INITIAL EQUALITY IMPACT ASSESSMENT

Name of the activity being assessed	Sexual Health Tender for Integrated Sexual Health Services				
Directorate / Department	Public Health	**Service**	Public Health	**Assessment lead**	Cathy Fisk
Is this a new or existing activity?	☐ New ☒ Existing	**Responsible manager / director for the assessment**		**Dominic Harrison**	
Date EIA started	21/01/2015	**Implementation date of the activity**		01/04/2016	

SECTION 1 - ABOUT YOUR ACTIVITY

How was the need for this activity identified?	Sexual health is an important area of public health. Most of the adult population of England are sexually active and access to quality sexual health services improves the health and wellbeing of both individuals and populations. The Government has set out its ambitions for improving sexual health in its publication, *A Framework for Sexual Health Improvement in England* (Department of Health, 2013). The Public Health White Paper Healthy Lives, Healthy People: Our Strategy for Public Health in England (Department of Health 2010) highlights a commitment to work towards an integrated model of service delivery to allow easy access to confidential, non-judgemental sexual health services (including for sexually transmitted infections (STIs) contraception, abortion, health promotion and prevention). Good sexual health is an important aspect of health and wellbeing, and it is vital that people have the information, the confidence and the means to make choices that are right for them, regardless of their age, gender, ethnicity, sexual orientation, religion or belief or disability. It helps people to develop positive relationships and enables them to protect themselves and their partners from infections and unintended pregnancy (Department of Health, 2010)
What is the activity looking to achieve? **What are the aims and objectives?**	The service will support delivery against the three main sexual health Public Health Outcome Framework measures: • Under 18 conceptions • Chlamydia diagnoses (15-24 year olds) • People presenting with HIV at a late stage of infection In addition it will deliver the following outcomes to improve the sexual health in the local population as a whole: • Clear accessible and up to date information about services providing contraception and sexual health for the whole population including information targeted at those at highest risk of sexual ill health • Improved access to services among those at highest risk of sexual ill health • Reduced sexual health inequalities amongst young people and young adults • Reduced sexual health inequalities amongst BME groups • Increased uptake of effective methods of contraception, including rapid access to the full range of contraceptive methods including LARC (Long Acting Reversible Contraceptive) for all age groups • A reduction in unwanted pregnancies in all ages as evidenced by teenage conception and abortion rates

	• Increased diagnosis and effective management of sexually transmitted infections • Increased uptake of HIV testing with particular emphasis on first time service users and repeat testing of those that remain at risk • Increased development of evidence-based practice
Services currently provided (if applicable)	**Community and Sexual Health Service** **Level 1** A Level 1 sexual health service encompasses the following aspects of service delivery: • Chlamydia screening • Contraceptive information and services. • Condom distribution • Cervical cytology screening and referral • Pregnancy testing and referral Level 2 In addition to the components of level 1, level 2 includes: • Contraceptive implant insertion and removal. • Intrauterine device/system insertion (IUD/IUS) and removal. • Treatment of people detected positive for Chlamydia as part of the Chlamydia screening programme. • Training of NHS and none NHS staff to treat people identified as positive for Chlamydia in their service and in accordance with agreed Patient Group Directions. • Partner notification of Chlamydia contacts identified as part of the Chlamydia screening programme activities in Blackburn with Darwen • Outreach for sexually transmitted infection prevention in Blackburn with Darwen. • Outreach contraception services in Blackburn with Darwen. • Training of health professionals around Chlamydia screening to be delivered in partnership with the Sexual Health in Practice team in NHS East Lancashire Level 3 In addition to the components of level 1 + 2, level 3 includes • Specialised contraception for women with medical conditions such as HIV positive, diabetes, cardiac conditions etc.; difficulties with IUD and implant fitting/removal; problems with obtaining cervical smear specimen. • Faculty of Sexual and Reproductive Health training. • Clinical governance support for services providing levels 1 + 2. Psychosexual service • To provide co-ordinated service of assessment, advice and treatment for clients with problems of sexual functioning • To provide equality of access to specialist skills and treatment as determined by clinical need • To adopt a holistic and integrated approach • To promote close links with other service providers, offering help to clients with sexual problems in primary, secondary and community care

- To raise awareness of psychosexual problems, provide ongoing specialist support and training for primary and secondary care
- To act as a reference point for training allied health professionals and clinicians
- To provide evidence based system of advice and treatment with quantifiable outcomes.

