NIGALA
NI Guardian Ad Litem Agency
A voice for Children and Young People in Family Courts

Equality and Human Rights Screening

Menopause at Work Policy

The NIGALA is required to address the 4 questions below in relation to all its policies. This template sets out a proforma to document consideration of each question.

1. What is the likely impact on equality of opportunity for those affected by this policy, for each of the Section 75 equality categories? (minor/major/none)

2. Are there opportunities to better promote equality of opportunity for people within the Section 75 equality categories?

3. To what extent is the policy likely to impact on good relations between people of a different religious belief, political opinion or racial group? (minor/major/none)

4. Are there opportunities to better promote good relations between people of a different religious belief, political opinion or racial group?

As part of the audit trail documentation needs to be made available for all policies and decisions examined for equality and human rights implications. The screening template is a pro forma to document consideration of each screening question.

For information (evidence, data, research etc.) on the Section 75 equality groups see the Equality Portal - Screening Resources & Evidence.

1. INFORMATION ABOUT THE POLICY OR DECISION

1.1 Title of policy or decision

Menopause at Work Policy

1.2 Description of policy or decision:

- **What is it trying to achieve (aims and objectives)?**
- **How will this be achieved (key elements)?**
- **What the key constraints (for example financial, legislation or other)?**

Aims and Objectives of the Policy

The Policy aims to ensure that managers and employees recognise their responsibility to:

- Understand the menopause and related issues and how it can affect staff and their work colleagues;
- Raise wider awareness and understanding among employees and to outline support and adjustments that are available;
- Ensure a consistent approach in the management of employees that are struggling whilst at work with menopausal symptoms and subsequently;
- Reduce menopause related sickness absence and promote the retention of menopausal employees in an attempt to retain a skilled and experienced workforce within the organisation;
- Foster an environment in which employees can openly and comfortably instigate conversations, or engage in discussions about menopause.

How will this be achieved?

This will be achieved through the following objectives:

- Provide a clear definition of what the menopause is, the stages of menopause, when it occurs, what happens, potential impact on performance at work, and the responsibilities of different groups within the organisation;
- Provide guidance on how to support employees going through menopause including Assessment and Action Plan.

Key Constraints

There may be some working environments where it is more difficult to offer adjustments to women. However NIGALA has a legal obligation to consider reasonable adjustments for staff who are considered to have a disability brought on by the symptoms of the menopause.

1.3 Main stakeholders affected (internal and external)

- All NIGALA employees including self-employed Guardians ad Litem, including Agency, Bank Staff & Volunteers in particular women.
- Trade Union

1.4 Other policies or decisions with a bearing on this policy or decision.

- **What are they?**
- **Who owns them?**

Policies & Procedures:

- Health & Wellbeing Strategy
- Attendance at Work Policy
- Attendance at Work Procedure
- Leave Pack

Legislation that have a bearing on this policy is as follows:

- Sex Discrimination (NI) Order 1976
- Disability Discrimination Act (DDA) 1995
- Employment Equality (Age) regulations (NI)2006

2. CONSIDERATION OF EQUALITY AND GOOD RELATIONS ISSUES AND EVIDENCE USED

2.1 Data Gathering

What information did you use to inform this equality screening? For example previous consultations, statistics, research, Equality Impact Assessments (EQIAs), complaints. Provide details of how you involved stakeholders, views of colleagues, services users, staff side or other stakeholders.

- Workforce Data (HRPTS)
- Census NI 2011
- NI HSC Workforce Census March 2020 (health-ni.gov.uk)
- Amanda Griffiths, Sara Jane MacLennan and Juliet Hassard, 'Menopause and work: An electronic survey of employees' attitudes in the UK', Maturitas, no.2 (2013), pp155-159
- Clare Hardy, Eleanor Thorne, Amanda Griffiths and Myra Hunter, 'Work outcomes in midlife women: the impact of menopause, work stress and working environment'. Women's Midlife Health, 4, no.1, (2018), pp.3.
- Annual Population Survey
- NISRA
- Health Survey NI (2017/18 – Published 2019)
- Carers NI Statistics
- Northern Ireland Life and Times (2018)

2.2 Quantitative Data

Who is affected by the policy or decision? Please provide a statistical profile. Note if policy affects both staff and service users, please provide profile for both.

