Rapid Appraisal Tool

for

Health Impact Assessment

A task-based approach

Eleventh iteration

Commissioned by the Directors of Public Health of Berkshire, Buckinghamshire, Northamptonshire, and Oxfordshire

Supported by the Faculty of Public Health Medicine

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Health is not merely the concern of the National Health Service (NHS) - there is increasing awareness at all levels of society that policy areas such as education, housing, poverty, and environment all have a key role to play in promoting good health and preventing ill health. But this general understanding of the wider determinants of health does not always translate into formal assessments of the impacts of non-health policy decisions, such as those about local road building or the national food and farming policy, on health.

Although health impact assessment (HIA) is often talked about, it is less often understood. As an approach, HIA has been developed to support people from different backgrounds and in different situations in the assessment of a proposal’s potential impacts on health. The tool presented in this document will enable users to understand better the health impacts of a proposal and to apply this information in policy decision-making.

Health impact assessment may be a particularly useful approach at a time of massive structural change in the NHS involving among other things new responsibilities for primary care and new relationships with local government. HIA is rooted in a partnership approach and involves all those who have an interest in the public health, including local health workers, local government personnel, local people and local communities.

The Faculty of Public Health Medicine has been pleased to add its support to this project; this document will be made available on its website. My thanks go to all those involved in the project, and to Erica Ison in particular.

Sian Griffiths
President, Faculty of Public Health Medicine
December 2001
Acknowledgements

Steering Group

- Sian Griffiths ~ Chair
  Faculty of Public Health Medicine
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  Berkshire Health Authority
- Claire Cheong-Leen
  Berkshire Health Authority
- Michaela Cogan
  Chiltern District Council
- Judi Downward
  Chiltern District Council
- Valerie Elliott
  Aylesbury Vale District Council
- Tracey Ironmonger
  Buckinghamshire Health Authority
- Tom Knowland
  Oxford City Council
- Jane Leaman
  Oxfordshire Health Authority
- Val Messenger
  Oxfordshire Health Authority
- Dot Morrison
  Vale of White Horse District Council
- Jane Reed
  Milton Keynes Council

Pilots

<table>
<thead>
<tr>
<th>Proposal</th>
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<td>Oxford City Council</td>
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<td>Handyvan Scheme for the Elderly</td>
<td>Judi Downward</td>
<td>Chiltern District Council</td>
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<td>Tenancy Support Officer Scheme for Recently Homeless</td>
<td>Jane Reed</td>
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<td>SRB ~ Housing Programme</td>
<td>Ben Cave</td>
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<td>New Settlement and Rapid Transit System</td>
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<td>Cambridge and Huntingdon Health Authority</td>
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<tr>
<td>SRB ~ Housing</td>
<td>Cheryl France</td>
<td>Cambridge and Huntingdon Health Authority</td>
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<td>Housing Estate ~ Retrospective</td>
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<td>Reading Borough Council</td>
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<td>Berkshire Health Authority</td>
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<td>Food and Health Strategy</td>
<td>Valerie Elliott</td>
<td>Aylesbury Vale District Council</td>
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<tr>
<td>Air Quality Management Plan</td>
<td>Felicity Owen &amp; Iona Lidington</td>
<td>Merton, Sutton &amp; Wandsworth Health Authority</td>
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<td></td>
<td>Tom Knowland</td>
<td>Oxford City Council</td>
</tr>
</tbody>
</table>
Acknowledgements of Principal Tool Developer

The support of the Policy Committe of the Faculty of Public Health Medicine has been invaluable.

I am grateful to the Project Steering Group for their guidance and commitment.

I am thankful for the help and hard work of the lead personnel who organised each pilot.

I am indebted to every participant who attended a pilot stakeholder workshop — they have taught me more than I can say.

However, this document would have not seen the light of day had it not been for the support, encouragement and, often, patience of some of my friends and colleagues - to these people, I owe a great deal: Kukuwa Abba, Pat Adams, Jane Biddulph, Clive Blair-Stevens, Chris Bloomfield, Caron Bowen, Ben Cave, Sobia Chaudhry, Valerie Elliott, Muir Gray, Sian Griffiths, Steve Hajioff, Agnes Hibbert, Judith Hooper, Nick Irish, Tracey Ironmonger, Mike Joffe, Tom Knowland, Rosemary Lees, Iona Lidington, Mark McCarthy, Val Messenger, Jenny Mindell, Dot Morrison, Felicity Owen, Colin Perry, Rob Quigley, Jane Reed, Linda Sheridan, Ann Southwell, Judith Stanton, Lorraine Taylor, and Julie Wickham.
Introduction

What is health impact assessment?
Health impact assessment (HIA) is a combination of procedures or methods by which a policy, program, or project may be judged as to the effects it may have on the health of a population (European Centre for Health Policy, 1999).

The results of HIA are used to change a proposal such that the health of the community or population is protected and improved.

For further information about HIA, refer to Appendix 2.

Context for the tool and supporting process
This tool for HIA, and the process developed to support its application, have been designed and refined for use:

- during a participatory stakeholder workshop
- (mainly) in the context of rapid appraisal
- by a range of stakeholders at a local level – from the public, private and voluntary sectors, including community organisations
- on a range of health and non-health proposals

Coverage of this document
Although there are five main stages in the process of HIA, the text in this document relates to only two of them:

- scoping - the second stage
- appraisal - the third stage

Screening (the first stage of HIA) is not described, although reference is made to the outputs from screening and how they can be used to prepare for and undertake a participatory stakeholder workshop.

Decision-making (the fourth stage of HIA) is not described because it fell outside the terms of the commission. However, decision-making is discussed in the context of its relationship to appraisal, to the outputs of appraisal, and to monitoring and evaluation.

Monitoring and evaluation (the fifth stage of HIA) is not described because it also fell outside the terms of the commission. However, the responsibilities of the Steering Group with respect to establishing the basic requirements for monitoring and evaluation are outlined.

Using this document
A task-based approach has been used to structure the contents of this document and thereby provide practical guidance on how to undertake rapid appraisal based on a participatory stakeholder workshop.

There are seven sections, in which are described groups of tasks that relate to undertaking a participatory stakeholder workshop, as follows:

Section 1 - Scoping;
Section 2 - Workshop administration
Section 3 - Information preparation
Section 4 - Preparation for core workshop tasks
Section 5 - Workshop tasks
Section 6 - Reporting the results
Section 7 - The outcomes of decision-making

To make use of this document, the sections as listed above do not necessarily have to be read in sequence; the potential user can access relevant sections as required.

The personnel needed to undertake a participatory stakeholder workshop
are shown in Table 1, together with their roles and responsibilities. Refer to Table 2 to ascertain the tasks that the various personnel involved in the participatory stakeholder workshop should read. Refer to Schedule 1 for the relationship between key events in the process and the timing of tasks involved in a rapid appraisal based on a participatory stakeholder workshop.

**Level of experience required**

This text has been written on the assumption that potential users do not necessarily have an in-depth knowledge of HIA nor much experience of undertaking HIA. However, those with some knowledge and/or experience of HIA will find certain sections useful, especially if they have little or no experience of running and/or leading participatory stakeholder workshops for HIA.

The tasks described have been developed for completion by workshop participants who have not necessarily taken part in an HIA before. However, the core workshop tasks have been designed for use at more than one level and can be adapted for participants who do already have some experience of HIA, especially participatory stakeholder workshops.

For some tasks, where it is not possible to work at more than one level, alternative tasks have been suggested that would be suitable for participants who have some experience of HIA and therefore a more sophisticated understanding of the process.

**Learning by doing**

In this document, the need for careful preparation is stressed, especially if usable and useful outputs are to be obtained from the process, however it is important to bear in mind that HIA as a process exemplifies action research and learning by doing. Although some of the tasks described in this document may represent substantial investments in time for various personnel when they are first undertaken, subsequent HIAs will not require the same investment of time for certain tasks because the work done for previous HIAs can be built upon, e.g. information preparation tasks (Section 3).

**Inequalities**

The impacts of proposal implementation on people suffering from health and other inequalities is addressed throughout the HIA process described in this document - see Sections 1, 3, 4, 5, 6 and 7.
Table 1: Personnel required to undertake a participatory stakeholder workshop together with their roles and responsibilities

<table>
<thead>
<tr>
<th>Personnel</th>
<th>Roles and Responsibilities</th>
</tr>
</thead>
<tbody>
<tr>
<td>Steering Group</td>
<td>• scoping&lt;br&gt;• participating in stakeholder workshop&lt;br&gt;• if not responsible for decision-making, reviewing the quality of the report before it is sent to decision-makers&lt;br&gt;• if responsible for decision-making, considering the recommendations to change the proposal</td>
</tr>
<tr>
<td>Proposal developer(s)</td>
<td>• planning and development of the proposal&lt;br&gt;• presentation at participatory stakeholder workshop&lt;br&gt;• monitoring the implementation of recommendations</td>
</tr>
<tr>
<td>Assessor(s)</td>
<td>• preparing information for participatory stakeholder workshop, including materials to support small group facilitators&lt;br&gt;• facilitation of participatory stakeholder workshop or observation and note-taking at workshop&lt;br&gt;• writing the report/presenting the results of the appraisal&lt;br&gt;• compiling list of recommendations accepted by decision-makers</td>
</tr>
<tr>
<td>Main workshop facilitator</td>
<td>• facilitation of participatory stakeholder workshop</td>
</tr>
<tr>
<td>Main workshop observer</td>
<td>• observation and note-taking at participatory stakeholder workshop</td>
</tr>
<tr>
<td>Main workshop scribe</td>
<td>• note-taking at the participatory stakeholder workshop in support of the main workshop facilitator</td>
</tr>
<tr>
<td>Small group facilitators</td>
<td>• facilitation of small workgroups for the completion of core workshop tasks</td>
</tr>
<tr>
<td>Workshop administrator(s)</td>
<td>• administration of participatory stakeholder workshop</td>
</tr>
<tr>
<td>Chairperson for the workshop</td>
<td>• opening and closing the participatory stakeholder workshop</td>
</tr>
<tr>
<td>Stakeholders</td>
<td>• people involved in or affected by proposal implementation&lt;br&gt;• who are invited to attend the participatory stakeholder workshop&lt;br&gt;• who receive the results of the workshop, and the list of recommendations accepted</td>
</tr>
<tr>
<td>Participants</td>
<td>• stakeholders who participate in the workshop</td>
</tr>
<tr>
<td>Decision-makers</td>
<td>• if the Steering Group are the decision-makers, scoping&lt;br&gt;• if not, representation on the Steering Group&lt;br&gt;• participating in stakeholder workshop&lt;br&gt;• considering the recommendations to change the proposal&lt;br&gt;• notification of the recommendations accepted</td>
</tr>
<tr>
<td>Information management personnel</td>
<td>• preparing information for stakeholder workshop&lt;br&gt;• presentation of information at stakeholder workshop&lt;br&gt;• monitoring and evaluation of indicators and health outcomes</td>
</tr>
<tr>
<td>Evaluator(s)</td>
<td>evaluation of the HIA process</td>
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### Table 2: Tasks for the personnel involved in a participatory stakeholder workshop to read

<table>
<thead>
<tr>
<th>Personnel</th>
<th>Tasks</th>
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<tbody>
<tr>
<td>Steering Group</td>
<td>• Responsible for Tasks 1.1-1.13, and 6.7</td>
</tr>
<tr>
<td></td>
<td>• Refer to Tasks 2.1-2.7 for completion of Task 1.7; refer to Tasks 3.1-3.7 for completion of Tasks 1.5 and 1.8; refer to Tasks 5.1-5.6 for completion of Tasks 1.9 and 1.10; refer to Tasks 6.1-6.6 for completion of Task 1.11; refer to Tasks 7.1-7.2 for completion of Task 1.13; refer to Task 1.11 for completion of Task 6.7</td>
</tr>
<tr>
<td>If Steering Group is responsible for decision-making</td>
<td>see 'Decision-makers’ entry below, and ignore Task 6.7</td>
</tr>
<tr>
<td>Proposal developer</td>
<td>• Responsible for Task 3.2</td>
</tr>
<tr>
<td></td>
<td>• Refer to Tasks 1.13, and 7.2</td>
</tr>
<tr>
<td>Assessor(s)</td>
<td>• Responsible for Tasks 3.1 A or B, 3.6, 3.7, Tasks 4.1-4.6, and Tasks 6.1-6.6; if assessor is main workshop facilitator, Tasks 5.1-5.6</td>
</tr>
<tr>
<td></td>
<td>• Refer to Tasks 7.1, and 7.2</td>
</tr>
<tr>
<td>Information management personnel</td>
<td>• Tasks 3.3, 3.4 and 3.5</td>
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<tr>
<td></td>
<td>• Refer to Tasks 1.13, 7.1, and 7.2</td>
</tr>
<tr>
<td>Workshop administrator(s)</td>
<td>• Responsible for Tasks 2.1-2.7 (see also Summary of Tasks for Workshop Administration, p. 2-1)</td>
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<td>• Refer to Tasks 1.4 and 1.7</td>
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<tr>
<td>Main workshop facilitator</td>
<td>• Tasks 5.1-5.6</td>
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<td>Small group facilitators</td>
<td>• Tasks 5.3-5.6</td>
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<td>Main workshop scribe</td>
<td>• Tasks 5.2, 5.5 and 5.6</td>
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<td>Main workshop observer</td>
<td>• Tasks 5.1-5.6</td>
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<td>• Refer to Task 1.10</td>
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<tr>
<td>Decision-makers</td>
<td>• Tasks 7.1, and 7.2</td>
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<tr>
<td>Evaluator(s)</td>
<td>• All sections, but see in particular Task 1.13</td>
</tr>
<tr>
<td>Personnel responsible for monitoring and evaluation</td>
<td>• Tasks 7.1, and 7.2</td>
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<td>• Refer to Task 1.13</td>
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### Schedule 1: The relationship between the timing of key events and the tasks for a rapid appraisal based on a participatory stakeholder workshop

<table>
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<tr>
<th>Key events in the process</th>
<th>Decision to conduct HIA</th>
<th>First meeting of Steering Group</th>
<th>First mailing: to stakeholders</th>
<th>Second meeting of Steering Group</th>
<th>Deadline for replies from stakeholders</th>
<th>mailing: to participants</th>
<th>Participatory stakeholder workshop</th>
<th>Third meeting of Steering Group</th>
<th>Decision making/ Sending the report to stakeholders</th>
<th>Monitoring &amp; Evaluation/ Sending the report to stakeholders</th>
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<tbody>
<tr>
<td>Section 0 tasks</td>
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<td>Section 2 tasks</td>
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<td>1.1-1.9</td>
<td>1.10, 1.11 &amp; 1.13</td>
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<td>Section 3 tasks</td>
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<td>2.1, then 2.2 &amp; 2.3</td>
<td>2.4 &amp; 2.5</td>
<td>2.6 &amp; 2.7</td>
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</tbody>
</table>
Major learning points from the piloting process

Although each of the tasks described in this document has been developed as a result of learning through the conduct of pilots, there are several major learning points that deserve to be highlighted:

- The advantages of using a tool for HIA to assess proposals.
- The advantages of running a participatory stakeholder workshop.
- The fundamental importance of preparation in order to achieve good-quality outputs from a participatory stakeholder workshop.

**Advantages of using a tool for HIA on proposals**

The advantages of using a tool for HIA include the following:

- It provides a structured framework for the investigation and discussion of the health impacts of both health and non-health proposals.
- It improves the quality of the investigation/discussion:
  - it is possible to identify many more impacts than would be the case without it;
  - it highlights the interrelated nature of causes and effects in public health;
  - it clarifies the way in which a proposal needs to be modified to protect and improve health.

**Advantages of a participatory stakeholder workshop**

The advantages of conducting a participatory stakeholder workshop include the following:

- The added value of being together:
  - learning as individuals and teams across partnerships and within organisations;
  - developing a greater understanding of the different viewpoints and perspectives held by various professions and sectors, including those of the community;
  - being able to make a contribution, and build on the contributions of others;
  - reaching a consensus about priorities for the modification of a proposal.
- An effective use of time to achieve added value for a proposal

**Preparation**

In this document, the importance of preparation is underlined by the number of tasks that need to be undertaken in preparation for the workshop (see Sections 1-4).
Section 1: Scoping

Scoping is the second main stage in the process of HIA - it follows Screening, the first main stage, during which it is decided whether a proposal should be subjected to HIA. [NB: Screening is not described in this document, although the outputs from screening are referred to when they relate to tasks in scoping the HIA and for the appraisal of health impacts.]

Scoping is a critical stage in the process of HIA because it is during Scoping that the boundaries of a particular HIA are set, and the relevant management arrangements are made. These form the foundations for the future conduct of the HIA.

Scoping is usually undertaken by a Steering Group, led by a chairperson appointed by members of the Steering Group. The Steering Group should comprise representatives from key stakeholder groups. Some of the decisions made during Scoping will be informed by decisions that have already been made during Screening.

Summary of Tasks for Scoping

♦ Establishing the aims for the HIA ~ Task 1.1*
♦ Deciding which elements or aspects of the proposal are to be assessed ~ Task 1.2*
♦ Identifying the boundaries for the HIA ~ Task 1.3*
♦ Identifying the stakeholders ~ Task 1.4*
♦ Identifying key information necessary to undertake the HIA ~ Task 1.5*
♦ Establishing the management arrangements for the HIA ~ Task 1.6*
♦ Assigning responsibility for workshop administration ~ Task 1.7*
♦ Assigning responsibility for information preparation ~ Task 1.8*
♦ Assigning responsibility for leading the workshop ~ Task 1.9*
♦ Structuring the workshop: balancing talks and tasks ~ Task 1.10
♦ Establishing the requirements for reporting the results ~ Task 1.11
♦ Clarifying the process for decision-making about the proposal ~ Task 1.12*
♦ Establishing the basic requirements for monitoring and evaluation ~ Task 1.13

A Summary Table for Section 1 (see page 1-2) lists the inputs needed to complete each task, and the destination for, or use of, the outputs from each task.

Meetings of the Steering Group to complete the tasks involved in Scoping

To complete all the tasks in Scoping, it may be necessary for the Steering Group to hold more than 1 meeting. The tasks marked with an asterisk in the Summary above (Tasks 1.1-1.9, and 1.1.2) are those that need to be completed at the first meeting; the others (Tasks 1.9, 1.10, and 1.13) can be completed subsequently. However, it is important that the second meeting is held fairly soon after the first, although it will not require as much time as the first as there are less tasks to complete.

Irrespective of whether one or two meetings are held for the purposes of Scoping, it is vital that detailed notes are taken of the outputs from each agenda item, which should then be produced as minutes as soon after the meeting as possible. The minutes should be circulated immediately to all those involved in preparations for the workshop, and in leading it, because they contain information that will form the basis of work for various people who have been assigned responsibility for other tasks. It is advisable to highlight which outputs are relevant to which personnel ~ the outputs column of the Summary Table for Section 1 can be used as a guide.

Further meetings of the Steering Group (beyond Scoping)

♦ If the Steering Group is not responsible for decision-making about the proposal, it is necessary to have a meeting after the participatory stakeholder workshop to review the quality of the report written by the assessor(s) (see Task 6.7).
♦ If the Steering Group is responsible for decision-making about the proposal, it is necessary to have a meeting after the participatory stakeholder workshop to decide which recommendations to change the proposal to accept.
### Summary Table for Section 1: Inputs needed to complete each task, and the use of outputs from each task

<table>
<thead>
<tr>
<th>Inputs needed to complete task</th>
<th>Task</th>
<th>Destination for/use of outputs from task</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>1.1</td>
<td>Workshop administrator for completion of Task 2.2; notification to all other personnel</td>
</tr>
<tr>
<td>From screening: Health impacts of concern</td>
<td>1.2</td>
<td>Workshop administrator for completion of Task 2.2; assessor(s) for completion of Task 4.1; proposal developer(s) for completion of Task 3.2; notification to all other personnel</td>
</tr>
<tr>
<td>From screening: Vulnerable groups in community; geographical area; health impacts of concern</td>
<td>1.3</td>
<td>Assessor(s); evaluator(s); personnel responsible for information preparation</td>
</tr>
<tr>
<td></td>
<td>1.4</td>
<td>Workshop administrator</td>
</tr>
<tr>
<td></td>
<td>1.5</td>
<td>Personnel responsible for information preparation, including assessor(s)</td>
</tr>
<tr>
<td></td>
<td>1.6</td>
<td>All personnel involved in the workshop</td>
</tr>
<tr>
<td></td>
<td>1.7</td>
<td>Workshop administrator; for information: all personnel involved in the workshop</td>
</tr>
<tr>
<td></td>
<td>1.8</td>
<td>Personnel responsible for information preparation, including assessor(s); notification to workshop administrator(s)</td>
</tr>
<tr>
<td></td>
<td>1.9</td>
<td>Main workshop facilitator; small group facilitators; main workshop observer; main workshop scribe; for information: all other personnel involved in the workshop</td>
</tr>
<tr>
<td>If not first HIA, evaluation(s) of process</td>
<td>1.10</td>
<td>Workshop administrator; main workshop facilitator; small group facilitators; main workshop observer; main workshop scribe; presenters at workshop; assessor(s)</td>
</tr>
<tr>
<td>If not first HIA, evaluation(s) of process</td>
<td>1.11</td>
<td>Assessor(s) for completion of Tasks 6.1-6.6; those responsible for reviewing the quality of the report for completion of Task 6.7; evaluator(s)</td>
</tr>
<tr>
<td></td>
<td>1.12</td>
<td>Chair of workshop; assessor(s)</td>
</tr>
<tr>
<td></td>
<td>1.13</td>
<td>Evaluator(s); proposal developer(s); personnel responsible for monitoring and evaluation</td>
</tr>
</tbody>
</table>
Task 1.1: Establishing the aims for the HIA

**Why**
It is vital to be clear about the aims for the HIA, especially as the process is participatory and will involve a diversity of stakeholders. The aims form the foundation for the HIA, and will influence not only the way the HIA is conducted but also the outputs from the process.

**What**
The aims should reflect the main reasons for undertaking the HIA.

**When**
The aims of the HIA should be established at the first meeting of the Steering Group.

**Who**
The Steering Group is responsible for establishing the aims of the HIA.

**How**
Although it is important to define what needs to be achieved by undertaking a particular HIA, the decision-making process or framework for the proposal must also be taken into account. Moreover, the nature of the aims may be influenced by:
- The values underpinning the introduction or use of HIA in an organisation or partnership.
- The values underpinning the promotion of health and well-being in that organisation or partnership.

**Examples from pilots**
The aims of the HIA for two of the pilots are shown in Box 1.1.

---

**Box 1.1: Examples from Pilots ~ Aims for the HIA**

**Lead organisation: Oxford City Council**

**Proposal: Air Quality Management Plan**
- To identify the potential health impacts of elements that could be included in an Air Quality Management Plan
- To identify options for the Air Quality Management Plan which would optimise health gain

**Lead organisation: Aylesbury Vale District Council**

**Proposal: Healthy Living Centre**
- To inform the writing of the Business Plan for the Healthy Living Centre (HLC), and thereby help to secure funding to improve the development of the HLC and so benefit the community
- To encourage transparency in the inter-agency work for the community
- To act as part of the team-building process for partners in the HLC
Task 1.2: Deciding which elements or aspects of the proposal are to be assessed

**Why**

It is of fundamental importance to consider which elements or aspects of the proposal need to be assessed during the HIA because this decision will influence the boundaries set for the HIA (see Task 1.3). This task also ensures that all participants will be clear about the elements or aspects of the proposal that fall within the boundaries of the HIA.

**What**

When making the decision about which elements or aspects of the proposal to assess, it is important to consider those which are of:

- Greatest priority, bearing in mind local, regional and/or national targets, goals and priorities.
- Greatest concern in terms of potential health impact – some information on this may have been generated during Screening.
- Greatest interest in terms of local needs and circumstances.

The views of the community affected by the proposal's implementation should also be considered.

**When**

The elements or aspects of the proposal that need to be assessed should be decided upon at the first meeting of the Steering Group (see also ‘How’ below).

**Who**

The Steering Group is responsible for deciding which elements or aspects of the proposal should be assessed.

**How**

As there are only 3 hours available for a participatory stakeholder workshop, the following should be taken into account when deciding whether to assess the whole proposal or only certain aspects or elements of it:

- The content and coverage of the proposal.
- The length of the proposal.

*If the HIA is prospective*, it is advisable for the Steering Group to liaise with the personnel who have been involved in planning and development of the proposal and elicit their views on which aspects or elements they will find it useful to receive feedback.

It is also important to ascertain from the proposal developers which elements or aspects of the proposal, if any, are *non-negotiable*. If there are any non-negotiable elements or aspects, it is necessary to inform the assessor(s), who must ensure that small group facilitators are instructed about this, and the other personnel involved in the workshop.

*If the HIA is concurrent or retrospective*, it is advisable for the Steering Group to liaise with people responsible for serving the community or population (e.g. community development workers, health visitors) who will be aware of any relevant problems that have arisen since the proposal was implemented.

**Learning point**

In general, most people feel comfortable when they are asked to assess something tangible, and many people find it easier to appraise a project or programme rather than a policy or strategy because the former types of proposal contain more detail. This learning point is especially pertinent when first introducing HIA into an organisation or partnership because most stakeholders or participants will have no, or very little experience, of the methodology. This lack of experience may make participants feel unconfident or insecure. It is advisable, therefore, particularly when working with those who have limited experience, to concentrate on assessing the *tangible* elements of a proposal, e.g. the Action Plan associated with a Strategy.
Advice

If the Steering Group decides that only certain aspects/elements of the proposal will be assessed, ensure that in the participatory stakeholder workshop participants are given the opportunity of appraising other aspects/elements once they have finished assessing the aspects/elements assigned by the Steering Group. This is because participants may feel, sometimes quite strongly, that there are important potential impacts on health arising from other aspects/elements which should also be addressed. It is always best to let participants raise such issues, even if the attention that can be paid to them during the workshop is only cursory.

Examples from pilots

Proposals for which only certain aspects or elements were assessed:

- **Particular aspect**: HIA of the Housing Theme in an SRB Programme (lead: Cambridge and Huntingdon Health Authority)
- **Particular element**: HIA of the Action Plan of the Food and Health Strategy (lead: Merton, Sutton & Wandsworth Health Authority).

Proposals for which the entire content of the proposal was assessed:

- HIA of the Handyvan Scheme for the Elderly (lead: Chiltern District Council)
- HIA of the Tenancy Support Scheme for the Recently Homeless (lead: Milton Keynes Council)

Alternatives

There are situations when the HIA of a proposal may involve the appraisal of:

- more than one option, in order to identify that (or those) which might be suitable for implementation, for instance, the HIA of options for the Air Quality Management Plan (lead: Oxford City Council);
- more than one phase in the life-cycle of a project, for instance, the building, operation, and decommissioning of new plant such as a power station or waste management facility.

In these situations, it is important for the Steering Group to outline clearly the options or phases that need to be considered during the appraisal.
Task 1.3: Identifying the boundaries for the HIA

**Why**
Identifying the boundaries is a necessary prerequisite to undertaking any HIA. It provides clear guidelines on what will be included in the appraisal. This demarcation of the boundaries gives all participants whatever their role a focus around which they can work on the proposal despite their different knowledge bases, experience and perspectives.

Being explicit about the boundaries of HIA is also part of the drive towards openness and transparency in decision-making.

An explicit statement of the boundaries for an HIA also provides essential baseline information which is useful:
- for monitoring and evaluation both of health outcomes, and of the process of HIA
- when comparing the results of several HIAs, whether in the same policy area but on different populations or on the same population but in different policy areas

**What**
For an HIA based on a participatory stakeholder workshop, it is important to establish the following:
- The community or population affected by the proposal.
- The vulnerable, disadvantaged or marginalised groups within that community or population (some information on this may have been generated during Screening).
- Any neighbouring communities that might be affected by proposal implementation (some information on this may have been generated during Screening).
- The geographical area affected by proposal implementation.
- The factors affecting health/determinants of health through which the main impacts on health might be mediated (some information on this may have been generated during Screening).
- Any potential impacts on health of particular concern (some information on this may have been generated during Screening).
- Depending on the method to be used for prioritising recommendations to change the proposal (see Task 5.6), criteria for prioritisation

**When**
The boundaries for the HIA should be set at the first meeting of the Steering Group.

**Who**
The Steering Group is responsible for identifying the boundaries for the HIA.

**How**
To make these decisions, Steering Group members should reflect on:
- the contents of the proposal - indeed, some of the boundaries may have already been delineated, e.g. the geographical area affected, or the community involved
- their knowledge of the subject area
- their knowledge of the communities or populations involved
- information from Screening, the first stage of HIA

It is also advisable to liaise with those responsible for developing the proposal (who will be most familiar with its contents) to check the appropriateness of the boundaries being set, and if any points of clarification are needed.

