# WOMEN'S HEALTH & WELLBEING

# Joint Strategic Needs Assessment

2024 Report

Public Health Jersey

JSNA
Joint Strategic Needs Assessment

# Contents

# Executive Summary

Jersey's first Joint Strategic Needs Assessment (JSNA) focuses on women's health and wellbeing. Its aim is to **understand the health and wellbeing needs of women and girls** in Jersey and provide an evidence base to support decision makers to plan, prioritise and make improvements to services.

The needs assessment involved a comprehensive review of existing local data, gathering views from the public and professional stakeholders via surveys, interviews and focus groups, and examining best practice and research in other jurisdictions.

## Key findings

1. **Population trends and female health challenges.**
    - Jersey's declining birth rates and increase in the average age of mothers reflect global trends.
    - Women, particularly female single parents, are disproportionately affected by financial stress, which is negatively impacting their health and wellbeing
    - The population is aging but healthy life expectancy and measures of wellbeing for women have declined, meaning that women are living longer, but spending more years with poor health than men with a projected increase in age related diseases, such as dementia.
2. **Barriers to health and wellbeing.**
    - Societal and cultural biases shape women's experiences, with women and professionals describing dismissive and misogynistic attitudes, leading to the stigmatisation of women's health issues.
    - Financial insecurity, work-related stress, and limited access to health services are key barriers to women's health and wellbeing.
    - Women report that cost, logistical challenges, and limited access to specialist care, particularly in gynaecology and mental health, hinder their ability to maintain their health.
    - Women and professionals identified better gynaecological care, improved mental health services, and more accessible menstrual and menopausal support as key priorities for improvement.
3. **Healthy behaviours and prevention.**
    - Women in Jersey drink more alcohol on average than their English counterparts, with rising consumption rates, especially in mid-life, while smoking remains a concern in lower-income groups.
    - Poor diet, obesity, and low physical activity, particularly among disadvantaged women, exacerbate health inequalities.
    - Screening programmes for conditions like breast and cervical cancer are performing well, but show gaps in coverage, whilst there is a lack of understanding of skin cancer clinics available in Jersey.
4. **Mental health and wellbeing.**
    - Mental health issues are rising, particularly amongst adolescent girls, and are compounded by factors such as financial stress and social isolation.
    - A perceived lack of specialised, trauma-informed care is felt to leave many vulnerable women without the support they need, especially those who have experienced violence.

5. **Reproductive and gynaecological health.**
    - Societal attitudes toward reproductive health, including menstruation, miscarriage and menopause, are felt to leave many women without adequate care and support.
    - Delayed motherhood is linked to increasing health risks. Caesarean section rates and abortion rates are rising, highlighting changing reproductive trends.
6. **Wider determinants of health.**
    - Despite high employment rates, women face a significant pay gap, career limitations, and the mental strain of balancing work and family, all of which affect their overall health and wellbeing.
    - Women, particularly single mothers, report that financial and time pressures including those associated with high childcare costs, limit their access to quality healthcare, healthy food, and housing.
    - Violence against women and girls (VAWG) is reported to be a significant issue, with almost half of teenage girls having experienced inappropriate sexual comments or attention, and VAWG being the leading cause of homelessness among women.

## Points for consideration

Evidence collected as part of this needs assessment suggests that women and girls living in Jersey remain at risk of inequality when it comes to health and wellbeing outcomes. The needs assessment has identified the following areas for consideration:

- **reducing preventable disease by investing in healthy behaviours** from childhood and across the life course. This includes stopping smoking and vaping, encouraging healthy eating, reducing alcohol consumption, increasing physical activity, improving sleep, and fostering connections with the local community
- **prioritising gynaecological and reproductive health improvements**, through normalising societal attitudes, addressing widespread dismissal of women who raise gynaecological and reproductive health needs and addressing systemic gaps in treatment and care
- **improving mental health support for females around key life stages** including adolescence, perinatal period, and following traumatic events
- **recognising the impact of the wider determinants of health on women and girls**, in particular the challenges of achieving a work-life balance and the cost of housing, childcare and daily living. Single parent families and single pensioners are more likely to be impacted by the wider determinants increasing inequality
- **reducing the barriers to accessing care and support** including lowering costs, considering options for self-referral, person-centred joined-up care and tackling stigma, particularly in relation to accessing mental health support and gynaecological and reproductive services
- **addressing the impact of an aging population and declining birthrate** on Jersey's workforce and healthcare system, considering opportunities for women and girls to play a key future role in the Island's growth and productivity

# Foreword from the Director of Public Health

I am delighted to write this foreword to Jersey's first Joint Strategic Needs Assessment (JSNA). JSNA's have been a routine part of the work of public health teams and local governments in the UK for more than a decade now, so I am pleased to have this resource available here in Jersey.

Focusing on the health and wellbeing of women and girls as this first topic shows some of the insights that are possible from this type of work, bringing together a diverse range of quantitative evidence from across Government and dovetailing that with evidence collected directly from those working in the health system and from our community. It provides a rich evidence base on which decisions can be made.

Many of the findings of this report do not come as a surprise but show that the Island has some significant issues, and the health of our population is impacted by a range of determinants, most outside of the control of individuals. Women and girls in Jersey have kindly told us about their experiences, how their health is impacted by the environment in which they live, grow, work and play, and how their needs are currently met or not. I would like to take this opportunity to thank those people who were involved in our public and professional engagement for taking the time to share their experiences with us. It is thanks to you that the evidence presented here is so rich and detailed.

The publication of this JSNA comes as Jersey's health and care system starts to undergo significant change, with the proposed establishment of a new Partnership Board that brings together partners from across the health and care system, and the formation of Health and Care Jersey, a department of Government focused on preventing illness and improving the health and wellbeing of Islanders, in addition to the delivery of safe, effective services.

As these changes start to embed and support us to work better together, this JSNA will allow us to hear voices from our community and, I hope, provide a good evidence base on which future decisions can be made.

**Professor Peter Bradley**

**Director of Public Health**

**December 2024**

# 1. About the JSNA

This report outlines the findings of Jersey's first Joint Strategic Needs Assessment (JSNA). The core goal of a JSNA is to **understand the health and wellbeing needs of Islanders** both now, and in the future, to help Government plan, prioritise and make improvements to support and services.

While a JSNA is not legally required in Jersey, as it is in the UK, it was initiated due to a number of strategic drivers, notably the health minister's prioritisation of it in the 2022 ministerial plan. This led to the formation of a JSNA steering group, chaired by Public Health and involved a wide range of stakeholders across government and partner organisations.

JSNAs are an assessment of need for a particular topic area. This report presents the findings of Jersey's first JSNA which focuses on women's health and wellbeing.

## Prioritisation process

The topic for Jersey's first JSNA was chosen through a collaborative process led by the JSNA steering group, which included 20 representatives from government, and partner organisations.[i]

The process began by identifying the Government of Jersey's major strategy, policy, and delivery priorities. A prioritisation scoring matrix was then used to assess each topic's potential impact, considering factors such as the population cohort size, scale of the issue, data availability, potential for early intervention, the presence of inequalities, and alignment with existing policies and strategies.

Women's health and wellbeing emerged as the top priority for the first JSNA.

## Spotlight on women's health and wellbeing

Women and girls make up over half of Jersey's population and are known to spend more years in poor health than their male counterparts. While the JSNA focuses mainly on women aged 18 and over it also includes analysis of girls, particularly in the teenage years, where disparities are evident, such as poor mental health or low uptake of physical activity.

Several additional factors contributed to the selection of women's health and wellbeing as a focus this year, including:

- certain health conditions are more likely to affect women, or affect men and women differently, yet women have historically been underrepresented in research and clinical trials
- recent studies in the UK have highlighted gender disparities in healthcare access and outcomes, with many women reporting that their voices are not listened to[1]
- the wider determinants of health, such as pay and working conditions, the role of women as caregivers, and gender-based violence, disproportionately affect some women, leading to poorer health and wellbeing outcomes.

## Equalities statement

It is recognised that solely referencing cisgender women (women who identify with the sex they were assigned at birth) in the context of women's health, particularly in relation to sexual and reproductive health needs, may exclude transgender and non-binary people who have needs and experiences that can be similar to but also unique from those of cisgender women. Nonetheless, some areas of the report may be of relevance to transgender/non binary people.

[i] Further information on the JSNA steering group and prioritisation process can be found online: JSNA website (gov.je/jsna)

## Aims of the women's health and wellbeing JSNA

This JSNA aims to:

- identify and explore key health and wellbeing challenges faced by women and girls in Jersey
- set out any evidence of gender disparities, or female-specific issues in healthcare access and outcomes
- promote a whole-system view when it comes to assessing health and wellbeing needs
- provide data-driven insights to support evidence-based policy development and decisions

This JSNA is focussed on identifying areas for consideration, that decision makers across Government and the community can utilise to plan, prioritise and make improvements to women and girls' health and wellbeing support and services.

## Where did the evidence come from?

This JSNA gathers evidence about the state of women's health and wellbeing from different sources. This includes looking at:

- views and feedback from the public and professional stakeholders
- analysing local data on health, wellbeing and wider societal factors which can determine health outcomes[ii]
- examining best practice and research in other jurisdictions.

## Reading this report

This report is structured into six main chapters:

1. Women's population overview
2. Voices from the community
3. Healthy behaviours
4. Mental health and wellbeing
5. Reproductive and gynaecological health
6. Wider determinants of health

Each chapter begins with a summary page which outlines the key points from that chapter. When interpreting the report findings, it is important to note that:

- unless specified otherwise, all evidence referenced within this report is based on Jersey data
- the public consultation findings are not statistically representative of the Jersey population, rather, they represent the views of the people that chose to respond to the survey
- similarly, the professional stakeholder consultation findings only represent the views of those who chose to take part in the consultation
- the qualitative findings are based on people's self-reported perceptions – some of these perceptions may not be factually accurate, nevertheless, they represent "the truth" to the respondents and, as such, are vital in understanding their attitudes and views

## Feedback

If you would like to provide feedback, then please contact us at the following address or email us at: jsna@gov.je

Public Health Intelligence
Government of Jersey
Union Street
St. Helier
JE2 3DN

Your feedback will be assigned to the right person so it can be responded to in the right way. All feedback will be handled in line with our Customer Feedback Policy

[ii] Local data collection and analysis ended in November 2024. Efforts have been made to incorporate relevant data from more recent publications where possible.

# 2. Women's population overview

This chapter provides an overview of the population of women in Jersey, exploring demographic makeup, household makeup, general health, long-term conditions, mortality, and life expectancy.

## Key insights

- Birth rates have been declining in Jersey, with women having fewer children and/or having children later in life. This is a global trend.
- The majority of single parents with dependent children are female.
- Women make up a larger share of Jersey's growing aging population, with more females than males aged 65 and older; many of these older women are living alone, often with long-term health conditions and increased care needs.
- Both healthy life expectancy and measures of wellbeing for women have declined recently, meaning that women are living longer, but in poorer health than men.
- Dementia and Alzheimer's disease is a leading cause of death for women.
- Prevention is key; it is estimated that 80% of new cases of heart disease, stroke and type 2 diabetes, 45% of dementia and Alzheimer's disease and 40% of cancer incidence, could be prevented by living healthily (not smoking, eating a healthy diet, limiting alcohol consumption and keeping physically active).

**799** live births in 2023: This represents a **29%** decline since 2012

**88%** of **single parents** with dependent children are women

**67%** of those **living alone** at age 65+ are women

The Age Standardised Rate (ASR) of breast cancer and skin cancer in Jersey is **higher** than in England

| Cancer Site | Jersey | England |
|---|---|---|
| Breast | 189 | 161.6 |
| Skin (Malignant Melanoma) | 47 | 27.1* |

*males and females

**Dementia and Alzheimer's disease** are the leading cause of death for:

**13%** of females

**7%** of males


## Considerations

Policy planning could consider:

- whether incentives are required to support and increase the birth rate in Jersey
- population and inward migration policies
- prevention strategies for disease reduction and to promote healthy aging

## 2.1. General demographics

Jersey's population as at the 2021 census was 103,267, comprising of slightly more females (52,264) than males (51,003).[2] Figure 1 outlines the makeup of Jersey's population by age and sex. It shows that there are significantly more females than males in over 65 age groups, with 59% of over 80's being female.

The birth rate in Jersey is declining, with women having fewer children and/or having children later in life.[3] The total fertility rate has been below 2 for decades, meaning it falls short of the replacement level needed to maintain population size without inward migration.

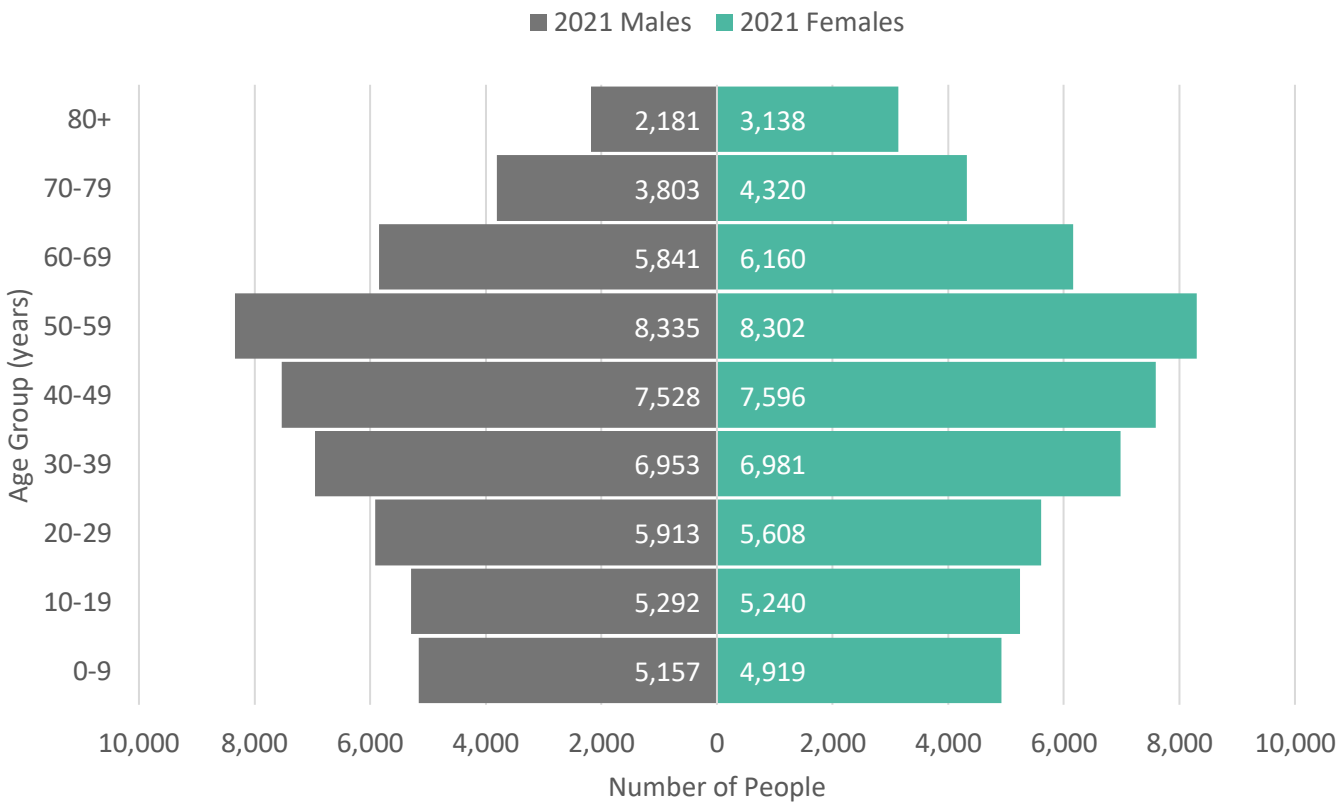
Adults of working age are the largest contributor towards net inward migration in the last 10 years, with the greatest levels of inward migration occurring for adults aged 30 to 39 years.[2]

There has also been an increase in ethnic diversity amongst Jersey's female population over this time. The proportion of females of white Jersey/British/Irish ethnicity has decreased from 81% to 77%. The proportion of Portuguese/Madeiran ethnicity saw a slight increase (8% to 9%) and accounts for just under 1 in 10 Jersey females, a similar proportion to 'other' white ethnicities which also saw a slight increase. The population of Asian, black, and mixed ethnicities almost doubled, from just over 2% of the population to 4%, and accounts for approximately 1 in 25 Jersey females.[2]

In 2021, 20% of females in Jersey were aged 65 or older. By 2043, this figure is projected to rise to between 24% and 29%,[4] reflecting an overall aging population. As illustrated in Figure 1, the largest population groups (ages 35–64) will transition into older age within the next 10–15 years. These demographic shifts must be factored into planning and developing future health and care services.

Jersey follows many of the key health related demographic trends seen across other jurisdictions,[5] such as an increasing age of first-time mothers and women having a higher life expectancy.

***Figure 1. Population structure of Jersey by sex and age group (2021 Census)***




*Source: Statistics Jersey*

## 2.2. Household makeup

According to the 2021 census, 45% of females aged over 16 were married or in a civil partnership, 32% had never married, 14% were divorced or otherwise separated and 8% were widowed.[6] Compared to 40 years ago,[7] people are getting married later and divorce/separation rates have increased. These shifts have implications on the number of single parent families.

Single parent families are more likely to struggle with the cost of living and housing and are more likely to suffer with anxiety and depression.[8] While this is not an issue exclusive to women and girls, the vast majority (88%) of single parents with dependent children are female.[6] Additionally, the public consultation findings emphasised that women bear the brunt of these challenges. Many shared experiences highlighting the unique pressures placed on women due to caregiving responsibilities, financial inequalities, and societal expectations. This is a theme that will arise multiple times throughout this report.

> **"Being a single parent having to work more than one job to make ends meet (just), very challenging to dedicate time to physical health."** (Survey, Female, 45-54yrs)

Working aged (16-64 years) women in Jersey are less likely to be in employment than working aged men (77% vs. 85%).[2] However, this female employment rate is a notable increase on 40 years ago and higher than the United Kingdom and all EU countries except Sweden.[9]

## 2.3. General health

When asked to self-rate their general health, the vast majority of females (75%) rated their health as 'good' or 'very good', which was a similar proportion to males (76%). Women aged 75+ were the least likely to report their health as 'good' or 'very good', with just 59% reporting 'good' or 'very good' health.[8] A survey of school children aged 9 – 18 years revealed that females were more likely than males (5% vs 3%) to rate their health as 'poor' or 'very poor'.[10]

Jersey has a higher female life expectancy than any region in England.[11] However, similar to other jurisdictions, **women in Jersey are living longer but spending more years in poor health compared to men**. With the likelihood of poor health rising significantly with age, especially in those aged over 75 – the ageing population in Jersey makes this an increasingly critical concern.[11]

On average, women attend 450 GP appointments over the course of their lives, which is approximately 44% more than men.[12]

## 2.4. Long-term conditions and multi-morbidity

The 2021 Census found that 16% of females overall reported their daily activities being limited 'a little' or 'a lot' by longstanding illness.[2] This proportion varied by age, with older females, being more likely to report limiting disability (41% of over 75's) than younger females (13% aged 15-29 and 13% aged 30-44). The proportion of females with limiting disabilities was also slightly higher than that of males, particularly among younger adults aged 15-44.

A theme that emerged through the public and professional consultation was a lack of joined up care in Jersey, with the health and care system for women and girls often acting in a fragmented way, particularly for those with multiple long-term conditions (multi-morbidities) who were frequent users of health and care services.

