Reproductive Health Policy

guidance and support for <u>all</u> staff impacted by reproduction health, including:

Menstruation

Termination of pregnancy

Unplanned pregnancy

Miscarriage

Fertility treatment

Menopause

Dedication

For those who felt loss or lost, as a result of reproductive health. You are seen.

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1. Introduction

This policy is written with the intention of supporting all employees who are experiencing reproductive health challenges at work.

This policy has been shaped by:

- Asking staff for their experiences and their ideas for how we can improve
- Looking at examples of similar policies in other organisations
- Talking to wellbeing professionals who work in this field
- Reviewing specific articles and research papers

By combining all of these strands, EAAA aims to meet the aims and objectives of this project. We acknowledge language of gender identity and sexual orientation is always evolving. If something is uncomfortable for you, tell us and we'll talk about how we can improve.

At the start of every health section is a quote from an EAAA staff member who has lived experience of the topic and wanted to help improve understanding of the area.

2. Aims and objectives

The aim of this policy is to:

- Improve understanding of the specific health issues in reproductive health
- Highlight specific support that is available for reproductive health concerns, for all gender identities
- Reduce the stigma which surrounds this topic

EAAA want to support your wellbeing, and that includes reproductive health. You have our support when managing your personal experiences – be they positive or painful. Some people find it difficult to talk about this subject. However, we expect all managers and colleagues to be kind, compassionate and show empathy when our people disclose reproductive health problems.

We do not expect managers to be experts on all reproductive matters at all times – remember you have back up in our HR Team. We recognise that not everyone will want to disclose reproductive health matters – for whatever reason. However, there are choices for disclosure and different ways we can help. We encourage your openness, so we can support you better.

This policy offers education and guidance. If it can be improved, please tell us.

3. Reproductive Health Areas

3.1 What if I don't want to talk to my manager?

It is appreciated that all of the topics in this policy are sensitive and there may be some people who feel reluctant to talk to their manager about them. To help with this EAAA will:

- Promote development opportunities to all managers to help them support staff effectively in this area
- Encourage an open and safe environment where people feel conversations on this topic will be respected
- Make HR available to be part of any conversations, for any party who is nervous about broaching the topic
- Provide templates to structure certain conversations
- In some circumstances, particularly the Clinical directorate where there are a number of managers who work collaboratively, offering an alternative to the direct line manager. The line manager will still need to be brought up to speed and gradually phased in for support, but initial conversations with an alternative person who you feel more comfortable with will be supported

It is hoped that these measures will reduce as much anxiety as possible to have these conversations. The key to effective support involves the line manager and staff member talking/working together to understand what help is possible.

3.1 Menstruation (period)

Staff voice

"The reality is I struggle most months, at some point, when I have my period"

3.1.1 Definitions/Terminology

Menstruation - the process of blood being released from the uterus lining, typically on a monthly cycle.

Term	Explanation
Dysmenorrhea	Painful periods which affect a person's day-to-day life.
Endometriosis	A condition where cells which typically line the uterus grow in other areas of the body. Endometriosis can cause Dysmenorrhea. It is typically at its most painful around ovulation/menstruation.
Flooding	When the flow of blood is particularly high and sanitaryware requires frequent changing, typically at least every hour
Premenstrual Tension (PMT/PMS)	Refers to the physical and mental symptoms experienced before a period.
Premenstrual Dysphoric Disorder (PMDD)	A more severe form of PMT. Diagnosis is extremely difficult and often confused with bipolar disorder. Symptoms may go unrecognized / misunderstood for many years. Unfortunately in black women and ethnic minorities, this figure leaps to 5 times longer to diagnose / get appropriate help.
Polycystic Ovarian Syndrome (PCOS)	A common condition that affects how the ovaries work. The 3 main features of PCOS are: • Irregular periods • High levels of "male" hormones in your body, which may cause physical signs such as excess facial or body hair • Ovaries become enlarged and contain many fluid-filled sacs (follicles)

3.1.2 Symptoms

Symptoms caused by a menstrual cycle, at any time not necessarily at the moment of bleeding, can include:

- abdominal pains/cramps
- abdominal swelling
- lower back pain
- changes in mood and irritability
- bloating, fluid retention
- joint pain
- sore breasts
- food cravings
- headaches
- low energy or fatigue
- dizziness
- nausea
- increased urination
- acne

- diarrhoea or constipation
- dehydration
- anxiety
- depression
- exacerbation of other conditions
- trouble sleeping

Menstruating people experience symptoms differently. In a survey by the organisation Unfabled, 92% of people who have periods stated they experienced symptoms which were difficult to manage.

