Foundation Trust.

3. OVERVIEW OF BIRMINGHAM'S FEMALE POPULATION

Birmingham has an estimated population of 1.145 million people, of these 51.05% are female and 48.95% are male.[6] ONS data shows that gender distribution between males and females is relatively equal city-wide and at the ward level. Birmingham's total gender split is 51.1% female and 48.9% male.[7] As demonstrated in Table 2, the city's gender distribution remains relatively the same at the constituency level.

Table 2. Birmingham gender distribution by constituency, ONS data, Census 2021 [8]

CONSTITUENCY	FEMALE (%)	MALE (%)
Birmingham Edgbaston	51.2	48.8
Birmingham Erdington	51.4	48.6
Birmingham Hall Green and Moseley	50.3	49.7
Birmingham Hodge Hill and Solihull North	51.6	48.4
Birmingham Ladywood	50.0	50.0
Birmingham Northfield	52.3	47.7
Birmingham Perry Barr	50.2	49.8
Birmingham Selly Oak	52.0	48.0
Birmingham Yardley	50.8	49.2
Sutton Coldfield	51.5	48.5

Census 2021 data estimates that there are approximately 28,804 residents in the city who identify as lesbian, gay, bisexual, queer and all other (non-heterosexual) sexual orientations.[9] Approximately 7,826 residents in the city identify as a gender different than that assigned at birth, 1,327 identifying as trans women.[10] However, there is very limited national, regional, or local quantitative data on the population of trans/non-binary groups, so it is believed these numbers may be underestimated.

The Census 2021 data also shows that ethnic communities make up 51.4% of the city's population. Of the 11 core cities in the UK, Birmingham has the highest percentage of residents from ethnic communities outside of London.[11] Table 3 presents the ethnic composition of female populations in Birmingham's 10 parliamentary constituencies, in half of which majority of women represent ethnicities other than White British.

Using census 2021 datasets, Table 3 (on the following page) provides an overview of the racial composition of women in each constituency. Birmingham's female population by race as a percentage of the total female population in each constituency, highlighting the differences in geographic distribution between women of different racial groups. These categories are further expanded by ethnicity in Table 4.

Table 3. Birmingham's female population by constituency and race. Source: ONS Census Data 2021.[12]

	RACE				
CONSTITUENCY	ASIAN / ASIAN BRITISH	BLACK, BLACK BRITISH, AFTRICAN OR CARIBBEAN	MIXED OR MULTIPLE ETHNIC GROUPS	WHITE	OTHER ETHNIC GROUPS
Edgbaston	22.7%	11.7%	5.9%	54.6%	5.1%
Erdington	15.1%	13.8%	5.9%	62.9%	2.3%
Hall Green & Moseley	54.4%	5.9%	3.9%	29.5%	6.4%
Hodge Hill & Solihull North	33.5%	8.2%	5.0%	50.0%	3.4%
Ladywood	41.1%	25.1%	5.1%	20.7%	8.0%
Northfield	6.2%	8.0%	6.0%	77.7%	2.1%
Perry Barr	52.8%	17.5%	3.9%	21.1%	4.7%
Selly Oak	16.3%	6.5%	5.5%	68.8%	2.8%
Yardley	40.7%	6.6%	4.2%	44.0%	4.5%
Sutton Coldfield	10.7%	2.9%	3.4%	81.4%	1.7%

Figure 4. Map of Parliamentary constituencies in Birmingham

Table 4. Distribution of Birmingham's female population - ethnic analysis by constituency. Source: ONS Census Data 2021.[13]

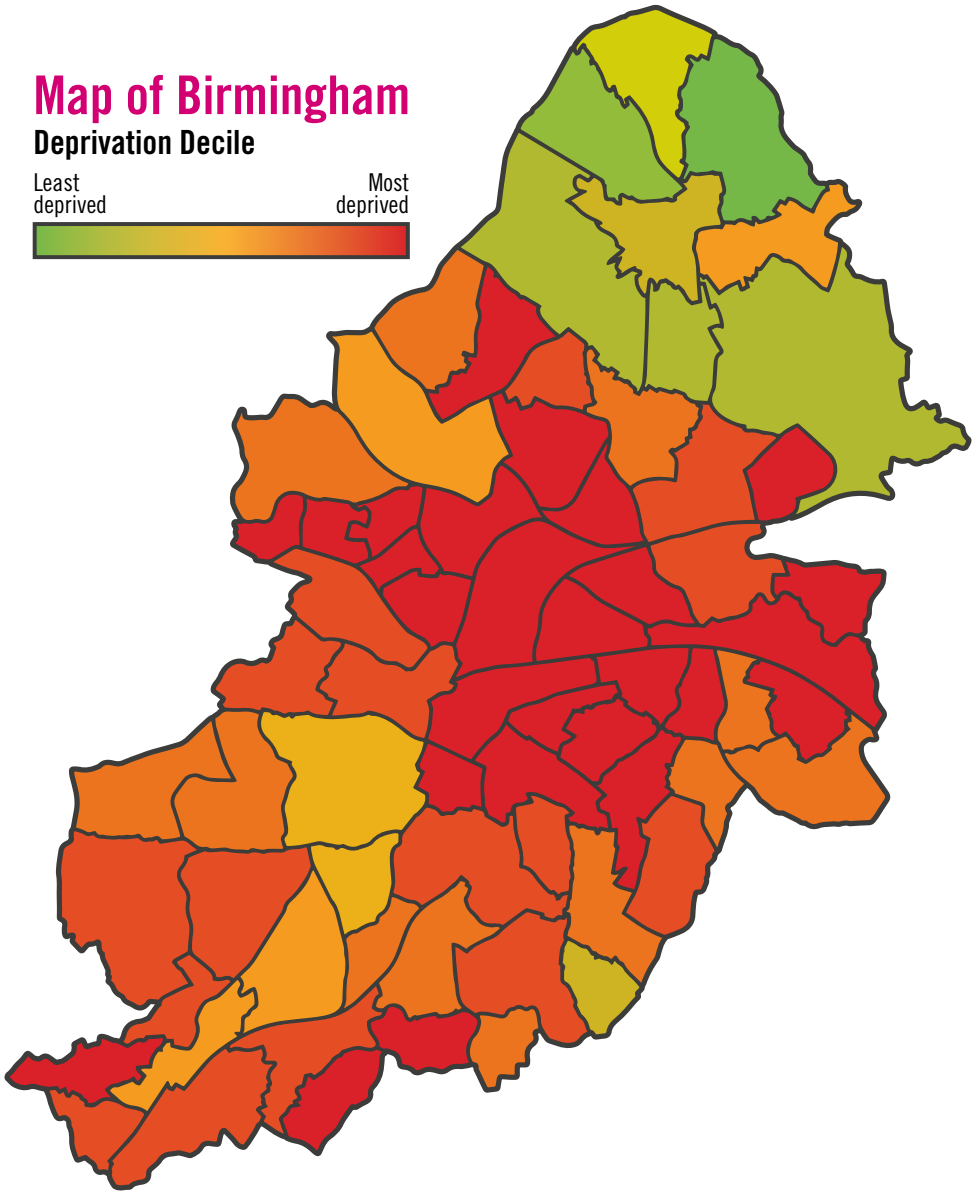
ETHNICITY	EDGBASTON	ERDINGTON	HALL GREEN AND MOSELEY	HODGE HILL & SOLIHULL NORTH	LADYWOOD	NORTHFIELD	PERRY BARR	SELLY OAK	YARDLEY	SUTTON COLDFIELD
Bangladeshi	1.0	1.7	5.1	2.8	5.9	0.4	13.7	1.3	6.8	0.5
Chinese	2.2	0.8	0.5	0.3	2.5	1.0	0.5	2.0	0.3	1.1
Indian	8.9	3.0	6.9	1.2	5.3	1.6	16.0	4.1	3.8	5.9
Pakistani	7.5	7.8	38.7	25.9	23.3	1.6	19.4	7.0	26.8	2.1
Other Asian	3.2	1.7	3.2	3.3	4.0	1.6	3.2	2.0	3.0	1.1
African	6.4	5.0	3.2	4.5	16.6	4.0	6.8	3.2	3.8	0.9
Caribbean	4.1	7.0	2.1	2.7	6.5	2.8	8.6	2.6	2.1	1.5
Other Black	1.3	1.8	0.6	1.0	2.1	1.2	2.1	0.7	0.6	0.4
Mixed White & Asian	1.3	1.0	1.3	1.1	1.1	1.1	0.9	1.4	1.2	1.0
Mixed White & Black African	0.8	0.5	0.3	0.3	0.6	0.5	0.3	0.4	0.3	0.2
Mixed White & Black Caribbean	2.4	3.3	1.2	2.7	1.9	3.3	1.7	2.5	1.7	1.6
Mixed Other	1.4	1.1	1.1	0.8	1.4	1.1	1.0	1.2	0.9	0.7
English, Welsh, Scottish, Northern Irish or British	46.9	54.7	24.2	46.2	13.9	73.1	16.4	62.4	38.5	76.7
Irish	1.5	2.0	1.9	1.0	0.7	1.6	0.7	2.3	1.9	1.9
Gypsy or Irish Traveller	0.0	0.1	0.0	0.1	0.1	0.0	0.1	0.0	0.1	0.0
Roma	0.2	0.1	0.1	0.2	0.3	0.1	0.2	0.1	0.1	0.0
Other White	6.0	6.0	3.2	2.5	5.7	3.0	3.8	4.0	3.4	2.7
Arab	1.8	0.7	3.4	0.9	3.5	0.7	0.7	1.1	1.7	0.4
Any other ethnic group	3.3	1.6	3.0	2.4	4.4	1.4	4.0	1.7	2.8	1.3
TOTAL	100	100	100	100	100	100	100	100	100	100

Table 5. Distribution of Birmingham's female population by constituency: depravation and ethnicity. Source: Census 2021; ONS IMD Data 2019.

RANK	CONSTITUENCY	IMD DECILE	LARGEST RACIAL GROUP (FEMALE)	TOP 3 LARGEST ETHNIC GROUPS (FEMALE)		
1	Hodge Hill	1	Asian / Asian British (55.1%)	Pakistani (43.0%)	White English (22.7%)	African (6.7%)
2	Ladywood	1	Asian / Asian British (38.9%)	African (17.2%)	Pakistani (15.5%)	White English (14.3%)
3	Erdington	1	White (61.6%)	English (53.0%)	Pakistani (8.4%)	Caribbean (7.1%)
4	Hall green	2	Asian / Asian British (54.0%)	Pakistani (38.7%)	White English (22.7%)	Indian (6.7%)
5	Yardley	2	White (50.2%)	White English (44.2%)	Pakistani (22.3%)	Bangladeshi (5.2%)
6	Northfield	2	White (78.0%)	White English (73.5%)	African (3.9%)	Mixed - White & Black Caribbean (3.3%)
7	Perry Barr	2	Asian / Asian British (43.1%)	White English (26.8%)	Pakistani (15.3%)	Indian (15.0%)
8	Edgbaston	3	White (58.6%)	White English (50.9%)	Indian (8.4%)	Other White (6.0%)
9	Selly Oak	3	White (68.9%)	White English (62.5%)	Pakistani (6.9%)	Indian (4.2%)
10	Sutton Coldfield	7	White (81.4%)	White English (76.7%)	Indian (5.9%)	Other White (2.7%)

Poor health disproportionately affects those experiencing poverty and social exclusion. Forty three percent of the population living in LSOAS1 in Birmingham are in the ten percent most deprived areas in England. Birmingham is the 7th most deprived local authority in England and the 3rd most deprived English Core City.[14] Deprivation is most heavily clustered around the city centre as illustrated in Figure 5. Hodge Hill is the most deprived constituency in Birmingham followed by Ladywood and Erdington. The largest female populations in these constituencies are of Pakistani, White English, African and Caribbean ethnic origin.

Figure 5. Map of Birmingham, Deprivation Decile. Source: Birmingham City Observatory, 2021.



4. BIRMINGHAM WOMEN'S HEALTH NEEDS

Office for Health Improvement and Disparities (OHID) data highlights that there are disparities between Birmingham's female population compared to the rest of England. Across several indexes, women in Birmingham experience poorer health outcomes than women nationally. These include lower life expectancy at birth[15]; higher under 75 mortality rates from all causes[16]; higher rates of obesity in early pregnancy[17] and higher mortality rates from drug misuse[18].

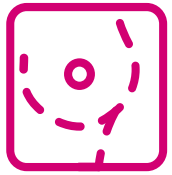
Birmingham is a super-diverse city and has an estimated population of 1.145 million people, of whom 51.05% are female (Census 2021)

Life expectancy and mortality

- Women in Birmingham have a healthy life expectancy which is 3.7 years less than the national average (OHID, 2020)
- Except for Covid in 2020-21, the causes of most deaths in females are circulatory, respiratory and cancer (OHID, 2021)

Cancer

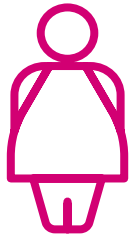
- 17.7% more women under 75 died from cancer in Birmingham compared to England (OHID, 2022)
- Cervical cancer screening coverage for 25–29-year-olds is 9.2% lower for Birmingham than the whole of England (OHID, 2023)



- Birmingham has the worst breast cancer screening coverage in the region at 56.3% compared to England's 66.2% (OHID, 2023)
- Asian, Caribbean and African women have higher rates of not attending cervical screening appointments (PHE, 2020)

Cardiovascular health

- It is estimated that there are more than 800,000 women in the UK living with coronary heart disease, 14,000 of which might be living in Birmingham (BHF, 2019)
- A woman is 50% more likely than a man to receive the wrong initial diagnosis for heart attack (BHF, 2019)
- Between 2017-2019, 32% more women under 75 died from all cardiovascular diseases in Birmingham compared to women nationally. 38.4% of these deaths were considered preventable (OHID, 2020)



Obesity

- Obesity prevalence for Birmingham's Asian women is increasing (NHS Health Checks, 2023)
- Black women in the most deprived areas of the city have the highest prevalence of obesity at 67.4% (NHS Health Checks, 2023)

Mental Health

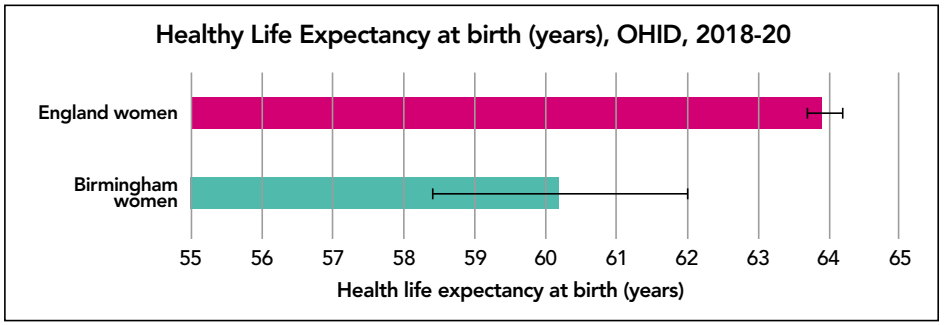
- Women between the ages of 16 and 24 are almost three times as likely to experience a common mental health issue as males of the same age (MHF, 2017)
- Women are twice as likely to be diagnosed with anxiety as men (MHF, 2017)
- Women are more than three times as likely to experience eating disorders than men (MHF, 2017)
- Young women are three times more likely than young men to experience post-traumatic stress disorder (MHF, 2017)

The following sub-sections explore key differences in health outcomes impacting life expectancy and quality of life for Birmingham's female population based on findings from the data and evidence reviews carried out as part of this project. As this phase of the project is underpinned by the objectives and ambitions of the National Women's Health Strategy, the data narrowly focuses on health outcomes for women in Birmingham and benchmarks them against the national average for women in England to understand where there is a need for greater intervention for Birmingham's female population.

4.1 LIFE EXPECTANCY AND MORTALITY

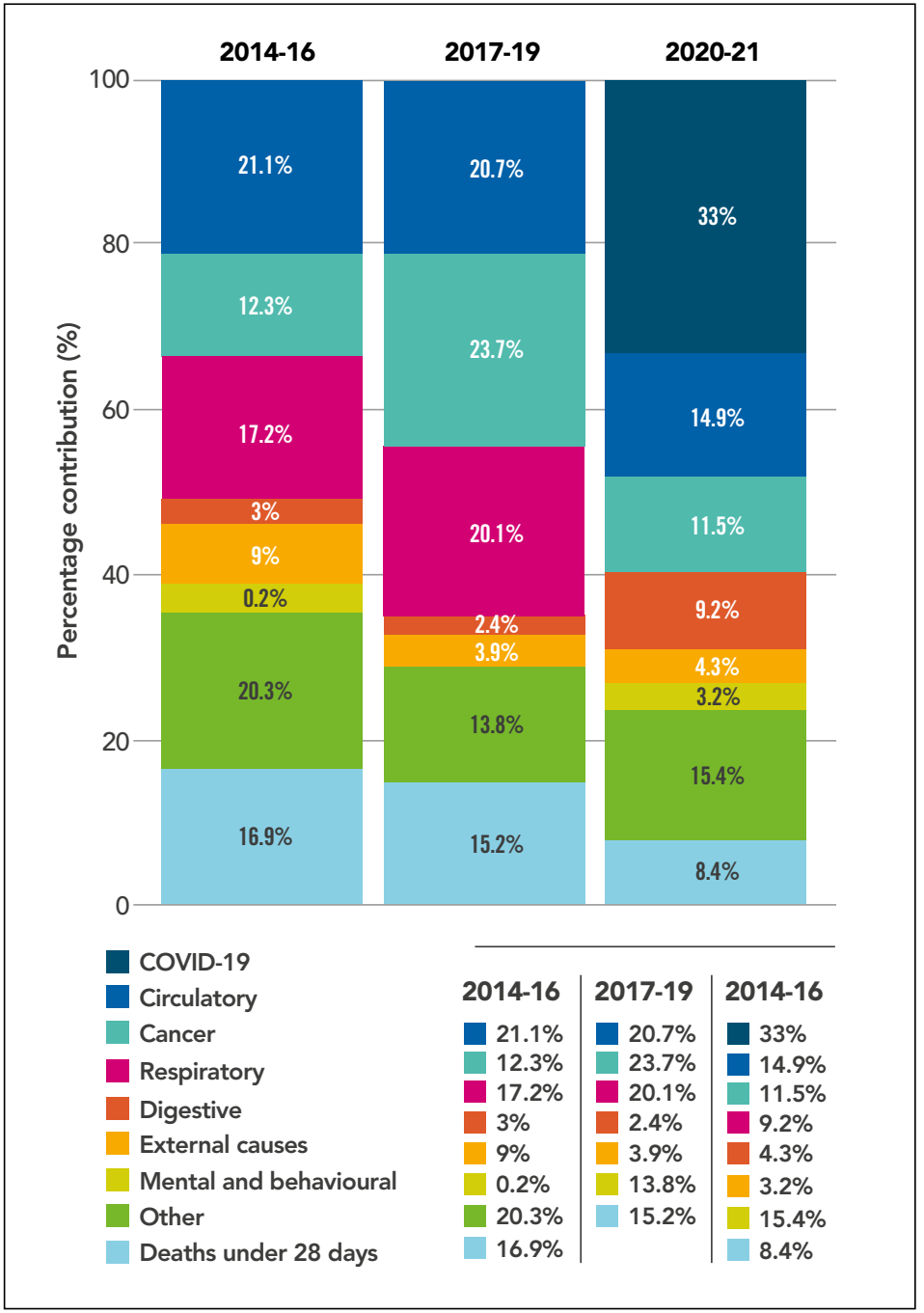
Poorer health outcomes for women in Birmingham are evidenced across the life course, and this is shown both by lower life expectancy at birth and higher under 75 mortality rates. On average, women in Birmingham have a healthy life expectancy which is 3.7 fewer years than the national average[19].

Figure 6. Healthy Life Expectancy at Birth (years) in Birmingham compared to England. Source: OHID, 2020



In 2017-2019, the mortality rate of women under 75 in Birmingham was 18% higher than the rest of England. This mortality rate focuses on all deaths for all causes which were considered preventable[20] and extends to preventable instances of diseases such as cardiovascular disease (CVD) and coronary heart disease (CHD). The OHID chart[21] overleaf provides a breakdown of causes and drivers of premature mortality for women in Birmingham between 2014 to 2021.

Figure 7. Cause of death for Birmingham women 2014 – 2021. Source: OHID, 2021



4.1.1 PREMATURE MORTALITY, INTERSECTIONALITY, AND SOCIO-ECONOMIC FACTORS

Graham's (2007) model of the social determinants of health[22] considers other aspects of social position for understanding population health, premature mortality, and health inequalities. These factors include ethnicity, sexual orientation, class, occupation, cultural norms, and disability.

The COVID-19 pandemic highlighted the importance of understanding health inequalities from an intersectional lens, evidenced by the disproportionate impact on most ethnic communities[23], including Bangladeshi women in the UK. COVID-19 death was two times more likely in Bangladeshi women during the second wave compared to people of White British ethnicity.[24]

Geographical and social-demographic factors explained more than half of the difference in COVID-19 mortality risk including higher rates of overcrowding in Bangladeshi households, lower levels of physical activity in women due to socio-cultural norms and a higher percentage of Bangladeshis in Birmingham living in areas classified as the 20% most deprived areas in Birmingham[25,26]. They experienced higher infection and mortality rates than the White population, largely due to differences in location, occupation, deprivation, living arrangements and health conditions such as CVD and diabetes.[27] It is therefore important to consider health disparities affecting women in the wider context of their intersectionality.