> **"Patients face the burden of navigating the healthcare system and advocating for themselves, often without the necessary continuity of care"** (Professional Stakeholder)

In Jersey, more women (16,750) have at least one long-term condition[iii] than men (16,055), while men account for the majority of those with two or more long-term conditions (7,255 men compared to 6,880 women).[13]

While many long-term conditions affect males and females relatively equally in Jersey, some conditions affect women more than men, such as dementia (63% female, 37% male) and chronic kidney disease (59% female, 41% male).[13] For these conditions, the sex difference is largely attributable to the age profile of the condition. For example, there are more females than males overall in older age groups, so there is expected to be a higher proportion of female patients for conditions affecting primarily older patients such as dementia and chronic kidney disease (average age is 84 amongst dementia patients, and 78 amongst chronic kidney disease patients).[13] The prevalence of dementia increases with age, with 21% of females over 90 years old having dementia.[14]

**A significant proportion of long-term conditions can be prevented**; it is estimated that 80% of new cases of heart disease, stroke, and type 2 diabetes and 40% of cancer incidence could be prevented simply by changing four sets of behaviours (smoking, unhealthy diet, consumption of alcohol and insufficient physical activity).[15] The prevalence of unhealthy behaviours earlier in life, which can be seen more prominently in girls rather than boys, increases the risks of many women getting long-term conditions (morbidities) that are prevalent across the older age groups. This will be discussed in more detail in the healthy behaviours chapter.

## 2.5. Cancer

The age-standardised rate[iv] for cancer incidence in Jersey has been consistently lower for females than for males since 2007 but has been consistently higher than that of females in England.[16]

Over the last ten years Jersey has had a higher rate of breast cancer than that recorded in England, with an age-standardised incidence rate across 2018-2020 of 189 per 100,000 population, compared to England's rate of 162 per 100,000. [16] However, the mortality rate associated with breast cancer (29 per 100,000) is similar to England's (33 per 100,000). Although cancer staging data is not readily available, this indicates that breast cancers are caught at an earlier and more treatable stage, potentially due to the shorter interval in screening. That said, there are longer term effects from cancer treatments which can affect quality of life.[17]

Similarly, as shown in Table 1, women in Jersey have a significantly higher incidence rate of skin cancers than those seen in England but similar mortality rates.

***Table 1: Skin Cancer incidence and mortality age-standardised rates (ASR) per 100,000 population, 2018-2020***

| *Type of Skin Cancer* | *Jersey Female Incidence ASR* | *England Overall Incidence ASR* | *Jersey Female Mortality ASR* | *England Overall Mortality ASR* |
|---|---|---|---|---|
| ***Malignant Melanoma*** | 46.9 | 27.1 | 3.6 | 3.8 |
| ***Non-Melanoma*** | 397.3 | 233.7 | 1.2 | 1.5 |

*Source: Channel Islands Cancer Report*

Cancer screening may help prevent cancer by identifying early signs, often before symptoms appear. Screening is discussed in more detail under the Healthy Behaviours chapter.

[iii] There are 12 long-term conditions which form the basis of Jersey's multi-morbidity analysis: Atrial Fibrillation, Asthma, Coronary Heart Disease, Chronic Kidney Disease, Chronic Obstructive Pulmonary Disease, Dementia, Diabetes, Heart Failure, Hypertension, Mental Health Problems, Obesity, and Stroke and Transient Ischemic Disease. The Government of Jersey incentivises GPs to record patients with any of these long-term conditions through the Jersey Quality Improvement Framework (JQIF).

[iv] Age-standardised rates allow a fair comparison between different areas, or the same area through time. This method looks at the occurrence of condition/death in the population of interest and calculates what the rate would be in a pre-determined population (known as the standard population), controlling for age.

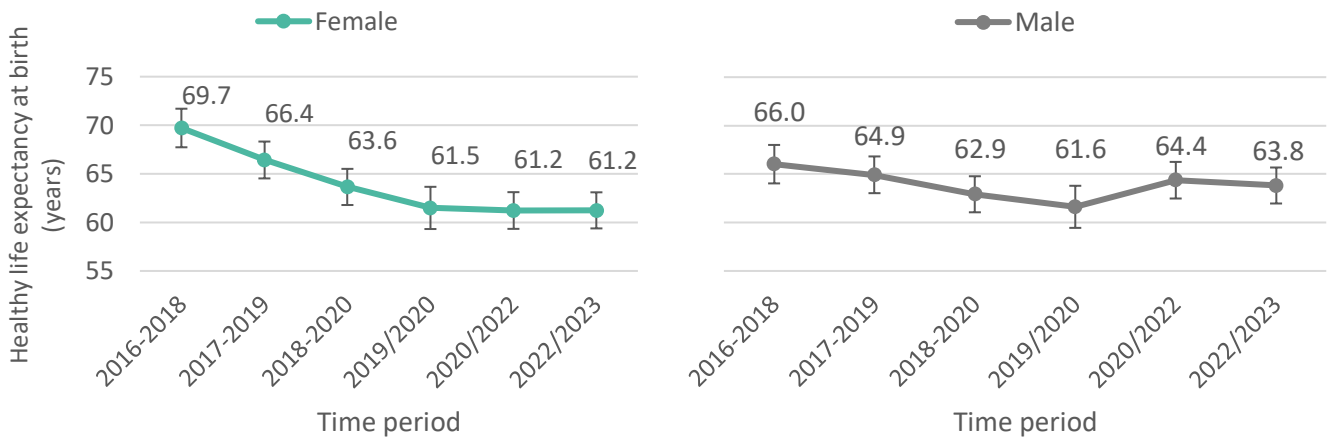
## 2.6. Mortality & life expectancy

The age-standardised mortality rate (per 100,000 population) in Jersey has been lower for females than for males over the last decade.[18] This reflects the fact that average life expectancy is longer for females than for males.[11]

When comparing to regions of the UK, females in Jersey have one of the lowest overall mortality rates, comparable to the Southwest, Southeast and London regions. In general, the cause of death data for men and women follows similar patterns, but most notably, dementia and Alzheimer's disease is the leading cause of 13% of female deaths, compared to just 7% of male deaths.[19]

Although women have a longer life expectancy than men, an increasing amount of this is being spent in poorer health, resulting in women having a shorter healthy life expectancy than men.[11]

***Figure 2: Female and male healthy life expectancy at birth, 3 yearly average (2016-2018 to 2022/2023)***




*Source: Population from Statistics Jersey, Deaths from Superintendent Registrar*

Interestingly, women themselves are worried about ageing well and tackling frailty but only once they are aged 65 and over. Findings from the public consultation showed that 40% of women aged over 65 put 'ageing well and tackling frailty' as a top priority area for improvement, prevention is key here and needs to be promoted and emphasised earlier in the lifespan.

# 3. Voices from the community

This chapter explores the findings of a Government of Jersey consultation that gathered insights from the public and professional stakeholders. It covers views on whether women and girls' health and wellbeing needs are being met, harmful factors, barriers that prevent access to services, and priority areas for improvement.

## Key insights

- Financial insecurity, work-related stress and poor mental health were felt to be the most harmful factors affecting women and girls' health and wellbeing.
- Cost, logistical challenges, and inability to self-refer to specialists were identified as key barriers to women accessing health and wellbeing services.
- Gynaecological care, housing conditions, and mental health were reported as top priority areas for improvement for women and girls' health and wellbeing.
- Younger women prioritised menstrual health, stigma reduction and mental health resources, while older women emphasised menopause support, service accessibility and frailty prevention.
- Focus groups identified the need for better coordination of services, reduced waiting times, and tailored support for vulnerable groups including care and support for people experiencing trauma.

**1,647** public consultation responses **97%** from women

Only **27%** of women felt their mental health needs were being met

**40%** identified financial insecurity as the most harmful factor

**62** professional stakeholder consultation responses

*"Waiting lists for mental health support are too long. Many feel forgotten"*

*"The cost of living here makes basic healthcare a luxury"*

*"We need open conversations about women's health issues, from periods to menopause"*

## Considerations

Policy planning could consider:

- promoting preventative health and wellbeing support, such as education campaigns, interventions to increase healthy behaviours and improved access to screening and services
- reducing barriers to accessing health and wellbeing services, such as costs, logistical challenges, disjointed care and the requirement for GP referrals to access specialist care i.e. gynaecology
- implementing evidence-based mental health support, particularly for adolescent girls (building resilience, empowerment and self-care) and vulnerable groups, (i.e. those that are socially isolated)
- prioritising gynaecological and reproductive health improvements, through normalising societal attitudes and addressing systemic gaps in treatment and care particularly around, menstruation literacy, menopause support and, ante and postnatal care
- enhancing affordability and accessibility of childcare, housing, and healthcare to alleviate financial stress

# Consultation methodology

## 3.1. Public consultation

The public consultation was conducted between February and May 2024 to gather the public's views and experiences relating to the health and wellbeing needs of women and girls in Jersey. It comprised a survey and follow-up qualitative focus groups.

### Public survey

The survey was open to all Islanders and was conducted both online and using paper copies. Respondents had the option to complete the survey either:

- based on their own experiences as a woman / girl in Jersey
- on behalf of a specific woman / girl they know or care for, based on their experiences
- based on their experiences of women / girls in Jersey in general

The survey questions focused on:

- the factors that women and girls feel affect their health and wellbeing
- the extent to which their health and wellbeing needs are met
- any barriers they face in accessing health and wellbeing services
- the areas women and girls want prioritised for improvement

Most questions provided a range of answer options for respondents to select from, though there were a number of open text box questions which gave respondents the opportunity to explain the reasons behind their answers. At the end of the survey, respondents were asked whether they would be interested in taking part in a follow-up focus group.

In total, 1,647 people completed the survey, nearly all of whom (97%) were female. Respondents ranged from 13 to 85+ years of age.

### Follow-up focus groups with the public

Three follow-up focus groups were conducted with a total of 16 women who had completed the survey. One focus group was conducted with younger women (16-19 years old) and two with older women (25-84 years old). Two focus groups were held face-to-face and one online.

The focus groups were facilitated by a Public Health researcher, using a semi-structured topic guide to explore the topics of the survey in further detail. The data was analysed using thematic analysis.[v]

## 3.2. Professional stakeholder consultation

The professional stakeholder consultation was conducted in Summer 2023 to gather insights from key professionals about the health and wellbeing needs of women and girls in Jersey. It consisted of a survey and follow-up interviews and focus groups.

[v] Thematic analysis is a method for identifying, analysing, and reporting patterns within qualitative data.

### Professional stakeholder survey

The survey was sent to a list of key professional stakeholders identified by the JSNA steering group. This included healthcare providers, social workers, educators, non-profit organisations, and public health experts.

The survey questions focused on:

- women and girls' health and wellbeing service gaps and future needs
- priority areas for improving services for better health and wellbeing outcomes for women and girls
- views on how health issues affect women's wellbeing, work, education, family life, and finances
- the key strengths and challenges faced by women and girls' health and wellbeing services

Most questions consisted of open text boxes, allowing respondents to provide detailed answers. At the end of the survey stakeholders were asked if they were interested in discussing their views further at a follow-up interview or focus group.

In total, 62 professional stakeholders completed the survey.

### Follow-up interviews and focus groups with professional stakeholders

Twenty interviews and three focus groups were conducted with a total of 32 professional stakeholders who had completed the survey.

The interviews and focus groups were facilitated by a Public Health researcher, using a semi-structured topic guide to explore the topics of the survey in further detail. The data was analysed using thematic analysis.

## Consultation findings

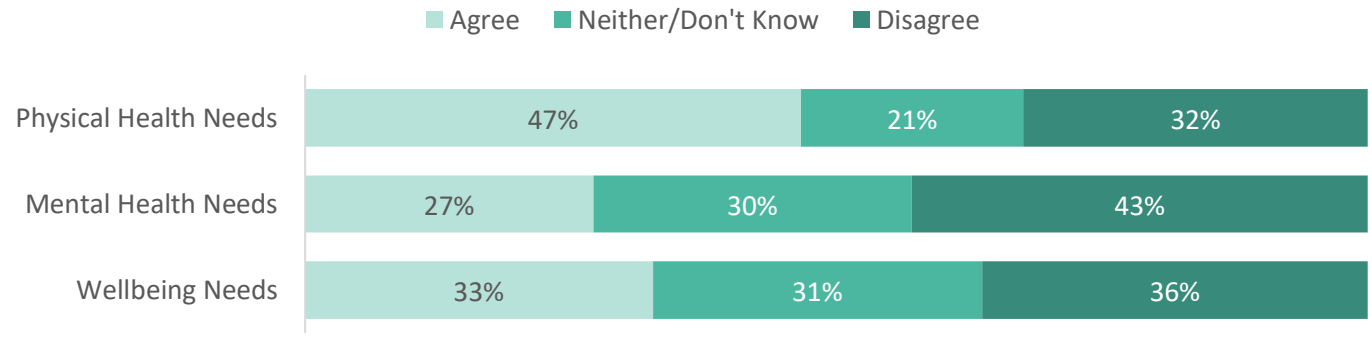
## 3.3. Extent to which women and girls' health and wellbeing needs are being met

### Public views

The survey asked respondents the extent to which they felt that women / girls' health and wellbeing needs were being met in Jersey. The responses of women who completed the survey based on their own experiences were mixed (see Figure 3), although overall **the majority did not agree that their needs were being met**. Less than half (47%) agreed that their physical health needs were met, a third (33%) agreed that their wellbeing needs were met, and only 27% agreed that their mental health needs were met.

The reasons why respondents felt their needs were not being met are detailed in the following sections, which outline the harmful factors, barriers, and areas of prioritisation identified through the survey responses.

***Figure 3: Proportion of respondents agreeing/disagreeing that physical health, mental health and wellbeing needs are met in Jersey. "Agree" = Agree or strongly agree, "Disagree" = disagree or strongly disagree***



### Professional stakeholder views

The following themes emerged from professional stakeholders' feedback regarding whether women and girls' health and wellbeing needs are being met:

- **gaps in women's health services:** they suggested that there are significant gaps in health and wellbeing services for women in Jersey, emphasising a need for improvement to meet current and future demands
- **limited access to family planning:** stakeholders highlighted limited access to long-acting reversible contraception (LARC), which they believe restricts effective family planning and reproductive health management
- **strained mental health services:** they reported that long waiting lists and gaps in implementing allocated mental health funding hinder timely support for women in need
- **need for preventive care:** stakeholders recommended increased funding and development of preventive and primary care services to address these challenges effectively

## 3.4. Factors felt to be harmful to women's health and wellbeing

### Public views

Respondents were asked to select the top three factors they felt were most harmful to women and girls' health and wellbeing in Jersey. Overall, the most selected factors were:

1. ***Financial insecurity (40%).***
2. ***Work-related stress (36%).***
3. ***Poor mental health (30%).***

The factors selected varied across age groups and type of respondents:

- 'poor mental health' was one of the most harmful factors for those aged 13-44, but not for those aged 55+
- those aged 65+ and those who responded on the behalf of a woman / girl they know or care for, were the only groups for whom 'loneliness and social isolation' was the most harmful factor
- those aged 13-24 and those responding based on their experiences of women / girls in general, were the only groups for whom 'violence against women and girls' was one of the most harmful factors

Thematic analysis of the qualitative data gathered through the survey and focus groups revealed the underlying reasons why these factors were felt to be so harmful to women's health and wellbeing:

- **financial challenges and essentials:** respondents said financial insecurity limits access to basic needs like food, housing, healthcare, and childcare, increasing stress and hardship; high costs for housing, therapy, and childcare, along with financial dependence and gender inequalities, were noted as significant barriers, with calls for systemic changes like appointing a Minister for Women
- **work-life balance:** respondents reported struggles balancing work and personal life, often leading to burnout and harming mental and physical health
- **job insecurity:** factors like health issues, long hours, inadequate breaks, and lack of support were cited as key contributors to career stress

- **employment barriers:** women in lower-paid jobs or without qualifications faced challenges affecting financial stability, independence, and mental health
- **sickness impact**: missed work due to illness was said to heighten stress, particularly for those with ongoing health issues
- **inadequate mental health services**: respondents consistently highlighted a lack of adequate mental health services on the Island, leaving many feeling unsupported

> **"The mental health services on the Island are absolutely terrible - as females are more likely to suffer with mental health problem however the help, we receive is extremely limited and often the services are understaffed."** (Survey, Female, 25-34yrs)

Analysis of the qualitive data revealed varying experiences and priorities among these groups:

- **young women and girls:** younger respondents highlighted violence and discrimination, including gender-based violence normalised by societal attitudes, as significant concerns affecting their safety and mental health
- **older women:** respondents aged 65+ highlighted loneliness, social isolation, declining health, and transport barriers as key concerns, suggesting shuttle buses to improve access to healthcare
- **responses on behalf of other women:** respondents pointed to systemic issues, gender inequities in healthcare access, and infrastructure challenges like poor public toilets and inadequate parking

### Professional stakeholder views

Professional stakeholders reported the following key themes as factors that were harmful to women's health and wellbeing:

- **mental health and societal pressures:** professionals identified mental health challenges—such as depression, stress, and anxiety—stemming from societal pressures like balancing work, caregiving, and personal health as key concerns affecting women's wellbeing
- **financial barriers:** high living costs, low wages, and limited access to affordable contraception, childcare, and healthcare (including HRT) were highlighted as significant challenges, restricting women's ability to maintain health and independence
- **cultural and social pressures:** stakeholders reported that societal expectations for women to prioritise family and work over self-care, combined with stigma around mental health, reproductive health, and domestic violence, prevent many from seeking necessary support
- **service accessibility and workforce constraints:** professionals pointed to long waiting times, staffing shortages, and limited specialised services (e.g., pelvic health, menopause, and eating disorders), leaving women without adequate care and delaying essential interventions

> **". . . working long hours, often at lower wages, bearing the brunt of expensive childcare and rising costs of living . . . This overwhelming pressure impact's [women's] ability to eat well, exercise, sleep, or look after their mental health"** (Professional stakeholder)

## 3.5. Barriers preventing women and girls from accessing health and wellbeing services

### Public views

Respondents were asked what barriers they felt stopped women / girls in Jersey from accessing health and wellbeing services. Overall, the top three barriers selected most often were:

1. ***Cost issues (e.g. service too expensive) (49%).***
2. ***Difficulty attending appointments / activities (e.g. not having time, long waiting lists, inconvenient time slots, etc.) (44%).***
3. ***Inability to self-refer to specialists (35%).***

The factors selected varied across age groups and type of respondents:

- in contrast to all other age groups, those aged 65+ commonly reported that 'nothing prevented them' from accessing either health or wellbeing services
- those aged 13 – 24 were the only age group for whom 'anxiety, embarrassment, or privacy concerns' was a top barrier

Thematic analysis of the survey and focus group qualitative data revealed the underlying reasons why these were felt to be the top barriers stopping women from accessing health and wellbeing services:

- **costly health services:** the high costs of accessing healthcare in Jersey, including private counselling, mental health treatments, and specialist consultations like gynaecology and fertility care, were described as outrageous, often delaying necessary care
- **logistical challenges:** respondents highlighted difficulties attending appointments due to conflicting work schedules and inconvenient timing, with calls for more flexible hours, including evenings and weekends
- **advocacy barriers:** those responding on behalf of others noted that accessing services often depends on the individual's or caregiver's assertiveness, disadvantaging those lacking confidence or advocacy skills
- **service quality issues**: focus group participants reported that disorganised care, poor communication, and a lack of coordination—particularly in women's health departments—negatively impact health and wellbeing
- **relying on doctors for referrals:** respondents expressed frustration over reliance on GPs for specialist referrals, citing long wait times and inefficiencies, and called for easier self-referral pathways, especially for mental health services

> **"Doctors need to stop dismissing people's issues and actually look into concerns. Help with symptom management and continue to test if you can't figure out what's wrong."** (Survey, Female, 16-19yrs)

Analysis of the qualitive data revealed varying barriers and reasons among these groups:

- **young women and girls:** younger respondents frequently cited dismissive healthcare professionals, long wait times, and stigma around age or hormones as major stressors. This perspective was echoed across the public consultation, not just young people
- **older women:** some respondents aged 65+ reported no barriers to healthcare, with some praising the efficiency of online systems for managing appointments. However, others mentioned transport barriers as key concerns.
- **responses on behalf of other women:** similar concerns about dismissive attitudes and delayed diagnoses were raised by those responding on behalf of others, with anxiety, embarrassment, or privacy concerns also identified as key barriers

### Professional stakeholder views

The following themes emerged from the feedback provided by professional stakeholders regarding the barriers that prevent women and girls from accessing health and wellbeing services:

- **fragmented service coordination:** professional stakeholders noted that many women struggle to navigate the healthcare system due to disjointed care pathways, long referral times, and a lack of coordination between services, particularly for those with mental health or complex needs
- **stigma and cultural attitudes:** stakeholders highlighted the persistent stigma surrounding reproductive health, caregiving, and mental health, especially for women experiencing domestic abuse or substance dependence, which discourages them from seeking help
- **financial constraints:** professionals pointed out that the high costs of healthcare services, including contraception, hormone treatments, and long-term care, as well as the financial burdens of childcare, are significant obstacles that exacerbate stress and limit women's ability to access essential services; these challenges are particularly acute for those from lower-income backgrounds, further deepening health inequalities
- **inadequate support for vulnerable women:** stakeholders emphasised that women facing mental health issues, caregiving responsibilities, or social isolation often lack tailored support, which contributes to poor physical and mental health outcomes; they stressed the need for equitable funding and resources for charities supporting vulnerable women.