3.1.3 Guidance for language

One of the biggest barriers to effective support in this area is rooted in people's reluctance to talk about periods and/or the impact of a monthly hormone cycle. This is a societal issue and by improving our confidence to discuss periods, we make managing their impact easier. Here are some general tips for framing conservation on the topic:

- Call a period, a period. Try and avoid euphemisms or medical terminology which at best can be confusing and in the worst cases cause embarrassment
- If you are listening to someone explain about period issues, avoid attributing other problems into the conversation. e.g. "Last month when you forgot to send that report through, was it because of your period?". Instead try "Are there any other times where your period has impacted your work that you would like me to know about, so I can better understand the impact this has on you?"
- Ask open questions like "How can I help you with this?" and "what do you need from me right now?"
- Managers can offer to structure the conversation using a Wellness Action Plan (WAP)

3.1.4 What support is available from EAAA?

- Flexible working – consider working slightly different hours or locations if your cycle is impacting you
- A referral to occupational health – particularly useful if there are regular issues which are affecting your work
- Provision of free sanitaryware in the EAAA facilities for when people suddenly find themselves in need. There is also additional supplies and changes of clothes in the crew changing rooms for front line staff who need additional items and cannot leave base due to being on shift

3.1.5 Being off work because of a period

Research as part of this policy's development showed that a lot of staff didn't book time off work, despite feeling they needed it, because they were too worried/embarrassed about disclosing the reason for their absence. Some staff shared they "hide" their absence by taking a wellbeing day instead of reporting as unwell.

If you feel unable to work because of your menstrual cycle please do not try and battle through or mask it using wellbeing days. You should book the day as sickness, for several reasons:

- It gives you time off from work to manage your symptoms

- It helps you understand the pattern and frequency of your symptoms. If your monthly cycle is routinely causing frequent absences from work, you should speak to your GP for advice and support on how to reduce their impact
- It shows others it is ok to take time out. Periods are part of life and it is ok to need some downtime to manage them, if you need it.
- It keeps the wellbeing days in reserve for their intended purpose – support with mental health.

3.2 Unplanned Pregnancy

Staff voice

> *"There are some real sensitivities to a person coming to terms with being pregnant, not wanting an abortion, but maybe feeling they don't have the choice or control over what is happening to them."*

Findings from Department of Health, show that 45% of pregnancies and one third of births in England are unplanned or associated with feelings of ambivalence. The Charity's Maternity Policy should be used for specific advice on how to support pregnancy in the workplace, this section acknowledges the specific challenges of people who find themselves unexpectedly due to become a parent.

3.2.1 Guidance for language

The way colleagues listen and respond will affect how much someone shares and how comfortable they feel about further disclosure. Ensure you create a safe and comfortable environment to talk, avoiding any risk of interruption where possible. Ask simple, open questions. Let them explain in their own words. Give them time and be prepared for some silences.

Suggested ways to respond to any disclosure/discussion regarding an unplanned pregnancy:

- "How are you feeling?"
- "Who else have you talked to about this?"
- "Are you able to talk to your partner/other half of the pregnancy?"
- "I'm here if you ever need to talk."

If you wish to, share your own personal experience of unplanned pregnancy. Be careful not to shift the focus away from what the member of staff is sharing however and share your lived experience to show empathy and understanding.

Things to avoid saying:

- Discussing your personal views on contraception/management of an unplanned pregnancy
- "At least you know early on, so you can take steps if that's what you want"
- "Everything happens for a reason."

Be sure to understand how much the person is sharing with colleagues and commit to supporting that intention.

3.2.2 **What support is available?**

Counselling - All employees have access to counselling via SimplyHealth, there is also the option to add your partner to this (for a monthly fee). This will give them access to the same health benefits, including counselling. Please contact Payroll@eaaa.org.uk to progress this.

Paid Leave - Unlike many employers, EAAA does have paid sickness absence available for staff, which is offered at their normal rate of pay for a certain period of time. Wellbeing Days are also available. Either of these are appropriate for someone to use when processing the news of an unplanned pregnancy,

3.3 Miscarriage

Staff voice:

> *"I have experienced three miscarriages, one of which was very traumatic. My doctor said I would have, what felt like a bad period, which was the clearing out. This was not the case, I went into full blown labour and then bled like there was no tomorrow. There really was not much support offered at the time for either of us but especially for [my partner]."*

and

> *"I just didn't want anyone to know. I was keeping my pregnancy a secret until my first scan and it was important to me that people didn't know because it felt private. The miscarriage happened relatively painlessly, partly because it was so early on, so it was very easy to keep it to myself. The only person I ever told was my manager and I didn't take any time off work."*

and

> **"***I completely underestimated the impact of miscarriage. As medical professionals, we can be quite pragmatic about the whole process, however, it is really important that we think about the whole person, not just their medical needs. Miscarriage is a deeply personal experience, with many factors that may contribute to the impact on an individual."*

3.3.1 Definition

Miscarriage is the spontaneous loss of a pregnancy before the 20th week. Around 1 in 4 pregnancies end because of miscarriage.

Under the umbrella term of miscarriage there are lots of different types of pregnancy loss:

