HSC Public Health Agency

# Equality and Human Rights Screening Template

The PHA 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.

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)

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

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)

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

# SCREENING TEMPLATE

See Guidance Notes for further information on the 'why' 'what' 'when', and 'who' in relation to screening, for background information on the relevant legislation and for help in answering the questions on this template.

## (1) INFORMATION ABOUT THE POLICY OR DECISION

### 1.1 Title of policy or decision

Farm Family Health Check Programme (FFHCP)

### 1.2 Description of policy or decision

Farm Families is a joint programme between PHA & Department for Environment, Agriculture & Rural Affairs (DAERA) that provides an accessible health check programme specifically targeting farmers their families. Initiated in 2012, it is delivered by Northern Health & Social Care Trust (NHSCT) staff on a regional basis. The health checks are performed by trained nurses in an accessible van that has two private treatment rooms and a waiting area. The van attends farmers' marts and rural community events, bringing the service to the target clientele.

This service is specifically targeted to rural dwellers in order to address the health needs of the wider farming community who are recognised as particularly susceptible to poor health and wellbeing; particular hazards include accidents, stress and mental health problems, musculo-skeletal disorders, a reluctance to seek outside help in relation to mental health issues and fear over confidentiality in small communities.

All client information collected during the health checks are recorded on an IT system designed specifically for this purpose. As a result of the health checks, clients may be advised to see their GP or signposted to other services (including Rural Support, smoking cessation etc.). Nurses also provide lifestyle advice tailored to the client's needs. A follow up phone call is provided to all clients who have been asked to see their GP to encourage those who haven't made an appointment to do so, or to reinforce health messages. QRISK assessment tool and Patient Health Questionnaire (PHQ9) scores are gathered from clients and entered into an IT system for analysis and evaluation purposes. QRISK is an assessment tool for estimating the 10-year risk of having a cardiovascular event, in people who do not already have heart disease. A person's 10-year risk of CVD can be used to inform treatment decisions, such as lifestyle advice or drug treatment. PHQ9 The Patient Health Questionnaire (PHQ-9) is a multipurpose instrument for screening, diagnosing, monitoring and measuring the severity of

depression. To date (March 2019) a total of 18,003 health checks have been performed. These figures provide evidence to confirm that the programme is embedded within the rural and farming communities and is an accessible and necessary service.

- Farming is a vital part of the Northern Ireland economy providing employment to nearly 47,700 people across 24,500 farms.
- 55% of farmers work their farms on a full-time basis, while the remainder seek employment outside the farm to supplement income.
- The farming community is an important group in terms of food production, provision of jobs and stewardship of the countryside (Haunsome et al., 2006) and makes a significant contribution to the Northern Ireland economy. This represents a significant scope of workplaces and associated workforce throughout Northern Ireland.
- People in rural areas tend to come from a culture of self-sufficiency and there is a reluctance to seek outside help particularly in relation to mental health issues.
- Social factors round fear over confidentiality in small communities can also prevent individuals from making use of services.
- Stresses are magnified by isolation, single worker situations (farmers), a lack of knowledge about services and difficulty accessing them (Institute of Rural Health 2009).
- According to a 2018 preliminary study by researchers at Ulster University more than three quarters of male farmers would not seek help for emotional problems despite displaying high levels of stress. Analysis of the responses (199 males and 75 females) showed that participants showed greater signs of loneliness, depression and anxiety than the non-farming community (https://www.bps.org.uk/news-and-policy/male-farmers-are-reluctant-seek-help-mental-health-issues ).The preliminary report highlighted men in particular reported higher levels of depression and stress as well as less likely to seek help than female farmers (73 per cent; 27 per cent). Family support was cited more by women as well as better levels of wellbeing.
- The availability and range of services are limited in rural areas in comparison to those provided in towns and cities. A change in the nature of healthcare provision has also occurred and recent policy developments have led to the centralisation of healthcare services. Rural communities have witnessed closures of acute hospitals as a result of resource

constraints and the need to provide safe, high quality care.

- As a consequence, this has reduced access to numerous types of care such as the availability of primary care services – pharmacies, G.P. and dental practices, and community based services. Patient choice therefore is restricted and accessing services elsewhere can result in increased waiting times and poorer health outcomes (Northern Ireland Assembly, Research and Library Service Briefing Paper 2010).