## 3.6. Priority areas for improvement in women and girls' health and wellbeing services

### Public views

Respondents were asked which areas of health and wellbeing services for women / girls they thought the Government should prioritise for improvement. Overall, the most selected items were:

1. ***Gynaecological health (e.g. endometriosis, fibroids, pelvic floor issues) (41%).***
2. ***Housing / living conditions (33%).***
3. ***Mental health disorders (e.g. depression, anxiety, schizophrenia) (33%).***

The areas respondents selected for prioritisation varied across age groups and type of respondents:

- those aged 13-24 were the only age group for whom 'menstrual health' was the top priority
- those aged 45-64 were the only age groups for whom 'menopause' was the top priority
- older respondents (aged 65+) were the only age group for whom 'ageing well and tackling frailty' and 'cancer and preventative screening' were top priorities

Thematic analysis of the qualitative data gathered through the survey and focus groups revealed the underlying reasons why these factors were felt to be the top priority areas for improvement:

- **accessing adequate care:** respondents shared challenges with conditions like endometriosis and PCOS, highlighting delays in diagnosis, lack of specialist knowledge, and inadequate support. Infertility treatments were noted as excessively costly, and participants called for a stronger focus on women's health. Concerns included ignorance around menstrual health and its impact, as well as systemic issues such as reliance on GPs and limited access to knowledgeable professionals
- **housing affordability and quality:** respondents raised concerns about unaffordable housing, poor living conditions, and their impact on mental and physical health, emphasising the need for affordable, secure housing and better living conditions
- **stigma around mental health**: respondents emphasised that mental health challenges remain stigmatised, making it difficult for individuals to seek help openly

> **"The housing on offer here is expensive and doesn't match the majority of people's income."** (Survey, Female, 35-44yrs)

- **inadequate mental health services**: many described Jersey's mental health services as insufficient, citing long wait times, lack of follow-up care, and inadequate support for conditions like eating disorders
- **over-reliance on medication**: frustration was expressed about antidepressants being prescribed without sufficient follow-up or additional support systems in place
- **gaps in preventative support**: young people highlighted the transition from school to adulthood as a particularly vulnerable time, with limited mental health resources and preventative care available
- **specialised facilities for vulnerable groups**: respondents called for facilities tailored to vulnerable groups, such as specialist care facilities for those with eating disorders or mental health crises

Analysis of the qualitive data revealed notable differences in the areas for prioritisation across age groups and respondent types, reflecting varying experiences and priorities among these groups:

- **young women and girls:** young respondents emphasised the impact of menstrual health on daily life, stigma surrounding the topic, and delays in implementing initiatives like free menstrual products; they called for comprehensive, inclusive education on women's health starting early and involving all genders to reduce stigma
- **adult women:** menopause was a key concern for respondents aged 45–64, who cited insufficient education, support, and dismissive healthcare attitudes
- **older women:** respondents stressed the importance of timely healthcare access, with delays in procedures and screenings impacting health, and highlighted nutrition and service accessibility as crucial for preventing frailty
- **responses on behalf of other women:** respondents noted barriers like GP referral requirements, logistical challenges, and healthcare inefficiencies. They advocated for streamlined systems, flexible scheduling, and improved access to services, especially for vulnerable groups

### Professional stakeholder views

Professional stakeholders identified several priority areas for improvement to women and girls' health and wellbeing services:

- **reproductive health and contraception**: professional stakeholders recommend ensuring free access to contraception and expanding the focus on comprehensive reproductive health
- **affordable childcare and workforce support**: stakeholders suggest providing affordable childcare and additional support for women returning to work to ease financial pressures and promote gender equity
- **mental health care**: professionals emphasise the need for prioritising holistic mental health support, including prevention and treatment of perinatal and postpartum conditions
- **primary care funding**: increased funding is recommended to expand access to services, including long-acting reversible contraception (LARC)
- **community networks**: stakeholders propose leveraging community networks to improve care accessibility and create a more connected system
- **domestic abuse support**: there is a call for developing comprehensive support systems for women and families affected by domestic abuse
- **training for healthcare professionals**: professionals advocate for enhancing training on women-specific needs, such as menopause and reproductive health, to ensure informed and tailored care
- **service integration**: stakeholders highlight the importance of coordinating health and support services to provide seamless, holistic care across occupational health, mental health, and preventative services
- **early education and intervention**: there is a strong emphasis on focusing early education and preventative measures to address women's health needs proactively

## 3.7. Conclusion

Many of the key findings identified from the professional stakeholder consultation align with the findings of the public consultation. The public consultation captures personal experiences and age-specific concerns, providing insights into lived realities, while the professional stakeholder consultation offers a more system focused view, emphasising structural challenges and resource limitations.

Overall, the findings of both consultations point towards the following areas that policy planning could consider addressing to improve women and girls' health and wellbeing:

- **increase prevention support and care**, particularly for vulnerable groups such as girls transitioning from primary to secondary school and to women that are ageing, starting support and care at an earlier stage in the lifecycle. Preventative services mentioned included:
    - education and selfcare
    - healthy behaviours i.e. eating well, improved sleep, physical activity
    - preventative screening for early disease detection
    - preventing frailty services including nutrition advice and service accessibility
    - befriending/community services to reduce social isolation and loneliness
- **change cultural attitudes and reduce stigma surrounding seeking support**, to encourage people to seek help and feel empowered and listened to – this could include training for health professionals to ensure girls and women feel empowered and listened to, and implementing education and health literacy programmes starting in schools
- **improve access and affordability of health and wellbeing services**, including self-referral to specialist providers, a flexible range of appointments and providing clear information. Services listed included:
    - reproduction and contraception (including menopause, perinatal and postpartum)
    - gynaecological care (e.g. endometriosis, PCOS)
    - mental health
    - long-term conditions
    - frailty
    - domestic abuse
- **improve coordination between different services and follow up care** so that care pathways are not so confusing for patients to navigate particularly where the individual has a number of health and care needs
- **enhancing affordability and accessibility of wider wellbeing support** including childcare, housing, and healthcare to alleviate financial stress, promote gender equality and enable an improved work-life balance

# 4. Healthy behaviours

This chapter provides an overview of healthy behaviours in women and girls, exploring topics such as healthy eating, smoking and vaping, alcohol consumption, physical activity, screenings, sun exposure, and sleep.

## Key insights

- A significant proportion of long-term conditions can be prevented by changing four sets of behaviours- stopping smoking, eating a healthy diet, consuming less alcohol and having adequate physical activity.
- Women and girls from low socio-economic groups are less likely to follow healthy behaviours which perpetuates health inequalities.
- Women in Jersey drink more alcohol and face higher alcohol-related health risks compared to women in England, particularly noticeable in the 45-54 age group.
- Smoking rates among women are declining (currently 12% overall) but there is continuing concern about smoking rates in lower-income groups and by people with low life satisfaction; additionally, the usage of e-cigarettes by younger females is an emerging concern.
- Healthy eating is shaped by social and economic inequalities, with financial constraints limiting access to nutritious food, contributing to poor diets and persistent obesity rates; this is particularly evident among women aged 55-64, who face higher levels of obesity.
- Physical activity rates differ amongst different group, with lower participation among women in poor health, women with low incomes and adolescent girls.
- Screening programs perform well overall but show gaps in breast cancer coverage compared to England and a lack of understanding around the skin cancer clinics available in Jersey.

**1 in 5** women from **low-income** groups are current smokers

**1 in 2** women aged 16-34 have used **e-cigarettes**

**1 in 5 women aged 45 to 54** exceed the weekly limit of 14 units

Roughly **1 in 2** women and **1 in 3** girls aged 10-11 are **overweight** or **obese**

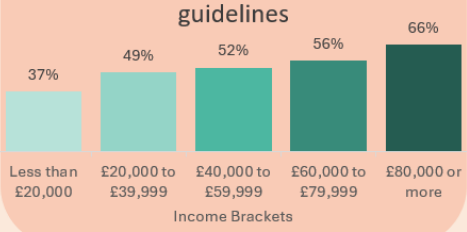
**24%** of **girls aged 8-9** and **5%** of **girls aged 16-17** do **1 hour of physical activity** every day

Jersey achieved **cervical cancer** screening coverage rates of

**76%** for women aged 25-49 (England 66%)

**86%** for women aged 50-64 (England 75%)

**2 in 5** of women in low-income households meet physical activity guidelines




### Considerations

Policy planning could consider:

- continuing to promote screening
- investing in prevention to increase healthy behaviours including targeting women and girls in low socio- economic groups

## 4.1. The importance of healthy behaviours for disease prevention

It is estimated that 80% of new cases of heart disease, stroke and type 2 diabetes and 40% of cancer incidence could be prevented simply by changing four sets of behaviours (smoking, unhealthy diet, consumption of alcohol and insufficient physical activity).[15] This is of particular relevance to women, as this chapter outlines that the prevalence of unhealthy behaviours earlier in life can be seen more prominently in girls rather than boys.

Primary prevention promotes whole population health and wellbeing and prevents disease and harm before it occurs- it is an "upstream" approach by strengthening socio-economic factors that can act as protective influences such as the environment, family, and friends which in turn reduces risk factors operating in the local community.

There is a strong evidence base to demonstrate that a wide range of preventive approaches are cost-effective, including interventions that address the environmental and social determinants of health, build resilience, and promote healthy behaviours.[20] Investing in primary prevention generates cost-effective health outcomes and can contribute to wider sustainability, with economic, social, and environmental benefits.

## 4.2. Substance use including alcohol

Excessive alcohol consumption is a major contributor to poor physical and mental health. As highlighted by the UK Chief Medical Officers[21] and the World Health Organization (WHO),[22] alcohol misuse increases the risk of numerous chronic diseases, mental health disorders, and metabolic issues, creating a significant public health challenge.

Jersey has a high level of alcohol consumption when compared to other countries.[23] While women in general drink less than men, there are some concerning trends across some age ranges including secondary school age girls who were more likely than males to drink alcohol and women aged 45-54 years.

Further analysis of the Jersey Opinions and Lifestyle Survey 2022 revealed that younger women in Jersey were more likely to drink alcohol than older women, with 88% of women aged 16-44 consuming alcohol in the last 12 months compared to 78-87% of women in older age groups.[24] However, younger women were less likely to drink excessive amounts of alcohol, with only around 7% of women aged 16-44 consuming more than recommended limit of 14 units per week. In contrast, 19% of women aged 45-54 and 10% of women aged 55-64 drink more than 14 units of alcohol per week.

Alcohol-specific hospital admission rates for women in Jersey (490 per 100,000)[23] were significantly higher than those in England (355 per 100,000).[25] Additionally, female admission rates for alcohol-related conditions have remained relatively stable between 2015 and 2021. Girls aged under 18 in Jersey also experienced higher alcohol-specific admission rates (80 per 100,000) compared to their counterparts in England (34.7 per 100,000).[23, 26]

Findings from the public consultation revealed a perceived lack of affordable, alcohol-free leisure activities, and younger women emphasised safety concerns linked to alcohol.

> **"… I think alcohol is one of the most damaging things to society. It puts us in vulnerable positions, can make us more emotionally charged and can cause depression."** (Survey, Female, 25-34yrs)

Evidence suggests that many of alcohol's effects pose a greater risk to women's physical health at lower consumption levels than men.[27] [28] [29] The relationship between moderate alcohol intake and cancer incidence in women has been established over the past few years. A 2009 publication using data from the Million Women Study identified that for women up to age 75, the risk of breast cancer rises by 11 cases per 1,000 for every 10g of alcohol (i.e. every additional drink) consumed daily.[30] This finding was consistent even at low consumption levels; for instance, a group of 1,000 women who have just 1 drink a day will have 11 more cases of breast cancer compared to non-drinkers. It was also estimated that 11% of all breast cancer in women in the United Kingdom is attributable to alcohol, equivalent to 5,000 cases annually.[31]

Alcohol use has several impacts on women's reproductive health. In a 2017 review, heavier drinking and heavy episodic drinking were linked to menstrual cycle dysfunction, poorer measures of 'ovarian reserve' (a clinical measure of a woman's reproductive potential), a decreased chance of conceiving, increased likelihood of seeking fertility treatment, worse outcomes of assisted reproductive technology (ART) treatment, and earlier menopause.[32]

The Government of Jersey advises; 'If you're pregnant or trying to get pregnant, do not drink any alcohol as it can damage your unborn baby'.[33] It is well documented that drinking alcohol during pregnancy carries risks to the baby including growth retardation, miscarriage, still birth, premature delivery and Foetal Alcohol Syndrome (FAS) and Foetal Alcohol Spectrum Disorder (FASD).[33] While limited data is available on alcohol consumption among pregnant women in Jersey, a 2017 international study found the UK has the fourth highest rate of drinking during pregnancy in the world.[34] It is challenging to determine how many women drink during pregnancy, as self-reported alcohol consumption is often underreported. This also makes it difficult to fully understand the impact of prenatal alcohol exposure on babies. However, global prevalence data estimates that FASD affects approximately 32.4 cases per 1,000 population in the UK. [35] Applying this rate to Jersey suggests that over 530 individuals aged 0-15 may be affected.

Drug use can be a particularly concerning issue for women due to its potential impact on mental health, social roles, and physical wellbeing, with challenges such as stigma, trauma, and caregiving responsibilities.[36] The overall trend of youth drug use in Jersey has remained relatively stable over the past decade.[10] In the 2021 Children and Young People's Survey, 31% of females in Year 12 (age 16-17 years) reported that they had taken drugs at least once, compared to 24% of males, this is a similar rate to the 2018 survey.[37] Meanwhile, almost one in three (30%) girls reported knowing someone who uses drugs compared to just one in four (25%) boys.

> **"The high substance use culture in Jersey is shocking. The fact that when I was as young as 14, I knew of people taking and dealing class A drugs was insane."** (Survey, Female, 16-19yrs)

## 4.3. Smoking and vaping

### Smoking

Smoking is the single biggest cause of premature death in the UK and is responsible for at least half the difference in life expectancy between the richest and poorest in society.[38] Smoking rates in Jersey have significantly declined since 2013, with only 12% of women smoking in 2023.[39] However, smoking remains prevalent among those living in social housing (19%) and among those with low life satisfaction (28%).[40] This highlights the association between smoking, socioeconomic disadvantage, and reduced wellbeing.

Furthermore, responses from the Children and Young People's Survey 2021 showed that female children of secondary school age were more likely than males to both smoke (5% females regularly smoke vs 2% males) and vape (12% females regularly vape vs 5% males).[10] Evidence suggests tobacco addiction further locks children from low-income backgrounds into a cycle of inequality, by increasingly their likelihood of smoking later in life. Inequality in smoking rates maintains the disproportionate burden of death and disease placed on people from low socio-economic groups and perpetuates health inequalities.[41]

> **"[Need] more education around alcohol, drugs, and smoking."**(Survey, Female, 55-64yrs)

Smoking during pregnancy poses serious health risks to both the mother and baby, including complications such as preterm birth and low birth weight.[vi]

The States of Jersey Tobacco Control Strategy (2010-2015)[42] identified smoking as a concern among women and their households, particularly highlighting the harmful effects of passive smoking on children. While the strategy has led to a decline in smoking prevalence among adults, recent JOLS surveys suggest that concerns about smoking

[vi] Obtaining honest feedback from mothers can be challenging due to the stigma surrounding smoking during pregnancy.

among women and their households persist.[39] The prevalence of smoking among women, as well as exposure to second-hand smoke in homes, raises health concerns, particularly for both mothers and infants.[43,44,45] In 2023 at their booking appointment, 6% of pregnant women were recorded as current smokers, while 22% reported that their partner was a current smoker.[3] In addition, approximately 12% of babies assessed during their 6-8-week check were living in households where they were likely to be exposed to tobacco smoke by an adult.

### Vaping

Vaping is growing in popularity, especially among younger women (46% of those aged 16-34 have used e-cigarettes at some point).[8] In 2021, 35% of Year 12s reported having used or using them.[10] E-cigarettes pose a small fraction of risk as compared to smoking.[46 47] However, this increase in young people vaping is not risk-free and the long-term effects are not yet known;[48] hence these products should not be used by non-smokers, particularly children and young people.

> **"Please do something to address vaping. It is a scourge to anyone who doesn't smoke, and the problem is growing."** (Survey, Female, 45-54yrs)

According to WHO, there is particular concern over the use of nicotine in e-cigarettes which is addictive and has negative impacts on brain development in adolescents.[49] Furthermore, some e-cigarette products that become available are illicit and in other jurisdictions have been found to contain banned chemicals, unsafe levels of lead, nickel, and chromium, and super-strength nicotine.[50] Although it is currently illegal to sell vaping products to under 18s both in the UK and Jersey, many young people in Jersey are still able to buy their own vaping devices.

## 4.4. Healthy eating

More than one in three (36%) women in Jersey meet the recommended intake of 5 portions of fruits and vegetables each day,[39] surpassing England (30%)[51] and the OECD average for adults (15%).[52]

Differences were found in the population,[39] with:

- those who are financially secure (43%) were more likely to meet the recommended intake compared to those who report struggling financially (23%)
- only 20% of adults of Portuguese ethnicity met the recommended 5 portions of fruit and vegetables a day compared to those identifying as Jersey (36%)

> **"… [we] rely on processed foods because you don't have time or energy or funds to prepare a home cooked meal to nourish yourself and your family."** (Survey, Female, 35-44yrs)

Around 1 in 5 females are already overweight or obese when starting school in Reception – a similar proportion compared to males. By Year 6, 27% females are overweight or obese, again a similar proportion to males. There is evidence of a disparity in the rates of those who are overweight or obese among children in Year 6 attending fee-paying schools versus non-fee-paying schools, with 1 in 5 of children attending fee-paying schools being overweight or obese compared to 1 in 3 children attending a non-fee-paying school.[53] Meanwhile, obesity rates in women in Jersey increase with age, peaking in the 55-64 age group (58%).[8]

During the public consultation, it was highlighted that caregiving responsibilities and social isolation can significantly impact women's nutritional health. Women who serve as primary caregivers often experience increased stress and time constraints, which may lead to irregular eating habits and a decline in diet quality. Additionally, social isolation has been linked to negative eating behaviours, including reduced appetite and poor dietary choices, further compromising nutritional wellbeing.[54]

## 4.5. Physical activity

Only 52% of adult women meet recommended aerobic activity guidelines,[55] with costs, childcare responsibilities and lack of cycling infrastructure cited as obstacles by survey respondents. Women from lower-income households (earning under £20,000) are less likely to meet activity guidelines, with only 37% achieving the recommended levels.[39] In contrast, 66% of women in higher-income households (earning £80,000 or more) meet the guidelines.