Term	Explanation
Blighted ovum	occurs when the cells of a baby stop developing early on, and the tiny embryo is reabsorbed. However, the pregnancy sac, where the baby should develop, continues to grow.
Chemical pregnancy	a very early pregnancy loss which usually happens just after the embryo implants (before or around 5 weeks). It is likely that the only sign of pregnancy is a positive pregnancy test, as it would be too early for anything to be detected on a scan and unlikely that pregnancy symptoms have started.
Ectopic pregnancy	when a fertilised egg implants itself outside of the womb, usually in one of the fallopian tubes. The fallopian tubes are the tubes connecting the ovaries to the womb. If an egg gets stuck in them, it won't develop into a baby and unfortunately, it's not possible to save the pregnancy. It usually has to be removed using medicine or an operation. In the UK, around 1 in every 90 pregnancies is ectopic. This is around 11,000 pregnancies a year.
Missed miscarriage (sometimes referred to as a silent miscarriage)	This is where a baby has died or not developed, but there are no outward signs. In many cases the news will have come as a complete shock and is likely to have been detected on a routine scan.
Molar pregnancy	Where an abnormal fertilised egg implants in the uterus. The cells that should become the placenta grow far too quickly and take over the space where the embryo would normally develop. About one in 600 pregnancies is a molar pregnancy, so it's quite rare. It requires careful treatment and monitoring to support the body in removing the cells.
Recurrent miscarriage	Three consecutive miscarriages. After three consecutive losses the NHS will begin investigations to try and detect any underlying issues. In around half of cases no underlying issue will be found.

3.3.2 What is likely to happen during a miscarriage

All miscarriages are different from how they are detected right the way through to how much medical support is needed. Also, there are varying levels of support for partners, and it is important they are recognised throughout the miscarriage process.

If a miscarriage is diagnosed there are several ways the process can happen:

- The miscarriage happens naturally i.e. the body takes care of the process without any kind of assistance

- The pregnancy is removed surgically i.e. person attends hospital and has a procedure under anaesthetic to remove the pregnancy
- Medical assistance through tablets, given to the pregnant person, to trigger the body into removing the pregnancy.

Some miscarriages happen very quickly and it is almost immediately obvious to the pregnant person (and partner) what is happening. For others, is not always possible to diagnose a miscarriage straight away.

Once concern about a pregnancy has been raised it can take multiple trips for scans and/or blood tests to determine if the pregnancy is progressing. Some tests are performed over several days before a clinical decision can be made as to what is happening with the pregnancy. This is an important factor to consider, as a drawn-out process can often lead to additional psychological trauma. For some, the process begins very suddenly with heavy bleeding which can be very intense and frightening.

The level of trauma may vary significantly between individuals, it is important to be aware that each individual (and their partner) may sit anywhere within a wide spectrum of psychological impact, and to avoid assumptions such as 'the individual remains at work, therefore they must be ok'.

What is common in all of these experiences are the following symptoms:

- Heavy bleeding
- Cramping
- Mental exhaustion*
- A feeling of grief*
- Anxiety*
- Loss of confidence*
- Tiredness*

*Likely to appear in partners too

Some patients are asked to take a pregnancy test several weeks after a diagnosed miscarriage to confirm to the hospital it is negative and so show the body has fully completed the process of removing the pregnancy, so that no further intervention is required. Although very sensible and cost effective as a method, the process of hoping for a negative pregnancy test when you have likely been willing for a positive one, can be upsetting.

3.3.3 Late miscarriage/still birth

It is recognised that miscarriages which happen later on in the pregnancy i.e. after the 12 week scan, and still born pregnancies require slightly different support. Advice should be taken from HR, although much of the advice contained in this document is appropriate particular awareness is drawn to the fact that:

- The Maternity Policy may be involved depending on the number of weeks of the pregnancy
- There is likely to be a much wider set of people aware of the pregnancy, making internal communications much more complex
- Treatment is likely to be more complex

3.3.4 Guidance for language and how to talk to someone affected

The way colleagues listen and respond will affect how much someone shares and how comfortable they feel about further disclosure. Ensure you create a safe and comfortable environment to talk, avoiding any risk of interruption where possible. Ask simple, open questions. Let them explain in their own words. Give them time and be prepared for some silences. You will see the Staff Voices section at the start of this section, how different responses can be.

Expectant parents will often have a personal preference on language when discussing their miscarriage. For example, some people prefer to use the term "pregnancy" and others use the term "baby". The best advice is to follow the cues of the person you are speaking to and mirror their language.

Suggested ways to respond to any disclosure/discussion regarding miscarriage:

- "I'm sorry for your loss."
- "This must be really hard, I'm so sorry."
- "Please let me know if there is anything you need."
- "I'm here if you ever need to talk."

If you wish to share your own personal experience of miscarriage that is often helpful. Be careful not to shift the focus away from what the member of staff is sharing however and share your lived experience to show empathy and understanding.

Things to avoid saying:

- "You can always try again."
- "At least it was early on."
- "It's a common thing to happen"
- "At least you can get pregnant."
- "It was probably for the best."
- "Everything happens for a reason."
- "It must be so much harder for your partner than you"

If you're not sure how to start a conversation about miscarriage, these may be helpful:

During and immediately after a loss

- How are you feeling?
- What do you feel would help you right now?
- What, if anything, would you like colleagues/the team to know?
- Do you need any time off work?
- How is your partner? Are you able to talk to each other about how you are feeling?
- How would you like me to keep in touch while you are away?
- What other support do you have?
- Have you seen the Miscarriage Association's information on miscarriage and our own policy on Reproductive Health?

- Have you seen any of the Miscarriage Association's information or support?

Returning to work

- Is there anything I/we can do to make coming back to work easier for you?
- Would you like to meet up before coming back?
- Is there anything you are worried about?
- What kind of support do you think might help if you become upset or tearful at work?
- Would you like me to tell/email colleagues about your return? Would you like to draft an email yourself or check what I write?