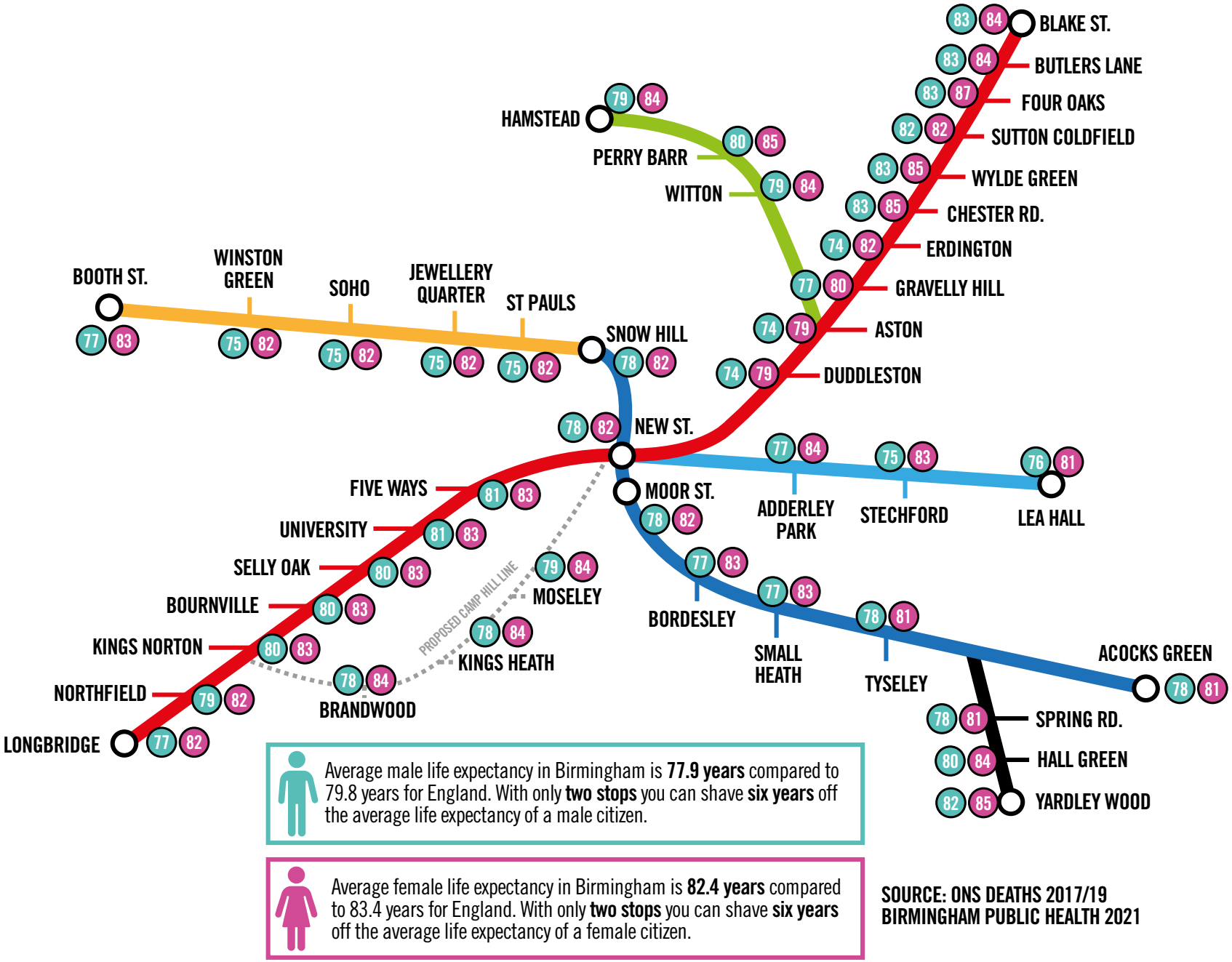
Similarly, such disparities driven by wider determinants of health are also common for Black and other ethnic communities in Birmingham, as evidenced by the Birmingham and Lewisham African Caribbean Health Inequalities Review (BLACHIR)[28] and other Asian and African communities' health profiles.[29]

There are strong links between life expectancy and poverty and social exclusion. The mean age at death for homeless females in 2019 was 43.4 years compared to the general female population of England and Wales at 80.9 years.[30] This stark inequality indicates the need for support of highly vulnerable female populations.

The role of place when measuring gender health inequality is important to consider in the context of levels of deprivation present in the area, as the evidence suggests women who live in more deprived parts of the city have worse health outcomes than those living in more affluent areas.

The following diagram extracted from the Birmingham Health and Wellbeing Strategy demonstrates the link between locality, index of multiple deprivation and life expectancy by Birmingham Railway Stations. As illustrated in Figure 8, Five Ways Railway Station and Aston Railway Station are only 4 stops and 3.5 miles apart, but the average life expectancy is reduced by 4 years for female residents in Aston.[31] Aston is in the top 10% of most deprived areas nationally, ranked 13 out of 69 most deprived wards in the city. This contrasts with Edgbaston (where Five Ways is located), which is ranked 61 out of 69 and is one of the least deprived areas in the city.[32]

Figure 8: Life expectancy at birth by Birmingham railway stations. Source: Birmingham Public Health, 2021[33]



4.2 CANCER

4.2.1 KEY FINDINGS

Cancer mortality

Between 2020-22, 17.7% more women under 75 died from all types of cancer in Birmingham (45.1 per 100,000 population) compared to the national figures (38.3 per 100,000 population). These deaths were considered preventable; and compared to males, whose outcomes in Birmingham are also significantly worse than in England, the gap is bigger for females by 2.1%.[34]

Figure 9. Under 75 mortality rate from cancer considered preventable (Birmingham females). Source: OHID, 2022

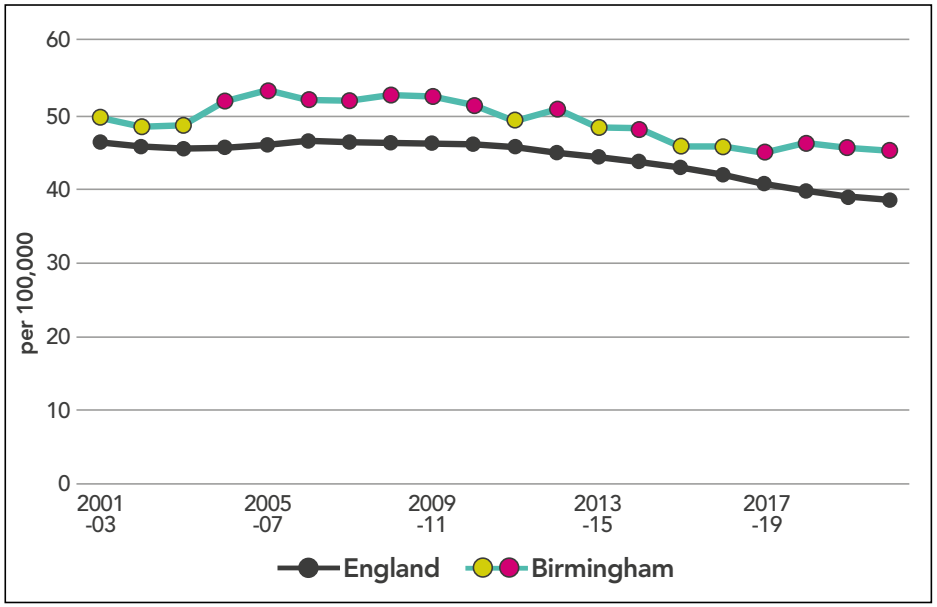
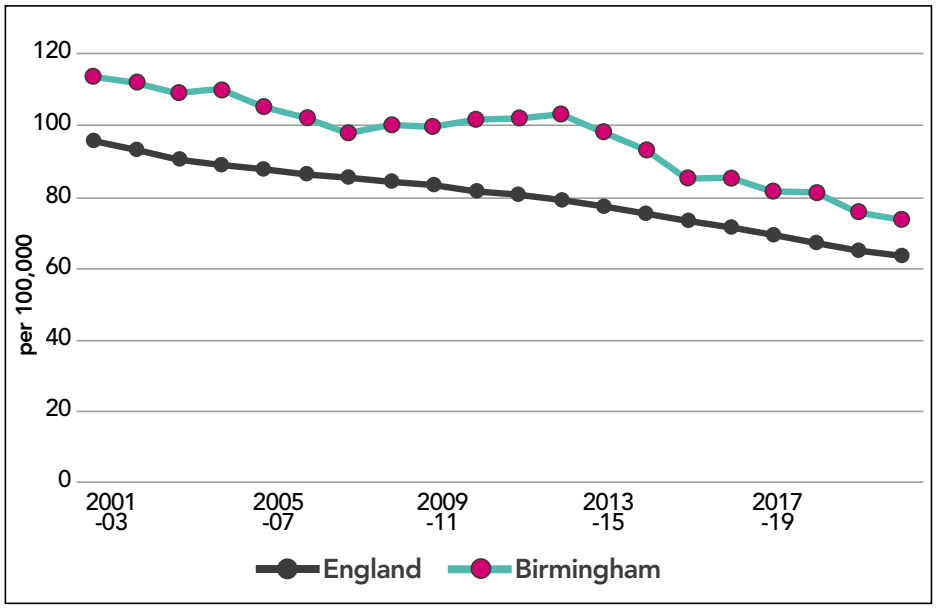


Figure 10. Under 75 mortality rate from cancer considered preventable (Birmingham males). Source: OHID, 2022



Patient satisfaction

There is evidence that for many aspects of their care, female cancer patients in Birmingham and Solihull demonstrated lower levels of satisfaction than the average levels of satisfaction for cancer patients in England.[35] This may be impacting on cancer screening coverage, prevention and early detection for women who are eligible.

Cervical cancer screening

For both age groups: 25-49 years and 50-64 years, the coverage of cervical cancer screening for Birmingham women is significantly lower than for women in England. Cervical cancer screening coverage is 9.2% and 4.4% lower for Birmingham than the whole of England for 25–29-year-olds and 50–64-year-olds respectively.[36]

Figure 11. Cervical cancer screening coverage (age 25 to 49 years) for Birmingham. Source: OHID, 2023

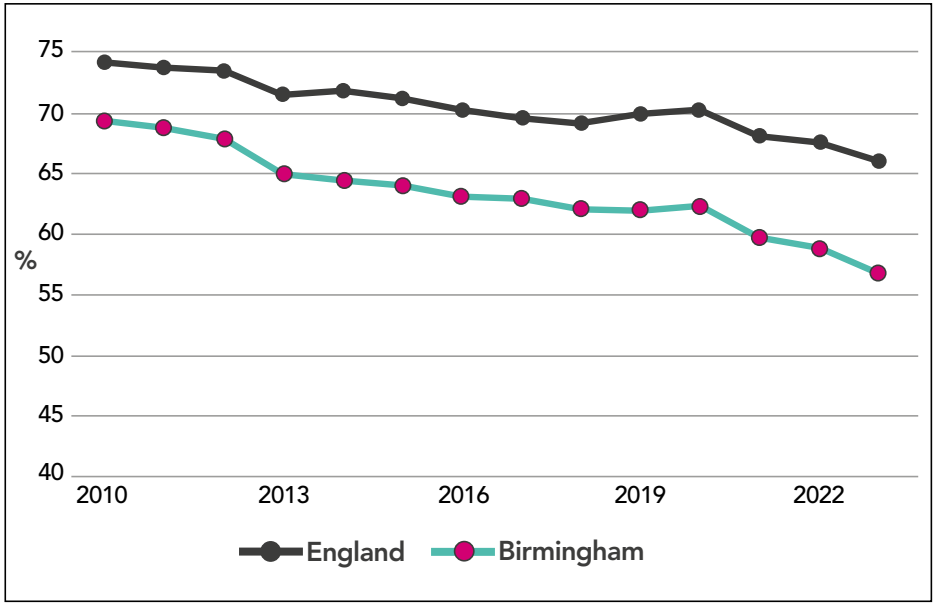
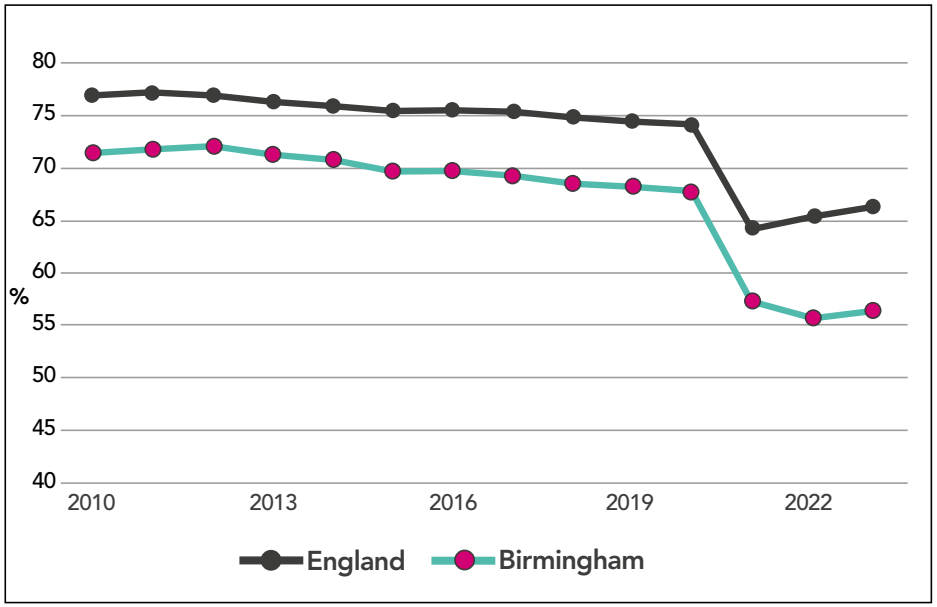


Figure 12. Breast cancer screening coverage for Birmingham. Source: OHID, 2023



Breast cancer screening

Breast cancer screening coverage is significantly worse for the West Midlands (65.5%) compared to England (66.2%) and Birmingham has the worst coverage in the region (56.3%).[37]

Ethnicity

Women from ethnic communities report high rates of non-attendance at cervical cancer screenings. Bangladeshi women had the highest rate of not attending cancer screening (70.6%) compared to all minority ethnic groups followed by Indian women (66%), Caribbean women (62.1%), Pakistani women (61%) and African women (44%).[38]

Studies found that 30% of Asian women do not understand what cervical screening is, and there is a higher non-attendance rate for cervical cancer screening amongst South Asian women in comparison to White women[39], extending to 12.86 for Bangladeshi women, and 10.69 for Indian women.[40]

Disability

Literature highlights that women with disabilities experience barriers in accessing preventative cancer care. A study from 2022 showed that in the UK, women with disabilities are 36% less likely to attend breast cancer screening and 25% less likely to attend bowel cancer screening when compared to women without disabilities.[41] The evidence from local community health profiles[42], BLACHIR[43] and women's health complementary review indicate that cultural barriers, stigmas, and misconceptions are still impacting the uptake for some of the cancer screening programmes.

The evidence further suggests that women experiencing multiple barriers, which can include ethnic minority background and disability are the least likely to attend screening.

4.2.2 CONCLUSIONS

Despite higher incidences of cancer-related deaths than the national average, cancer screening for women in Birmingham is lower than the national rates. National trends highlight that specific ethnic communities, in particular South Asians, are disproportionately represented in non-attendance rates for breast and cervical cancer screening. There is a need to evaluate and improve cancer screening programs, ensuring the approaches are more inclusive and intersectional, to prevent avoidable morbidity and mortality. Targeted culturally sensitive interventions which improve access to and information about these services, are likely to improve the uptake of female-specific cancer screening.[44]

4.2.3 RECOMMENDATIONS

1. Birmingham & Solihull Integrated Care System (BSol ICS) to continue to routinely collect, monitor and publish data on female cancer patient satisfaction with health care and use it effectively to improve quality of care.
2. BSol ICS to develop a whole system approach to improving recording of attendance in cancer screenings to ensure that sex, gender, disability, ethnicity, and locality are captured. This will help inform targeted approaches to improve cancer screening coverage.
3. NHS England supported by local ICS and Public Health to develop culturally sensitive targeted campaigns to promote breast, cervical and other cancer screenings within the target populations/ communities to improve early diagnosis and reduce mortality.
4. NHS England to produce a series of accessible and culturally appropriate resources and literature to increase awareness of the importance of cancer screening and the improved service offer for ethnic communities.

4.3 CARDIOVASCULAR DISEASE (CVD) AND CORONARY HEART DISEASE (CHD)

4.3.1 KEY FINDINGS

Health literacy

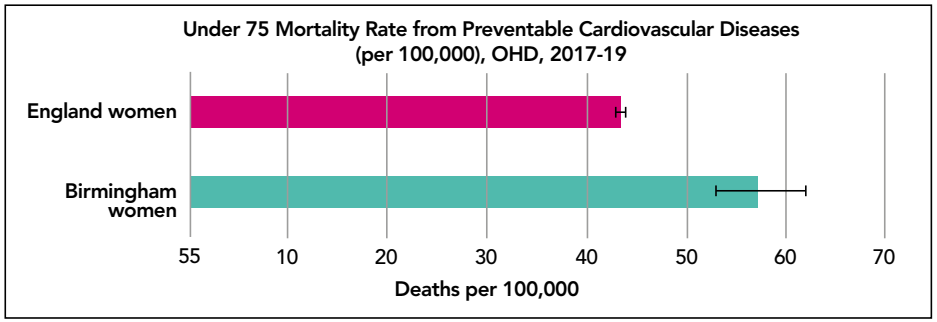
The European Society of Cardiology (2018) published report with findings on the link between increased morbidity, premature death, and CHD prevention. It found that in general, low health literacy is associated with less participation in health promotion and disease detection activities, risky health behaviours and poorer management of chronic diseases.[45] Furthermore, a 2016 systematic review on the linkages between health literacy and clinical outcomes in patients with CHD found significant associations of low health literacy with higher age, non-white ethnic groups, lower educational level, and lower income.[46] It can therefore be assumed that low awareness and poor health literacy are also associated with higher risk and poor health outcomes related to CHD.

These findings correspond with a Danish, large population-based study conducted in 2017 in patients with CVD, which has shown that low health literacy is significantly associated with risky health behaviours.

CVD mortality

Even though gender does not seem to be a risk factor for female populations affected by CVD, as significantly more men die of the disease compared to women, Birmingham women are more affected compared to women in England. Between 2017-2019, 32% more women under 75 died from all cardiovascular diseases in Birmingham compared to women nationally. 38.4% of these deaths were considered preventable.[47]

Figure 13. Under 75 mortality rate for cardiovascular diseases considered preventable: Birmingham women. Source: OHID, 2019.



CHD prevalence and mortality

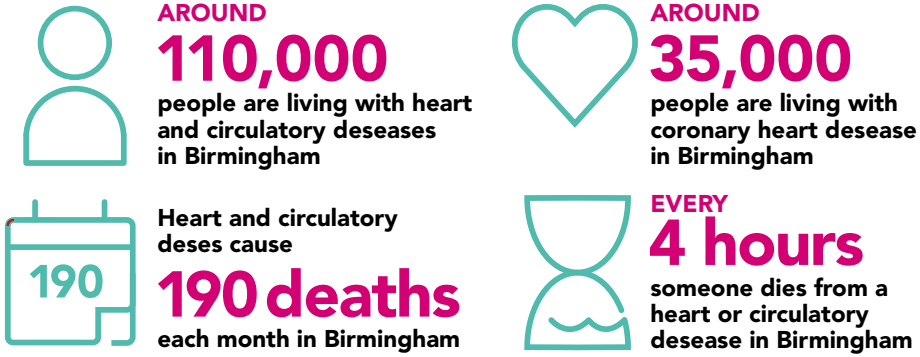
The Quality and Outcomes Framework (QOF) prevalence (of all ages) for CHD in 2021/22 was 2.6% in Birmingham and 3.0% in Solihull and England. The rate does not take into account the age and sex distribution of the population.

However, there is sufficient evidence identifying CHD as the single most common cause of premature death in the UK. Across Birmingham, CHD is the main cause of early death with almost 3,200 excess years of life lost between 2014-2016.[48]

The research evidence relating to the management of CHD is well established and if implemented can reduce the risk of death from CHD and improve the quality of life for patients.[49] This may be resulting in the slowly decreasing recent trend for CHD prevalence both nationally and in Birmingham, where the outcomes are slightly better than England's even though, CHD remains one of the biggest killers for both men and women.[50]

CHD, the main cause of heart attacks, kills more than twice as many women as breast cancer in the UK every year and it is estimated that there are more than 800,000 women in the UK living with coronary heart disease.[51] If we applied this statistic to Birmingham, the number of women living with CHD in the city would be nearly 14,000.

The most recent statistics from the British Heart Foundation (BHF, 2023) show that heart and circulatory diseases kill nearly 1 in 4 people in Birmingham.[52]



Gender as a CHD risk factor

Coronary heart disease (CHD) is the leading cause of death (LCOD) for women worldwide, and the third cause of death for women in the United Kingdom (UK).[53]

According to the British Heart Foundation, there is a widespread misperception amongst women that CHD predominantly impacts men, and this is linked to under-diagnosis. A woman is 50% more likely than a man to receive the wrong initial diagnosis for heart attack and women have less awareness of the symptoms of heart attack, which puts them at a greater risk of seeking treatment too late.[54]

Birmingham and Solihull ICB are working to improve general literacy around CHD and CVD which may reduce this inequality. The Healthy Heart website[55] and Million Hearts programme are used to engage and communicate about available services and resources.

