Appendix C

Equality Analysis – Full Equality Impact Assessment

This template is an adapted version of the NHS England Equality template which was published in September 2014 and is the current standard.

Title of policy, service, proposal etc being assessed:
Female Sterilisation IFR East and North Hertfordshire CCG has assessed the provision of Female sterilisation for its population against the prioritisation framework and deemed the procedure to be low priority. Female sterilisation is therefore only funded on an individual basis in exceptional circumstances.

What are the intended outcomes of this work?

Female Sterilisation will only be funded in exceptional circumstances. Individual cases will go through the IFR team to be reviewed and if appropriate they will authorise funding. All commissioning organisations across the STP have committed to delivering high quality services that meet local needs at optimum cost. East and North Hertfordshire CCG, as part of its financial recovery plan, must prioritise its expenditure to ensure we are best utilising resource to meet the needs of a growing population with ever more complex health and social care requirements. The CCG has therefore reviewed the Female Sterilisation services, with clinical and public health input, and has deemed it to be of low priority. The CCG therefore considers resource is better utilised elsewhere.

How will these outcomes be achieved?

Before Governing Body consider moving the Female Sterilisation policy from interim to substantive the public will be engaged with the policy and feedback collated. Our current Providers for Female Sterilisation will be contacted to inform them of the new policy and contract variations enacted where appropriate. GP Practices as referrers will also be contacted and the new policy communicated to them. The IFR team will review any submissions of evidence of exceptionally.

Who will be affected by this work?

Women in East and North Hertfordshire will be the main cohort of individuals affected by this policy. However, most women do not choose sterilisation as contraception. Our most popular contraceptive method is the combined oral contraceptive pill. Our activity in 16/17 for female sterilisation was 68 individuals.

Our Providers for female sterilisation will also be affected as they will see a reduction in referrals and estimated at 95% of activity. GPs will need to consider each request for sterilisation and determine if they believe a case for exceptionality can be made.

Sometimes female sterilisation is offered as part of the maternity pathway at the point of caesarean. These individuals will not be affected by this policy as this activity is encompassed in the maternity pathway tariff and the CCG do not pay additionally for this. Therefore an IFR is not required. Women should still receive appropriate counselling if a Provider wishes to offer them sterilisation during a caesarean.

Evidence

What evidence have you considered?

Against each of the protected characteristics categories below list the main sources of data, research and other sources of evidence (including full references) reviewed to determine impact on each equality group (protected characteristic).

This can include national research, surveys, reports, research interviews, focus groups, pilot activity evaluations or other Equality Analyses. If there are gaps in evidence, state what you will do to mitigate them in the Evidence based decision making section of this template.

If you are submitting no evidence against a protected characteristic, please explain why.

Female Sterilisation was reviewed against the Prioritisation Framework in the context of one of many contraceptive methods available to women. The references below were considered in this review. Our own activity data was also utilised to understand demand on these services and what age groups were accessing sterilisation services.

1. Trussell J; Contraceptive failure in the United States, Contraception, 2011
2. Contraceptive Failure Rates: New EstimatesFrom the 1995 National Survey of Family Growth By Haishan Fu, Jacqueline E. Darroch, Taylor Haas and Nalini Ranjit Family Planning Perspectives, 1999, 31(2):56–63 UPDATED VERSION ON: https://www.guttmacher.org/sites/default/files/article_files/3105699.pdf
3. https://bmcpregnancychildbirth.biomedcentral.com/articles/10.1186/s12884-017-1223-x
4. http://www.nhs.uk/Conditions/Abortion/Pages/Risks.aspx#complications
5. Balasch J, Gratacós E. **Delayed childbearing: effects on fertility and the outcome of pregnancy**. Fetal Diagn Ther. 2011;29(4):263-73. doi: 10.1159/000323142. Epub 2011 Jan 12.
6. http://emedicine.medscape.com/article/1848429-overview#a6
7. Trollip, G. S., et al. "**Vasectomy under local anaesthesia performed free of charge as a family planning service: complications and results**." *SAMJ: South African Medical Journal* 99.4 (2009): 238-242.
8. http://www.nhs.uk/conditions/contraception-guide/pages/combined-contraceptive-pill.aspx#Risks
9. http://patient.info/doctor/sterilisation-vasectomy-and-female-sterilisation
10. http://theagc.org.uk/wp-content/uploads/2016/12/Private-lives-public-health-Final.pdf
11. http://content.digital.nhs.uk/catalogue/PUB21969/srh-serv-eng-15-16-rep.pdf
12. Lifestyles team, HSCIC **"NHS Contraceptive Services: England, Community Contraceptive Clinics Statistics for 2013-14"**, [online] 2014 Oct 30. Available at: http://content.digital.nhs.uk/catalogue/PUB15746/nhs-cont-serv-comm-cont-clin-eng-13-14-rep.pdf [Accessed 20th Feb 2017]

13. http://www.yourtango.com/experts/lissa-rankin/sexual-frequency-how-much-sex-enough - Kinsey Institute
14. Curtis et al, **"Unit Costs of Health and Social Care 2016"** [online] Personal Social Research Unit. 2016 Available at: http://www.pssru.ac.uk/project-pages/unit-costs/2016/index.php [Accessed 20th Feb 2017]

Age

The average age of those accessing female sterilisation was reviewed. Female sterilisation is most commonly accessed by those aged 28-44. Therefore, this policy will have more of an impact on this specific age group.