Young people sexual health services

The service provides:

Contraception;

- Condoms
- Femidom condoms
- Hormonal contraceptive pills
- Emergency Hormonal Contraception
- Coils – IUD/IUS
- Injections (Depo-Provera)
- Hormonal Implant
- Vaginal ring
- Contraceptive patch

STI Testing;

- Opportunistic Chlamydia screening as part the national Chlamydia Screening programme
- Chlamydia treatment as part of the national programme

Pregnancy Testing;

- Including counselling and referral for termination and ante natal care
- Post termination of pregnancy counselling where appropriate

Information and Advice;

- 1:1, telephone, internet, including Facebook and other emerging social media where relevant
- Signposting to other agencies, including availability of leaflets from the most relevant local agencies
- Advice and discussion around risk taking behavior, in particular sexual risk taking, use of alcohol and other legal and illegal substances, discussions are focused on enhancing self-esteem and increasing self confidence
- Health promotion and prevention advice on a range of health and wellbeing topics
- Outreach and education

Genitourinary medicine (GUM)

Basic and Intermediate Care (Level 1 and 2)

- Information on services provided by local voluntary sector sexual health providers including referrals and/or signposting
- Full sexual history taking and risk assessment (all practitioners)5
- Supply of male and female condoms and lubricant offered to all clients
- Domestic abuse screening and referral (all practitioners)

- Assessment and referral for psychosexual issues
- referral for Brief Alcohol Interventions (BAIs)
- Referral for Female Genital Mutilation (FGM) specialist advice and care
- STI testing and treatment of symptomatic but uncomplicated infections in men (except MSM)6 and women excluding:
  - Men with dysuria and/or genital discharge
  - Symptoms at extra-genital sites e.g. rectal or pharyngeal
  - Pregnant women (except women with uncomplicated infections requesting abortion)
  - Genital ulceration other than uncomplicated genital herpes
- Chlamydia screening for sexually active under 25 year olds
- Case Management of uncomplicated Chlamydia
- HIV and syphilis testing and pre and post-test discussions (with referral pathways in place)
- Initiation of Post Exposure Prophylaxis with referral to Level 3 for on-going management
- Promotion and delivery of Hepatitis A and B vaccination, with a particular focus on key target groups
- Hepatitis C testing and discussion (with referral pathways in place)
- Uncomplicated contact tracing/partner notification
- Management of first episode uncomplicated vaginal discharge (low risk)
- Management of contacts of gonorrhea and TV (excluding symptomatic men)
- Assessment & treatment of genital ulceration with appropriate referral pathways for those at high risk of syphilis/LGV (Lymphogranuloma Venereum)
- Assessment and referral of sexual assault cases
- Holistic sexual health care for young people including child protection / safeguarding assessment
- Outreach clinic services for STI prevention
- Urgent and routine referral pathways to and from related specialties (general practice, urology, A&E, gynecology) should be clearly defined. These may include general medicine /infectious diseases for inpatient HIV care
- Urgent and routine referral pathways to and from social care
- Regular audit against national guidelines

<u>Complex (Level 3) Service Provision in addition to Levels 1 and 2</u>

- Management of complicated/recurrent STIs (including tropical STIs) with or without symptoms
- Management of STIs in pregnant women (except women with uncomplicated infections requesting abortion)
- Management of HIV partner notification
- Coordination of outreach clinical services for high risk groups
- Interface with specialised HIV services as commissioned by NHS England
- Provision and follow up of post-exposure prophylaxis after sexual exposure to HIV
- Referral for contraceptive and STI care across a network including:
  - Clinical leadership of GUM and STI management
  - Co-ordination of clinical governance
  - Co-ordination and oversight of training in Sexual; and Reproductive Health (SRH) – this is available in other services under but no an explicit part of the delivery of GUMNW TPD for C-SRH and GTPD for DRSRH and GUM
  - Co-ordination of pathways across clinical services
  - Co-ordination of partner notification for STIs and HIV

Please outline recommendations that have been identified for implementation following a review of the activity.	An integrated sexual health service model aims to improve sexual health by providing easy access to services through open access 'one stop shops', where the majority of sexual health and contraceptive needs can be met at one site, usually by one health professional, in services with extended opening hours and accessible locations. The provision of integrated sexual health services is supported by current accredited training programmes and guidance from relevant professional bodies including Faculty of Sexual and Reproductive Healthcare (FSRH), British Association for Sexual Health and HIV (BASHH), British HIV Association (BHIVA), Medical Foundation for HIV & Sexual Health (MEDFASH), Royal College of Obstetricians and Gynaecologists (RCOG) and National Institute for Health and Care Excellence (NICE) and relevant national policy and guidance issued by the Department of Health and Public Health England.
Type of activity	☒ Budget changes ☐ Decommissioning ☐ New activity ☐ Change to existing activity ☒ Commissioning ☐ Other [**please state here**]

SECTION 2 - UNDERSTANDING YOUR CUSTOMER

Who else will be involved in undertaking the equality analysis and impact assessment?
Please identify additional sources of information you have used to complete the EIA, e.g. reports; journals; legislation etc.