A general checklist of vulnerable, disadvantaged or marginalised groups it is worth considering in relation to any proposal is given in Box 1.2.

Suggestions of criteria that could be used for the prioritisation of
recommendations are shown in Box 1.3. When selecting criteria, it is important to choose no more than 1 or 2; beyond this number, it becomes difficult for participants to fulfil the task because there are too many factors to consider.

Tip

For some proposals, particularly those designed to reduce health and other inequalities, the vulnerable, disadvantaged or marginalised groups may comprise what are sometimes referred to as ‘target’ groups (see, for example, Box 3.4, and also Table 4.1 in which are listed the ‘target’ groups for the initiatives that were assessed in the HIA of the Food and Health Strategy, some of whom are vulnerable, for example, low-income families, refugees, and older people in residential homes).

Box 1.2: A general list of vulnerable, disadvantaged and marginalised groups

- Older people
- Lone parents
- Families
- Children
- Young people
- Pregnant women
- Unemployed
- People on a low income
- Homeless
- People from ethnic minority groups
- Refugees and asylum seekers
- People who have a physical disability
- People who have a learning disability
- Carers

Box 1.3: Criteria for prioritisation

- Priority in community
- Priority in organisation or partnership
- Priority regionally and/or nationally
- Effectiveness of intervention
- Amount of benefit to community or population
- Likelihood of benefit to community or population
- Time for benefit to be manifest
- Cost:benefit ratio to maximise benefit and minimise harm
- Impact on public services
Task 1.4: Identifying the stakeholders

**Why**

One of the distinguishing characteristics of HIA as a process is that it is *participatory*. Other distinguishing characteristics of the process are that it is *multidisciplinary* and *intersectoral*. All three characteristics point to a process that requires input from many people, which thus has the potential to explore the richness of knowledge, experience and perspective that exists in relation to any proposal and incorporate it into the decision-making process. Thus, stakeholder identification is vital because all stakeholders should participate in an HIA.

**What**

One of the most helpful definitions of stakeholders in relation to HIA is: “those who are concerned with, or will be affected by the proposal” (Health Promotion Division for the National Assembly for Wales, 1999).

A general list of stakeholder groups worth considering in relation to any proposal is shown in Box 1.4.

**When**

Stakeholders should be identified at the first meeting of the Steering Group.

**Who**

The Steering Group is responsibility for identifying stakeholders with respect to the particular proposal being investigated. This list can be added to by the assessor(s) afterwards.

**How**

A good starting point is to go through the proposal and systematically note the communities, populations, staff groups/personnel, organisations, sectors, etc., that are mentioned on each page. In this way, a fairly comprehensive list of stakeholders can be built up. Once this has been done, it is advisable to brainstorm other stakeholders who may not have been mentioned in the proposal but who will nonetheless be concerned with or affected by its implementation, for example, any neighbouring communities.

**Advice**

It is vital not to limit the identification of stakeholders to the immediately obvious. It is important to take a broad view of who the stakeholders might be, bearing in mind, and being guided by, the wider determinants of health.

**Learning point**

Having identified the stakeholders, it is helpful if key informants are identified in relation to the proposal, as a subset of the stakeholder group. Key informants are people whose roles or standing in the community mean that they have valuable knowledge of relevance to the proposal. By identifying key informants, it enables those responsible for workshop administration to target them for follow-up if they do not respond to the invitation. Such action could secure the participation of key informants in the process.
<table>
<thead>
<tr>
<th>Box 1.4: A general list of stakeholder groups (adapted from Ison, 2000)</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Members of the community or population affected by the proposal</td>
</tr>
<tr>
<td>• Community organisations</td>
</tr>
<tr>
<td>• Community representatives</td>
</tr>
<tr>
<td>• Representatives from neighbouring communities</td>
</tr>
<tr>
<td>• People who have been involved in planning and developing the proposal (sometimes known as “proposal proponents”)</td>
</tr>
<tr>
<td>• Professionals from public sector agencies who provide services to the community or population affected, e.g. local government, health, police and probation services, fire service - include both strategic and operational level staff</td>
</tr>
<tr>
<td>• Representatives from the voluntary sector who provide services to, and advocacy for, the affected community or population, or specific groups within it</td>
</tr>
<tr>
<td>• Representatives from relevant commercial and business sectors</td>
</tr>
<tr>
<td>• Those responsible for decision-making about the proposal</td>
</tr>
<tr>
<td>• Political representatives of the community or population affected, e.g. parish councillors, councillors, MPs, MSPs, MEPs</td>
</tr>
</tbody>
</table>
Task 1.5: Identifying key information necessary to undertake the HIA

Why
If participants are to generate useful and usable outputs during the participatory workshop, it is important to provide information that will help them not only to assess the potential health impacts of the proposal, but also to identify appropriate changes to the proposal.

What
The key sets of information useful to participants are:
- Data comprising a baseline population profile, including any relevant information about the vulnerable, disadvantaged or marginalised groups.
- Data comprising a summary of local environmental conditions relevant to the proposal.
- A summary of the *available* evidence base relating to the potential impacts of the proposal, and to the effectiveness of interventions that could be undertaken to optimise the positive impacts on health.
- A summary of the relevant experience base, i.e. reports of previous HIAs on similar proposals or on the same community or population.

Other information useful to participants includes:
- an introduction to HIA/a resume of the HIA process locally
- proposal documentation (see Task 1.2)
- a list of the vulnerable, disadvantaged or marginalised groups (see Task 1.3)

When
Key information necessary to undertake the HIA should be identified at the first meeting of the Steering Group.

Who
The Steering Group is responsible for identifying the key information necessary to undertake the HIA.

How
The Steering Group should give clear guidance to those responsible for preparing the information by specifying the data they wish to see included in any documentation for the workshop. However, it is important to give personnel the option of adding to the information specifications, as appropriate.

This task can be undertaken in conjunction with Task 1.8.
Refer to Tasks 3.1–3.7 for further details about preparing information for the participatory stakeholder workshop.
Task 1.6: Establishing the management arrangements for the HIA

Why
To achieve the aims of an HIA and obtain good-quality outputs from the process, it is essential to establish appropriate management arrangements. These management arrangements extend not only to the participatory stakeholder workshop, but also to the decision-making process, and to monitoring and evaluation once the proposal has been implemented. Although rapid appraisal does not involve as much work as a comprehensive or in-depth appraisal, it still requires good management if useful and usable outputs are to be obtained.

What
It is vital to define the following management arrangements for the HIA:

- Timetable covering preparations for the workshop, the workshop itself, and reporting arrangements after the workshop.
- Budget available for the HIA, sources of funding, and any major items of expenditure.
- Date, time, and potential venue for the workshop.
- Dissemination of the report.
- Issues associated with dissemination of the report.

The Steering Group needs to appoint various personnel to take part in the participatory stakeholder workshop. The most important role to assign is that of the assessor, or small group of assessors, for the HIA, who will be responsible for:

- Preparation of materials for the conduct of the workshop.
- Writing the report and framing the recommendations.

It is also important to assign responsibility for the following tasks associated with the workshop:

- Leading the workshop.
- Information preparation.
- Workshop administration.

The Steering Group may also choose to appoint a subgroup responsible for co-ordinating the various tasks necessary to preparation for the workshop – workshop administration, information preparation, and preparation of core workshop tasks (Sections 2-4). This is probably advisable as there are so many tasks associated with workshop preparation, the outputs from some of which are dependent on receiving the outputs from others. If it is decided to appoint a subgroup for workshop preparation, it is suggested that the following personnel are included:

- assessor(s)
- main workshop facilitator
- workshop administrator

It may be necessary for these personnel to meet, but most of their business can be conducted via e-mail or on the telephone.

When
The management arrangements for the HIA should be established at the first meeting of the Steering Group.

Who
The Steering Group is responsible for establishing the management arrangements for the HIA.

How
When deciding on the timetable, it is of paramount importance to ensure that the results of the appraisal can be fed into the decision-making process.

When deciding upon the budget, and sources of funding, the items of expenditure shown in Box 1.7 should be considered.
When deciding upon the date, time, and venue for the participatory stakeholder workshop, it is important to consider accessibility for all stakeholders, but particularly for members of the community: the workshop should be held at a venue that is acceptable and accessible to the community. It is also important to consider whether the time of day is acceptable to the community; for example, for the retrospective HIA of the housing estate, we organised two participatory stakeholder workshops, on different days, one in the afternoon, and the other in the evening, in order to give the community a choice about which workshop was most convenient for them to attend.

When considering the dissemination of the report, refer to Task 1.11. When considering issues associated with the dissemination of the report, it is important to take account of ownership, confidentiality, and any sensitivities within the community affected by the proposal.

When deciding upon an assessor, it is best if a member of staff from within the organisation or partnership who has extensive knowledge of the evidence base or whose area of interest coincides with the subject area of the proposal is appointed; this person is likely to be a public health practitioner/specialist, although using the term in its broadest sense, i.e. the specialist does not necessarily have to work within the NHS. In some cases, if there are no suitable internal personnel, it may be necessary to commission external practitioners to undertake the work of the assessor(s).

When deciding upon personnel to lead the workshop, refer to Task 1.9. When deciding upon personnel to prepare the information for the participatory stakeholder workshop, refer to Task 1.8. When deciding upon the personnel to be responsible for workshop administration, refer to Task 1.7.

**Advice**

If an external assessor or group of assessors is appointed, it is advisable to give responsibility for tasks associated with workshop administration and information preparation to personnel in the organisation or partnership, even if they will require some support from the assessor(s). Such personnel will have a good knowledge of the local population and geographical area, and a network of local contacts which will be particularly useful.

### Box 1.5: Items of expenditure that could be incurred during the organisation of a participatory stakeholder workshop

- Hire of venue
- Catering
- Crèche or childcare
- Photocopying information prepared for the workshop
- Mailings to stakeholders/participants (1: letter of invitation; 2: information for the workshop)
- Production and dissemination of report(s) to various stakeholder audiences

*If people external to the organisation are commissioned, consultancy fees for:*

- Assessor
- Independent Evaluator
- Main Workshop Facilitator
- Summary of Evidence/Experience Base

*If the participatory stakeholder workshop is part of an HIA that is more comprehensive:*

- Research, e.g. in the retrospective HIA of the Housing Estate a survey of residents was undertaken which was used to inform the themes covered in the two participatory stakeholder workshops
Task 1.7: Assigning responsibility for workshop administration

Why
For the workshop to run as smoothly as possible, it is important to assign responsibility for workshop administration, i.e. making the practical arrangements.

What
Responsibility needs to be assigned for the following tasks:
- booking the venue
- confirming the date and time of the workshop
- making arrangements for catering
- making arrangements for a crèche/childcare, as relevant
- compiling the invitation list (including names, addresses/e-mail addresses, and possibly telephone numbers) from the list of stakeholders and key informants identified by the Steering Group
- preparing the letter of invitation
- sending the invitations to stakeholders together with any relevant background information
- securing the participation of the main workshop facilitator for the confirmed date and time of the workshop
- securing the participation of the main workshop scribe and main workshop observer for the confirmed date and time of the workshop
- approaching potential small group facilitators for the workshop
- targeting key informants who do not respond to the initial invitation to participate
- preparing the agenda
- collating the information to be sent to participants
- collating the information to be sent to small group facilitators

When
Responsibility for workshop administration should be assigned at the first meeting of the Steering Group.

Who
The Steering Group assigns responsibility for workshop administration.

How
None of the tasks listed above requires specialist knowledge or experience of HIA. As such, it is appropriate to delegate responsibility for these tasks to a person or people who have administration skills, particularly in organising seminars, conferences, or workshops.
Task 1.8: Assigning responsibility for information preparation

**Why**
As there is a diverse range of information needed to undertake an HIA, it is important to distribute the workload according to the skills and knowledge base of available personnel. It is essential therefore to identify each individual responsible for producing the necessary items of information.

**What**
It is advisable to prepare the following information for participants:
- background to HIA or a resume of the HIA process locally
- proposal documentation
- profile of community or population affected by the proposal
- the vulnerable, marginalised or disadvantaged groups in the community or population
- summary of local environmental conditions relevant to the proposal
- summary of the evidence base relevant to the proposal
- summary of the experience base relating to the proposal
A description of what could be included in each of these documents is provided in Tasks 3.1-3.7.

**When**
Responsibility for information preparation should be assigned at the first meeting of the Steering Group.

**Who**
The Steering Group assigns responsibility for information preparation.

**How**
Suggestions about which personnel could be assigned responsibility for preparing the main items of information are given in Table 1.1. For some items of information, for example, the summary of the evidence base and/or of the experience base, depending on the knowledge base of internal personnel, it may be considered more effective to commission a person external to the organisation/partnership, who is considered an expert in the policy area covered by the proposal, to complete either or both of these tasks.

It is helpful to personnel preparing the information if the Steering Group give clear guidance about what they wish to see included in any documentation for the workshop (see Task 1.5). General guidance about the essential contents of each document is given in Table 1.2.
<table>
<thead>
<tr>
<th>Information</th>
<th>Person Responsible for Preparation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Background to HIA/Resume of the HIA process locally</td>
<td>Assessor(s)</td>
</tr>
<tr>
<td>Proposal documentation</td>
<td>Proposal developer(s) or proponent(s)</td>
</tr>
<tr>
<td>Profile of community/population</td>
<td>Staff from information departments in health and/or local government</td>
</tr>
<tr>
<td>Vulnerable groups</td>
<td>Steering Group with support from assessor(s)</td>
</tr>
<tr>
<td>Summary of local environmental conditions</td>
<td>Staff from local government departments, e.g. environmental health, planning, housing and transport</td>
</tr>
<tr>
<td>Evidence base</td>
<td>Assessor(s); if a health-related proposal is being assessed, proposal developer(s)</td>
</tr>
<tr>
<td>Experience base</td>
<td>Assessor(s) or person who has a good knowledge of HIA activity not only locally but also regionally and nationally - they will have an extensive network of contacts on which to draw for unpublished reports or relevant anecdotal information</td>
</tr>
</tbody>
</table>
Table 1.2: Guidance about the essential contents for various items of information for the HIA

<table>
<thead>
<tr>
<th>Information</th>
<th>Essential Contents</th>
</tr>
</thead>
</table>
| Background to HIA/Resume of the HIA process locally | *Background to HIA:* brief outline of the process of HIA; brief outline of the methods/methodology; anticipated outputs from the process; indication of how those outputs will be used  
  *Resume of the HIA process locally:* context in which HIA is being used locally; brief outline of the HIAs undertaken and the key changes made as a result; brief outline of the way the HIA process has developed locally; anticipated outputs from the HIA of the proposal currently under investigation |
| Proposal documentation                            | *For prospective HIAs:* most up-to-date version of proposal; if the proposal is short: complete copy with instructions about which elements/aspects are to be assessed; if the proposal is long: relevant parts of the document to be assessed plus summary of the remainder  
  *For retrospective and concurrent HIAs:* summary of the proposal as implemented |
| Profile of community/population                   | Baseline data about the composition of the community or population (age-sex structure, ethnic minorities, etc.), their health status, and relevant socio-economic data (see Box 3.1) |
| Vulnerable groups                                 | Refer to Box 1.2                                                                                                                                 |
| Summary of local environmental conditions          | Environmental conditions relevant to the implementation of the proposal                                                                         |
| Evidence base                                     | Evidence relating to impacts on health within the proposal’s particular policy area, and to the effectiveness of interventions in that particular policy area |
| Experience base                                   | Summary of HIAs conducted on similar proposals, or in similar policy areas but not necessarily on the same population, and of those conducted on the same population but in different types of proposal or different policy areas |
Task 1.9: Assigning responsibility for leading the workshop

**Why**
If participants are to generate useful and usable outputs during the workshop, it is of paramount importance for the workshop to be led and facilitated well.

**What**
Responsibility needs to be assigned for the following roles:
- main workshop facilitator
- small group facilitators
- main workshop observer
- main workshop scribe
- chairperson for workshop

**When**
Responsibility for leading the workshop should be assigned at the first meeting of the Steering Group.

**Who**
The Steering Group assigns responsibility for leading the workshop.

**How**
The skills required for the various personnel involved in leading the workshop are shown in Box 1.6.
- Main workshop facilitator requires skills 1-3, and ideally skills 4 and 5.
- Small group facilitators require skills 1-3, and preferably skill 4.
- Main workshop observer requires skills 2 and 3 (possibly skill 4).
- Main workshop scribe requires skill 2 and the ability to write legibly under stress/time pressure.
- Chairperson for workshop requires skills 2 and 3 (possibly skill 4)

Suggestions about which personnel could be assigned responsibility for the various roles in leading the workshop are given in Table 1.3. The assessor for the HIA does not necessarily have to fulfil the role of the main workshop facilitator, especially if their facilitation skills are not of a high order. It is best if the workshop is led by someone skilled in facilitation. If the Steering Group considers that there are no internal personnel who have the necessary level of facilitation skills and/or experience in leading participatory stakeholder workshops, it may be advisable to commission an external person to be the main workshop facilitator.

It can sometimes be more helpful for the assessor to be the main workshop observer because he/she then has the opportunity to attend fully to the responses participants make to the tasks. This will be of value when the assessor compiles the report of workshop results and recommendations.

**Tip**
It is sensible to have at least 10 suggestions about people who would be suitable for the role of small group facilitator.

---

**Box 1.6: Skills required of personnel involved in leading the workshop**
1. facilitation skills
2. understanding of the wider determinants of health and the broader public health agenda
3. knowledge of HIA
4. experience of taking part in HIAs
5. experience of leading participatory stakeholder workshops for HIA
Table 1.3: Suggestions about which personnel could be assigned responsibility for various roles involved in leading the participatory stakeholder workshop

<table>
<thead>
<tr>
<th>Role</th>
<th>Personnel</th>
</tr>
</thead>
<tbody>
<tr>
<td>Main workshop facilitator</td>
<td>Assessor, or local person from one of the main agencies involved in the HIA who is skilled in facilitation</td>
</tr>
<tr>
<td>Small group facilitators</td>
<td>Local personnel from the main agencies involved in the HIA who are skilled in facilitation</td>
</tr>
<tr>
<td>Main workshop observer</td>
<td>Assessor, or local person from one of the main agencies involved in the HIA</td>
</tr>
<tr>
<td>Main workshop scribe</td>
<td>Local person from one of the main agencies involved in the HIA</td>
</tr>
<tr>
<td>Chairperson of workshop</td>
<td>Member of Steering Group for the HIA</td>
</tr>
</tbody>
</table>
Task 1.10: Structuring the workshop: balancing talks and tasks

Why
The way in which the workshop is structured will influence the quality of responses from participants. It is necessary to incorporate both talks and tasks into the workshop to achieve the best results. The content of talks should be selected with the aim of helping participants undertake the tasks. However, as workshop time is limited, a balance between the two must be achieved.

When
The structure of the workshop can be decided at the second meeting of the Steering Group.

Who
The Steering Group is responsible for structuring the workshop, with support from the assessor(s) and main workshop facilitator. However, if the Steering Group has appointed a subgroup for workshop preparation, responsibility for this task can be delegated to this subgroup, and suggestions for workshop structure approved at the second meeting of the Steering Group.

a) Talks

What
Irrespective of whether participants have read the information sent out before the workshop, it is important to recap salient points about:
- the aims of the specific HIA
- the proposal
- the community or population affected by the proposal
Other information it is important to give participants:
- a general introduction to the tasks for small workgroups
- the process for reporting and dissemination of the results
- the decision-making process for considering the recommendations to change the proposal
If participants have little or no experience of HIA, it may be necessary to outline briefly:
- the aims of HIA in general, and the HIA process

How
It is important to gauge several factors that will influence how much information is presented to participants in the limited time available:
- The general level of knowledge/experience of HIA that participants are likely to have.
- The extent to which participants can be relied upon to read the workshop information beforehand.
- The amount of time needed for participants to fulfil the workshop tasks and discuss the key outputs.
An appropriate balance needs to be achieved between the time allocated to giving participants information, which is pertinent to HIA and the proposal, and that allocated to tasks during which participants contribute to the appraisal of the proposal.
The personnel best placed to give the various talks/presentations are shown in Table 1.4.

Tip
If participants have little or no knowledge and/or experience of HIA, try to combine a brief sketch of HIA with the general introduction to the tasks for small workgroups.
Alternative talk

If the proposal under assessment is targeted at certain groups in the community or it affects a well-defined community, consider asking a representative from that group/community to present their perspective of the proposal. Invite them to talk about some of the problems they face, and the potential that could be realised within their community. This talk could replace that highlighting salient points from the population profile. This alternative was used during the HIA of the Healthy Living Centre.

Table 1.4: Suggestions about which personnel could be assigned responsibility for giving presentations at the participatory stakeholder workshop

<table>
<thead>
<tr>
<th>Presentation</th>
<th>Personnel</th>
</tr>
</thead>
<tbody>
<tr>
<td>Introduction to workshop/Aims of specific HIA</td>
<td>Chairperson for the workshop</td>
</tr>
<tr>
<td>Salient points of the proposal</td>
<td>Proposal developer/proponent</td>
</tr>
<tr>
<td>Salient points of population profile/local conditions</td>
<td>Information management personnel from health/local government</td>
</tr>
<tr>
<td>Introduction to tasks/HIA</td>
<td>Main workshop facilitator</td>
</tr>
<tr>
<td>Closing remarks – reporting the results, and the decision-making process</td>
<td>Chairperson for the workshop</td>
</tr>
</tbody>
</table>

b) Tasks

What

The tasks it is essential to undertake during the participatory workshop are:
- identifying the health impacts of the proposal (core workshop task; see Task 5.3)
- identifying changes to the proposal that will address those impacts (core workshop task; see Task 5.4)
- prioritising the changes to the proposal (see Task 5.6)

It is also advisable:
- to identify barriers to successful implementation of the proposal (see Task 5.2)

The exact nature of each of these tasks is described in Section 5. Some of these tasks are undertaken in plenary sessions, and others (particularly the core workshop tasks) are undertaken in small workgroups (see Figure 1.1).

How

For the two core workshop tasks, it is advisable to use a semi-structured approach as a way of eliciting useful and usable outputs from participants (see Task 4.5). A series of questions that could be used for this semi-structured approach is presented in Annex 2, which can be adapted according to participants’ general level of:
- understanding of the broader determinants of health.
- knowledge of the evidence base relevant to the proposal under investigation.
- experience of rapid appraisal/HIA.

Learning point

As participants gain experience of the process of HIA, they will be able to respond to the tasks at a greater level of detail.

If participants are relatively inexperienced at HIA:
• Select a relatively simple level of questions (see, for example, Level 1 Questions in Annex 3).
• Allocate as much time as possible to tasks.

*If participants are relatively experienced at HIA:*
• Select a more detailed set of questions (see, for example, Level 2 Questions in Annex 3)

c) Overall structure for workshop

The basic structure for a participatory stakeholder workshop is shown in Table 1.5, which can be used to prepare the agenda (see Task 2.5). The relationship between talks and tasks is presented as a flow diagram in Figure 1.1.

**Table 1.5: Basic structure for a participatory stakeholder workshop (total duration = 3½ hours)**

<table>
<thead>
<tr>
<th>Agenda Item</th>
<th>Time (minutes)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Registration and Graffiti wall</td>
<td>30</td>
</tr>
<tr>
<td>Introduction to workshop</td>
<td>5</td>
</tr>
<tr>
<td><strong>Presentation</strong> about the proposal</td>
<td>10</td>
</tr>
<tr>
<td><strong>Task:</strong> Identifying barriers/conflicts</td>
<td>20</td>
</tr>
<tr>
<td><strong>Presentation</strong> of population profile/local environmental conditions</td>
<td>10</td>
</tr>
<tr>
<td>Introduction to core tasks</td>
<td>5</td>
</tr>
<tr>
<td><strong>Task:</strong> Identifying impacts</td>
<td>30</td>
</tr>
<tr>
<td><strong>Task:</strong> Identifying changes to the proposal</td>
<td>30</td>
</tr>
<tr>
<td>Feedback about impacts/changes</td>
<td>30</td>
</tr>
<tr>
<td>Discussion about impacts/changes</td>
<td>15</td>
</tr>
<tr>
<td><strong>Task:</strong> Prioritisation of changes to the proposal</td>
<td>15</td>
</tr>
<tr>
<td>Closing remarks – What next? (to include reporting and dissemination of the results, and the process for decision-making about the proposal)</td>
<td>5</td>
</tr>
</tbody>
</table>

**Alternative structure for workshop**

An alternative structure for the workshop was used in the retrospective HIA of the housing estate. For these two participatory workshops, we explored impacts on residents’ health within three themes:
1. Community Safety
2. Housing and Estate Design
3. Access to Services and Facilities.

These themes were selected on the basis of responses to a survey of 200 households on the estate. All residents on the estate were invited to participate in the HIA.
As residents are the only people who have direct experience of living on the estate, we felt it was appropriate to give them the opportunity of identifying the health impacts and potential solutions in all three themes. So we used a ‘carousel’ approach in which a facilitator was allocated to each theme, and participants were allocated to one of three workgroups. In this approach, each workgroup ‘visits’ each of the themes in rotation (rather than staying with a facilitator and working on a limited number of themes, as in Task 4.1). On a workgroup’s visit to the first theme, group members identify health impacts within that theme; however, in ‘visits’ to the second and third themes, group members add to or qualify the impacts that have already been identified by other workgroups. The suggested structure for a workshop using the ‘carousel’ approach is shown in Table 1.6, and the relationship between talks and tasks is presented as a flow diagram in Figure 1.2. As the HIA was retrospective, we did not explore barriers to/any conflicts around implementation.

Table 1.6: Basic structure for a participatory stakeholder workshop using the ‘carousel’ approach (total duration = 3 hours)

<table>
<thead>
<tr>
<th>Agenda Item</th>
<th>Time (minutes)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Registration and Graffiti wall</td>
<td>30</td>
</tr>
<tr>
<td>Introduction to the workshop</td>
<td>5</td>
</tr>
<tr>
<td>Introduction to workshop tasks</td>
<td>5</td>
</tr>
<tr>
<td><strong>Task:</strong> Identifying impacts on health in the first theme for a workgroup</td>
<td>25</td>
</tr>
<tr>
<td><strong>Task:</strong> Adding to the impacts already identified in a second theme for a workgroup</td>
<td>15</td>
</tr>
<tr>
<td><strong>Task:</strong> Adding to the impacts already identified in a third theme for a workgroup</td>
<td>15</td>
</tr>
<tr>
<td>Feedback from each ‘theme’ facilitator</td>
<td>30</td>
</tr>
<tr>
<td><strong>Task:</strong> In each workgroup, identifying changes to the proposal for all themes [NB: each facilitator no longer assigned to a particular theme but to a workgroup]</td>
<td>20</td>
</tr>
<tr>
<td>Feedback from each facilitator</td>
<td>15</td>
</tr>
<tr>
<td><strong>Task:</strong> Prioritisation of changes to the proposal</td>
<td>15</td>
</tr>
<tr>
<td>Closing remarks - What next? (to include reporting and dissemination of the results, and the process for decision-making about the proposal)</td>
<td>5</td>
</tr>
</tbody>
</table>

**Differences between the basic structure for a participatory stakeholder workshop and that for one using a ‘carousel’ approach**

The main differences between the basic structure for a participatory stakeholder workshop and that for one using a ‘carousel’ approach are as follows:

- in general, less time is required for the carousel approach (3 hours versus 3.5 hours)
- the number of people in each workgroup (10-12) will probably be higher for the carousel approach than in those for the basic structure workshop (see Task 4.1), depending on the number of themes explored
- owing to the pressure of time available, a simple method of prioritisation will probably be used
Figure 1.1

**REGISTRATION**

**Task:** “What does health mean to you?”

**PLENARY**

**Talk:** Introduction to workshop

**Talk:** Salient points about proposal

**Task:** Barriers to/conflicts around proposal implementation

**Talk:** Salient points from population profile

**Talk:** Introduction to tasks

**Task:** Identify proposal’s impacts on health

**Task:** Identify changes to address proposal’s impacts on health

**Task:** Feedback from workgroups opening into discussion

**Task:** Prioritise recommendations to change proposal

**Talk:** What next?

**WORKGROUPS**
Figure 1.2 Using the Carousel Approach to Explore 3 Themes/Elements during the Workshop

**REGISTRATION**

**Task:** “What does health mean to you?”

**PLENARY**

**Talk:** Introduction to workshop

**Talk:** Salient points about proposal

**Talk:** Introduction to tasks

**Workgroups**

**Task:** Identify proposal’s impacts on health in first theme/element

**Move to second theme/element**

**Task:** Add to impacts identified in a second theme/element

**Move to third theme/element**

**Task:** Add to impacts identified in a third theme/element

**Task:** Feedback from facilitator assigned to each theme

**Task:** Feedback on suggested changes from each workgroup

**Task:** Prioritise recommendations to change proposal

**Talk:** What next?

Rapid Appraisal Tool/Eleventh Iteration/January 2002
Task 1.11: Establishing the requirements for reporting the results

**Why**
If the report of the participatory stakeholder workshop is to be read and acted upon, it is vital for the Steering Group to be clear about the different target audiences to whom it will be disseminated. The nature of the target audiences will determine the reporting requirements for the HIA. It is likely that for some HIAs there will be different reporting requirements for the different stakeholder audiences.