Disability

This policy is not considered to disproportionately impact anyone with a disability. Having a disability in itself would not necessarily be considered as exceptionality for this policy. However, Female sterilisation can be considered as an option for funding through IFR if use of routinely commissioned female contraception methods are considered clinically unsuitable as assessed by a clinician.

Gender reassignment (including transgender)

Not applicable to this policy as it will only affect a small proportion of women.

Marriage and civil partnership

Not applicable to this policy. Although contraceptive choice may be considered a decision to be made by couples we do not hold records of the relationship status of those women accessing Female Sterilisation services. Therefore, we cannot determine if this policy will disproportionately impact those who are married.

Pregnancy and maternity

The primary purpose of offering sterilisation services is to protect against unintended pregnancy. If Female Sterilisation is not routinely funded a woman may choose to use a less effective contraceptive. There is a small chance this may result in an unintended pregnancy. Any unintended pregnancy as a result of implementing this policy may be higher risk due to the age of those accessing these services.

Race

Not applicable to this policy. Female Sterilisation will be available in cases of clinical exceptionality. Race will have no impact on whether or not funding will be approved by the IFR team.

Religion or belief

Not applicable to this policy. Female Sterilisation will be available in cases of clinical

exceptionality. Religion or belief will have no impact on whether or not funding will be approved by the IFR team.

Sex

Female Sterilisation and Vasectomy were assessed together as contraceptive options commissioned by the CCG and compared to other contraceptives. Although contraception is normally considered to be a decision made by couples it was noted that Vasectomy is one of the only alternatives to condoms available to men. Condoms do not offer the same level of protection from unplanned pregnancy as Vasectomy. It was considered that not providing full access to Vasectomy would push the burden of contraception back to the female partner.

However, It was found that women do have a number of alternative contraceptive options available to them including the combined oral contraceptive pill, the progestogen-only pill, vaginal ring, intrauterine system, intrauterine device, diaphragms, contraceptive patch, contraceptive injection, contraceptive implant, caps and female condom. Most of these alternative contraceptive methods are more cost effective and some (Implant and IUS) have greater clinical efficacy than sterilisation. This policy was considered to somewhat disproportionately affect women over men. This impact, following a review of available evidence, was considered to be minimal as women already have greater access to effective forms of contraception whereas men's choices are limited.

It was considered that there may be cases of exceptionality in which a female is found unsuitable for any of the alternative contraceptive methods mentioned above. In this case the individual will likely receive funding for Female Sterilisation after the case is reviewed by the IFR team.

Female Sterilisation was also considered slightly less favourable to Vasectomy due to the slightly higher risks associated with the procedure. Female Sterilisation is a somewhat more invasive procedure requiring a general anaesthetic and endoscopic abdominal approach. The recovery period is also longer. Vasectomy is a minimally invasive procedure ordinarily carried out under local anaesthetic. Any man requiring a general anaesthetic for Vasectomy will also require IFR approval for funding.

Female Sterilisation was also found not to be a particularly popular form of contraception within our population. Based on our activity data and GP prescribing data we found that only 0.13% of our female population chose to undergo sterilisation. Our activity for 16/17 was 68 individuals. Vasectomy activity was 462 individuals.

Sexual orientation

Not applicable to this policy. Female Sterilisation will be available in cases of clinical exceptionality. Sexual orientation will have no impact on whether or not funding will be approved by the IFR team.

Carers

Not applicable to this policy. Female Sterilisation will be available in cases of clinical exceptionality. Whether an individual is a carer or has a carer in itself will not necessarily be considered as exceptionality for this policy. Evidence submitted to the IFR team will be considered on a case by case basis.