Blackburn with Darwen Borough Council (2013) Integrated Strategic Needs Assessment Local Strategic Review of Sexual Health, http://www.blackburn.gov.uk/lists/downloadabledocuments/sexual-health-jsna.pdf
British Association for Sexual Health and HIV (BASHH) Parliamentary Briefing (2013) Making the case for improved sexual health testing for men who have sex with men (MSM)
http://www.bashh.org/documents/BASHH%20MSM%20Parliamentary%20Briefing%20December%202013.pdf
Change http://www.changepeople.org/?s=sexual+health (accessed 04/02/15)
Department of Health (2009) Religion or belief: a practical guide for the NHS
http://webarchive.nationalarchives.gov.uk/20130107105354/http:/www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_093133
Department of Health (2010) Healthy Lives, Healthy People: Our strategy for public health in England https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/216096/dh_127424.pdf
Department of Health (2013) A Framework for Sexual Health Improvement in England
https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/142592/9287-2900714-TSO-SexualHealthPolicyNW_ACCESSIBLE.pdf
Department of Health (2013) Abortion Statistics, England and Wales: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/319460/Abortion_Statistics__England_and_Wales_2013.pdf
Healthwatch Blackburn with Darwen (2013) What Young People Think of their Local NHS Services: http://www.healthwatchblackburnwithdarwen.co.uk/sites/default/files/uploads/collegereport.pdf
Healthwatch Blackburn with Darwen (2014) Lesbian, Gay, Bisexual and Transgender people accessing Health and Social Care services http://www.healthwatchblackburnwithdarwen.co.uk/sites/default/files/lgbt_report.pdf
National Institute for Healthcare and Excellence (2011) Increasing the uptake of HIV testing among black Africans in England
https://www.nice.org.uk/guidance/ph33
National Institute for Healthcare and Excellence (2014) Contraceptive services with a focus on young people up to the age of 25
https://www.nice.org.uk/guidance/ph51/chapter/2-public-health-need-and-practice
Public Health England - Public Health Outcomes Framework http://www.phoutcomes.info/further-information (accessed 04/02/15)
Public Health England - Sexually transmitted infection risk in England is greatest in gay men and young adults
https://www.gov.uk/government/news/sexually-transmitted-infection-risk-in-england-is-greatest-in-gay-men-and-young-adults (accessed 04/02/15)
Sexual Offences Act (2003) http://www.legislation.gov.uk/ukpga/2003/42/contents (accessed 04/02/15)
Teenage Pregnancy Knowledge Exchange http://www.beds.ac.uk/knowledgeexchange/briefings (accessed 04/02/15)
The Lesbian & Gay Foundation (2013) 'Beyond Babies & Breast Cancer – Expanding our understanding of women's health needs'
http://www.lgf.org.uk/womenshealth?fp

Who are you consulting with? How are you consulting with them? (*Please insert any information around surveys and consultations undertaken)*

- Consultation with local services and a stakeholder event is planned for February and March 2015 as part of the process for the development of a BwD Sexual Health Strategy and tender process.
- Integrated Strategic Needs Assessment Local Strategic Review of Sexual Health: http://www.blackburn.gov.uk/lists/downloadabledocuments/sexual-health-jsna.pdf

- Young People's Views on Sexual Health Services across Lancashire Narrative for the Sexual Health Needs Assessment 2014 (can be obtained on request)
- The Dream Service is a film to show Lancashire young people's views on Sexual Health Services http://www.youtube.com/watch?v=Vgvnakkhzcw&list=UUYT2b4Ee98gxiK9y6AbRd1Q
- Market Consultation Event behalf of Lancashire and Cumbria County Councils, and Blackpool and Blackburn with Darwen Borough Councils
- What Young People Think of their Local NHS Services: http://www.healthwatchblackburnwithdarwen.co.uk/sites/default/files/uploads/collegereport.pdf
- Lesbian, Gay, Bisexual and Transgender people accessing Health and Social Care services: http://www.healthwatchblackburnwithdarwen.co.uk/sites/default/files/lgbt_report.pdf
- Young Peoples Experiences of Health & Social Care: http://www.healthwatchblackburnwithdarwen.co.uk/sites/default/files/collegereport14.pdf

The specifications (all age and young people) will be shared with the British Advisory for Sexual Health and HIV (BASHH) for their approval (February 2015), with a view that the specifications may be amended dependent on any feedback received. Following this, the local variations appendix document to the specification will be finalised, which takes into account local needs. At this point the EIA will be reviewed prior to tender documents being uploaded onto the procurement system.

August 2015 update: It has been agreed that the 2 specifications are combined into one Prime Provider Model specification, the ITT questions reflect the requirement by all bidders to the model to demonstrate robustly their understanding of local needs as well as best methods of engagement and increasing access to services for all in particular the vulnerable groups highlighted within the ISNA and local and national guidance.