**What**
A general list of stakeholder audiences is shown in Box 1.7. For each of these stakeholder audiences, there are three main considerations when deciding upon the requirements for reporting the results:
- the level of detail in, and length of, the report
- the format of the report
- the style of language and the use of specialist terminology

**When**
The requirements for reporting the results can be established at a second meeting of the Steering Group.

**Who**
The Steering Group is responsible for establishing the requirements for reporting the results.

**How**
Once the stakeholders for an HIA have been identified, it is possible to group those stakeholders into target audiences with respect to reporting the results of the appraisal. Once the target audiences have been identified, it is necessary to define their needs with respect to the level of detail, preferred format, and style of language when reporting the results. Suggestions about various target audiences and the needs they might have with respect to reporting the results are presented in Table 1.7.

---

**Box 1.7: Stakeholder audiences for the report of the HIA**
- The community
- Community organisations
- Community representatives
- Public sector professionals at both strategic and operational levels
- Private sector professionals at both strategic and operational levels
- Voluntary sector personnel, both professionals and volunteers
- Steering or Management Group for HIA
- Decision-makers with respect to the proposal
- Proposal developer(s) or proponent(s)
- Personnel responsible for monitoring and evaluation
Table 1.7: Suggestions about the reporting requirements for various target audiences

<table>
<thead>
<tr>
<th>Target Audience</th>
<th>Reporting Requirements</th>
</tr>
</thead>
<tbody>
<tr>
<td>Steering Group</td>
<td>Full account of impacts on health, and recommendations to change the proposal, in clear, concise language but use of specialist terminology allowed</td>
</tr>
<tr>
<td>Those responsible for decision-making about the proposal</td>
<td>An executive summary, plus a full account of impacts on health, and recommendations to change the proposal, in clear, concise language - if any specialist terminology is used, it must be explained</td>
</tr>
<tr>
<td>Proposal developer(s) or proponent(s)</td>
<td>Full account of the impacts on health, and recommendations to change the proposal, in clear, concise language - if any specialist terminology is used, it must be explained</td>
</tr>
<tr>
<td>Personnel responsible for monitoring and evaluation</td>
<td>Full account of the impacts on health, and recommendations to change the proposal, in clear, concise language but use of specialist terminology allowed</td>
</tr>
<tr>
<td>The community/community organisations and community representatives</td>
<td>Summary of the impacts on health, and recommendations to change the proposal, in clear, concise language avoiding the use of specialist terminology</td>
</tr>
<tr>
<td>Professionals in the public, private and voluntary sectors</td>
<td>Summary of the impacts on health and recommendations to change the proposal, in clear, concise language - if any specialist terminology is used, it must be explained (because the range of professionals in this audience will cross many disciplines)</td>
</tr>
</tbody>
</table>
Task 1.12: Clarifying the process for decision-making about the proposal

Why

The fundamental reason for undertaking an HIA is to effect change, that is, to change a proposal in such a way that its implementation does not compromise the public health, or the health of a particular community. For this reason, it is important to clarify the process by which the results of the participatory stakeholder workshop will be considered by those responsible for decision-making about the proposal.

In the absence of such a process, which has been agreed by all relevant parties, there is a danger that the results of the appraisal will be ignored. This can result in:

- The demotivation of stakeholders/participants.
- The ghetto-isation of HIA, and its dismissal as ineffectual.

What

It is best to integrate HIA into established planning processes within an organisation or partnership, and address the health impacts of specific proposals within a defined framework for action. Some proposals for assessment, however, may fall outside the regular cycle of planning and development.

When

The process for decision-making about the proposal should be clarified at the first meeting of the Steering Group.

Who

It is the responsibility of the Steering Group to clarify, or negotiate, the process for decision-making about the proposal such that the results of the appraisal can be considered.

In some cases, the Steering Group will be responsible for decision-making; in others, it will not.

How

Factors that must be taken into account when clarifying or negotiating the process whereby the results of the appraisal will be considered include:

- The framework for a proposal’s ratification (from planning and development through to final implementation).
- Opportunities in the planning and development process during which the proposal can be changed, e.g. periods of public consultation, or during annual policy review.
- The timeframe available to influence a proposal’s development.
- Willingness on the part of decision-makers to consider a proposal’s impacts on health and the ways in which they can be addressed.

Advice

If the Steering Group is not responsible for decision-making about the proposal, it is helpful if at least one person responsible for decision-making about the proposal is a member of the Steering Group for the HIA. This has the following advantages:

- The Steering Group will have access to someone’s working knowledge of the decision-making process/mechanism.
- The decision-makers will gain an understanding of the process of HIA, and the potential benefits of assessing a proposal in this way.

Tip

If none of the decision-makers responsible for a proposal are members of the Steering Group, ensure that they are invited as participants to the participatory stakeholder workshop. This will
give them an insight into the HIA process, and might have a direct influence on which recommendations to change the proposal they subsequently decide to adopt.

**Examples from pilots**

Decision-making processes or frameworks in which the results of some of the pilot HIAs were considered are shown in Table 1.8.

Table 1.8: Examples from Pilots – Decision-making processes or frameworks in which the results of the appraisal were considered

<table>
<thead>
<tr>
<th>Pilot</th>
<th>Decision-making Process/Framework</th>
</tr>
</thead>
<tbody>
<tr>
<td>Food and Health Strategy</td>
<td>Coronary Heart Disease National Service Framework (CHD NSF)</td>
</tr>
<tr>
<td>Housing Estate ~ Retrospective</td>
<td>Planning and development process for new estate; Council's undertaking to remedy problems on existing estate</td>
</tr>
<tr>
<td>Healthy Living Centre</td>
<td>Development of bid to attract funding</td>
</tr>
<tr>
<td>Air Quality Management Plan</td>
<td>Part of the overall assessment (economic, social and environmental) of options for inclusion in the Air Quality Management Plan</td>
</tr>
</tbody>
</table>
Task 1.13: Establishing the basic requirements for monitoring and evaluation

**Why**
If the fundamental reason for undertaking an HIA is to change a proposal to protect and improve the public health, it is essential to incorporate elements of monitoring and evaluation into the process in order:

- To determine what effects the proposal (as implemented) will actually have.
- To identify ways in which the process of HIA can be improved. [Although good process does not necessarily lead to good outcomes, good process will help to achieve good outcomes (Gray, 2001).]

**What**
The Steering Group should establish the following requirements for monitoring and evaluation:

- Evaluation of the process.
- A process to monitor whether recommendations accepted by decision-makers are implemented.
- Monitoring trends in indicators and health outcomes following proposal implementation.
- Evaluation of trends in indicators and health outcomes following proposal implementation.

**When**
The basic requirements for monitoring and evaluation can be established at the second meeting of the Steering Group.

**Who**
The Steering Group is responsible for establishing the basic requirements for monitoring and evaluation.

**How**

*Evaluation of process*
Process evaluation is fundamental to the development of HIA not only in a given locality but also to the methodology as a whole. It is an important source of information about what works, and where there is a need for improvement.

- Identify criteria for evaluation of the process (see Box 1.8).
- Appoint an evaluator. This person may or may not be independent of the HIA. Appointment of an independent evaluator will guard against bias in the evaluation; however, this option may require extra resources. Non-independent evaluator(s) will probably have a greater understanding of the process on a specific HIA because they are involved as participants.
- Identify a process whereby learning points can be incorporated into the conduct of subsequent HIAs.

*Monitoring the implementation of recommendations*
This is an essential pre-requisite for the monitoring and evaluation of indicators and outcomes because it provides a record of the proposal as implemented against which the actual impacts of the proposal can be judged.

- Identify, in consultation with the proposal developer(s) and those responsible for decision-making about the proposal, a process by which the implementation of the proposal is monitored. This process should include systems for recording the results, and disseminating those results to the personnel responsible for monitoring and evaluation and to the Steering Group responsible for the particular HIA.
Monitoring indicators and health outcomes

Monitoring, and evaluation, of indicators and health outcomes is important to establish the effects on health the proposal actually has.

- Identify indicators that could be used to monitor the effects of proposal implementation. It is most practicable to select those for which data are collected routinely, otherwise there are resource implications.
  
  NB: Participants at the workshop and/or the assessor(s) may make suggestions about appropriate indicators.

- Identify health outcomes that could be used to monitor the effects of proposal implementation. It is most practicable to select those for which data are collected routinely, otherwise there are resource implications.
  
  NB: Participants at the workshop and/or the assessor(s) may make suggestions about appropriate health outcomes to use.

Evaluation of indicators and health outcomes

- Identify the point(s) in time after proposal implementation when indicators and health outcomes are to be evaluated.

These basic requirements will be built on and enlarged by the assessor(s) after the workshop, and the decision-makers following their consideration of the report and recommendations.

Suggestions about personnel who could be involved in the various types of monitoring and evaluation are shown in Table 1.9.
Box 1.8: Suggestions about criteria for the evaluation of the HIA process (those marked with an asterisk have been adapted from Fleeman, 1999)

**Appropriateness**

- Were the boundaries and management arrangements set by the Steering Group appropriate for the HIA?*
- Was the timing of the appraisal appropriate to the opportunities available to change the proposal?*
- Was the information prepared for the workshop participants appropriate to the proposal?
- Was the structure of the workshop appropriate to the proposal, and participants’ knowledge/experience?
- Were the tasks set for participants appropriate for their level of knowledge and/or experience?
- Was the range of health impacts investigated appropriate to the proposal?
- Were the reporting requirements set by the Steering Group appropriate?
- Was the report of the appraisal submitted within an appropriate decision-making process/framework?
- Were the processes for noting the recommendations accepted, and for the implementation of recommendations, appropriate?

**Fulfilling the scope/requirements for the HIA**

- Did the HIA meet the boundaries and management arrangements set by the Steering Group?*
- Did the report written by the assessor(s) meet the requirements of the Steering Group?

**Comprehensiveness**

- Were all relevant local circumstances surrounding implementation taken into account?*
- Were all relevant vulnerable, marginalised, or disadvantaged groups considered during the appraisal?
- Were all relevant determinants of health considered during the appraisal, i.e. those prioritised?

**Inclusiveness**

- Were all the relevant stakeholders invited to attend the participatory stakeholder workshop?

**Feasibility**

- Were the recommendations made to change the proposal practical and feasible?*

**Impartiality**

- Was the assessor impartial?*

---

Table 1.9: Suggestions about personnel who could be involved in the various types of monitoring and evaluation

<table>
<thead>
<tr>
<th>Type of Monitoring or Evaluation</th>
<th>Personnel Involved</th>
</tr>
</thead>
<tbody>
<tr>
<td>Evaluation of process</td>
<td>Evaluator in consultation with the Steering Group, and with the involvement of all stakeholder groups including decision-makers and workshop participants.</td>
</tr>
<tr>
<td>Monitoring the implementation of recommendations</td>
<td>Proposal developer(s) and/or the formal body responsible for proposal implementation.</td>
</tr>
<tr>
<td>Monitoring of indicators and health outcomes</td>
<td>Information management personnel.</td>
</tr>
<tr>
<td>Evaluation of indicators and health outcomes</td>
<td>Information management personnel.</td>
</tr>
</tbody>
</table>
Section 2: Workshop Administration

Workshop administration is best undertaken by personnel skilled in the administration of seminars and conferences. Responsibility for workshop administration is assigned by the Steering Group (see Task 1.7).

All the tasks listed in the Summary below should be completed; however, not all of them are described in this section because they are general to the organisation of any workshop and do not require explanation in terms of HIA.

Summary of Tasks for Workshop Administration

- Booking the venue ~ Task 2.1
- Confirming the date and time of workshop
- Making arrangements for catering (according to needs)
- Making arrangements for crèche/childcare as relevant
- Compiling the invitation list with contact details from the stakeholders’ list prepared by Steering Group (refer to Task 1.4)
- Preparing the letter of invitation ~ Task 2.2
- Sending the invitation to stakeholders
- Securing the participation of key personnel for the workshop ~ Task 2.3
- Targeting key informants (as designated by Steering Group) who are non-responders (refer to Task 1.7)
- Compiling a list of participants ~ Task 2.4
- Preparing the agenda ~ Task 2.5
- Collating the information for participants ~ Task 2.6
- Collating the information for small group facilitators ~ Task 2.7

A Summary Table for Section 2 lists the inputs needed to complete each task, and the destination for, or use of, outputs from each task.

On completion of the first 5 tasks listed in the Summary of Tasks above, including Tasks 2.1 and 2.2: the letter of invitation will be ready for circulation to stakeholders BUT it must be accompanied by the background information/resume on HIA being prepared by the assessor(s) (refer to Task 3.1 A or B)

On completion of Tasks 2.3-2.7: the information needed to undertake the HIA should be ready for circulation to participants and to small group facilitators; however, the successful completion of Tasks 2.6 and 2.7 is dependent on personnel responsible for information preparation fulfilling their tasks according to schedule
Summary Table for Section 2: Inputs needed to complete each task, and the use of outputs from each task

<table>
<thead>
<tr>
<th>Inputs needed to complete task</th>
<th>Task</th>
<th>Destination for/use of outputs from task</th>
</tr>
</thead>
<tbody>
<tr>
<td>From Steering Group: outputs from Task 1.6</td>
<td>2.1</td>
<td>For completion of Tasks 2.2 (letter of invitation) and 2.3 (securing participation of key informants)</td>
</tr>
<tr>
<td>Output from Task 2.1; from Steering Group: output from Tasks 1.1 and 1.2; from assessor(s): output from Task 3.1 A or B</td>
<td>2.2</td>
<td>All stakeholders, including decision-makers; Steering Group; all personnel involved in the workshop</td>
</tr>
<tr>
<td>From Steering Group: outputs from Tasks 1.6 and 1.9: outputs from Task 2.1</td>
<td>2.3</td>
<td>For completion of Tasks 2.6 and 2.7 (mailing to participants, and to small group facilitators)</td>
</tr>
<tr>
<td>Responses from stakeholders to invitation, and key informants to follow-up</td>
<td>2.4</td>
<td>Assessor(s) for completion of Task 4.1; for notification: all participants</td>
</tr>
<tr>
<td>From Steering Group: output from Task 1.10</td>
<td>2.5</td>
<td>For completion of Tasks 2.6 and 2.7 (mailing to participants, and to small group facilitators)</td>
</tr>
<tr>
<td>From Steering Group: memorandum of notification detailing outputs from Task 1.8; from personnel responsible for information preparation, including assessor(s): outputs from Tasks 3.2-3.7; from assessor(s): outputs from Task 4.1</td>
<td>2.6</td>
<td>Circulation of information to all participants</td>
</tr>
<tr>
<td>From Steering Group: memorandum of notification detailing outputs from Task 1.8; from personnel responsible for information preparation, including assessor(s): outputs from Tasks 3.2-3.7; from assessor(s): outputs from Tasks 4.1-4.6</td>
<td>2.7</td>
<td>Circulation of information to small group facilitators</td>
</tr>
</tbody>
</table>
Task 2.1: Booking the venue

**What** Booking the venue, and thereby securing the date and time of the workshop, should be the first task of those assigned responsibility for workshop administration because several of the other tasks are dependent on having this key information confirmed.

**When** Booking the venue should be undertaken immediately upon receiving notification from the Steering Group of the need to organise a participatory stakeholder workshop on a particular proposal.

**Who** The workshop administrator(s) is responsible for booking the venue.

**How** When selecting the venue, it is advisable to consider the following:

- Will it hold the number of people you expect to attend, bearing in mind the plenary sessions?
- Is there enough space for participants to work in small groups?
- Are the catering facilities appropriate to the type of refreshments you wish to provide?
- If members of the community are invited, are there facilities to run a crèche/provide childcare?

**Advice** If you do have not have first-hand experience of the venue, visit before you book to make sure it is suitable for your needs. It is advisable to book a pleasant venue, particularly one that has a source of natural light - it can make a noticeable difference to the atmosphere during the workshop.

**Tip** Notwithstanding any constraints on the budget, it does help if you can provide refreshments for participants. In order to attend the workshop, people will have to give up more than 3 hours of their time (including travel there and back). Therefore, it is best to provide food, e.g. sandwiches or finger buffet, before or after the workshop whichever is appropriate given the timing of the workshop.
Task 2.2: Preparing the letter of invitation

What  The invitation to stakeholders should contain the following information:
- notice of the intention to conduct an HIA on a particular proposal by means of a participatory stakeholder workshop
- aims of the HIA
- a list of any background information enclosed
- date, time and venue for the workshop
- reply slip, including:
  - date by which a response is required
  - participant’s specific needs, e.g. for diet, access, or childcare
  - participant’s previous experience of HIA/rapid appraisal (optional)
  - named contact responsible for queries about the workshop

Enclosures  The letter of invitation to stakeholders may be accompanied by either a brief introduction to HIA (see Task 3.1A) or a resume of the HIA process locally (see Task 3.1B), as decided by the Steering Group.

When  The letter of invitation can be prepared after the venue, date, and time for the workshop have been confirmed, but cannot be sent out until the background information for enclosure has been received from the assessor(s).

Who  The workshop administrator(s) is responsible for preparing the letter of invitation.

Task 2.3: Securing the participation of key personnel for the workshop

Why  Once the venue, date, and time for the workshop have been confirmed, it is vital to ensure that the people assigned responsibility for leading the workshop are available, and can undertake the roles they have provisionally been assigned.

What  It is necessary to confirm arrangements with the following people:
- main workshop facilitator
- main workshop scribe
- main workshop observer
- chairperson for the workshop
- personnel responsible for giving presentations at the workshop, e.g. proposal developer and information management personnel

It is also important to contact the people who have been suggested as small group facilitators to ascertain their willingness to undertake this role. If they are willing to be involved, explain that arrangements for running the small workgroups and detailed instructions about the tasks will be sent to them when all participants for the workshop have been confirmed.

When  Securing the participation of key personnel for the workshop should be done immediately after the venue, date, and time for the workshop have been confirmed.

Who  The workshop administrator(s) is responsible for securing the participation of key personnel for the workshop.
Task 2.4: Compiling a list of participants

Why
Compiling a list of participants is vital because the assessor(s) needs to prepare information for the small group facilitators partly on the basis of the knowledge and experience of participants.
It is also useful to give each participant a list of all participants attending the workshop.

What
The list of participants should include the following details:
• participant’s name
• participant’s organisation or affiliation
• if possible, indication of whether a participant has attended previous local HIAs

When
Compiling a list of participants should be done as soon as stakeholders have responded, and key informants have been targeted (refer to Task 1.4, ‘Learning point’).

Who
The workshop administrator(s) is responsible for compiling a list of participants.

How
The list of participants needs to be collated from responses to the invitation and the results of targeting any key informants who have not responded.
It is helpful to the assessor(s) if the workshop administrator can indicate whether participants have been involved in other HIAs that have been conducted locally. This can be accomplished in one, or both, of the following ways:
• by keeping a record of the involvement of personnel from various agencies/affiliations each time an HIA is conducted locally - these records can be referred to each time a new HIA is to be undertaken
• by eliciting this information on the reply slip on the letter of invitation (see Task 2.2)
If possible, names of small group facilitators should be given as a subset on the list of participants.
Task 2.5: Preparing the agenda

Why  Providing an agenda beforehand will give participants an idea of the structure of the workshop, and their role within it. The agenda will also give an indication of the anticipated outputs from the workshop, which were initially signalled in the aims for the HIA sent out with the invitation to attend.

What  The agenda should include the following information:

- date, time, and venue for the workshop;
- the amount of time scheduled for all items on the agenda, including talks, tasks, and any refreshment breaks;
- for talks, the name of the presenter;
- for all tasks, a brief outline of what the task involves and the arrangements for doing the task (e.g. brainstorm in plenary, work in small groups);
- for feedback sessions, the name of the facilitator.

Suggestions for the basic structure for the workshop are presented in Table 1.5, including time allocations for each talk and task. If a ‘carousel’ approach has been chosen by the Steering Group, suggestions for the structure of the workshop are shown in Table 1.6.

When  Preparing the agenda should be done when key personnel involved in leading the workshop have confirmed their participation.

Who  The workshop administrator(s) is responsible for preparing the agenda.
Task 2.6: Collating the information for participants

Why
As the information for circulation to participants will be prepared by various personnel, and needs to be collated before it can be sent out.

What
It is necessary to compose a covering letter to accompany the collated documents. The covering letter to participants should contain the following details:

- date, time, and venue for the HIA;
- a named contact responsible for organising the workshop;
- notification of the aspects or elements of the proposal to be assessed during the workshop;
- a listing, and brief explanation, of the documents enclosed;
- notification of the small group to which the participant has been allocated for the workshop, including the name and affiliation of the small group facilitator if possible (see Task 4.1).

Enclosures
See Box 2.1.

When
It is advisable to collate the information for mailing to participants at least 2 weeks before the workshop is scheduled to take place to give participants sufficient time to read and assimilate it. However, this task cannot be completed until all those responsible for information preparation have finished their tasks (Tasks 3.2-3.7).

Who
The workshop administrator(s) is responsible for collating the information for participants.

How
To accomplish this task it is necessary for the workshop administrator to liaise with the various personnel responsible for preparing the information for participants, which includes the assessor(s). The memorandum of notification from the Steering Group should include details of who is responsible for preparing the various items of information. The assessor(s) should also provide details of the small workgroups to which participants have been allocated (see Task 4.1).

If information for the workshop has not been prepared according to the schedule laid out by the Steering Group, it could have implications for the quality of the outputs from the workshop. In this situation, the workshop administrator should refer to the chairperson of the Steering Group for advice and support.

Once the information has been collated, it must be sent to participants as soon as possible; if there has been a delay in information preparation for whatever reason, consider sending the mailing first class.

Advice
It is vital to emphasise in the covering letter the need for participants to read the information prepared for the workshop, particularly the proposal documentation, before attending the workshop. This will save time during the workshop because participants will be conversant with the proposal, and therefore in a better position to appraise it.
**Box 2.1: Information to be collated and sent to participants**

- the agenda
- the profile of the community or population affected by the proposal’s implementation
- the vulnerable, marginalised or disadvantaged groups in that community or population
- summary of local environmental conditions, as appropriate
- summary of the evidence base relevant to the proposal
- summary of the experience base relating to the proposal
Task 2.7: Collating the information for small group facilitators

**What**

The bulk of the information for circulation to small group facilitators will be the same as that for participants; however, there will also be some important supporting materials, mainly relating to the core workshop tasks, to circulate.

It is also necessary to compose a covering letter to accompany the collated documents, which should contain the following details:

- date, time, and venue for the HIA
- a named contact responsible for organising the workshop
- the name of the assessor(s) in case of queries
- notification of the aspects or elements of the proposal to be assessed during the workshop
- notification of the specific aspects or elements of the proposal that the facilitator’s small group will be appraising
- a listing, and brief explanation, of the documents enclosed
- an explanation of the supporting materials prepared for small group facilitators to lead the core workshop tasks during the appraisal

**Enclosures**

See Box 2.2.

**When**

It is advisable to collate the information and supporting materials for mailing to small group facilitators at least 2 weeks before the workshop takes place in order to give facilitators sufficient time to read the information, and to examine the supporting materials. However, this task cannot be completed until all those responsible for information preparation have finished their tasks (Tasks 3.2-3.7), and the assessor(s) has finished the preparations for the core workshop tasks (Tasks 4.1-4.6).

**Who**

The workshop administrator(s) is responsible for collating the information for small group facilitators.

**How**

To accomplish this task it is necessary for the workshop administrator to liaise not only with the various personnel responsible for preparing the information for participants, but also with the assessor(s) who is responsible for preparing the supporting materials for small group facilitators. The memorandum of notification from the Steering Group should include details of who is responsible for preparing the various items of information.

If the supporting materials for small group facilitators is not prepared according to the schedule laid out by the Steering Group, this will have implications for the quality of the outputs from the workshop. In this situation, the workshop administrator should refer to the chairperson of the Steering Group for advice and support.

Once the information and supporting materials for small group facilitators have been collated, it must be sent to them as soon as possible; if there has been a delay in preparing the supporting materials for whatever reason, consider sending the mailing first class.

**Advice**

It is vital to emphasise in the covering letter the need for facilitators to be conversant with the aspects or elements of the proposal that have been allocated to their small group for appraisal. It is also recommended that the facilitators familiarise themselves with:

- the tailored version of the tool (see Task 4.4) marked up to show the determinants of health it is a priority for their small group to address in relation to the aspects or elements of the proposal for which they are responsible;
the schedule of questions to be used during the core workshop tasks (see Task 4.5).

Box 2.2: Information, and supporting materials, to be collated and sent to small group facilitators

**Information**
- the agenda
- the profile of the community or population affected by the proposal’s implementation
- the vulnerable, marginalised or disadvantaged groups in that community or population
- summary of local environmental conditions, as appropriate
- summary of the evidence base relevant to the proposal
- summary of the experience base relating to the proposal

**Supporting materials**
- list of instructions
- the tool/list of determinants of health tailored for each small workgroup
- schedule of questions for core workshop tasks
- names and affiliations of participants in small workgroup for which facilitator is responsible
**Section 3: Information Preparation**

Responsibility for information preparation is assigned by the Steering Group (refer to Task 1.8). Suggestions about which personnel could prepare the diverse range of information required to undertake the participatory stakeholder workshop are shown in Table 1.1. The assessor(s) for the HIA has a major role in this series of tasks.

The Steering Group will also have identified information requirements for undertaking the HIA (refer to Tasks 1.5 and 1.8).

**Summary of Tasks for Information Preparation**
- Background information: brief introduction to HIA ~ Task 3.1A
- Background information: resume of the HIA process being undertaken locally ~ Task 3.1B
- Proposal documentation ~ Task 3.2
- Profile of the community or population ~ Task 3.3
- Vulnerable, disadvantaged or marginalised groups ~ Task 3.4
- Summary of local environmental conditions relevant to the proposal ~ Task 3.5
- Summary of the evidence base relevant to the proposal ~ Task 3.6
- Summary of the experience base relating to the proposal ~ Task 3.7

A Summary Table for Section 3 lists the inputs needed to complete each task, and the destination for, or use of, the outputs from each task.

**Timing**
- The document comprising either a background to HIA or a resume of the HIA process being undertaken locally - **Task 3.1 A or B** - needs to be prepared **first** for circulation with the letter of invitation (and therefore in a short amount of time).
- The remaining information/documents - Tasks 3.2-3.7 - need to be prepared for distribution when stakeholders have confirmed their participation at the workshop. Consequently, there may be at least 2-3 weeks and possibly longer available for document preparation.

**Summary Table for Section 3: Inputs needed to complete each task, and the use of outputs from each task**

<table>
<thead>
<tr>
<th>Inputs needed to complete task</th>
<th>Tasks</th>
<th>Destination for/use of outputs from task</th>
</tr>
</thead>
<tbody>
<tr>
<td>From Steering Group: output from Task 1.8; Appendix 2 could be used</td>
<td>3.1A</td>
<td>Workshop administrator (for circulation to all participants)</td>
</tr>
<tr>
<td>From Steering Group: output from Task 1.8; information from HIAs undertaken previously</td>
<td>3.1B</td>
<td>Workshop administrator (for circulation to all participants)</td>
</tr>
<tr>
<td>From Steering Group: outputs from Tasks 1.2 and 1.8</td>
<td>3.2</td>
<td>Workshop administrator (for circulation to all participants)</td>
</tr>
<tr>
<td>From Steering Group: outputs from Tasks 1.5 and 1.8</td>
<td>3.3</td>
<td>Workshop administrator (for circulation to all participants)</td>
</tr>
<tr>
<td>From Steering Group: outputs from Tasks 1.3, 1.5 and 1.8</td>
<td>3.4</td>
<td>Workshop administrator (for circulation to all participants)</td>
</tr>
<tr>
<td>From Steering Group: outputs from Tasks 1.5 and 1.8</td>
<td>3.5</td>
<td>Workshop administrator (for circulation to all participants)</td>
</tr>
<tr>
<td>From Steering Group: outputs from Tasks 1.5 and 1.8</td>
<td>3.6</td>
<td>Workshop administrator (for circulation to all participants)</td>
</tr>
<tr>
<td>From Steering Group: outputs from Tasks 1.5 and 1.8</td>
<td>3.7</td>
<td>Workshop administrator (for circulation to all participants)</td>
</tr>
</tbody>
</table>
Task 3.1A: Background information: brief introduction to HIA

**Why**
For stakeholders who have little or no experience of HIA, it is helpful to provide them with a brief introduction to the methodology so that they can at least familiarise themselves with the basics. The provision of this information may also make them feel more confident about attending the workshop. For those who have heard of HIA, but may be confused about what it might entail, the introduction can clarify some of these issues. Finally, the provision of a brief introduction to HIA beforehand means that precious time during the workshop does not have to be allocated to a general explanation of HIA.