<table>
<tr><th>Category</th><th>What is the makeup of the affected group (%)? Are there any issues or problems? For example, a lower update that needs to be addressed or greater involvement of a particular group?</th></tr>
<tr><td>Gender</td><td>NIGALA staff data at March 2021:

<table><tr><td>Male</td><td>13.64%</td></tr><tr><td>Female</td><td>86.36%</td></tr></table>
DoH reported 79% (54,043) of HSCNI employees were female. The gender split of NIGALA employees is currently 86.36% female 13.64% male.

Census NI 2011: The proportion of females in 2011 is 51% (923,540). The male population is 49% (887,323) in 2011.

Mid-year population estimate (2018; published June 2019): The size of the resident population in Northern Ireland at 30 June 2018 is estimated to be 1.88 million people. Just over half (50.8 per cent) of the population were female, with 955,400 females compared to 926,200 males (49.2 per cent).

https://www.nisra.gov.uk/sites/nisra.gov.uk/files/publications/MYE18Bulletin.pdf

The Gender Identity Research and Education Society (GIRES) estimate the number of gender nonconforming employees and service users, based on the information that GIRES assembled for the Home Office (2011) and subsequently updated (2014):

▪ Gender variant to some degree 1%
▪ Have sought some medical care 0.025%
▪ Having already undergone transition 0.015%</td></tr>
</table>

<table>
<tr><td></td><td>The number who have sought treatment seems likely to continue growing at 20% per annum or even faster. Few younger people present for treatment despite the fact that most gender variant adults report experiencing the condition from a very early age. Yet, presentation for treatment among young people is growing even more rapidly (50% p.a.). Organisations should assume that there may be nearly equal numbers of people transitioning from male to female (trans women) and from female to male (trans men).

Applying GIRES figures to NI population (using NISRA mid-year population estimates for June 2018) N=1,881,600:

▪ 18,816 people who do not identify with gender assigned to them at birth
▪ 470 likely to have sought medical care
▪ 282 likely to have undergone transition.</td></tr>
<tr><td>Age</td><td>NIGALA staff data at March 2021:

<table><tr><td>16-24</td><td>0.00%</td></tr><tr><td>25-29</td><td>0.00%</td></tr><tr><td>30-34</td><td>3.03%</td></tr><tr><td>35-39</td><td>9.09%</td></tr><tr><td>40-44</td><td>13.64%</td></tr><tr><td>45-49</td><td>12.12%</td></tr><tr><td>50-54</td><td>22.73%</td></tr><tr><td>55-59</td><td>24.24%</td></tr><tr><td>60-64</td><td>15.15%</td></tr><tr><td>>=65</td><td>0.00%</td></tr></table>
Menopause occurs between 45-55 years for most women, and in the UK the average is 51 years. In HSC, 22% of the total workforce is female aged 45-54 years (just over 1 in 5 people) with a further 10% in the 40-44 years.</td></tr>
</table>

Population profile:

Mid-year population estimates published by NISRA in 2019 show that:

0-19	485,064	25.7%
20-34	364.623	19.3%
35-49	366,967	19.5%
50-64	356,790	19%
65-74	169,725	9%
75-89	125,3344	6.6%
90+	13138	0.7%

https://www.nisra.gov.uk/statistics/population/mid-year-population-estimates

Age projection:

NISRA Estimated and projected population by age, mid-2016 to mid-2041 show that in 2016, 20.8% of the NI Population were aged 0-15 years, and this is projected to decrease 18.2% in 2041. The proportion of adults aged 16-64 in 2016 was 63.2% of the whole population, set to decrease to 57.2 by 2041. However, the proportion of people aged 65 years and over is projected to rise from 16.0% in 2016 to 24.5% in 2041, overtaking the numbers of children.

https://www.nisra.gov.uk/publications/2016-based-population-projectionsnorthern-ireland-statistical-bulletin-charts

Religion

NIGALA staff data at March 2021:

Perceived Protestant	4.55%
Protestant	27.27%
Perceived Roman Catholic	4.55%

Roman Catholic	57.58%
Neither	1.52%
Perceived Neither	0.00%
Not assigned	4.55%

Population Profile from Census 2011 figures:

Religion or Religion brought up in:

- 45.14% (817, 424) of the population were either Catholic or brought up as Catholic.
- 48.36% (875, 733) stated that they were Protestant or brought up as Protestant.
- 0.92% (16, 660) of the population belonged to or had been brought up in other religions and Philosophies.
- 5.59% (101, 227) neither belonged to, nor had been brought up in a religion.