3.3.5 What support is available?

Counselling - All employees have access to counselling via SimplyHealth. Further details on how to access this can be found on our wellbeing page. There is also the option to add your partner to this (for a monthly fee). This will give them access to the same health benefits, including counselling. Please contact Payroll@eaaa.org.uk to progress this.

Phased return to work – A phased return, usually offered over one or three weeks, will help someone who feels unable to manage their normal working hours straight away. HR can offer guidance on how this can work. A phased return is always paid at the person's full rate of pay.

Wellness Action Plan – this can be used to help frame discussions about what support somebody needs. It can be particularly helpful with the partner of the person who has experienced the miscarriage, where it is not always clear what support they might need and/or they feel less confident in asking for help

For those who ask to work during the miscarriage process – support for where they complete their role. For those who are pregnant they often need easy, frequent, access to the bathroom and will have anxiety about bleeding through their clothing. For partners, they may need to take short notice phone calls and suddenly need to travel to their partner.

Flexible working – consider working slightly different hours and/locations.

Paid Leave - For pregnancies which end after 24 weeks, maternity leave is often used to give someone paid time away from work. The law says maternity leave cannot be paid for a pregnancy which ends before this point.

For the first week, time away from work is treated as compassionate leave and is fully paid. Unlike many employers, EAAA does have paid sickness absence available for staff, which is offered at their normal rate of pay for a certain period of time.

EAAA ask that any absence as a result of miscarriage, after the initial week, is covered using Sickness Absence allowance. The reason for using the Sickness Absence is as follows:

- If the miscarriage is affecting your ability to be at work, it is important that your GP is aware and providing support. Treating an absence from work as sickness means the individual has

to engage with their GP's surgery to obtain a Fit Note, and gives people more access to support

- There can sometimes be a tendency to ask for different types of paid leave because the reason is "not sickness". It is certainly true that miscarriage is not sickness, but a better approach may be to change the language around what sickness absence is there for – to cover someone's absence from work because their health has been impacted.

3.4 The Fertility Journey

Staff voice:

"To try and have your baby, you have to hand your life over to others"

3.4.1 Definition

The NHS defines infertility as when a couple cannot get pregnant despite having regular unprotected sex. A couple may also be unable to get pregnant naturally because they are not in a male/female relationship.

3.4.2. Diagnosis

Some people may already understand the reason they are unable to conceive (same sex relationship, previous medical treatment), but for many the first stages of the fertility journey will involve a series of tests to understand the root cause. Medications and procedures associated with this area can cause side-effects and associated stress.

Testing fertility can include scans, blood tests, semen analysis and key hole surgery. There are far more things to test on women than men, meaning women will need to have a greater range of assessments. For 1 in 4 couples, the reason will never be determined. Not having a reason for the fertility can, for many, be as upsetting as those with a diagnosis as they will feel they don't know what to "fix". If a reason is determined and associated with one person, it is usual for the person to experience feelings of guilt, failure and in some cases shame.

3.4.3 Initial discussions

At the outset of investigations into infertility issues it is helpful for a manager and staff member to talk about what is happening. If the manager knows assessment/treatment is underway then they can ensure suitable support is available (see section 3.4.5.)

You will find below a list of areas it might be useful to talk through, the list is not exhaustive, and some people may not want to share everything, but is a useful guide if you are unsure of what things to discuss.

Topic	How it helps
Where you are on your fertility journey	To understand what you have been dealing with so far and what you foresee happening in the short to medium term
How much financial support is required	The cost of investigations and treatments are not necessarily covered by the NHS. Understanding any

	additional financial burden helps to have full sight of the situation.
If you have a diagnosis and how that is impacting you	Key issues are understanding how much information the person has and the medical issues connected to the fertility problems. An important aspect to understand who "owns" any fertility issues and how they are feeling about it and how they are supported/supporting others
If there are any key dates/times which are known	This helps to manage workloads and to be sensitive to heightened emotions around key times.
Any triggers or events which your manager needs to be mindful of	There may be some less obvious things which a manager won't appreciate are upsetting. Sharing these helps them be sensitive to individual's needs.
What you don't know	It is not uncommon for people to have to build their understanding up over time as the journey progresses. It would be helpful to share what isn't yet known and how that uncertainty is impacting.
What you are happy for others to know	A crucial understanding between line manager and staff member. This helps to manage information sharing and ensure sensitivity.
Space for injections	People undertaking things like IVF will often need to inject themselves at certain times in the day. If they are working in an office you should discuss how this can be supported.

3.4.4 Guidance for language

The way colleagues listen and respond will affect how much someone shares and how comfortable they feel about further disclosure. Ask simple, open questions. Let them explain in their own words.

If you wish to share your own personal experience of infertility/treatment that can be helpful. Be careful not to shift the focus away from what the member of staff is sharing however and share your lived experience to show empathy and understanding. The person struggling will above all, be looking for support and examples of hope.

One aspect which is important to understand is that the person will often be researching the subject and be spending time on forums comparing experiences with other people. There is no right or wrong way to respond to this, but people are often surprised to learn how quickly someone dealing with infertility will become immersed in the subject. Even if they do not wish to talk about it, they will constantly be thinking about it.