Ethnicity as a CHD risk factor

Additionally, ethnicity is recognised as a risk factor for developing coronary heart disease.[56] BHF-funded research has shown that Black Africans, Black Caribbeans and South Asians in the UK are at higher risk of developing high blood pressure or type 2 diabetes compared with White Europeans. This correlates with the risk of developing CHD.[57]

Given the size and diversity of Birmingham's population understanding the relationship between deprivation, gender, ethnicity, and lifestyle-related risk factors is both complex and important in reducing the risk of CHD and CVD premature mortality rates in women. This is explored further in section 4.4.

4.3.2 CONCLUSIONS

Women in Birmingham are more likely to die from CVD than women in England and almost 40% of these deaths are considered preventable.[58] CHD is one of the main causes of early death in Birmingham and is linked to under-diagnosis in women, which puts them at a greater risk of heart attack and death. The risks are even higher for those from Black African, Black Caribbean and Asian ethnic groups.[59] It is assumed that low health literacy is linked to poorer health outcomes associated with CHD.[60]

4.3.3 RECOMMENDATIONS

5. BSol ICS and Public Health to develop awareness campaigns for women and primary care providers/ practitioners to raise awareness of CHD/CVD risks in women and improve early detection and diagnosis.

4.4 LIFESTYLE AND PREVENTABLE RISK FACTORS

To identify key areas of intervention to improve health outcomes and reduce under 75 mortality rates for women in Birmingham, the following measurable lifestyle and preventable risk factors have been explored:

- obesity
- alcohol consumption
- physical inactivity
- smoking.

This section examines evidence collected through optional health checks delivered in Birmingham, although the project acknowledges there is wider analysis of specific health behaviours and risk factors that identifies gender inequalities in the Birmingham Physical Activity Needs Assessment and the Million Hearts Programme Needs Assessment. The NHS Health Checks (HC) programme within Birmingham is one of the mandated public health services commissioned by Birmingham City Council.

More specifically, the data examined here has been drawn from the 5-year NHS health checks (HCs) rolling dashboard where checks were completed between June 2018 and June 2023, with data recorded from 108,514 patients.[61]

As health checks are an optional programme targeted at 40-74 year-olds, we cannot assume the outcomes reflect the needs of the total population. However, the health check data can provide a level of understanding of gender and ethnic differences in lifestyles and preventable risk factors.

4.4.1 KEY FINDINGS

Obesity

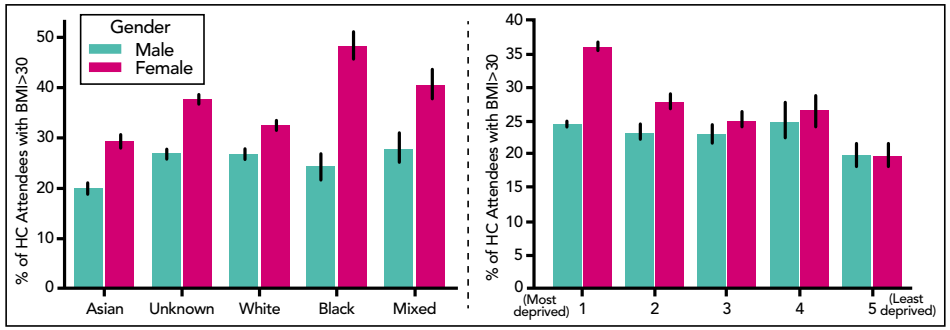
The terms 'overweight' and 'obesity' are used to describe excess body fat. Obesity poses an increased risk of developing (or exacerbating) several chronic diseases and conditions, including type 2 diabetes, coronary heart disease, hypertension, and stroke.

As with other risk factors, there are inequalities in adult obesity prevalence by age and deprivation. In the West Midlands region, the percentage of adults who were overweight or obese has increased from 64.2% in 2015/16 to 66.2% in 2021/22, significantly higher than the England average of 63.8% for 2021/22.[62]

The Health Profile for England reported that in 2019 the prevalence of obesity was lowest in those aged under 25 with a gradual increase by age group up to ages 65 to 75 after which the prevalence decreased. This pattern was seen for both males and females. The limitations in data on adult obesity for localities make it difficult to gauge a better understanding of specific risk factors in Birmingham's female population.

From the 2018-2023 Birmingham health check data, the percentage of male and female HC attendees found to have a BMI in the obese range are shown in the graphs below as a function of ethnicity (left) and IMD (right). It shows that women tend to have much higher rates of obesity than men, with Black women and those living in the most deprived areas experiencing the highest rates. Here obesity is defined as having a BMI greater than 30 for all ethnic groups. Under this definition of obesity, the Asian HC attendees had the lowest rates of obesity.

Figure 14: IMD-ethnicity obesity prevalence in Birmingham between 2018-2023. Source: NHS Health Checks, 2023.



However, according to NICE guidance on obesity, people with a South Asian, Chinese, other Asian, Middle Eastern, Black African, or African-Caribbean family background are prone to central adiposity and their cardiometabolic risk occurs at a lower BMI, so healthcare providers should use lower BMI thresholds as a practical measure of overweight and obesity: overweight: BMI 23 kg/m2 to 27.4 kg/m2 and obesity: BMI 27.5 kg/m2 or above.[63]

Using the NICE obesity definition, the prevalence of obesity amongst Asian health check attendees would therefore be higher, as indicated below in Figure 15. When looking at obesity prevalence across ethnicity and IMD for female (left) and male (right) HC attendees, it becomes clear that the obesity prevalence for Asian women in the most deprived area has increased from 32.6% to 49.7% and for Asian men - from 20.8% to 40.3%. Black women in the most deprived quintile still have the highest prevalence of obesity at 67.4% under the NICE definition.

Figure 15: IMD-ethnicity obesity prevalence (updated threshold) in Birmingham between 2018-2023. Source: NHS Health Check, 2023

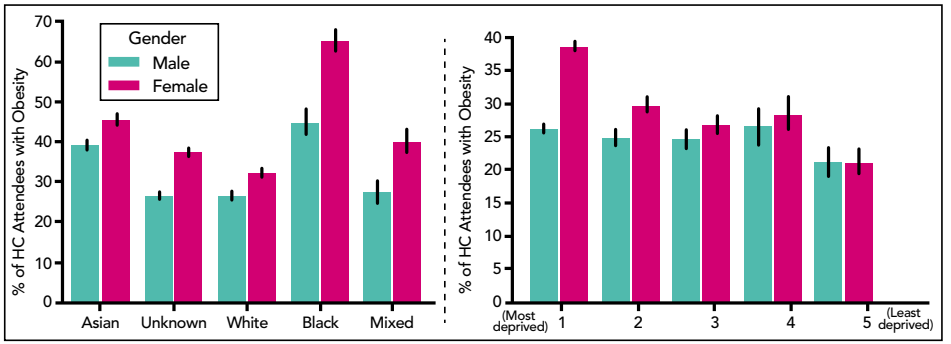


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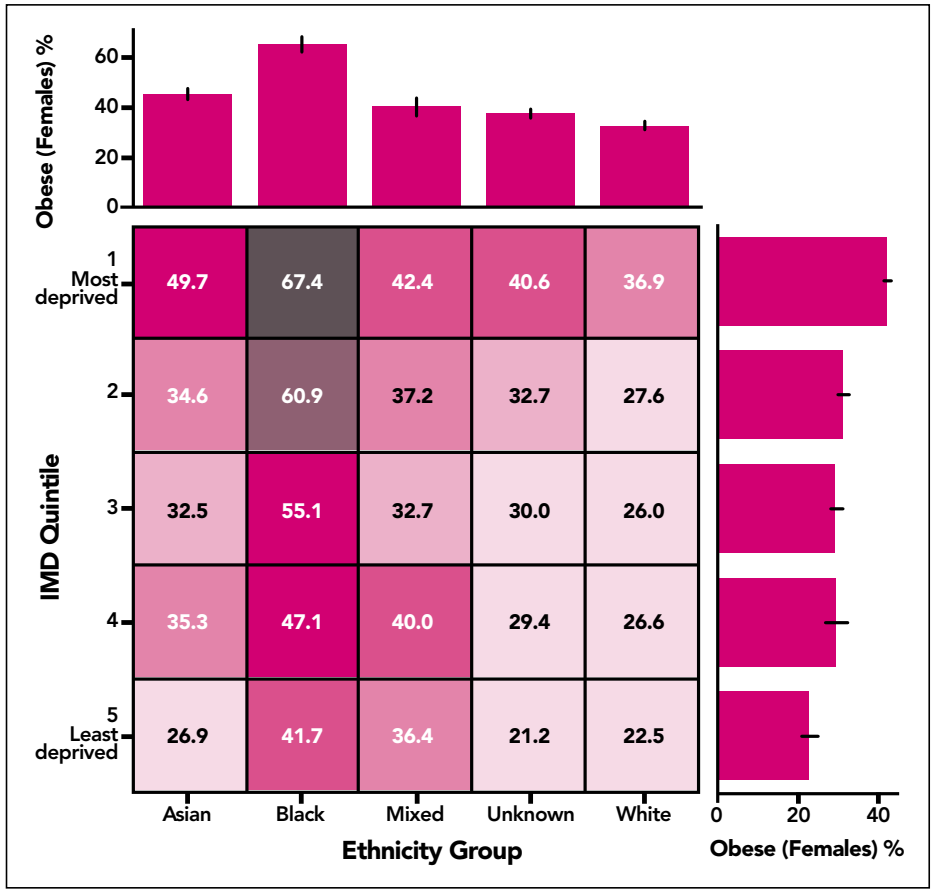
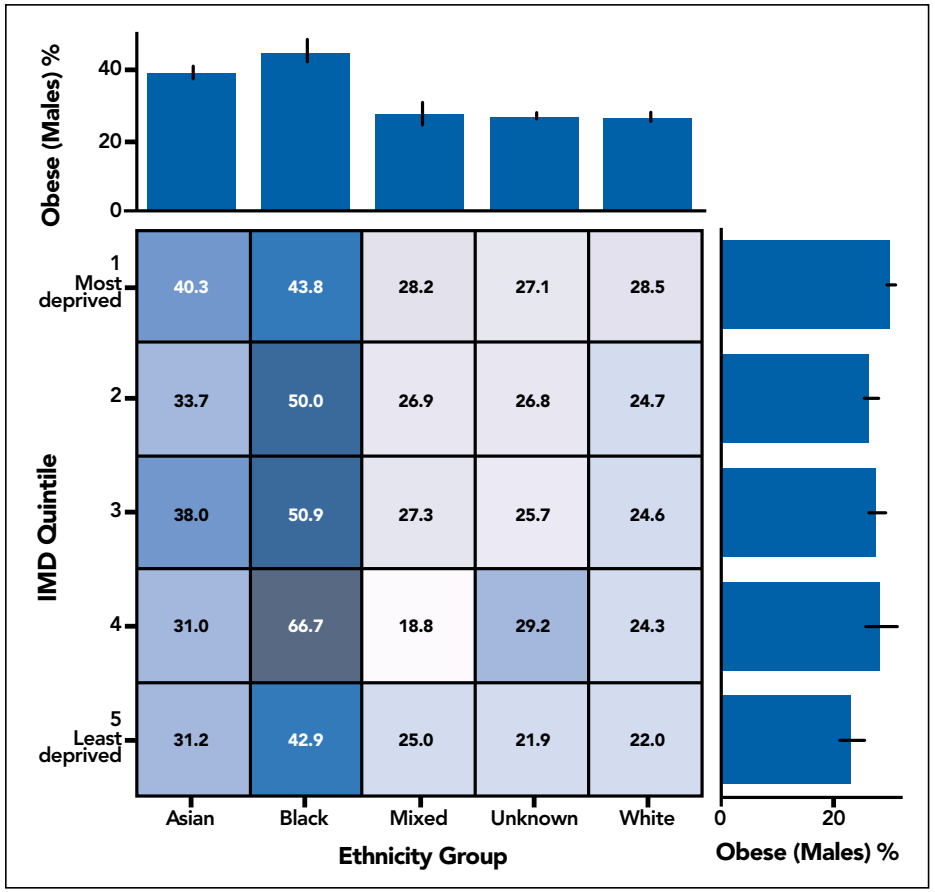
Figure 16. IMD-ethnicity obesity prevalence matrices (updated threshold) in Birmingham between 2018-2023. Source: NHS Health Check, 2023





Interestingly, data from the NHS 2015 Health Survey for England[64] showed that obesity was generally more prevalent in the Midlands than in the South of England, and that men were more likely to be overweight or obese than women (68% of men compared with 58% of women), but women were more likely to be morbidly obese (3.6% of women compared to 2.2% of men).

According to evidence within the OECD Obesity Update 2017, social inequalities in overweight and obesity are strong, especially among women.[65] 39% of women in the 2nd lowest household income quintile were obese compared with 17% of women in the highest income quintile.

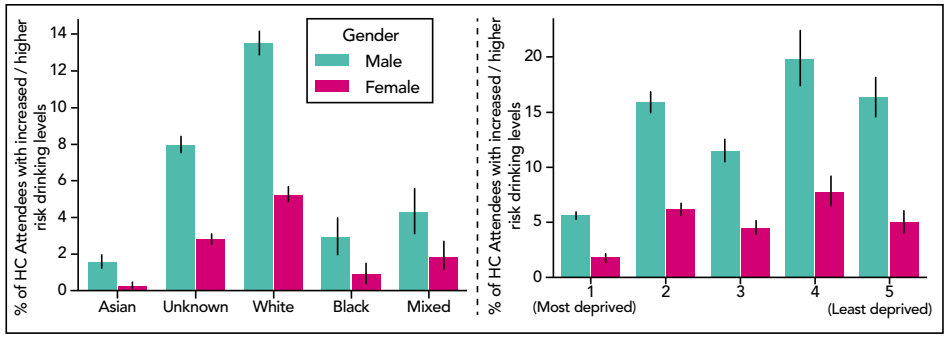
Alcohol consumption

Alcohol consumption is recorded at the annual health check as number of units of alcohol consumed per week. This was categorised into "Non-drinkers", "Low risk drinking" if the number of alcohol units consumed weekly falls below or is equal to 14, "Increasing risk drinking" if number of alcohol units consumed weekly is between 15 and 35, and "High-risk drinking" if number of alcohol units consumed weekly is above 35.

The graphs below show the percentage of HC attendees who consume 15 or more units of alcohol a week with an ethnicity (left) and IMD (right) breakdown for both males and females.

The trends in alcohol consumption across ethnicity and deprivation are almost reversed compared to obesity. Men are much more likely than women to have high levels of alcohol consumption. This is particularly true for White men and those living in less deprived areas. For women, white women are at higher risk than women of all other ethnic backgrounds.

Figure 17. IMD-ethnicity alcohol consumption prevalence in Birmingham between 2018-2023.
Source: NHS Health Check, 2023



Excessive alcohol use can lead to the development of chronic diseases and other serious problems including high blood pressure, heart disease, liver disease, cancer of the breast, mental health problems, social problems and more.[66]

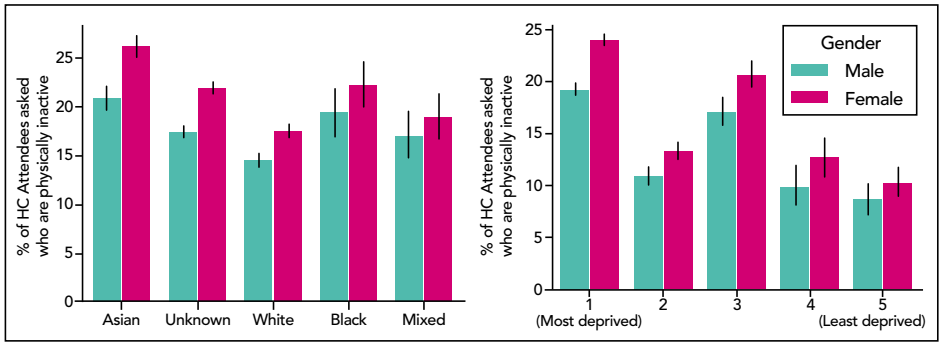
Physical inactivity

Physical inactivity is one of the leading risk factors for noncommunicable diseases (NCDs) and death worldwide. It increases the risk of cancer, heart disease, stroke, and diabetes by 20–30%.[67]

The General Practice Physical Activity Questionnaire (GPPAQ) was used as a validated tool to measure the physical activity index. The output was given as active, moderately active, moderately inactive, and inactive.

The graphs below show the percentage of HC attendees who self-report as inactive as a function of ethnicity (left) and IMD (right). It demonstrates that women of all ethnicities and deprivation levels are more likely to be inactive than men. It also shows that the rates of inactivity are highest for Asian patients and those living in the most deprived quintiles.

Figure 18. IMD-ethnicity physical activity prevalence in Birmingham between 2018-2023.
Source: NHS Health Check, 2023

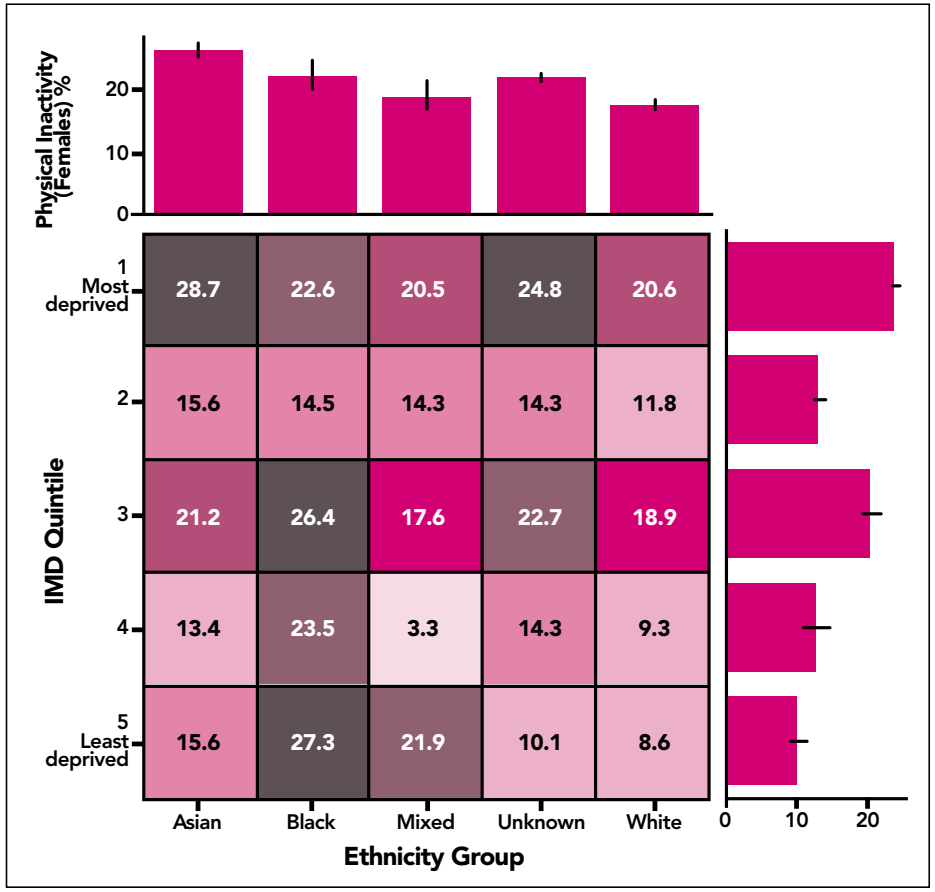


Case study: Birmingham Kickstart Project - Increasing Bangladeshi Women's Health Awareness (2022)

Birmingham Public Health and Birmingham and Solihull ICB are also currently developing interventions to improve the uptake of general health screening. In 2022, Birmingham Public Health identified lower levels of physical activity, particularly among women in the local Bangladeshi community. The qualitative literature consistently highlighted lower levels of awareness of the causes and disease management among patients with long term illnesses. In response, the Public Health Communities Team commissioned a local engagement partner - the Bangladeshi Women's Association, to develop a project to increase levels of health education and promote healthy behaviours such as physical activity, diabetes prevention and reduction and uptake of health screening. Case studies highlight a positive impact on health behaviours of female participants.

From the IMD-ethnicity inactivity prevalence matrix below, inactivity levels are generally slightly higher in the most deprived areas for all ethnic groups. The high levels of inactivity are seen for Black men in the 3rd and 4th IMD quintiles (40%-80% most deprived i.e., middle to low levels of deprivation). However, the number of people in these cohorts is comparatively low so caution should be taken when interpreting these results. Asian women in the most deprived quintile had the highest rates of inactivity at 28.7%. Physical inactivity can therefore be improved to address poor health outcomes amongst Asian women.