**What**
It is useful if the following information is included in the introduction:
- brief outline of the process of HIA;
- brief outline of the methods/methodology;
- anticipated outputs from the process;
- indication of how those outputs will be used.

**When**
The brief introduction to HIA should be prepared as soon as possible after the first meeting of the Steering Group. Without this, the first mailing including the letter of invitation cannot be sent out.

**Who**
The assessor(s) is most likely to be assigned responsibility for preparing the brief introduction to HIA.

**How**
Information in Appendix 2 can be adapted to write the introduction.

**Advice**
It is important to make the introduction easy to understand, and as clear and concise as possible, otherwise participants may not bother to read it.

**Learning point**
The brief introduction to HIA will have more relevance to stakeholders if it is set in context locally, for instance, by describing the strategic or decision-making framework in which HIA is being integrated, e.g. the Local Strategic Partnership or the implementation of the National Service Frameworks. For examples from the pilots of the decision-making processes or frameworks in which the results of the appraisal were considered, see Table 1.8.
Task 3.1B: Background information: resume of the HIA process being undertaken locally

**Why**

For participants who have gained experience of HIA, it is more useful to provide them with a resume of the introduction and development of HIA locally. This will update them not only on what has been achieved thus far, but also on what has been learnt. Such a resume will demonstrate the usefulness of the methodology, and thereby reinforce the importance of participation, which will encourage stakeholders to continue to participate when relevant.

**What**

It is useful if the following information is included:

- the context in which HIA is being used locally;
- a brief outline of HIAs that have already been undertaken, and the major or key changes that were made as a result;
- a brief outline of the way the HIA process has developed locally as a result of feedback and evaluation of previous HIAs;
- the anticipated outputs from the HIA of the proposal currently under investigation and the framework in which they will be considered.

It may be interesting for stakeholders if the following are also mentioned:

- potential future uses of HIA locally
- potential future developments in the methodology as applied locally
- the contribution the proposal currently under investigation could make to the development of the HIA process

**When**

The resume of the HIA process being undertaken locally should be prepared as soon as possible after the first meeting of the Steering Group. Without this, the first mailing including the letter of invitation cannot be sent out.

**Who**

The assessor(s) will probably be assigned responsibility for preparing the resume of the HIA process being undertaken locally.

**How**

To write the resume, it is advisable to review any HIAs undertaken locally, including any evaluations of the process, and to summarise not only the changes to proposals made as a result, but also the learning points from the process.

Once the first version of the resume has been written, it will be relatively easy to add to, and amend, the basic document as subsequent HIAs are undertaken, and further developments are made to the process.

**Advice**

It is important to make the resume easy to understand, and as clear and concise as possible, otherwise participants may not bother to read it.
Task 3.2: Proposal documentation

**Why**
It is of the utmost importance to provide participants with documentation about the proposal. It is not possible to appraise a proposal effectively in the absence of documentation, giving details of what is involved in proposal implementation.

**What**
- *For prospective HIAs:* circulate the most up-to-date version of the proposal.
- *For retrospective and concurrent HIAs:* circulate a summary of the proposal as it was implemented (which may be different to the proposal that was approved by decision-makers).

**When**
The proposal documentation can be prepared after the first meeting of the Steering Group for circulation in the second mailing (see Tasks 2.6 and 2.7).

**Who**
The proposal developer(s) or proponent(s) are likely to be assigned responsibility for preparing the proposal documentation.

**How**
- If the proposal is a short document, send a complete copy to participants irrespective of whether only certain aspects or elements of it are to be assessed. However, make it clear to participants which aspects or elements are to be appraised.
- If the proposal is a long document and only certain aspects or elements are to be assessed, prepare the relevant parts of the proposal together with a summary of the remainder of the document to give participants some contextual or background information.

It is also important to indicate to participants whether there are any non-negotiable aspects/elements of the proposal.

**Advice**
If parts of the proposal are sensitive, or even confidential, participants must be notified in the covering letter (see Tasks 2.6 and 2.7).

**Examples from pilots**
- For the HIA of the Food and Health Strategy, participants were sent a copy of the Action Plan for delivering the strategy *plus* a summary of the strategy.
- For the HIA of the Healthy Living Centre, participants were sent details of the services to be provided at the HLC *plus* a summary of the bid to secure funding.
Task 3.3: Profile of the community or population

*Why*
As HIA is a methodology that highlights or brings to attention the effects a proposal’s implementation might have on health, it is essential to define, and provide information on, the current health status of the community or population affected, and on that of any vulnerable groups in that community or population. It is also helpful to provide information on socio-economic factors that might influence health.

*What*
For a population profile, the data should cover the following:
- age-sex structure of the community
- composition of the community with respect to ethnic minority groups
- health status data for the community
- socio-economic data for the community

The types of data that could be included in a profile of the population or community affected by the proposal’s implementation are shown in Box 3.1.

*When*
The population profile can be prepared after the first meeting of the Steering Group for circulation in the second mailing (see Tasks 2.6 and 2.7).

*Who*
Staff responsible for information management in health and/or local government are likely to be assigned responsibility for preparing the profile of the community or population affected by proposal implementation.

*How*
For rapid appraisal, including those based around participatory stakeholder workshops, it is usual practice to confine information collection and collation to:
- routine data that are readily available;
- data that are readily available which may have been collated for other purposes, e.g. for a public enquiry.

Data for the profile can be obtained from a variety of sources:
- public health observatory
- information teams at the Strategic Health Authority (SHA), the Primary Care Trust (PCT), or various departments within the local council
- published documents
- grey literature

Depending on the nature of the proposal, it may also be relevant to obtain data from local voluntary organisations.

*Learning points*
Although it is necessary for participants to have a profile of the community or population, it is important not to swamp them with data. It is best to select information that is key to an understanding of the proposal’s potential impacts on the local community or population, including that relevant to the impacts on vulnerable, disadvantaged or marginalised groups.

It is also important to present this information in a readily accessible form.

*Tip*
Once prepared, the population profile can also be used as part of the baseline against which the effects of a proposal can be identified and assessed. It may also be useful for monitoring and evaluation of indicators and health outcomes following proposal implementation.
**Example from pilots**

The data for the profile of the local community which were sent to participants attending the HIA of the Healthy Living Centre are shown in Box 3.2; the sources of these data are shown in the small box within Box 3.2.

<table>
<thead>
<tr>
<th>Box 3.1: Types of data that could be included in a population profile</th>
</tr>
</thead>
<tbody>
<tr>
<td>• number of individuals in community or population</td>
</tr>
<tr>
<td>• age/sex profile of community or population</td>
</tr>
<tr>
<td>• socio-economic groupings in community or population</td>
</tr>
<tr>
<td>• ethnic minority groupings in the community or population</td>
</tr>
<tr>
<td>• index of deprivation within parts of community or population</td>
</tr>
<tr>
<td>• employment/unemployment figures</td>
</tr>
<tr>
<td>• uptake of benefits</td>
</tr>
<tr>
<td>• indicators of health behaviour, e.g. smoking habit, exercise</td>
</tr>
<tr>
<td>• mortality and morbidity figures for key diseases, e.g. coronary heart disease and stroke, cancer, mental health</td>
</tr>
<tr>
<td>• figures on accidents, admissions to A&amp;E, admissions to hospital</td>
</tr>
</tbody>
</table>

*Sometimes, environmental conditions can be included in the population profile.*
### Box 3.2: Examples from Pilots ~ Population profile

**Lead organisation:** Aylesbury Vale District Council

**Proposal:** Healthy Living Centre

#### Information on Deprivation
- Unemployed
- Minority ethnic groups
- Owner-occupiers
- No car
- Occupancy per room
- Lone parents
- Child Poverty Index
- Number of Income Support Claimants
- Number of Unemployment claimants
- Number of Lone Parent claimants

  *For children (<16 years):*
  - Families on Income Support
  - Free school meals
  - English as an additional language
  - Special Needs Education Register

  *For young people:*
  - Unemployment
  - Crimes committed

#### Environment
- Number of nuisance complaints
- Number of arson cases
- Number of burnt out cars

#### Health
- Mental health: number of cases for neighbourhood mediation
- Coronary heart disease and stroke: standardised mortality ratios
- Teenage pregnancies (<18 years)
- Number of drug misusers

#### Learning and work disadvantage
- Number of Schools in Special Measures (by OfSTED)
- Teacher recruitment
- Unemployment profiles: by age, gender, ethnicity and skills level
- Literacy skills level
- Numeracy skills level

#### Community minority groups
- Ethnic minorities
- Single parents
- Carers - profile by age, ethnicity and Income Support

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#### Sources of data
- DETR: Indices of Deprivation 2000 Index
- Income Support Data 1996
- Education Action Zone Submission 1999
- Aylesbury Vale District Council
- Vale Neighbourhood Mediation Report
- Buckinghamshire Health Authority
- Addiction Counselling Trust 2000
- Continuing Education Service
- Buckinghamshire Community Profile 2000
- Getting Equal (Thames Valley Enterprise)
- 1991 Census Data
- Caring on the Breadline 1999 (Carer's Association)
Task 3.4: Vulnerable, disadvantaged or marginalised groups

**Why**

*Equity* is one of the underpinning values for the conduct of HIA, and the majority of practitioners believe it is important to consider not only whether the implementation of a proposal might have impacts on the health of a community/population, but also whether the proposal’s impacts may be different for any vulnerable groups in that community or population, particularly those people who are already suffering from health and/or other inequalities.

**What**

*For proposals that will affect the whole population*: identify the vulnerable, disadvantaged or marginalised groups within the community or population.

*For proposals that are targeted at particular groups in the population*: in this instance, some of the target groups are likely to be vulnerable, disadvantaged or marginalised in some way (see, for example, Table 4.1 in which are listed the target groups for the Food and Health Strategy); however, it may be useful to identify subgroups within these target groups who may be particularly vulnerable.

**When**

The list of vulnerable, disadvantaged or marginalised groups in the community or population can be prepared after the first meeting of the Steering Group for circulation in the second mailing (see Tasks 2.6 and 2.7).

**Who**

The Steering Group will have identified the vulnerable, disadvantaged or marginalised groups in the community during Task 1.3; however, the assessor(s) can supplement this list, as appropriate.

**How**

A systematic way for the assessor(s) to ensure that all the vulnerable, disadvantaged or marginalised groups have been identified by the Steering Group is to go through each aspect or element of the proposal, noting which vulnerable group(s) are mentioned explicitly or could be affected, and then checking whether the group has already been identified. In this way, a relatively comprehensive list of vulnerable groups can be built up.

**Tip**

It is important to allow participants the opportunity in the workshop to add to this list if they feel an important group of vulnerable, disadvantaged or marginalised people has been overlooked.

**Example from pilots**

The vulnerable, disadvantaged or marginalised groups for the HIA of the Affordable Housing Policy are shown in Box 3.3. The vulnerable, disadvantaged or marginalised groups in the HIA of the Handyvan Scheme for the Elderly are shown in Box 3.4 - in this case, older people are the ‘target’ group for the scheme, who are a vulnerable group anyway, and within this group some of the older people are more vulnerable than others.
Box 3.3: Examples from Pilots ~ Vulnerable, disadvantaged or marginalised groups

Lead Organisation: Oxford City Council
Proposal: Affordable Housing Policy

- Low income families
- Lone parents
- Those living in houses where there is multiple occupation
- Ethnic minority communities
- People who have mental health problems
- Homeless people
- Refugees and asylum seekers
- Drug and other substance users
- Key workers, e.g. in health or police services, teachers

Box 3.4: Examples from Pilots ~ Vulnerable, disadvantaged or marginalised groups

Lead Organisation: Chiltern District Council
Proposal: Handyvan Scheme for the Elderly

In this HIA, the ‘target’ group is older people (60 or more years of age) who comprise a ‘vulnerable’ group; however, within this target group, there are some people who are more vulnerable than others, as follows:

- those over 80 years of age (mainly women)
- those who live on their own
- those who have been victims of crime
- those who belong to the Pakistani ethnic minority group
Task 3.5: Summary of local environmental conditions relevant to the proposal

Why
For some proposals, particularly projects that involve either the construction of new infrastructure, build, or plant (e.g. new industrial developments or transport infrastructure) or the major refurbishment of old (e.g. housing programmes, or the reconfiguration of amenities), local environmental conditions may be relevant to the impacts a proposal’s implementation may have. Thus, for participants to be able to identify and characterise some of the potential health impacts, it is helpful to bring any relevant environmental conditions to their attention.

What
Depending on the nature of the proposal, the types of information that may be relevant include:

- transport flows, points of congestion, and accident black spots;
- current levels of pollutants in the various media, i.e. soil, water, air;
- prevailing wind direction, e.g. if odour or stack emissions are a concern;
- noise hotspots;
- geographical locations where vulnerable groups in the community are concentrated, e.g. schools, nursing homes, or particular housing estates.

When
The summary of local conditions relevant to the proposal can be prepared after the first meeting of the Steering Group for circulation in the second mailing (see Tasks 2.6 and 2.7).

Who
It is likely that personnel from local government will be assigned responsibility for preparing the summary of local environmental conditions.

How
The Steering Group will have indicated which of the local environmental conditions may be relevant for consideration during the workshop. However, it is possible for this list of local conditions to be added to by the personnel responsible for compiling the data because they will have a good working knowledge of the local area.

A useful starting point to source such information is the Environmental Health Department of the local council, with support from other departments such as Housing, Planning, and Transport depending on the nature of the proposal.

However, it may be necessary to obtain data from other agencies, such as local housing associations.

Example from pilots
The environmental conditions relevant to the HIA of the Healthy Living Centre were integrated into the population profile and are shown in Box 3.2. The tactic of integrating data about any relevant environmental conditions into the population profile is to be recommended because it reduces the amount of documentation sent to participants.
Task 3.6: Summary of the evidence base relevant to the proposal

**Why**

The ethical use of evidence is one of the underpinning values for the conduct of HIA. Moreover, one of the distinguishing characteristics of HIA is the use of both quantitative and qualitative (or non-quantitative) evidence.

Providing access to the evidence base is fundamental to informing participants’ judgements about a proposal’s potential impacts on health, and the changes they might suggest to address those impacts.

The evidence base is also an important support for the assessor(s) when collating the results from the workshop, writing the report, and framing any recommendations.

**What**

It is helpful to provide participants with the following types of evidence:

- that relating to the impacts on health a particular type of proposal might have;
- that relating to the effectiveness of interventions which could be recommended to minimise the negative and maximise the positive impacts on health.

It is also important to provide evidence of any differential effects of proposal implementation that might be experienced by vulnerable groups in the community or population.

It is helpful for participants if gaps in the evidence can be identified, and/or where the evidence of effect or of effectiveness is uncertain or conflicting.

**When**

The summary of the evidence base relevant to the proposal can be prepared after the first meeting of the Steering Group for circulation in the second mailing (see Tasks 2.6 and 2.7).

**Who**

Usually, the assessor(s) will be assigned responsibility for preparing the summary of the evidence base; however, if a health-related proposal is under investigation, the responsibility may be assigned to the proposal developer(s).

**How**

For rapid appraisals, including those based around participatory stakeholder workshops, it is usual practice to confine the summary of evidence to that which is readily available in the literature, grey literature, or other documents.

It is possible to commission a summary or rapid review of the relevant evidence base. However, this option does require financial resources, which may not be available.

**Learning point**

Although it is necessary for participants to have a summary of the evidence base, it is important not to swamp them with information. It is best to select the evidence that is key to an understanding of the proposal’s potential impacts on the health of the local community or population, and to identifying effective changes to the proposal to address those impacts.

It is also important to present this information in a readily accessible form.

**Tip**

One way of presenting the evidence of impacts on health in a readily accessible form is to condense it into a series of diagrams accompanied by a small amount of explanatory text. Most people find it easier to access information when it is presented in a diagrammatic rather than a textual form.

**Example from pilots**

A neat solution to providing participants with the relevant evidence base in summary form was used by Iona Lidington for the HIA of the Food and...
Health Strategy. She incorporated both the evidence of impacts and that of the effectiveness of interventions into the Action Plan, which was the element of the proposal that the Steering Group had selected for appraisal. Thus, participants had the evidence base presented alongside the proposal (in a tabular format), which not only made the evidence easy for them to access, but also made the evidence easy to apply in relation to the proposal. Moreover, it reduced the amount of documentation sent to participants.
Task 3.7: Summary of the experience base relating to the proposal

Why
The experience base is another source of information that can be used to support the appraisal of a proposal. It represents the experience gained from conducting other HIAs.

What
The experience base relating to a proposal can be derived from two potential sources:
- HIAs conducted on similar proposals or in similar policy areas but not necessarily on the same local population or community.
- HIAs conducted on the local population or community but on different types of proposal or in different policy areas.

When
The summary of the experience base relevant to the proposal can be prepared after the first meeting of the Steering Group for circulation in the second mailing (see Tasks 2.6 and 2.7).

Who
Usually, the assessor(s) will be assigned responsibility for preparing the summary of the experience base. If the assessor(s) is external to the local area, it is advisable for them to consult local personnel about the HIA process being undertaken locally.

How
For rapid appraisals, including those based around participatory stakeholder workshops, it is usual practice to confine information collection to data that are readily available. This is particularly important to bear in mind when attempting to summarise the experience base because this information can be difficult to obtain. It is often recorded in the grey literature (e.g. unpublished reports), sometimes anecdotal, or occasionally held in the minds of those who conducted the HIAs.

For HIAs on similar proposals
Any information gained from this source of experience must be interpreted carefully. It is important to compare not only the profiles of the populations involved, i.e. the one that has been studied with the one about to be studied, but also any local circumstances or conditions, to identify whether there are differences that might affect the outcomes of proposal implementation, the potential health impacts identified, and thereby the recommendations made. Questions that could be posed to ascertain the applicability of HIAs on similar proposals to the local community or population are shown in Box 3.5.

For HIAs on the same population or community
Information gained from this source of experience may indicate in a general way how the local population or community could react to, and be affected by, proposal implementation. For example, for proposals that are targeted at particular vulnerable groups, did people make use of the services on offer, and, if not, why not? Such experience can help to shape the suggestions to change the proposal during the current HIA.

Advice
If some information for the experience base is proving difficult to obtain (for instance, there are issues of confidentiality or sensitivity relating to some unpublished reports, or colleagues have not managed to provide information within the necessary timescale), be pragmatic and limit the summary to experience it is easy to obtain, e.g. that from local HIAs. Remember, there is only limited time available to complete this task.

Tip
To reduce the burden of documentation sent to participants, it may be helpful to incorporate the summary of the experience base into that of the evidence base, especially if the same person is compiling both items of information. However, if the two sets of information are to be incorporated
into one document, ensure that the source of the information presented is made clear.

Box 3.5: Checklist for ascertaining the applicability of HIAs on similar proposals to the local community or population

- Does the population affected by the similar proposal differ from the local population in ways that are likely to be important with respect to:
  - age-sex structure
  - proportion of various ethnic minority groups
  - health status
  - socio-economic factors
  - health behaviours
- Is the level of investment in the similar proposal the same as the level of investment for the proposal being assessed during the current HIA?
- Is the level of service provision in the similar proposal the same as that for the proposal being assessed during the current HIA?
- Is the level of skills for service provision in the similar proposal the same as that for the proposal being assessed during the current HIA?
Section 4: Preparation for Core Workshop Tasks

All the tasks in the preparation for core workshop tasks are undertaken by the assessor(s), with support from other personnel including the proposal developer(s).

Summary of Tasks for Preparation for Core Workshop Tasks

- Allocating elements or aspects of the proposal and participants to small workgroups ~ Task 4.1
- Putting the proposal in context ~ Task 4.2
- Assessing the proposal’s implications for service planning ~ Task 4.3
- Using the determinants of health as prompts during core workshop tasks ~ Task 4.4
- Using a semi-structured approach for core workshop tasks ~ Task 4.5
- Compiling an instruction sheet for small group facilitators ~ Task 4.6

A Summary Table for Section 4 lists the inputs needed to complete each task, and the destination for, or use of, the outputs from each task.

On completion of all tasks in Section 4: the information and supporting materials prepared for facilitators should be to the workshop administrator for circulation to the small group facilitators.

Summary Table for Section 4: Inputs needed for each task, and the use of outputs from each task

<table>
<thead>
<tr>
<th>Inputs needed to complete task</th>
<th>Task</th>
<th>Destination for/use of outputs from task</th>
</tr>
</thead>
<tbody>
<tr>
<td>From workshop administrator: output from Task 2.4</td>
<td>4.1</td>
<td>For completion of Tasks 4.2-4.4; workshop administrator for circulation to participants and small group facilitators</td>
</tr>
<tr>
<td>From Steering Group: output from Task 1.2; output from Task 4.1</td>
<td>4.2</td>
<td>Workshop administrator for circulation to small group facilitators</td>
</tr>
<tr>
<td>From Steering Group: output from Task 1.2; output from Task 4.1</td>
<td>4.3</td>
<td>Workshop administrator for circulation to small group facilitators</td>
</tr>
<tr>
<td>From Steering Group: output from Tasks 1.2 and 1.3; output from Task 4.1; the tool/list of determinants of health in Annex 1</td>
<td>4.4</td>
<td>Workshop administrator for circulation to small group facilitators</td>
</tr>
<tr>
<td>From Steering Group: output from Task 1.2; the tool/list of determinants of health in Annex 1</td>
<td>4.5</td>
<td>Workshop administrator for circulation to small group facilitators</td>
</tr>
<tr>
<td>Outputs from Tasks 4.1-4.5</td>
<td>4.6</td>
<td>Workshop administrator for circulation to small group facilitators</td>
</tr>
</tbody>
</table>
Task 4.1: Allocating elements or aspects of the proposal and participants to small workgroups

**Why**
To make efficient use of the limited time available in the participatory stakeholder workshop, and obtain useful and usable outputs, it is best to allocate participants to small workgroups to complete the core workshop tasks and certain elements or aspects of the proposal to each small workgroup for appraisal.

**When**
Allocating elements or aspects of the proposal and participants to small workgroups should be undertaken once stakeholders have registered as participants for the workshop, and key informants have been targeted.

**Who**
The assessor(s) are responsible for allocating elements or aspects of the proposal and participants to small workgroups.

**How**
**Calculate the number of small workgroups**
Once stakeholders have responded to the invitation to participate, the numbers expected to attend will be known. It is then possible to calculate the number of small workgroups needed. We recommend that workgroups comprise about 5 to 6 people (including their facilitator) – beyond this, group dynamics can be such that some participants will contribute little to the tasks. However, depending on the number of participants, larger groups may sometimes be necessary because of the amount of time needed for feedback about core workshop tasks. As a rough guide: 6 workgroups or less are relatively easy to manage in the plenary feedback session; 7 or 8 are manageable with careful facilitation if workgroups are given, and stick to, strict instructions about feedback requirements in the plenary session; 9 or 10 are difficult to manage effectively in the time available, and the plenary feedback session is likely to over-run and thereby limit discussion time and the task or prioritisation, unless feedback is tightly restricted to a few key points from each task.

**Confirm participation of small group facilitators**
Once you have established the number of small workgroups needed, contact the relevant number of people who provisionally agreed to be facilitators to confirm their participation.

**Calculate the number of elements or aspects of the proposal to be allocated to each small workgroup**
Once the number of small workgroups has been established, you can decide how best to allocate elements or aspects of the proposal. There are several ways in which this can be done, but it is important to cover all the elements or aspects of the proposal specified by the Steering Group. The larger the number of workgroups, the greater the capacity to cover the proposal without demanding too much from each group, although bear in mind the guidelines about the upper limit of small workgroups given above. We recommend you allocate no more than 2-3 elements or aspects of a proposal to each workgroup. Beyond this, participants will struggle to complete the core workshop tasks for each of the elements or aspects.

**Allocate participants to small workgroups**
Once you have established how many and which elements or aspects are to be allocated to each small workgroup, you can allocate participants and facilitators to small workgroups according to their knowledge, experience, and perspective of the specific elements or aspects of the proposal.

**Tip**
If you have a relatively large number of workgroups and a similar number of elements or aspects to be appraised, e.g. 10 elements and 10 groups, instead of allocating one element or aspect to each group, you could ask each group to appraise two elements or aspects, and have two small
workgroups appraising the same elements or aspects of the proposal. This tactic ensures that each element or aspect is appraised thoroughly. Although it is true both workgroups will identify some health impacts that are the same and make some suggestions to change the proposal which are similar, they will also identify different impacts and make different suggestions for change because of differences in participants’ knowledge and experience.

Example from pilots

For the allocation of elements or aspects of the proposal to small workgroups for the HIA of the Food and Health Strategy, see Table 4.1.

Alternatives

If a proposal comprises more than one option for investigation, ensure that there are enough small workgroups to cover all options involved - for example, in the HIA of the Air Quality Management Plan, 2 small workgroups appraised 4 options each. However, if each of the options is of major significance, for instance, when conducting an HIA of two main options for the reconfiguration of health services in an area, it is advisable to ensure that each option is appraised by more than one small workgroup, i.e. in this hypothetical situation, there should be at least 4 small workgroups, 2 groups appraising each of the two options.

If a proposal covers more than one phase of a project’s life-cycle, ensure that there are enough small workgroups to cover each phase of the project’s life-cycle by allocating at least one small workgroup to each phase, but preferably by having more than one small workgroup appraise each phase. For instance, in a situation where there are 3 phases to a proposal - building, operation, and decommissioning - at least 3 small workgroups are needed, but preferably.
It was decided to split participants into 10 small workgroups (2 x A, 2 x B, 2 x C, 2 x D, 2 x E), comprising 4-5 people per group. Each workgroup was allocated between 2 and 4 Action Plan Areas to appraise, but a total of 10 or 11 initiatives per workgroup.

*Table 4.1: Example from Pilots – The allocation of elements or aspects of the proposal (Action Plan Areas) to small workgroups for the HIA of the Food and Health Strategy*

<table>
<thead>
<tr>
<th>Workshop Group</th>
<th>Action Plan Areas</th>
<th>Number of Initiatives</th>
<th>Target Groups</th>
</tr>
</thead>
<tbody>
<tr>
<td>A</td>
<td>Healthcare – Primary Care</td>
<td>3</td>
<td>Clients attending primary care</td>
</tr>
<tr>
<td></td>
<td>Healthcare – Secondary Care</td>
<td>5</td>
<td>Clients in hospital/nursing homes</td>
</tr>
<tr>
<td></td>
<td>Older people</td>
<td>3</td>
<td>Older people in community/residential homes</td>
</tr>
<tr>
<td>B</td>
<td>Schools</td>
<td>6</td>
<td>School age children</td>
</tr>
<tr>
<td></td>
<td>Young people</td>
<td>2</td>
<td>Young people</td>
</tr>
<tr>
<td></td>
<td>Mass media</td>
<td>1</td>
<td>General public</td>
</tr>
<tr>
<td></td>
<td>Supermarkets</td>
<td>2</td>
<td>People purchasing food</td>
</tr>
<tr>
<td>C</td>
<td>Reducing inequity/community settings</td>
<td>7</td>
<td>Low income individuals and families</td>
</tr>
<tr>
<td></td>
<td>Minority ethnic groups</td>
<td>3</td>
<td>Ethnic minorities/refugees</td>
</tr>
<tr>
<td>D</td>
<td>Women of childbearing age</td>
<td>7</td>
<td>Women of childbearing age, particularly pregnant women and new mothers</td>
</tr>
<tr>
<td></td>
<td>Infants and pre-school children</td>
<td>3</td>
<td>Infants and pre-school children in community/nurseries</td>
</tr>
<tr>
<td>E</td>
<td>Workplace</td>
<td>5</td>
<td>Workforce</td>
</tr>
<tr>
<td></td>
<td>Catering</td>
<td>5</td>
<td>Consumers visiting food preparation outlets</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Consumers eating at institutions (public/private)</td>
</tr>
</tbody>
</table>

*Note to Table 4.1: The reason that the Action Plan Areas of ‘Mass media’ and ‘Supermarkets’ were included in the same small workgroup as “Schools” and “Young people” is because there is evidence to show that children and young people have an influence on what food families buy.*
Task 4.2: Putting the proposal in context

**Why**
It is advisable to undertake a brief assessment of the proposal’s importance within the prevailing policy framework. This information can be helpful to participants during the two core tasks of the workshop, but especially when making suggestions to change the proposal, and then assessing which recommendations to prioritise.