Things to avoid saying when someone is on their fertility journey:

- "I'm sure it will happen, try and forget about it"
- "Let nature take its course"
- "At least you already have a child" [if they do]
- "Whose problem is it?"

Supportive things which are helpful to say/ask:

- What would you like to tell me?
- Is there anything I can do to support you?
- I don't understand what this is like, but it sounds so difficult

3.4.5 Support available

Counselling - All employees have access to counselling via SimplyHealth. Further details on how to access this can be found on our wellbeing page. There is also the option to add your partner to this (for a monthly fee). This will give them access to the same health benefits, including counselling. Please contact Payroll@eaaa.org.uk to progress this.

Paid leave – EAAA offers 1 week (pro rata for part time) per holiday year for fertility issues. You should agree with your manager how this is used as it may make more sense to see it as 37.5 hours rather than full or half days. This will give you maximum flexibility. The leave is available to both partners so even if someone is not receiving medical assessment at an appointment, they can attend alongside their partner.

Flexible working – Adjusting working hours and locations to work around appointments can be a great help. The core responsibility of the role does need to be delivered so flexible working is best used in conjunction with paid fertility leave.

Wellness Action Plan – this can be used to help frame discussions about what support somebody needs.

3.4.6 Support with the results of a treatment

A fertility journey has different steps within it. Advice below will help detect you to the most appropriate policy/section in different circumstances:

- If the impact of a specific treatment means someone is unable to attend work, e.g. recovery from surgery, then sickness absence arrangements should be followed.
- If a specific treatment was designed to create a pregnancy and is unsuccessful then the principles of the miscarriage section (3.3) should apply.
- If the specific treatment was designed to create a pregnancy and is successful then Charity's Maternity Policy should be followed.

3.4.7 The decision to stop the fertility journey

The decision to stop trying to have children or end fertility treatment is difficult and deeply personal. The decision to stop fertility treatment can be made for the person, or it can be made by the person/couple. The reasons may be emotional, physical or financial: some people limit themselves to a certain number of attempts, while others may set a date or a financial limit and when it's reached, they stop.

The decision will involve speaking with healthcare professionals and may include specialist counselling. Some people feel a huge sense of failure, and some can feel a huge sense of relief that the journey is over. Making contact with others who have come to the same conclusion can also

help, either through specialist support groups or speaking with those you have met through the process.

Your decision to stop treatment will have been made based on the information and medical expertise that is currently available. However, future advances may alter the issue, so don't feel that you have to stick to the decision forever; you can always reconsider at a later date if you feel it appropriate.

3.5 Termination of Pregnancy (T.O.P.)

Staff voice:

> *"This is not something I had considered until it was given to me as an option by a consultant. It wasn't a choice I had ever wanted to make but I had to weigh up whether I could deal with the consequences of me not taking this route. It was something I felt a huge sense of guilt over; I worried about being judged and spent many hours asking myself 'what if…', even though this was made very clear to me.*
>
> *Having someone trustworthy to turn to at work, and that support was available, would have helped me immensely, which is why this policy is so important."*

3.5.1 Definition

A Termination of Pregnancy (T.O.P.) is a procedure to end a pregnancy. It's also sometimes known as an abortion. Most T.O.P.s in England, Wales and Scotland happen before 24 weeks of pregnancy. They can be carried out after 24 weeks in very limited circumstances – for example, if the mother's life is at risk or the child would be born with a severe disability.

There are different types of T.O.P. and the method is ideally decided upon by the pregnant person but is also influenced by the individual's specific medical history.

T.O.P. type	Explanation
Medical T.O.P.	Where the person takes 2 tablets, usually 24 to 48 hours apart, to induce a T.O.P. The tablets do not have to be prescribed following a physical examination, allowing people to manage the entire process themselves from their own home, with prescriptions being issued following a video call with a clinician
Surgical T.O.P.	Where the person has a procedure to remove the pregnancy in a clinical setting. A surgical T.O.P. covers several different procedures so it should not be assumed all surgical T.O.P.s are delivered in exactly the same way.

	The level of anaesthesia and the surgical skills used are varied based on the specific individual.

3.5.2 Why is T.O.P. considered?

The British Pregnancy Advisory Service (BPAS) have shared that 1 in 3 women will have had an T.O.P. by the time they are 45.

There is a legal definition on when an T.O.P. can be performed but looking at the situation with softer language, it can be summarised that an T.O.P. is being considered because:

- There is real physical medical danger to the pregnant person and/or the pregnancy if an T.O.P. does not occur
- Real mental harm will occur to the pregnant person if the pregnancy continues

The individual is likely to feel very conflicted about the procedure. They may feel it is their only option or they may feel, even in cases where the pregnancy stands no chance of surviving birth, that they are being asked to make an impossible choice. There can also be complex religious aspects to their decision making.

3.5.3 Guidance for you, someone impacted by T.O.P.

If you are considering an T.O.P. or have been impacted by it, you may wish to keep this confidential. EAAA can fully support this, but it will mean support will be limited. Further along in this document are suggestions your manager can help put in place for you but if you choose not to involve your manager here are some ideas on what you can legitimately access, without disclosure:

- Wellbeing Days
- Sickness absence – after 7 days of continuous absence you will need to provide a "fit note" from your Doctor. You will need to discuss with your Doctor what they declare on the note to protect your confidentiality
- Accessing SimplyHealth – EAAA receives no information on who is using this service or why they are using it
- Contacting organisations such as the British Pregnancy Advisory Service (BPAS), who have comprehensive and supportive support for people dealing the challenges of T.O.P.