Figure 19: IMD-ethnicity physical inactivity matrices (updated threshold) in Birmingham between 2018-2023.Source: NHS Health Check, 2023



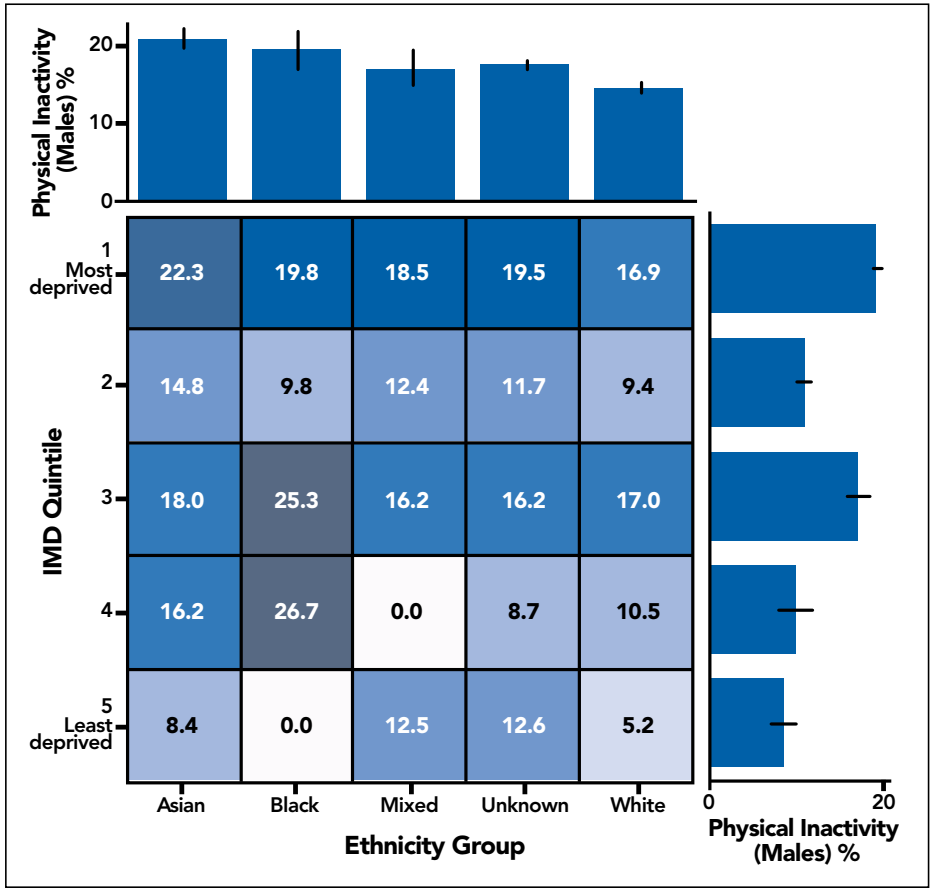
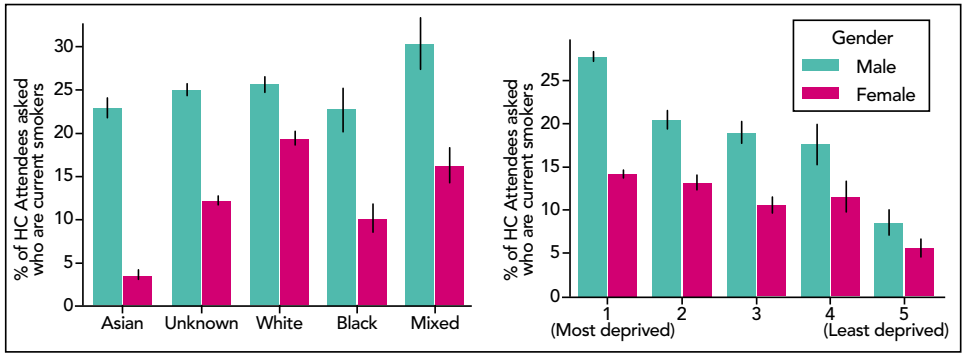


Figure 20. IMD-ethnicity smoking prevalence in Birmingham between 2018-2023. Source: NHS Health Check, 2023

Smoking

Smoking damages your heart and your blood circulation, increasing your risk of developing conditions such as coronary heart disease, heart attack, stroke and more.[68] The graphs below show the percentage of HC attendees who self-report as current smokers as a function of ethnicity (left) and IMD (right). It demonstrates that women of all ethnicities and deprivation levels are less likely to be current smokers than men.



4.4.2 CONCLUSIONS

In conclusion, the available data and evidence highlights that the key areas of improvement in relation to preventable risk factors are obesity and weight management, particularly amongst Black and Asian women living in the most deprived quintiles. Work must continue to increase physical activity amongst all women, particularly those from Asian communities. Even though evidence suggests men at a significantly higher risk, the local alcohol strategies should not overlook risks associated with excessive drinking by women, especially White women.

4.4.3 RECOMMENDATIONS

6. Public Health (in collaboration with relevant service providers and community partners) to develop and deliver culturally sensitive targeted community-based campaigns to promote healthy behaviours with a specific focus on women's health needs.
7. Public Health to raise awareness of available support and continue to encourage the take up of health checks with a specific focus on women's health needs.

4.5 MENTAL HEALTH

4.5.1 KEY FINDINGS

Generally, Birmingham has a significantly higher estimated prevalence of common mental health disorders, depression and anxiety prevalence and claimants for mental and behavioural disorders are higher than the national average.[69] Between 2015 and 2017, the suicide rate in Birmingham was the lowest among the core cities. In Birmingham, the female suicide rate is lower, and the male rate is similar to the England average, with the overall rate being significantly lower in Birmingham compared to England.[70]

Whilst the data on mental health in Birmingham is under researched, there is evidence to suggest that mental health in Birmingham requires a gendered approach to improving health outcomes. This is evidenced by the 2022 Thriving Places Index[71] (TPI), a framework which identifies the local conditions required for good mental wellbeing and measures whether those conditions are being delivered fairly and sustainably by local authorities in England. Equality within Birmingham ranked 5.35 (a medium score) but ranked low-medium for gender equality (4.07). This is the lowest gender score of all the core cities in England as demonstrated in figure 33 below.

Figure 21. TPI Index by Gender – England's Core Cities. Source: TPI, 2022.

TPI Index (Gender) - England's Core City Ranking

City	Score	
Birmingham	↓	4.07 Low-Medium
Sheffield	↓	4.71 Medium
Leeds	→	5.34 Medium
Bristol	↑	6.4 Medium-High
Manchester	↑	6.52 High
Nottingham	↑	6.79 High

Low		Medium		High
<3.5	3.5-4.5	4.5-5.5	5.5-6.5	>6.5

The Adult Psychiatric Morbidity Survey of Mental Health and Wellbeing, last published in 2014 estimates that in a given week, 1 in 6 adults in England have experienced a common mental disorder (CMD)[72], including forms of depression and anxiety. The 2014 Adult Psychiatric Morbidity Survey gave national level insights into groups at higher risk of mental illness, the survey indicated that young women have a higher risk of CMD and self-harm and that the gap between young female and male mental illness has increased.[73] than any other group.

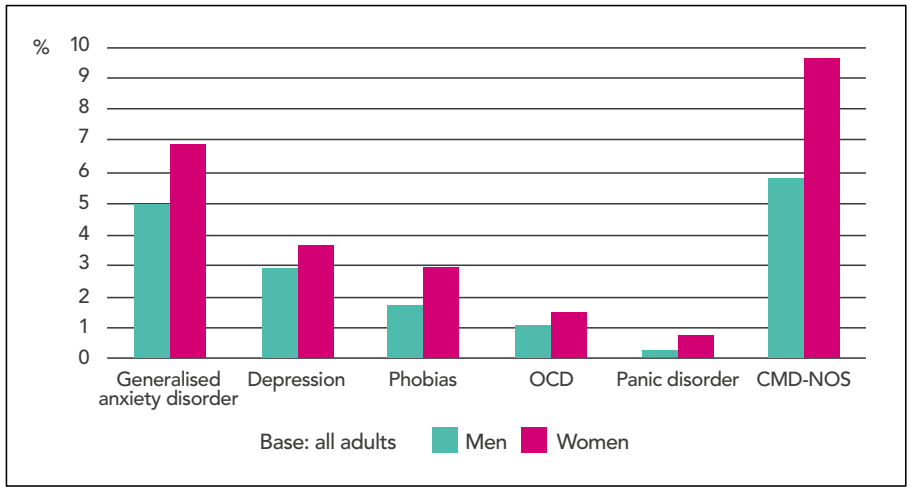
Whilst premature mortality in adults with severe mental illness (SMI) is higher in men compared to women, between 2018 and 2020, females with SMI were from 2.6 to 6.9 times more likely to die before the age of 75 than females without SMI, and the rate of premature mortality in female

adults in Birmingham with severe mental illness was higher at 112.6 per 100,000 higher than the national mean average at 111.3.

The Mental Health Foundation's statistics from their report published in 2017[74] suggest that:

- Women between the ages of 16 and 24 are almost three times as likely (26%) to experience a common mental health issue as males of the same age (9%)
- Women are twice as likely to be diagnosed with anxiety as men
- 25.7% of women and 9.7% of men aged 16 to 24 report having self-harmed at some point in their life
- Rates of self-harm among young women have tripled since 1993
- Women are more than three times as likely to experience eating disorders than men
- Young women are three times more likely than young men to experience post-traumatic stress disorder
- Young women are more likely to experience anxiety-related conditions than any other group.

Figure 22. Prevalence of common mental health disorders by gender. Source: Mental Health and Wellbeing in England: Adult Psychiatric Morbidity Survey 2014. NHS Digital



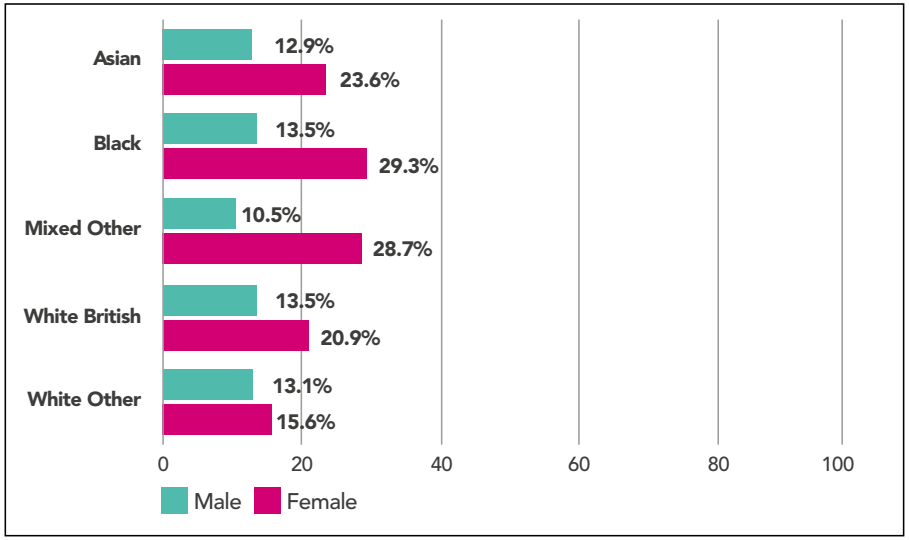
Women's mental health through an intersectional lens

The following section focuses on women's experiences of poor mental health by ethnicity, sexual orientation and disability.

Ethnicity and cultural competency

People from ethnically diverse backgrounds are highlighted to potentially have greater rates of mental health illness compared to White British people. For example, Black women are more likely to experience anxiety disorders or depression compared to White British women[75] and older South Asian women have been identified as an at-risk group for suicide.[76]

Figure 23. Common mental disorder by sex and ethnicity in England.
Source: Adult Psychiatric Morbidity Survey: Survey of Mental Health & Wellbeing, 2014[77]



Evidence suggests that Pakistani women's networks display high levels of stigmatising attitudes towards mental health problems and mental health services. This in turn acts as a deterrent to seeking help and using mental health services.[78] Language difficulties as well as religious and cultural practices were also identified as barriers, particularly to female treatment.[79]

A published study on migration, ethnicity and mental health used outcome data for over 10,000 women at 9 months and over 8,000 women at 5 years after migration.

Compared with White British women, Indian and Pakistani women had a two-fold increase in odds of distress. At the 5-year mark compared with White British women, odds of psychological distress remained significantly increased for Indian women and Pakistani women.[80]

The official mental health statistics for the UK tell us that approximately 136 per 100,000 Bangladeshis were detained under the Mental Health Act in 2019/20, which is a decrease of approximately 6 per 100,000 Bangladeshis from 2018/19. This is a higher rate compared to Indian and Pakistani (approximately 72 to 121 per 100,000) and White British (approximately 71 per 100,000), but lower than all Black categories (ranging from 197 to 810 per 100,000).[81]

Published research[82] suggests that, among Somali refugees, rates of mental illness are high. Yet research shows Somalis underutilize mental health services. Understanding their perceptions of mental illness and its cures may help practitioners to design more effective treatments for this population. The study identified that due to stigma associated with mental illness, it is often perceived through a description of physical symptoms accompanying the mental illness, for example, women explained that mental illness and feelings of distress start with and would be described to a GP as a "headache", illustrating the way mental illness symptoms in the community are described differently and as a result, may not be fully recognised if this cultural nuance is not understood.

Sexual orientation

Data shows that the prevalence of mental health problems is higher in lesbian and bisexual women in the West Midlands compared to the general population over 16. The prevalence of mental health problems in a West Midlands lesbian population was 31-35%, and suicide attempts were between 20-31%. Compared to heterosexual women, there is a 38% higher chance of poor mental health (anxiety or depression) in lesbians.[83] Whilst they are at a greater risk of poor mental health, lesbians tend to have negative encounters with mental health services, 2 in 5 lesbians have experienced negative or mixed reactions from mental healthcare professionals.[84]

As reported in the Birmingham Trans Community Health Profile,[85] trans adults and young people are between 1.5 and 3 times more likely to report self-harming thoughts and behaviours than their non-trans (LGB) peers. There is a higher prevalence of mental health problems in young trans people aged 16-25 compared to trans adults and trans children. Trans people assigned females at birth are significantly more likely to experience mental health problems than trans people assigned male at birth.

Disability

There is evidence that mental illness may be more common amongst the deaf population than the hearing population and deaf people face additional difficulties accessing services. The precise figures are inconsistent, but there is no doubt of a higher incidence of mental health problems among the deaf compared to the hearing population. Evidence shows that the rate of depression is double that in the deaf community compared to the general population (average 27% compared to 12%).[86] There is also a significant gender difference in the reported history of depression. Rates of depression were much higher in deaf women (31%) than in deaf men (14%).[87]

4.5.2 RECOMMENDATIONS

8. Bsol ICS Mental Health Provider Collaborative to develop a greater insight into Birmingham women's mental health and promote a gender-based and culturally competent approach to service delivery and mental health practice, focused on prevention and early intervention.
9. Bsol ICS Mental Health Provider Collaborative to work with the local LGBT+ organisations and the lesbian communities themselves to develop accessible wellbeing resources to address low level mental health needs and promote pathways to addressing more complex needs around self-harm, suicide and eating disorders within these communities. This work needs to be incorporated into the local suicide prevention programme.
10. BSol ICS to strengthen direct referral routes to specialist mental health services for women from inclusion health groups, women with disabilities and lesbian/ bi-sexual women and girls.

5. WOMEN-SPECIFIC HEALTH NEEDS

This section explores women-specific health needs in line with the national strategy. Due to limitations in the existing local data, the following areas a variety of indicators is used as proxy measures for identification of women-specific health needs. Intersectionality is also taken into account. This helps to gauge a better understanding of the health needs of Birmingham's female population. Alongside the available data and proxy indicators, the following sub-sections consolidate key findings from the Birmingham Community Health Profiles, stakeholder engagement and local qualitative research.

Menstrual health

- Nearly half of female respondents to YouGov 2022 survey said they felt unprepared for their first period
- Menstrual awareness sessions held in the Ladywood and Perry Barr locality found 40% of girls had at one point stayed off from school due to their period (BCC, 2023)

Sexual health literacy

- Twice as many Black African ethnicity and Mixed ethnicity women reported lower sexual competency, compared to White British women. Lower levels of sexual health literacy also extend to other ethnic groups (NATSAL-3, 2017)

Abortion rates

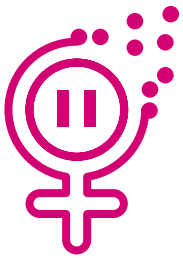
- Repeat abortions in women aged under 25 are significantly higher in Birmingham compared to England (OHID, 2022)

Infant mortality

- Birmingham has the 3rd highest rate of infant mortality in England. For every 1000 births in the city, 7 die before reaching their first birthday (OHID, 2021)

Maternal mortality

- Black women are 4 times more likely to die, and Asian women twice more likely to die, than White women during and shortly after pregnancy (MBRRACE-UK, 2023)
- 12% of women who died during or up to a year after pregnancy had multiple severe disadvantages, such as histories of substance abuse or domestic violence.
- Women living in the most deprived areas continue to have the highest maternal mortality rate compared to those living in the least deprived areas.



Menopause

- Approximately 210,000 women above the age of 45 in Birmingham are likely to be experiencing menopause (ONS, 2022)
- 44% of menopausal women in employment say their ability to work has been affected by their symptoms (Fawcett Society, 2022)

Domestic abuse

- In 2022-23 Birmingham recorded 2849 high risk cases of female victims of domestic abuse (Birmingham City Council, 2023)
- There were 992 homeless presentations in Birmingham, where domestic abuse was cited as the main reason. Most of them were women (Birmingham City Council, 2023)

5.1 SEXUAL HEALTH

5.1.1 KEY FINDINGS

The consultation findings from the Women's Health Strategy for England[88] found that for most women, preventing pregnancy was the most important reproductive issue throughout most of their lives. This priority was most significant for younger women, who were also most likely to use the least reliable contraceptive methods such as pills and condoms. Older women tended to use more effective methods such as the intrauterine device (IUD).

It is important to recognise in the context of sexual health that females who are vulnerable, at-risk or from disadvantaged backgrounds are more susceptible to physical and sexual abuse that can directly or indirectly lead to risky sexual behaviour.[89] There is a heightened risk of contracting sexually transmitted infections (STIs) and unplanned pregnancies for victims of intimate partner violence. One study highlighted that 45% of physically assaulted women have experienced forced intercourse and risky sexual behaviour[90], the prevalence of gender-based violence locally and its health impacts are further explored in section 5.5.

Sexually transmitted infections (STIs)

Women bear a higher risk of contracting STIs compared to men. Although women's anatomy and physiology are contributing factors, the key role is played by relationship-associated factors such as gender power imbalance, and negative attitudes regarding condom use.[91]

The data below highlights STI diagnoses between 2019 to 2022 collected by the UK Health Security Agency (UKHSA)[92] and presents the rate of new diagnoses of Chlamydia, Gonorrhoea, and genital herpes in women in the West Midlands compared to England to identify if population sexual health is improving at the local level.

The data across all three charts (Figures 24, 25 and 26) indicate that the trends in STI diagnoses in the West Midlands are similar nationally – a significant decrease between 2020 to 2021 followed by an increase in 2022. A cross-sectional population survey assessed sexual behaviour in Britain 1 year after lockdown, and the survey found that compared with trends from 2010 to 2019, there was lower than expected use of STI-related services and HIV testing, lower levels of chlamydia and reduced sexual frequency.[93] The decrease in rates of new STI diagnoses between 2020 to 2021 could partially be attributed to the Covid-19 lockdown, therefore highlighting that the rate of new STIs could slowly return to pre-pandemic levels.

Figure 24. Rate of new Chlamydia diagnoses in women by year. Source: UKHSA, 2023

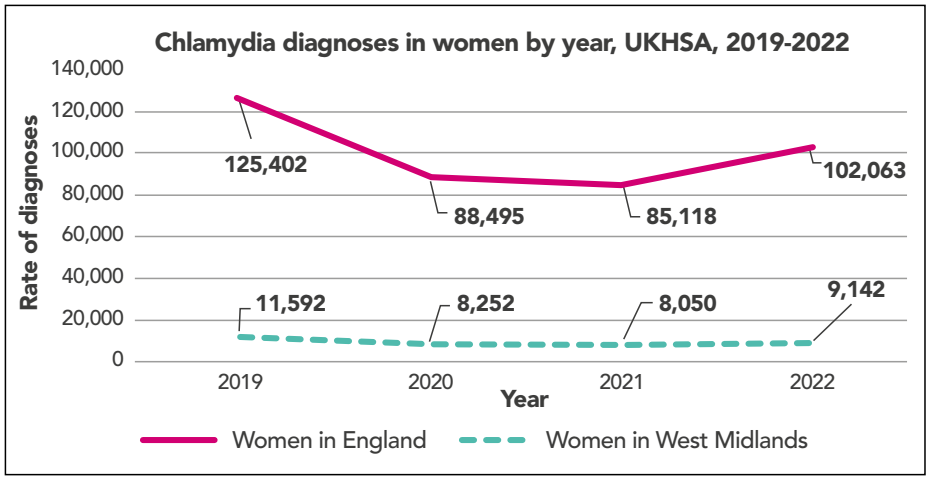


Figure 25. Rate of new Gonorrhoea diagnoses in women by year (2019 - 2022). Source: UKHSA, 2023

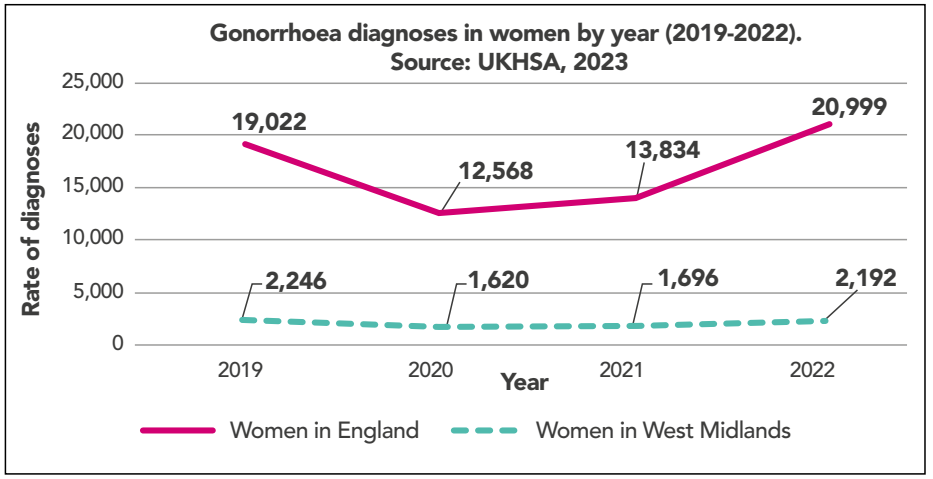
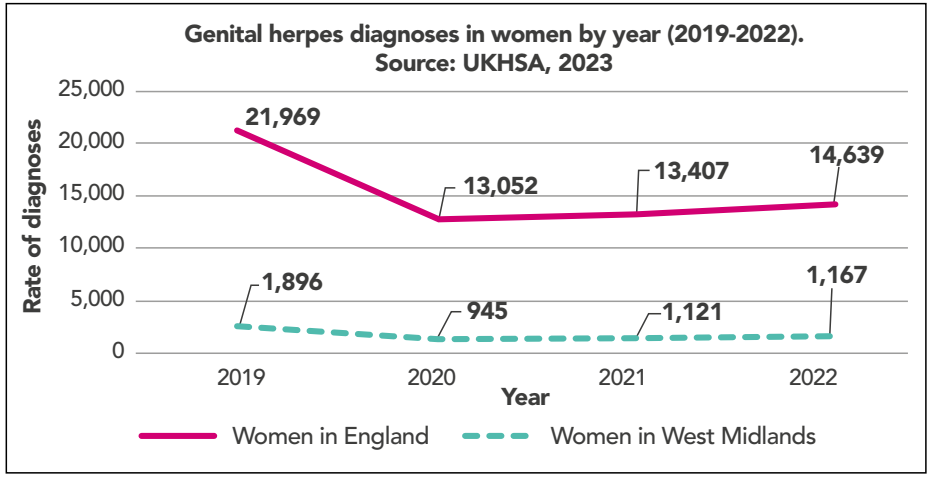


Figure 26. Rate of first episode of genital herpes diagnoses in women by year (2019 - 2022), Source: UKHSA 2023



PHOF data also suggests a significantly lower coverage of one and two doses of HPV vaccination for girls in Birmingham compared to girls in England.[94] This may be linked to poorer outcomes.