**What is it trying to achieve? (aims and objectives)**

1. To provide health checks and advice to farmers who visit the Farmers Markets throughout Northern Ireland and to provide health improvement advice and health checks at community based events in rural areas accessible to rural farmer's and their families.
2. To explore opportunities to engage with other agri-food sectors including hard to reach farmers and food producers.
3. Ensure an effective onward referral/signposting process is in place for those clients identified as requiring medical treatment or further support.
4. To effectively use existing resources and local community infrastructure to promote and advertise a service that is accessible and appropriate to the specific health and social wellbeing needs of the farming community.

**How will this be achieved? (key elements)**

- By providing a health improvement advice and health check service to farmers via the 28 marts (65 visits per annum)
- By providing health improvement advice and health check service at 60 community based events in rural areas accessible to rural farmers and their families
- By providing a health check service to 12 other farming enterprises per annum
- By ensuring a total of 2,600 health checks are provided each annum.
- By attending 6 farming enterprise meetings to promote the programme and exploring opportunities to access harder to reach farmers
- By continuing to develop opportunities with stakeholders to address the issue of hard to reach farmers
- By recording the nature and number of engagements & referrals.
- By analysing this data and developing additional identified referral pathways.
- By establishing and maintaining effective linkages with appropriate organisations including HSENI, UFU, Rural Support and sporting organisations such as GAA, IFU and Healthy Living Centres.

**What are the key constraints? (for example financial, legislative or other)**

- **Financial Constraints**; DAERA can only confirm funding for 2019/20 however they anticipate a further TRPSI budget in 2020/21 & 21/22.
- **Retaining appropriate staff to deliver the programme**; A band 6 nurse will be recruited and trained and to assist the nurse co coordinator. Plus a core group of approx. 10 bank nurses are currently trained to deliver the programme. The programme coordinator will continue to monitor and recruit new staff if required.

**1.3 Main stakeholders affected (internal and external)**

**For example staff, actual or potential service users, other public sector organisations, voluntary and community groups, trade unions or professional organisations or private sector organisations or others**

This accessible health check programme specifically targets farmers and farm families.

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

**What are they?**

The Draft Programme for Government sets out a clear direction for collaborative working between key departments, organisations and groups and focuses on 14 agreed high level outcomes. The effective partnership developed between DAERA, PHA and NHSCT is an example where expertise, resource and knowledge can address a particular need and can clearly demonstrate how this approach can work towards the delivery of PFG outcomes, namely;

**Outcome 3: We have a more equal society,** by promoting access to services in rural isolated areas
**Outcome 4: We enjoy long, healthy, active lives,** by giving people the information and support they need to make healthy lifestyle choices.

As outlined in the Public Health Framework, **Making Life Better** (DHSS, 2014) some population groups face specific challenges to their health and wellbeing including vulnerability to certain conditions and to broader issues such as social exclusion. The strategy recommends that programmes and services at regional and local level should be accessible and address specific needs and risk factors, including those of vulnerable groups.

**The Farm Families Health Checks Programme (FFHCP) – Link to TRPSI**

The Tackling Rural Poverty and Social Isolation (TRPSI) Framework[1] is a rural initiative led by DAERA which aims to address the issues facing farmers, farm families and rural dwellers. The FFHC programme contributes to the TRPSI framework which has the following objectives:

**Tackling Rural Poverty and Social Isolation (TRPSI) Framework Objectives**

- To promote the development of new and innovative approaches to tackling poverty and social isolation in rural areas;
- To encourage effective partnership working between the Department, other statutory organisations and the rural community sector in seeking to tackle poverty and social isolation among vulnerable people in rural areas;
- To support interventions which lever additional resources to tackle poverty and social isolation among vulnerable people in rural areas to maximise the benefits from TRPSI funding;
- To facilitate the piloting of new projects aimed at tackling poverty and social isolation in rural areas more effectively and to encourage the mainstreaming of new approaches by public authorities if they prove to be successful;
- To promote the sharing of information, best practice and expertise and to promote an increase in understanding of the causes of poverty and social isolation in rural areas.

**Community Planning Processes**

Community planning is about wider engagement with communities in the co-design and production of services, and engagement with those sectors that influence the determinants of health and wellbeing i.e. education, employment, urban planning and so forth. From a health perspective, it is about working with communities in order to co-create health and wellbeing.

Health and wellbeing is now firmly embedded as a theme of all the community plans drawn up for each of the eleven District Councils.

**Other strategies and programmes contributing to community development**

[1] DARD. (2016). Tackling Rural Poverty and Social Isolation – A New Framework. Retrieved from: https://www.daera-ni.gov.uk/sites/default/files/publications/dard/tackling-rural-poverty-and-social-isolation-2016-new-framework.pdf

Enabling individuals, families, and communities to live healthy lives requires action across a wide range and variety of policy areas. This includes policies and programmes for:

- improving health and wellbeing outcomes, addressing harmful behaviour and promoting healthy behaviour
- addressing the complex inter-relationship between mental and physical health and wellbeing, and inequality and disadvantage;
- improving educational, social, cultural, environmental, and economic outcomes; and
- preventing violence and abuse.