**What**
Putting the proposal in context involves assessing whether the proposal meets targets, goals or priorities at a local, regional or national level within 4 major policy areas ~ economic, social, environmental and health.

**When**
The task of putting the proposal in context can be started as soon as the first Steering Group meeting has taken place; however, the task cannot be completed until the outputs of Task 4.1 are available.

**Who**
The assessor(s) in consultation with the proposal developer(s) are responsible for putting the proposal in context. This assessment is then checked by workshop participants in their small workgroups.

**Supporting materials**
Matrix 4.1.

**How**
Use Matrix 4.1 to note whether various elements or aspects of the proposal meet any targets, goals or priorities at a local, regional, or national level within 4 major policy areas.
Matrix 4.1: Putting the proposal in context

Instructions for assessor(s):
- Fill in the name of the proposal
- Fill in the element or aspect of the proposal being assessed
- Fill in the matrix, indicating, by means of a tick in the relevant box, whether this particular element or aspect of the proposal meets a priority, target or goal for any of 4 major policy areas and at what level, i.e. local, regional or national. NB: Any one element or aspect of a proposal may meet more than one priority, target and/or a goal at more than one level, i.e. answers are not mutually exclusive.

Proposal:

Element/aspects of the proposal:

<table>
<thead>
<tr>
<th>Does this element or aspect of the proposal meet a priority, goal or target in any of the following policy areas:</th>
<th>At local level for the community</th>
<th>At local level for own organisation</th>
<th>At local level for a partner organisation</th>
<th>At local level for a partnership</th>
<th>At regional level</th>
<th>At national level</th>
</tr>
</thead>
<tbody>
<tr>
<td>Health</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Social</td>
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<td></td>
</tr>
<tr>
<td>Economic</td>
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<tr>
<td>Environmental</td>
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</tr>
</tbody>
</table>

Instructions for small workgroups:
- Review the matrix above and amend it as appropriate.
- Use this information when undertaking the two core workshop tasks ~ identifying impacts on health (Task 5.3) and changes to the proposal to address those impacts (Task 5.4) ~ and also when prioritising recommendations (Task 5.6).
Task 4.3: Assessing the proposal’s implications for service planning

**Why**
The implementation of any proposal will have implications for service planning in the public, private, or voluntary sectors. If these implications can be identified, it is possible to take them into account when planning services. However, if the implications are not recognised, and thereby ignored during service planning, it is possible that this omission could also have an impact on the community’s health as a result.

**What**
There are two strands to this assessment:
- Determining whether any of the proposal’s potential impacts on health will change the community’s needs for various services, and thereby have implications for service planning.
- Determining whether the proposal involves any changes to current service provision in terms of:
  - configuration
  - volume
  - quality
  - accessibility

And, if so, whether those changes will have an impact on health and therefore the community’s need for various services, and thereby have implications for service planning.

The two main routes by which proposal implementation can influence the need for various services, and thereby have implications for service planning, are shown in Figure 4.1.

**When**
The first strand of this assessment can be undertaken during the workshop. Preparation for the second strand of this assessment can be started after the first meeting of the Steering Group; however, this preparation cannot be completed until the outputs of Task 4.1 are available. If these assessments are not completed by participants during the stakeholder workshop, the assessor(s) must complete them afterwards.

**Who**
If time is available in the workshop, the first strand of the assessment can be conducted by participants in their small workgroups. If time is not available, the assessor(s) must complete the task.

It is the responsibility of the assessor(s) to prepare the second strand of the assessment, in consultation with the proposal developer(s). If time is available workshop participants can complete the task in their small workgroups. If time is not available, the assessor(s) must complete the task.

**Supporting materials**
Matrices 4.2 (blanks), 4.3 (partially completed), and 4.4 (blanks).

**How**
*First strand of the assessment*: After participants have identified the proposal’s impacts on health, it is then possible for them to assess whether any of these impacts will have implications for service planning. Matrix 4.2 can be used to record the results.

*Second strand of the assessment*: The assessor(s) prepares some information beforehand to lessen the workload for participants during the workshop. For each element of the proposal, the assessor(s) identifies and records any changes to service provision on Matrix 4.3. Copies of the partially completed matrices should be sent to the relevant small group facilitators according to the elements or aspects of the proposal for which their workgroup is responsible during the workshop. This information can be used to guide participants when identifying the impacts on health.
mediated by changes in service provision, and the consequent implications for service planning. To record the results, Matrix 4.3 should be completed, in conjunction with Matrix 4.4.

Figure 4.1
Matrix 4.2: Implications for service planning of the health impacts identified during the participatory stakeholder workshop ~ for use during Task 5.3

Instructions for small workgroups:
- Fill in the element or aspect of the proposal being assessed
- Fill in the impact on health which you have identified as being associated with that element/aspect
- Fill in the matrix, indicating by means of a tick in the ‘increase’, ‘decrease’ or ‘no change’ column, whether this particular impact will result in a change in the need for services, and thereby have implications for service planning

Element/aspect of the proposal:

Impact on health:

<table>
<thead>
<tr>
<th>Will this health impact result in a change in the need for any of the following services:</th>
<th>Increase in need</th>
<th>Decrease in need</th>
<th>No change</th>
</tr>
</thead>
<tbody>
<tr>
<td>Health</td>
<td></td>
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</tr>
<tr>
<td>Social services</td>
<td></td>
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<tr>
<td>Respite care</td>
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<td></td>
</tr>
<tr>
<td>Environmental health</td>
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<td></td>
<td></td>
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<tr>
<td>Education</td>
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<tr>
<td>Child care</td>
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<tr>
<td>Housing</td>
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<tr>
<td>Public transport</td>
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<tr>
<td>Leisure &amp; recreation</td>
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<tr>
<td>Planning</td>
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<tr>
<td>Trading standards</td>
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<td>Police</td>
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<td></td>
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<tr>
<td>Probation services</td>
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<tr>
<td>Fire service</td>
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<td></td>
</tr>
<tr>
<td>Emergency planning</td>
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<td></td>
<td></td>
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<tr>
<td>Voluntary sector</td>
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<td></td>
</tr>
</tbody>
</table>
Matrix 4.3: Implications for service planning of changes to service delivery that result from proposal implementation

Instructions for assessor(s):
- Fill in the name of the proposal
- Fill in the element or aspect of the proposal being assessed
- Fill in the first 4 columns of the matrix, with the words ‘increase’ or ‘decrease’, indicating whether this particular element/aspect of the proposal involves a change in the provision of services, and whether that change is in one or more of the following variables: volume, quality, accessibility or configuration

Proposal:

Element/aspect of the proposal:

<table>
<thead>
<tr>
<th>Does this element or aspect of the proposal involve a change in the provision of any of the following services:</th>
<th>Change in volume</th>
<th>Change in quality</th>
<th>Change in accessibility</th>
<th>Change in configuration</th>
<th>Impacts on health?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Health</td>
<td></td>
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<tr>
<td>Social services</td>
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<td>Education</td>
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<td>Voluntary sector</td>
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</tbody>
</table>

Instructions for small workgroups:
Review the matrix above and answer the following questions:
- Are any of these changes in service provision intended to have an impact on health, and will they actually have an impact on health ~ fill in the fifth column of the matrix?
- If so, will the impacts on health have implications for service planning either in the ‘original’ service or in any other services? Responses can be recorded on blanks of Matrix 4.4. Ensure that any copies of Matrix 4.3 that are completed are attached to the relevant copies of Matrix 4.4.
Matrix 4.4: Implications for service planning of the health impacts identified as a result of changes in service provision ~ for use during Task 5.3

Instructions for small workgroups:
- Fill in the change in service provision being assessed
- Fill in the impact on health which you have identified as being associated with that change in service provision
- Fill in the matrix, indicating by means of a tick in the ‘increase’, ‘decrease’ or ‘no change’ column, whether the impact on health as a result of a change in service provision will result in a change in the need for services, and thereby have implications for service planning

Change in service provision:

Impact on health:

<table>
<thead>
<tr>
<th>Will this health impact, mediated by a change in service provision, result in a change in the need for any of the following services:</th>
<th>Increase in need</th>
<th>Decrease in need</th>
<th>No change</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Health</td>
<td></td>
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<tr>
<td>• Social services</td>
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<tr>
<td>• Respite care</td>
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<tr>
<td>• Environmental health</td>
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<tr>
<td>• Education</td>
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<td>• Child care</td>
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<td>• Housing</td>
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<td>• Public transport</td>
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<tr>
<td>• Leisure &amp; recreation</td>
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<tr>
<td>• Planning</td>
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<td>• Trading standards</td>
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<td>• Police</td>
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<td>• Probation services</td>
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<td>• Fire service</td>
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<tr>
<td>• Emergency planning</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Voluntary sector</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Task 4.4: Using the determinants of health as prompts during core workshop tasks

**Why**

The factors affecting health, commonly referred to as the determinants of health, are central to the two core tasks of HIA:

- Identifying the proposal’s impacts on health.
- Identifying what changes could be made to the proposal to address those impacts.

Thus, the determinants of health form the heart of any tool or model for HIA (see Annex 1).

To help participants undertake the two core workshop tasks, small group facilitators can use the determinants of health as prompts to stimulate participants’ assessment of the proposal. To support facilitators in this role, the tool or list of determinants of health can be marked up for each small group facilitator to highlight those determinants of health it is a priority for each small workgroup to explore in relation to the specific elements or aspects of the proposal for which they are responsible.

**When**

This task can be undertaken as soon as the outputs from Task 4.1 are available.

**Who**

The assessor(s) is responsible for preparing the tool/list of determinants of health for use as a prompt during core workshop tasks.

**Supporting materials**

The tool/list of determinants of health - see Annex 1.

**How**

Make a photocopy of the tool/determinants of health for each of the small workgroups. Each workgroup will have been allocated certain elements or aspects of the proposal to appraise (see Task 4.1). For each element or aspect of the proposal allocated to a small workgroup, highlight the determinants of health through which it might act to have an impact on health. Thus, for each of the small workgroups, there will be a copy of the tool tailored to show the determinants of health most likely to be involved in mediating the health impacts of the elements/aspects of the proposal they must consider.

During Scoping, the Steering Group may have identified impacts on health of particular concern or key determinants of health to be considered by participants. This information can be used to support and supplement the assessors’ work in marking-up the tool for small group facilitators.

**Learning points**

The use of a tool/list of determinants of health:

- Increases the efficiency with which participants undertake core workshop tasks.
- Increases the quality of outputs from core workshop tasks by prompting the identification of impacts, and any associated suggestions for change, that would otherwise have been missed in the absence of a tool.

A tailored version of the tool for each workgroup increases efficiency further - participants do not have to waste time scanning the tool for the relevant determinants of health, which is highly desirable as time is so limited in the workshop.

**Advice**

Although each small workgroup has a prompt sheet highlighting the determinants of health it is a priority for them to explore, if there is time it is important for the facilitator to give participants the opportunity to explore any of the other determinants of health in relation to the...
elements/aspects of the proposal they are appraising.

**Tips**

*Depending on your situation:*

- *Participants new to HIA.* It is probably best not to give individual participants a copy of the tool/list of determinants of health or even a ‘tailored’ version of the tool. At first sight, the tool can seem overwhelming and may put participants off.

- *Participants gaining experience.* Once participants have gained experience in HIA, but particularly in participatory stakeholder workshops, it may be helpful to provide them with a copy of the tool, which they can use as an aide-memoire when completing tasks.

Whatever your situation, **always** give tailored versions of the tool to the small group facilitators.

**Example from pilots**

The tool has been reproduced in Annex 2 and flagged to show the determinants of health each of the small workgroups (designated as Groups A through to E) in the HIA of the Food and Health Strategy was asked to explore in relation to various Action Plan Areas. (Annex 2 should be read in conjunction with Table 4.1, in which information on the Action Plan Areas allocated to each small workgroup is presented.)
Task 4.5: Using a semi-structured approach for core workshop tasks

Why
If useful and usable outputs are to be obtained during the workshop, it is important for small group facilitators to take a semi-structured approach to the two core workshop tasks. Successful completion of the core workshop tasks requires that participants take a broad perspective on various elements/aspects of the proposal. This may prove difficult at first for some people because it can appear to be a boundless task; this difficulty is compounded by the short amount of time available during the workshop. Thus, to achieve useful and usable outputs, it is advisable to give the core workshop tasks a structure or framework.

What
One of the best ways to introduce structure or framework, and thereby give participants a focus, is to pose a series of questions within the task, i.e. use a semi-structured approach.

When
This task can be undertaken as soon as stakeholders have registered as participants for the workshop, and key informants have been targeted. It is then possible to assess the level of knowledge and experience of HIA that the majority of participants will have.

Who
The assessor(s) are responsible for deciding which questions it is appropriate to use during core workshop tasks.

Supporting materials
Schedule of questions: Level 1 and Level 2 - see Annex 3.

How
The decision about which questions to use during the two core tasks will be influenced by:

- The level of experience that participants have.
- The nature and quality of the available evidence in relation to the proposal.
- Participants’ knowledge of the available evidence in relation to the proposal.

Depending on your situation:

- Participants new to HIA/relatively poor evidence base. For each of the core workshop tasks, you could use the questions designated as Level 1 in Annex 3. Amend or alter this list according to your circumstances or needs.
- Participants gaining experience/relatively good evidence base. For each of the two core workshop tasks, you could use the questions designated as Level 2 in Annex 3. Amend or alter this list according to your circumstances or needs.
- It is also possible to use a combination of the questions from Levels 1 and 2, depending on participants’ experience and the quality of the evidence base.
Task 4.6: Compiling an instruction sheet for small group facilitators

Why
As small group facilitators are responsible for leading the two core workshop tasks around which the whole HIA pivots, it is helpful to compile an instruction sheet. In order to encourage the achievement of useful and usable outputs, small group facilitators need to use a battery of supporting materials which may at first sight appear confusing if not accompanied by a full explanation and a set of instructions.

What
The instruction sheet should contain the following:
- Instructions to ‘open’ the small workgroup session:
  - introductions of workgroup members
  - appointing a small group scribe
  - appointing a person responsible for feedback to the plenary session
- Explanation of how to use the following supporting materials:
  - Putting the proposal in context (refer to Task 4.2): Matrix 4.1 filled out for each element/aspect of the proposal to be assessed, which the small workgroups can review and amend as appropriate;
  - Identifying the proposal’s impacts on health (Task 5.3): the ‘prompt’ sheet, i.e. the tool marked up to show which factors affecting health/determinants of health it is a priority for facilitators to explore with their small workgroup (see Annex 2 as an example); Schedule of questions (see Task 4.5, and Annex 3A)
  - Assessing the proposal’s implications for service planning (Task 4.3): blanks of Matrix 4.2 - to be filled out during the workshop after the proposal’s impacts on health have been identified; Matrix 4.3 filled out for each element/aspect of the proposal to be assessed, which can then be used to ascertain whether the changes to service provision intended in the proposal will have impacts on health, which in turn can then have implications for service planning (fill out blanks of Matrix 4.2);
  - Identifying changes to the proposal (Task 5.4): Schedule of questions (see Task 4.5, and Annex 3B);
  - Prioritising changes to the proposal (Task 5.6): Criteria for prioritisation

When
The skeleton of the instruction sheet can be started after the first meeting of the Steering Group; however, the task cannot be completed until the outputs from Tasks 4.1-4.5 are available.

Who
The assessor(s) are responsible for compiling the instruction sheet for small group facilitators.

How
The basic framework for the instruction sheet is shown in Box 4.1. This framework can be adapted according to needs and circumstances for each particular HIA.
Box 4.1: Instruction sheet for small group facilitators ~ amend as appropriate

Task 5.3: Identifying the impacts on health

Materials required for recording responses
- Flip-chart
- Marker pens (at least 2)

Supporting materials
- Notification of the elements or aspects of the proposal that have been allocated to your small workgroup
- Tool/list of determinants of health, marked up to show the determinants it is a priority for your small workgroup to explore
- List of the vulnerable, marginalised, or disadvantaged groups in the community or population
- Completed versions of Matrix 4.1 (putting the proposal in context)
- Blank versions of Matrix 4.2, partially completed versions of Matrix 4.3, blank versions of Matrix 4.4 (implications for service planning)

Information for reference
- Population profile
- Summary of local conditions relevant to the proposal
- Summary of the evidence base relevant to the proposal
- Summary of the experience base relevant to the proposal

Time allocated to complete the task
30 minutes

Instructions

1. Ask workgroup members to introduce themselves, giving their name and affiliation; start the introductions by introducing yourself.

2. Identify a scribe willing to record the responses to the two core workshop tasks.

3. Identify a person willing to be responsible for feedback for the two core workshop tasks.

4. Explain that as the small group facilitator for the core workshop tasks you have materials to help prompt participants during the exercises but that you are also allowed to contribute to the responses.

5. Ask participants to review the completed versions of Matrix 4.1, and amend as appropriate.

6. Identify the potential impacts on health of the elements or aspects of the proposal for which your small workgroup is responsible. You can take a semi-structured approach to this task, using the questions below. You can use the tool showing the determinants of health it is a priority for your small workgroup to explore to prompt participants in their responses. Take into account the Information prepared for the workshop (see above), as relevant. Make sure that you appraise the proposal’s impacts on any vulnerable, marginalised, or disadvantaged groups in the community or population (see list) ~ allow participants to add to this list if they feel a vulnerable group has been overlooked. If time is available, address the proposal’s implications for service planning as a result of its impacts on health ~ use Matrices 4.2, 4.3, and 4.4 to record the responses.

Insert here the questions selected by the assessor(s) from Annex 3A

If time is available, and once all tasks have been completed, some participants may wish to identify the health impacts of elements or aspects of the proposal that were not selected by the Steering Group. Allow them to do this quickly, but do not compromise the workgroup’s time to complete Task 5.4.
Box 4.1 continued: Instruction sheet for small group facilitators ~ amend as appropriate

Task 5.4: Identifying changes to the proposal

Materials required for recording responses
- Flip-chart
- Marker pens (at least 2)

Supporting materials
- Notification of the elements or aspects of the proposal that have been allocated to your small workgroup
- Responses to Tasks 5.2, and 5.3
- Tool/list of determinants of health, marked up to show the determinants it is a priority for your small workgroup to explore
- List of the vulnerable, marginalised, or disadvantaged groups in the community or population

Information for reference
- Population profile
- Summary of local conditions relevant to the proposal
- Summary of the evidence base relevant to the proposal
- Summary of the experience base relevant to the proposal

Time allocated to complete the task
30 minutes

Instructions
1. Review which of the determinants of health were involved in causing the impacts on health the workgroup identified (responses to Task 5.3), and determine which of these determinants appear to be more influential than the others. Use these as a focus around which to devise suggestions to change the proposal to minimise the negative and maximise the positive impacts on health. You can refer to the tool if this helps.

2. Review the barriers/threats to, and conflicts around, proposal implementation (responses to Task 5.2).

3. Identify changes to the proposal to protect and improve health, including that of the vulnerable, marginalised, or disadvantaged groups (see list). You can take a semi-structured approach to this task, using the questions below. You can refer to the tool if this helps. Take into account the Information prepared for the workshop (see above), as relevant. Make sure that any of the suggestions devised to change the proposal do not have a negative impact on any of the vulnerable, marginalised, or disadvantaged groups in the community or population.

Insert here the questions selected by the assessor(s) from Annex 3B

Towards the end of the time allocated to this task (~5-10 minutes), especially if participants are beginning to run out of suggestions, you can ask if they feel anything is missing from the proposal which if included would bring health gain, or have a positive impact on health. Make sure that any of the suggestions to add to the proposal do not have a negative impact on any of the vulnerable, marginalised, or disadvantaged groups in the community or population.
**Section 5: Workshop Tasks**

**Summary of Workshop Tasks**
- Graffiti wall ~ Task 5.1
- Identifying barriers/threats to, and conflicts around, proposal implementation ~ Task 5.2
- Identifying the impacts on health ~ Task 5.3
- Identifying changes to the proposal ~ Task 5.4
- Feedback and discussion of health impacts and of suggestions to change the proposal ~ Task 5.5
- Prioritising changes to the proposal ~ Task 5.6

A Summary Table for Section 5 lists the inputs needed to complete each task, and the destination for, or use of, the outputs from each task.

**Summary Table for Section 5: Inputs needed to complete each task, and the use of outputs from each task**

<table>
<thead>
<tr>
<th>Inputs</th>
<th>Tasks</th>
<th>Outputs</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>5.1</td>
<td>Assessor(s) for completion of Task 6.2</td>
</tr>
<tr>
<td></td>
<td>Alternative to 5.1</td>
<td>Assessor(s) for completion of Task 6.2</td>
</tr>
<tr>
<td>From Steering Group: values underpinning HIA in organisation or partnership</td>
<td>5.2</td>
<td>Assessor(s) for completion of Task 6.3</td>
</tr>
<tr>
<td>Proposal documentation; from personnel responsible for information preparation: evidence base; experience base; population profile; vulnerable groups; local environmental conditions; from assessor(s): instruction sheet; tool marked up - prompt sheet; schedule of questions; Matrix 4.3 (partially completed); blanks of Matrices 4.2 and 4.4</td>
<td>5.3</td>
<td>Assessor(s) for completion of Task 6.4</td>
</tr>
<tr>
<td>Outputs from Tasks 5.2 and 5.3; proposal documentation; from personnel responsible for information preparation: evidence base; experience base; population profile; vulnerable groups; local environmental conditions; from assessor(s): instruction sheet; schedule of questions;</td>
<td>5.4</td>
<td>Assessor(s) for completion of Tasks 6.5 and 6.6</td>
</tr>
<tr>
<td>Outputs from Tasks 5.3 and 5.4</td>
<td>5.5</td>
<td>Assessor(s) for completion of Tasks 6.5 and 6.6</td>
</tr>
<tr>
<td>Outputs from Tasks 5.3 and 5.4; from Steering Group: criteria for prioritisation</td>
<td>5.6</td>
<td>Assessor(s) for completion of Tasks 6.5 and 6.6</td>
</tr>
</tbody>
</table>
Task 5.1: Graffiti wall

**What**
This is a warm-up exercise for the participants which takes place before the formal structure of the workshop.

**When**
During registration (see Figure 1.1).

**Question**
‘What does health mean to you?’

**Why**
This task is designed to help participants begin to focus on the workshop’s overarching purpose in a relaxed way. It is an informal exercise by which to introduce the many different meanings health has for participants. It also enables each participant to appreciate these differences in perspective, and to reflect on their own, without being publicly challenged. This is particularly helpful when the majority of participants do not know one another well, or have not worked with one another before.

The task is also valuable in that the majority of responses tend to reveal definitions based on a broad model of health which reflects many of the determinants of, or factors affecting, health. Thus, the responses on the Graffiti wall can be used by the main workshop facilitator to underline the focus of the workshop.

*Added advantages of the Graffiti wall:*
Participants interact with each other during the making of the Graffiti wall, and also when they read it during any refreshment breaks.

Some people write humorous or imaginative responses; others may draw pictures. This all adds to the enjoyment of the exercise.

**Who**
Personnel required for this task:
- workshop administrator(s) at registration desk
- main workshop facilitator
- participants

**Materials**
Materials required for this task:
- blocks of Post-It notes, or similar item
- at least 4 sheets of flip-chart paper stuck to the wall at the front of the main room, labelled ‘Graffiti wall’ and/or ‘What does health mean to you?’

**Time allocated**
Registration period (usually of 30 minutes’ duration).

**How**
Each participant is given 1 to 5 Post-It notes when they register. Participants are asked to describe what health means to them on one or more notes, then stick them on the Graffiti wall before the workshop starts.

[NB: Some people may use only one note; others may use more than one.]

As the notes are put onto the Graffiti wall, the main workshop facilitator arranges them into groups of similar definitions.

As the participants drink coffee/tea, talk and network, the main workshop facilitator should encourage them to write at least one contribution for the Graffiti wall.

**Learning point**
It is best to undertake this task before the main workshop begins. We have run the exercise as part of the main workshop and, although it is a useful thing to do, it does take time away from the core workshop tasks of identifying health impacts and suggesting ways in which the proposal can be changed to address those impacts.
**Tips**

Sometimes I give a running commentary as the wall develops, which can be heard by those participants who are nearest. I also pick out those definitions that are illustrative or appealing in some way, which I can mention in my introduction to the core workshop tasks.

**Alternatives**

If the majority of participants have worked together long enough to be aware of each other’s perspective on health or have taken part in 2 or more HIAs, you can explore other questions for the Graffiti wall, for example:

- What are your underlying values about health?
  
  [NB: some people find this question difficult probably because they have not consciously reflected on the values they have with respect to health – and they frequently ask what is meant by the word ‘values’.]

- What are your organisation’s/partnership’s underlying values when undertaking HIA?

**Examples from pilots**

- Participants’ responses to the question ‘What does health mean to you?’ from the HIA on the Food and Health Strategy are shown in Box 5.1.

- Participants’ responses to the question ‘What are your underlying values about health?’ from the HIA of the Housing Theme in an SRB Programme are shown in Box 5.2.

- Participants’ responses to the question ‘What are your organisation’s/partnership’s underlying values when undertaking HIA?’ from the HIA on the New Settlement and Rapid Transit System are shown in Box 5.3.

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**Box 5.3: Examples from Pilots ~ Values about HIA**

**Lead organisation: Cambridge and Huntingdon Health Authority**

**Proposal: New Settlement and Rapid Transit System**

- The promotion of health, and the prevention of harm
- Equity
- Sharing a picture - exploding the myth of ‘everybody knows’
- Partnership working
- Use of expert knowledge, encompassing professional expertise and that of the real experts in the community
- Evaluation
- Focus on the wider determinants of health
- Involving local people - they have a right to be involved
- Focus on local issues while working on the big picture
- Interface with other impact assessment methodologies
Box 5.1: Examples from Pilots ~ ‘What does health mean to you?’

Lead organisation: Merton, Sutton & Wandsworth Health Authority
Proposal: Food and Health Strategy

- Being happy and doing what I want when I want
- The ability to do what I want for as long as I want
- Health can mean better use of leisure time: less pre-prepared food = more money
- Social aspects of family involved in cooking
- Having a quality of life that enables me to enjoy may family, my work and my leisure and hobby/activity
- Being thankful for what I have
- Not feeling as though I’m drowning
- Not being ill, getting fit and taking control
- As fit as possible according to your metabolism - eating wholefood, balanced diet - being aware of the exterior we are daily exposed to, especially the food chain
- Being healthy means a complete sense of well-being: physical and mental - sense of being in a good relationship with the world
- Waking up happy every morning
- Being able to do what I want - physical capacity, mental capacity and time!
- Mental and physical well-being
- Feeling fit and enjoying life
- Being happy and having lots of energy and enthusiasm
- Feeling good, enjoying life - getting the best out of it
- Health is mental, physical, emotional and spiritual
- being able to be and do all I can
- Health is a state of physical, mental and spiritual well-being
- Healthy is a mental, physical, emotional and spiritual feeling of well-being! An optimism, a zest for life
- Being physically, mentally and emotionally well and able to most of what I enjoy/want to make life meaningful
- Condition/efficient working of your body
- Being/having a body that functions without thought
- Being fit, being well, eating the right type of food, being happy
- Being well, feeling well
- Being able to live life to the full and enjoy it at the same time. To make sure that this applies to my family and friends
- Happier life, less off-days, can achieve more, better self-esteem
- The ability to still be able to lead a full and active life
- A balanced low-salt fibre-rich diet, free from harmful chemicals, allied to regular exercise
- Having a choice to enable a quality of life

Box 5.2: Examples from Pilots ~ Values about health

Lead organisation: Cambridge and Huntingdon Health Authority
Proposal: SRB Programme - Housing Theme

- Equity and equality
- Involving the poorest and most marginalised people in decision-making
- Focus on wider determinants of health, which are more important than a narrow perspective on treatment and care
Task 5.2: Identifying barriers/threats to, and conflicts around, proposal implementation

What
This is the first task participants undertake during the formal structure of the workshop. It is an important preparatory exercise designed to help participants begin to focus on the workshop’s aims. It has been developed from elements of what is often referred to as Policy Analysis in standard texts on HIA.