Other identified groups

- In the US unplanned pregnancies have been shown to be more prominent in groups of lower socioeconomic status and on lower incomes[1, 2].
- Population studies in the US also suggest those that are less educated and on lower income are less likely to access sterilisation services[3], however, due to significant differences in delivery models between the NHS and US systems it is difficult to generalise based on this.
- A further study in the US has found that there were higher levels of vasectomies carried out in times of greater unemployment, suggesting that access may be disproportionately high in more deprived areas, although UK and local evidence was not found[4].
- Conversely a study from Manitoba, Canada showed that vasectomy rates decrease as income increases, but that the opposite is true of female sterilisation[5].
- A recent UK study has not replicated the US findings of increased rates of unplanned pregnancy in lower socioeconomic groups, but did find a significant correlation between lower educational level and higher unplanned pregnancy rates[6]. Positive smoking status, drug use and earlier age of first sexual encounter were also strongly correlated.

The lack of consensus in this area makes it difficult to assess the effect of deprivation on access to sterilisation services without local data.

1. Dehlendorf, Christine et al. "**Disparities in Family Planning**." *American journal of obstetrics and gynecology* 202.3 (2010): 214–220. *PMC*. Web. 24 Jan. 2017
2. Finer, Lawrence B., and Mia R. Zolna. "***Unintended Pregnancy in the United States: Incidence and Disparities, 2006***." *Contraception* 84.5 (2011): 478–485. *PMC*. Web. 24 Jan. 2017.
3. Anderson, John E., et al. "***Contraceptive sterilization among married adults: national data on who chooses vasectomy and tubal sterilization***." *Contraception* 85.6 (2012): 552-557
4. Shama et al, "***Relating Economic Conditions to Vasectomy and Vasectomy Reversal Frequencies: a Multi-Institutional Study***" J Urol. 2014 Jun;191(6):1835-40. doi: 10.1016/j.juro.2013.12.045. Epub 2014 Jan 11
5. Fransoo et al, "***Social Gradients in Surgical Sterilization Rates: Opposing Patterns for Males and Females***", J Obstet Gynaecol Can. 2013 May;35(5):454-60.

Wellings et al, "***The prevalence of unplanned pregnancy and associated factors in Britain: findings from the third National Survey of Sexual Attitudes and Lifestyles (Natsal-3)",*** The Lancet 382 (2013): 1807-16

Engagement and involvement

How have you engaged stakeholders with an interest in protected characteristics in gathering evidence or testing the evidence available?

The interim Female Sterilisation Policy is undergoing public engagement.

How have you engaged stakeholders in testing the policy or programme proposals?

The policy is interim and will not be made substantive until feedback from the public engagement has been considered.

For each engagement activity, please state who was involved, how and when they were engaged, and the key outputs:

To be updated following public engagement.

Summary of Analysis

Considering the evidence and engagement activity you listed above, please summarise the impact of your work.

Impact on all patient groups has been considered and will be mitigated where possible. The policy is considered to disproportionately affect women over men as the policy will limit access to a particular form of contraception available only to women. However, this impact is considered minimal due to the availability of other forms of contraception for women of equal or greater clinical efficacy. The mitigating action put in place to counteract this impact will be to review cases of exceptionality through the IFR team. Women found unsuitable for other forms of contraception may be considered for funding for Female Sterilisation.

Now consider and detail below how the proposals could support the elimination of discrimination, harassment and victimisation, advance the equality of opportunity and promote good relations between groups (the General Duty of the Public Sector Equality Duty).

Eliminate discrimination, harassment and victimisation

Not applicable to this policy. This policy will not in any way eliminate discrimination, harassment or victimisation.

Advance equality of opportunity

Contraception has been shown in general to reduce inequalities. Access to contraception has promoted women's economic empowerment and reduced gender inequality in the UK. This policy will slightly reduce women's contraceptive choice.

However, women do still have access to a number of other effective contraceptives which will protect against unplanned pregnancy. Those found unsuitable for other contraceptive methods will be considered for exceptional funding through the IFR team on a case by case basis. Therefore, the policy still allows for as many individuals as possible to access effective contraception and reduce inequalities.

Promote good relations between groups

Not applicable to this policy. This policy affects a small number of individuals and therefore is unlikely to have a wider impact on relations between groups.

Next Steps

Please give an outline of what you are going to do, based on the gaps, challenges and opportunities you have identified in the summary of analysis section. This might include action(s) to eliminate discrimination issues, partnership working with stakeholders and data gaps that need to be addressed through further consultation or research. This is your action plan and should be SMART.

- The interim female sterilisation policy is out to public engagement and will be reviewed following this. The policy may become substantive or its implementation reversed.
- The IFR process provides mitigation against this policy negatively impacting any particular group or individual by reviewing incidence of exceptionality on a case by case basis.

How will you share the findings of the Equality analysis? This can include sharing through corporate governance or sharing with, for example, other directorates, partner organisations or the public. The completed EqIA will be published on the East and North Herts CCG website.

The Equality analysis once updated, following public engagement, will be shared with Governing Body at which point they will be asked to review the interim policy and make a decision as to how to proceed.