> **"There is little availability to do things for my own wellbeing because I can't afford it or arrange cover to go to exercise classes or anything."** (Survey, Female, 35-44yrs)

Despite these challenges some survey respondents commented on the ready availability of free outdoor activities in Jersey, such as sea swimming and walking routes, that help promote physical and mental health. One participant observed, *"Jersey being a geographically small Island lends opportunity for physical accessibility to walk or cycle to your place of work."* (Survey, Female, 35-44yrs). This was balanced by concerns about the availability and safety of cycling *"Not enough cycling routes."* (Survey, Female, 35-44yrs).

The guideline for adolescent girls is to have 1 hour of physical activity every day.[56] The majority of girls in Jersey do not meet these guidelines and this worsens as they age – only 24% of Year 4 girls (age 8-9 years) meet this, and just 5% of Year 12 girls (age 16-17 years).[10] In comparison, 45% of girls aged 5-16 in England meet the guideline.[57] Globally the situation is equally as worrying as according to a recent report by the World Health Organization (WHO) only 15% of girls are meeting the recommended target.[58] In Jersey, although girls, when compared with boys, are less enthusiastic about sports, are less likely to attend sports clubs, or, say they enjoy sports, when asked, around two thirds (69%) of girls expressed an interest in engaging in more physical activity.[10]

According to WHO, regular physical activity has well-known positive effects for the prevention and control of noncommunicable diseases, such as cardiovascular diseases, cancer, diabetes and depression, as well as reduced overall mortality and risk of premature death. In children and adolescents, physical activity also provides benefits to cognitive development, motor skills, self-esteem, social integration, musculoskeletal health, academic achievement, and overall wellbeing.[59]

The WHO report on the Barriers and Facilitators of Physical Activity Participation in Adolescent Girls outlines key strategies to encourage more girls to participate in sports and physical activity, with a focus on addressing gender-specific needs and challenges. The recommendations include, taking a 'whole school' approach to link the school curriculum with the broader school environment and the local community.[60]

## 4.6. Screening

Cancer screening is a vital component of preventive healthcare in Jersey, focusing on early detection and timely intervention to improve health outcomes. Screening rates in Jersey are generally comparable to England, though differences in age ranges and screening intervals complicate direct comparisons. In 2023, Jersey reported a 70% bowel cancer screening rate for men and women,[61] slightly below England's 72%.[62] Cervical cancer screening coverage in Jersey was 76% for women aged 25–49 and 86% for women aged 50–64, both notably higher than England's rates of 66% and 75%, respectively.[16 63, 64]

Jersey's higher breast cancer incidence rate compared to England underscores the critical role of breast cancer screening.[16] While Jersey's breast cancer screening coverage rate (63%) is slightly lower than England's (67%), Jersey employs more frequent screening intervals. However, higher screening frequency does not necessarily offset lower coverage, as achieving high participation across the

> **"Provide more information for self-led healthcare, including guidance on woman-specific health tests like breast cancer screening by GPs who check lumps, and skin cancer"** (Survey, Female, 25-34yrs)

eligible population is essential for maximising the benefits of early detection. This highlights the need to prioritise both accessibility and participation in breast cancer screening programmes.

Survey responses highlighted a lack of adequate gynaecological care services, with accessibility concerns particularly affecting women with learning disabilities. Dissatisfaction was also expressed regarding the lack of consistent education for young people on self-led healthcare. While financial barriers to services like cervical screening remain a concern, efforts to improve access to preventative care were noted.

## 4.7. Sun exposure

The melanoma incidence rates (ASR) for females in Jersey (47 per 100,000) are significantly higher than those recorded in England (27 per 100,000) with around 75 new cases of melanoma skin cancer diagnosed among females in Jersey every three-year period.[16] The non-melanoma skin cancer incidence rates (ASR) for females in Jersey (397 per 100,000) is also considerably higher than those recorded in England (234 per 100,000).[16] Survey responses expressed a strong desire for broader skin cancer/ mole screening initiatives. Over half of adolescent girls in Year 10 and 12 report that they 'sometimes' or 'never' take steps to avoid sunburn.[10]

**"Skin cancer screening should be made available."** (Survey, Female, 55-64yrs)

## 4.8. Sleep

Women may face increased risk of sleep disorders like insomnia and sleep apnoea due to hormonal shifts throughout life stages, including menstruation, pregnancy, and menopause.[65] Balancing caregiving, work, and household responsibilities often leads to sleep deprivation, exacerbated by societal pressures, such as the expectation of women to juggle multiple responsibilities.

Limited data hinders the understanding of women's specific sleep needs and related health outcomes, yet it is clear that sleep profoundly impacts women's mental and physical health. There is significant evidence to suggest sleep influences mood and emotional reactivity and insufficient sleep is tied to mental health disorders.[66] Additionally, higher rates of anxiety, chronic pain, and conditions like fibromyalgia contribute to disrupted sleep. Sleep apnoea remains underdiagnosed in women, especially post-menopause, leading to further health risks if untreated.[67]

A concerning trend of sleep deprivation has been identified among school-age children, as highlighted by the 2021 Children and Young People's Survey.[10] Over half (53%) of Year 10 students reported getting less than eight hours sleep while 16% reported 5 hours or less of sleep the previous night. When comparing sleep patterns between boys and girls, subtle differences emerge. Equal proportions of boys and girls (4%) reported less than three hours of sleep, while a similar proportion of girls (12%) and boys (11%) reported sleeping 4 to 5 hours. A slightly higher proportion of girls (38%) reported getting 6 to 7 hours of sleep, compared to 35% of boys. However, boys were more likely to achieve the recommended 8 or more hours of sleep, with 49% compared to 46% of girls.

These figures suggest that while both genders are experiencing inadequate sleep, girls are slightly more likely to report shorter sleep durations in the 4–7-hour range, whereas boys are more likely to achieve the recommended 8 or more hours.

Interestingly, in the public consultation, respondents aged 13-24 recognised the importance of sleep and relaxation as the number one factor benefiting their health and wellbeing. There is a recognition of the importance of sleep amongst islanders, particularly for certain groups where getting the recommended amount of sleep is challenging, such as carers.

**"I really struggle if I don't get enough sleep or downtime"** (Survey, Female, 35-44yrs)

# 5. Mental health & wellbeing

This chapter provides an overview of mental health and wellbeing in Jersey, exploring topics such as prevalence, treatment and waiting times; challenges for adolescent girls; perinatal mental health, and dementia and social isolation.

## Key insights

- Increasing prevalence of mental health issues among adolescent girls in Jersey are concerning given that approximately 75% of adult mental health issues develop by age 18 – this highlights the need for prevention and earlier intervention.
- Financial stress is widespread among women in Jersey, with many reporting that economic pressures negatively affect their life satisfaction, compounding mental health challenges.
- Mental health conditions accounted for 19% of all female Short-Term Incapacity Allowance claims in 2021, up from 12% in 2016.
- Social isolation, especially among younger women (16-34) and older women (65+), further complicates mental health outcomes.
- There is a perceived gap in the availability of specialised mental health services, particularly psychological care for women who have experienced violence and abuse. Women have told us that limited access to these services, combined with long wait times, leaves them without the critical support they need during times of vulnerability.

In 2023, there were **520** women on the dementia register...

...with the number expected to rise by **74%** to **900** by 2053

Around **1 in 7** women experience perinatal mental health conditions

Around **1 in 4** women feel lonely "Quite often" or "Very often"

Referrals to Child and Adolescent Mental Health Service (CAMHS) for females have **increased** by **167%** over a six-year period (2018 to 2023)

About **4 in 10** women disagreed or strongly disagreed that mental health needs were met

The average wait for ADHD services is notably high at **456 days**

**21%** of all referrals to CAMHS for girls under 16 were related to self-harm

**A quarter** of Year 10 girls reported low life satisfaction

Between 2017 and 2021, ED attendances by women for mental health-related concerns...

...increased by **73%**, with over half of these women being **under 20**

### Considerations

Policy planning could consider:

- improving mental health support for females around key life stages or events, including adolescence, perinatal period, and following traumatic events
- measures to reduce social isolation amongst vulnerable groups

## 5.1. Prevalence, treatment and waiting times

Women's mental health in Jersey reflects a range of challenges, with concerns around conditions such as anxiety, depression, and self-harm, alongside broader social factors including gender inequalities and access to mental health services. Generally, the prevalence of mental health conditions in Jersey follows the trends seen in the UK.

- Short-Term Incapacity Allowance (STIA) is a benefit provided in Jersey to individuals who are temporarily unable to work due to illness or injury. Mental health conditions accounted for 19% of all female STIA claims in 2021, up from 12% in 2016; women are more likely than men to submit mental health-related claims, reflecting the higher rates of anxiety and depression among women in Jersey[68]
- as of December 2024, 2,103 people are receiving community mental health treatment across all services and age groups for adults. In addition, approximately 500 people are on waiting lists for specific assessments or treatments, such as ADHD assessments or psychological therapy. [69] Women comprise a higher proportion of the service users, reflecting global trends where anxiety and depression are more prevalent among females[70]
- approximately 440 women are recorded on the Mental Health Register maintained by GPs which tracks individuals with significant mental health conditions such as schizophrenia, bipolar disorder, and other psychoses; this represents about 1% of the female population aged 16+ in Jersey[12]

Over the last 5 years there has been a 15% rise in prescriptions for antipsychotics, antidepressants, anxiety medications, and mood stabilisers, highlighting a growing recognition of mental health needs such as depression, anxiety, and mood disorders.[71]

Respondents in the public consultation highlighted their concerns about the lengthy wait lists for adult mental health services, including waiting times for adult ADHD and autism diagnosis. One participant shared her experience, "I am on the waiting list for an autism diagnosis. I have been told this can be up to a five-year wait. I am very anxious, and without support, it is impacting my daily life" (Survey, Female, 20-24yrs).

According to the November 2024 Health and Community Services (HCS) Advisory Board papers,[72] the average waiting times as of October 2024 for adult mental health services are as follows:

- 159 days from Jersey Talking Therapies (JTT) referral to the first attended treatment session
- 233 days for Autism Assessment
- 456 days for an ADHD assessment, which has steadily increased from 50 days in April 2021

According to the HCS Quality and Performance Report,[73] the waiting list for JTT has continued to significantly reduce (from 168 people in April 2023 to 71 people in August 2023) although the percentage of people waiting for assessment for over 90 days was increasing (5.6% in August 2023). Waiting times for psychological / talking therapies and diagnostic assessment services remains a key challenge for the service, as a result of increased demand and limited staffing capacity.

While increasing mental health concerns affect individuals across all genders, evidence suggests that hormonal fluctuations specific to women can significantly contribute to heightened mental health challenges.[74] Changes in reproductive hormone levels, such as oestrogen and progesterone, during different life stages—including the menstrual cycle, perimenopause, and menopause—have been linked to mood disturbances and an increased risk of mental health disorders.[75] A systematic review found that mental health conditions, such as depression and anxiety, may worsen during periods of hormonal change, including the menstrual cycle. [76] Furthermore, the perimenopausal period—a time of significant hormonal fluctuation—has been associated with new onset or worsening of psychiatric symptoms, particularly depression. This underscores the importance of monitoring mental health during hormonal transitions.[76] These findings

> **"There is not enough support, resources or awareness of women's mental health issues such as Premenstrual Dysphoric Disorder..."** (Survey, Female, 35-44yrs)

highlight the intricate relationship between female hormonal fluctuations and mental health, emphasising the need for awareness and appropriate evidenced based management strategies that are specifically directed to women and girls during periods of hormonal change.

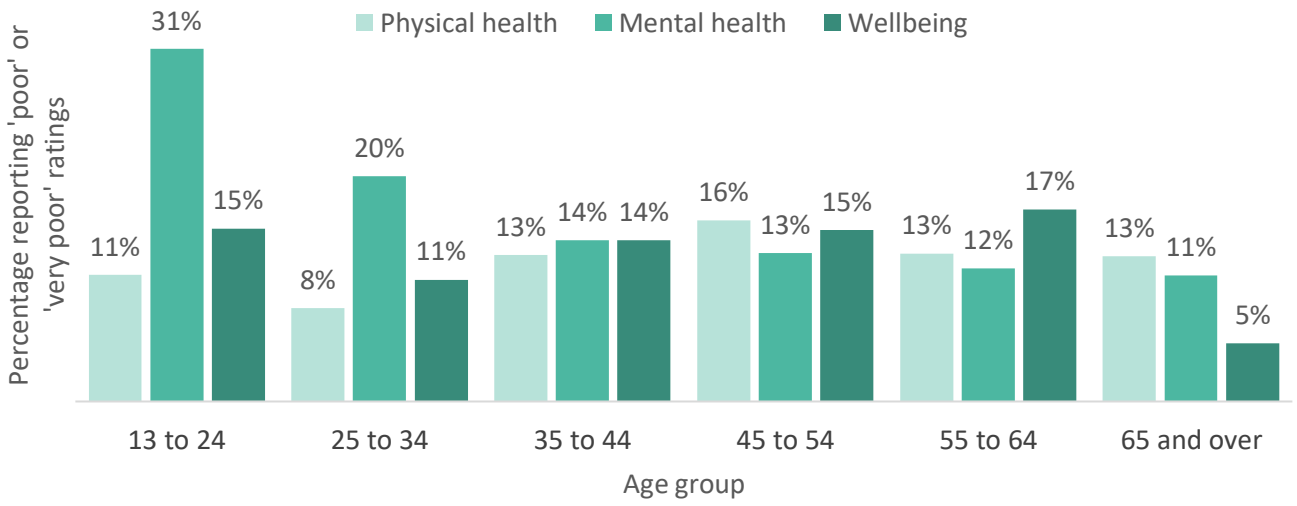
## 5.2.Self-reported mental health and wellbeing

> **"Mental health issues are a silent killer for a lot of people, and it's still frowned upon to admit you have problems."** (Survey, Female, 55-64yrs)

In the public consultation, respondents were asked to rate their physical health, mental health and wellbeing as very good, good, fair, poor or very poor. Single parents, those of Portuguese/Madeiran ethnicity, those who were carers, and those with long-term health conditions were more likely to report poor or very poor mental health.

Self-reported mental health varied significantly with age (Figure 4). Those aged 13-24 years were most likely to report poor or very poor mental health (31%), with the likelihood decreasing consistently with age; just 11% of those aged 65 years or over self-reported poor or very poor mental health. Those who were at school or studying were also more likely to report poor or very poor mental health.

***Figure 4: Proportion of respondents reporting 'poor' and 'very poor' ratings for physical health, mental health and wellbeing, by age group***

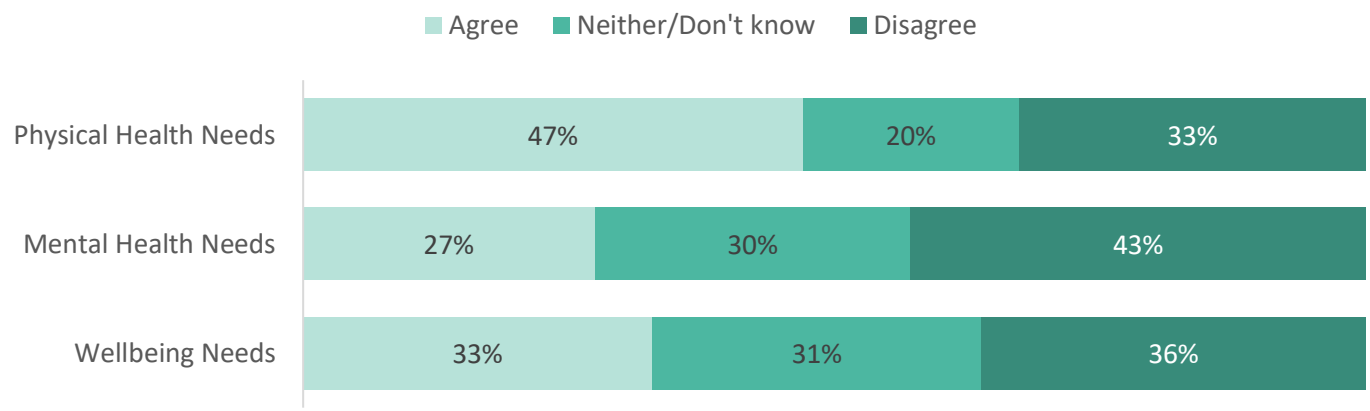



*Source: Women's Health and Wellbeing JSNA public consultation survey*

Respondents were asked to what extent they agreed that their health needs were met in Jersey.

Physical health needs scored highest in terms of proportion of respondents in agreement that needs *were* met (47%), however, one third (33%) of respondents said that physical health needs *were not* met (Figure 5). An even higher proportion of respondents said that mental health and wellbeing needs *were not* met (43% and 36% respectively).

*Figure 5: Proportion of respondents agreeing/disagreeing that physical health, mental health and wellbeing needs are met in Jersey. "Agree" = Agree or strongly agree, "Disagree" = disagree or strongly disagree.*




*Source: Women's Health and Wellbeing JSNA public consultation survey*

Some commonly cited reasons in the public consultation identified why respondents felt women's health and wellbeing needs were not met included:

- **wider determinants:** high costs of living, housing, cost of private care and GPs
- **access challenges:** long waiting lists, outdated or inadequate healthcare resources
- **stigma and lack of awareness:** feeling dismissed by healthcare providers, a misunderstanding of gender specific issues, lack of support from employers (misogyny)
- **lack of investment in prevention and early intervention:** little education and incentivisation around sleep hygiene, improving access to physical activity, eating more healthily and taking advantage of Jersey's natural resources such as the sea

> **"Misogyny is an ongoing problem and erodes mental health and wellbeing. It is present in every aspect of Jersey society - government, education, sport, health."** (Survey, Female, 65-74yrs)

## 5.3. Perinatal mental health

Perinatal mental health (PMH) encompasses emotional and psychological challenges that arise during pregnancy or within the first year after birth. These conditions significantly impact maternal wellbeing and the parent-infant relationship, which in turn can influence the child's early development. In Jersey, the Perinatal Mental Health Team supports women before, during, and after pregnancy, providing specialised care to address these needs and promote healthy parent-child bonds.

Early detection and intervention are critical, with UK studies suggesting that approximately 10-20% of women experience mental health issues during pregnancy or within the first year after childbirth.[77]

The proportion of women in Jersey who receive mental health support during the perinatal period aligns with these national trends, with 164 Perinatal Mental Health Team service users in 2023.[78]

Untreated perinatal mental health conditions can have lasting effects. Risk factors include having a child with a disability, which increases the likelihood of maternal depression and anxiety, and the unique challenges faced by LGBTQ+ parents, who may encounter stigma and legal barriers that complicate access to care. When left unaddressed, these conditions can hinder maternal self-care and infant development, leading to difficulties in attachment and long-term developmental challenges for children.[79]

Addressing these conditions early can mitigate long-term consequences for both mothers and children but the opportunity to provide continuity of care in the early years of a child's life is of equal importance. Some respondents to the public consultation highlighted a drop off in support following the initial midwifery and health visiting support which could be considered in service development.