Political Opinion

NIGALA staff data at March 2021:

Broadly Nationalist	4.55%
Other	0.00%
Broadly Unionist	4.55%
Not assigned	84.85%
Do not wish to answer	6.06%

NI Population Statistics * (Census 2011)

British only	722,379	39.89%
Irish only	457,482	25.26%
Northern Irish only	379,267	20.94%
British and Irish only	11,877	0.66%
British and Northern Irish only	111,748	6.17%
Irish and Northern Irish only	19,132	1.06%
British, Irish and Northern Irish only	18,406	1.02%

	Other	90,572	5.00%	

Marital Status

NIGALA staff data at March 2021:

Divorced	0.00%
Married/Civil Partnership	60.61%
Other	4.55%
Separated	1.52%
Single	16.67%
Unknown	16.67%
Widow/er	0.00%
Not Assigned	0.00%

NI Population Statistics (2011)

- 47.56% (680,840) of those aged 16 or over were married
- 36.14% (517,359) were single
- 0.09% (1288) were registered in same-sex civil partnerships
- 9.43% (134,994) were either divorced, separated or formerly in a same-sex partnership
- 6.78% (97,058) were either widowed or a surviving partner

Northern Ireland Life and Times (2018)

- Single (never married) 32%
- Married and living with husband/wife 51%
- A civil partner in a legally-registered civil partnership 0%
- Married and separated from husband/wife 3%
- Divorced 6%
- Widowed 7%

Civil partnerships

Annual Reports of the Registrar General for NI show that from 2005 to 2018 (inclusive), there have been 1298 civil

<table>
<tr><td></td><td>partnerships registered in NI.

Available at https://www.nisra.gov.uk/statistics/births-deaths-andmarriages/registrar-general-annual-report</td></tr>
<tr><td>Dependent Status</td><td>NIGALA staff data at March 2021:

<table><tr><td>Yes</td><td>10.61%</td></tr><tr><td>Not assigned</td><td>86.36%</td></tr><tr><td>No</td><td>3.03%</td></tr></table>
NI Census Statistics

▪ 11.81% (213,863) of the usually resident population provide unpaid care to family members, friends, neighbours or others because of long-term physical or mental ill-health/disabilities or problems related to old age.
▪ 3.11% (56,318) provided 50 hours care or more.
▪ 33.86% (238,129) of households contained dependent children.
▪ 40.29% (283,350) contained a least one person with a long – term health problem or a disability.

Carers NI Statistics:

▪ 1 in every 8 adults is a carer
▪ There are approximately 207,000 carers in Northern Ireland
▪ Any one of us has a 6.6% chance of becoming a carer in any year
▪ One quarter of all carers provide over 50 hours of care per week
▪ People providing high levels of care are twice as likely to be permanently sick or disabled than the average person
▪ 64% of carers are women; 36% are men.</td></tr>
</table>

<table>
<tr><td></td><td>CarersNI State of Caring 2019 Annual Survey (UK wide, including NI):

▪ 2 in 5 carers (39%) responding reported being in paid work.
▪ 38% of all carers reported that they had given up work to care.
▪ 18% had reduced their working hours.
▪ 1 in 6 carers (17%) said that they work the same hours but their job is negatively affected by caring, for example because of tiredness, lateness, and stress.
▪ 12% of carers said they have had to take a less qualified job or have turned down a promotion to fit around their caring responsibilities.
▪ Just over 1 in 10 carers (11%) said they had retired early to care.
▪ Only 4% of respondents of all ages said that caring has had no impact on their capacity to work.
▪ Only one quarter (25%) of carers who aren’t yet retired and had an assessment in the last year felt that their need to combine paid work and caring was sufficiently considered in their carer’s assessment.
▪ Carers who are not yet retired were also asked about their future plans and 53% said they are not able to save for their retirement.
▪ Some carers are saving or have saved less for their retirement with 17% saying they did this because their working hours were reduced.</td></tr>
<tr><td>Disability</td><td>NIGALA staff data at March 2021:

<table><tr><td>Yes</td><td>1.52%</td></tr><tr><td>Not assigned</td><td>18.18%</td></tr><tr><td>No</td><td>80.30%</td></tr></table></td></tr>
</table>