The slow increase in STI diagnoses in women in England would indicate that the drivers behind poor sexual health outcomes and sexual health literacy require further exploration and intervention.

Ethnicity and sexual health literacy

The research shows that ethnicity is a key driver in sexual health disparities, a disparity recognised both in the UK and globally.[95] British screening data and national surveys consistently highlight that people from Black ethnicities are over-represented in UK STI statistics. Black African men and women account for 1.8% of the UK population, but account for almost one-third of people accessing HIV care.[96] 2015 Public Health STI and Chlamydia screening data showed that people of Black ethnicity also account for a disproportionate number of UK STI diagnoses.[97]

A 2017 survey of sexual attitudes in Britain found that women of Black African ethnicity and Mixed ethnicity reported lower sexual competency, compared to White British women, (18% for Black African, 35·3% for Mixed ethnicity and 47.9% for White British).[98] Lower levels of sexual health literacy also extend to other ethnic groups. Research exploring attitudes around sexual health in the South Asian community also demonstrates significant levels of poor sexual health literacy, sexual health testing and stigma around sexual health. Knowledge about sex was poorest amongst Bangladeshi young people[99] and for many Bangladeshi women, their first discussions about contraception were following the birth of their first child.[100]

Even after adjusting for risk factors such as socioeconomic status, substance use, depression, sexual behaviours and geography, the data still highlights ethnicity as the key factor in sexual health disparities.[101] Further ethnographic work could help improve sexual health outcomes by understanding the drivers of poor sexual health in specific communities. If a community views sexual health testing as a stigma, it could indicate STIs remain undiagnosed. This research could help in developing culturally targeted messages and services based on community-specific sexual behaviours and attitudes.

Female sex workers' health

In the UK, a cumulative body of research has developed since the mid-1980s which highlights the barriers to accessing mainstream health and social welfare provisions for sex workers.[102] Those more affected by austerity and with less access to employment, such as marginalised identities – women, people of colour, disabled people, for example – are more likely to be engaged in sex work. However, there are still major gaps in understanding the health and well-being needs of Birmingham's sex worker population. The early findings from the Birmingham Public Health led sex worker health needs analysis carried out by the University of Birmingham (yet to be published) suggest that in the West Midlands, 27% of sex workers attending sexual health services in 2018 were diagnosed with at least one STI, compared to 31% in 2021.

From the consultation with various community based and front-line services, there is a concern around the in-depth understanding of the complexities of the Birmingham's sex worker population, their heightened risk of ill health linked to substance misuse, mental ill health, sexual ill health, and workplace violence. Developing a greater understanding of sex workers needs will help in delivering tailored targeted services, which address the complex sexual and other health needs of this highly marginalised at-risk group.

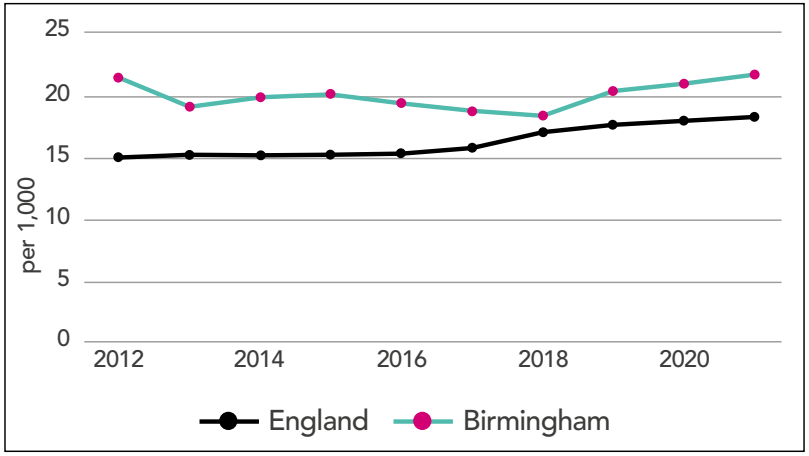
Abortion and contraception

Birmingham is 'Europe's youngest city', with under-25s accounting for nearly 40% of its population. Wards in the centre of the city have median ages of between 21 and 28.[103] Adolescents and Young Adults (Puberty-24) as a demographic have specific needs regarding sexual health around contraception, and this is evidenced by the current data available.

There is a significantly higher proportion of repeat abortions in women aged under 25 in Birmingham compared to women of the same age in England, 31.8% and 29.7% respectively.[104] In Birmingham and Solihull, the total abortion rate, at 22.1 and 23.4 per 1,000 respectively, is significantly higher than that of the nearest neighbours (20.4) and the national rate (19.2).[105] There is also a lower rate of total prescribed Long-Acting Reversible Contraception (LARC), excluding injections, for women in Birmingham (35.6 per 1,000) compared to women in England (44.1 per 1,000).[106]

It is important to explore and understand the circumstances and factors that are a barrier to preventing unplanned pregnancies. These may be linked to sexual violence, poverty and other risk factors. For example, one national study found that lesbian and bisexual young women have a 37% higher risk of teenage conception than heterosexual women.[107] Another study of young women of diverse sexual orientations found risk factors for teen pregnancy linked to childhood maltreatment and bullying.[108]

Figure 27. Total abortion rate per 1,000 in Birmingham compared to England.
Source: OHID, 2021Source: UKHSA 2023



5.1.2 CONCLUSIONS

As young people are a significant population group in Birmingham, exploring effective ways to improve sexual health outcomes is highly important. These outcomes for Birmingham female populations are generally worse than England's. This includes the slowly increasing (post pandemic) STI rates, repeat abortions and risky sexual behaviour in females under 25 years of age, some potentially linked to poorer prevention through HPV vaccination coverage and effective contraception.

Intersectionality, including sexual orientation, and cultural factors in this superdiverse female population in our city need to be further explored to improve our understanding of the drivers of poor outcomes and to identify appropriate and effective preventative measures.

The research and data consistently highlight ethnic disparities in STI diagnoses. As the West Midlands is starting to see similar rates of increase in new STI diagnoses in women as the rest of England, developing culturally appropriate messages and services will be important in improving sexual health outcomes amongst Birmingham women, who are also impacted by gender dynamics in sexual relations.

As a high-risk group often experiencing multiple disadvantages, sex workers' unique needs and experiences need to be considered within sexual health service design and practice and targeted interventions.

5.1.3 RECOMMENDATIONS

11. Sexual and reproductive health service providers to collaborate with the education sector to develop culturally competent messages, resources and services to improve sexual health outcomes amongst young women.
12. NHS England to conduct a deep dive research to explore reasons behind repeat abortions, particularly in lesbian and bisexual, and vulnerable women, and explore tailored targeted interventions that can prevent them.

5.2 MENSTRUAL HEALTH

5.2.3 KEY FINDINGS

Menstrual health is defined as 'a state of complete physical, mental, and social well-being and not merely the absence of disease or infirmity, in relation to the menstrual cycle'.[109]

Good menstrual health is measured by women, girls and all other people who experience a menstrual cycle, throughout their life-course being able to meet 5 key requirements:

1. have access to accurate, timely, age-appropriate information about the menstrual cycle and menstruation
2. care for their bodies during menstruation such that their preferences, hygiene, comfort, privacy, and safety are supported
3. access timely diagnosis, treatment and care for menstrual cycle-related discomforts and disorders
4. experience a positive and respectful environment in relation to the menstrual cycle, free from stigma and psychological distress, and
5. decide whether and how to participate in all spheres of life, including civil, cultural, economic, social, and political, during all phases of the menstrual cycle, free from menstrual-related exclusion, restriction, discrimination, coercion, and/or violence.

Period poverty within marginalized at-risk communities

The Tackling Period Poverty & Raising Awareness Inquiry (2019-2020)[110] concluded that there is no in-depth research where conclusions can be drawn about the prevalence of period poverty or the physical or mental health impacts of low period awareness, amongst specific groups or different population groups. Much of the generic research carried out nationally does not focus sufficiently on specific communities where this issue may arise to pick up the nature and extent of it.

We know, however, that menstrual issues have a particularly big impact on vulnerable women. Local research carried out by Spring Housing into women and rough sleeping in Birmingham highlighted that education and awareness around both period poverty and menstruation itself were low to non-existent in the homelessness sector. A consultation with 103 homelessness practitioners across the city found that there were significant gaps in knowledge around periods, which meant they were unable to support the health concerns of service users, who experience multiple complex needs.

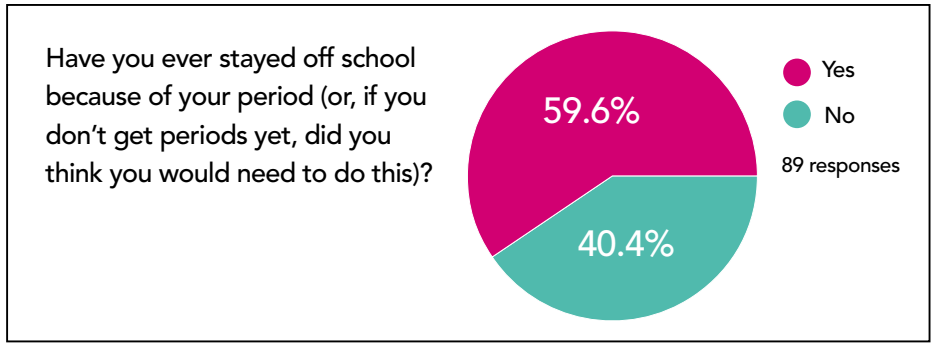
Menstrual health literacy among young people

Swansea University conducted a survey of 789 UK primary and secondary school teachers, 88% of whom felt that periods affected pupils' attendance, participation in exercise, as well as behaviour and confidence. The study found that only 53% of secondary school teachers reported that menstrual cycle education lessons were taught in their school. Of the teachers who were aware of their school's menstrual cycle syllabus across primary and secondary schools, 144 reported that a maximum of two lessons were provided within one academic year.[111]

A 2022 YouGov survey found that nearly half of female respondents (45%) said they felt unprepared for their first period, with 37% saying they felt prepared. 53% of 18–29-year-old women who felt prepared for their first period said that girls are not taught well enough about menstruation in schools – this figure declines with each age group to just 15% of those aged 60 and over.[112]

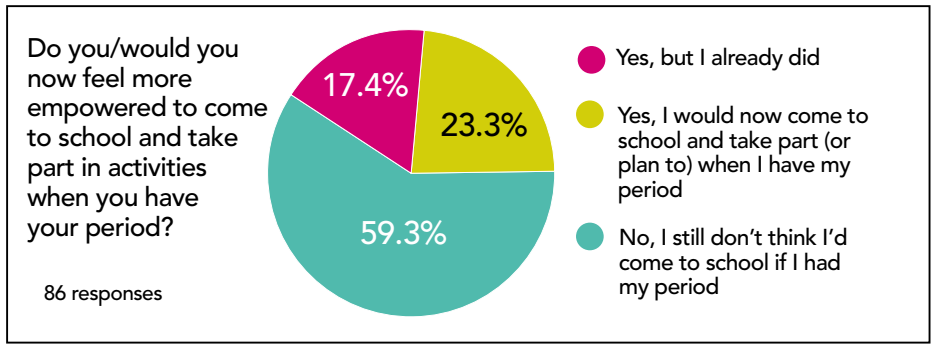
To gauge a better understanding of menstrual health literacy amongst girls specifically in Birmingham, menstrual awareness sessions were held in Ladywood and Perry Bar Locality Partnership and George Dixon Academy. Although the cohort evaluated is a small cohort in one area of Birmingham, the findings are consistent with the research conducted nationally. Menstrual health and literacy impact Birmingham girls' education as it was found that 40% of girls had at one point stayed off from school due to their period. A post-workshop evaluation showed that there was a 40% increase in confidence levels across the participant's groups in recognising symptoms relating to menstrual health which they should seek help from their GP for.

Figure 28. Ladywood and Perry Bar Locality Partnership period literacy workshop. Source: Workshop evaluation Q2, 2022.



40.4% of participants have stayed off school at least once because of their period.

Figure 29. Ladywood and Perry Bar Locality Partnership period literacy workshop. Source: Workshop evaluation Q4, 2022.



After the session, 23.3% of girl participants still felt they were unable to come to school due to their period.

The results from the workshop above suggest further work should be carried out in schools in Birmingham to raise awareness of menstrual health and when to seek support for period problems

Case study: Period product scheme for schools and colleges

In England, the period product scheme was launched by the Department for Education (DfE) in January 2020 to reduce the drivers in period poverty and reduce its impact on girls' education. The period product scheme provides free period products to girls and women in their place of study. It is available to state-maintained schools. The scheme is available for organisations to order until at least July 2024. Since its launch 99% of eligible secondary schools and 94% of post-16 organisations have ordered products using this scheme, supporting students from disadvantaged backgrounds to improve access and end period poverty.

The DfE have also developed a comprehensive guidance supporting the scheme. The guidance contains information on:

- choosing and ordering period products
- distributing products within institutions
- tackling stigma

The key message within the guidance is that period products should be available for all who need them, when they need them, so they can access education. Having periods should not be a barrier to education for anyone.

Case study: Period literacy toolkit for the homelessness and housing sector

Following the research by Spring Housing and the work that Birmingham Public Health and partners undertook to explore and address period poverty in disadvantaged and marginalised communities, the Inclusion Health Team commissioned Spring Housing to develop a period literacy toolkit for the homelessness sector. Its purpose is to equip the front-line practitioners and officers within the sector with accessible information and guidance on how to help homeless women to access the practical support and guidance they need to manage their periods and menstrual health safely and with dignity, preventing adverse impacts on health and wellbeing. The toolkit is being co-produced with both the homeless women and front-line staff, and even though it is still in development, the practitioners involved are already reporting the positive impacts this project has started to have in terms of improving knowledge and awareness and the support they are now able to offer.

5.2.2 CONCLUSIONS

The national findings on menstrual health correspond with the anecdotal evidence collected in schools in Birmingham – women and girls need high-quality health education and awareness, and those who support them need guidance on how to support them competently and sensitively. Moreover, consultation with local third sector partners found that there is a gap in the national strategy in addressing the menstrual and gynaecological conditions of homeless/ marginalised women, particularly in Birmingham. . The stark disparity in long term physical health problems indicates that interventions to address women's health should incorporate the poorly reported needs of highly vulnerable females.

5.2.3 RECOMMENDATIONS

13. Children and Families Directorate and Education providers should work with Public Health to support the education settings in raising awareness of menstrual health and support amongst children and young people to reduce stigma associated with periods, period poverty, absenteeism related to menstrual health and improve young females' wellbeing.

5.3 REPRODUCTIVE HEALTH: PREGNANCY, FERTILITY AND POSTNATAL SUPPORT

5.3.1 KEY FINDINGS

The NHS England's commitment to improve maternity and neo-natal services sets out a 3-year plan to improve disparities in maternal care.[113] Objective 2 of the plan focuses on improving outcomes for mothers and babies from ethnic groups.

Neonatal mortality and stillbirths

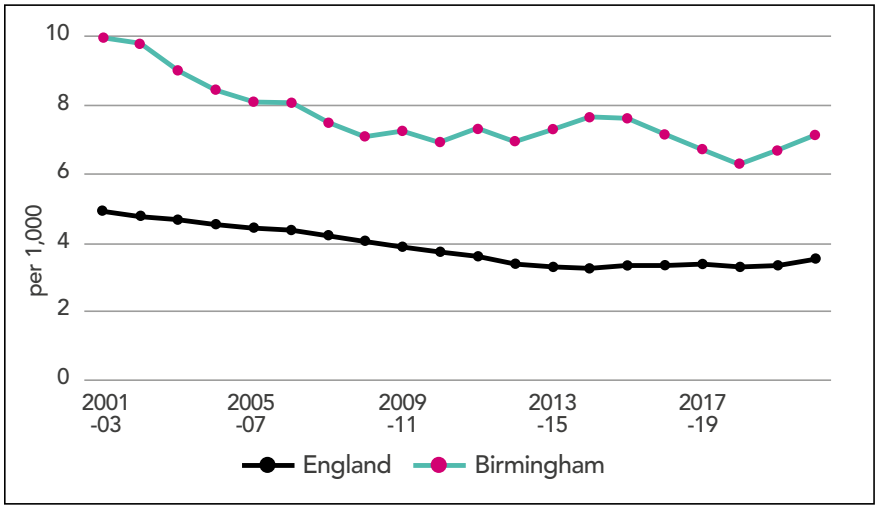
According to the Healthwatch Birmingham report[114], the highest number of stillbirths in Sandwell and West Birmingham were found in the following postcodes: B66 and B67 (16%), B70 and B71 (15%), B20 and B21 (13%), and B19 (12%). These areas contain some of the most deprived neighbourhoods in the UK.

Birmingham has some of the highest rates of neonatal mortality and stillbirths at 5.5 per 1,000 (OHID PHOF, 2021). Birmingham also has high rates of low birth weight of term babies – 3.5% in 2021 (OHID PHOF, 2022) and a high prematurity rate.[115] Addressing disparities in maternal care is a key area of improvement for Birmingham, which is highlighted in the following section

Infant mortality, deprivation & ethnicity

2019-21 data found that Birmingham had the 3rd highest rate of infant mortality in England. For every 1,000 births in Birmingham, 7 die before reaching their first birthday.[116]

Figure 30. Infant mortality rate for Birmingham. Source: OHID, PHOF 2022



The relation between deprivation and infant mortality is an important factor. The most recent national report on perinatal mortality reported that 42% of births at University Hospitals Birmingham (UHB) and 38% of births at Birmingham Women's Hospital (BWH) were in the most deprived decile. In Birmingham, 28.1% of Birmingham children live in low-income families compared to 17% nationally.

The Child Death Overview Panel (CDOP) reviewed deaths of children residing in Birmingham between April 2018 and March 2020 and showed a disproportionate percentage of child deaths amongst those who identify as Pakistani.[117]

The Birmingham and Lewisham African and Caribbean Health Inequalities Review (BLACHIR) (2022) found some of the highest infant mortality rates in England are also among mothers born in the Caribbean (9.0 deaths per 1000 live births) and central Africa (8.3 deaths per 1000 live births). Pre-term birth rates were higher in Black Caribbean and other Black African women in 2020 compared to White British women.[118] Data from Department of Health and Social Care shows there is an almost two-fold difference in mortality rates between women from Asian ethnic groups and White women, and the rates are also higher for Black women. Studies have found Black women are 40% more likely to experience a miscarriage than White women.[119]

Maternal mortality

A report published by MBRRACE-UK[120] shows that over 10 years up until 2021, the rate of maternal death in the UK has risen by 15%. Suicide is the leading direct cause of death between 6 weeks and 12 months after the end of pregnancy. The high rate between 2020 and 2021 would have been also impacted by Covid-19.

Similarly to the BLACHIR research, MBRRACE-UK report shows that Black women and birthing people remain 4 times more likely to die, and Asian women twice as likely to die, than White women during and shortly after pregnancy.