**"Currently postpartum (6 months) and while there is recognition of the effects of postpartum on new mothers, the support provided does not feel adequate or genuine."** (Survey, Female, 25-34yrs)

## 5.4. Emerging mental health challenges for adolescent girls in Jersey

Given that approximately 75% of adult mental health issues develop during childhood, adolescence, or by age 18,[80] there is a strong argument for earlier intervention and targeted care during the younger year.

Mental health issues among adolescent girls in Jersey are becoming increasingly concerning, reflecting broader national trends. Local data[10] underscores a growing burden of anxiety, self-esteem concerns, and self-harm, particularly among those facing socio-economic hardships. This is evidenced by the following:

- 25% of Year 10 girls reported low life satisfaction, compared to 11% of boys
- anxiety levels among Year 10 girls have significantly risen, with the average anxiety score increasing to 5.9 in 2021, compared to 3.7 in 2018
- 25% of Year 10 girls reported low life satisfaction, compared to 11% of boys
- 35% of Year 10 and 36% Year 12 female students reported having considered self-harm, with around 80% of these individuals acting on their thoughts

Girls are especially influenced by social and cultural pressures around body image. The Children and Young People's Survey shows that girls have lower self-esteem than boys and worry more about what people think of them and the way they look-_"The way you look" ranked as one of the top concerns; rates were highest among Year 12 girls (67%), followed by Year 10 (62%) and Year 8 (44%); this pattern indicates that body image concerns peak in mid-adolescence but persist across all age groups. Furthermore, girls scored significantly more in the questions asked about feeling pressurised to look a certain way in social media, with 61% of Year 12 and 53% of Year 10 girls feeling pressurised compared to only 18% of Year 10 and 12 boys respectively.[10]

In Jersey, there has been a notable increase in CAHMS referrals and in the latest Children and Young People's Survey 25% of Year 10 girls reported low life satisfaction, a much higher rate than that of boys (11%). There are also higher levels of self-harm and an increase in mental health related emergency department attendance. This may indicate better awareness but has highlighted the need for additional support for mental health challenges.

Referrals to Child and Adolescent Mental Health Service (CAMHS) for females have increased significantly, from 230 in 2018 to 610 in 2023, a 167% increase over this six-year period.[81]

In 2023, 21% of all referrals to CAMHS for girls under 18 were related to self-harm, with anxiety (30%) and suicidal ideation (12%) also prominent concerns.

In the CAMHS caseload there are nearly five times as many females with a diagnosis of anxiety than males.

**"I have seen examples recently of teenage girls suffering with serious anxiety and depression following Covid, left without any support. Families have had nowhere to turn… "** (Survey, Female, 35-44yrs)

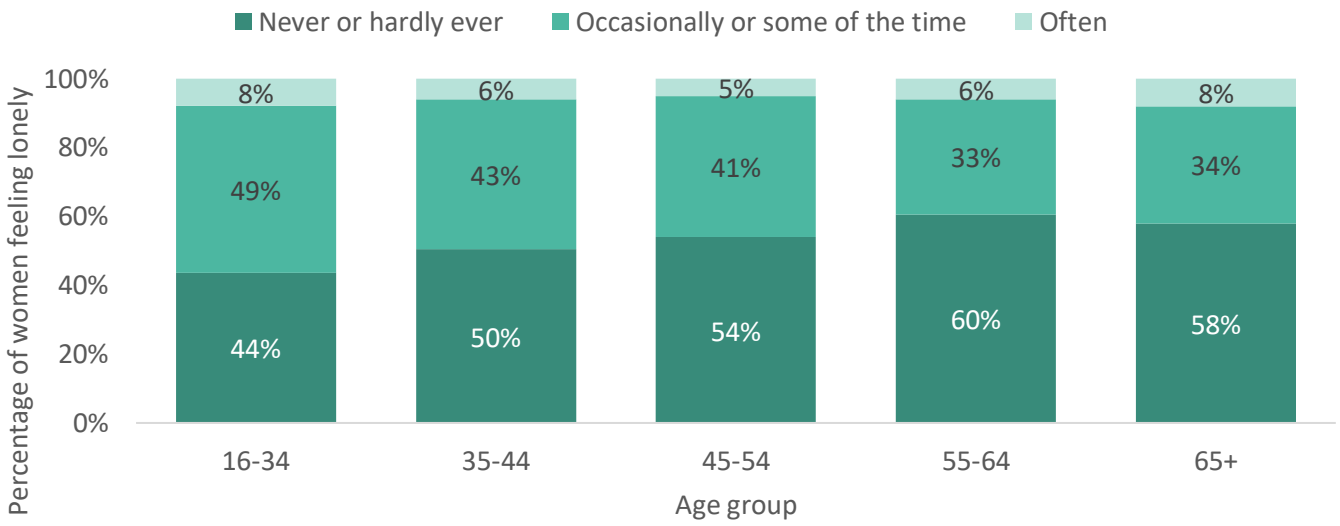
## 5.5. Social isolation and loneliness

Further analysis of the JOLS 2023 data reveals that that 52% of women report never or hardly ever feeling lonely compared to 61% of men, suggesting women experience slightly higher levels of loneliness.[8] Additionally, 40% of women report feeling lonely occasionally or some of the time, which is higher than 33% of men. This indicates that women experience intermittent loneliness more frequently, which could impact their mental health and emotional wellbeing.

Loneliness is often linked to poorer mental health outcomes, including depression and anxiety, and the higher rates of loneliness among women may indicate a greater risk for these conditions. Young women (16-34) and older women (65+) report the highest levels of frequent loneliness (8%), possibly due to life stage challenges such as transitioning into adulthood or loss of a partner.[8] Despite higher rates of "never or hardly ever" loneliness in older women, 34% still report feeling lonely occasionally, highlighting their vulnerability to loneliness as well. Middle-aged women (45-64) experience lower rates of frequent loneliness, but still report occasional loneliness, which suggests more stable social networks.

Overall, the data suggests that loneliness among women is a significant factor to consider when addressing mental health needs, with younger and older women particularly at risk for loneliness and its associated mental health challenges. Tailored interventions for these groups, alongside efforts to reduce occasional loneliness in middle-aged women, could help improve overall mental health and emotional wellbeing for women in Jersey.

***Figure 6: Frequency of women feeling lonely, by age***




Source: JOLS, 2023

## 5.6. Dementia

> **"More dementia support services and advice are a must"** (Survey, Female, 45-54yrs)

Dementia is one of the long-term conditions that disproportionately affects women, with 63% of all those who suffer dementia in Jersey being female.[82] This is partially due to the longer life expectancy of women as the prevalence of dementia increases significantly with age, but it also affects a greater proportion of women, with 21% of females over 90 having dementia compared to 12% of males. With the population ageing, it is projected there will be an additional 380 women with dementia by 2053 (a 74% increase).[83]

There are better outcomes following an early diagnosis as this allows the opportunity to adjust and get the necessary support.[84] In 2022 the waiting times to access the Memory Assessment Service were over 120 days on average with almost a quarter of people waiting over 180 days.[85]

Healthy behaviour choices made throughout our life including not smoking or stopping smoking, eating well, can make a significant difference to the number of people developing dementia. There is evidence that if 14 modifiable factors were addressed, from obesity to uncorrected vision loss, this could reduce the risk of developing dementia by up to 45% globally,[86] and potentially slow cognitive decline.

Additionally, there is growing international evidence for the importance of maintaining brain health, and reducing risk factors for dementia, which has become a focus for action globally.[87] These risk factors include physically inactivity, poor sleeping, unhealthy diet, isolation, alcohol consumption, and smoking.

# 6. Reproductive and gynaecological health

This chapter provides an overview of reproductive and gynaecological health in Jersey, exploring topics such as the stigma, lack of education and not feeling listened to (described in some instances as 'misogyny').

## Key insights

- Women highlighted widespread dismissal of gynaecological and reproductive health needs, (including menstruation, miscarriage and menopause) amongst health and care professionals, in their workplaces and in wider society.
- Women in Jersey have highlighted systemic gaps in care and support around menopause.
- Live births in Jersey have recently reached a historic low, reflecting a significant decline from previous years. The average maternal age in Jersey is higher than in England and Wales, highlighting a trend toward delayed motherhood as women prioritise careers, education, and financial stability before starting families.
- The number of abortions in Jersey has increased steadily over the last few years. A growing proportion of abortions are performed before 10 weeks gestation, in line with trends in England.
- Caesarean section rates in Jersey have risen significantly in recent years, reflecting global trends in childbirth practices. The current rate exceeds that of England.

**799** live births in 2023 represents a **29%** decline since 2012

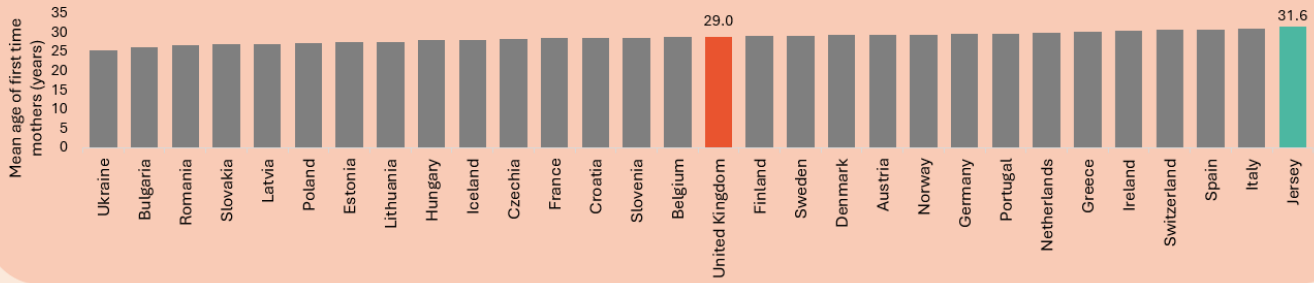
Stillbirth rate in Jersey for the period of 2021-2023 was **3.5 per 1,000 births**

Abortions in Jersey have risen from **165** in 2014 to **260** in 2023

**42%** of live births delivered by C-section between 2021 and 2023, a **15%** increase compared to 2001 and 2003

approximately **13,500** women may currently be experiencing menopause, perimenopause, or postmenopausal symptoms

The **mean age of first-time mothers** European Union (2018) and Jersey (2023)




## Considerations

Policy planning could consider:

- commissioning a broader review of societal and cultural attitudes towards women and girls' health specifically focusing on reproductive and gynaecological health
- improving health literacy and education around reproductive and gynaecological health

## 6.1. Available data

There is a disparity between the rich qualitative feedback collected from the public consultation and the more limited quantitative data available on reproductive health in Jersey. While the quantitative data provides a broad overview of trends such as declining birth rates, rising maternal age, and increasing abortion rates, the qualitative data sheds light on the lived experiences of women navigating the reproductive and gynaecological healthcare system. This section introduces the key quantitative findings alongside the nuanced personal insights from the qualitative data, explaining the critical gaps in service provision and patient satisfaction that the numbers alone cannot fully capture.

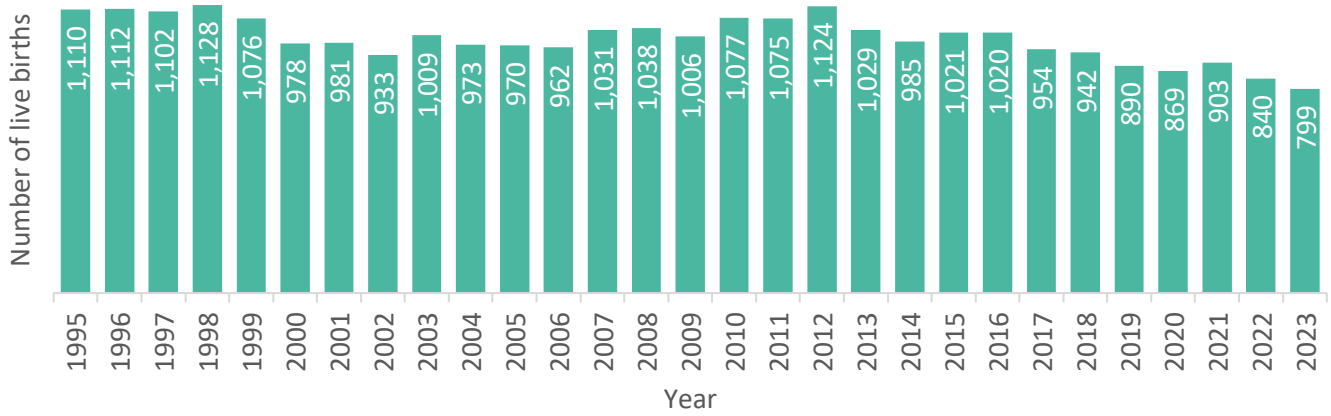
The chapter was largely written prior to the publication of the UK government Women and Equalities Committee report 'Women's Reproductive Health Conditions' (11th December 2024), [88] and hence information from this report is not discussed in this chapter. However, it is worthy of note as many of the key themes raised in Jersey are reflected in the report by the Women and Equalities Committee. In particular the views and experiences of women captured in the Voices of the Community Chapter around stigma, lack of education and what they term 'medical misogyny'.

> **" Address medical misogyny in all levels of the health services."** (Survey, Female, 35-44yrs)

## 6.2. Live births rates

Jersey has experienced a significant decline in the number of live births, this trend reflects a broader pattern seen in many high-income countries. The number of live births in Jersey in 2023 (799) is the lowest since 1995, marking a 29% decline from the peak in 2012 (1,124).[3]

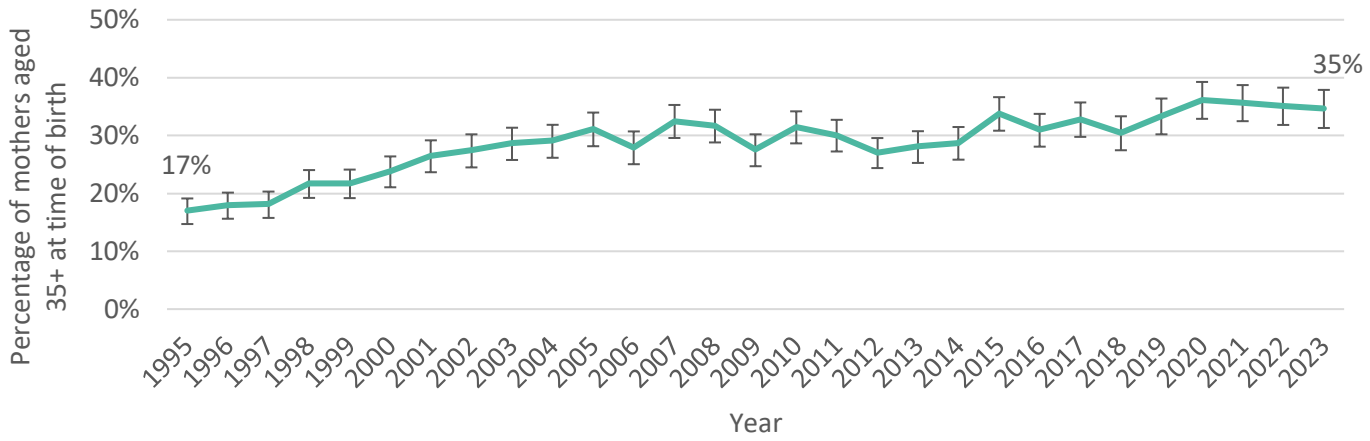
***Figure 6: Annual number of live births (Jersey, 1995 to 2023)***




*Source: Trak/Maxims/Careplus*

Jersey's conception rate decreased from 61.8 conceptions per 1,000 women of reproductive age (15–44) in 2013 to 56.1 in 2023, reflecting similar trends observed in England and Wales.[89] Births to younger mothers (under 20) have significantly declined, while births to women aged 35 and older have increased markedly, rising from 17% of all births in 1995 to 35% in 2023.[3]

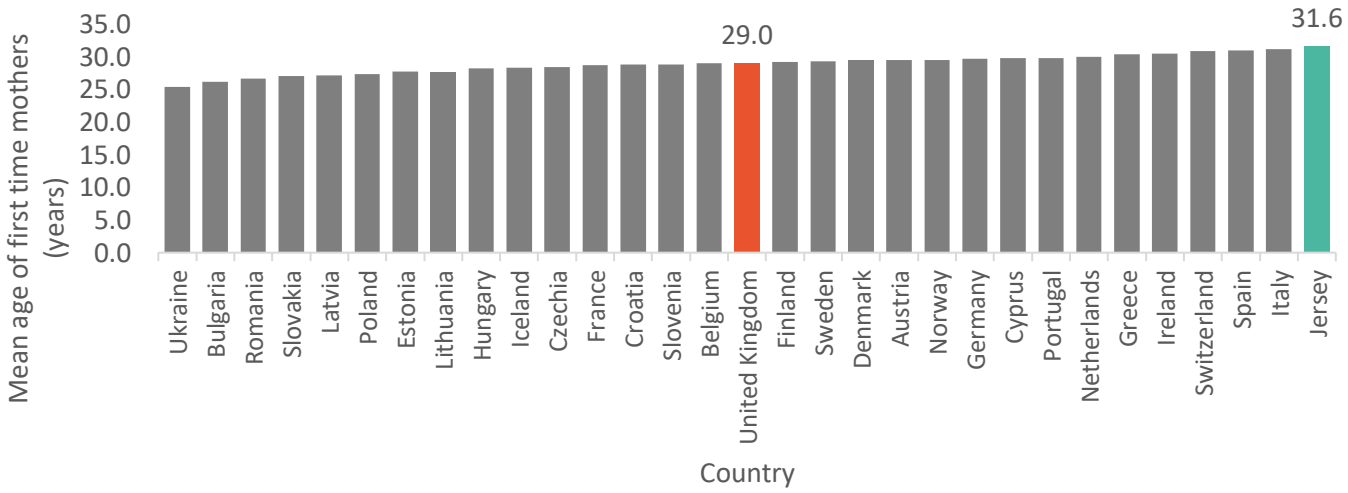
***Figure 7: Proportion of mothers in Jersey aged 35 years and over at the time of birth (Jersey, 1995 to 2023)***




*Source: Trak/Maxims/Careplus*

Older maternal age is associated with increased problems of fertility, and foetal and obstetric complications.[90] Jersey has seen a steady increase in maternal age, the average in Jersey over 2023 was 33 years,[3] compared to 31 in England and Wales.[89] The average age of first-time mothers was 31.6 years, higher than all EU countries (see Figure 8),[91] with 6 in 10 women having their first child aged 30-39.

