Health Impact Assessment

a practical guidance manual

THE INSTITUTE OF
PUBLIC HEALTH IN IRELAND

DEPARTMENT
OF HEALTH AND
CHILDREN

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The Institute of Public Health in Ireland

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CONTENTS

This guidance document has been written using a wide range of sources on HIA. (See Appendix 11 for further details). Elements of the document are adapted from the work of the DG Sanco funded project 'Policy Health Impact Assessment for the European Union'.

1. The purpose of this document

This document describes Health Impact Assessment (HIA) and the steps involved in HIA. It gives advice based on the experience of HIA practitioners and provides tools to help carry out these steps and to adapt HIA to local circumstances.

It aims to provide a user friendly and practical framework to guide policy makers through the HIA process and to enable them to undertake a HIA.

This is the first detailed methodology for HIA in Ireland. The development of methodology is an iterative process and this document will be reviewed in the light of feedback from users and ongoing developments in HIA.

Background

The health strategy *Quality & Fairness, A Health System for You,* the National Anti-Poverty Strategy and Health working group and the Chief Medical Officer's 2001 annual report *Better Health for Everyone* set out how the health and well-being of people in Ireland can be improved. They also outline how the unacceptable inequalities in health can be reduced by taking action to tackle the factors which impact on health. *Quality & Fairness* committed to developing a methodology to enable the health impacts of new policy developments to be evaluated to help ensure that any positive impacts on health can be maximised and negative impacts minimised.

The Department of Health and Children commissioned the Institute of Public Health in Ireland to assist in this task by advising on methodology, producing guidance and facilitating training.

2. Overview of HIA

2.1 Definition of health

The World Health Organisation's definition of health as 'a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity' serves to emphasise the range of factors that influence health and is the definition adopted in this guide.

In addition to genetic factors and lifestyle decisions, health is also determined by social, environmental and economic factors. The policies and programmes of many sectors therefore have significant impacts on health.

For example, a decision on housing renovation to tackle damp and heating problems will improve the health of residents. A transport policy that favours other forms of transport over cars will affect the amount of exercise people take.

By raising awareness of these connections between public policy and health and by addressing the health implications of policy decisions HIA attempts to maximise health gain and minimise health loss from decisions taken in the policy arena.

2.2 What is Health Impact Assessment?

HIA is commonly defined as a combination of procedures, methods and tools by which a policy, programme or project may be judged as to its potential effects on the health of a population, and the distribution of those effects within the population. It is designed to inform and influence decision-making and to reduce health inequalities.

2.3 HIA's contribution to reducing health inequalities

HIA aims to reduce health inequalities by informing policy makers of the potential health impacts of a proposal on different population groups and where appropriate, recommending changes to enable a more equitable distribution of impacts.

All stages and methods of the HIA should consider the implications for health inequalities. For example, a profile of the population should assess how the vulnerable sections of a population are adversely affected by the policy. Priorities and recommendations of the HIA should aim at 'levelling up', or raising the health status of the least healthy population groups to that of the healthiest.

2.4 How HIA intersects with other areas

There is considerable overlap between HIA and other policy assessments, in particular Environmental Impact Assessment. But HIA has a broader outlook on health and uses qualitative as well as quantitative evidence. EIA tends to concentrate on health hazards such as pollution and disease and safety issues. A HIA may be similar to other assessment exercises such as equality proofing, poverty proofing and social inclusion monitoring. HIA adds a health dimension to this kind of exercise and can complement such exercises and enrich them. It has elements in common with needs assessment but has a stronger emphasis on health inequalities and on the voice of the community.

Most of the individual elements or steps of HIA are not new. Rather, it is a collection of familiar approaches put together in a way designed to raise the profile of health.

2.5 What are the benefits of HIA?

Some of the main stated benefits of HIA are as follows:

- extends the protection of human health and reduces the burden of ill health
- enhances the coordination of action to improve health across various sectors
- promotes greater equity in health
- offers the potential to reduce the costs (transferred to the health care sector) of treating the health consequences of non-health policies that have been overlooked during planning and development.

2.6 The policy context - Where has HIA come from and why the current interest?

HIA is an approach that has been developing internationally over the past five to ten years. It has been used extensively in Canada, Sweden, the Netherlands, Australia and other countries.

In the European Union, the Amsterdam Treaty makes provision for HIA in policy making and the public health action programme, commenced in 2003, will promote the development of HIA across Europe. The World Health Organisation has developed a HIA programme and has set targets for member states to develop HIA mechanisms by 2010.

2.7 What is involved in doing a HIA?

There are a variety of approaches to undertaking HIA but most of them follow a similar step-by-step and methodical approach as laid out in this guidance. Experience shows that the different stages laid out here sometimes run into each other. For example, screening and scoping are sometimes carried out as one exercise. Aspects of it can be adapted depending on local circumstances, resources or subject matter.   Each HIA is uniquely determined by local conditions, such as:

- the status and complexity of the policy, programme or project
- whether the HIA is to be undertaken before, during or after decisions on the policy, programme or project are made
- the likelihood of health impacts occurring
- the scale and severity of the impacts
- the resources available
- the quality of the evidence base and availability of data
- locally determined health priorities & targets.

Whatever the approach, it should be rigorous, systematic and transparent.