	It is estimated that 80% of women in the UK report noticeable changes, whilst 25% of women experience very debilitating symptoms. Around 30%-60% of women experience physical and/or psychological symptoms during the menopause. **NI Population Statistics 2011 Census** 20.69% (374, 668) regard themselves as having a disability or long-term health problem, which has an impact on their day to day activities. 68.57% (1,241,709) of residents did not have long-term health condition**.** ▪ Deafness or partial hearing loss: **5.14%** (93,078) ▪ Blindness or partial sight loss: **1.7%** (30,785) ▪ Communication Difficulty: **1.65%** (29,879) ▪ Mobility or Dexterity Difficulty: **11.44%** (207,163) ▪ A learning, intellectual, social or behavioural difficulty: **2.22%** (40,201) ▪ An emotional, psychological or mental health condition: **5.83%** (105,573) ▪ Long-term pain or discomfort: **10.10%** (182,897) ▪ Shortness of breath or difficulty breathing: **8.72%** (157,907) ▪ Frequent confusion or memory loss: **1.97%** (35,674) ▪ A chronic illness (such as cancer, HIV, diabetes, heart disease or epilepsy: **6.55%** (118,612) ▪ Other condition: **5.22%** (94,527) ▪ No Condition: **68.57%** (1,241,709) **Health Survey NI (2017/18 – Published 2019)** ▪ 43% longstanding illness (32% limiting and 11% non-limiting illness) ▪ Females (44%) were more likely than males (40%) to have a

<table>
<tr>
<td></td>
<td>long-term condition.
▪ Prevalence also increased with age with 22% of those aged 16-24 reporting a long-term condition compared with 70% of those aged 75 and over.
▪ Four-fifths of respondents (81%) had contact with the Health and Social Care System in Northern Ireland
▪ Of these, 84% were either very satisfied or satisfied with their
▪ experience
▪ A fifth (21%) reported high levels of anxiety, while 45% reported very low levels

Health Inequalities Annual Report 2019 can be found here: https://www.health-ni.gov.uk/news/health-inequalities-annual-report-2019</td>
</tr>
<tr>
<td>Ethnicity</td>
<td>NIGALA staff data at March 2021:

<table>
<tr><td>Not assigned</td><td>84.85%</td></tr>
<tr><td>White</td><td>15.15%</td></tr>
<tr><td>Other</td><td>0.00%</td></tr>
<tr><td>Black African</td><td>0.00%</td></tr>
<tr><td>Indian</td><td>0.00%</td></tr>
<tr><td>Chinese</td><td>0.00%</td></tr>
</table>

NI Population Statistics (Census 2011)

1.8% (32,596) of the usual resident population belonged to minority ethnic groups:

<table>
<tr><td></td><td></td><td>%</td></tr>
<tr><td>White</td><td>1,778,449</td><td>98.21%</td></tr>
<tr><td>Chinese</td><td>6303</td><td>0.35%</td></tr>
<tr><td>Irish Traveller</td><td>1301</td><td>0.07%</td></tr>
<tr><td>Indian</td><td>6198</td><td>0.34%</td></tr>
</table>
</td>
</tr>
</table>

Pakistani	1091	0.06%	
Bangladeshi	540	0.03%	
Other Asian	4998	0.28%	
Black Caribbean	372	0.02%	
Black African	2345	0.13%	
Black other	899	0.05%	
Mixed	6014	0.33%	
Other	2353	0.13%	

Sexual Orientation

NIGALA staff data at March 2021:

Do not wish to answer	1.52%
Not assigned	84.85%
Opposite sex	13.64%
Both Sexes	0.00%
Same sex	0.00%

Population Profile:

In 2016, estimates from the Annual Population Survey (APS) showed that:

- 93.4% of the UK population identified as heterosexual or straight and 2.0% of the population identified themselves as lesbian, gay or bisexual (LGB). This comprised of:
  - 1.2% identifying as gay or lesbian
  - 0.8% identifying as bisexual
- A further 0.5% of the population identified themselves as “Other”, which means that they did not consider themselves to fit into the heterosexual or straight, bisexual, gay or lesbian categories. A further 4.1% refused, or did not know how to identify themselves.
- The population aged 16 to 24 were the age group most likely to identify as LGB in 2016 (4.1%).
- More males (2.3%) than females (1.6%) identified themselves as LGB in 2016.