Who does the activity impact upon?	Service users	☒ Yes	☐ No	☐ Indirectly			
	Members of staff	☒ Yes	☐ No	☐ Indirectly			
	General public	☒ Yes	☐ No	☐ Indirectly			
	Carers or families	☒ Yes	☐ No	☐ Indirectly			
	Partner organisations	☒ Yes	☐ No	☐ Indirectly			
Does the activity impact positively or negatively on any of the protected characteristics as stated within the Equality Act (2010)?	Positive impact	☒ Age	☒ Disability	☒ Gender reassignment	☒ Marriage & Civil Partnership	☒ Pregnancy & maternity	
		☒ Race	☒ Religion or belief	☒ Sex	☒ Sexual orientation		
	Negative impact	☐ Age	☐ Disability	☐ Gender reassignment	☐ Marriage & Civil Partnership	☐ Pregnancy & maternity	
		☐ Race	☐ Religion or belief	☐ Sex	☐ Sexual orientation		
	Don't know	☐ Age	☐ Disability	☐ Gender reassignment	☐ Marriage & Civil Partnership	☐ Pregnancy & maternity	
		☐ Race	☐ Religion or belief	☐ Sex	☐ Sexual orientation		

Does the activity contribute towards meeting the Equality Act's general Public Sector Equality Duty? *Refer to p.2 of the guidance*		
DUTY	**DOES IT CONTRIBUTE?**	**EXPLAIN HOW**
Eliminate unlawful discrimination, harassment and victimisation and other conduct prohibited by the Act (*i.e. the activity removes or minimises disadvantages suffered by people due to their protected characteristic)*	☒ Yes ☐ No	The needs assessment has demonstrated the inequalities faced by certain groups which have in turn informed the specification document which is commissioning services to provide universal services as well as specific services to mitigate and address inequalities faced by residents.
Advance equality of opportunity between those who share a protected characteristic and those who do not *(i.e. the activity takes steps to meet the needs of people from protected groups where these are different from the needs of other people)*	☒ Yes ☐ No	
Foster good relations between people who share a protected characteristic and those who do not *(i.e. the function encourages people from protected groups to participate in public life or in other activities where their participation is disproportionately low)*	☒ Yes ☐ No	

ASSESSMENT	**Is a full EIA required?**	☒ Yes ☐ No
Please explain how you have reached your conclusion *(A lack of negative impacts must be justified with evidence and clear reasons, highlight how the activity negates or mitigates any possible negative impacts)*		

***If no impact is identified on any of the protected characteristics a full EIA may not be required. Please contact your departmental Corporate Equality & Diversity representative for further information.**

SECTION 3 – ANALYSIS OF IMPACT

Does the activity have the **potential** to:
- Have a **positive** impact (benefit) on any of the groups?
- Have a **negative** impact/exclude/discriminate against any group?
- Have a **disproportionate** impact on any of the groups?

Explain how this was identified – through evidence/consultation.
Any negative impacts that are identified within the analysis need to be captured within the action plan in **Section 2**

N.B. Marriage & Civil Partnership is only a protected characteristic in terms of work-related activities and NOT service provision

Characteristic	Positive	Negative	Don't know	Reasons for positive and/or negative impact Please include all the evidence you have considered as part of your analysis	Action No.
Age	☒	☐	☐	The Integrated Sexual Health service will be commissioned to provide open access, cost-effective, high quality provision for contraception and prevention, diagnosis and management of sexually transmitted infections, according to evidence-based protocols and adapted to the needs of local population. The service will be characterised by being provided on an open access basis and available to anyone requiring care, irrespective of their age, place of residence or GP registration, without referral a to provide services to women and men of any age. However, whilst many aspects of the sexual health services are universal national research has identified specific age groups for targeted interventions and are included in the Public Health Outcome Framework measures: • Under 18 conceptions (see Pregnancy & Maternity) • Chlamydia diagnoses (15 to 24 year olds) The service will be part of the National Chlamydia Screening Programme (NCSP) to provide opportunistic chlamydia screening for young people age 16 to 24 years. Public Health England recommends screening of sexually active young adults, annually or on change of partner, in a variety of settings. The rationale being Chlamydia: • is the most common bacterial sexually transmitted infection; around 2%-3% of sexually active young adults (age 16 to 24) are infected • is often asymptomatic; around 70%-80% of young adults with chlamydia will be unaware that they have the infection • it has serious consequences if left untreated including pelvic inflammatory disease (PID), ectopic pregnancy and infertility. • can be detected and treated easily, reducing the risk of complications for an individual In 2013, BwD did not achieve the Public Health Outcomes Framework target of at least 2,300 chlamydia diagnoses per 100,000 population aged 15 to 24 years. BwDs diagnostic rate (positive test per head of population) was 1472 per 100,000. Across England, 30% of Upper Tier Local Authorities met the target with	**1** **2** **3**