3.5.4 Guidance for you, a colleague/manager of someone who is impacted by T.O.P.

The way colleagues listen and respond will affect how much someone shared and how comfortable they feel about further disclosure. Ask simple, open questions. Let them explain in their own words. Give them time and be prepared for some silences.

Individuals will often have a personal preference on language when discussing the end of their pregnancy. The best advice is to follow the cues of the person you are speaking to and mirror their language.

Suggested language

- "I'm sorry you are going through this"

- "This must be really hard, I'm so sorry."
- "Please let me know if there is anything you need."
- "I'm here if you ever need to talk."

If you wish to share your own personal experience of T.O.P. as that is often helpful. Be careful not to shift the focus away from what the member of staff is sharing however, share your lived experience to show empathy and understanding.

Things to avoid saying:

- "At least T.O.P. is available in our country"
- "Given your situation, it must have been an easy choice"
- "Try not to think about it"
- "It was probably for the best."
- "Everything happens for a reason."

If you're not sure how to start a conversation about T.O.P., these may be helpful:

- How are you feeling?
- What do you feel would help you right now?
- What, if anything, would you like colleagues/the team to know?
- Do you need any time off work?
- Is there anything you need me to find cover for, so you are not worrying while you are off?
- How would you like me to keep in touch while you are away?
- What other support do you have?
- Have you seen the BPAS information on T.O.P. and our own policy on Reproductive Health?

3.5.5 What support is available?

Phased return to work – A phased return, usually offered over one or three weeks, will help someone who feels unable to manage their normal working hours straight away. HR can offer guidance on how this can work. A phased return is always paid at the persons full rate of pay.

A temporary revision to your work pattern and/or place of work may be helpful, especially if you are recovering from surgery, but feel well enough to undertake some desk-based duties.

Wellness Action Plan – this can be used to help frame discussions about what support somebody needs. It can be particularly helpful with the partner of the person who has had the T.O.P., where it is not always clear what support they might need and/or they feel less confident in asking for help.

For those who ask to work during their T.O.P. –support for where they complete their role. For those who are pregnant they often need easy, frequent, access to the bathroom and will have anxiety about bleeding through their clothing. For partners, they may need to take short notice phone calls and suddenly need to travel to their partner.

Flexible working – consider working slightly different hours or locations.

Paid Leave - For the first week, time away from work is treated as compassionate leave and is fully paid. Unlike many employers, EAAA does have paid sickness absence available for staff, which is offered at their normal rate of pay for a certain period of time.

EAAA ask that any other absence as a result of T.O.P. is covered using Sickness Absence allowance. The reason for using the Sickness Absence is as follows:

- If the T.O.P. is affecting your ability to be at work, it is important that your GP is aware and providing support. Treating an absence from work as sickness means the individual has to engage with their GP's surgery to obtain a Fit Note, and gives people more access to support
- There can sometimes be a tendency to ask for different types of paid leave because the reason is "not sickness". It is certainly true that T.O.P. is not sickness, but a better approach may be to change the language around what sickness absence is there for – to cover someone's absence from work because their health has been impacted.

3.6 <u>Menopause</u>

Staff voice

> *"Periods were coming every couple of weeks (not always with warning) and were so incredibly heavy that I had to bring a spare change of clothes to work, wear only dark colours on my bottom half and to go to the ladies every half hour (or less) to change sanitary products."*
>
> and
>
> *"I experience many symptoms from hot flushes (not a flush but like someone has ignited a bonfire inside of you), dizziness, headaches, migraines, aching joints"*

3.6.1 Definition

In clinical terms, 'Menopause' (big 'M') refers to a specific event, the ending of periods. In everyday conversation, 'menopause' (little 'm') is also used to mark the transition from the reproductive phase to the non-reproductive state.

It is generally accepted that this process starts several years before and continues several years after Menopause itself.

The 'perimenopause' is the phase leading up to the menopause, when hormone balance starts to change, this phase typically lasts around 7 years. During this time the person may start to suffer with menopause symptoms but is still having periods. People are said to have reached the menopause when they haven't had a period for a year.

3.6.2 What is menopause like?

The menopause experience is different for everyone and has a large range of symptoms. Many people have mild symptoms, some moderate, and others are severe. Often these symptoms are temporary, but occasionally they're long-lasting. The menopause typically happens between age 45 and 55, but for some can be later.

Symptoms of the perimenopause vary but are commonly listed as:

- Night sweats
- Hot flushes
- Broken Sleep
- Anxiety
- Depression
- Dizziness
- Fatigue
- Memory Loss
- Headaches
- Recurrent urinary tract infection
- Aphasia – forgetting words whilst speaking
- Mood swings
- Vaginal dryness and vaginal atrophy – causing discomfort and pain
- Joint stiffness and aches

For every ten people experiencing menopausal symptoms, six say it has a negative impact on their work. Age, other medical conditions, diet, exercise, adverse childhood events, and the effects of trauma may also impact this transition. Therefore, it's essential to step back and look at the whole picture. It is important not to conclude that every symptom is hormone-related. Instead, it is helpful to gain reliable information about everything that is 'menopause-adjacent'. The greater this understanding, the more people can advocate for the care, interventions or support they need.