	▪ The population who identified as LGB in 2016 were most likely to be single, never married or civil partnered, at 70.7%. There are no accurate statistics on sexual orientation in the community as a whole, it is however estimated that between 5% and 10% of the population would identify as lesbian, gay or bisexual.

2.3 Qualitative Data

What are the different needs, experiences and priorities of each of the categories in relation to this policy or decision and what equality issues emerge from this? Note if policy affects both staff and service users, please discuss issues for both.

Category	Needs and Experiences
Gender	The menopause affects all women, and it can often indirectly affect their partners, families and colleagues as well. For example stress or relationship difficulties caused by the symptoms or wellbeing of their partner. This can, in turn affect workplace performance. Whilst women/she/her is used in the policy, it is for all employees regardless of their perceived gender. The menopause can often come at a time of life when women are already experiencing other issues or difficulties, such as the onset of age related health conditions, increasing caring responsibilities for elderly or sick parents and relatives as well as children or grandchildren. Women still tend to have a larger share of caring responsibilities and these can be an added source of stress during the time of the menopause. Increases in the state pension age also mean that some women will now have to work longer

	than they may have planned. Men can be indirectly affected by the menopause for example if their partner is experiencing insomnia and night sweats, men may also experience disrupted sleep and fatigue. If a man's partner experiences significant physical or psychological symptoms (such as depression) he may be concerned for her wellbeing and feel increased levels of stress. In some cases, people can experience relationship problems or difficulties at home at this time. These issues can have an impact on men in the workplace. Different genders can also be affected, for example transgender, non-binary and intersex people can also experience the menopause. Transgender people may not want to disclose their trans status which cause stress and in turn affect workplace performance and wellbeing. Transgender men (those who identify as male but were assigned female at birth) will experience a natural menopause if their ovaries remain in place and no hormone therapy is given. Transgender men will also experience menopausal symptoms if the ovaries and uterus are surgically removed (this may happen at an earlier age than commonly happens with a natural menopause). Symptoms may be reduced or complicated if hormone therapy (such as the male hormone testosterone) is in place. Transgender women (those who identify as female but were assigned male at birth) undertaking hormone therapy will usually remain on this for life and should generally experience limited 'pseudo'

	menopausal (menopausal-like) symptoms - unless hormone therapy is interrupted, or hormone levels are unstable. Such treatment interruptions however can be a common experience for transgender women (and transgender men). The Policy and Guidance will increase support for those experiencing menopause related issues at work and promotes understanding to those who are indirectly affected.
Age	Evidence shows with an ageing population increasing numbers of women are working whilst experiencing the menopause. In the UK it is estimated that around 1 in 3 women are either currently going through or have reached the menopause. However it is important to remember some women may experience an early menopause or premature ovarian insufficiency (around 1 in every 100 women will have the menopause before the age of 40) or they may experience a surgical or medical menopause. As well as the symptoms of the menopause, these women may have a range of related difficulties to deal with at the same time – for example, fertility problems and side effects from fertility treatments or recovery from cancer treatment (or both). Many fertility treatments can also in themselves cause side effects similar to the menopause such as fatigue, night sweats, anxiety and depression. Women who have an early or premature menopause are also more at risk of developing osteoporosis (‘brittle bones’) and heart disease. It is important to recognise that variance exists in age of onset of symptoms and the severity and longevity

	of symptoms experienced. In many cases it is an individual experience, not comparable with colleagues of the same age or stage of menopause.
Religion	There is no data to suggest that the needs and experiences of service users differ on the basis of Religion.
Political Opinion	There is no data to suggest that the needs and experiences of service users differ on the basis of Political Opinion.
Marital Status	Partners/spouses of menopausal women may be indirectly affected. For example if their partner/spouse is experiencing insomnia and night sweats, they may also experience disrupted sleep and fatigue. If a partner experiences significant physical or psychological symptoms (such as depression) they too may be concerned for her wellbeing and feel increased levels of stress. In some cases, people can experience relationship problems or difficulties at home at this time, in turn may affect their workplace performance.
Dependent Status	There is no data to suggest that the needs and experiences of service users differ on the basis of Dependant Status.
Disability	Evidence suggests that the menopause can affect and exasperate existing conditions. Physical and psychological symptoms can adversely affect the quality of both personal and working life. There may be occasions in which severe and prolonged menopausal symptoms have a significant impact on daily functioning and have lasted or are likely to last for 12 months or more that the disability legislation