***Figure 8: the mean age of first-time mothers European Union (2018) and Jersey (2023)***




*Source: Eurostat, 2024*

## 6.3. Pre-term births

Pre-term birth, defined as delivery before 37 weeks of gestation, impacts the health of both the mother and baby.[92]

Pre-term births are associated with long-term health risks for infants, including developmental delays, respiratory issues, and an increased risk of neonatal death (representing the loss of life within the first 28 days after birth). Factors contributing to pre-term birth include maternal age, with younger and older mothers being at higher risk, as well as lifestyle factors such as smoking and stress.[93]

In 2023 9% of all live births to Jersey resident mothers (70 babies) were classified as preterm, occurring before 37 weeks gestation,[3] this is slightly higher than the percentage of preterm live births in England and Wales, which was 7.9% in 2022.[94]

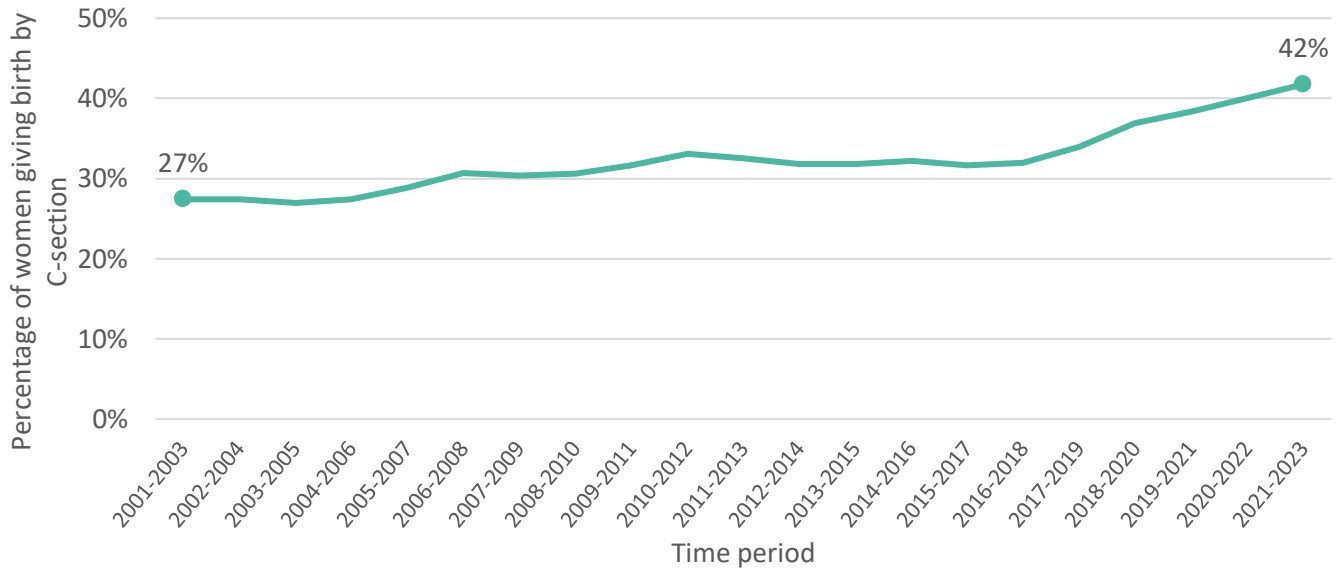
## 6.4. Delivery practices

Older women (especially those over 40) have a much higher likelihood of undergoing a Caesarean section (C-section)[3] due to the increased risk of complications during pregnancy and childbirth.

The rate of C-sections in Jersey has seen a significant increase, reflecting a broader global trend towards higher surgical delivery rates.[95]

The rate of C-sections among women in Jersey has increased significantly, with 42% of live births delivered by C-section between 2021 and 2023, a 15% rise compared to the 2001-2003 period; this trend aligns with global shifts towards more frequent surgical deliveries. The C-section rate in Jersey is slightly higher than the national figure for England, where 38% of births were delivered by C-section in 2023.[96]

***Figure 9: 3-yearly percentage of women giving birth by C-section (Jersey, 2001-2003 to 2021-2023)***




*Source: Trak/Maxims/Careplus*

## 6.5. Birth outcomes

### Neonatal deaths

Neonatal deaths are low in Jersey; between 2014 and 2023, there were fewer than 10 neonatal deaths.[3] This low incidence reflects the generally high standard of neonatal care in Jersey, however, for the families affected, the emotional impact of such a loss is profound. Professional stakeholders highlighted the need for enhanced bereavement care and emotional support for parents.

**"Most often, I see women who have experienced the sometimes traumatic and unexpected loss of their baby. That deep grief can impact every facet of their life, sometimes for many years."** (Professional Stakeholder)

### Still births

Stillbirth refers to the death of a baby after 24 weeks of pregnancy but before or during birth. Despite advancements in prenatal care, there remain identifiable risk factors for stillbirth, including obesity, smoking, and complications like preeclampsia and gestational diabetes, which can affect both maternal and foetal health.[97]

There is a relatively low incidence of stillbirths in Jersey. The stillbirth rate in Jersey for the period of 2021-2023 was 3.5 per 1,000 births;[3] in England, there were 4.0 stillbirths per 1,000 births in 2022.[89] In the 10-year period of 2014 to 2023, there were around 25 stillbirths in Jersey.

Feedback from the public consultation indicates gaps in the support provided to families experiencing stillbirth. Stakeholders emphasised the need for standardised operating procedures and additional bereavement training for healthcare professionals. *"Not enough qualified people in counselling after child loss!"* (Survey, Female, 35-44yrs).

## 6.6. Miscarriage

A miscarriage, defined as the loss of a pregnancy before the 24th week, can occur due to factors such as maternal and paternal age, previous pregnancy history, and lifestyle choices.[98] It is estimated that approximately 10-20% of known pregnancies end in miscarriage.[99] Based on population estimates for Jersey,[4] it is therefore estimated that approximately 200 to 250 pregnancies may end in miscarriage each year.

While the emotional and physical toll on women can be substantial, professional stakeholders have highlighted areas where support services fall short—particularly in terms of the availability of suitable, welcoming environments. As one survey respondent highlighted "Very little support for early pregnancy problems and miscarriage support. Loss of women's dedicated gynaecology ward is a sin. Always seems to be services for women that get axed." (Survey, Female, 55-64yrs). Delays in service provision and the financial burdens faced by women further exacerbate the challenges. Enhanced funding and dedicated counselling environments are critical to addressing these gaps.

Data collected from members of the public through online surveys, focus groups and public consultations highlighted shortcomings in mental health support for those experiencing miscarriages. The emotional toll of miscarriage was repeatedly emphasised. Participants described feeling abandoned and traumatised by their experiences. Support following miscarriages was seen as minimal, with many reporting long waits for counselling, with some waiting up to six months before being seen by services like Talking Therapy. The absence of structured follow-up care pathways left women to navigate their grief and recovery on their own.

> **"There was no one to speak to about what my body was going through, which was frightening, distressing, and painful."** (Survey, Female, 35-44yrs)

To address these challenges, stakeholders in interviews and Focus groups suggest implementing measures such as establishing dedicated, private counselling spaces, increasing the number and geographic spread of clinics, and offering flexible appointment times that accommodate busy or vulnerable clients. Enhancing digital access to booking and follow-up services, as well as expanding training for healthcare professionals to provide empathetic and trauma-informed care, are also seen as positive steps. These improvements have the potential to better meet women's needs, ensuring that they can access care easily, feel supported in a comfortable setting, and ultimately experience more positive health outcomes.

## 6.7. Abortion trends

> **"I had to go off island for an abortion which was incredibly stressful."** (Survey, Female, 35-44yrs)

Abortion is legal in Jersey up to the end of the 12th week of pregnancy, after which people need to travel to the UK or other jurisdictions where later termination is permitted. The abortion law (the Termination of Pregnancy (Jersey) 1997 Law) will be amended during 2025. Many people need to pay to have an abortion in Jersey. [vii] The current abortion law highlights issues around access to essential reproductive health and care services.

[vii] Women on income support, women whose pregnancy arises from rape and under 18s do not need to pay for an abortion in Jersey.

Over the past two decades, there have been significant fluctuations in abortion rates in Jersey.[100] The most recent statistics show that:

- abortions in Jersey have risen from 190 in 2020 to 260 in 2023 (37%)
- the repeat abortion rate[viii] (25%) is significantly lower than England's average (41%)
- the majority of abortions (92%) in Jersey are performed before 10 weeks, mirroring trends in England (88%)

One professional noted that "women have to pay £185 for an abortion in Jersey and there is no cost in the NHS".

## 6.8. Gynaecological and urogynaecological conditions

Gynaecological conditions are conditions that affect the female reproduction organs, including, for example, heavy menstrual bleeding, premenstrual syndrome (PMS), endometriosis, fibroids and polycystic ovary syndrome (PCOS). Urogynaecological conditions include, urinary incontinence, vaginal prolapse and recurrent urinary tract infections (UTIs). *"No help for women with PCOS besides telling them to lose weight, when it's a hormonal imbalance. Problems with chronic UTIs, not enough following up from specialists and not taken seriously. Also, for who is trying to conceive IVF is not offered here and extremely sad as not everyone can travel for these appointments besides the huge amount of money spent."* (Survey, Female, 25-34yrs)

There is very little data available in Jersey on how many women suffer incontinence issues and prolapse after birth but a new study by Glasgow Caledonian University revealed 61% of women surveyed had recently experienced urinary incontinence, 22% faecal incontinence and 17% prolapse symptoms.[101]

During the public consultation, respondents consistently emphasised the importance of gynaecological health, and the need for better support to help women and girls look after themselves. As one respondent noted, *"We should see a gynaecologist for a check-up every year. But here, no one will send you to one unless you have symptoms"* (Survey, Female, 35-44yrs). Respondents further highlighted the daily challenges women and girls face, particularly in managing menstruation, pregnancy, and menopause. These conditions often necessitate frequent medical appointments and regular check-ups, underscoring the need for accessible and proactive care.

> **"I went for a hospital appointment because my doctor thinks I've got endometriosis. They said, "if you have endometriosis, we're going to put you on contraception anyway and I am like no you're not and he was so dismissive of me, and I walked out there in tears."** (Focus Group, Female, 20-24yrs)

Many respondents in the public consultation expressed frustration over a perceived lack of funding for gynaecology services. The closure of the dedicated gynaecology ward was seen as an indication that women's health services are being deprioritised. One participant explained, *"Always seems to be services for women that get axed. Why?"* (Survey, Female, 55-64yrs).

Accessing timely and adequate care for gynaecological and reproductive health needs was another recurring concern. Both public and professional consultations revealed a consensus that women should be able to self-refer to specialised healthcare services for conditions like endometriosis, PCOS, and menopause.

> **"There should be the option to self-refer to specialists when it is obvious what you need. Obs [Obstetrics] and Gynae for example."** (Survey, Female, 25-34yrs)

[viii] Repeat abortion rate refers to the percentage of abortions performed on individuals who have previously had one or more abortions.

## 6.9. Societal and cultural views of gynaecological conditions

Respondents in the public consultation highlighted how societal and cultural biases significantly shape women's experiences with gynaecological services. They described dismissive attitudes, systemic barriers, and the stigmatisation of reproductive health issues. These challenges left women feeling unsupported and underserved. Females also discussed not feeling listened to and ignored, this view was consistent among the public and professional consultation. One professional shared, *"Women are often told to get on with things, don't be so hormonal or emotional"* (Professional Stakeholder).

The impact of societal attitudes towards gynaecological health was a recurring theme during public and professional consultation. Women often feel unsupported when managing conditions like heavy periods or menopause, leading to missed work and financial consequences.

Menstrual health emerged as the top priority for young people (13–24 years) in the public consultation, reflecting its profound impact on daily life and wellbeing. Participants highlighted the challenges associated with managing menstrual health, including its effect on education, work, and overall quality of life. An older participant emphasised the economic consequences of unmanageable periods for younger people, stating: *"There are girls at work who have their periods and are really, really ill, so they might be home for two or three days. They don't get paid because it's not classified as being ill. On average, they lose two to three days' wages every single month"* (Focus Group, Female, 75-84yrs).

Menopause symptoms can have a major impact on a woman's professional life. *"Discrimination to women in the workplace is still present,"* (Survey, Female, 55-64yrs) one woman said, with many reporting inadequate support. Women have proposed simple interventions such as leafleting: *"Every woman could be sent a leaflet about the menopause & its numerous symptoms before the age of 40 years to prepare them."* (Survey, Female, 45-54yrs). Professional stakeholders echoed these concerns, revealing that some women miss work due to severe period-related problems or menopause-related challenges. One professional noted: *"Workplaces need to become more sympathetic to women dealing with heavy periods or menopause-related challenges, fostering an environment where women feel supported rather than embarrassed"* (Professional Stakeholder). Another professional remarked on the financial and emotional burden of justifying gynaecological health needs to their employer: *"I have regularly written letters to employers explicitly outlining the impact of heavy periods—this usually works, but it is shameful that women have to incur this"* (Professional Stakeholder). However, the cultural stigma persists, making it difficult for women to speak openly about their experiences at work.

These findings underscore the need for increased awareness, workplace accommodations, and health services that address menstrual health, ensuring that women and girls can thrive without stigma or financial penalty.

Stakeholders emphasised the need for improved education and advocacy within healthcare and wider society to address these biases and ensure equitable care. One professional stated, *"The system needs to recognise the emotional and physical toll of conditions like heavy periods and miscarriages. Women shouldn't have to justify their pain or pay extra to be believed"* (Professional Stakeholder).

## 6.10. Assisted reproduction

Infertility, defined as the inability to conceive after 12 months of regular unprotected intercourse, affects both men and women. Jersey offers some assisted reproduction services and support through the Assisted Reproduction Unit (ARU). Whilst some assisted reproduction treatments are funded or part-funded locally, most are self-funded by Jersey residents. Self-funded procedures include IVF, genetic screening, and surrogacy.[102]

> **"Lack of options for fertility aids locally (IVF). Lack of funding for fertility aid is a huge negative! People are using their life savings, selling their homes and taking big loans to pay for this"** (Survey, Female, 25-34yrs).

The high cost of assisted reproductive technologies (ART) presents significant financial and emotional pressures. For example, self-funded IVF typically costs around £5,000 per cycle. In 2025 the Government of Jersey is investing more monies to allow more people to access government-funded IVF cycles in UK clinics, but this will not include everyone who would benefit from IVF. In addition, patients must still fund their own travel and accommodation costs. Some countries like France and Spain offer more affordable and accessible fertility treatments.[103]

Demand for assisted reproduction services peaked in 2019 at 460 patients but declined slightly in 2020 and 2021.[104]

## 6.11. Menopause

Menopause is a natural life stage that marks the end of menstruation and a decline in reproductive hormones, typically occurring between the ages of 45 and 55. Perimenopause—the transitional phase before menopause—can start as early as the mid-30s and last several years. Once a woman has not menstruated for 12 consecutive months, she is considered postmenopausal. In Jersey, approximately 13,500 women[ix] are estimated to currently be experiencing menopause, perimenopause, or postmenopausal symptoms.

Menopause symptoms can vary in duration, often lasting between five and seven years, but some women report experiencing them for up to 12 years. Over 30 recognised symptoms include hot flushes, fatigue, sleep disturbances, mood swings, anxiety, muscle aches, and cognitive issues like poor concentration.[105]

Bone density begins to decrease as oestrogen levels decline in the lead-up to menopause and continues to decrease after menopause.[106] Lower oestrogen levels increase the risk of developing osteoporosis. Studies support this link, emphasising the importance of early diagnosis and proactive treatment to prevent further bone loss and fractures in post-menopausal women.[107]

> **"I believe there needs to be more research and services targeted at menopause so that older women can manage symptoms and prevent conditions such as osteoporosis"** (Survey, Female, 45-54yrs).

While bone loss is a natural part of aging, but some individuals experience a more rapid decline, which can lead to osteoporosis and an increased risk of fractures. Women lose bone mass more quickly in the first few years after menopause. They are at a higher risk of developing osteoporosis than men, especially if menopause begins early (before the age of 45) or if they have had their ovaries removed.[108]

Osteoporosis affects over 3 million people in the UK, and half of women over 50 and one-third of men over 60 will experience a low-trauma fracture due to osteoporosis.[109]

A 2019 UK survey by the Primary Care Women's Health Forum[110] found that 79% of women sought healthcare support for perimenopausal or menopausal symptoms, a significant increase from 50% in 2016. Although local

[ix] Estimate the number of perimenopausal/menopausal women by multiplying the 45–55 age group of the Jersey Population Projections[4] by 80%. Add women aged 55+, as most will be postmenopausal.

Jersey data is unknown, respondents to the public consultation shared that stigma and misinformation continues to remain a barrier.

Women in Jersey have shared personal experiences, highlighting systemic gaps in care and support:

- **lack of systemic support:** many women feel neglected by the healthcare system. As one woman said, *"The government in Jersey doesn't provide anything for menopause wellbeing, which is unacceptable."* (Survey, Female, 45-54yrs) Another echoed this, highlighting that *"not sufficient support or education [is available] for women of my age during menopause—particularly with GP."* (Survey, Female, 55-64yrs)
- **dismissive attitudes:** several women shared instances of delayed diagnoses and dismissive attitudes from healthcare providers. For instance, *"My diagnosis was delayed, and I was often told I was too young for it to be the menopause."* (Survey, Female, 45-54yrs)
- A Jersey resident shared, *"During the menopause, I was given antidepressants and told to try and cheer up,"* (Survey, Female, 55-64yrs) this illustrates the need for better education and training for healthcare providers. One doctor reportedly admitted he had a lack of training: *"My doctor was very honest that he was not an expert and needed to refresh knowledge."* (Survey, Female, 45-54yrs).

> **"Women are dismissed... mental health is dismissed and referred to as hysterical or just menopausal, while giving no help or information for menopause." (**Survey, Female, 55-64yrs)

## 6.12. Sexual health

Between 2010 and 2021, sexual activity among Year 10 girls remained relatively consistent, with 88% reporting in 2021 that they had never been sexually active.[10] Of the remaining girls, 8% reported past sexual activity, and 4% were currently sexually active. In contrast, sexual activity was significantly higher among Year 12 girls: 47% reported never having been sexually active, 22% reported past sexual activity, and 31% were currently sexually active. Among those who were sexually active, only 46% of Year 10 and Year 12 girls reported using a condom during their last sexual encounter. This potentially indicates a lack of sexual health education, particularly for younger women.

Contraceptive use in Jersey plays a pivotal role in empowering individuals, particularly women and girls, to make informed decisions about their reproductive health. Access to a wide range of contraceptive methods is crucial for preventing unintended pregnancies, managing health conditions, and ensuring reproductive autonomy.

> **"More options in contraception to be provided over the counter."**(Survey, Female, 35-44yrs)

In recent years, Jersey has seen a shift toward long-acting reversible contraceptives (LARCs), such as intrauterine devices (IUDs) and implants, which offer highly effective, low-maintenance solutions. According to data from the Health Insurance Fund (HIF), prescription trends indicate a decline in the use of combined hormonal contraceptives, with a slight increase in the uptake of LARCs.

The availability of contraceptive options is an area for improvement identified in the Women's Health Survey. One participant stated, *"Family planning services should be free. It is backwards and archaic that we are charging for contraception and terminations"* (Female, Survey, 35-44yrs), particularly noting that some contraceptives, like the coil, are expensive (£130). Another respondent shared their frustration about being denied permanent contraception due to age, highlighting restrictions that limit women's autonomy over their reproductive health. Furthermore, respondents raised concerns about outdated contraception advice being offered, as one individual described*, "My daughters were offered the same contraception as I was 40 years ago with no follow-ups or support,*

*I have learnt more from social media about menopause than I have from my GP."* (Survey, Female, 55-64yrs) stressing the need for updated, personalised care and better follow-up services

During the public consultation, respondents felt there is a lack of information about the risk of using contraception for an extended period of time. Including concerns about the potential link between contraception and osteoporosis. "There is lack of awareness about the side effects of contraception given for example the risk of osteoporosis" (Survey, Female, 25-34yrs). Another emphasised the need for broader education on contraception's impact on overall health, stating: "There also needs to be greater education on how types of contraception can impact a women's health overall." (Survey, Female, 20-24yrs)

**"The Government should set up a similar sexual health clinic that is FREE. Even having to pay for my contraception pill now feels unfair when males do not have to pay for this and there are free condoms available everywhere. Why is the price put on women?"** (Survey, Female, 25-34yrs)

## 6.13. Sexually transmitted diseases

Between 2016 and 2021, approximately 2,375 sexually transmitted infections (STIs) were diagnosed in Jersey across the entire population, not just among females.[111] Chlamydia accounted for the highest proportion of diagnoses (50%), followed by genital warts (24%), genital herpes (14%), gonorrhoea (10%), and syphilis (2%). The rates of STIs in Jersey have remained statistically consistent since 2016. It is important to note that the figures for chlamydia and gonorrhoea may include reinfections and could involve some double counting, as swabs from both the Sexual Health Clinic (GUM) and general practitioners (GPs) are sent to laboratories for confirmation. Meanwhile, the data for genital warts, genital herpes, and syphilis reflect individuals diagnosed specifically through the Sexual Health Clinic (GUM). Additionally, the current data systems do not allow for a breakdown of cases by sex, limiting more detailed analysis. It should also be acknowledged that some concerns have been raised about the accuracy and reliability of these figures due to ongoing issues with data recording and reporting systems.