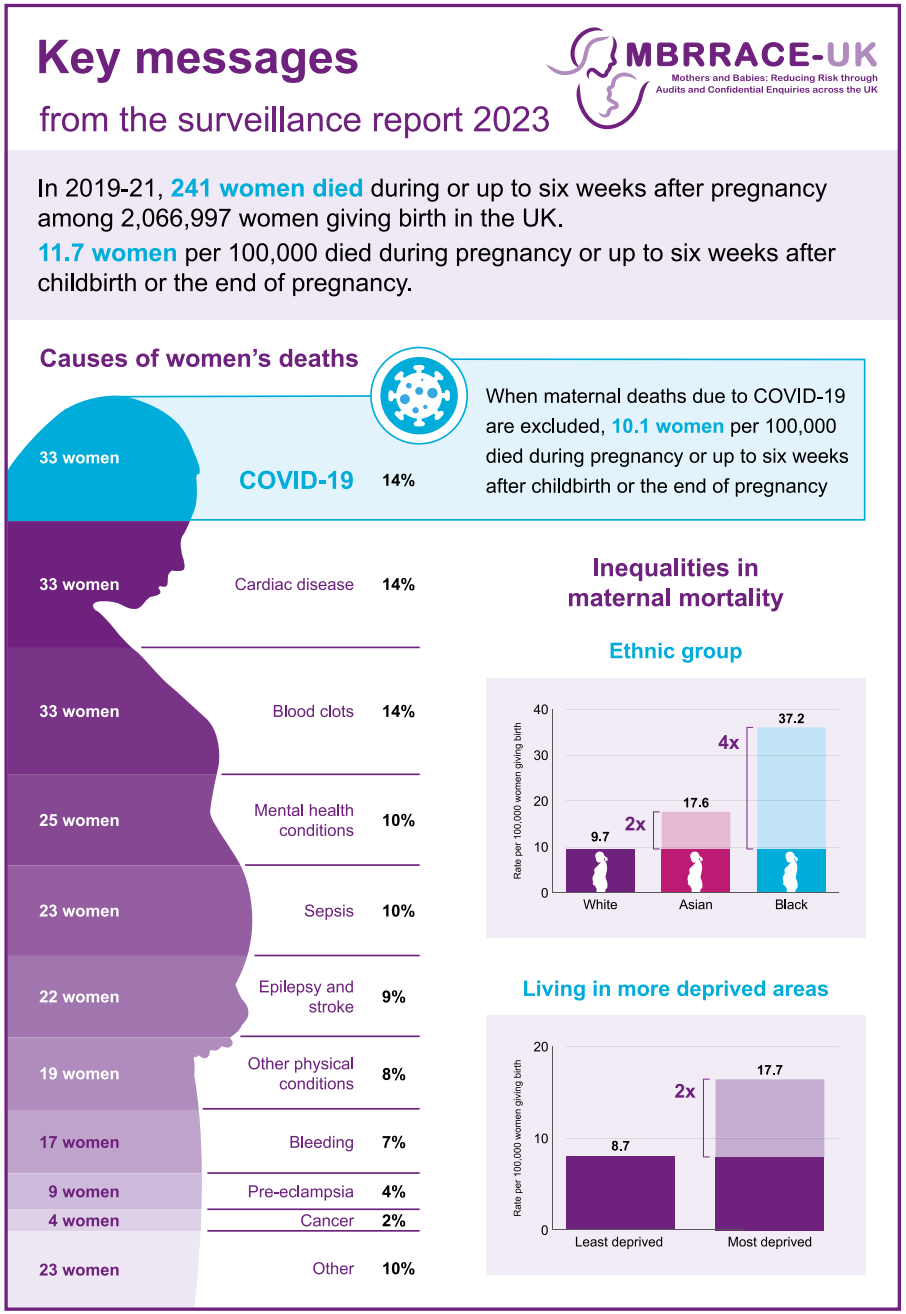
12% of women who died during or up to a year after pregnancy had multiple severe disadvantages, such as histories of substance abuse or domestic violence, and women living in the most deprived areas continue to have the highest maternal mortality rate compared to those living in the least deprived areas.

Quality of care

Black Caribbean women frequently report reduced access, poor quality care and poorer health outcomes in antenatal and postnatal care. Severe maternal morbidity is 80% higher among Black Caribbean women than White European women (this did not differ by socio-economic status, smokers/non-smokers, or BMI).[121]

Experiences heard at a West Birmingham Listening Session of recent women's births at the Saathi House in January 2023 suggest there are cases of low quality pre- and post-natal care and women's concerns around their pregnancy and the birth of their babies are not listened to. These experiences are not limited to Black or ethnic minority women.

Figure 31. Causes of women's deaths. Source: MBRRACE-UK – Saving Lives, Improving Mothers' Care 2023.



"With the pregnancy where I had a still born, I did not have any consultant appointments to assure me that I was okay, and baby was okay. All the appointments were virtual. My waters broke at 32 weeks, I went to the hospital, and they gave me injections to stop birth. I went back after two weeks; I was still losing water and I said to them how is the child surviving there. They said I had to wait until I reach 37 weeks. I kept going back in and they kept saying I should wait. (…) When they finally agreed to admit me, she put me on a monitor for the baby, she looked at me and said there is no heartbeat…. (Long pause) …. When they told me I just said, 'I told you so'. I had to give birth, I gave birth, had high temperature, kidney infection. Then I was put in a room where next door people were giving birth. I couldn't stay there, and I discharged myself after three days. Someone came down from the bereavement team. The consultant apologized but it's not enough. They said they followed their rules. They said it was preeclampsia. I did do a complaint – the NHS won't admit they are wrong. They followed their procedure (and that does not include listening to the patient)."

Maternity Services in West Birmingham, Healthwatch Birmingham (2023)

Findings from the Seldom Heard Conversations about Pregnancy in Birmingham Report found low satisfaction levels across women, with participants stating that their concerns were not valued or taken seriously, often leading to complications, or even stillbirth.[122]

Across all focus groups, there was a consensus that communication strategies need to be improved to ensure healthcare professionals are active and empathetic listeners, interpreters and clinicians adopt a culturally appropriate framework to care and to reduce barriers to accessing services.

Intersectionality (findings from Seldom Heard Conversations about Pregnancy Report)

- **Ethnicity and religion**: There are concerns with the quality of care for patients from ethnically diverse communities, with a particular focus on communication styles, cultural competency, and adopting non-digital communication strategies with a single point of access (SPA) for pregnancy related information advice. Participants from Black, Asian and minority ethnic groups discussed how they didn't know what to expect in their first pregnancy, what signs to look for and that they wanted to be better informed about risks. Services, support, and information delivered thoroughly digital technology makes access difficult for those who don't have the right equipment or internet access. Somali women's focus group pointed out that women who have been circumcised can't openly discuss how circumcision impacts them during pregnancy and pain management. Cultural awareness should be improved to understand challenges for women from specific religious and ethnic communities.
- **Disabilities**: BSL interpreters should be available at all stages of pregnancy/parenting journey from pre-conception through to breastfeeding support. Deaf and hard of hearing groups commented on how they felt invisible and isolated when health professionals would speak directly to family, friends or interpreters who accompanied them. One participant felt that the lack of interpreters in Birmingham (in comparison to London) made the birth of their second child more difficult than the first (in London). A participant from the deaf and hard of hearing focus group felt that using 'gestures and written English' made it challenging to communicate difficulties in breastfeeding.
- **Asylum seekers**: Asylum seekers and refugee women shared that they did not know how to access maternity accesses and available information and resources were often out of date. This was further intensified by COVID-19. There was a consensus that there are multiple barriers to access for newly arrived families in the city, language and literacy in particular, and for those with limited or no recourse to public funds
- **Care leavers**: Young people felt adults would talk down to them and were often told 'how not to do things' as opposed to the best things to do. The children's social care staff were very judgemental and did not provide support needed for parents struggling emotionally.
- **Sexual orientation**: There are higher rates of polycystic ovary syndrome in lesbian women (38% vs. 14% in the overall female population).[123] Lesbian women face barriers to accessing IVF treatment (e.g., issues being referred for by a doctor, being too afraid to ask for IVF and thinking that they had to fund it themselves) despite NICE guidelines that include same-sex partners in treatment.[124]

In response to the seldom heard voices report, Birmingham Public Health and Bsol ICS are working in partnership to develop a pre-pregnancy package, produced in the city's 11 most-spoken languages. Linked in with children and family hubs, English language classes are currently being piloted in 3 areas for adults who don't speak English as a first language to support the way they access services and promote education for a healthy pregnancy. Maternity listening events are being rolled out across different communities in the city, Birmingham Public Health aims to deliver co-production workshops to better address the needs of diverse communities in maternal care.

5.3.2 CONCLUSIONS

The findings suggest that training for healthcare professionals requires change across the local system to provide better quality, compassionate, culturally sensitive and trauma-informed care during and post-pregnancy. Evidence tells us that support and care for women from inclusion health groups and women experiencing multiple barriers to accessing healthcare need to improve to reduce the health inequalities they currently experience. This includes a need for improving access to other support that they may need during their journey with a specific focus on mental health and wellbeing.

As one of Birmingham's 4 major ethnicities, the data indicates focused interventions are needed to address poorer care and health outcomes for women from ethnic communities, including Black African and Black Caribbean women, Asian women and women who are deaf or hard of hearing. Interventions to address the specific medical discrimination against Black Caribbean women and Lesbian women could improve their satisfaction with care and outcomes, leading to reducing the health inequalities they experience.

To support the objectives set out in the NHS 3-year plan, local stakeholders for women's health across all sectors can support this plan by providing spaces and outlets for women from all backgrounds to share their experiences of maternity care in the city, ensuring their voices are heard.

5.3.3. RECOMMENDATIONS

14. Bsol ICS to co-produce with communities of experience robust training and performance framework for community midwives, nurses, and local hospitals to address poor quality of ante- and post-natal care for women, particularly disadvantaged women and those from ethnic communities. The framework should include cultural awareness and humility, learning from lived experience, awareness of inclusion practices and policies, and awareness of trauma caused by racism and discrimination and how to deliver sensitive care. Healthcare professionals who serve the most socially deprived areas of Birmingham with a larger ethnic population should be prioritised (e.g., Heartlands Hospital).
15. Independent Chair of the Quality Committee of the LMNS to oversee the improved data collection by specific ethnicity in maternity and early years services, so that the unique needs of specific ethnic and inclusion health groups can be further explored and considered to improve quality of care.
16. Birmingham & Solihull Maternity Voices to implement a robust monitoring and patient feedback system across ante-/ post-natal clinics and maternity services to evaluate and improve care experiences of all women, with a particular focus on care quality and outcomes for women from ethnic communities, inclusion health groups as well as Lesbian women accessing IVF services and referrals.
17. GP and midwifery services to support all women who are migrants, refugees, and asylum seekers, particularly those with no access to public funds, to access appropriate care during and post-pregnancy.

5.4 MENOPAUSE

5.4.1. KEY FINDINGS

Menopause is when your periods stop due to lower hormone levels and affects anyone who has a period. It typically affects women between the ages of 45 and 55, but it can happen earlier. Menopause can cause symptoms like anxiety, mood swings, hot flushes, brain fog, irregular periods, and many more. Menopause symptoms can start years before periods stop and can continue afterwards.

In 2021, women over the age of 45 accounted for 35.9% of Birmingham's female population. Approximately 209,832 women above the age of 45 in Birmingham are likely to be experiencing menopause.[125] However, it is important to stress that women can be affected by menopause in different ways, and not all will experience severe or even debilitating symptoms.

Stigma

Whilst there is limited local data available around menopause, an all-party parliamentary inquiry to assess the impacts of menopause carried out in 2022 concluded that 'despite the fact that 51% of the population will experience the menopause, the entrenched taboo around women's health issues, at times underpinned by sexism and ageism, has meant that the support for the 13 million women currently going through peri-menopause or menopause is completely inadequate'.[126] Another study confirms that due to the stigma around menopause, almost half (45%) of women experiencing menopause did not speak to their GP surgery about their symptoms.[127]

Menopause literacy and support

The research carried out by the APPG Menopause (2022) also found that women are often not equipped with the information they need to understand what is happening to them and their bodies. The studies used as part of the inquiry show that around 75% of menopausal women experience symptoms, which in some cases can last for years or even decades, and the lack of awareness and understanding within the medical profession, has meant that many suffer without their symptoms being recognised. Breaking down the barriers to menopause support is a particular challenge for those from ethnic minority backgrounds and the LGBT+ community.

Risk of suicide

During this inquiry it was highlighted that the risk of suicide is one of the many hidden costs of menopause. The ONS data shows that those aged 50 to 54 years had the highest suicide rate in 2022 (15.2 deaths per 100,000); consistent with 2021 (14.9 deaths per 100,000). Females aged 50 to 54 years also had the highest rate in 2022 (7.8 per 100,000).

Menopause in the workplace

According to the Fawcett Society study from the same year, 44% of menopausal women in employment say their ability to work has been affected by their symptoms. Despite this, 8 in 10 menopausal women say their workplace has no basic support in place for them – no support networks (79%), no absence policies (81%) and no information sharing with staff (79%).[128]

National research conducted by the NHS indicates that compassionate workplaces are needed to support women at work.[129] Public Health Birmingham has been involved in raising awareness of menopause and implementing compassionate HR policies in response. There are a few initiatives which can help women experiencing menopause across the city. GP training is also needed to ensure women are comfortable seeking medical support, guidance and, if needed, appropriate treatment for their symptoms.

Access to treatment

Menopause is essentially a hormone deficiency, and there is an effective and safe treatment available – Hormone Replacement Therapy (HRT) that includes oestrogen, often progestogen and in some cases testosterone. HRT is recommended by NICE[130] and is proven effective in managing menopause symptoms such as hot flushes, night sweats, mood swings, brain fog, vaginal dryness and bladder symptoms, as early as during perimenopause. It also can have significant wider health benefits such as reducing the risk of developing conditions including heart disease, osteoporosis, diabetes, depression and dementia in the future as a result of the low hormone levels. The benefits of taking HRT outweigh any risks for the majority of women, yet only the minority of menopausal women (around 14%) take HRT. [131]

Case study: University Hospitals Birmingham 'Menopause Passport'

University Hospitals Birmingham (UHB) developed the NHS's first ever menopause passport to further support female staff, as the trust employs more than 18,000 women. The passport changed the working culture around menopause, as Wendy Madden – the nurse who developed the initiative – said that menopause was previously a taboo subject within the workplace. The initiative has helped to keep more female employees in the workforce as they approach the menopause.

Case study: Birmingham City Council's Workplace Menopause Policy

BCC recognises that a significant proportion of its workforce will be impacted by the menopause and its symptoms, either individually, working with colleagues or through managing others. The purpose of this policy is to raise awareness of the menopause, to develop and foster an understanding of the impact in the workplace that the menopause can have on individuals and to assist employees and managers to sources of relevant advice and support. This policy aims to enable employees to have informed and secure conversations in the workplace as well as help identify reasonable working adjustments where appropriate. This policy is inclusive of all gender identities, including transgender and non-binary employees.

5.4.2 CONCLUSIONS

Support for women experiencing menopause needs to improve. The same applies to information and advice available to women, so that they are better equipped to understand their symptoms and if needed, seek appropriate treatment. Unfortunately, many women suffer without their symptoms being recognised and barriers to menopause support are of a particular challenge for women from ethnic minority backgrounds and LGBT+ community, impacting their mental as well as physical health. Although not proved, there may be a link between higher rates of suicide amongst women aged 50-54 years and menopause due to the likelihood of experiencing it at this age. Work must continue to improve awareness amongst women, health professionals and employers to improve diagnosis, access to treatment and support within workplaces.

5.4.3 RECOMMENDATIONS

18. Birmingham City Council to champion across the city the adoption of the Menopause Workplace Pledge, an accreditation scheme for employers providing flexible working arrangements for employees experiencing menopause.
19. Birmingham City Council to evaluate the impact of the Birmingham City Council's workplace menopause policy as a model of good practice and promote its positive impacts.
20. BSol ICS to support the evaluation of the menopause passport initiative and continue to promote menopause friendly policies across its workplaces.
21. BSol ICS to continue to increase awareness of menopause symptoms, and improve diagnosis and access to appropriate treatment, if needed.

5.5 IMPACTS OF VIOLENCE AGAINST WOMEN AND GIRLS

5.5.1 KEY FINDINGS

Violence against women and girls has both immediate and long-term effects on physical, sexual and mental health. Victims of violence commonly report that they experience migraines, infections, gastrointestinal disorders, chronic pain, hypertension and musculoskeletal problems, and that these symptoms can persist for a long-time after the abuse.[132] Violence also has an adverse impact on female mental health and is associated with higher rates of depression, anxiety, stress-related illness, self-harm, and suicide.[133] Therefore, health interventions for victims of gender-based violence should have greater inclusion of mental health services.

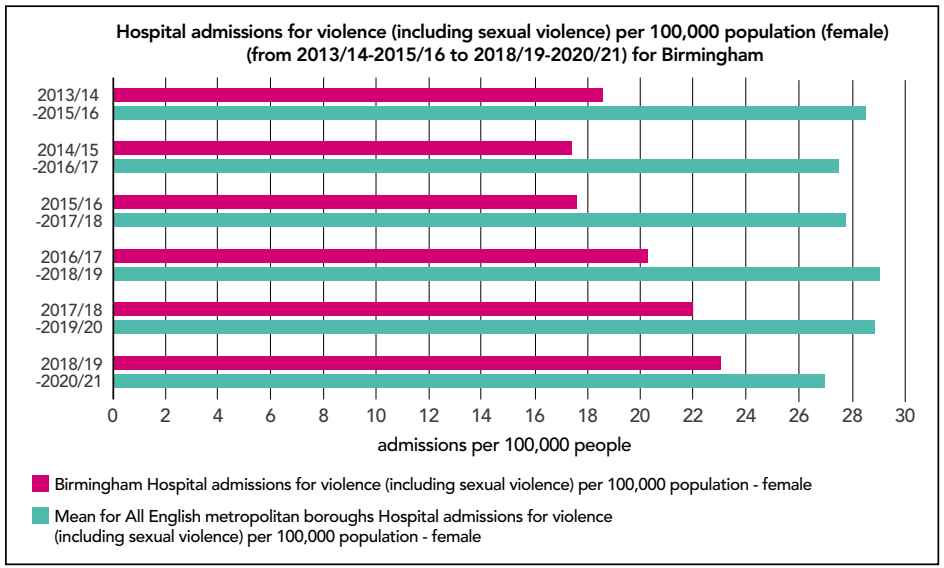
Violence against women is a major area of concern in Birmingham. Between 2022 to 2023, there were 4317 high-risk cases of domestic abuse in the city. Of these 4317 cases, 66% involved female victims indicating that there is a higher prevalence of female victims with greater support needs in Birmingham as shown in Table 6.

Table 6. Birmingham MARAC Cases, 2022/23

Birmingham Multi Agency Risk Conference (MARAC) Cases 2022/23				
Total	Female	Male	Transgender	Unkown
4,317	2,855	195	5	1,262

Since 2014-15, the number of hospital admissions for violence (including sexual violence) for Birmingham females has been increasing – see Figure 32.

Figure 32. Hospital admissions for violence (female) - Birmingham. Source: OHID, 2021



Domestic violence and complex needs

The relationship between mental wellbeing and domestic violence is bidirectional; people who have mental health problems are more likely to experience DVA compared to those who do not[134], and DVA itself can cause mental health difficulties.[135] It is estimated that more women take their own lives due to DVA than those who are murdered by their abuser; whilst two women a week are killed by an abuser, 30 women everyday attempt suicide as a result of experiencing DVA, and three women a week take their own lives.[136]

Intersecting factors such as ethnicity, sexual orientation and disability pose an increased risk to health for victims and survivors of gender-based violence. According to a SafeLives study, domestic abuse is more prevalent amongst Black Caribbean than White British women.[137] The evidence suggests that the prevalence of DVA may be higher among lesbian and bisexual females than heterosexual females and that bisexual females experience more DVA than females belonging to other sexual identities.[138] The same study also found that that females in same-sex relationships reported a higher prevalence of physical assault, injuries, psychological aggression and the highest frequency of overall victimization. We have also found that in England, disabled people experience twice the rate of sexual assault, domestic abuse and stalking than non-disabled people.[139]

Deprivation, homelessness and barriers to employment and education further exacerbate the health (particularly mental health) impacts in female victims of gender-based violence.

Between 2022 to 2023, there were 992 instances of homelessness presentation in Birmingham where domestic abuse was cited as the main reason for homelessness. 17.3% of households reported domestic abuse as the main reason for being placed in temporary accommodation, making up 483 households – domestic abuse was the third highest reason.[140] Of the 992 presentations, the overwhelming majority were female, the three most impacted ethnicities being Pakistani, White British and Black African – 209, 205 and 90 respectively. A full breakdown by gender and ethnicity is provided in Table 7.

Table 7. Homelessness presentations where the main reason for homelessness was domestic abuse, gender, and ethnicity breakdown. Source: Birmingham City Council, Housing Service data 2022-2023.

Ethnicity	Female	Male	Transgender	Total
Pakistani	209	9		218
White British	205	10		215
Black African	90	2		92
Any Other White Background	68	1		69
Black Caribbean	58	3		61
Bangladeshi	45	3		48
Mixed White & Black Caribbean	38	1		39
Information Not Yet Obtained	31	6	1	38
Any Other Asian Background	32	1		33
Indian	28			28
Any Other Black Background	25			25
Arab	19	4		23
Prefer Not To Say	20			20
Any Other Ethnic Background	18			18
Not Known	12	6		18
Mixed White & Asian	17			17
Any Other Mixed Background	15			15
Mixed White & Black African	6	1		7
Irish	4	1		7
Chinese	2			2
Gypsy/Roma	1			1
Total	**943**	**48**	**1**	**992**

The 2022-2023 homelessness data for Birmingham also demonstrated the additional support needs of women in Birmingham facing homelessness due to domestic abuse. Of the 847 households who had a full Housing Needs Assessment, 123 had a history of poor mental health, 22 reported a learning disability, and 69 were experiencing physical ill health or disability. 301 households reported barriers to education, employment, and training.[141] A full breakdown on additional support needs identified in Housing Needs Assessment is provided in Table 8

Table 8. Breakdown of Housing Needs Assessment where additional support needs were identified. Source: Birmingham City Council, Housing Service data 2022-2023.