	could potentially apply and reasonable adjustments should be considered in the workplace. Additionally those with disability may perceive menopausal symptoms differently and may find it more difficult to access medical help for symptoms or to get the right support. The aim of this policy is to provide support and guidance.
Ethnicity	Reporting of the most common and significant symptoms of menopause has also been found to vary among different ethnic groups. It is unclear to what extent these differences are caused by social, economic, language and cultural factors rather than a woman's ethnic origin. People who do not have English as a first language or with diverse cultural backgrounds may have more difficulty in communicating symptoms or difficulties they are experiencing, as many cultures do not have a term to recognise the menopause. This may make it more difficult for them to access medical advice or ask for help or adjustments at work. The aim of this policy is to provide support and guidance.
Sexual Orientation	Women in same sex relationships may have a partner who is going through the menopause at the same time. While this can be positive in terms of increased mutual understanding and support at home, sometimes, if both partners are experiencing symptoms such as sleep disturbance or night sweats, this may increase tiredness and fatigue for both partners. It may also be more difficult if both partners experience symptoms such as depression or mood swings at the same time.

2.4 Making Changes **Based on the equality issues you identified in 2.2 and 2.3, what changes did you make or do you intend to make in relation to policy or decision in order to promote equality of opportunity?**	
In developing the policy or decision what did you do or change to address the equality issues you identified?	**What do you intend to do in future to address the quality issues you identified?**
Gender Whilst menopause occurs in women, it was important to highlight how it can affect different genders both directly and indirectly. This policy and supporting guidance are intended to provide clarity and direction on how NIGALA should deal with menopause related issues, for all individuals irrespective of their perceived gender who are experiencing difficulties associated with the menopause. **Age** Although menopause is part of the natural ageing process, medical conditions or surgical intervention can bring on menopause irrespective of age. This policy and supporting guidance highlights how variance exists in age and will raise wider awareness and understanding of	This policy shall be reviewed: ▪ Every 2 years or; ▪ following receipt of new information; ▪ upon implementation of new ▪ agreements which may affect the ▪ procedure ▪ Regular communication to staff on ▪ awareness/education on menopause ▪ Consultation with appropriate groups ▪ from the voluntary sector via ▪ Employment Equality Network Group ▪ Ensure appropriate language is used ▪ and update where necessary ▪ Provide awareness sessions on ▪ Menopause on a regular basis ▪ Update Health and Wellbeing ▪ SharePoint site with up to date ▪ information, webinars, infographics, ▪ toolkits where appropriate

menopause. In many cases it is an individual experience, not comparable with colleagues of the same age or stage of menopause. **Disability** Menopause of itself is not a disability, however, depending on the severity of and longevity of menopause-related symptoms experienced by the individual it may be classified as such. Davies v Scottish Courts & Tribunal Service in May 2018, an employee's menopausal symptoms were deemed to be a disability for the purposes of the Disability Discrimination Act 1995. Therefore when dealing with employees who have menopausal symptoms, NIGALA will need to be mindful of the need to consider if an employee is disabled as a result of those symptoms and if it is concluded that they are reasonable adjustment(s) will be considered in line with relevant policies and related legislative provisions such as the DDA 1995. Case law has also recognised the importance of putting in place 'timely' reasonable adjustments for staff with a disability.	

Marital Status/Ethnicity/Sexual Orientation Menopause Assessment and action plan guidance for managers and employees included in appendices to support the policy outlining how the menopause can have an effect on marital status, and how the menopause can affect people differently depending on their ethnicity and sexual orientation. This policy covers the impact o the menopause of employees working within HSC organisations recognising that severe menopausal symptoms can adversely affect health and wellbeing, work performance absenteeism, presenteeism, staff retention and/or health and safety at work. The policy sets out the key principles to which NIGALA should adhere to, to ensure that individuals affected by the menopause or peri-menopause are treated fairly and given appropriate support and any reasonable adjustments if applicable.	