Conversely, some people feel immense relief – almost an 'unburdening' and a very positive outlook throughout the peri- and menopause itself. It is important to understand everyone's perspective.

3.6.3 Unexpected menopause

As many as one in 20 people may go through early menopause. Early menopause happens when periods stop before the age of 45. It can occur naturally or as a side effect of some treatments or surgery.

Naturally: premature ovarian failure (also known as primary ovarian insufficiency) possibly due to chromosome abnormalities (e.g. Turner Syndrome in women), an autoimmune disease – where the body attacks its body tissues, certain infections, e.g. mumps, malaria and tuberculosis (this is rare). Premature ovarian failure can sometimes run in families, especially if any relatives went through menopause at a very young age (20s or early 30s).

Cancer treatments: radiotherapy and chemotherapy can cause premature ovarian failure. This occurrence may be permanent or temporary.

Surgical removal of ovaries: the surgical removal of both ovaries will bring on premature or early menopause.

Trans/nonbinary: these employees can sometimes experience menopause symptoms if they are taking hormonal treatments and have to titrate these for any reason

3.6.4 What support is on offer

The most useful place to start is with a Menopause Action Plan, also known as a MAP (see appendix 1). This is where a manager and a staff member sit together and discuss all of the symptoms the individual needs support with and all of the adjustments which can be made. The MAP should be revisited regularly and can explore the possibility of offering any of the following:

- Offering flexibility, including supporting staff to work from home where practicable
- Referral to Occupational Health for specific guidance on how to support those in the workplace who are struggling to manage their symptoms, which is impacting their ability to deliver their role
- Providing a fan and a desk seated near a window that opens
- Allowing the employee to take breaks when needed
- Providing a private area where the employee can rest for a while to help manage their symptoms
- Changing specific duties in the employee's role
- If a uniform is required, can it be layered, can other garments be provided, is the fabric breathable, can the fit be adjusted?
- Provide spare uniform to help with any flooding
- Discuss possibility of accessing shower facilities throughout the day

This list is not exhaustive.

3.6.5 What else can colleagues/managers do?

The best place to start is for colleagues and managers to read and research the topic of menopause. This shows support and understanding for the issue.

It is also important to create a space where people feel comfortable discussing their symptoms (if they want to) and supported if they need a moment to manage a sudden issue. A classic example would be someone experiencing a sudden hot flush. Ask them if they need anything fetching (e.g. a fan, a cold drink, to open a window) and wait for the moment to pass. What you shouldn't do is ignore them, tease or look frustrated.

3.6.6 What can employees do to reduce the impact

The following areas are shown to reduce the impact of the menopause and are offered as some additional suggestions if you or someone you know is struggling.

Stress Reduction

Stress reduction has a significant effect on troublesome menopause symptoms. Even 5-10 minutes of mindfulness meditation per day and breathing exercises, for example, can be incredibly beneficial through lowering the stress response – although cultivating longer practices are recommended for maximum effect. EAAA offers access to the Headspace app for all staff, which can help with relaxation.

Ensuring adequate sleep (7-9 hours per night) is paramount, but menopausal symptoms can make this difficult. Making sure the bedroom is well-ventilated, with the absence of electronic devices, if possible, will help. It also helps to wear light natural clothing, and if possible, use a fan.

To minimise sleep disruption, avoid electronic devices at least 90 minutes before bed and follow a personalised wind-down routine. For example, having a warm bath. If you can, go to bed and get up at the same time every day, including weekends. Ideally, get outside in the morning daylight for at least 20 minutes. Try to have your breakfast close to a window or outside in a naturally lit area whenever possible. Failing this, try to get as much natural light as you can in the morning. These activities will help to regulate your sleep cycle and hormones.

Nutrition

It is important to be curious about food, nutrition and your requirements. One way is to take quality evidence-based short courses, such as those offered free via Future Learn. There is evidence that those who follow a plant-based and wholefood diet have fewer menopausal symptoms and a lower risk of heart disease, diabetes and cancer (MD Andersen Center, 2019).

Even if you do not follow an entirely plant-based diet, aim to focus your meals around fruits, vegetables, whole grains, beans/legumes and nuts/seeds. Try to include foods rich in plant-based oestrogens in your daily diet, e.g. soya beans, chickpeas/hummus, and lentils. Minimise processed and refined foods, including sugar, junk food, animal products, trans fats and alcohol. Consider switching cow's milk for fortified soya/oat/hemp milk (better for heart health). Include minimally processed soya foods in your diet: e.g. edamame beans, tofu, tempeh, miso – helpful for menopausal symptoms, heart and breast health.

Some people find that spicy food, caffeinated drinks and alcohol worsen their symptoms. Alcohol and caffeine can also exacerbate psychological symptoms (e.g. anxiety and low mood). Lived and learned experience indicates that fad diets are the least helpful at this time of life.

Above all else, stay hydrated. Fresh water, herbal teas, reducing or removing caffeine & alcohol can help with minimising symptoms.