**Who owns them?**

- The Executive Office (TEO)
- Department of Health (DoH)
- Department for Environment, Agriculture & Rural Affairs (DAERA)
- Department for Communities (DfC) & a variety of public sector partners

## (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, service users, staff side or other stakeholders.**

Variety of academic and public research including:

- Social Survey of Farmers and Farm Families, Department of Agriculture and Rural Development, Economics and Statistics Division, 2001/02
- Haunsome et al, 2006
- Institute of Rural Health 2009
- https://www.bps.org.uk/news-and-policy/male-farmers-are-reluctant-seek-help-mental-health-issues
- Northern Ireland Assembly, Research and Library Service Briefing Paper 2010
- NI Census Report 2011, NISRA September 2014
- The levels of stress, loneliness, mental health and wellbeing, coping and support in the farming community (in Northern Ireland, Professor Tony Cassidy and Emma Carswell, University of Ulster, 2018

- Draft Programme for Government, Framework 2016-21
- Making Life Better Strategy, A Whole System Strategic Framework For Public Health, Department for Health, social Services and Public Safety, 2013-2023
- Tackling Rural Poverty & Social Isolation – A New Framework, Supporting Communities, DAERA, March 2016
- Health and Wellbeing, Delivering Together, Department for Health, social Services and Public Safety, May 2017
- Equality Indicators for NI Farmers (EINIF) , DAERA, Oct 2018
- Northern Ireland Life and Times, 2016
- Northern Ireland Life and Times Attitude Survey, Political Party Support Survey - http://www.ark.ac.uk/nilt/2016/Political_Attitudes/POLPART2.html
- Farmers and Farm Families in Northern Ireland, The results of a Social Survey of Farmers and Farm Families Sheila A.E. Magee, Economics & Statistics Division, 2001/02, DAERA,
- State of Caring, Annual survey Carers NI, 2017
- Incidents and Crimes with a Hate Motivation Recorded by the Police in Northern Ireland, Update to 31 March 2019, PSNI Statistics Branch May 2019
- NI Health Survey
- Northern Ireland policing Board *Thematic Review of Policing Race Hate Crime* (NIPB, 2017)
- Regional Interpreting Service (RIS) statistics (2018-19)

### 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.**

| Category | What is the makeup of the affected group? ( %) Are there any issues or problems? For example, a lower uptake that needs to be addressed or greater involvement of a particular group? |
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| Gender | Farmers<br>According to the results of a Social Survey of Farmers and Farm Families 2001, based on 26,490 active family farms;<br>• More than 9 out of ten farmers are men<br>– *Equality Indicators for NI Farmers (EINIF) Oct 2018*<br><br>General Population<br>Mid-year population estimate (2018; published June 2019) suggest 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).<br><br>No data specific to farms could be sourced in relation to transgender and non-binary people. However, limited data is available on the number of transgender people in Northern Ireland. The Gender Identity Research and Education Society (GIRES) provide the following estimates for numbers of gender nonconforming people, based on the information that GIRES assembled for the Home Office (2011) and subsequently updated (2014):<br><br>• gender variant to some degree 1%<br>• have sought some medical care 0.025%<br>• having already undergone transition 0.015%<br><br>The number of people who have sought treatment seems likely to continue growing at 20% per annum or even faster. While few younger people currently present for treatment, most gender variant adults report experiencing the condition from a very early age, and presentation for treatment among young people is growing rapidly (50% p.a.). |