When
During plenary (see Figure 1.1).

Questions
• What are the barriers or threats to the implementation of the proposal?
• Are there any potential conflicts that may affect the successful implementation of the proposal?

Why
The main purpose of this task is to brainstorm any difficulties surrounding the implementation of the proposal. It is important for two reasons:
• Primary reason. Any difficulties surrounding the implementation of a proposal that are not recognised, acknowledged and managed may actually prevent the potential positive health impacts of a proposal being realised. This is particularly pertinent when considering either proposals targeted on vulnerable, marginalised or disadvantaged groups in the community, which ostensibly may be thought to have only positive effects on health, or proposals that are contentious. Identifying the difficulties during the workshop not only brings them out in the open but also serves as a reminder to participants to take them into account when considering changes that could be made to the proposal to protect and improve health.
• Secondary reason. Some workshop participants may feel sceptical about the proposal, or the usefulness of HIA (seeing it as an anodyne methodology). This exercise helps to channel any feelings of negativity into a useful and usable form in a structured and facilitated way.

Who
Personnel required for this task:
• main workshop facilitator
• main workshop scribe
• participants

Materials
Materials required for this task:
• flip-chart and marker pens
• participants’ notepads/paper

Time allocated
Brainstorm: maximum 10 minutes
Feedback: try to keep to 10 minutes

How
The main workshop facilitator asks participants to turn to their neighbour(s) and, if there is a small number of participants (e.g. 20 or less), to work in pairs, or if more there are more than 20 participants to work in groups of 3 to 5. Ask each pair/group to nominate a scribe and a person responsible for feedback. Participants are then asked to brainstorm:
• the barriers or threats to implementation of the proposal
• any potential conflicts surrounding implementation
Give each group 5 minutes to brainstorm barriers/threats and 5 minutes to brainstorm conflicts. Tell them when the first 5 minutes is up, and then close the brainstorming at 10 minutes, unless it is obvious all pairs/groups have finished beforehand.
When participants have finished brainstorming, undertake quickfire

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feedback from the pairs/groups asking the person responsible for feedback only to give information that does not repeat earlier feedback. The main workshop scribe should record the responses legibly on a flip-chart at the front of the room. Do not treat this session as a forum for discussion. At the end of feedback, the main workshop facilitator should summarise the important barriers, threats and conflicts, and ask participants to bear these in mind when considering changes to the proposal to address the health impacts. Remember to have these responses visible/accessible during the core workshop tasks.

**Learning point**

It is best to do this exercise before the identification of health impacts because it helps participants to realise that the implementation of a proposal does not necessarily guarantee positive health impacts even if it has been designed to deliver those outcomes. It also acts as an introduction to the need to explore the negative as well as the positive when undertaking HIA.

**Advice**

Indeed, some participants may see this exercise as negative, especially as it is the first task they do within the formal structure of the workshop. It is worth emphasising that the task is being undertaken not as a criticism of the proposal developers, but in a positive way in order to be mindful of the situations that need to be managed to deliver positive outcomes for health.

**Tips**

Some participants do not perceive a difference between a barrier and a conflict; indeed, a conflict can become a barrier to implementation. However, ‘barriers’ tend to be tangible obstacles, e.g. funding for a project that is short term and not sustainable, whereas conflicts tend to be difficulties that can arise from differences of opinion, behaviour, aims, goals, or concerns. It can be helpful if the main workshop facilitator illustrates the difference between barriers and conflicts with appropriate examples. Invariably, however, some participants will report a barrier as a conflict and vice versa. Ultimately this is not important. What is important is that these difficulties are recognised, vocalised, and taken into account.

**Alternatives**

If you feel that the barriers/conflicts surrounding a proposal are well known and acknowledged among participants, or that the question is not appropriate with respect to a particular proposal, you could explore the following:

- Are there any conflicts between the values underpinning HIA and the aims and objectives of the proposal?

If this alternative is to be explored, it requires that the values underpinning HIA have already been identified, either as a warm-up exercise (see Box 5.3, for example), or by the Steering Group and then communicated to workshop participants beforehand.

It may be appropriate to explore this question in relation to proposals that will bring benefit to the population at large but not necessarily to the community immediately affected by proposal implementation, for example, if the proposal concerns the installation of a new waste management facility.

**Example from pilots**

The potential threats to, and conflicts around, the implementation of a proposal from the HIA of the Healthy Living Centre are shown in Box 5.4.
Box 5.4: Examples from Pilots – Potential Threats to and Conflicts around Proposal Implementation

Lead Organisation: Aylesbury Vale District Council
Proposal: Healthy Living Centre (HLC)

**Threats:**
- Funding ends after 5 years - what happens then?
- What if the community does not use the HLC?
- Will the building be big enough?
- Difficulty in getting people to the area
- Funding is related to numbers using the HLC
- Will the services meet the needs of local people?
- Anti-social behaviour of local youths
- Media focus on bad points of the area
- Cost of some services at the HLC - e.g. prices in cafe
- Security issues
- Vandalism
- Recruitment difficulties
- Withdrawal of partners providing services at the HLC
- Difficulty in getting Trustees
- Potential for lack of take-up due to low self-esteem of people for whom the services are being provided
- Local shopping centre fails, and this has a knock-on effect on HLC
- HLC dominated by one particular sector

**Conflicts:**
- Among users, e.g. about times of using the HLC or different uses for the HLC
- Between certain groups using the centre, e.g. between young and older people or between majority and minority groups
- Among partners over usage of the buildings
- About aims - each organisation providing services will have their own agenda apart from that of the HLC
- Between organisations over seniority - some services will be provided from the HLC’s inception and others will be introduced later
- Some groups in the community feel excluded and as such may be resistant to taking up the services
- Cultural intolerance
- Overlap in the provision of services/facilities
- Split or gap between professionals providing the services and their potential clients
- Local residents using the HLC versus ‘in-comers’ or ‘outsiders’ using the HLC; facility needs to serve the local community
- Increase in traffic and the need for parking
- Smoking - some users may want to smoke, especially in the cafe, but many of the services being provided are health-related and the focus of the HLC is health promotion
Task 5.3: Identifying the impacts on health

What

This is one of the two core workshop tasks, and it is pivotal to undertaking HIA.

When

In small workgroups (see Figure 1.1).

Main Question

What are the potential impacts on health, positive and negative, arising from the implementation of this proposal?

Why

The responses to this task are key to understanding the effect a proposal may have on health, and form the basis for suggesting changes to the proposal to protect and improve health.

Who

Personnel required for this task:
- main workshop facilitator
- small workgroup facilitators
- participants in small workgroups
- main workshop observer

Materials

Materials required for this task:
- 1 flip-chart per workgroup
- 2 marker pens per workgroup

Supporting information for small group facilitators
- instruction sheet including questions to structure core workshop tasks
- the tool/list of determinants of health marked up to highlight the determinants it is a priority for each workgroup to explore (see Task 4.4 and Annex 1)
- list of vulnerable groups (see Task 3.4)
- completed versions of Matrix 4.1 ~ proposal’s importance in the prevailing policy framework
- blank versions of Matrix 4.2, partially completed versions of Matrix 4.3, blank versions of Matrix 4.4

Time allocated

30 minutes.

How

Ask participants to split into the small workgroups to which they have been allocated. Each small workgroup has a facilitator who has been approached beforehand to undertake this role (see Task 2.3). Elements or aspects of the proposal to be appraised by each small workgroup will have been allocated beforehand (see Task 4.1). Before embarking on the tasks, the small group facilitator should ask workgroup members to introduce themselves. Identify a scribe for the workgroup who can write legibly, and a person responsible for feedback (which can be the facilitator). It is important for the facilitator to lead the exercise, and prompt participants as necessary, but he or she is also able to participate in the exercise from their own perspective.

The small group facilitator leads the workgroup in identifying the positive and negative impacts on health of the elements or aspects of the proposal allocated to that group. Essentially, small group facilitators must encourage participants to be explicit about the following points:
- What will the implementation of this particular element or aspect of the proposal mean? For example, will a new service or facility be provided?
- Will the outcomes of proposal implementation have a direct effect on health? What is the nature of those impacts on health?
• Will the outcomes of proposal implementation have an *indirect* effect on health, that is, through one or more of the factors affecting health/the determinants of health? What is the nature of those impacts on health?
• Will the impacts on health be *different* for various groups in the population? It is important to pay particular attention to any differential effects on marginalised, vulnerable, or disadvantaged groups in the population.

Small group facilitators can use the tailored version of the tool to help participants complete this exercise.
If time is available, participants can be asked to assess the implications for service planning that arise as a result of proposal implementation, either through impacts on health or through changes in service provision that have a consequent impact on health (see Figure 4.1).

*Learning point*

Participants inexperienced at HIA can find this exercise difficult, which is one of the reasons why the small workgroups need to be facilitated. Careful explanation and leadership are required from the small group facilitator if the task is to be completed successfully. If the small workgroups are not facilitated, there is a danger that poor-quality outputs will be generated, which has implications not only for the overall appraisal but also for participants’ level of motivation.

*Tip*

Participants to whom the concept and process of HIA are new may require support during this exercise. The main workshop facilitator should visit each small workgroup to check that they understand the task and are managing to appraise the impacts on health.
Task 5.4: Identifying changes to the proposal

**What**
This is the second core workshop task and is essential to fulfilling the overall aim of HIA by exploring changes that could be made to the proposal to protect and improve health.

**When**
In small workgroups (see Figure 1.1).

**Main Questions**
- What changes could be made to the proposal to enhance the positive impacts on health?
- What changes could be made to the proposal to prevent, minimise or moderate the negative impacts on health?

**Why**
The responses to this task provide those responsible for the proposal with suggestions about the ways in which the proposal can be changed to improve or enhance its impact on health. These suggestions reflect the views of stakeholders and are based on their knowledge and experience.

**Who**
Personnel required for this task:
- main workshop facilitator
- small workgroup facilitators
- participants in small workgroups
- main workshop observer

**Materials**
Materials required for this task:
- 1 flip-chart per workgroup
- 2 marker pens per workgroup

**Supporting information for small group facilitators**
- instruction sheet including questions to structure core workshop tasks
- responses carried forward from previous tasks:
  - barriers/conflicts with respect to proposal implementation (Task 5.2)
  - impacts on health, and the determinants through which those impacts act (Task 5.3)
- the tool/list of determinants of health (see Task 4.4 and Annex 1)

**Time allocated**
30 minutes.

**How**
Although the objective in this task is to identify changes to the proposal, it is not appropriate in the first instance to make suggestions for change that are not related to the impacts which have just been identified. Before making any suggestions, therefore, for each element or aspect of the proposal appraised, it is best for the small group facilitator to review with the workgroup which of the factors affecting health/determinants of health were involved in causing any of the impacts on health. This information is the foundation from which participants need to work when devising suggestions to change the proposal. During this review, it may become apparent that some of the factors affecting health are more influential in causing impacts on health than others, for instance, if they feature as mediators of impacts for more than one element or aspect of the proposal. These factors in particular should be noted, and used as a focus around which to build suggestions for changes to the proposal.

It is also advantageous at this point to review the barriers/threats to, or conflicts around, successful implementation of the proposal, especially as they could exacerbate some of the negative impacts or compromise some of the positive impacts.
Essentially, the small group facilitator must get participants to be explicit about the following points:

- Through which of the factors affecting health do elements or aspects of the proposal give rise to negative impacts?
- Is there an intervention that will prevent or reduce the effect of any of these factors giving rise to the negative impacts on health?
- Is there a way of changing the proposal to prevent, minimise or moderate the negative impacts? This may involve:
  - Making changes to the element or aspect of the proposal that gives rise to the negative impact (prevention/minimisation).
  - Making changes to another element or aspect of the proposal to offset the negative impact caused by the original element or aspect (moderation).
  - Introducing a new element or aspect to the proposal to offset the negative impact caused by an original element or aspect (moderation).

When devising changes to the proposal, it is important to pay attention to those negative impacts that affect only, or that affect to a greater degree, vulnerable, marginalised or disadvantaged groups in the community when compared with the whole population. It is also important to ensure that any suggestions for changes do not have a negative effect on vulnerable, marginalised or disadvantaged groups.

- Through which of the factors affecting health/determinants of health do elements or aspects of the proposal give rise to positive impacts?
- Is there an intervention that will enhance the effect of any of these factors giving rise to the positive impacts on health?

Thus, is there a way of changing the proposal to enhance the positive impacts? This may involve:

- Making changes to the element or aspect of the proposal that gives rise to the positive impact.
- Making changes to another element or aspect of the proposal to enhance the positive impact of the original element or aspect.
- Introducing a new element or aspect to enhance the positive impact of the original element or aspect.

**Tip**

Only towards the end of this task (~5-10 minutes left) do I encourage participants to discuss what might be missing from the proposal which, if introduced, would confer health gain or have a positive impact on the whole community and/or on vulnerable, marginalised or disadvantaged groups. This discussion can be initiated by asking the following question:

- ‘Is there a way of adding to the proposal to introduce further positive impacts on health?’

Again, it is important to ensure that any suggestions involving additions to the proposal to obtain health gain for the population do not have a negative impact on vulnerable, marginalised or disadvantaged groups.
Task 5.5: Feedback and discussion of health impacts and of suggestions to change the proposal

*What*  
This task is designed to draw together the outputs from the various small workgroups. It also has the potential to generate a feeling of consensus among participants.

*When*  
During plenary (see Figure 1.1).

*Why*  
Feedback is an important way of sharing each small workgroup’s appraisal of the proposal, especially if workgroups have been assigned different elements or aspects of the proposal to appraise. Discussion then provides a valuable opportunity to develop some of the suggestions for changes to the proposal that were made by the various small workgroups.

*Who*  
Personnel required for this task:  
- main workshop facilitator  
- main workshop scribe  
- workshop observer  
- those responsible for feedback from small workgroups

*Materials*  
Materials required for this task:  
- flip-chart at front  
- marker pens

*Time allocated*  
Feedback: 30 minutes.  
Discussion: 15 minutes.

*How*  
The main workshop facilitator asks the person responsible for feedback from each small workgroup:  
- to state which elements or aspects of the proposal they appraised;  
- to present the main health impacts they identified, and the factors giving rise to those impacts;  
- to present the suggestions for changes.  
If more than one small workgroup appraised the same elements or aspects of the proposal, ask the second workgroup *not* to repeat information but to list areas where they were in agreement. If impacts have been identified by a small workgroup but they have no suggestion how to remedy them, put the problem to the plenary discussion.  
The main workshop scribe records the responses during feedback, but should list all suggestions for changes to the proposal on a separate set of flip-chart sheets to those used to record the health impacts.  
After each small workgroup has given their feedback, it is helpful if the main workshop facilitator identifies any emerging themes on which the small workgroups are in agreement, particularly with respect to suggestions about changes. This is a useful way to start the discussion in plenary.

*Advice*  
If there is a large number of small workgroups (6 or more), the main workshop facilitator must manage the feedback session rigorously. In this situation, it is important to emphasise what and how much feedback is required, while assuring participants that all the work they have done will be included in the final report (as long as it has been duly recorded by them during the small workgroup session). It is best for the main workshop facilitator to ask for *only* a quick summary of the impacts and any key or influential factors/determinants of health involved in causing them, followed by the group’s suggestions to change the proposal. It is important that the main workshop facilitator is firm in keeping feedback to time...
while at the same time being even-handed among the groups (i.e. to ensure
that one or more groups are not given more time for feedback than others),
otherwise there may not be time to collect feedback from all the small
workgroups or to complete the remaining workshop task of prioritisation
(see Task 5.6).

**Tip**

It is likely that some discussion will occur during feedback: one small
workgroup may comment on another workgroup’s feedback. If this
discussion builds on suggestions to change the proposal, capture it at the
time; otherwise, make a note of the point for subsequent discussion.
Task 5.6: Prioritising changes to the proposal

What
This task is undertaken to identify participants’ priorities for action on the proposal.

When
Depending on the method of prioritisation chosen, during plenary after feedback and discussion of the proposal’s potential health impacts and suggestions for changes to the proposal or in a brief return to small workgroups (see Figure 1.1).

Question
Which of the suggestions about changes to the proposal would you prioritise for action?

Why
It is important to prioritise the suggested changes to the proposal for several reasons:
• To support decision-makers and help them consider the potential health impacts of proposal implementation.
• To give decision-makers and those responsible for the proposal a clear indication of stakeholder priorities about changing the proposal to minimise the negative impacts and maximise the positive impacts on health.
• To inform the decision-taking process, such that the decision-makers can weigh the priorities to change the proposal on health grounds in the context of other priorities, such as economic development, especially if resources for proposal implementation are limited.

Who
Personnel required for this task:
• main workshop facilitator
• main workshop scribe
• main workshop observer
• participants

Materials
Materials required for this task:
Simple method of prioritisation
• coloured sticky dots
• flip-chart sheets with list of suggestions of changes to the proposal (displayed in a prominent position in the room) - see Task 5.5, ‘How’

More complex method of prioritisation
• criteria for prioritisation
• matrix for recording results

Time allocated
15 minutes.

How
Simple method of prioritisation
Give all participants 5 coloured sticky dots (red stands out well) and ask them to place the dots next to the suggestions they wish to prioritise (as listed on the flip-chart sheets). The advantage of this method is that it is quick. The disadvantage is that any criteria participants might use to prioritise suggestions are not made explicit, although participants’ priorities will have been informed by the feedback and discussion session.

More complex method of prioritisation
Ask participants to rank each of the suggestions according to only 1 or 2 criteria. Criteria that could be used for this exercise are shown in Box 1.3, and will have been selected by the Steering Group during Scoping. It is probably quickest if participants briefly rejoin their small workgroups to rank the recommendations in this way, and then feedback the results of the
ranking; however, with a small number of participants (~10-12), it may be possible to perform the ranking in plenary.

**Tip**

Whichever method of prioritisation is selected beforehand, it is best to have the materials for the simple method of prioritisation (coloured sticky dots) available at the workshop. This is because participatory stakeholder workshops rarely run to time, and, as prioritisation is the last exercise, it tends to get compromised. The simple method of prioritisation has the advantage that it is quick and can be completed within 10 minutes at the most.

**Alternative**

If it is not possible to complete this task during the workshop, participants can be asked to prioritise the recommendations after the workshop on receipt of the workshop report. The disadvantage of this tactic is that the priorities participants select subsequent to the workshop may reflect a series of individual perspectives, which could coincide with each other but will not have been achieved as a result of agreement or consensus during the workshop. The achievement of agreement or consensus at the workshop may be more powerful at influencing decision-makers.

**Examples from pilots**

For a list of the issues prioritised for action during the HIA of the Healthy Living Centre, see Box 5.5.

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### Box 5.5: Examples from Pilots – Issues Prioritised

**Lead organisation: Aylesbury Vale District Council**

**Proposal: Healthy Living Centre (HLC)**

- Potential stigma attached to visiting the HLC
- Smoking policy in the HLC
- Managing the use of the HLC by non-residents
- The need for visionary management of the HLC - issues to be addressed include the sustainability of the HLC, conflict resolution, sensitivity in providing services as well as the practicalities of facilities management
- Local people and local services - use of the HLC by residents, empowering the local community, opportunities for volunteering, encouraging the award of local contracts and the use of local services
- Attending to the needs of the providers of services and the managers of projects at the HLC
Section 6: Reporting the Results

The assessor is responsible for the completion of Tasks 6.1-6.6. If the Steering Group is not responsible for decision-making, they undertake Task 6.7. If the Steering Group is responsible for decision-making, it is advisable to select independent (i.e. not involved in the HIA) colleagues to complete Task 6.7.

Summary of Tasks for Reporting the Results

♦ Communicating with stakeholders ~ Task 6.1
♦ Responses on the Graffiti wall ~ Task 6.2
♦ Responses to brainstorming barriers, threats and conflicts ~ Task 6.3
♦ The proposal’s potential impacts on health ~ Task 6.4
♦ The recommendations to protect and improve health ~ Task 6.5
♦ Testing whether recommendations assess important factors in the causation of health impacts ~ Task 6.6
♦ Reviewing the quality of the report ~ Task 6.7

A Summary Table for Section 6 lists the inputs needed to complete each task, and the destination for, or use of, the outputs from each task.
Summary Table for Section 6: Inputs needed to complete each task, and the use of outputs from each task

<table>
<thead>
<tr>
<th>Inputs needed to complete task</th>
<th>Tasks</th>
<th>Destination for/use of outputs from task</th>
</tr>
</thead>
<tbody>
<tr>
<td><em>From Steering Group:</em> outputs from Task 1.11; consult main workshop facilitator and main workshop observer</td>
<td>6.1</td>
<td>Assessor(s) for completion of Tasks 6.2-6.6</td>
</tr>
<tr>
<td>Outputs from Task 5.1</td>
<td>6.2</td>
<td>For inclusion in the report; if Steering Group not decision-makers: report to Steering Group for completion of Task 6.7; if Steering Group are decision-makers, report to colleagues for completion of Task 6.7</td>
</tr>
<tr>
<td>Outputs from Task 5.2</td>
<td>6.3</td>
<td>For inclusion in the report; if Steering Group not decision-makers: report to Steering Group for completion of Task 6.7; if Steering Group are decision-makers, report to colleagues for completion of Task 6.7</td>
</tr>
<tr>
<td>Outputs from Task 5.3; <em>from personnel responsible for information preparation:</em> evidence base; experience base</td>
<td>6.4</td>
<td>For inclusion in the report; if Steering Group not decision-makers: report to Steering Group for completion of Task 6.7; if Steering Group are decision-makers, report to colleagues for completion of Task 6.7</td>
</tr>
<tr>
<td>Outputs from Tasks 5.4-5.6</td>
<td>6.5</td>
<td>For inclusion in the report; if Steering Group not decision-makers: report to Steering Group for completion of Task 6.7; if Steering Group are decision-makers, report to colleagues for completion of Task 6.7</td>
</tr>
<tr>
<td>Outputs from Tasks 5.4-5.6; <em>from personnel responsible for information preparation:</em> evidence base; experience base</td>
<td>6.6</td>
<td>For inclusion in the report; if Steering Group not decision-makers: report to Steering Group for completion of Task 6.7; if Steering Group are decision-makers, report to colleagues for completion of Task 6.7</td>
</tr>
<tr>
<td>Report (culmination of Tasks 6.1-6.6)</td>
<td>6.7</td>
<td>To assessor(s) for amendment as necessary; to decision-makers for completion of Task 7.1; to all stakeholders; to evaluator(s)</td>
</tr>
</tbody>
</table>
Task 6.1: Communicating with stakeholders

Why
As accountability is an underlying value of HIA, it is important to communicate the results of the appraisal to all stakeholders, and not just to the workshop participants and decision-makers.

What
When communicating the results to stakeholders, the following information should be included:
- The proposal in context, including any results from Screening.
- The elements or aspects of the proposal that were assessed.
- Important boundaries for the HIA, including:
  - population or community affected
  - geographical area affected
  - vulnerable, marginalised or disadvantaged groups in the community or population
- Barriers/threats to, and conflicts around, proposal implementation.
- The impacts on health that were identified.
- The suggestions made to change the proposal to maximise the positive and minimise the negative impacts on health.
- The recommendations prioritised by workshop participants.
- A summary of the analysis to test whether the recommendations address influential factors in the causation of impacts on health.
- Suggestions about the monitoring and evaluation of indicators and outcomes to detect health gain.
- A list of workshop participants, together with their affiliations.

When
Final decisions about communicating with stakeholders should be made immediately after the participatory stakeholder workshop.

Who
The personnel best placed to make decisions about communicating with the various stakeholder audiences after the workshop are:
- The assessor(s).
- The main workshop facilitator/main workshop observer.
- The Steering or Management Group for the HIA.
The assessor(s) are responsible for writing the report.

How
A full account of the appraisal must be written and kept as a documentary record of the HIA. General guidance about the structure and contents of the full report is shown in Box 6.1.
The Steering Group will have made various specifications in relation to different stakeholder audiences about reporting the results during Scoping (see Task 1.11 and Table 1.7). These must be taken into account.
However, when communicating the results of the appraisal, it is also important to consider these specifications in the light of what happened at the participatory stakeholder workshop, at which specific suggestions about the report’s format and content may have been made.
The full report is likely to be the version sent to decision-makers and proposal proponents. However, it may be more appropriate to send a summary to other stakeholders, together with details of how to access the full report.

Tip
It is easier to prepare different versions of the report for various stakeholder audiences once the basic record of the workshop has been...
prepared, and the recommendations have been tested for the degree of influence they have over the impacts on health.

**Example from pilots**

The results of the retrospective HIA of the housing estate were presented in two different formats and at two levels of detail:

- A full report for decision-makers, written in clear, concise language, with some use of specialist terminology where necessary; also sent to professionals in the public, private, and voluntary sectors who serve the community on the estate.
- A summary, presented in newsletter format, written in clear, simple language, sent to all residents living on the estate.

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**Box 6.1: General guidance about the structure and contents for the full account of the report**

**Introduction**
- **Background to the proposal**, including the proposal in context (outputs from Task 4.2, which may have been reviewed and amended by participants), and relevant results from Screening.
- **Background to the HIA**, including the aims (outputs from Task 1.1), the elements or aspects of the proposal that were assessed (outputs from Task 1.2), the boundaries for the HIA (outputs from Task 1.3), and the decision-making process in which the results of the appraisal will be considered (outputs from Task 1.12).

**Methods**
- Structure of the workshop (outputs from Task 1.10), allocation of elements or aspects of the proposal to workgroups (outputs from Task 4.1), questions used to prompt participants (outputs from Task 4.5 and Annex 3), determinants of health it was a priority to address (outputs from Task 4.4 and Annex 1), and method of prioritisation of recommendations (outputs from Tasks 1.3, and 5.6)

**Results**
- Barriers/threats to, and conflicts around, proposal implementation (outputs from Task 5.2).
- Results of the appraisal, including a summary of the health impacts identified, and their implications for service planning (outputs from Task 5.3).
- Recommendations to change the proposal to protect and improve health, including a summary of the recommendations prioritised by participants (outputs from Tasks 5.4-5.6).

**Testing the Recommendations**
- A summary of the analysis to test whether the recommendations address influential factors in the causation of the proposal’s impacts on health (outputs from Task 6.6).

**Monitoring and Evaluation**
- Suggestions about the monitoring and evaluation of indicators and outcomes to detect health gain (outputs from Task 1.13, combined with suggestions from participants and from assessor(s)).

**Appendices**
- Steering Group members (outputs from Task 0.1), personnel involved in preparations for the workshop, and in leading the workshop (outputs from Tasks 1.7-1.9), and workshop participants (outputs from Task 2.4), including the affiliations of all people listed.
- Stakeholders invited to participate (outputs from Task 1.4)
- Responses on the Graffiti wall (outputs from Task 5.1)
- Population profile (outputs from Tasks 1.5, 1.8, and 3.3)
- Summary of local conditions relevant to the proposal (outputs from Tasks 1.5, 1.8, and 3.5) [NB: this could be combined with the population profile.]
- Summary of the evidence base relevant to the proposal (outputs from Tasks 1.5, 1.8, and 3.6)
- Summary of the experience base relevant to the proposal (outputs from Tasks 1.5, 1.8, and 3.7) [NB: this could be combined with the evidence base.]
- The tool/list of determinants of health (see Annex 1)
Task 6.2: Responses on the Graffiti wall

Why
It is helpful to present the responses on the Graffiti wall in the report because it will give readers an indication of:
- participants’ understanding of health
- the perspectives from which participants addressed the proposal

When
The report of the appraisal should be undertaken as soon as possible after the workshop has taken place.

Who
The assessor(s) is responsible for writing the report of the workshop.

How
Transcribe the responses from the Post-It notes, and, if possible, group them according to similarities of definition.
There are two main options for presenting these responses in the report:
- Insert the text as a box in the introduction to the report.
- Insert the text as an appendix to the report, and then refer to it in the introduction.

Advice
The mode of presentation of Graffiti wall responses will depend on the audience. For instance, it is best to present this text as an appendix to the report for decision-makers because their main concern will be to consider the impacts on health and the recommendations made to address those impacts.

Task 6.3: Responses to brainstorming barriers, threats and conflicts

Why
It is essential to report on the barriers, threats and conflicts that might affect the implementation of the proposal for two main reasons:
- To ensure that decision-makers and those responsible for the proposal are aware of any potential difficulties.
- It provides important contextual information for decision-makers when considering which recommendations to adopt – some of the recommendations will have been made with these difficulties in mind.