Between 2021 and 2023, fewer than five births per year were recorded among mothers aged 17 or younger. Over the past decade, 70% of pregnancies among women under 18 in Jersey have ended in termination. The community have expressed concerns about the accessibility, confidentiality, and affordability of sexual health services on the Island. Evidence suggests improved access to high-quality sex education and making it easier for all, but particularly women and girls, to access contraception services will improve sexual health.[112]

## 6.14. Sexual Health Screening

Regular sexual health screenings are essential for early detection and prevention of sexually transmitted infection s (STIs).[113] Although data on STI diagnoses in Jersey is available, it has been challenging to obtain up-to-date and comprehensive screening statistics, possibly due to ongoing systems issues. Concerns have been raised about the accessibility and availability of routine screening, especially for younger individuals.

Online postal self-sampling (OPSS) has emerged in a number of jurisdictions as an alternative to testing in sexual health clinics and other clinic-based settings. Increased efforts to promote STI testing and make screening more accessible, particularly for those with new sexual partners or engaging in unprotected sex, could help reduce the incidence of STIs and ensure better sexual health outcomes for women and girls.

**"There's no way of doing your own postal/self-checking with sexual health screening like they offer in the UK."** (Survey, Female, 35-44yrs)

Women under the age of 25 are at a higher risk for certain sexually transmitted infections (STIs), including chlamydia and gonorrhoea, which can have long-term health consequences if left undiagnosed.[114] Routine sexual health screenings for this group are crucial in detecting infections early and preventing complications such as infertility. Increased access to regular STI check-ups, particularly for younger women, would help reduce the spread of STIs, ensure better sexual health outcomes, and provide opportunities for early intervention and education on safe sexual practices.

# 7. Wider determinants of health

This chapter provides an overview of the non-medical factors (wider determinants) that influence health and wellbeing outcomes. These are the conditions in which women and girls are born, grow, work, live, and age, as well as the broader social, economic, and political systems that shape their day-to-day lives.

## Key insights

- there is a slightly higher proportion of working age women in Jersey who are employed compared to those in the UK (77% vs 72%).
- Women achieve higher levels of education, however there are fewer women in senior jobs and there is a significant gap in pay between the genders.
- Over 50% of households with children find it difficult to cope financially; this is especially notable for single parents (who are predominantly female), with 75% finding it difficult to cope financially and over 50% living in relative low income.
- Half of women said that they had to choose between being a good mother and their career.
- Childcare costs are considerably higher than in England, with women in Jersey saying this causes financial and mental stress.
- More lower income households, including single parents, are forced to settle for cheaper, poor-quality housing.
- Over half of women who are homeless attribute their homelessness to abusive relationships or domestic violence.
- Almost half of girls aged 15-17 have experienced inappropriate sexual comments or attention, much more than boys of the same age (1 in 7).
- More broadly, men perceive less inequality against women than women experience themselves.

**30%** females aged 16-64 had a qualification at degree level or above...

...While **13%** of females had no formal qualifications

Analysis of the public sector workforce showed a gender pay gap of **10.3%**

Around **1 in 3** of households in 2023 reported having difficulty coping financially

Around **1 in 3** females in Years 8, 10 and 12 experienced inappropriate comments or unwanted attention in the last year

The top two reasons for women being homeless, making up **60%**

**39%** at risk of, has experienced or escaping domestic violence

**20%** due to the breakdown of relationships-abusive behaviour

Around **4 in 10** of manager, director or senior official roles being held by women

Jersey childminders fees are **37%** higher than those charged in England

### Considerations

Policy planning should consider:

- the potential adverse health impacts on single parent families and single pensioners
- the direct and indirect impacts to health and wellbeing equity when producing housing, infrastructure, education and childcare

## 7.1. Background

The wider determinants of health, also known as the social determinants of health, are defined by the World Health Organization (WHO)[115] as the non-medical factors that influence health and wellbeing outcomes. These are the conditions in which women and girls are born, grow, work, live, and age, as well as the broader social, economic, and political systems that shape their day-to-day life.

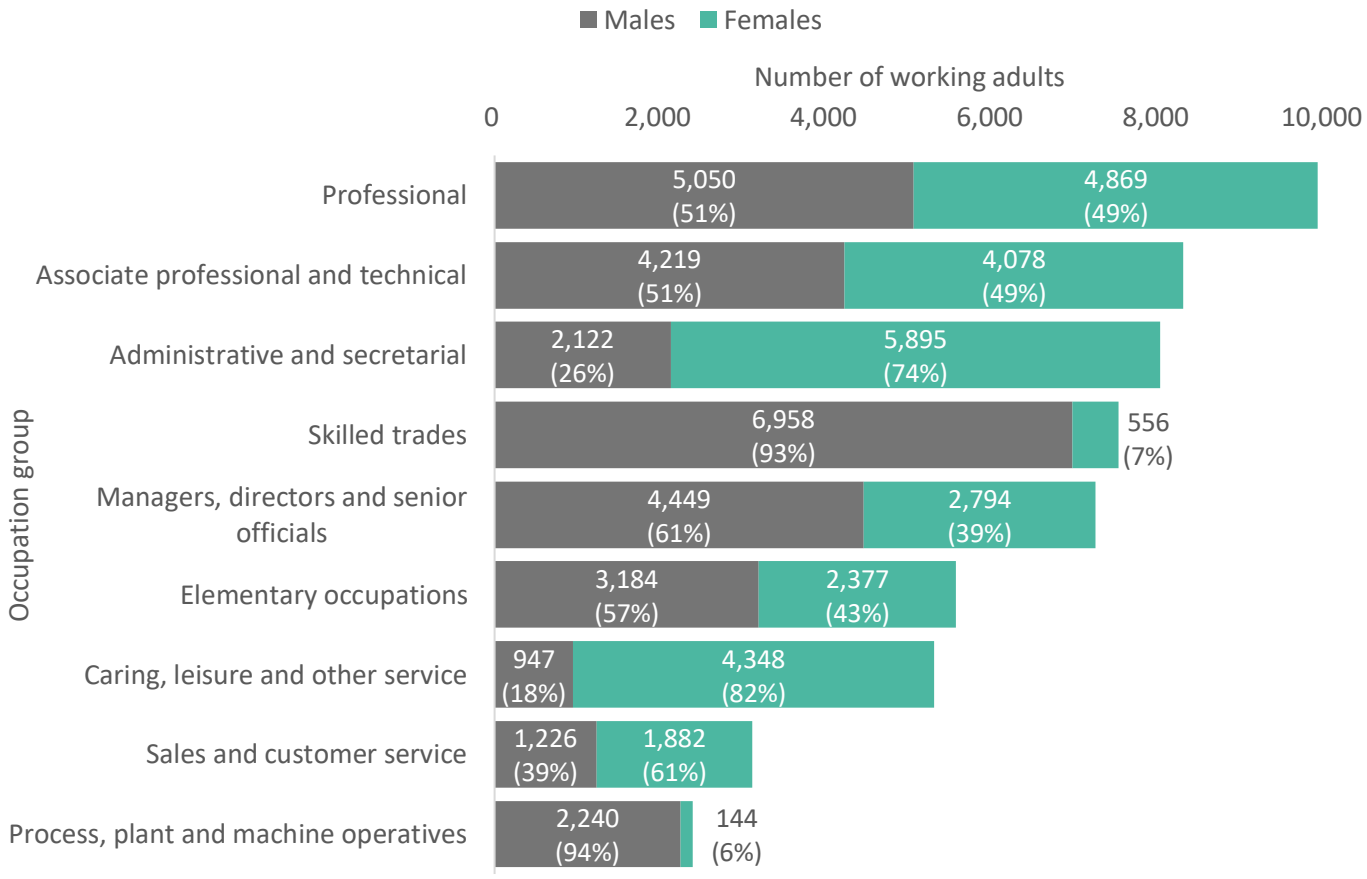
It has been theorised that society operates under a "contract of the sexes", [116] which defines distinct gender-based roles, responsibilities, and expectations for men and women. Since social factors are known to greatly affect health outcomes, these gender roles lead to a significant difference in the health outcomes of men and women.

This section highlights how women and girls are disadvantaged across several non-medical factors that are essential for maintaining good health. Despite some progress towards eliminating the social and environmental disparities between men and women during the last century, gender equality remains an elusive goal. In 2024, women and girls continue to face systemic gender inequalities; [117] by the very nature of being a woman or girl, they are at a greater risk of poor health. Furthermore, those with intersecting health, social, or environmental disparities – such as being a woman as well as living in poverty, having a disability, or belonging to an ethnic minority group – are at an even greater risk of inequality.

## 7.2. Income and economic status

Women in Jersey are more economically active than many similar jurisdictions – in the 2021 census, the employment rate for working-aged women in Jersey was 77%, compared to 72% in the UK.[2] This remains lower than the employment rate for men in Jersey, which stood at 85%, with there being notable differences in the type of employment that women do.

***Figure 10: Major occupation group of working adults (aged 16 and over) by sex***




*Source: Census 2021*

In Jersey, the *Professional* and *Associate professional and technical* occupations were balanced between males and females. However, the proportion of males and females in some of the other occupation groups varied significantly, emphasising the stereotypical societal gender roles. Fr example, males accounted for most workers in *Skilled trades* (93%) and *Managers, directors, and senior officials* (61%). In contrast, females accounted for around four fifths of those engaged in *Caring, leisure and other service occupations* (82%) and three-quarters of those in *Administrative and secretarial occupations* (74%).

**"When you work two jobs to meet basic needs, it's a real struggle to find the additional money needed for healthcare"** (Survey, Female, 55-64yrs)

More women work part-time jobs compared to men, and women are more likely to juggle multiple jobs while managing household responsibilities. In households with children, around 1,120 women were recorded as working multiple jobs, compared to 870 men.[6]

Household income in Jersey dropped by 4% between 2019/20 and 2021/22 after adjusting for inflation.[118] This will have been exacerbated in recent years by increases in living costs, putting a further strain on Islanders' finances.

In the UK, more than one fifth of women (22%) have a persistent low income, compared to approximately 14% of men. Living in persistent poverty denies women the opportunity to build up savings and assets, leaving them vulnerable in times of hardship. This effect accumulates for older women which can result in extensive poverty.[119]

The Jersey Household Income Distribution Report revealed that, in 2022, after housing costs, a quarter (24%) of households in Jersey were classified as living in relative low income (RLI).[118] This is defined as having a household income below 60% of the median equivalised income. This threshold equated to £520 per week before housing costs, and £430 per week after housing costs. Living alone in Jersey – either as a single parent (88% of which are mothers) or a single pensioner – significantly increased the risk of living in relative poverty. Key disparities included:

- one in five (21%) individuals were in RLI, marginally lower than the UK (22%)
- one in four (24%) children were in RLI, a lower proportion than the UK (29%)
- over half of single parent households (54%) were in RLI
- more than one in four (28%) pensioners were in RLI, a higher proportion than the UK (18%); among single pensioners, this figure rises to 47% for both males and females.

The 2023 Jersey Opinion and Lifestyle Survey (JOLS)[39] revealed that almost a third (31%) of households in 2023 reported difficulty coping financially, up from a quarter of households (24%) in 2022. This is particularly the case for single parent households, where 77% reported struggling financially. Households with children had greater difficulty coping (51%) than those without children (26%).

**"Women often perform difficult, often stressful and demanding jobs. They raise children, often relying only on themselves."** (Survey, Female, 45-54yrs)

Clear patterns of financial hardship among Jersey residents emerged from the Jersey Household Income Distribution Report and the Jersey Opinion and Lifestyle Survey (JOLS). In addition to gender, factors such as the presence of children, relationship status, and age significantly shape financial stability. Consequently, single parents, couples with children, pensioners, and individuals living alone are disproportionately affected by financial difficulty, likely due to caregiving responsibilities and the absence of partner support.

The public consultation highlighted the challenges of trying to balance work with personal and family life, especially for working mothers, single parents, and those with the responsibility of caring for parents.

## 7.3. Education

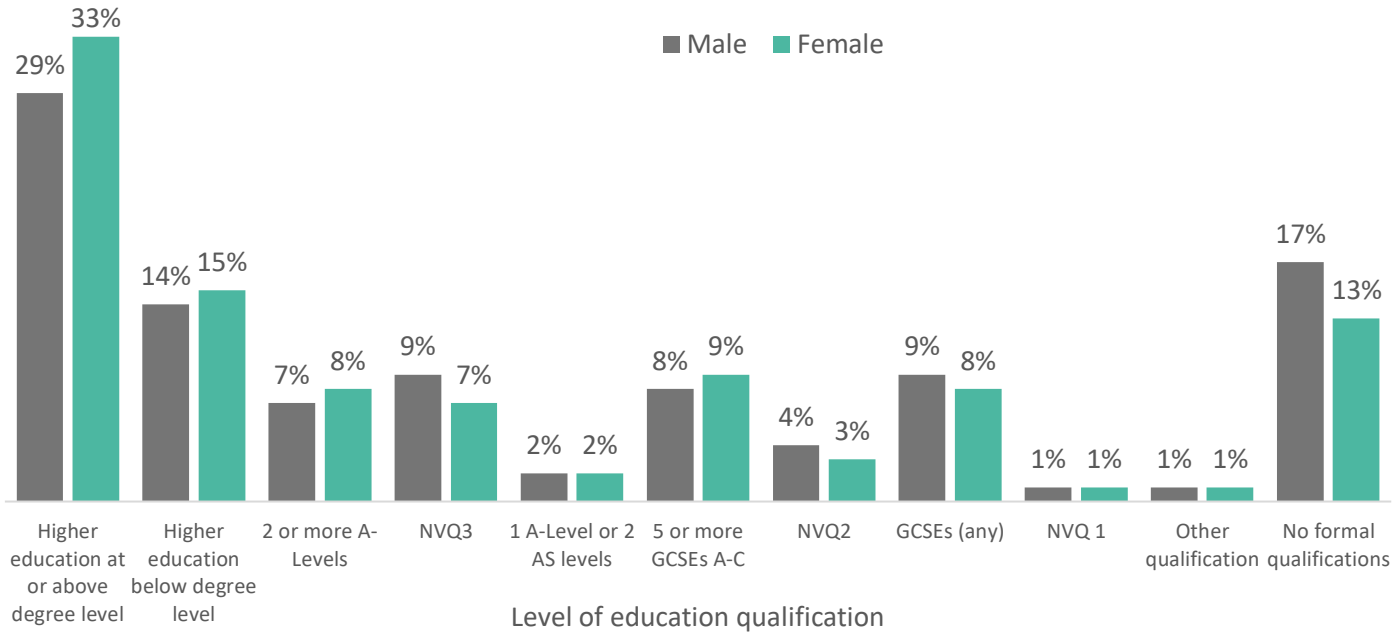
As Figure 11 shows, one in three (33%) females aged 21-64 and just under three in ten (29%) males aged 21-64 had a qualification at degree level or above.[6] In contrast, around one in six (17%) males aged 21-64 had no formal qualifications in comparison to around one in eight (13%) females aged 21-64 years.

A similar proportion of males (40%) and females (38%) aged 21-64 had secondary-level qualifications. Of these, around one in seven (14%) males aged 21-64 stated that their highest qualification was an NVQ (level 1,2 or 3), whereas one in nine (11%) females aged 21-64 reported an NVQ as their highest qualification.

Additionally, a comparison of English and Maths GCSE results from the 2021/2022 academic year shows that a higher proportion of girls (83%) achieved grade 4 or above compared to boys (79%).[120]

These statistics show that females achieve higher education levels than males on average. However, despite this, there are fewer women in manager, director, and senior official roles in the workplace and males continue to be paid more than women on average.

***Figure 11: Highest level of education qualification by sex (aged 21-64) (percent)***




*Source: Census 2021*

The education fee-paying model in Jersey contrasts to other jurisdictions like the UK as some fee-paying schools are state owned and others are subsidised by the Government. For those that are subsidised, this results in lower tuition costs and, subsequently, they are more affordable to a larger number of islanders; the annual fees are less than half the cost of an average UK private school. Approximately 32% of students in Jersey attend fee-paying schools, which is significantly higher compared to international norms.[121] For example, only 6% of students in the England attend fee-paying schools.[122]

Work commissioned by the Jersey Community Foundation[123] suggests this has resulted in a two-tier education system, where an overwhelming majority of students from middle- and high-income families enrol in fee-paying schools. This was evident in the Children and Young People's Survey 2021, with 34% of children attending fee-paying schools describing their family as well off compared to 13% of children attending non-fee-paying schools.[10]

This division is a significant factor contributing to the disparities within the education system. As a result, non-fee-paying schools tend to have student populations predominantly from lower-income families, including a substantial proportion from first- and second-generation migrant families.

## 7.4. Gender and pay

Despite advancements in gender equality, women in Jersey continue to face economic disparities such as lower wages and financial dependence. The lack of statutory reporting requirements means that very few private sector organisations in Jersey currently disclose their gender pay gap. Consequentially, the Government Gender Pay Gap reports[124] focus on those working within the Public Sector.

The 2020 States of Jersey Gender Pay Gap Report showed that there was a significant increase in the gender pay gap from 18.3% in 2019 to 24.3% in 2020,[125] a follow-up review was published in 2022 to assess whether any progress had been made towards closing the gender pay gap.[126] The report cited several factors contributing to this disparity, such as gender stereotypes, occupational segregation, unconscious bias, "glass ceilings" (or "sticky concrete floors"), and the disproportionate domestic and caregiving responsibilities often shouldered by women. More recent analysis (June 2024) undertaken using a different methodology showed an average (median) gender pay gap of 10.3%.[127]

The report also highlights that the COVID-19 pandemic exacerbated the gender pay gap in Jersey, as many women left work or reduced their hours to accommodate extra childcare duties, limiting their opportunities for promotion. In contrast, men were more likely to stay in continuous full-time employment, and therefore did not experience such limitations on career progression.

PwC's Women in Work Index attempts to measure gender equality by looking at measures like the gender pay gap and female employment rates. A 2021 report for the Channel Islands[128] found that workplace gender inequality in the Channel Islands ranked 24th of the 35 jurisdictions examined. The report mentions that Jersey and Guernsey outperform the OECD average for female workforce participation, but rate worse for the gender pay gap. In addition, historical gender disparities in caring responsibilities and economic activity have also led to financial inequalities between men and women in retirement.[x]

> "**Historical inequalities in social security contributions have led to significant financial disparities between men and women in retirement."** (Survey, Female, 45-54yrs)

*"Wellbeing would be improved significantly if there was no gender pay gap, greater work flexibility and affordable childcare. Women bear the brunt of unpaid and often unrecognised caregiving labour, often to our own detriment because society places these expectations on women as caregivers due to gender stereotypes. Women are expected to adapt their lives to meet the needs of others (children, elderly relatives and other dependents) whilst men can have children with very little impact on their income, work life or social life."* (Survey, Female, 35-44yrs)

## 7.5. Family life

The 2021 census showed that over a fifth (22%) of Jersey households have dependent children under sixteen.[2] Many women are the primary caregivers within these families, as evidenced by the fact that 89% of single parents are female. This role can lead to chronic stress and burnout. Insights from the public consultation reveal that many women feel overwhelmed by the dual demands of work and family life.