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| | Applying GIRES figures to the NI population (using NISRA mid-year population estimates for June 2018) N=1,881,600 estimates that:<br><br>• 18,816 people do not identify with gender assigned to them at birth;<br>• 470 are likely to have sought medical care, and;<br>• 282 are likely to have undergone transition. |
| Age | Farmers<br>According to the results of a Social Survey of Farmers and Farm Families 2001, based on 26,490 active family farms;<br>• Nearly half are aged 60 or over & female farmers have an older age profile than male farmers<br>• The average age of male farmers is 58 and female 63 *(EINIF) Oct 2018*<br>General population<br>Mid-year population estimates published by NISRA in 2019 show that:<br>• 0-19 yrs (inclusive) = 485,064 (25.7% of all NI population)<br>• 20 – 34 yrs = 364,623 (19.3%)<br>• 35 – 49 yrs = 366,967 (19.5%)<br>• 50 - 64 yrs = 356,790 (19.0%)<br>• 65 – 74 yrs = 169,725 (9.0%)<br>• 75 – 89 yrs = 125,334 (6.6%)<br>• 90+ yrs = 13,138 (0.7%) |
| Religio n | Farmers<br>According to the results of a Social Survey of Farmers and Farm Families 2001, based on 26,490 active family farms;<br>• Around half are Protestant and just over two fifths are Catholic<br>• Catholic farmers are much more likely than Protestant farmers to farm very small farms<br>• More Protestant than Catholic farmers have 'lowland cattle/sheep or dairy farms<br>• More than twice the proportion of Catholic than Protestant farmers farm in Disadvantaged or Severely Disadvantaged Areas - *(EINIF) Oct 2018* |
| Political Opinion | **No data specific to farms could be sourced on political opinion so a variety of NI wide data sources are listed below.** |

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| | • British only – 39.89% (722, 353)<br>• Irish only – 25.26% (457, 424)<br>• Northern Irish only – 20.94% (379, 195)<br>• British and Northern Irish only – 6.17% (111, 730)<br>• Irish and Northern Irish only – 1.06% (19, 195)<br>• British, Irish and Northern Irish – 1.02% (1847)<br>• British and Irish only – 0.66% (11, 952)<br>• Other – 5.00% (90, 543) -(Census 2011)<br>**"Which of these political parties do you feel closest to?"** **(**Northern Ireland Life and Times, 2016)<br>• DUP/Democratic Unionist Party 17%<br>• Sinn Fein 14 %<br>• Ulster Unionist Party (UUP) 12%<br>• Social Democratic and Labour Party (SDLP) 12%<br>• Alliance Party 9%<br>• Other Party (WRITE IN) 3%<br>• None of these 23%<br>Other answer (WRITE IN)/ Don't know 12%. **"Generally speaking, do you consider yourself as a unionist, a nationalist or neither?" (**Northern Ireland Life and Times, 2016) - Unionist 29%; Nationalist 24%; Neither 46%; Other/ don't know 2%. |
| Marital Status | According to the NI Census, 2011;<br>• 47.56% (680, 840) of those aged 16 or over were married<br>• 36.14% (517, 359) were single<br>• 9.43% (134, 994) were either divorced, separated or formerly in a same – sex partnership<br>• 6.78% (97, 058) were either widowed or a surviving partner<br><br>**Northern Ireland Life and Times (2016)**<br>• Single (never married) 33%<br>• Married and living with husband/wife 50%<br>• Married and separated from husband/wife 3%<br>• Divorced 6%<br>• Widowed 8%<br><br>**Civil partnerships**<br>Annual Reports of the Registrar General for NI show that between 2005 to 2018 inclusive, There have been 1298 civil partnerships registered in NI.<br><br>According to the results of a Social Survey of Farmers and Farm |

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| | Families 2001, based on 26,490 active family farms; Nearly three quarters of farm households are married - *(EINIF) Oct 2018* |
| Dependent Status | According to the NI Census, 2011;<br>• 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.<br>• 3.11% (56, 318) provided 50 hours care or more.<br>• 33.86% (238, 129) of households contained dependent children.<br>• 40.29% (283, 350) contained a least one person with a long – term health problem or a disability. (Census 2011)<br><br>**CarersNI State of Caring 2019** Annual survey (UK wide, including NI)<br><br>• Only 2 in 5 carers (39%) responding reported being in paid work.<br>• 38% of all carers reported that they had given up work to care.<br>• 18% had reduced their working hours.<br>• 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.<br>• Just over 1 in 10 carers (11%) said they had retired early to care.<br>• Only 4% of respondents of all ages said that caring has had no impact on their capacity to work.<br><br>**Northern Ireland Life and Times (2016)**<br>• 17% respondents were carers: 21% of women and 13% of men.<br><br>**Health Survey NI (2016/17)**<br>• 13% have caring responsibilities<br>• Approx. 70% receive no monetary reward for giving this care<br>• 48% received help from other family members, but 38% received no support from others<br><br>**Parents with dependent children (NI Census 2011)**<br>• Responsibility for dependent children: 238,094 households |