Support Need	No. Customers
18-25 Years	18
Abuse (Non-Domestic)	13
Access Education/Employ/Train	301
Aged 16-17	8
Alcohol Dependency	2
Care Leaver 18-20	1
Care Leaver 21+	8
Domestic Abuse	709
Drug Dependency	8
History Mental Health	123
History Offending	2
History Rough Sleeping	4
Learning Disability	22
Physical Ill Health/Disability	69
Repeat Homelessness	13
Sexual Abuse/Exploitation	42
Young Parent	3
Total	**1,346**

Honour-Based Violence (HBV), Forced Marriage & Female Genital Mutilation (FGM)

Wider literature reports that HBV is typically perpetrated by males against their female relatives, to control and punish behaviour (usually related to female chastity) that brings shame on the family.[142] Forced marriage as an abuse against women's human rights is also deemed as a form of gender-based violence.

In 2022, the Forced Marriage Unit (FMU) gave advice and support in 297 cases related to possible forced marriage and 5 cases to possible female genital mutilation.[143] The West Midlands is associated with the second highest number of cases, accounting for 17% of all referrals. The majority (78%) of victims were in the UK at the time the case was referred to the FMU.

- 88 cases (29%) involved victims aged 17 years and under
- 119 cases (39%) involved victims aged 18 to 25
- 62 cases (19%) involved victims with mental capacity concerns
- 235 cases (78%) involved female victims, and 67 cases (22%) involved male victims

In 2022, the FMU handled cases relating to 25 'focus countries', excluding the UK. The 'focus country' is the country to which the forced marriage risk relates. This could be the country where the forced marriage (or FGM) is due to take place, the country where it has taken place, and/or the country that the spouse is currently residing in. The 'focus countries' (other than the UK) with the highest number of cases in 2022 were:

- Pakistan 147 cases (49%)
- Bangladesh 41 cases (14%)
- India 20 cases (7%)
- Afghanistan 9 cases (3%)
- Iraq 7 cases (2%)
- Somalia 5 cases (2%)

In the UK, South Asian women represented over 70% of all cases of forced marriage. UK literature reviews highlight an elevated rate of completed suicides and self-harm in South Asian women in the UK that may be related to these types of abuse.[144]

A freedom of information request to the West Midlands Police showed that a total of 325 instances of honour-based offences were reported to the WMP in 2021, this increased to 404 in 2022. In 2021, 3850 instances of controlling/coercive behaviour in an intimate / family relationship were reported, this increased to 4047 in 2022.[145] Table 9 below lists the 10 most reported offences categorised under honour-based violence.

Table 9. Honour-based abuse 10 highest report offences (2021 – 2022). Source: West Midlands Police, 2023

Honour-Based Offence	2021	2022	Total
Engage in controlling/coercive behaviour	61	94	155
Threats to kill	38	52	90
Assault without injury - common assault & battery	34	42	76
Sending letters etc with intent to cause distress or anxiety	32	32	64
Assault with injury - grievous bodily harm and actual bodily harm	23	17	40
Harassment	19	15	34
Cruelty to Children/Young Persons - cruelty to and neglect of children	19	15	34
Harassment - putting people in fear of violence	11	15	26
Rape of a female aged 16 or over	11	13	24
Kidnapping - forced marriage offences	8	11	19

Birmingham's current domestic abuse prevention strategy comes to an end this year. A cross-agency working group, that reports to Birmingham's Domestic Abuse Local Strategic Partnership Board has been working to draft the new strategy. The Birmingham's new Violence against Women and Girls Strategy is also in development. Birmingham City Council & Birmingham Community Safety Partnership are working to reduce and prevent the occurrences of violence and abuse against women and girls, strengthen the support available for victims and survivors and improve responses to reports of violence and abuse.

5.5.2 CONCLUSIONS

Sexual violence and domestic abuse are a gendered issue, disproportionately affecting females in Birmingham and nationally. Domestic abuse is the biggest driver for female homelessness, and preventing sexual violence and domestic abuse is key to reducing both physical and mental health risks in the Birmingham female population. Ethnicity and disability are other key factors that exacerbate the disparities.

As the additional support needs of victims of violence and abuse indicate, the local healthcare system needs to provide further support for the mental health needs of victims of domestic abuse, as advocated in the Women's Health Strategy for England, particularly those who already have poor health and/ or learning disabilities. The evidence also indicates that lesbian and bisexual women are at a greater risk of poor mental health and suicide that can be exacerbated by experiences of domestic and sexual violence. They are also, similarly to Black and women from ethnic communities, more likely to receive poorer quality care.

5.5.3 RECOMMENDATIONS

22. BSol ICS to work with the Community Safety Partnership to improve services (particularly mental health support) and promote a trauma informed approach to supporting victims of domestic violence and abuse.
23. Domestic Abuse and VAWG Strategies and associated action plans for the city to consider public health evidence and preventative approaches to tackling domestic abuse and reducing the impacts that violence against women and girls has on their health and mental wellbeing. This includes, but is not limited to, working with:
    a) the education sector on developing healthy attitudes towards relationships early on
    b) BCC and local employers to implement or strengthen policies that promote attitude and behaviour change towards violence and abuse towards females, protect them from it in the workplace and support them to seek help

6. WHAT WORKS? EXAMPLES OF EFFECTIVE INTERVENTIONS FOR WOMEN'S HEALTH

Following the recommendations and guidelines established within the National Women's Health Strategy, and the Royal College of Obstetricians & Gynaecologists (RCOG) 'Better for Women' (2019) Report[146], the following areas will be key to reducing health inequalities for women in Birmingham and need to be considered as part of the recommendations from this report and key priority areas.

1. **Women's Health Hubs** - Women's health one-stop clinics. Easy access to contraception, abortion, and fertility services and upskilling local clinicians with an interest in women's health.
2. **Women's Health Literacy** – Improving access to reliable information on women's health, with a focus on tailored and targeted intervention for marginalised communities and culturally competent early age education on women's health.
3. **Women's Health in Workplace Policies** - Keeping women in the workforce by raising awareness and promoting flexible and compassionate working cultures for health issues such as menstruation and menopause.
4. **Women's Health Screening** - Prevention and early diagnoses of gynaecological cancers across the life course.
5. **Improving Data** – ending the gender data gap, learning from indicators in the reproductive years to influence future health.
6. **Ending Violence against Women & Girls** – promoting a multi-agency approach to reducing instances of violence against women and girls and encouraging support within the workplace.

Below are case studies and further guidelines of best-practice interventions to reduce women's health inequalities that are being or need to be considered in the local action on Birmingham women's health.

Women's Health Hubs[147]

The primary care women's health forum promotes a hub-based model of care to address women's health inequalities, which enables primary care networks (PCNs) to develop a sustainable approach to meeting the specific needs of the local female population, and ensuring services are accessible.

The core principles of the hub model are as follows:

- Making services accessible – by delivering services that are closer to patients' home and that there is a single point of access to service.
- Improving patient experience by training and upskilling local healthcare professional.
- Reducing health inequalities through the support of specialists.
- Delivering services which empower women to look after their health.
- Fully networked service, including general practices, specialist contraception services and secondary care.
- Improving patient pathways.
- Moulded to suit area and population.

Bringing together core services to improve health outcomes for local female populations:

- Contraception and Long-Acting Reversible Contraception (LARC) Services.
- Emergency Contraception.
- Ring Pessary Fitting.
- Heavy menstrual bleeding.
- Menopause management.

Based on local population needs, additional services can also be included such as abortion services. For further guidance and resources for developing a women's health hub: Primary Care Women's Health Forum - The Women's Health Hub Toolkit.

There is currently progress being made by the Birmingham & Solihull ICS and local healthcare stakeholders to implement a hub-based model of care for Birmingham's female population.

Below are examples of good-practice models.

Case Study: Community Gynaecology Service in Birmingham (2015)[148]

In March 2015, Modality Partnership was announced as one of 14 multi-speciality community provider (MCP) vanguards in NHS England's national New Care Models programme. The initial vanguard pilot covered a population of just over 160,000 across the Sandwell and West Birmingham area.

"It's not been about just shifting the hospital model out into the community. It is about actually redesigning the whole service end to end." Dr Aamena Salar, Medical Director for Modality Partnership Community Services.

The service has been received positively by patients who have provided consistent positive feedback suggesting that there are shorter waiting times in locations closer to home with a 'primary care style' of consulting. For further information on the case study: **Setting up a Community Gynaecology Service in Birmingham - A Case Study**

modality partnership
A Commitment to Care

Women's Health Literacy[149]

Adult health education and literacy programmes should respond using flexible, creative, and innovative training and use of technologies.

UNESCO highlights the value of building on learners' prior experience and incorporating local knowledge, culture, and language - fostering a diversity of approaches to women's health literacy and empowering them to make healthier choices and lead healthier lifestyles should be used. The Birmingham Public Health Communities Team commissioned a local engagement partner in 2022 – the Bangladeshi Women's Association, to develop a project to increase levels of health education and promote healthy behaviours such as physical activity, diabetes prevention and reduction and uptake of health screening. Anecdotal evidence provided below highlighted the positive impacts of women-focused health literacy projects in the context community-based peer support and valuing local culture.

Case study: Bangladeshi Women Project

"Mrs Bibi is a mother of 5 children and from a Bangladeshi background. Mrs Bibi had been staying at home busy looking after her young children and family members, with little time for herself. Mrs Bibi heard about our well-being workshops and exercise classes through her sister who is one of our volunteers. Mrs Bibi came to our centre, and we gave her a one-to-one advice session. She was 7 months pregnant with her fifth child.

Mrs Bibi wanted to join the healthy diet workshops. Mrs Bibi with the support of her husband and family members managed to come regularly to the workshops. Two months after joining Mrs Bibi gave birth to a healthy son. A few months after her son was born, Mrs Bibi wanted to join the exercise class and was able to come to our centre whilst family members looked after her baby and other children.

Mrs Bibi has been regularly attending the Yoga and Pilates class, she has health conditions with back problems and severe knee pain. After coming to the classes, the health problems have become easier to cope with, and less painful. She enjoys coming to the class and exercising in a woman only group. This is the only time Mrs Bibi says she has for herself, to socialise with others and she is feeling happier. Mrs Bibi has made friends with other women in the class and has experienced the health benefits of exercise. Mrs Bibi is now telling her friends and family about the importance of keeping fit and healthy. Mrs Bibi encourages them to join these classes and health awareness workshops."[150]

These principles have been shown to have a stronger influence on women's engagement in literacy and health programmes than on men.[151]

Increasing uptake of cervical cancer screening

A recent systematic review of studies on attitudes and perceptions of women to breast cancer screening reported a strong association between negative perceptions of screening and the following factors: low literacy level, negative attitude to a cancer diagnosis (i.e., cancer will invariably be fatal, will affect the relationship with their partner, is shameful to have), and denial (i.e., "normal women cannot have cancer"). Interestingly, "partners having a good knowledge of breast cancer" has been shown to be associated with a positive attitude to breast cancer screening in women. The same factors are likely to influence perceptions of cervical screening.[152]

The members of the working groups noted other evidence relating to participants' perspectives about the uptake of, follow-up of, and adherence to the cervical screening programme that is relevant to the design of communication messages and strategies.

These are summarized as follows:

- When communicating the risks and limitations, it may be useful to inform people that the government or health authorities have carefully evaluated the benefits and risks and have decided to offer screening to all eligible women because the benefits outweigh the risks.
- Communication should emphasize the value of any changes in testing methods (this is highly relevant for programmes adopting screening based on HPV detection), citing appropriate recommendations from recognized international or national expert groups, because people may view changes in practice as "less care" or cost-cutting measures.
- The communication strategy needs to consider the competing priorities of the participants (e.g. parental duties or occupation) and existing barriers (e.g. transportation to the health-care facility and opportunity costs, including time missed from work).
- Use of a contact point that women are more familiar with (e.g. community health workers) improves acceptance of the messages.

Supporting women in the workplace

Anchor institutions such as the NHS and the local authority are large, public-sector organisations which have a significant role in the local geographical area and the community which works and resides within it. They are major drivers of employment in local and regional economies, and their assets can be used as a tool to advance the welfare and development of the local population. The workforce strategies of anchor institutions can support the health and well-being needs of its staff by implementing fair pay and good working conditions, thereby beginning to narrow health inequalities.[153]

Workplace policies such as the UHB menopause passport and Birmingham City Council's flexible working policy are designed to improve working conditions for the female workforce including flexible working and creating a support environment, in which women are more comfortable discussing their health conditions with their managers and employers.

7. NEXT STEPS

We aim to develop a local strategic framework and action plan with the women's health steering group and local system partners to support reducing health inequalities experienced by women in Birmingham through the following next steps:

- Disseminate report findings across the BSol ICS and the wider partnership.
- Discuss and agree the ownership of the recommendations with the women's health working group and other relevant strategic partnerships.
- Continue the implementation of the recommendations that have already been progressed.
- Develop a metrics framework for measuring success against the implementation of the recommendations from this report and improvements in Birmingham women's health outcomes.
- Commence the implementation of the outstanding recommendations through the agreed system action plan.

8. SUMMARY OF RECOMMENDATIONS & KEY PRIORITY AREAS

Theme 1: Cancer		
Ref #	**Recommendation**	**Lead Organisation(s)**
1	Routinely collect, monitor and publish data on female cancer patient satisfaction with health care and use it to improve quality of care.	BSol ICS
2	Develop a whole system approach to improving recording of attendance in cancer screenings to ensure that sex, gender, disability, ethnicity, and locality are captured. This will help inform targeted approaches to improve cancer screening coverage.	BSol ICS
3	Develop culturally sensitive tailored campaigns to promote breast, cervical and other cancer screenings within the target populations/ communities to improve early diagnosis and reduce mortality.	NHSE supported by BSol ICS and Birmingham Public Health
4	Produce a series of accessible and culturally appropriate resources and literature to increase awareness of the importance of cancer screening and the improved service offer for ethnic communities.	NHSE

Theme 2: Cardiovascular Disease & Coronary Heart Disease		
Ref #	**Recommendation**	**Lead Organisation(s)**
5	Develop awareness campaigns for women and primary care providers/ practitioners to raise awareness of CHD/ CVD risks in women and improve early detection and diagnosis.	BSol ICS, Birmingham Public Health

Theme 3: Lifestyle and preventable risk factors		
Ref #	**Recommendation**	**Lead Organisation(s)**
6	Develop and deliver culturally sensitive targeted community-based campaigns to promote healthy behaviours with a specific focus on women's health needs.	Birmingham Public Health with relevant service providers and community partners
7	Raise awareness of available support and continue to encourage the take up of health checks with a specific focus on women's	Birmingham Public Health

Theme 4: Mental health		
Ref #	**Recommendation**	**Lead Organisation(s)**
8	Develop a greater insight into Birmingham women's mental health and promote a gender-based and culturally competent approach to service delivery and mental health practice, focused on prevention and early intervention.	Bsol ICS Mental Health Provider Collaborative
9	Work with the local LGBT+ organisations and the lesbian communities themselves to develop accessible wellbeing resources to address low level mental health needs and promote pathways to addressing more complex needs around self-harm, suicide and eating disorders within these communities. This work needs to be incorporated into the local suicide prevention programme.	Bsol ICS Mental Health Provider Collaborative
10	Strengthen direct referral routes to specialist mental health services for women from inclusion health groups, women with disabilities and lesbian/ bi-sexual women and girls.	BSol ICS

Theme 5: Sexual health		
Ref #	**Recommendation**	**Lead Organisation(s)**
11	Collaborate with the education sector to develop culturally competent messages, resources and services to improve sexual health outcomes amongst young women.	Sexual and reproductive health service providers
12	Conduct deep dive research to explore reasons behind repeat abortions, particularly in lesbian and bisexual, and vulnerable women, and explore tailored targeted interventions that can prevent them.	NHSE

Theme 6: Menstrual health		
Ref #	**Recommendation**	**Lead Organisation(s)**
13	Support the education settings in raising awareness of menstrual health and support amongst children and young people to reduce stigma associated with periods, period poverty, absenteeism related to menstrual health and improve young females' wellbeing.	Children and Families Directorate and Education providers supported by Birmingham Public Health

Theme 7: Reproductive health: fertility, pregnancy and postnatal support		
Ref #	**Recommendation**	**Lead Organisation(s)**
14	Co-produce robust training and performance framework for community midwives, nurses, and local hospitals to address poor quality of ante- and post-natal care for women, particularly disadvantaged women and those from ethnic communities. The framework should include cultural awareness and humility, learning from lived experience, awareness of inclusion practices and policies, awareness of trauma caused by racism and discrimination and how to deliver sensitive care. Healthcare professionals who serve the most socially deprived areas of Birmingham with a larger ethnic population should be prioritised (e.g., Heartlands Hospital)	BSol ICS with communities of experience

Theme 7: Reproductive health: fertility, pregnancy and postnatal support		
Ref #	**Recommendation**	**Lead Organisation(s)**
15	Oversee improved data collection by specific ethnicity in maternity and early years services, so that the unique needs of specific ethnic and inclusion health groups can be further explored and considered to improve quality of care.	Independent Chair of the Quality Committee of the LMNS
16	Implement a robust monitoring and patient feedback system across ante-/ post-natal clinics and maternity services to evaluate and improve care experiences of all women, with a particular focus on care quality and outcomes for women from ethnic communities, inclusion health groups as well as Lesbian women accessing IVF services and referrals.	Birmingham & Solihull Maternity Voices
17	Support all women who are migrants, refugees and asylum seekers, particularly those with no access to public funds, to access appropriate care during and post pregnancy.	GP and midwifery services

Theme 8: Menopause		
Ref #	**Recommendation**	**Lead Organisation(s)**
18	Champion across the city the adoption of the Menopause Workplace Pledge, an accreditation scheme for employers providing flexible working arrangements for employees experiencing menopause.	Birmingham City Council
19	Evaluate the impact of the impact of the Birmingham City Council's workplace menopause policy as a model of good practice and promote its positive impacts.	Birmingham City Council
20	Support the evaluation of the menopause passport initiative and continue to promote menopause friendly policies across its workplaces.	BSol ICS
21	Continue to increase awareness of menopause symptoms, and improve diagnosis and access to appropriate treatment, if needed.	BSol ICS

Theme 9: Impacts of violence against women and girls		
Ref #	**Recommendation**	**Lead Organisation(s)**
22	Work to improve services (particularly mental health support) and promote a trauma informed approach to supporting victims of domestic violence and abuse.	BSol with the Birmingham Community Safety Partnership
23	Domestic Abuse and VAWG Strategies and associated action plans for the city to incorporate public health evidence and preventative approaches to tackling domestic abuse and reducing the impacts that violence against women and girls has on their health and mental wellbeing. This includes, but is not limited to, working with: a) the education sector on developing healthy attitudes towards relationships early on b) BCC and local employers to implement or strengthen policies that promote attitude and behaviour change towards violence and abuse towards females, protect them from it in the workplace and support them to seek help.	Birmingham City Council (Adult Social Care), Birmingham Community Safety Partnership

KEY PRIORITY AREAS:

1. **Women's Health Hubs** - Women's health one-stop clinics. Easy access to contraception, abortion, and fertility services and upskilling local clinicians with an interest in women's health.
2. **Women's Health Literacy** – Improving access to reliable information on women's health, with a focus on tailored and targeted intervention for marginalised communities and culturally competent early age education on women's health.
3. **Women's Health in Workplace Policies** - Keeping women in the workforce by raising awareness and promoting flexible and compassionate working cultures for health issues such as menstruation and menopause.
4. **Women's Health Screening** - Prevention and early diagnoses of gynaecological cancers across the life course.
5. **Improving Data** – ending the gender data gap, learning from indicators in the reproductive years to influence future health.
6. **Ending Violence against Women & Girls** – promoting a multi-agency approach to reducing instances of violence against women and girls and encouraging support within the workplace.

APPENDIX 1.
WOMEN'S HEALTH WORKING GROUP

The dissemination and delivery of the recommendations from the Birmingham Women's Health Needs Report will be driven and monitored by the Women's Health Taskforce (currently known as the Women's Health Working Group), serviced by the Public Health's Inclusion Health Team.

The oversight of the delivery of the implementation plan will be maintained by:

- The Assistant Director of Public Health (Healthy Behaviours and Communities) and the Director of Public Health
- Cabinet Members for Health and Social Care and Social Justice, Community Safety and Equalities
- Birmingham Health and Wellbeing Board via the Creating a City Without Inequality Forum
- Birmingham and Solihull Integrated Care System's Inequalities Board.

The taskforce will be responsible for developing and maintaining a comprehensive understanding of the health inequalities experienced by women in Birmingham, driving improvements in the current provision addressing these inequalities, understanding of service provision gaps and possible solutions to bridge these gaps.

This taskforce is comprised of stakeholders working across the system (e.g., third sector organisations, NHS England, Birmingham and Solihull ICS, local/regional public health, local women's health experts). This function will steer and drive the implementation of the report recommendations and addressing the key priority areas, adding their insight and experience to address the health inequalities experienced by Birmingham's female populations.

Current Membership of the Women's Health Taskforce

Name	Organisation	Role
Monika Rozanski	Birmingham City Council, Public Health	Service Lead – Inclusion Health
Yasmin Nessa	Birmingham City Council, Public Health	Public Health Senior Officer – Gender Project
Becky Pollard	Birmingham City Council, Public Health	Assistant Director – Adults & Older People
Dr Marion Gibbon	Birmingham City Council, Public Health	Assistant Director – Population Health
Joanne Bradley	Public Health Birmingham, Family	Public Health - Education, Young People & Families Lead
Keiran Mckenzie	Public Health Birmingham, Sexual Health	Public Health – Sexual Health Lead
Kathy Lee	Public Health Birmingham, Family	Senior Officer – Children, Young People & Families
Salma Yaqoob	Integrated Care Board (ICB) Inequalities	Programme Director for Health Inequalities
Lorrenda Waite	Integrated Care Board (ICB) Inequalities	Programme Manager – Health Inequalities
Nicola Pugh	Integrated Care Board (ICB) Inequalities	Health and Qualities Programme Manager
Wendy Madden	University Hospital Birmingham	Menopause Lead
Randeep Kular	University Hospital Birmingham	Director of Strategic Projects
Amy Maclean	West Birmingham Integrated Care Partnership (ICP)	Director of Midwifery/Deputy Chief Nurse Women's Division
Rachel Carter	Women's and Children's Hospital NHS Trust	Director of Midwifery/Deputy Chief Nurse Women's Division
Catherine Swann	Office for Health Improvement and Disparities	Regional Oversight
Susheel Randhawa	GP Modality partnership	Clinical Lead in Community Gynaecology
Shabana Qureshi	Ashiana Community Project	Women Wellbeing Manager

The membership may be extended to other experts and will include representatives with lived experience.