> **"A woman simply cannot be it all and give 100% to motherhood, a career, a relationship, maintaining a household, a social life, maintaining physically active etc"** (Survey, Female, 25-34yrs)

Many women take on primary caregiving roles, whether it is bringing up children or providing care for elderly parents, which can result in chronic stress, feelings of inadequacy, and burnout. In Jersey, approximately 15% of the population (around 10,000 people) provide unpaid care to someone, often a family member. Of those receiving care, 85% rely on family support, and nearly two-thirds are aged 70 or older.[129]

[x] Historically, women were able to elect to not pay Social Security contributions and to take a state pension based on two thirds of their husbands' contributions if married before 1 Apr 2001.

The 1,001 days from conception to a child's second birthday, are crucial for development and have a lasting impact on health throughout life. Supporting mothers and new parents during these critical stages of life is essential. The WHO emphasises that "social support during and after pregnancy has been linked to improved maternal mental health and better child development outcomes"[130]. In Jersey, community resources such as antenatal education and peer support networks help to alleviate stress. However, gaps in these support systems can lead to social isolation, negatively affecting both maternal and child health.

> **"Postnatal care (after the 6-week check-up) is lacking and almost non-existent"** (Survey, Female, 35-44yrs)

One of the most significant concerns raised in the public consultation were cost issues, including the high cost of childcare, which was often cited as a reason for causing stress. Local data reveals that childcare fees in Jersey are substantially higher than in England, with childminder fees being 37% higher and nursery fees 22% higher on average across all English regions.[131]

> **"Childcare being £2000 per month is disgusting, I do not understand how anyone can afford that alongside paying for a mortgage. My heart breaks that I have to go back to work - but I have no choice, I have to earn to pay my mortgage, and now the majority of those earnings are going on early years care - I feel completely out of choices. These things stress me and my partner out every day and make me consider leaving the Island regularly"** (Survey, Female, 25-34yrs)

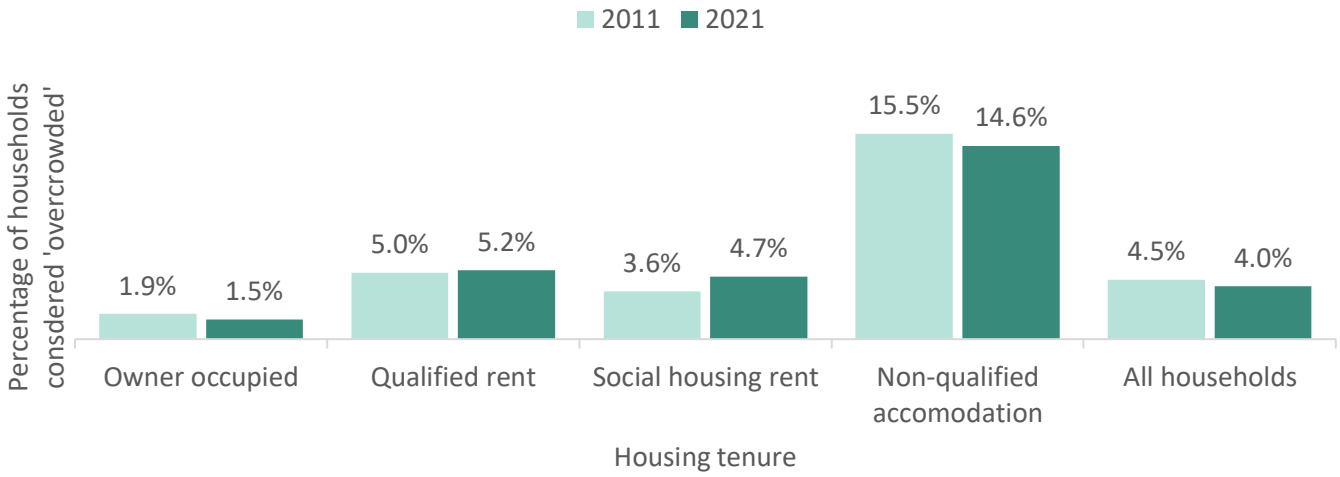
To address these challenges, significant policy work has been undertaken to consider options for extending job-protected leave beyond the current 32 weeks and improving the quality, accessibility, and affordability of early childhood education and childcare (ECEC) for children under three.[132] Subsequently, a commitment has been made in the Government of Jersey Common Strategic Policy (CSP) 2024-2026 to implement a childcare offer for children aged 2-3 with additional needs, with plans to later expand to universal options for this age group.[133]

## 7.6. Housing and environment

The 2021 Census provided insight into overcrowding in Jersey using the 'Bedroom Standard' measure, which assesses whether households have enough bedrooms to meet their needs.[xi] According to this measure, 1,783 households — equivalent to 4% of all households — were classified as overcrowded. Overcrowding was particularly prevalent among households in non-qualified accommodation, where 14.6% were affected. Additionally, 9% of single-parent households with children were reported as overcrowded, highlighting a significant disparity in living conditions for some of Jersey's most vulnerable families.

[xi] The 'Bedroom Standard' (UK Housing Overcrowding Bill, 2003) defines the number of bedrooms that would be required by the household, where a separate bedroom is allowed for each married or cohabiting couple, any adults aged 21 or over, pairs of adolescents aged 10-20 of the same sex and pairs of children under 10 years. Unpaired persons of 10-20 years are notionally paired with a child under 10 of the same sex.

*Figure 12: Proportion of households considered to be 'overcrowded' by the Bedroom Standard, by tenure (percent), 2011 and 2021*




*Source: Census 2021*

Safe and comfortable housing was consistently highlighted as essential to feeling a sense of security and protection, making a significant contribution to positive mental wellbeing. Stable housing reduces anxiety and promotes stability, playing a vital role in overall quality of life.

**"I need to know me and my family can sleep safely at night."** (Survey, Female, 35-44yrs)

The affordability of suitable housing emerged as a recurring concern, directly affecting individuals' quality of life and their sense of stability and comfort. Financial insecurity is closely tied to housing quality, with unqualified islanders, single parents, and many other low-income individuals forced to endure substandard living conditions due to the high cost of rent. According to the Jersey Opinion and Lifestyle Survey (JOLS), 26% of single parents reported dissatisfaction with their housing compared to 9% overall.[8] In the Children and Young People's Survey 2021, children from single parent families made up 12% of all responses, yet they accounted for 18% of all those who were materially deprived (lack 2 or more of a 10 common belongings).[134]

Issues such as dampness and mould in homes have severe repercussions for both physical and mental health. These conditions not only worsen respiratory problems like asthma but also contribute to mental health challenges, including depression. 8% of children living in single-parent households reported black mould in their bedrooms, compared to 6% of children in other family situations.

**"Housing in Jersey is unsuitable... damp and mould have a detrimental effect on health."** (Survey, Female, aged 35-44 years)

In the public consultation there was a strong acknowledgment that poor housing conditions contribute to long-term health problems. Addressing these fundamental housing issues is regarded as a critical step in improving health outcomes.

Jersey homelessness data from the second quarter of 2024 reveals that women account for 25% of those classified as homeless. The two leading causes of homelessness among women, were 'at risk of, has experienced, or is escaping domestic abuse' (39%) and 'breakdown of relationships – abusive behaviour' (20%). In comparison, the primary causes of homelessness among men were 'substance use (alcohol and drug use)' (14%) and 'lack of affordable accommodation' (13%).[135]

**"By improving housing/living conditions, you will help to reduce the number of GP/hospital appointments for conditions that are exacerbated by poor housing conditions."** (Survey, Female, 20-24yrs)

## 7.7. Violence against women and girls

The issue of violence against women and girls (VAWG) is the focus of a taskforce report in Jersey.[136] The Taskforce defines VAWG as "Any act of gender-based violence that results in, or is likely to result in, physical, sexual or psychological harm or suffering to women, including threats of such acts, coercion or arbitrary deprivation of liberty, whether occurring in public or in private life".[137]

The report revealed alarming statistics, with 1 in 4 (27%) Jersey survey respondents reporting that they had experienced rape and/or attempted rape in their lifetime, and over half (56%) stating they had been subjected to unwanted sexual touching. These findings align closely with similar data from the UK Home Office,[138] highlighting that this is a widespread issue that extends beyond just Jersey.

VAWG was also highlighted in responses to the public consultation, with several women saying that they do not feel safe at night. Additionally, in the focus groups participants noted that financial insecurity can be linked to violence against women, discussions focused on how women may struggle to escape harmful situations, such as abusive relationships or unsafe housing due to financial insecurity

The Government of Jersey has received the report of the Taskforce on Violence against Women and Girls and has accepted its recommendations. The Minister of Justice and Home Affairs response to the taskforce report recognises that inequality, distrust of institutions, stigmatisation, the reluctance of victims to speak out and resistance to bad news are all features of our society, just as they are in all others. The reporting of the actions will be delivered on an annual basis.[139]

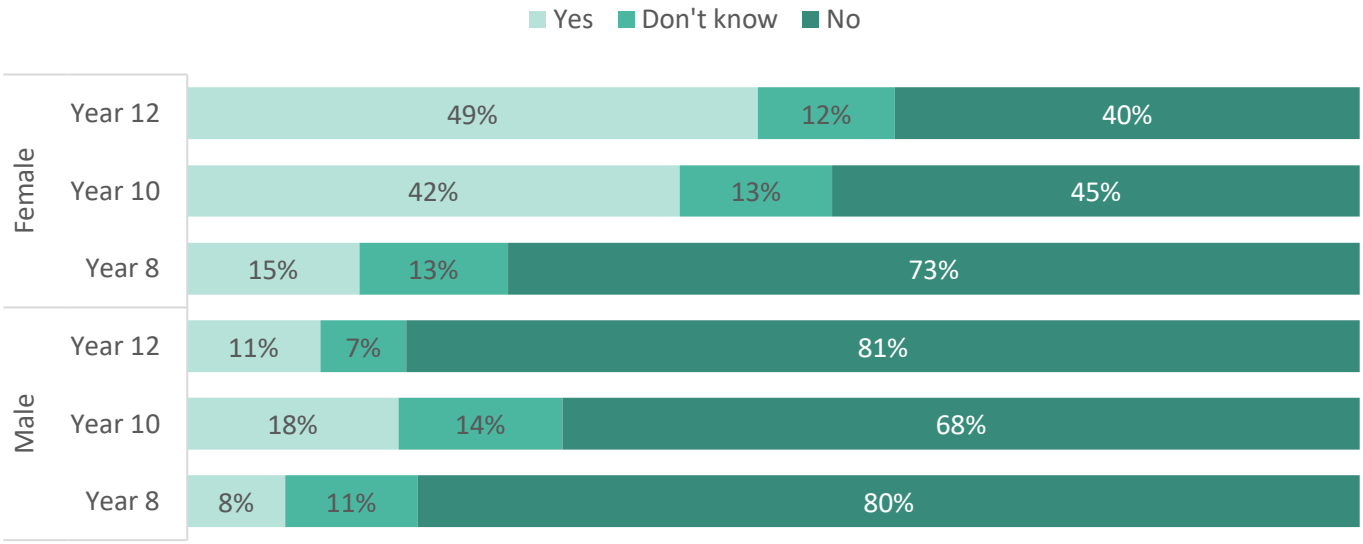
> **"I regularly do not feel safe at night in Jersey and feel the States are not doing enough to tackle this problem, nor the problems of violence against women and girls. It feels like there is a rape or domestic abuse case in the courts every week, and those are only the women and girls who are brave enough to come forward."** (Survey, Female, 35-44yrs)

It is well-documented that VAWG has a profound and long-lasting impact, not only on their health and wellbeing, but also on their children and families. Experiencing violence can significantly harm women's physical, mental, sexual, and reproductive health. According to the World Health Organization, women with a history of abuse are more likely than those without such experiences to report chronic health conditions, including headaches, chronic pelvic and back pain, abdominal pain, irritable bowel syndrome, and other gastrointestinal disorders.[140]

The Children and Young People's Survey 2021 also highlighted that a worrying proportion of children in years 8, 10, and 12 have encountered inappropriate comments or unwanted sexual attention. This issue was especially prevalent among young girls, who were disproportionately affected.

- The proportion of young females who had experienced inappropriate comments or unwanted attention increased with age from 15% of Year 8 to 49% of Year 12.
- 35% of females across Years 8, 10 and 12 experienced inappropriate comments or unwanted attention in the last year compared to 13% of males.
- Pupils in fee-paying schools were more likely (28%) to have experienced inappropriate comments or unwanted attention than pupils in non-fee-paying schools (23%).

***Figure 13: Percentage of children who have experienced inappropriate comments or unwanted attention of a sexual nature in the last year (Years 8, 10 and 12)***




*Source: Children and Young People's Survey 2021*

The Children and Young People's Survey 2021 also asked whether young people would tell someone if they were sexually taken advantage of. Overall, 71% of respondents indicated they would 'definitely' or 'probably' disclose such an incident – a decrease from 78% in the 2018 and 2019 surveys. In addition, 15% reported they would 'definitely not' or 'probably not' tell anyone, an increase from 10% in 2019. Among year 12 students, there was a significant gender disparity in answers: 20% of females reported they would not disclose such incidents, compared to just 9% of males. These findings highlight a concerning trend of decreasing willingness of children and young people to report sexual abuse, particularly among girls.

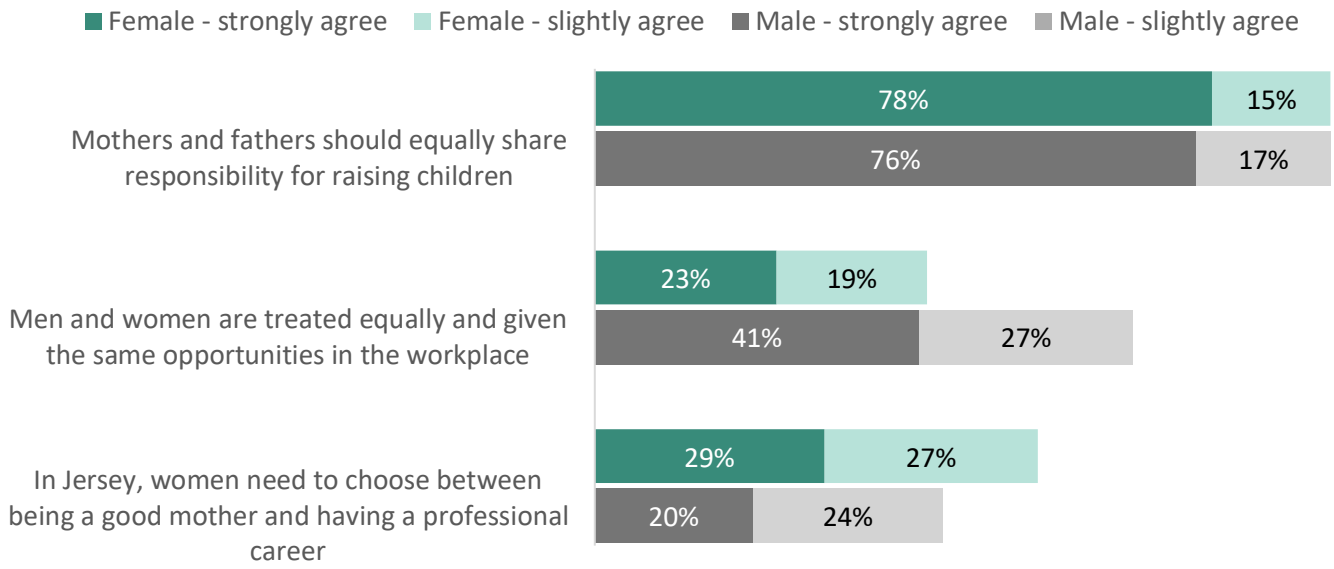
The 2024 Jersey Opinions and Lifestyle Survey (JOLS)[141] asked respondents whether they would feel safe walking alone at night in the area where they live. It found that three in ten women (30%) did not feel safe, compared to just 8% of men. The proportion of women who reported feeling safe decreased from 77% in 2022 to 70% in 2024. Despite this decline, women in Jersey reported feeling safer than women in the UK, where only 50% feel safe walking alone after dark.

## 7.8. Societal and cultural attitudes

In Jersey there was no difference in the proportion of males and females who agreed mothers and fathers should equally share responsibility for raising children.[39] However, many women do not feel they have equal opportunities and treatment. While two thirds (67%) of men agreed that men and women are treated equally and given the same opportunities in the workplace, only two fifths (41%) of women agreed with the statement. Similarly, while more than half (56%) of women agreed that women need to choose between being a good mother and having a career, only two fifths (44%) of men agreed with the statement.

**"The island is not set up to let women succeed; we are always expected to compromise on something"** (Survey, Female, 35-44yrs)

***Figure 14: Proportion of adults who agree or strongly agree with statements about gender, by sex***




*Source: Jersey Opinions & Lifestyle Survey Report 2023*

These statistics show that men perceive women to experience less discrimination and career progression barriers in the workplace than are reported by women themselves. This is a crucial issue to address – with men occupying more senior positions and receiving more pay than women on average, ensuring that men understand the lengths at which women experience inequality is essential to addressing it.

**"Unchecked and ongoing misogyny and sexism within structures such as education, health and criminal justice. Outdated laws that favour males financially. Discrepancies in pay within employment. All of these inequalities place an additional stress burden on women and girls, navigating systems that are less accessible to them."** (Professional Stakeholder)

# 8. Data Development

The process of developing this JSNA highlighted several challenges in the availability of quantitative data relating to factors that impact Women's Health.

For some data sets, although the data is held in government databases, the limited resources of skilled analysts working with the data to access and analyse it meant that we were not able to include it in this JSNA.

One of the main challenges we faced in assessing need concerned the assessment of inequalities within many of our datasets. Other jurisdictions, such as the UK, have measures of deprivation and good quality ethnicity data, which allows them to be able to explore where there are inequalities within their outcome data or where certain sub-groups of the population are seeing different outcomes to others.

At present, the public health intelligence team, who led on the development of this JSNA, work under the Loi (1934) sur la Santé Publique,[142] (the public health law) which has limited references to the data the team can access for the purposes of conducting the JSNA. As such, the team have worked closely with other analysts across the Government of Jersey but have been unable to access all the data themselves and have relied on the resources of other analysts to access and interpret the data. Although work has started to update the public health law, the team are currently unable to join datasets together to assess whether need is being met, for example, looking at hospital service usage for those on GP disease registers or to understand if services are being used by those with the greatest need.

Gaps in knowledge were identified during the production of this JSNA and would be rectified with data on the following:

- an index of multiple deprivation
- good quality disability and ethnicity data in all major government datasets
- data on the specific factors influencing women's participation in physical activity in Jersey, particularly barriers faced by working mothers or women in low-income households
- data on the prevalence and attitudes towards gambling
- data on the prevalence of use and attitudes towards drugs
- statistics on the prevalence and severity of frailty
- expanded statistics on the incidents of sexually transmitted infections (STIs)
- good quality screening uptake and coverage indicators
- data on the prevalence of Foetal Alcohol Syndrome across society
- menstrual and menopause-related data including the prevalence of symptoms, the demand for healthcare services, and the socioeconomic impacts
- data on DNA (Did Not Attend) appointments and other potential indications of VAWG
- statistics around the amount of unpaid care being provided by different age groups
- dental care data
- data on housing quality, including fuel poverty
- data on diet, nutrition and food bank usage
- expanded statistics on mental health, including the ability to analyse by vulnerable groups such as younger women, women with low incomes, and women in the LGBTQ+ community

This first JSNA for Jersey has brought together much of the data about the health and wellbeing needs of women and girls in Jersey but should not be considered exhaustive as a result of the data challenges detailed here.

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