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| | (33.9% of all NI households)<br><br>**NI Lone parent families** = 115,959, with 123,745 dependent children in family (Census 2011).<br><br>**Gender disparity**: Of the 115, 959 lone parents, 16, 691 are males and 99,268 are female.<br>(NI Census 2011)<br><br>According to the results of a Social Survey of Farmers and Farm Families 2001, based on 26,490 active family farms:<br>• There were 25,630 children aged 16 and under<br>• Four in ten farm households contain dependents -<br>• 3,600 of the 29,360 households contained only persons of retirement age<br>• 32% of farm households included at least one member aged 65 or over - *(EINIF) Oct 2018* |
| Disability | According to the NI Census, 2011:<br><br>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.<br><br>68.57% (1, 241709) of residents did not have long – term health condition.<br><br>• Deafness or partial hearing loss – **5.14% (93, 078)**<br>• Blindness or partial sight loss – **1.7% (30, 785)**<br>• Communication Difficulty – **1.65% (29, 879)**<br>• Mobility of Dexterity Difficulty – **11.44% (207, 163)**<br>• A learning, intellectual, social or behavioural difficulty. **2.22% (40, 201)**<br>• An emotional, psychological - **5.83% (105, 573)**<br>• or mental health condition<br>• Long – term pain or discomfort – **10.10% (182, 897)**<br>• Shortness of breath or difficulty breathing – **8.72%**<br>• **(157, 907)**<br>• Frequent confusion or memory loss – **1.97% (35, 674)**<br>• A chronic illness (such as cancer, HIV, diabetes, heart disease or epilepsy. – **6.55% (118, 612)**<br>• Other condition – **5.22% (94, 527)**<br>• No Condition – **68.57% (1, 241, 709)** |

| | (Census 2011)<br><br>**Northern Ireland Life and Times 2016:**<br><br>“Do you have any physical or mental health conditions or illnesses lasting or expected to last for 12 months or more?”<br><br>Yes 24%; No 76%;**Health Survey NI (2017)**<br><br>42% longstanding illness (30% limiting and 12% non-limiting illness)<br><br>Evidence has shown that the farming community is particularly susceptible to poor health and wellbeing. Hazards associated with farm work include accidents (HSENI, 2016) stress and mental health problems, (Fraser et al, 2005; Lobley et al, 2004; Burnett & Mort 2003) and musculo-skeletal disorders (Meyers et al 1993; 1995).<br>Many of these conditions affect farmers and farm workers to a greater extent than the general population (Brumby, 2006). This includes occupational diseases caused by, aggravated or exacerbated by workforce exposure, for instance zoonotic infections and allergies. Farmers working long and anti-social hours, face greater isolation exacerbated by the rural setting as their presence is often less visible in rural communities.<br><br>According to the results of a Social Survey of Farmers and Farm Families 2001, based on 26,490 active family farms:<br>• Some 930 accidents which required someone to seek medical help occurred on 3% of farms during the year prior to the survey, mostly involving the farmers. The most common cause (28%) was being hit or trampled by an animal<br>• Farm accidents resulted in the loss of an estimated 140 person-years lost work<br>• Some 26% of farm workers (27% of farmers) suffered from a long standing illness or disability which limited their activities<br>• Three in ten report a disability<br>• 73% included either a member aged 65 or over, a child or a person claiming disability benefit<br>- *(EINIF) Oct 2018* |
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<td>Ethnicit<br>y</td>
<td>No data specific to farms could be sourced on ethnicity so a variety of NI wide data sources are listed below. 1.8% (32,596) of the usual resident population belonged to minority ethnic groups:<br>
• White – 98.21% (1, 778, 449)<br>
• Chinese – 0.35% (6, 338)<br>
• Irish Traveller – 0.07% (1, 268)<br>
• Indian – 0.34% (6, 157)<br>
• Pakistani – 0.06% (1, 087)<br>
• Bangladeshi – 0.03% (543)<br>
• Other Asian – 0.28% (5, 070)<br>
• Black Caribbean – 0.02% (362)<br>
• Black African – 0.13% (2354)<br>
• Black Other – 0.05% (905)<br>
• Mixed – 0.33% (5976)<br>
• Other – 0.13% (2354) - (Census, 2011)<br><br>
Northern Ireland Pooled Household Survey (NIPHS) tables, 2017. Data (2013/14 and 2014/15) from four NI Household Surveys (i.e. Labour Force Survey, Family Resources Survey; NI Health Survey, and Continuous Household Survey). Results presented for 11 Local Government Districts. Presented as ‘Ethnicity White’ and ‘All Other Ethnicities’ due to small cell sizes. Available here https://www.nisra.gov.uk/publications/northern-ireland-pooled-household-survey-niphs-tables<br><br>
2014/15: Ethnicity White 98.2% (1,409,000); All other Ethnicities 1.8% (26,000)<br>
• Between 2000 and 2014, an estimated 175,000 long-term international migrants came to Northern Ireland, while 143,000 left, leaving a net total of 32,000. Local government districts in the west and south-west of Northern Ireland saw the largest net inflow of new residents, in particular: Mid Ulster (9,800), Armagh, Banbridge and Craigavon (9,300) and Newry, Mourne and Down (6,000).<br>
• Poland continues to be the most popular country of origin for international migrants coming to live in Northern<br>
• Ireland. During 2014 and 2015, however, migration from Romania rose substantially, albeit from a low baseline.<br>
• Around 1,000 members of the Roma community, mostly from Romania, are thought to be living in Northern Ireland, mainly in South Belfast.</td>
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| | • International migration impacts upon the host community in a myriad number of ways, including maternity services, school enrolments, social housing, health and social care, and hate crime.<br>• Births to mothers born outside the UK and Ireland now account for over 10 per cent of all births in Northern Ireland each year. In 2014, 18 per cent of all births in the Mid Ulster local government district were to non-UK and Ireland mothers, followed by Armagh, Banbridge and Craigavon (15%), Belfast (15%), Fermanagh and Omagh (14%) and Newry, Mourne and Down (14%).<br><br>In 2017, the Northern Ireland Policing Board conducted a *Thematic Review of Policing Race Hate Crime* reporting that:<br>• In Northern Ireland, a race hate incident is reported approximately every seven hours.<br>• Racist hate crimes are the second most common type of hate crime recorded by PSNI, with sectarian hate crime being the most common.<br><br>The HSC Interpreting Service (also referred to as Regional Interpreting Service RIS) statistics reveal a trend of increasing numbers of ethnic minority groups requiring support to access healthcare services in the region over the last 15 years. These data show a dramatic rise in requests for interpreters from 1,850 in 2004-2005 to 114,382 requests in 2017-2018.<br><br>The most popularly requested languages in 2017-18 were:<br>1. Polish 30292<br>2. Lithuanian 15763<br>3. Arabic 11360<br>4. Romanian 9908<br>5. Portuguese 8524<br>6. Tetum 6162<br>7. Slovak 5320<br>8. Bulgarian 5154<br>9. Chinese - Mandarin 5011<br>10. Hungarian 2887 |
| Sexual Orientation | **No data specific to farms could be sourced on Sexual Orientation so a variety of NI wide data sources are listed**<br>In 2016, estimates from the Annual Population Survey (APS) |