ENDNOTES

1 Marmot, M (2020), Health Equity in England: The Marmot review 10 years on. British Medical Journal, 368.

2 Ibid. (2020).

3 World Health Organisation (2021), Gender and Health – How do sex and gender influence health?, https://www.who.int/news-room/questions-and-answers/item/gender-and-health

4 World Health Organisation (2021), Gender and Health – How else does gender link with health?, https://www.who.int/news-room/questions-and-answers/item/gender-and-health

5 Department of Health and Social Care (2022), Women's Health Strategy for England. https://www.gov.uk/government/publications/womens-health-strategy-for-england/womens-health-strategy-for-england

6 Office for National Statistics (2022), Census 2021 Data, United Kingdom.

7 Birmingham City Council (2022), Ward Profiles, Birmingham Total Population, All Topics by city – Census 2021, Birmingham City Observatory.

8 Birmingham City Council (2022), Ward Profiles, Birmingham Total Population, All Topics by city – Census 2021, Birmingham City Observatory.

9 Birmingham City Council (2022), Birmingham Total Population, Sexual Orientation and Gender Identity – Census 2021, Birmingham City Observatory.

10 Birmingham City Council (2022), Birmingham Total Population, Sexual Orientation and Gender Identity – Census 2021, Birmingham City Observatory.

11 Birmingham City Council (2022), Birmingham Total Population, All Topics by city – Census 2021, Birmingham City Observatory.

12 Office for National Statistics (2022), Census 2021, Custom filtered dataset – ethnic group, sex, electoral wards in Birmingham, United Kingdom.

13 Office for National Statistics (2022), Census 2021 Data, Custom filtered dataset – ethnic group, sex, electoral wards in Birmingham, United Kingdom.

14 Birmingham City Council (2019), Deprivation of Birmingham – Analysis of the 2019 Indices of Multiple Deprivation (IMD)

15 Office for Health Improvement and Disparities (OHID) (2020), A01a - Healthy life expectancy at birth (years) – 2018-20 data, Fingertips Public Health Outcomes Framework.

16 OHID (2021), Under 75 mortality rate from all causes (female) – 2021 data, Fingertips Mortality Profile.

17 OHID (2018-19), Obesity in early pregnancy, Fingertips Public Health Profile.

18 OHID (2018-19), Deaths from drug misuse, Fingertips Mortality Profile.

19 OHID (2020), Fingertips PHOF: A01a - Healthy life expectancy at birth (years) – 2018-20 data.

20 OHID (2019), Fingertips Mortality Profile: E03 - Under 75 mortality rate from causes considered preventable (3-year range) – 2017-19 data.

21 OHID based on ONS death registration data and midyear population estimates for the relevant years. Where provided, results for 2020-21 are based on 2020 population data.

22 Graham, H (2008), Unequal Lives: Health and Socioeconomic Inequalities, International Journal of Epidemiology, 37(5):1195-1196

23 Raleigh, V (2023), The health of people from ethnic minority groups in England, The Kings Fund, www.kingsfund.org.uk/publications/health-people-ethnic-minority-groups-england.

24 Birmingham City Council (2022), Bangladeshi Community Health Profile, birmingham.gov.uk.

25 Birmingham City Council (2022), Bangladeshi Community Health Profile, birmingham.gov.uk.

26 Public Health England (2020), Beyond the data: Understanding the impact of Covid19 on BAME groups, gov.uk.

27 Raleigh, V (2023), The health of people from ethnic minority groups in England, The Kings Fund, https://www.kingsfund.org.uk/publications/health-people-ethnic-minority-groups-england.

28 Birmingham City Council (2022), Birmingham and Lewisham African Caribbean Health Inequalities Review (BLACHIR), https://www.birmingham.gov.uk/info/50266/other_public_health_projects/2309/birmingham_and_lewisham_african_and_caribbean_health_inequalities_review_blachir/7

29 Birmingham City Council (2022), Community Health Profiles, birmingham.gov.uk, https://www.birmingham.gov.uk/info/50305/community_health_profiles.

30 ONS (2020), Deaths of homeless people in England and Wales: 2019 registrations, gov.uk.

31 Birmingham City Council (2022), Birmingham Joint Health and Wellbeing Strategy: Creating A Bolder, Healthier City 2022-2030.

32 Birmingham City Council (2019), Deprivation in Birmingham – Analysis of the 2019 Indices of Deprivation, birmingham.gov.uk

33 Birmingham City Council (2022), Birmingham Joint Health and Wellbeing Strategy: Creating A Bolder, Healthier City 2022-2030, birmingham.gov.uk.

34 OHID (2022), Fingertips Mortality Profile: Under 75 mortality rate from cancer (female)

35 Birmingham & Solihull CCG (2021), Cancer Patient Experience Survey.

36 OHID (2023), Fingertips PHOF: C24b-c Cancer Screening Coverage: Cervical Cancer.

38 Public Health England (2020), PHE Screening Inequalities Strategy

37 OHID (2023), Fingertips PHOF: C24a Cancer Screening Coverage: Breast Cancer. 38 Public Health England (2020), PHE Screening Inequalities Strategy

39 Cervical Cancer Trust (2011), The differing understanding of cervical screening among white women and women a BAME community, bme_research_2011_final.pdf (jostrust.org.uk).

40 Marlow, L A V et al (2015), Understanding cervical screening non-attendance among ethnic minority women in England, British Journal of Cancer, 113,5 (2015): 833-9. doi:10.1038/bjc.2015.248.

41 Andiwijaya FR, Davey C, Bessame K, Ndong A, Kuper H (2022)., Disability and Participation in Breast and Cervical Cancer Screening: A Systematic Review and Meta-Analysis. Int J Environ Res Public Health. 2022;19(15):9465.

42 Birmingham City Council (2022), Community Health Profiles, https://www.birmingham.gov.uk/info/50305/community_health_profiles

43 Birmingham City Council (2022), Birmingham and Lewisham African Caribbean Health Inequalities Review (BLACHIR), https://www.birmingham.gov.uk/info/50266/other_public_health_projects/2309/birmingham_and_lewisham_african_and_caribbean_health_inequalities_review_blachir/7

44 Birmingham City Council (2022), Community Health Profiles, https://www.birmingham.gov.uk/info/50305/community_health_profiles.

45 Albus, C. (2018), Health Literacy: Is it important for cardiovascular disease prevention? European Journal of Preventive Cardiology, Vol.25, pp.934-935.

46 Piepoli MF, Hoes AW, Agewall S et al. (2016), European Guidelines on Cardiovascular Disease Prevention in Clinical Practice: The Sixth Joint Task Force of the European Society of Cardiology and Other Societies on Cardiovascular Disease Prevention in Clinical Practice, European Journal of Preventive Cardiology, 23, pp. NP1–NP96.

47 OHID (2019), Fingertips PHOF: E04a - Under 75 mortality from all cardiovascular diseases (per 100,00) 3 year range.

48 PHE (2019), Birmingham Health Profile 2019.

49 NHS England (2022-23), Quality and Outcomes Framework.

50 OHID (2022-23), Fingertips PHOF: CHD: QOF prevalence (all ages).

51 British Heart Foundation (2019), 'Bias and Biology – Briefing Paper', www.bhf.org.uk.

52 British Heart Foundation (2023), Local heart and circulatory disease statistics: Birmingham.

53 British Heart Foundation (2019), 'Bias and Biology – Briefing Paper', www.bhf.org.uk.

54 British Heart Foundation (2019), 'Bias and Biology – Briefing Paper', www.bhf.org.uk.

55 Birmingham and Solihull Integrated Care System, Healthy Hearts https://www.bsolhealthyhearts.nhs.uk/

56 Astin F and Karl, A., (2010), Ethnicity and Coronary Heart Disease: Making Sense of Risk and Improving Care', Race Equality Foundation, England.

57 British Heart Foundation (BHF, 2021): How your ethnic background affects your risk of heart and circulatory diseases.

58 OHID (2019), Fingertips PHOF: E04a - Under 75 mortality from all cardiovascular diseases (per 100,00) 3 year range.

59 British Heart Foundation (BHF, 2021): How your ethnic background affects your risk of heart and circulatory diseases.

60 Piepoli MF, Hoes AW, Agewall S, et al. (2016), European Guidelines on Cardiovascular Disease Prevention in Clinical Practice: The Sixth Joint Task Force of the European Society of Cardiology and Other Societies on Cardiovascular Disease Prevention in Clinical Practice, European Journal of Preventive Cardiology, 23, pp. NP1–NP96.

61 This has been provided by the Midlands and Lancashire Clinical Support Unit (MLCSU) who extracted the General Practice (GP) data from Egton Medical Information Systems (EMIS) and The Phoenix Partnership (TPP) System One.

62 OHID (2022), Fingertips PHOF: Percentage of adults (aged 18 plus) classified as overweight or obese.

63 National Institute for Health and Care Excellence (NICE, 2023), Conditions and diseases - Diabetes and other endocrinal, nutritional, and metabolic conditions – 1.2.8. Obesity: identification, assessment, and management.

64 NHS Digital (2017), NHS Health Survey for England 2015.

65 OECD (2017), Obesity Update.

66 Centre for Disease Control and Prevention (2023), Alcohol & Public Health.

67 World Health Organisation (2023), Health Topics, Physical Inactivity.

68 NHS Online (2023), What are the health risks of smoking?

69 OHID (2023), Public health profiles – Birmingham, fingertips.phe.org.uk .

70 Birmingham City Council (2021), End of Life in Birmingham, Joint Strategic Needs Assessment Deep Dive Report, https://www.birmingham.gov.uk/downloads/file/22978/end_of_life_in_birmingham.

71 https://www.thrivingplacesindex.org/candidates/E08000025

72 https://webarchive.nationalarchives.gov.uk/ukgwa/20180328140249/http:/digital.nhs.uk/catalogue/PUB21748

73 https://www.england.nhs.uk/wp-content/uploads/2016/02/Mental-Health-Taskforce-FYFV-final.pdf

74 Mental Health Foundation. (2016). Fundamental Facts About Mental Health. https://www.mentalhealth.org.uk/sites/default/files/2022-06/The-Fundamental-facts-about-mental-health-2016.pdf

75 Cabinet Office (2017), Race Disparity Audit – Summary Findings from the Ethnicity Facts and Figures website, https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/686071/Revised_RDA_report_March_2018.pdf

76 McKenzie K , Bhui K, Nanchahal K and Blizard B (2008), Suicide rates in people of South Asian origin in England and Wales: 1993-2003. The British Journal of Psychiatry, 193, 406-409.

77 Common mental disorders - GOV.UK Ethnicity facts and figures (ethnicity-facts-figures.service.gov.uk)

78 Pakistani women's use of mental health services and the role of social networks: a systematic review of quantitative and qualitative research - PubMed (nih.gov)

79 Attitudes towards mental health in an urban Pakistani community in the United Kingdom - PubMed (nih.gov)

80 Moore, L, H Jayaweera, M Redshaw, and M Quigley. n.d. "Migration, Ethnicity and Mental Health: Evidence from Mothers Participating in the Millennium Cohort Study." Public Health 171: 66–75.

81 Detentions under the Mental Health Act - GOV.UK Ethnicity facts and figures (ethnicity-facts-figures.service.gov.uk)

82 Somali Refugees' Perceptions of Mental Illness - PubMed (nih.gov)

83 Meads C, Pennant M, McManus J, Bayliss S (2000), A systematic review of lesbian, gay, bisexual and transgender health in the West Midlands region of the UK compared to published UK research.

84 Government Equalities Office (2017), National LGBT Survey 2017: Healthcare amongst lesbian and bisexual women 2017.

85 Trans community health profile | Community health profiles | Birmingham City Council

86 NHS England. Joint strategic needs assessment guidance 2018 2018 [Available from: https://www.england.nhs.uk/wp-content/uploads/2017/09/joint-strategic-needs-assessment-guidance-jul19.pdf.

87 Emond A, Ridd M, Sutherland H, Allsop L, Alexander A, Kyle J (2015), The current health of the signing Deaf community in the UK compared with the general population: A cross-sectional study. BMJ open.

88 Department of Health and Social Care (2022), Women's Health Strategy for England.

89 Hill, D C, Stein, L A, Rossi, J S, Magill, M, Clarke, J G (2018), Intimate violence as it relates to risky sexual behavior among at-risk females. Psychological trauma: theory, research, practice, and policy, 10(6), 619.

90 Campbell, J C, Soeken K (1999), Forced sex and intimate partner violence: effects on women's health. Violence Against Woman 5, 1017–1035.

91 Patrão, A L (2017), Prevention Of HIV/AIDs and Other STIs In Women In The Context Of Relationships, Health and Health Psychology, European Proceedings of Social and Behavioural Sciences, Vol 30, pp. 236-247), https://doi.org/10.15405/epsbs.2017.09.22 .

92 United Kingdom Health Security Agency (UKHSA, 2023), Sexually Transmitted Infections (STIs): annual data tables.

93 Mitchell, K R, et al. (2022), Sexual and reproductive health in Britain during the first year of the COVID-19 pandemic: national population survey (Natsal-COVID study).

94 OHID (2022), Fingertips Sexual and Reproductive Health Profiles: HPV Vaccination Coverage.

95 PHE (2015), Sexually transmitted infections and chlamydia screening in England.

96 Chau C, et al. (2016), HIV diagnoses, late diagnoses and numbers accessing treatment and care report.

97 PHE (2015), Sexually transmitted infections and chlamydia screening in England.

98 Wayal, S, et al. (2017), Ethnic variations in sexual behaviours and sexual health markers: findings from the third British National Survey of Sexual Attitudes and Lifestyles (Natsal-3). The Lancet Public Health, 2(10),458-472.

99 French R, et al. (2004), Exploring the attitudes and behaviours of Bangladeshi, Indian and Jamaican young people in relation to reproductive and sexual health.

100 French R, et al. (2004), Exploring the attitudes and behaviours of Bangladeshi, Indian and Jamaican young people in relation to reproductive and sexual health.

101 Jewkes, R, Dunkle, K (2017). Drivers of ethnic disparities in sexual health in the UK. The Lancet Public Health, 2(10), 441-442.

102 Pitcher, D and Campbell, R (2020), Understanding the support needs of sex workers in the West Midlands using the Internet for their work, The Red Project.

103 Birmingham City Council and Solihull Metropolitan Borough Council (2021), Sexual Health Needs Assessment, Birmingham_Solihull_SHNA_V3.2.pdf

104 OHID (2021), Fingertips Sexual and Reproductive Health Profiles: Under 25s repeat abortions.

105 Birmingham City Council and Solihull Metropolitan Borough Council (2021), Sexual Health Needs Assessment, Birmingham_Solihull_SHNA_V3.2.pdf

106 OHID (2022), Fingertips Sexual and Reproductive Health Profiles: C01 - Total prescribed LARC excluding injections rate / 1,000.

107 Hodson K, Meads C, Bewley S (2017), Lesbian and bisexual women's likelihood of becoming pregnant: a systematic review and meta-analysis, BJOG, 124(3):393-402.

108 Charlton, B M, et al. (2018), Teen pregnancy risk factors among young women of diverse sexual orientations, Pediatrics, 141(4).

109 Hennegan J, et al. (2021), Menstrual health: a definition for policy, practice, and research. Reproductive Health Matters. 29(1):1911618.

110 Birmingham City Council (2020), Tackling Period Poverty and Raising Awareness Inquiry, birmingham.gov.uk.

111 Brown, N, et al. (2022), Teachers' perceptions and experiences of menstrual cycle education and support in UK schools, Frontiers in Global Women's Health, 3, 827365.

112 Yougov (2022), Survey on Period education in the UK.

113 NHS England (2023), Three-year delivery plan to improve maternity and neo-natal services.

114 Healthwatch Birmingham (2023), Maternity services in West Birmingham: The experiences of Black African and Black Caribbean women.

115 Department of Health and Social Care (2022), 'New taskforce to level-up maternity care and tackle disparities', gov.uk/government/news/new-taskforce-to-level-up-maternity-care-and-tackle-disparities.

116 OHID (2022), Fingertips Child and Maternal Health: Infant Mortality Rate 2019-21.

117 Birmingham City Council (2021), Infant Mortality Scrutiny Report, Health and Social Care Overview and Scrutiny Committee, birmingham.gov.uk.

118 Birmingham City Council (2022), Birmingham and Lewisham African Caribbean Health Inequalities Review.

119 Department of Health and Social Care (2022), 'New taskforce to level-up maternity care and tackle disparities', gov.uk/government/news/new-taskforce-to-level-up-maternity-care-and-tackle-disparities.

120 MBRRACE-UK (2023), Saving Lives, Improving Mothers' Care: Lessons learned to inform maternity care from the UK and Ireland Confidential Enquiries into Maternal Deaths and Morbidity 2019-21

122 Birmingham City Council (2022), Seldom Heard Conversation about Pregnancy, birmingham.gov.uk.

123 Cherguit J, Burns J, Pettle S, Tasker F (2013). Lesbian co-mothers' experiences of maternity healthcare services. Journal of Advanced Nursing; 69(6):1269-78.

124 Birmingham City Council (2022), Lesbian Community Health Profile, birmingham.gov.uk.

125 Office for National Statistics (2022), Estimates of the population for the UK, England, Wales, Scotland and Northern Ireland.

126 All-Party Parliamentary Group on Menopause (2022), Inquiry to assess the impacts of menopause and the case for policy reform - Concluding report.

127 Fawcett Society (2022), Landmark Study: Menopausal women let down by employers and healthcare providers.

128 Fawcett Society (2022), Landmark Study: Menopausal women let down by employers and healthcare providers.

129 NHS England (2018), Toward commissioning for workplace compassion: a support guide, www.england.nhs.uk/wp-content/uploads/2018/10/towards-commissioning-for-workplace-compassion-a-support-guide-v2.pdf.

130 NICE (2019), NG23: Menopause: diagnosis and management.

131 NICE (2019), NG23: Menopause: diagnosis and management.

132 Chrisler, J C & Ferguson, S (2006), Violence against women as a public health issue. Annals of the New York Academy of Sciences, 1087(1), 235-249.

133 Peckover, S (2002), Domestic abuse and women's health: the challenge for primary care, Primary Health Care Research & Development, 3(3), pp.151-158

134 Trevillion, Oram, Feder & Howard, (2012), Experiences of domestic violence and mental disorders: a systematic review and meta-analysis. PloS one; 7(12)

135 Oram, Khalifeh & Howard (2016), Violence against women and mental health. The Lancet Psychiatry, 4 (2).

136 SafeLives (2016), A Cry for Health: Why we must invest in domestic abuse services in hospitals.

137 Birmingham City Council (2022), Caribbean Community Health Profile, birmingham.gov.uk.

138 Badenes-Ribera L, Bonilla-Campos A (2021), Domestic violence and abuse within female same-sex relationships, Journal of Lesbian Studies, 2, 29—47.

139 PHE (2015), Disability and domestic abuse: risk, impact and response.

140 Birmingham City Council, (2023), Domestic Abuse Information 2022-23, Housing Service Data.

141 Birmingham City Council (2023), Domestic Abuse Information 2022-23, Housing Service Data.

142 Garg, P (2020), An Exploration into domestic abuse and so-called 'honour'-based violence and abuse experienced by South Asian Women, University of Birmingham Research Archive.

143 Forced Marriage Unit, Home Office and Foreign, Commonwealth & Development Office (2023), Forced Marriage Unite Statistics 2022.

144 Chantler, K (2012). Recognition of and intervention in forced marriage as a form of violence and abuse. Trauma, Violence, & Abuse, 13(3), 176-183.

145 West Midlands Police (2023), Incident and Crime Statistics – Honour Based Abuse (1317A/23).

146 Royal College of Obstetricians & Gynaecologists (2019), Better for Women: Improving the health and wellbeing of girls and women', https://www.rcog.org.uk/media/h3smwohw/better-for-women-full-report.pdf.

147 Primary Care Women's Health Forum (2023), 'Developing a Women's Health Hub', Primary care Women's Health Forum: The Women's Health Hub Toolkit, whh.pcwhf.co.uk/resources/developing-a-womens-health-hub/

148 Primary Care Women's Health Forum (2023), 'Setting Up A Community Gynaecology Service in Birmingham', Primary Care Women's Health Forum, https://whh.pcwhf.co.uk/wp-content/uploads/2023/01/Setting-up-a-Community-Gynaecology-Service-in-Birmingham-a-case-study.pdf

149 UNESCO (2016), Promoting Health and Literacy for Women's Empowerment, France.

150 UNESCO (2016), Promoting Health and Literacy for Women's Empowerment', France.

151 IARC, Department of Health and Health Service Executive of Ireland (2023), Recommendations on best practices in cervical screening programmes: audit of cancers, legal and ethical frameworks, communication, and workforce competencies. International Agency for Research on Cancer; 11.

152 Reed, S, et al. (2019), Building healthier communities: the role of the NHS as an anchor institution. The Health Foundation.

153 Reed, S, et al. (2019), Building healthier communities: the role of the NHS as an anchor institution. The Health Foundation

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