				the England average rate of 2016 per 100,000 and Cumbria and Lancashire average being 2166. BwD positivity rate (percentage of tests proving positive) was 9.9% compared with England, 8.1% and Cumbria and Lancashire 9.0%. However, BwD coverage (percentage of the age 15 to 24 population tested) was lower than England and Cumbria and Lancashire (14.9% compared with 24.9% in England and 23.9% in Cumbria and Lancashire). With regard to Sexual Transmitted Infections (STIs) across England as a whole, the overall number of sexually transmitted infections diagnosed in 2013 was similar to the year before. Among heterosexuals diagnosed in genitourinary medicine (GUM) clinics in 2013, young people (15 to 24 years) experienced the highest STI rates: 63% of chlamydia cases (56,034), 54% of genital warts (36,312), 42% of genital herpes (12,450) and 56% of gonorrhoea (8,122) https://www.gov.uk/government/news/sexually-transmitted-infection-risk-in-england-is-greatest-in-gay-men-and-young-adults However in BwD there was a considerable reduction of STI diagnosis, from 1043 diagnoses in 2012 to 808 in 2013. The continuing steep increase in Gonorrhoea diagnoses in England is a matter of national concern, but BwD only saw a marginal rise (from 28 cases in 2012 to 29 in 2013). BwD's relatively low overall rate of acute STI diagnoses in 2013 is largely due to the fact that the screening programme did not achieve its target number of chlamydia diagnoses (Sexual Health Data Release, PHE, June 2014).	
Disability	☒	☐	☐	All sexual health services are accessible to all regardless of their disability. Anyone who has been diagnosed with HIV is automatically covered by the Equality Act (2010) People with learning disabilities may have special and specific needs around sexual health and contraception. For example, they may require information on contraception to be delivered in a different format, or they may need support to enable them to communicate their choices (Department of Health, 2010). There is little published material on the sexual health and wellbeing of young people with learning disabilities. However, CHANGE, a disability rights organisation, carried out a research project on sexuality and young people with learning disabilities, with a particular focus on sex education. The findings of the research highlight the need for improved sex education for people with learning disabilities, including the provision of accessible information and increased support for parents and teachers www.changepeople.co.uk/showPage.php?id=9 The NICE guidance on long-acting reversible contraception (2005) states that: • Women with learning and/or physical disabilities should be supported in making their own decisions about contraception. • When a woman with a learning disability is unable to understand and take responsibility for decisions about contraception, carers and other involved parties should meet to address issues around the woman's contraceptive need and to establish a care plan. • Healthcare professionals should have access to advocates for women with sensory impairments or learning disabilities.	**1 2 3**
Gender reassignment	☒	☐	☐	All sexual health services are accessible to all irrespective of their gender reassignment status (see sex section)	**1 2**

					3
Marriage & Civil Partnership	☐	☐	☐	N/A	
Pregnancy & Maternity	☒	☐	☐	In addition to high quality sexual and reproductive health services that will be commissioned women of all ages, services will be required to target services to reduce teenage pregnancy as part of the Public Health Outcomes Framework. Teenage pregnancy is a significant public health issue in England and is associated with poor antenatal health, lower birth weight babies and higher infant mortality rates. Evidence supporting reducing teenage pregnancy includes: • 21% of the estimated young women 16-18 who are not in education , training or employments (NEETs) are teenage mothers • 20% of teenage mothers are more likely to have no qualifications at the age 30 • 22% of teenage mothers are more likely to be living in poverty at 30, and much less likely to be employed or living with a partner • Teenage mothers have 3 times the rate of post-natal depression and a higher risk of poor mental health for 3 years after the birth • Teenage mothers are 3 times more likely to smoke throughout pregnancy, and have 50% lower rates of breastfeeding, with negative health consequences for the child • Children of teenage mothers have a 63% increased risk of experiencing child poverty and are more likely to have accidents and behavioural problems • Babies born to teenage mothers have a 41% higher risk of infant mortality http://www.beds.ac.uk/knowledgeexchange/briefings From 2011 to 2013, the conception rates (per 1000) for women aged 15 to 18 for Blackburn with Darwen have, like England and the North West, shown an overall decline. The percentage difference in the rate of decline is 19% for England, 23% for the North West and 23% for Blackburn with Darwen. However, the UK still has one of the highest rates of teenage pregnancy in Western Europe, Locally, regionally and nationally, the abortion rate among females under 18 has changed very little since 1998, so the decline in conceptions has been essentially among those resulting in a birth. Accordingly the proportion of teenage pregnancies resulting in abortion has risen significantly, reaching 48.3% in Blackburn with Darwen in 2011, 48.9% in the NW and 49.3% in England as a whole. http://www.blackburn.gov.uk/lists/downloadabledocuments/sexual-health-jsna.pdf The under-16 abortion rate was 2.6 per 1,000 population in 2013 compared with 3.0 in 2012 and 3.9 in 2003 and the under-18 rate was 11.7 in 2013, compared with 12.8 in 2012 and 18.2 in 2003. Rates for women up to age 22 were all lower than in 2012, and rates for women over age 22 were similar to the 2012 rate.	**1 2 3**