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| | showed that:<br>• 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:<br>  ○ 1.2% identifying as gay or lesbian<br>  ○ 0.8% identifying as bisexual<br>• 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.<br>• The population aged 16 to 24 were the age group most likely to identify as LGB in 2016 (4.1%).<br>• More males (2.3%) than females (1.6%) identified themselves as LGB in 2016.<br>• The population who identified as LGB in 2016 were most likely to be single, never married or civil partnered, at 70.7%.<br>(Available at https://www.ons.gov.uk/peoplepopulationandcommunity/culturalidentity/sexuality/bulletins/sexualidentityuk/2016#main-points)<br><br>According to the latest figures on Homophobic Hate Crime in the 12 months from 1st April 2018 to 31st March 2019:<br>• There were 281 homophobic incidents recorded by the police in Northern Ireland, 14 more incidents than the previous 12 months.<br>• The number of homophobic crimes recorded by the police was 201, an increase of 38 on the previous 12 months.<br>• There were 2 homophobic incidents and 1 homophobic crime per 10,000 population2, compared with 1 homophobic incident and 1 homophobic crime during the previous 12 months.<br>• Homophobic crimes represented 0.2% of all police recorded crime. |

### 2.2 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 | According to the Institute of Rural Health (2009) Health stresses are magnified by isolation, single worker situations (farmers), a lack of knowledge about services and difficulty accessing them. According to a 2018 preliminary study by researchers at Ulster University more than three quarters of male farmers would not seek help for emotional problems despite displaying high levels of stress, Analysis of the responses (199 males and 75 females) showed that participants showed greater signs of loneliness, depression and anxiety than the non-farming community (https://www.bps.org.uk/news-and-policy/male-farmers-are-reluctant-seek-help-mental-health-issues ).The preliminary report highlighted men in particular reported higher levels of depression and stress as well as less likely to seek help than female farmers (73 per cent; 27 per cent). Family support was cited more by women as well as better levels of wellbeing. |
| Age | Individuals who are older are more likely to suffer from disability or long term limiting illness (NI Health Survey (2017/18), and as such may find it more difficult to access the service, particularly if they have mobility or balance issues. |
| Religion | Given that Northern Ireland has long been segregated along political and religious lines, some individuals may be less likely to participate in the service if it is located in an area perceived to be a particular religious enclave. |
| Political Opinion | Given that Northern Ireland has long been segregated along political and religious lines, some individuals may be less likely to participate in the service if it is located in an area perceived to be a particular religious enclave. |
| Marital Status | Participants may be more likely to access the service if they are encouraged or supported to do so by a partner or spouse. |
| Dependent Status | It is recognised that having caring responsibilities may limit the abilities of individuals to access the service. Those who have child care responsibilities, or other caring responsibilities may be less likely to able to physically visit the sites where the service is |