When
The report of the appraisal should be undertaken as soon as possible after the workshop has taken place.

Who
The assessor(s) is responsible for writing the report of the workshop.

How
Transcribe the responses from the flip-chart sheets, and amend the categorisation by workshop participants as necessary. For instance, a conflict may have been reported as a barrier, or vice versa.
It is important that this information is included in the main body of the report, irrespective of the intended audience. However, it is probably best to report the responses before describing the proposal’s potential impacts on health.
If the assessor believes important barriers, threats, or conflicts relevant to proposal implementation have been missed, it is important to supplement the participants’ responses so that any other problems surrounding implementation can be addressed.
Task 6.4: The proposal’s potential impacts on health

Why
The impacts on health arising from proposal implementation are the first of two key outputs from the participatory stakeholder workshop. It is vital to give decision-makers this information because it will help them not only to understand why certain recommendations to change the proposal have been made but also to appreciate the need for implementing the changes recommended.

What
For the text describing the proposal’s potential impacts on the health of the community or population, and on that of any of the vulnerable groups within it, it is important to include the following:
- The impacts, both positive and negative.
- The elements or aspects of the proposal that precipitate these impacts.
- The factors affecting health/determinants of health through which the impacts are mediated.
- The implications for service planning of the health impacts identified.

When
The report of the appraisal should be undertaken as soon as possible after the workshop has taken place.

Who
The assessor(s) is responsible for writing the report of the workshop.

How
In the first instance, it is important to transcribe and collate the results from each of the small workgroups at the participatory workshop, which will probably be in the form of lists on flip-chart sheets. Depending on the number of small workgroups, there may be more than one set of results relating to the same aspect or element of a proposal.

However, it is important to support and supplement the impacts identified by participants with relevant information from the evidence base, and the experience base (i.e. reports of other HIAs on similar proposals or on the same population/community), as compiled in preparation for the workshop. In addition, depending on whether workshop participants were able to complete the tasks, it is also important to identify the implications for service planning on the basis of the health impacts identified.

Although it is possible to present the collated results of identifying the proposal’s impacts on health in the form of text (a common approach), a useful way of condensing a large amount of information, and making that information readily accessible to readers, is to construct a flow diagram of the factors involved in the causation of health impacts. A diagram is also a more effective way of presenting the inter-related nature of the effects a proposal might have on health; it is difficult to describe some of these complexities succinctly using linear text.

Further advantages of using diagrams to present a proposal’s impacts on health include:
- The ease with which one can supplement the impacts identified in the workshop with those from the evidence base, which may have been missed by participants.
- The ease with which one can supplement the impacts identified in the workshop, with those identified during other HIAs.
- The ability to test whether suggestions made to change the proposal address important or influential factors in the generation of health impacts (see Task 6.6).

If you do decide to use this diagrammatic technique, it is advisable to
accompany each diagram with brief explanatory text.

**Advice**

It is probably best to construct a flow diagram for each of the elements or aspects of the proposal that were appraised, and then to use the clarity of the diagrams to identify common themes. Once this has been done, it is possible to construct a ‘master’ diagram showing the important or influential factors in the proposal’s overall impact on health.

**Example from pilots**

For an example of this method of presenting the impacts on health of a proposal, see Figures 1-3, in Appendix 3, which have been taken from the retrospective HIA of the housing estate.

- Figure 1 shows factors involved in the causation of health impacts which were identified by workshop participants under the theme of Community Safety.
- Figure 2 shows factors involved in the causation of health impacts, which were identified by workshop participants under the theme of Housing and Estate Design.
- Figure 3 shows factors involved in the causation of health impacts which were identified by workshop participants under the theme of Access to Services and Facilities.
Task 6.5: The recommendations to protect and improve health

Why

The recommendations made to change the proposal to minimise the negative and maximise the positive impacts on health are the second key output from the participatory workshop. They represent the options available to the decision-makers for changing the proposal to protect and improve health.

What

For the text describing the recommendations to change the proposal, it is important to include:

- All the recommendations made during the workshop.
- A summary of the recommendations prioritised during the workshop.

All the recommendations made during the workshop should be collated in the report because:

- Even if they were not prioritised, one or more of the recommendations may be effective in minimising the negative and/or maximising the positive impacts of the proposal according to the evidence and/or experience base.
- Even if they were not prioritised, one or more of the recommendations may be an appropriate way of managing some of the negative or enhancing some of the positive impacts on health. This can be tested quickly and easily if the factors involved in the causation of impacts on health have been presented in the form of a diagram (see Task 6.4).
- Those responsible for decision-making may want to be informed of all the options open to them - some of the recommendations not prioritised by workshop participants may accord with the decision-makers’ priorities.

However, it is also important to present the prioritised recommendations as a separate list, because they represent the combined (possibly consensual) conclusions of the stakeholders who participated in the workshop. As a faithful record of what participants suggested, it indicates clearly to those responsible for decision-making what stakeholders’ priorities are.

If Level 2 Questions from Annex 3B were used for Task 5.4, suggestions about indicators and outcomes for monitoring and evaluation of health gain after proposal implementation should be included.

When

The report of the appraisal should be undertaken as soon as possible after the workshop has taken place.

Who

The assessor(s) is responsible for writing the report of the workshop.

How

For each recommendation, it is advisable to report the following:

- The nature of the recommendation.
- The impact(s) on health the recommendation is intended to influence.
- The factor(s) affecting health/determinant(s) of health the recommendation is intended to alter or change and thereby minimise or maximise its impact(s) on health.
- Whether the recommendation was prioritised.
- If available, the evidence that supports the effectiveness of the intervention recommended.
- If available, the experience that supports the use of the intervention recommended.
- Analysis that supports the use of the intervention (see Task 6.6).

This information can be condensed into a tabular form.
If reporting suggestions for monitoring and evaluation of indicators and outcomes for health gain, combine the suggestions made by the Steering Group (see Task 1.13), with those made by workshop participants, and those reported in the relevant evidence/experience bases.

**Advice**

It is also possible for the assessor(s) to supplement the recommendations made and prioritised by participants with those that have been shown to be effective in the evidence base and/or experience base (i.e. reports of other HIAs on similar proposals or on the same population/community).
Task 6.6: Testing whether recommendations address important factors in the causation of health impacts

Why

Although it is important to present the set of recommendations prioritised by workshop participants (see Task 6.5), it is vital to test all the recommendations to assess whether they address important or influential factors in the causation of impacts on health. This is because:

- Some of the recommendations that were not prioritised at the workshop could address important or influential factors, and therefore should be considered by decision-makers.
- Some of the recommendations that were prioritised in the workshop might not address important or influential factors, and therefore decision-makers need to be made aware that although they were prioritised, if implemented, these recommendations may not be as effective as others which do address important factors.

This type of analysis is important to ensure the effective use of resources especially in situations where capacity and/or resources are limited, and decision-makers are not able to implement all the changes suggested.

What

For this analysis, it is necessary to identify:

- Whether a recommendation addresses any factor in the causation of health impacts.
- If so, whether that factor is important or influential in the causation of health impacts for a particular aspect or element of the proposal.
- If so, whether that factor is important or influential for the causation of impacts for more than one aspect or element of the proposal.

When

The recommendations should be tested as soon as the other tasks relating to the writing of the report have been completed (Tasks 6.1-6.5).

Who

The assessor(s) is responsible for testing the recommendations.

Supporting information

The flow diagrams of the factors involved in the causation of health impacts resulting from proposal implementation (see Task 6.4).

How

This description of how to test whether recommendations address important or influential factors in the causation of health impacts will be illustrated using information from the retrospective HIA of the housing estate.

Stage 1

For each diagram, showing the factors involved in the causation of health impacts for a particular aspect or element of the proposal, define the following:

- **Initial causes** – in the diagrams, initial causes can be readily identified as factors that have arrows which point or lead only towards other factors.
- **Intermediary nodes** – in the diagrams, nodes can be readily identified as factors that have arrows which point or lead to them and arrows which point or lead away from them, i.e. to other factors.
- **Outcomes** – in the diagrams, outcomes can be readily identified as factors that have arrows which point or lead only towards them. Outcomes may be either a health outcome or a risk factor affecting health.

For instance, in Figure 1, Appendix 3, an example of:

- an initial cause is the single access point to the estate
• an intermediary node is the isolation of individuals in the community
• an outcome is an increased risk of road traffic accidents

Stage 2
For each diagram, it is important to determine which of the nodes are important or influential in the causation of health impacts arising from a particular aspect or element of the proposal. Nodes that are important or influential tend:
• To have a relatively large number of arrows leading to and pointing away from them.
• To occur relatively early on in the chain of cause and effect.
The threshold number of arrows for a node to be categorised as important or influential is arbitrary, but it will depend on the richness or complexity of the diagram. For example, in Figure 1, Appendix 3, the threshold was set at 5 or more arrows, whereas in Figures 2 and 3, Appendix 3, the threshold was set at 3 or more arrows.
For each of the aspects or elements of the proposal appraised, initial causes, important or influential nodes and outcomes can be presented as a table.

Stage 3
Once important or influential nodes have been identified in relation to particular elements or aspects of the proposal, it is helpful to construct a simplified version of the flow diagrams which highlights the main routes between cause and effect.
For example, Figures 4-6 in Appendix 3 are the simplified versions of Figures 1-3, respectively, in Appendix 3.
Once the main routes between cause and effect have been outlined, it is possible to identify those factors which occur:
• As initial causes for one or more aspects or elements of the proposal.
• As nodes for two or more aspects or elements of the proposal.
• As a node early on in the chain of cause and effect ~ i.e. it has an influence on a relatively large number of other nodes ~ within a single element or aspect of the proposal.
These factors are highly influential in the causation of a proposal’s impacts on health and it is these factors that should be addressed when putting forward recommendations to change the proposal.
For example, Matrix 6.1 shows the initial causes it is important to address, and Matrix 6.2 shows the nodes it is important to address, when putting forward recommendations to remedy the health impacts experienced on the housing estate.

Stage 4
Once the influential factors (whether causes or nodes) in the causation of health impacts have been identified, it is possible to assess whether the recommendations made by participants actually address them. Thus, for each recommendation, identify:
• Which initial cause or intermediary node it addresses.
• Whether that initial cause or intermediary node is influential in the causation of health impacts for one element or aspect of the proposal.
• If so, whether that initial cause or intermediary node is influential in the causation of health impacts for more than one element or aspect of the proposal.
Thus, it is possible to identify which recommendations address an initial cause or an influential intermediary node, and then compare this list with the set of recommendations prioritised by workshop participants. This information should be presented to decision-makers.
For example: Of the 24 recommendations made during the participatory
workshops for the retrospective HIA of the housing estate:

- 16 (66.6%) addressed influential initial causes or influential intermediary nodes and were prioritised.
- 3 (12.5%) addressed influential initial causes or influential intermediary nodes and were not prioritised.
- 4 (16.7%) addressed non-influential intermediary nodes and were prioritised.

NB: 1 (4.2%) recommendation, which was not prioritised, suggested there should be better communication among stakeholders. If acted upon, this recommendation could help to ensure the successful implementation of other recommendations by the various sectors or agencies involved.

Thus, the following conclusions can be drawn from this example:

- The majority of recommendations prioritised by workshop participants in this HIA did address influential factors in the causation of health impacts.
- A few recommendations were not prioritised but would be worth implementing because they do address influential factors in the causation of health impacts.
- A few recommendations were prioritised but they are probably not worth implementing because they do not address influential factors in the causation of health impacts.

**Acknowledgement**

The idea of using flow diagrams to test whether the recommendations made by workshop participants actually address influential factors in the causation of health impacts was sparked by the work of Mike Joffe and Jenny Mindell (Imperial College, London) who have developed a path diagram of the effects of transport on health (Joffe and Mindell, 2002). Joffe and Mindell highlight the need to address factors that occur early on in the causation of health impacts if an intervention is to have a widespread effect on health.

**Matrix 6.1: Influential initial causes in the causation of health impacts in the retrospective HIA of the housing estate**

<table>
<thead>
<tr>
<th>Initial Cause</th>
<th>1 theme</th>
<th>2 themes</th>
<th>3 themes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lack of services and facilities on the estate</td>
<td></td>
<td></td>
<td>•</td>
</tr>
<tr>
<td>Single access to, and physical isolation of, the estate</td>
<td></td>
<td></td>
<td>•</td>
</tr>
<tr>
<td>Design of the estate (e.g. alleyways/poor lighting)</td>
<td></td>
<td>•</td>
<td></td>
</tr>
<tr>
<td>Groups of young people who have nothing to do</td>
<td>•</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Housing design (e.g. poor heating and noise insulation)</td>
<td>•</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Rapid expansion of the estate</td>
<td>•</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Matrix 6.2: Influential intermediary nodes in the causation of health impacts in the retrospective HIA of the housing estate

<table>
<thead>
<tr>
<th>Intermediary Node</th>
<th>1 theme</th>
<th>2 themes</th>
<th>3 themes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Poor bus service</td>
<td></td>
<td></td>
<td>●</td>
</tr>
<tr>
<td>Long distance to walk to services and facilities</td>
<td></td>
<td>●</td>
<td></td>
</tr>
<tr>
<td>Reduced social contact</td>
<td></td>
<td></td>
<td>●</td>
</tr>
<tr>
<td>Fear of crime</td>
<td></td>
<td>●</td>
<td></td>
</tr>
<tr>
<td>Fear of abuse or intimidation</td>
<td></td>
<td>●</td>
<td></td>
</tr>
<tr>
<td>Vandalism and hooliganism</td>
<td></td>
<td>●</td>
<td></td>
</tr>
<tr>
<td>Isolation of individuals in the community</td>
<td></td>
<td>●</td>
<td></td>
</tr>
<tr>
<td>Stress</td>
<td></td>
<td>●</td>
<td></td>
</tr>
<tr>
<td>Demotivation</td>
<td></td>
<td>●</td>
<td></td>
</tr>
<tr>
<td>No sense of community</td>
<td></td>
<td>●</td>
<td></td>
</tr>
<tr>
<td>Increased levels of traffic</td>
<td></td>
<td>●</td>
<td></td>
</tr>
<tr>
<td>Difficult to access services and facilities</td>
<td></td>
<td>●</td>
<td></td>
</tr>
<tr>
<td>Time management pressures (particularly for vulnerable groups in the community, e.g. families, older people, disabled)</td>
<td></td>
<td>●</td>
<td></td>
</tr>
</tbody>
</table>
Task 6.7: Reviewing the quality of the report

Why

It is vital to review the quality of the full report because it is on the basis of this document that decision-makers will take decisions about the potential health impacts of the proposal.

What

Reviewing the quality of the report involves comparing:

- Comparing the report, and any other formats for dissemination of the results, with the Steering Group’s requirements for reporting the results (see outputs from Task 1.11 ~ refer to minutes of Steering Group meeting(s)).
- Assessing whether participants’ responses during the workshop have been reported accurately.
- Comparing the contents of the report, and of any other formats for dissemination of the results, with the information prepared for participants including the population profile, the summary of local conditions, and the evidence/experience bases, to see if they have been incorporated appropriately into the responses obtained during the workshop.

When

The quality of the report, and of any other formats for dissemination of the results, should be reviewed as soon as possible after the report has been completed.

Who

If the Steering Group is not responsible for decision-making, the Steering Group is responsible for reviewing the quality of the report.

If the Steering Group is responsible for decision-making about the proposal, it is advisable to ask 2 colleagues active in the HIA field but who were not involved in this particular HIA to review the quality of the report. [NB: this is standard practice in the field of life-cycle assessment (LCA).] However, they must be prepared to complete this task within a short timescale.

How

A checklist of questions that could be used to review the quality of the report is shown in Box 6.2.

If any amendments are necessary following the review, notify the assessor(s) immediately so that they can undertake the corrections as soon as possible before the report is disseminated.
Box 6.2: A checklist of questions that could be used to review the quality of the report

- Have the Steering Group’s requirements for reporting the results to different stakeholder audiences been met in terms of format, level of detail and length of document, and use of language and specialist terminology?
- Was the proposal put into context, including any relevant results from Screening, possibly in an Introduction?
- Was the background to the HIA described, possibly in an Introduction, i.e. the aims, the elements or aspects of the proposal that were assessed, the boundaries to the HIA, and the decision-making process or framework in which the results are being considered?
- Was the structure of the workshop, the allocation of elements/aspects of the proposal to small workgroups, the questions used to prompt participants, the determinants of health it was a priority to address, and the method of prioritisation of recommendations to protect and improve health described, possibly in a Methods section?
- Were the barriers/threats to, and conflicts around, implementation as identified by participants recorded? Did the assessor(s) add to these? If so, was it clear the additions were those of the assessor(s), and on what basis the additions made?
- Were the health impacts as identified by participants recorded? Did the assessor(s) present any relevant evidence and/or HIA experience to support these responses? Were relevant gaps or conflicts in the evidence/experience base presented? Did the assessor(s) add to participants’ responses? If so, was it clear the additions were those of the assessor(s), and whether they were made on the basis of the evidence and/or experience bases?
- Were any service implications as identified by participants recorded? Did the assessor(s) present the relevant evidence and/or HIA experience to support these responses? Were relevant gaps or conflicts in the evidence/experience base presented? Did the assessor(s) add to participants’ responses? If so, was it clear the additions were those of the assessor(s), and whether they were made on the basis of the evidence and/or experience bases?
- Were the suggestions to change the proposal as devised by participants recorded? Did the assessor(s) present the relevant evidence and/or HIA experience to support these responses? Were relevant gaps or conflicts in the evidence/experience base presented? Did the assessor(s) add to participants’ responses? If so, was it clear the additions were those of the assessor(s), and whether they were made on the basis of the evidence and/or experience bases?
- Were the recommendations made to protect and improve health that were prioritised by participants presented clearly?
- Did the assessor(s) test the recommendations made by participants to see whether they addressed influential factors in the causation of the health impacts identified? If so, were the results of testing the recommendations presented?
- Did the assessor(s) suggest further recommendations to protect and improve health? If so, were these additional recommendations made on the basis of the evidence and/or experience bases?
- Were suggestions to monitor and evaluate any health gain following proposal implementation presented? Was it clear whether the suggestions were those of the Steering Group, those of workshop participants, or those made subsequently by the assessor(s)?
- Were the responses to the Graffiti wall presented (relevant only if such a task was undertaken)
- Was information given concerning the names and affiliations of Steering Group members, of personnel involved in preparations for, and leading, the workshop, and of workshop participants?
- Were the stakeholders invited to participate listed?
- Was the key information prepared for the participatory stakeholder workshop presented ~ the population profile, the summary of local conditions relevant to the proposal, the evidence base, and the experience base?
- If used, was the tool/list of determinants of health presented?
Section 7: The Outcomes of Decision-Making

Summary of Tasks for The Outcomes of Decision-Making
♦ Reporting which recommendations have been accepted ~ Task 7.1
♦ Recording which of the recommendations accepted have been implemented ~ Task 7.2

A Summary Table for Section 7 lists the inputs needed to complete each task, and the destination for, or use of, outputs from each task.

Summary Table for Section 7: Inputs needed to complete each task, and the use of outputs from each task

<table>
<thead>
<tr>
<th>Inputs needed to complete task</th>
<th>Tasks</th>
<th>Destination for/use of outputs from task</th>
</tr>
</thead>
<tbody>
<tr>
<td>Report - the output of the combination of Tasks in Section 6</td>
<td>7.1</td>
<td>Notification sent to Steering Group, assessor(s), and evaluator; assessor(s) to circulate information to all stakeholders</td>
</tr>
<tr>
<td>Outputs from Task 7.1</td>
<td>7.2</td>
<td>Notification sent to decision-makers, Steering Group, assessor(s), evaluator, and personnel responsible for monitoring and evaluation</td>
</tr>
</tbody>
</table>
Task 7.1: Reporting which recommendations have been accepted

Why

It is essential to give all stakeholders feedback on which of the recommendations to change the proposal were accepted by decision-makers. This task is an important part of the process of introducing transparency and accountability into the decision-making process. It will also demonstrate to participants the effectiveness of the rapid appraisal in changing the proposal to protect and improve the health of the population.

What

There are two main options for reporting which recommendations have been accepted by decision-makers:

- Providing a list of the recommendations accepted as an addendum to the report of the participatory stakeholder workshop.
- Providing a list of the recommendations accepted separate to the report of the participatory stakeholder workshop.

The option selected depends on when the decisions about the proposal are due to be taken:

- If decision-making is to take place 3-4 weeks (or more) after the report of the workshop has been submitted, it is best to send the recommendations as a separate list.
- If decision-making is to take place within 2 weeks of the report of the workshop having been submitted, it will be helpful for stakeholders if the list of accepted recommendations is incorporated into the workshop report.

When

The report of which recommendations have been accepted by the decision-makers should be made as soon as possible after the meeting at which the decisions were taken.

Who

Personnel involved in this task:

- decision-makers
- Steering Group
- assessor(s)

How

If the Steering Group is responsible for decision-making:

notification of which recommendations were accepted should be sent to the assessor(s), who is responsible for compiling the list for dissemination to stakeholders (either as a separate entity or as part of the workshop report).

If personnel other than the Steering Group are responsible for decision-making:

notification of which recommendations were accepted should be sent to the Steering Group, and then passed on to the assessor(s) who is responsible for compiling the list for dissemination to stakeholders (either as a separate entity or as part of the workshop report).

Advice

If some of the recommendations were not accepted, try to obtain from the decision-makers the reasons why these recommendations were not accepted, and put this information in the feedback to stakeholders.
Task 7.2: Recording which recommendations were implemented

Why It is important to record which of the recommendations accepted by decision-makers were implemented for two reasons.

- This record will comprise a baseline against which the outcomes of proposal implementation can be evaluated. If recommendations were accepted but *not* implemented, it is essential that those responsible for outcome evaluation are aware of this. If it is assumed in the evaluation that recommendations which were accepted were implemented when they were not, this will distort the results and give a false picture, not only of the outcomes of proposal implementation but also of the effectiveness of HIA as a method of enhancing proposals to protect and improve health.

- The reasons for non-implementation of certain recommendations need to be investigated and addressed, as appropriate. There may be implications for accountability in this situation.

When The recommendations accepted by the decision-makers that are actually implemented should be recorded during proposal implementation as part of Monitoring and Evaluation.

What The Steering Group for the HIA will have established, in co-operation with the proposal developer(s) and those responsible for decision-making about the proposal, the requirements for this process during Scoping (see Task 1.13). The process should include:

- a system for recording which of the recommendations accepted by decision-makers were implemented
- a system of dissemination for the record of which recommendations accepted by decision-makers were implemented
Annex 1: Tool for health impact assessment ~ the determinants of health

For use during core workshop tasks

The tool falls into two main parts:

1. factors that have a direct effect on health and well-being (mental and physical)
2. determinants of health, i.e. factors that mediate an effect, or have an indirect effect, on health and well-being (mental and physical)
### Direct Effects on Health

<table>
<thead>
<tr>
<th>Physical Health</th>
<th>Mental Health</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Accidents and injuries</td>
<td>• Self-esteem and confidence</td>
</tr>
<tr>
<td>• Communicable diseases, including foodborne diseases</td>
<td>• Stress</td>
</tr>
<tr>
<td>• Non-communicable diseases, e.g. coronary heart disease, stroke, diabetes</td>
<td>• Anxiety</td>
</tr>
<tr>
<td>• Birth defects</td>
<td>• Depression</td>
</tr>
<tr>
<td>• Conditions, e.g. low birthweight, hypertension, obesity</td>
<td>• Self-harm and suicide</td>
</tr>
<tr>
<td>• Dental health</td>
<td>• Other mental health problems</td>
</tr>
</tbody>
</table>
## Determinants of Health

<table>
<thead>
<tr>
<th>Lifestyle</th>
<th>Personal circumstances</th>
<th>Access</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Diet</td>
<td>• Structure of family unit</td>
<td>• to Employment opportunities</td>
</tr>
<tr>
<td>• Exercise and physical activity</td>
<td>• Cohesion of family unit</td>
<td>• to Workplaces</td>
</tr>
<tr>
<td>• Smoking habit</td>
<td>• Parenting</td>
<td>• to Housing</td>
</tr>
<tr>
<td>• Exposure to passive smoking</td>
<td>• Childhood development</td>
<td>• to Shops (to supply basic needs)</td>
</tr>
<tr>
<td>• Alcohol intake</td>
<td>• Life skills</td>
<td>• to Community facilities</td>
</tr>
<tr>
<td>• Dependency on prescription drugs</td>
<td>• Personal safety</td>
<td>• to Public transport</td>
</tr>
<tr>
<td>• Illicit drug and substance use</td>
<td>• Employment status</td>
<td>• to Education</td>
</tr>
<tr>
<td>• Sexual behaviour</td>
<td>• Working conditions</td>
<td>• to Training and skills development</td>
</tr>
<tr>
<td>• Other health-related behaviours, such as tooth-brushing, bathing, food preparation</td>
<td>• Level of income, including benefits</td>
<td>• to Healthcare</td>
</tr>
<tr>
<td></td>
<td>• Level of disposable income</td>
<td>• to Social Services</td>
</tr>
<tr>
<td></td>
<td>• Housing tenure</td>
<td>• to Childcare</td>
</tr>
<tr>
<td></td>
<td>• Housing conditions</td>
<td>• to Respite Care</td>
</tr>
<tr>
<td></td>
<td>• Educational attainment</td>
<td>• to Leisure and recreation services and facilities</td>
</tr>
<tr>
<td></td>
<td>• Skills level</td>
<td>• to Basic amenities</td>
</tr>
</tbody>
</table>

### Glossary

**Diet:** consider intake of fruit and vegetables, saturated fat, dietary fibre, salt, sugars, fish, folate, cereals and pulses, refined energy-dense foods

**Personal safety:** consider domestic abuse or violence, safety in the home or living accommodation, e.g. fire alarms, security arrangements, etc.

**Employment status:** consider secure employment, temporary employment, unpaid volunteer, long-term unemployed (>52 weeks) and short-term unemployed

**Other health-related behaviours:** consider behaviours such as tooth-brushing, bathing, food preparation, etc.

**Housing tenure:** consider status as owner-occupier, tenant, temporary accommodation, homeless

**Housing conditions:** consider overcrowding, damp, cold, mould

**Access to Education:** consider pre-school, primary, secondary, tertiary, adult/continuing education

**Access to Healthcare:** consider access to primary, secondary and tertiary care

**Basic amenities:** consider access to potable water, power source for heating, lighting, and cooking, waste disposal, sewage disposal, etc.
## Determinants of Health

<table>
<thead>
<tr>
<th>Social Factors</th>
<th>Economic Factors</th>
<th>Environmental Factors</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Social contact</td>
<td>• Creation of wealth</td>
<td>• Air quality</td>
</tr>
<tr>
<td>• Social support</td>
<td>• Distribution of wealth</td>
<td>• Water quality</td>
</tr>
<tr>
<td>• Neighbourliness</td>
<td>• Retention of wealth in local area/economy</td>
<td>• Soil quality</td>
</tr>
<tr>
<td>• Participation in the community</td>
<td>• Distribution of income</td>
<td>• Noise levels</td>
</tr>
<tr>
<td>• Membership of community groups</td>
<td>• Business activity</td>
<td>• Smell/odour</td>
</tr>
<tr>
<td>• Reputation of community/area</td>
<td>• Job creation</td>
<td>• Vibration</td>
</tr>
<tr>
<td>• Participation in public affairs</td>
<td>• Availability of employment opportunities</td>
<td>• Hazards (e.g. radiation)</td>
</tr>
<tr>
<td>• Level of crime and disorder</td>
<td>• Quality of employment opportunities</td>
<td>• Land use</td>
</tr>
<tr>
<td>• Fear of crime and disorder</td>
<td>• Availability of education opportunities</td>
<td>• Natural habitats</td>
</tr>
<tr>
<td>• Level of antisocial behaviour</td>
<td>• Availability of training and skills development opportunities</td>
<td>• Biodiversity</td>
</tr>
<tr>
<td>• Fear of antisocial behaviour</td>
<td>• Technological development</td>
<td>• Landscape</td>
</tr>
<tr>
<td>• Discrimination</td>
<td>• Amount of traffic congestion</td>
<td>• Townscape</td>
</tr>
<tr>
<td>• Fear of discrimination</td>
<td></td>
<td>• Green spaces and parks</td>
</tr>
<tr>
<td>• Public safety measures</td>
<td></td>
<td>• Civic areas</td>
</tr>
<tr>
<td>• Road safety measures</td>
<td></td>
<td>• Use/consumption of natural resources</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Carbon dioxide and other greenhouse gas emissions (energy efficiency)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Solid waste management</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Public transport infrastructure</td>
</tr>
</tbody>
</table>

### Glossary

**Social contact:** consider the number and frequency of contacts in various networks, e.g. community, school, work, etc.