				https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/319460/Abortion_Statistics__England_and_Wales_2013.pdf	
Race	☒	☐	☐	All sexual health services are available to all irrespective of their race; however certain racial groups will require specific targeted interventions. Black Africans living in England are disproportionately affected by HIV. A third of new HIV diagnoses in the UK are among this group, which makes up only approximately 1% of the UK population. (Health Protection Agency, 2010). It is estimated that a total 4% of black Africans living in England have been diagnosed with HIV, compared with 0.1% of the white population (Health Protection Agency: personal communication 2010). Of the 23,288 black African people who received care for HIV in the UK in 2009, 91.3% reported having acquired the infection through heterosexual intercourse (Health Protection Agency 2010b). Most black Africans (80%) who were newly diagnosed in that year acquired their infection heterosexually in Africa (Health Protection Agency: personal communication 2010) https://www.nice.org.uk/guidance/ph33 In 2013, there were a total of 105 HIV and AIDS cases in BwD, 66% classified as white and 31% Black African. 58% had acquired their infection via heterosexual transmission which is the second highest in the North West, and almost the reverse of the situation for Lancashire as a whole. Of the 4 newly diagnosed cases in 2013, the infection route was 3 heterosexual and 1 from injecting drug use. The Department of Health (2005) states that the available evidence indicates that girls and young women from some ethnic groups are more likely to become pregnant before they are 18 among black, black Caribbean and mixed white/black Caribbean groups. One indicator of unintended pregnancy is the abortion rate. Women in white ethnic groups are under-represented in the abortion statistics (compared with their position in census data), whereas women of black or black British and Asian and Asian British ethnicity are over-represented. This demonstrates that black or black British, Asian and Asian British women may have unmet contraceptive needs. The percentage of women having an abortion in 2013 who had one or more previous abortions varies by ethnic group. 33% of Asian women having abortions in 2013 had previously had an abortion, compared with 49% of Black women. 36% of White women had previously had an abortion. https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/319460/Abortion_Statistics__England_and_Wales_2013.pdf Poor sexual and reproductive health often affects those already experiencing inequalities related to ethnicity. Consultation work in Blackburn with Darwen in 2007 showed that many young people, particularly those from minority ethnic backgrounds, felt uncomfortable approaching traditional health service outlets to obtain supplies. Data from the 2011 Census sates that a third of the 15 to 24 year-old population of BwD is of Asian ethnicity, however Asian young people are seriously under represented among those receiving chlamydia tests. Data on the ethnicity of those screened is only available for NCSP tests. 81.1% of the young people tested in Blackburn with Darwen in 2011/12 were white and only 5.9% Asian, although ethnicity was not	**1** **2** **3**

				recorded for another 11.5%. http://www.blackburn.gov.uk/lists/downloadabledocuments/sexual-health-jsna.pdf	
Religion or Belief	☒	☐	☐	All sexual health services are available to all irrespective of their religion or belief system. The Integrated Sexual Health service based on allowing people to make informed decisions about their own sexual health, and these decisions may or may not be influenced by their religion or beliefs. The religion or beliefs of an individual or their community can have an impact on the service user's choice of contraception method, as well as on their ability to access contraceptive services. The factsheet Religion, contraception and abortion, developed by Family Planning Association aims to reflect the predominant attitudes to contraception of the main religious groups in the UK. http://www.fpa.org.uk/sites/default/files/religion-contraception-and-abortion-factsheet.pdf With regard to abortion, most of the six major religions of the UK – Buddhism, Christianity, Hinduism, Islam, Judaism and Sikhism – either condemn abortion or allow it only in very limited circumstances, such as when the mother's life is at risk or the baby is likely to be born with a genetic disease or severe disability, and where the baby has no chance of survival outside the womb. When abortion is allowed, it is normally only permitted in the very early stages of pregnancy (Department of Health, 2009) http://webarchive.nationalarchives.gov.uk/20130107105354/http:/www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_093133 Given the sensitive nature of the information, it is considered inappropriate to collect data – either from diagnoses in a GUM clinic or under the NCSP – on an individual's religion or belief. There is, therefore, limited data available to analyse (Department of Health, 2010)	**1 2 3**
Sex	☒	☐	☐	All sexual health services are available to all irrespective of their sex. All the currently available methods of contraception (with the exception of natural family planning, the male condom and male sterilisation) are primarily used by women. However, patient choice is paramount, and both men and women who request contraceptives should be given information about all methods, including long-acting reversible contraceptives (LARCs). The sexual health needs of both males and females taken into account in the Integrated Sexual Health as there may be particular initiatives to address any gender inequalities, for example encouraging more males to being part of the National Chlamydia Screening Programme (NCSP). Other areas justifiably target females – such as the provision of abortion services. However, there is a potential need to further examine the sexual health needs of trans people. While it is estimated that the number of trans people in the UK is relatively low, it is a group that often has particular health needs and that can face discrimination	**1 2 3**
Sexual orientation	☐	☐	☐	All sexual health services are available to all irrespective of their sexual orientation; however certain groups will require specific targeted interventions. Compared with the general population, MSM have worse sexual health including HIV and sexually transmitted infections (STIs). There is a strong body of evidence indicating that the estimated 850,000 MSM in the UK are at a greater risk of suffering from poorer sexual health outcomes in comparison to other groups. In particular: • HIV in MSM: MSM are the most at-risk group for acquiring HIV in the UK, accounting for 51% of all new cases in 2012, the highest number ever reported, and surpassing the number of heterosexual	**1 2 3**