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| | delivered. Consideration of timing of services should be taken into account when planning outreach re service delivery. |
| Disability | It is recognised that individuals who have different disabilities will have different needs with regards to information materials and access the Farm Families program than those without.<br>Individuals who have learning disabilities or other communication difficulties will have specific needs with regards to information about the service and participation. Also, individuals who have physical or mobility problems may find it more difficult to access the van in which the initial aspects of the service is provided. |
| Ethnicity | People from ethnic minority communities may experience or are likely to have particular needs in relation to cultural and communication needs. They may experience language barriers and may have particular needs regarding accessible communication and information including the provision of translated information as well as interpreting services and sometimes rely on children and young people to interpret. Consideration of the needs of a diverse population should be factored into advance planning re delivery. |
| Sexual Orientation | Treating all those who present for a health check with dignity and respect regardless of their Section 75 status is a prerequisite for all aspects of programme delivery.<br>People living in rural areas who are who are LGBTQI orientated may have concerns around confidentiality in accessing local or mainstream health services, they may be reluctant to disclose their identify due to increasing levels of hate crime and may feel their specific needs are not addressed. |

### 2.3 Multiple Identities

**Are there any potential impacts of the policy or decision on people with multiple identities? For example; disabled minority ethnic people; disabled women; young Protestant men; and young lesbians, gay and bisexual people.**

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### 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 the 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 equality issues you identified?*** |
|---|---|
| Marital status: Open access to the service will be facilitated by varying location, ensuring the vehicle is accessible and promoting the service to all people who are rural dwellers and are involved in farming or a member of a farming household. Continued targeting of groups at greatest risk of ill health and those least likely to seek out support (including those without the support of a spouse or partner) will be proactively targeted toward farmers markets, community events, farming enterprise activities etc. with input and advise from the cross sector programme advisory group and through continued relationship building with key agencies HSENI, UFU, Rural Support and sporting organisations such as GAA, IFU and Healthy Living Centres.<br><br>Disability: In order to address the needs of people with mental health difficulties who may find it more difficult to seek help, continued targeting of groups at greatest risk of ill health and those least likely to seek out support will be proactively targeted toward farmers markets, community events, farming enterprise activities etc. with input and advise from the cross sector programme advisory group and through continued relationship building with key agencies | Section 75 user information will be monitored at point of entry and this information will then be analysed by the service providers and the commissioners to assess how all, and particular, groups are accessing (or not) the service. Direct and/or indirect work may then be undertaken in terms of raising awareness with particular groups or gaining feedback re. experience by those groups to date.<br><br>The programme will be subject to both internal and external monitoring and evaluation with the findings then influencing future commissioning direction and decisions at local – and regional levels. |

| | |
|---|---|
| HSENI, UFU, Rural Support and sporting organisations such as GAA, IFU and Healthy Living Centres.<br><br>Vehicles used as part of the programme will be accessible and useable for people with a physical disability and that rooms are private, ensuring confidentiality for all health check clients.<br>Where feasible information materials will be provided in accessible easy read formats for People with a Disability (PWD - people with visual impairment/ learning disability etc.) to help with any communication difficulties that may be experienced.<br><br>Dependent status: In order to facilitate the needs of those with caring responsibilities consideration of location, timing of services and length of time allocated to each appointment should be taken into account when planning outreach re service delivery.<br><br>Ethnic minority groups: Where feasible, information will be translated upon request. Also, translation services are available from the Regional Interpreting Service, and the Big Word, which provides an immediate telephone interpreting service.<br><br>Gender: Treating all those who present for a health check with dignity and respect regardless of their gender status is a prerequisite for all aspects of programme delivery. All Trust and PHA staff have mandatory equality training which addresses issues of gender, including Transgender issues. Rooms used to deliver the programme | |