**Social support:** consider emotional and practical support

**Discrimination/Fear of discrimination:** consider discrimination by age, sex, sexual orientation, race, religion, disability

**Availability of education opportunities:** consider pre-school, primary, secondary, tertiary, adult/continuing

**Technological development:** consider domestic, commercial, industrial, agricultural, infrastructure, medical

**Water quality:** consider quality of controlled waters, i.e. rivers, streams, lakes, ponds, estuaries, seas, etc.

**Land use:** consider residential, industrial, commercial, agricultural/horticultural, leisure, conservation

**Natural habitats:** consider availability and quality

**Landscape/Townscape:** consider visual and aesthetic factors

**Solid waste management:** consider disposal, recycling, reuse, composting, collection, transport and storage
Annex 2: Using the determinants of health as prompts

Examples from Pilots ~ we have reproduced a ‘tailored’ version of the tool in which the direct effects on health and the determinants of health it was a priority for the various small workgroups in the HIA of the Food and Health Strategy to address are highlighted (the small workgroups asked to consider specific direct effects on health/determinants of health are shown in italic type after each listing as relevant).

NB: The Glossary is not shown in this example ~ please refer to Annex 1.
**Direct Effects on Health**

<table>
<thead>
<tr>
<th>Physical Health</th>
<th>Mental Health</th>
</tr>
</thead>
<tbody>
<tr>
<td>- Accidents and injuries</td>
<td>- Self-esteem and confidence - <em>Groups A, B, C, D</em></td>
</tr>
<tr>
<td>- Communicable diseases, including foodborne diseases - <em>Groups A, B, D, E</em></td>
<td>- Stress</td>
</tr>
<tr>
<td>- Non-communicable diseases, e.g. coronary heart disease, stroke, diabetes, cancers - <em>Groups A, B, C, D, E</em></td>
<td>- Anxiety - <em>Groups B, D</em></td>
</tr>
<tr>
<td>- Birth defects - <em>Group D</em></td>
<td>- Depression</td>
</tr>
<tr>
<td>- Conditions, e.g. low birthweight, hypertension, obesity - <em>Groups A, B, C, D, E</em></td>
<td>- Self-harm and suicide</td>
</tr>
<tr>
<td>- Dental health - <em>Groups A, B, C, D, E</em></td>
<td>- Other mental health problems</td>
</tr>
</tbody>
</table>

Rapid Appraisal Tool/Eleventh Iteration/January 2002
## Determinants of Health

<table>
<thead>
<tr>
<th>Lifestyle</th>
<th>Personal circumstances</th>
<th>Access</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Diet - <em>Groups A, B, C, D, E</em></td>
<td>• Structure of family unit</td>
<td>• to Employment opportunities - <em>Group C</em></td>
</tr>
<tr>
<td>• Exercise and physical activity - <em>Groups A, B, C, E</em></td>
<td>• Cohesion of family unit</td>
<td>• to Workplaces - <em>Group C</em></td>
</tr>
<tr>
<td>• Smoking habit - <em>Groups A, E</em></td>
<td>• Parenting</td>
<td>• to Housing - <em>Group C</em></td>
</tr>
<tr>
<td>• Exposure to passive smoking</td>
<td>• Childhood development</td>
<td>• to Shops to supply basic needs - <em>Groups B, C, D</em></td>
</tr>
<tr>
<td>• Alcohol intake - <em>Group A</em></td>
<td>• Life skills</td>
<td>• to Community facilities - <em>Group C</em></td>
</tr>
<tr>
<td>• Dependency on prescription drugs</td>
<td>• Personal safety</td>
<td>• to Public transport</td>
</tr>
<tr>
<td>• Illicit drug and substance use</td>
<td>• Employment status</td>
<td>• to Education - <em>Group C</em></td>
</tr>
<tr>
<td>• Sexual behaviour</td>
<td>• Working conditions</td>
<td>• to Training and skills development - <em>Groups B, C, D</em></td>
</tr>
<tr>
<td>• Other health-related behaviours, such as tooth-brushing, bathing, food</td>
<td>• Level of income, including benefits</td>
<td>• to Healthcare</td>
</tr>
<tr>
<td></td>
<td>preparation</td>
<td>• Level of disposable income</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Housing tenure</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Housing conditions</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Educational attainment - <em>Group B</em></td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Skills level - <em>Group C</em></td>
</tr>
</tbody>
</table>
### Determinants of Health

<table>
<thead>
<tr>
<th>Social Factors</th>
<th>Economic Factors</th>
<th>Environmental Factors</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Social contact - Groups A, B, C, D</td>
<td>• Creation of wealth</td>
<td>• Air quality</td>
</tr>
<tr>
<td>• Social support - Groups A, B, C, D</td>
<td>• Distribution of wealth - Group C</td>
<td>• Water quality</td>
</tr>
<tr>
<td>• Neighbourliness - Groups C, D</td>
<td>• Retention of wealth in local area/economy</td>
<td>• Soil quality - Group C</td>
</tr>
<tr>
<td>• Participation in the community - Groups A, B, C, D</td>
<td>• Distribution of income - Group C</td>
<td>• Noise levels</td>
</tr>
<tr>
<td>• Membership of community groups - Groups A, B, C, D</td>
<td>• Business activity - Group C</td>
<td>• Smell/odour</td>
</tr>
<tr>
<td>• Reputation of community/area</td>
<td>• Job creation - Group C</td>
<td>• Vibration</td>
</tr>
<tr>
<td>• Participation in public affairs</td>
<td>• Availability of employment opportunities - Group C</td>
<td>• Hazards, e.g. radiation, chemicals, micro-organisms</td>
</tr>
<tr>
<td>• Level of crime and disorder</td>
<td>• Quality of employment opportunities - Group C</td>
<td>• Land use - Group C</td>
</tr>
<tr>
<td>• Fear of crime and disorder</td>
<td>• Availability of education opportunities</td>
<td>• Natural habitats</td>
</tr>
<tr>
<td>• Level of antisocial behaviour</td>
<td>• Availability of training and skills development opportunities - Groups A, B, C, E</td>
<td>• Biodiversity</td>
</tr>
<tr>
<td>• Fear of antisocial behaviour</td>
<td>• Technological development</td>
<td>• Landscape</td>
</tr>
<tr>
<td>• Discrimination</td>
<td>• Amount of traffic congestion</td>
<td>• Townscape</td>
</tr>
<tr>
<td>• Fear of discrimination</td>
<td></td>
<td>• Green spaces and parks</td>
</tr>
<tr>
<td>• Public safety measures</td>
<td></td>
<td>• Civic areas</td>
</tr>
<tr>
<td>• Road safety measures</td>
<td></td>
<td>• Use/consumption of natural resources</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Carbon dioxide and other greenhouse gas emissions (energy efficiency)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Solid waste management - Groups A, B, E</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Public transport infrastructure</td>
</tr>
</tbody>
</table>
Annex 3: Schedule of questions for use during core workshop tasks

A. Identifying impacts on health ~ for use during Task 5.3

Two levels of questions have been provided for use during core workshop tasks:
- Level 1 questions are for use when the majority of workshop participants have little or no knowledge and experience of HIA.
- Level 2 questions are for use when workshop participants are already skilled at HIA or have gained experience during the introduction of HIA locally.

However, depending on participants’ knowledge and experience of HIA, it may be appropriate to use a combination of questions from Levels 1 and 2.

Level 1 Questions

For each element or aspect of the proposal, ask:
- What will be the outcome(s) of proposal implementation?
- Will these outcomes have a direct impact on health?
- Will these outcomes have an indirect impact on health?
- If so, which of the factors affecting health/determinants of health are key to mediating that impact?

For each impact on health identified, ask:
- What is the nature of the impact – positive or negative?
- Whom will it affect – the whole community/population, or various groups in the community/population?
- Will the nature of the impact be different for any of the vulnerable, marginalised or disadvantaged groups in the population?

If time is available, explore the implications for service planning of each health impact, as follows:
- Will this impact have implications for service planning:
  - in the public sector – if so, which service(s)?
  - in the private sector – if so, which service(s)?
  - in the voluntary sector – if so, which service(s)?
- If proposal implementation involves changes to service provision, will any of these changes have an impact on health and therefore the need for services, and thereby have implications for service planning:
  - in the public sector – if so, which service(s)?
  - in the private sector – if so, which service(s)?
  - in the voluntary sector – if so, which service(s)?
Level 2 Questions

In addition to Level 1 Questions, explore the following.

For each impact on health identified, ask as relevant:

- ‘How many people will it affect?’ [Magnitude]
- ‘Will the impact be continuous? If not, how often will it occur?’ [Frequency]
- ‘When will the impact occur?’ [Time of occurrence]
- ‘Will the impact be widespread, or will it be confined to certain geographical areas or locations?’ [Point of occurrence]
- ‘How likely is it that the impact will occur?’ [Likelihood of occurrence]

For negative impacts: ‘How harmful will it be?’ For positive impacts: ‘How beneficial will it be?’ [Severity/Benefit]

When participants identify impacts on health, ask:

- What is the basis for identifying this impact, is it:
  - information in the evidence base; if so, please give details
  - information in the experience base; if so, please give details
  - your own experience; if so, please give details

If time is available, explore the implications for service planning of each health impact, as follows:

- Will this impact have implications for service planning:
  - in the public sector ~ if so, which service(s)?
  - in the private sector ~ if so, which service(s)?
  - in the voluntary sector ~ if so, which service(s)?

- If proposal implementation involves changes to service provision, will any of these changes have an impact on health and therefore the need for services, and thereby have implications for service planning:
  - in the public sector ~ if so, which service(s)?
  - in the private sector ~ if so, which service(s)?
  - in the voluntary sector ~ if so, which service(s)?
B. Suggesting changes to the proposal to address the health impacts – for use during Task 5.4

Two levels of questions have been provided for use during core workshop tasks:

- Level 1 questions are for use when the majority of workshop participants have little or no knowledge and experience of HIA.
- Level 2 questions are for use when workshop participants are already skilled at HIA or have gained experience during the introduction of HIA locally.

However, depending on participants’ knowledge and experience of HIA, it may be appropriate to use a combination of questions from Levels 1 and 2.

**Level 1 Questions**

1. Recap the results of the first core workshop task, including the factors affecting health/determinants of health key to mediating the impacts on health that were identified.

2. For each of the factors affecting health/determinants of health key to mediating one or more impacts on health, ask:
   - Is there an intervention that could change or alter the way in which the factor/determinant has an effect on health, that is, could the intervention minimise a negative impact or maximise a positive impact?
   - How could that intervention be incorporated into the proposal:
     - Do we need to change the element/aspect that actually gives rise to the impact?
     - Do we need to change another element/aspect to moderate the negative impact or supplement the positive impact of the original element/aspect?
     - Do we need to introduce a new element/aspect into the proposal to moderate the negative impact or supplement the positive impact?

   For negative impacts it is not possible to prevent, minimise, or moderate, ask:
   - Is it feasible to remove from the proposal the element/aspect that gives rise to this impact? Remember to take into account whether this element/aspect is non-negotiable.

If particular elements/aspects of the proposal have been found to have negative impacts on vulnerable, marginalised, or disadvantaged groups but positive (or neutral impacts) on the community or population, it is vital to identify changes to address those negative impacts – the same series of questions can be used.

Towards the end of the time allocation for this task (~5 minutes remaining), explore the following:

‘Are there ways of adding to the proposal that would confer further positive impacts on health?’

*For both levels of questions,* ensure that any of the suggestions to change the proposal will **not** have a negative impact on any of the vulnerable, marginalised, or disadvantaged groups in the population.
**Level 2 Questions**

In addition to Level 1 questions, explore the following.

When participants suggest interventions to address the impacts arising through key determinants of health, ask:

- Is this intervention effective according to:
  - the evidence base; if so, please give details
  - the experience base; if so, please give details
  - your experience; if so, please give details

If there is time, ask:

- Bearing in mind the determinants of health through which proposal implementation will act, what indicators would you use to monitor the proposal’s impact?
- Bearing in mind the impacts on health you have identified, what health outcomes would you use to monitor and evaluate the proposal’s impact?

For each indicator or health outcome, explore whether:

- The data is collected routinely.
- If so, identify the agency responsible for data collection and analysis.
- If not, identify the resource implications for collecting this data *de novo*.

*For both levels of questions,* ensure that any of the suggestions to change the proposal will *not* have a negative impact on any of the vulnerable, marginalised, or disadvantaged groups in the population.
Appendix 1: The process of tool development

The Commission
Towards the end of 1999, the Directors of Public Health (DsPH) of Berkshire, Buckinghamshire, Northamptonshire, and Oxfordshire (known as the Four Counties) commissioned the Public Health Resource Unit, Oxford, to develop a rapid appraisal tool for health impact assessment (HIA). The tool was commissioned in response to a request from partners in local government who wanted to use HIA in their work.

Survey of DsPH
In preparation for the commission, a survey of DsPH was undertaken during Autumn/Winter 1999 to ascertain the following:

- HIA activity at a local level
- the availability of tools and/or models for HIA

The questionnaire was also posted on EH.net. A summary of the results was published in the Health Service Journal (Ison and Griffiths, 2000).

Specifications for the Commission
The general specifications for tool development were:

- the tool should be aimed at those working on the broader public health agenda at a local level – health, local government, voluntary sector, commercial and business sector, and community organisations;
- the tool should be designed and refined in conjunction with potential users;
- the process should be iterative.

The specified criteria for tool development are shown in Box A1.1.

Box A1.1: Criteria for tool development

- Usability – how easy is it to use the tool?
- Usefulness – are the outputs from the tool useful?
- Comprehensibility – is the tool easy to understand?
- Comprehensiveness – does the tool cover a range of determinants of health appropriate to the type of proposals to which it will be applied?

Preparatory Work
A Steering Group was set up, chaired by Professor Sian Griffiths, comprising representatives in health and local government from the Four Counties. The Steering Group took two fundamental decisions.

1. The tool and process to support its use should be devised for application in participatory stakeholder workshops.
2. The process of tool development should be undertaken through a series of pilots.

Tools for, and models of, HIA that were already available (or that had been sent to us as a result of the survey) were reviewed. A prototype tool and process were originated, which were trialled on the Steering Group.

Piloting the Tool
After the trial with the Steering Group, the first iteration of the tool was developed for use in the first pilot. The original intention was to pilot the tool on proposals for implementation in the Four Counties. However, a bid made to the Policy Committee of the Faculty of Public Health Medicine was successful, which meant that pilots could also be undertaken outside the Four Counties.

In total, 10 pilots have been conducted on a variety of proposals at a local level, involving a diversity of stakeholders, including where possible members of the community (see Table A1.1). A new
iteration of the tool, and instructions to support the process of organising the participatory workshop, were produced after each pilot.

Table A1.1: Pilots undertaken during the development of a rapid appraisal tool for HIA

<table>
<thead>
<tr>
<th>Proposal</th>
<th>Type of HIA</th>
<th>Lead organisation</th>
<th>Community involvement?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Affordable Housing Policy *</td>
<td>Prospective</td>
<td>Oxford City Council</td>
<td>No</td>
</tr>
<tr>
<td>Handyvan Scheme for the Elderly</td>
<td>Concurrent</td>
<td>Chiltern District Council</td>
<td>No</td>
</tr>
<tr>
<td>Tenancy Support Officer Scheme for Recently Homeless</td>
<td>Concurrent</td>
<td>Milton Keynes Council</td>
<td>No</td>
</tr>
<tr>
<td>Single Regeneration Budget – Housing Programme</td>
<td>Prospective</td>
<td>London Borough of Newham</td>
<td>Yes</td>
</tr>
<tr>
<td>New Settlement and Rapid Transit System*</td>
<td>Prospective</td>
<td>Cambridge and Huntingdon Health Authority</td>
<td>No</td>
</tr>
<tr>
<td>Single Regeneration Budget – Housing Programme*</td>
<td>Prospective</td>
<td>Cambridge and Huntingdon Health Authority</td>
<td>No</td>
</tr>
<tr>
<td>Housing Estate^</td>
<td>Retrospective</td>
<td>Reading Borough Council</td>
<td>Yes</td>
</tr>
<tr>
<td>Healthy Living Centre</td>
<td>Prospective</td>
<td>Aylesbury Vale District Council</td>
<td>Yes</td>
</tr>
<tr>
<td>Food and Health Strategy</td>
<td>Prospective</td>
<td>Merton, Sutton and Wandsworth Health Authority</td>
<td>Yes</td>
</tr>
<tr>
<td>Air Quality Management Plan</td>
<td>Prospective</td>
<td>Oxford City Council</td>
<td>No</td>
</tr>
</tbody>
</table>

* These pilots were undertaken as training sessions for staff to introduce them to the methodology of HIA.  
^ For this pilot, 2 participatory stakeholder workshops were undertaken; there was also a survey conducted of 200 households on the housing estate, the results of which informed the structuring of the workshops.
Appendix 2: Brief introduction to HIA

What is HIA?
The term health impact assessment can be used to describe:
• a concept
• a process
• a tool
• a complex of methodologies

Definition
‘a combination of procedures or methods by which a policy, program or project may be judged as to the effects it may have on the health of a population’
The Gothenburg Consensus Paper, European Centre for Health Policy, WHO Regional Office for Europe

Development
The methodology of HIA was developed in the context of assessing non-health policies.

Types of HIA
• Prospective - conducted before the implementation of a proposal
• Retrospective - conducted after the implementation of a proposal
• Concurrent - conducted during the implementation of a proposal

Distinguishing characteristics of HIA
• Multidisciplinary
• Intersectoral
• Participatory
• Use of more than one method
• Use of quantitative and qualitative evidence
• Focus on health inequalities

Underpinning values of HIA
• Sustainability
• Promotion of health
• Democracy
• Equity
• Equality
• Ethical use of evidence

Process of HIA
There are five main stages in the process of HIA:
1. Screening - ‘Which proposals should be subject to HIA?’
2. Scoping - ‘What are the boundaries for this particular HIA?’
3. Appraisal - ‘What are the health impacts of this proposal, and what changes could we suggest to minimise the negative and maximise the positive?’
4. Decision-making - ‘Which recommendations to change the proposal should we adopt?’
5. Monitoring and evaluation - ‘What are the health outcomes of implementing the proposal as modified by the HIA, and can we improve the process of HIA?’
Types of appraisal

- **Rapid** - Limited timeframe; use of information/data that are readily available
- **Comprehensive or in-depth** - Extended timeframe; collection of new information/data and a review of information/data that are already available
- **Intermediate** - A term sometimes used to describe an appraisal that is of a relatively limited timeframe and includes some new information/data

**Policy drivers for the introduction of HIA**

1. **Saving Lives: Our Healthier Nation** (Department of Health, 1999)
   
   ‘Local decision-makers must think about the effect which their policies may have on health, and in particular how they can reduce health inequality. In most cases this will require a change in the way that health authorities, local authorities and other local agencies see their role. They will in future need to act much more as health champions at a local level and ensure health is on the agenda of all local organisations and agencies outside the health field. An important part of their role will be to encourage all local agencies to make local health impact assessments when planning investment in, for example, amenities, buildings or local communities and in the location of services.’ (Paragraph 4.47)
2. **National Service Framework for Coronary Heart Disease (NSF for CHD)**
3. **Research and Development Strategy for Public Health**

**Context in the UK**

- HIA is a relatively young methodology
- Many different models and tools are in circulation/being developed
- For most models/tools, there is not a long history of use
- Relatively few evaluations have been performed on the models/tools currently available
- Evaluation of the process of HIA in its infancy
- There have been relatively few evaluations of health outcomes following the implementation of proposals modified during HIA

**The benefits of applying HIA to proposals**

- The potential for health gain
- Achieving added value from non-health proposals
- The use of best available evidence in decision-making
- Community participation in decision-making
- Accountability/transparency in decision-making

**The hallmark of HIA**

The hallmark of HIA is flexibility/adaptability.

- It can be applied to a policy, programme, or project (referred to as a proposal) – from strategic through to tactical use
- It can be applied to a wide range of policy areas, e.g. housing, regeneration, transport, economic development, health services provision, etc.
- It encompasses different types of appraisal, models, tools, and techniques, which means it can be adapted to fit a range of different situations and circumstances
- It involves a diversity of stakeholders

**Introducing HIA into an organisation/partnership**

- Gain commitment to the principles of HIA at a strategic level
- Identify policy and/or strategic frameworks suitable for the introduction and piloting of HIA in organisation/partnership (see Table A2.1)
- Integrate HIA into organisation’s/partnership’s planning and development cycle
- Build the capacity to undertake HIA
Table A2.1: Examples of policy and strategy frameworks in which HIA can be applied at a local level

<table>
<thead>
<tr>
<th>Partnerships</th>
<th>Local government</th>
<th>Health services</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Local strategic partnerships</td>
<td>• Best Value</td>
<td>• Our Healthier Nation (OHN) priority areas</td>
</tr>
<tr>
<td>• HAZs, Education Action Zones, Employment Action Zones</td>
<td>• Unitary Development Plan</td>
<td>• National Service Frameworks (NSFs)</td>
</tr>
<tr>
<td>• Health Improvement Programmes (HImp)</td>
<td>• Local Plan</td>
<td>• Access to services</td>
</tr>
<tr>
<td>• Local Agenda 21 (LA21)</td>
<td>• Sustainability appraisal</td>
<td>• Provision of services</td>
</tr>
<tr>
<td>• Single Regeneration Budget (SRB)</td>
<td>• Environmental impact assessment (EIA)</td>
<td>• Location of services</td>
</tr>
<tr>
<td>• New Deal for Communities (NDC)</td>
<td>• Social impact assessment (SIA)</td>
<td>• Reconfiguration of services</td>
</tr>
<tr>
<td>• Neighbourhood Renewal Schemes</td>
<td>• Local Transport Plan</td>
<td>• New build</td>
</tr>
<tr>
<td>• Sure Start initiatives</td>
<td>• Anti-poverty strategy</td>
<td>• Development of Primary Care Trusts (PCTs) and Care</td>
</tr>
<tr>
<td>• Drug Reference Group-Drug Action Teams</td>
<td>• Procurement and Contracting</td>
<td>• Trusts</td>
</tr>
<tr>
<td>• Joint Investment Plans</td>
<td></td>
<td>• Health promotion</td>
</tr>
<tr>
<td>• Community Safety Plans</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Healthy Living Centre (HLC) initiatives</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Health For All (HFA) initiatives</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Healthy Cities initiatives</td>
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<td></td>
</tr>
</tbody>
</table>
Appendix 3: Reporting the results ~ the proposal’s potential impacts on health

Example from Pilot ~ diagrammatic presentation of the factors involved in the causation of health impacts which were developed for the report of the retrospective HIA of the housing estate

- Figure 1 shows the initial causes, intermediary nodes and outcomes within the theme of Community Safety
- Figure 2 shows the initial causes, intermediary nodes and outcomes within the theme of Housing and Estate Design
- Figure 3 shows the initial causes, intermediary nodes and outcomes within the theme of Access to Services and Facilities
- Figure 4 is a simplified version of Figure 1
- Figure 5 is a simplified version of Figure 2
- Figure 6 is a simplified version of Figure 3
Figure 1: Community Safety

- Offenders evade capture
  - Police approach obvious
  - Single access point to estate
  - Difficulty moving from estate
  - Negative reputation of estate
  - Poor appearance of estate
  - Vandalism
  - Hooliganism
  - Isolation of community
  - Non-residents don’t visit
  - Car Crime
  - Vandalism Hooliganism
  - Isolation of individuals in community
  - Groups of young people with nothing to do
  - Unsafe play area
  - Fire Service withdrawn
  - Increased volume of traffic
    - Poor diet
      - Impaired childhood development
      - Lack of facilities: shops, post office
      - Reduced social contact in community
      - Lack of community participation
      - Isolation of community
    - Lack of primary + pre-school education facilities
      - Lack of play areas
      - Alleyways on estate
        - Fear of crime
          - Burglaries
            - Anxiety
              - Stress
                - Poor family functioning
                  - Irritability/tiredness
                - Poor performance at work
                - Domestic violence
          - Fear of abuse/intimidation
            - Siting of disabled units
              - Poor lighting of football pitch
                - Nuisance
                  - Loss of sleep
                    - Anxiety
                      - Stress
                        - Poor family functioning
                          - Irritability/tiredness
                            - Poor performance at work
                            - Domestic violence
      - alleyways on estate
      - Poor lighting on estate
        - Burglaries
          - Anxiety
            - Stress
              - Poor family functioning
                - Irritability/tiredness
                - Poor performance at work
                - Domestic violence
      - Increased risk of road traffic accidents
        - Children on streets
          - Alleyways on estate
            - Poor lighting on estate
              - Burglaries
                - Anxiety
                  - Stress
                    - Poor family functioning
                      - Irritability/tiredness
                      - Poor performance at work
                      - Domestic violence
Figure 2: Housing & Estate Design

- Allocation policy
- Unbalanced composition of community
  - No sense of community/neighbourliness
  - "Split" communities
  - Isolation of individuals in community
  - Conflict with neighbours
  - Stress
  - Back pain
  - Poor health
  - Fear of crime
  - Poor diet
  - Missed appointments/low take-up of preventative therapy in primary care
  - Depression
  - Fuel poverty
  - Poor housing design [heating/noise insulation]
  - Loss of sleep
  - Estate design [alleyways]

- Rapid expansion of estate
- Different building phases
  - "Split" communities
- Lack of meeting places
- No sense of community/neighbourliness
- Reduced social contact in and outside the community
  - Isolation of individuals in community
- Long distances to walk to service & facilities
  - Missed appointments/low take-up of preventative therapy in primary care
- Back pain
- Poor health
- Fear of crime
- Poor diet
- Demotivation/ "don't bother"

- Estate built on flood plain
- Access difficult for emergency services
- Increased level of traffic
- Increased air pollution
- Respiratory problems
- Increased risk of morbidity from injuries
- Physical isolation of estate/single access point
- Access difficult for emergency services
- Poor bus service
- Lack of areas for play
- Anxiety
- Ghetto-isolation

- Reduced social contact in and outside the community
- Conflict with neighbours
- Stress
- Back pain
- Poor health
- Fear of crime
- Poor diet
- Missed appointments/low take-up of preventative therapy in primary care
- Depression
- Fuel poverty
- Poor housing design [heating/noise insulation]
- Loss of sleep
- Estate design [alleyways]
Figure 3: Access to Services & Facilities

- Lack of GP surgery
- Lack of shops/post office
- Lack of education facilities (pre-school)
- Long distance to services & facilities to supply basic needs
- Time management pressures
- Stress
- Poor bus service
- Single access point to estate

Difficult to access services & facilities

- Loss of existing facilities
- Vandalism of existing facilities
- Anxiety
- Failure to thrive in children
- Poor diet
- Failure to take up primary care appointments
- Impaired personal development/health & well-being

Demotivation

Isolation of individuals & community

Impaired personal development/health & well-being

Time management pressures

Poor diet

Failure to thrive in children

Isolation of individuals & community
Figure 4: Simplified version of Figure 1
Showing Influential Causes, Nodes and Outcomes

- Increased risk of accidents
- Vandalism/Hooliganism
- Design of estate
- Burglaries
- Poor performance at work

- Groups of young people with nothing to do
- Single access point to estate
- Fear of Crime/abuse
- Stress
- Anxiety
- Domestic Violence

- Lack of facilities and services
- Reduced social contact
- Isolation of individuals in community

- Impaired childhood development
Figure 5: Simplified version of Figure 2
Showing Influential Causes, Nodes and Outcomes

Respiratory problems

Increased level of traffic

Poor bus service

Estate built on flood plain

Rapid expansion of estate/phased building

Physical isolation of estate/single access point

Long distances to walk to services and facilities

Estate design [alleyways]

Housing design [heating noise insulation]

“Ghetto”-sation/“Split” communities/No sense of Community neighbourliness

Reduced social contact

Lack of facilities and services on estate

Lack of meeting places

Depression

Demotivation

Stress

Poor diet

Poor health
Figure 6: Simplified version of Figure 3
Showing Influential Causes, Nodes and Outcomes

- Vandalism to existing services/facilities
- Impaired personal development/failure to thrive
- Long distances to walk to services and facilities to supply basic needs.
- Difficult to access services and facilities
- Stress
- Poor bus services
- Isolation of individuals and community
- Lack of services and facilities
- Lack of personal transport
- Single access point to estate
References

  
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  Follow links to HIA.
  
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