				infections in 2011 for the first time since 1999. • Sexually transmitted infections in MSM: There was a 39% increase in overall STI diagnoses amongst MSM in England during 2010-2011, including a 23% increase in the incidence of genital warts. • Anal cancer in MSM: MSM are also at a greater risk of anal cancer than other groups, with an estimated incidence of 35/100,000. For HIV positive MSM it is estimated that the incidence is 70-100/100,000, and rates have risen three-fold since 1996. (The general population anal cancer incidence is around 1/100,000). • Hepatitis C (HCV) in MSM**:** Evidence also indicates that MSM, particularly those with HIV, are at an increased risk of acquiring HCV infection through sexual contact, with HIV-positive MSM 8.5-fold more likely to acquire HCV compared to HIV-negative MSM. http://www.bashh.org/documents/BASHH%20MSM%20Parliamentary%20Briefing%20December%202013.pdf Lesbian, gay, bisexual and trans (LGBT) people experience a number of health inequalities. For example: • The vast majority of women who have sex with women engage in sexual practices which could result in the transmission of sexually transmitted infections (STIs) and very few of these women use barrier protection. • 40% of women attending GUM clinics who had exclusively female partners received an STI or other diagnosis, compared to 18.5% of women who had sex with men. • Sexual health information for women who have sex with women is rarely included in school sex education and is not readily available even in adulthood. 60% of lesbian and bisexual women say it is difficult to find sexual health information that is relevant to them • Over half of women who had gone to their GP for advice and nearly a third of those who had attended a GUM or sexual health clinic reported that they didn't feel safe enough to discuss their sexuality properly. http://www.lgf.org.uk/womenshealth?fp Healthwatch Blackburn with Darwen report 'Lesbian, Gay, Bisexual and Transgender people accessing Health and Social Care services' estimates that there are and estimated population of 10,324 Lesbian Gay Bisexual and Transgender (LGBT) people in Blackburn with Darwen. The report identifies that LGB&T people experience barriers to accessing healthcare and these barriers are particularly acute for Black and Minority Ethnic (BME) LGBT people. They are less likely to be open about their sexual orientation or gender identity to service providers due to a lack of trust regarding confidentiality with health care professionals from their own religious or cultural community, as well as a perceived intolerance of being LGB or T http://www.healthwatchblackburnwithdarwen.co.uk/sites/default/files/lgbt_report.pdf	
Vulnerable Groups	☒	☐	☐	In England, the age of consent for any form of sexual activity is 16 for both men and women, regardless of sexual orientation. Those under the age of 16 will be seen by a worker trained to assess competence to receive sexual health advice and interventions in the absence of a parent or guardian and to ensure that safeguarding issues are identified and appropriately referred on. The service will ensure contraception services are free and confidential – including to young people under the age of 16, as long as they are mature enough to understand the information and the decisions involved (Department of Health, 2010). The Sexual Offences Act 2003 provides definitions of the various forms of sexual offences, including rape	**1 2 3**