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| are private, ensuring confidentiality for all health check clients.<br><br>Age: Effective engagement with older people involves actively listening and genuinely responding to what matters to them most. Engagement is not only about giving older people a voice, it is about ensuring that older people are valued and are respectfully included in the decisions that ultimately affect them. When engaging with older people who may have mobility or balance issues location and access will need to be considered.<br><br>Religion and Political opinion: Consideration will be given to choice of location and access routes for engagements and delivery of the service to ensure services are not located in areas that are designated as belonging to one particular religion or another, or political opinion.<br><br>Sexual orientation: Treating all those who present for a health check with dignity and respect regardless of their gender status is a prerequisite for all aspects of programme delivery. All Trust and PHA staff have mandatory equality training which addresses issues of gender, including Transgender issues. Rooms used to deliver the programme are private, ensuring confidentiality for all health check clients. | |

## 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 | Not applicable | |
| Political Opinion | Not applicable | |
| Ethnicity | Not applicable | |

## (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 categorise 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 give reasons for your decisions.

This partnership based programme is was established to address the many health challenges rural areas face due to the issues outlined above, further impacted by their low population densities and distance from urban centres. These factors have the potential to contribute to further social isolation and to create a "domino effect" that further depletes rural areas of community spirit, strong cohesion and good quality of life.

This programme is a key mechanism in addressing identified health issues and in ensuring that all Section 75 groups who make up rural communities receive maximum benefit from government policies.

Due regard has paid to the needs of each of the Section 75 groups, with mitigation provided.

## (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?* |
|---|---|
| | Target organisations and services that cater to people with a disability so that awareness is maximised.<br>Involve organisations who work with or advocate on behalf of people with a disability in future service planning and delivery so that their views and experience can influence future service design and potential roll out. |

### 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 positive attitudes towards disabled people?* |
|---|---|
| Farm Family Health Check Programme (FFHCP) will be internally monitored and independently evaluated allowing for any issues re. access to, or use of, the service by people with a disability to be addressed.<br><br>Positive portrayals of people with a disability will be used in | Ensure that all organisations involved adhere to relevant legislation and have appropriate policies and procedures in place. |

| | |
|---|---|
| any literature produced. | |

## (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 & forced or compulsory labour | No |
| Article 5 – Right to liberty & security of person | No |
| Article 6 – Right to a fair & public trial within a reasonable time | No |
| Article 7 – Right to freedom from retrospective criminal law & no punishment without law | No |
| Article 8 – Right to respect for private & family life, home and correspondence. | No |
| Article 9 – Right to freedom of thought, conscience & religion | No |
| Article 10 – Right to freedom of expression | No |
| Article 11 – Right to freedom of assembly & association | No |
| Article 12 – Right to marry & found a family | No |
| Article 14 – Prohibition of discrimination in the enjoyment of the convention rights | No |
| 1$^{st}$ protocol Article 1 – Right to a peaceful enjoyment of possessions & protection of property | No |
| 1$^{st}$ 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 manager 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 and good relations, disability duties and human rights)?**

| Equality & Good Relations | Disability Duties | Human Rights |
|---|---|---|
| Section 75 user information will be monitored at point of entry and this information will then be analysed by the service providers and the commissioners to assess how all, and particular, groups are accessing (or not) the service. Direct and/or indirect work may then be undertaken in terms of raising awareness with particular groups or gaining feedback re. experience by those groups to date.<br><br>Section 75 monitoring data will be collected by the service provider and can then be analysed internally (via monitoring) and externally (as part of evaluation).<br><br>Quantative and | Section 75 user information will be monitored at point of entry and this information will then be analysed by the service providers and the commissioners to assess how all, and particular, groups are accessing (or not) the service. Direct and/or indirect work may then be undertaken in terms of raising awareness with particular groups or gaining feedback re. experience by those groups to date. | |

| | | |
|---|---|---|
| qualitative information will be collated as part of the programme delivery.<br><br>Compliments and complaints will be monitored.<br><br>All aspects of the programme will be independently evaluated and the views and experiences of service users will be a central component. | | |

Approved Lead Officer: Frances Dowds

Position: Health Improvement Officer

Date: 15.08.2019

Policy/Decision Screened by: Frances Dowds

Business Unit and contact details

**Please note that having completed the screening you are required by statute to publish the completed screening template, as per your organisation's equality scheme. If a consultee, including the Equality Commission, raises a concern about a screening decision based on supporting evidence, you will need to review the screening decision.**

**Please forward completed template to: Equality.Unit@hscni.net**

**Template updated January 2015**

Any request for this document in another format or language will be considered. Please contact us (see contact details provided above).