2.5	**Good Relations** **What changes to the policy or decision – if any – or what additional measures would you suggest to ensure that it promotes good**

relations? (Refer to guidance notes for guidance on impact.)		
Group	**Impact**	**Suggestions**
Religion	N/A	
Political Opinion	N/A	
Ethnicity	N/A	

3. SHOULD THE POLICY OR DECISION BE SUBJECT TO A FULL EQUALITY IMPACT ASSESSMENT?

A full equality impact assessment (EQIA) is usually confined to those policies or decisions considered to have major implications for equality of opportunity.

How would you categories the impacts of this decision or policy? (Refer to guidance notes for guidance on impact.)

Please tick:

Major impact	
Minor impact	x
No further impact	

Do you consider that this policy or decision needs to be subjected to a full equality impact assessment?

Please tick:

Yes	
No	x

Please given reasons for your decisions:

It is not felt that a full EQIA will highlight any further issues with regards to equality of opportunity for the Section 75 groups.

4. CONSIDERATION OF DISABILITY DUTIES

4.1 In what ways does the policy or decision encourage disabled people to participate in public life and what else could you do to do so?	
How does the policy or decision currently encourage disabled people to participate in public life?	**What else could you do to encourage disabled people to participate in public life?**
N/A	The BSO will be introducing a Disability Toolkit in 2021/22 that will support staff who have a disability. Guidance and protocol for managers and how to converse with staff who have a disability will also be provided.

4.2 In what ways does the policy or decision promote positive attitudes towards disabled people and what else could you do to do so?	
How does the policy or decision currently promote positive attitudes towards disabled people?	**What else could you do to promote attitudes towards disabled people?**
The policy will increase support for all employees experiencing the effects of the menopause. Where severe menopausal symptoms have a substantial adverse impact on an employee's daily functioning for 12 months or more – reasonable adjustments will be considered and provided for in line with the DDA 1995.	The BSO will be introducing a Disability Toolkit in 2021/22 that will support staff who have a disability. Guidance and protocol for managers and how to converse with staff who have a disability will also be provided.

5. CONSIDERATION OF HUMAN RIGHTS

5.1 Does the policy or decision affect anyone's Human Rights? Complete for each of the articles.

Article	Yes/No
Article 2: Right to Life	No
Article 3: Right to freedom from torture, inhuman or degrading treatment or punishment.	No
Article 4: Right to freedom from slavery, servitude and forced or compulsory labour.	No
Article 5: Right to liberty and security of person.	No
Article 6: Right to a fair and public trial within a reasonable time.	No
Article 7: Right to freedom from retrospective criminal law and no punishment without law.	No
Article 8: Right to respect for private and family life, home and correspondence.	No
Article 9: Right to freedom of thought, conscience and religion.	No
Article 10: Right to freedom of expression.	No
Article 11: Right to freedom of assembly and association.	No
Article 12: Right to marry and found a family.	No
Article 14: Prohibition of discrimination in the enjoyment of the convention rights.	No
1st protocol Article 1: Right to a peaceful enjoyment of possessions and protection of property.	No

1st protocol Article 2: Right of access to education.	No

If you have answered no to all of the above please move on to Question 6 on Monitoring.

5.2 If you have answered yes to any of the Articles in 5.1, does the policy or decision interfere with any of these rights? If so, what is the interference and who does it impact upon?

List the Article Number	Interfered with? Yes/No	What is the interference and who does it impact upon?	Does this raise legal issues?* Yes/No
N/A			

*It is important to speak to your line management on this and if necessary seek legal opinion to clarify this.

5.3 Outline any actions which could be taken to promote or raise awareness of human rights or to ensure compliance with the legislation in relation to the policy or decision.

N/A

6. MONITORING

6.1 What data will you collect in the future in order to monitor the effect of the policy or decision on any of the categories (for equality of opportunity or good relations, disability duties and human rights)?		
Equality & Good Relations	**Disability Duties**	**Human Rights**
Monitored through feedback from Occupational Health, Managers and Staff.	Monitored through feedback from Occupational Health, Managers and Staff.	Monitored through feedback from Occupational Health, Managers and Staff.

Approved Lead Officer: Sean Brown

Position: Head of Corporate Services

Date: 10 September 2021

Policy/Decisions Screened by: Sinéad Casey

Any request for this document in another format or language will be considered.

For advice and support on screening contact:

Equality Unit/ BSO /James House/ 2-4 Cromac Avenue/ Belfast/ BT7 2JA

Tel: 028 9536 3961