				and sexual assault, and includes offences committed against those aged under 16 http://www.legislation.gov.uk/ukpga/2003/42/contents Sexual violence, assault and abuse have negative consequences on the sexual health of victims/survivors. These can include STIs, as well as unwanted pregnancy and gynaecological problems for female victims/survivors, and can lead to sexual risk-taking behaviour and re-victimisation (Department of Health, 2010). There is evidence to link alcohol consumption and teenage pregnancy. Regular alcohol consumption is associated with both an early onset of sexual activity and multiple sexual partners, while alcohol use at first sex is associated with lower levels of condom use at first intercourse (Bellis et al, 2009). Services will develop and implement pathways to refer this vulnerable groups to appropriate agencies The services will also target sex workers who may have particular sexual health needs, and these are likely to differ according to their gender and personal circumstances (UK Network of Sex Work Projects, 2009).	
Deprived Communities	☒	☐	☐	Teenage pregnancy is both a cause and a consequence of social exclusion, health inequalities and child poverty. Reducing England's historically high rates of teenage pregnancy continues to be a government priority (Department of Health, 2010). There is increasing evidence that unplanned pregnancies have poorer pregnancy outcomes and that child born after unplanned pregnancies tend to have a more limited vocabulary and poorer non-verbal and spatial abilities. These differences are almost entirely explained by deprivation and inequalities (Carson C et al, 2011) https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/142592/9287-2900714-TSO-SexualHealthPolicyNW_ACCESSIBLE.pdf **I**t is estimated that between one-quarter and one-third of all young people have sex before they reach age 16. Among those leaving school at 16 with no qualifications, 60% of boys and 47% of girls had sex before they were 16 (Wellings et al. 2001). Among those aged 16 to19, 7% of men and 10% of women reported using no form of contraception at first intercourse (NICE guidelines PH51, 2014). Access to contraceptive services is most problematic for people in disadvantaged communities. There is a 6-fold difference in teenage conception and birth rates between the poorest areas in England and the most affluent. There is a clear link between sexual ill-health, deprivation and social exclusion; unintended pregnancies can have a long-term impact on people's lives (NICE guidelines PH51, 2014). https://www.nice.org.uk/guidance/ph51/chapter/2-public-health-need-and-practice Under 18 conceptions can lead to socioeconomic deprivation, mental health difficulties and lower levels of educational attainment. In addition, resulting children are at greater risk of low educational attainment, emotional and behavioural problems, maltreatment or harm, and illness, accidents and injuries (Department for Children, Schools and Families 2008).	**1** **2** **3**
Carers	☐	☐	☐		
Other [please state]	☐	☐	☐		

Does the activity raise any issues for community cohesion? **Does the activity contribute positively towards community cohesion?**	No
Does the activity raise any issues in relation to human rights as set out in the Human Rights Act 1998?	No
Does the activity support / aggravate existing departmental and/or corporate risk?	*Is the activity on the departmental risk register? If it is not, should it be?* No

CONCLUSIONS OF THE ANALYSIS

Action following completion of the impact assessment			
It is important that the correct option is chosen depending on the findings of the analysis. *The action plan must be completed as required.*			
☐ No major change in the activity	☐ Adjust activity	☒ Continue with activity	☐ Stop and reconsider activity
Please explain how you have reached your conclusion			
An extensive needs assessment programme has been completed as well as analysis on national and local trends which will be informing the local variations document which will be part of the tender documents.			

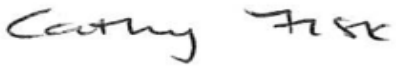
SECTION 4 – ACTION PLAN

Action No.	What is the negative / adverse impact identified?	Actions required to reduce / mitigate / eliminate the negative impact	Resources required	Responsible officer(s)	Target completion date
1	Protected characteristics	Potential providers will be requested to demonstrate how they will target groups with protected characteristics and address the identified needs highlighted by the needs assessment and current research & analysis in the invitation to Tender stage of the procurement process	Tender evaluation/scoring matrix will take into account how a provider aims to meet this requirement	Cathy Fisk	August 2015
2	Protected characteristics	Potential providers will be requested to demonstrate how they will collect and report data on groups with protected characteristics in the invitation to Tender stage of the procurement process	Tender evaluation/scoring matrix will take into account how a provider aims to meet this requirement	Cathy Fisk	August 2015
3	Increasing health inequalities faced by identified groups within the analysis	Prospective providers would be required to demonstrate their ability to ensure equitable access to services and a commitment to reducing the inequalities faced by residents and vulnerable groups	Tender evaluation/scoring matrix will take into account how a provider aims to meet this requirement	Cathy Fisk	August 2015

MONITORING AND REVIEW

The responsibility for establishing and maintaining the monitoring arrangements of the EIA action plan lies with the service completing the EIA. These arrangements should be built into the performance management framework. Monitoring arrangements for the completion of EIAs will be undertaken by the Corporate Equality & Diversity Group and the oversight of the action plans will be undertaken by the Management Accountability Framework.	
If applicable, where will the EIA Action Plan be monitored?	*e.g. via Service Management Team; Service Leadership Team; Programme Area Meetings* **Service Review Meetings**
How often will the EIA Action Plan be reviewed?	*e.g. quarterly as part of the MAF process* **Quarterly**
When will the EIA be reviewed?	*It should be reviewed at least every 3 years to meet legislative requirements* EIA will be reviewed annually
Who is responsible for carrying out this review?	**Public Health Development Manager**

SIGN-OFF

SIGNATURE OF EIA LEAD OFFICER	
DATE COMPLETED	**06/08/2015**

SIGNATURE OF HEAD OF SERVICE / DIRECTOR	
DATE SIGNED	**10/08/2015**
This signature signifies the acceptance of the responsibility and ownership of the EIA and the associated Action Plan (if applicable)	