Supplements

The following are generally recommended for everyone, irrespective of diet. If you are unsure whether these might be contraindicated with other prescribed medicines, please check with your pharmacist or doctor:

- Vitamin B12: Aim for 10 micrograms (mcg) daily or at least 2000 micrograms once a week
- Vitamin D3: Aim for 10-20 mcg/400-800 IU October-April (in spring/summer, ensure sun exposure to skin on arms/legs/back for at least 20 minutes daily; continue to supplement if not possible). If you are taking certain medicines that make the skin sensitive to sun, always check with your prescribing physician
- Iodine: RDA 150 mcg daily

- Omega 3 Essential Fatty Acids (EFAs): Algae derived (sustainable) combined EPA & DHA (250-500 mg/daily)

Exercise & Movement

Exercise is essential for physical and mental wellbeing, symptom reduction and bone, brain and heart health. Aim to move your body daily. For example, if you like to run or dance, these are beneficial for improving bone density; if not, yoga and Pilates can offer similar benefits and develop strength, improving balance and core strength.

Cardiovascular exercise (a movement that raises your heart rate for a sustained period) and weight-bearing exercise (an activity that increases lean muscle mass, reduces body fat and increases strength) are equally important. If you are a smoker, stopping smoking is one of the best things to reduce your symptoms and improve your long-term health.

Medical Treatments

It is essential to recognise that some people will only experience mild or no symptoms of menopause. They may not need any treatment at all. Others may manage their symptoms with skilful adjustments to their lifestyle. However, some people suffer and struggle with symptoms and will benefit from additional help and support. We recommend finding a suitable health care professional to discuss any medical treatments for menopause symptoms.

Hormone Replacement Therapy (HRT) and Other Treatments

Current treatments used by women for their menopausal symptoms include HRT, clonidine, vaginal lubricants, complementary therapies, herbal remedies and some types of antidepressants. HRT is still the most effective medical treatment for symptoms of menopause. It also protects the brain, heart and bones. All HRT contains the hormone oestrogen. For those who have not had a hysterectomy, a synthetic form of progesterone is also prescribed.

Appendix 1

Menopause Action Plan (Risk Assessment) - MAP

This document helps to structure discussions between an employee and their manager. It can be started whenever the employees feels the management of their menopause needs support at work. The MAP will be more effective if both the employee and the manager have read through the Menopause section in EAAA's "Reproductive Health Policy".

Name of employee		**Manager Completing Assessment**	
Role		**Work Location**	
Date of assessment			

Section A

Setting the scene (can be partially completed in advance by the employee if they wish, then discussed with the manager when completing this document)

How is the menopause affecting you in general?	
How is the menopause specifically affecting you at work?	
Are there any ways EAAA/your manager can help you to feel more comfortable discussing your menopause?	
Are you making any adjustments to your lifestyle to manage your symptoms, which you would like us to be aware of?	
Are you receiving any support for your symptoms from a healthcare professional?	
Please use this section to discuss how much detail you are sharing with colleagues about your menopause. This will help to ensure confidentiality and support the level of awareness you wish to have.	

Section B

Bespoke risk assessment

Area to consider	Further details	Adjustments to consider (This list is not exhaustive and the appropriateness of each adjustment will need to be determined on a case-by-case basis)	Reasonable adjustments agreed	Actions to be completed (Include any specific timescales for completion)
Information on menopause	This will help make sure both employee and manager have similar levels of understanding on what menopause is and how it can impact work	Manager and staff member to read through Reproductive Health Policy Consider additional training in menopause awareness in the workplace		
Workstation adjustments	The work environment we use can help support symptom management	Refresher on hotdesking, and best DSE practice Workstation proximity to toilet and availability of sanitaryware Review work pattern, flexible working		
Temperature – hot flashes and perspiration	The menopause can often cause people to have intense hot flashes and can also cause them to sweat excessively	Location of desk e.g. away from direct sun, near good ventilation Using EAAA issued desk fan		

		Spare uniform available Adjustment to uniform Access to showers during the day Familiarisation of where cold water stations are		
Aches and pains	Menopause symptoms can include physical pain in joints and muscles. The body can also become more prone to damage and strain.	Review manual handling training Review level of manual handling undertaken in role Consider referral to Occupational Health		
Brain fog/memory issues	Memory issues and a feeling of "foggy thinking" can occur due to the menopause.	Do processes need more documentation? Implement a strategy to aid task management (notebook, MS OneNote, etc) Frequency of breaks Referral to Occupational Health		
Change in mood	Mood changes are often towards more negative thinking, such as irritability, becoming more	Flexible working		

	emotional, anxiety or possible apathy	Adjustment to timing of when certain tasks can be carried out		
Uniform	Hot flashes, heavy bleeding and perspiration could all be more easily managed by a change in our clothing.	Review material available for uniform Additional uniform available in case of need to change during shift		
Stress/wellbeing	Changes in lifestyle and reasonable adjustments to an individual's role, can help to reduce the impact of symptoms.	Direction to wellbeing support page Frequent check-ins with manager Review of this document Stress risk assessment		
Space for anything additional				

Section C

You should revisit this document frequently. Please use the table below to update the plan with any changes, or just to record you have checked it through and it remains appropriate.

Date of review	Review undertaken by	Changes in symptoms	Changes in any support