2.8 When to conduct a HIA

Ideally HIA should be carried out early in the policy-making process when health considerations can still influence the decisions at stake. In deciding when to undertake a HIA, it is important both to be clear about who is making key decisions, and to identify key decision points in a given proposal for a new policy, programme or project.

The following is a classification to denote the stage at which the HIA is undertaken.

Prospective HIA – A prospective HIA is carried out when a policy, programme or project is in its developmental stage and findings and recommendations can influence decision-making. This is the ideal time to carry out a HIA.

Concurrent HIA - A concurrent HIA takes place while the policy, programme or project is being implemented. This might be applicable when the policy, programme or project is subject to review.

Retrospective HIA - A retrospective HIA is carried out on a policy, programme or project that has already been implemented. This can be useful where something similar is being suggested for the near future and it is important to learn from the lessons of previous exercises.

2.9 What are the steps involved in HIA?

This section gives an overview of the stages typically involved in HIA. These steps are described in detail in Section 3.

Screening

Screening quickly and systematically establishes whether a particular policy, programme or project has an impact on health and whether a HIA is appropriate or necessary.

Scoping

If screening has determined that HIA is to be carried out, the next stage is the scoping stage. This stage produces the blueprint for the HIA, establishes a steering group and produces a work plan for the HIA.

Appraisal

The Appraisal stage is the main part of the HIA where health impacts are considered, evidence is gathered and recommendations are framed.

Statement of influence

Once the assessment is complete a statement of influence is produced showing how the HIA has influenced both the decision-making process and outcomes.

Monitoring and evaluation

This stage assesses whether the aims and objectives set at the beginning of the HIA were achieved and whether the methodology used was effective or suitable.

2.10 Schematic representation of HIA procedure and methods

3. Guidance on the methodology

3.1 Gaining knowledge of health and the determinants of health

To begin the process an awareness of the main determinants of health in the relevant policy area is required. This awareness will help judge where a HIA might be appropriate, what research needs to be carried out, what expertise may be required and who needs to be consulted. Evidence to illustrate the effects on health of policy in non-health areas is increasingly available.

There are details of important sources of such evidence in Appendix 10. In Appendices 7 to 9 some of the main determinants of health in Transport, Employment and Housing and sources of information are summarised.

3.2 Screening

A screening process quickly and systematically establishes:

- whether a particular policy, programme or project has an impact on health
- how a policy may affect the health of the vulnerable sections of the population
- the likely direction and scale of the health impacts - are they negligible, serious or speculative
- whether the effects are short term or long term and whether effects are direct or indirect
- if there is a need for a more detailed assessment
- if HIA is the best way to effectively address health and equity issues
- whether there is an opportunity for influence within the policy, administrative and political context

Screening should be kept as simple as possible. Even if the decision is not to do a HIA, screening will be beneficial because it can raise awareness of health impacts among decision makers and prompt them to consider these in the future.

3.2.1 What are the steps involved in screening?

Setting up a core group

It is strongly recommended that screening is carried out by more than one person, and that a core group of key informants and major stakeholders are involved. This will help ensure a wide perspective and will promote ownership of the process at an early stage. This could include, for example, somebody with health knowledge, a voluntary sector representative, the initiator of the policy, an official from another affected department or a community representative. Keeping the number of people involved fairly small at this stage (perhaps 5 or 6 people) will make it easier to manage.

Understanding the proposed policy, programme or project

Study the policy, programme of project and its background context and understand its rationale and aims and objectives. Consider the health impacts of similar policies elsewhere.

Using a screening tool

A tool is provided (Appendix 1) which helps with the tasks involved in screening. The main purpose of the screening tool is to give a structure to discussions or meetings with stakeholders. It aims to prompt consideration of health implications that may otherwise be overlooked and give pointers on the affected population groups that should be considered. Keeping the number of people involved fairly small at this stage (perhaps 5 or 6 people) will make it easier to manage.

Prepare for the meeting

Prior to the meeting it might be useful to:
- Circulate to stakeholders a summarised description of the policy, programme or project
- Establish what aspects of the policy, programme or project is open to negotiation and what is not
- Produce and circulate a basic profile of the population, environment, living conditions, and access to services. (See section 3.4.1 below on profiling)
- Identify the vulnerable, marginalized groups

Establish health impacts and affected population groups

At the meeting have a brainstorming session to get the stakeholders' and key informants' perspectives on what the health impacts might be and what population groups might be affected and how. Out of a list of potential health impacts identified, attempt to prioritise them. This will help to focus scarce resources on the most significant impacts. The screening tool can help to structure this exercise.

Make the process transparent

The screening tool also provides transparency for the process, enabling the recording of decisions and will demonstrate a quality consideration of the health implications.

The outcome of the screening process will determine whether it is necessary and appropriate to conduct a more detailed HIA. If the decision is to proceed with a HIA, the following steps should be followed.

3.3 Scoping

The scoping stage produces the blueprint for the HIA and how it is managed. It establishes a foundation for the rest of the assessment. Some of the suggested steps are as follows:

Setting up a steering group

A HIA steering group is normally set up. The nature and size of the group depends on the complexity of the policy, the resources available and the time available to do the HIA. There may be the core of a steering group from the group already assembled at the screening stage.

Appendix 2 provides a checklist of items to consider when setting up and managing the Steering Group. Appendix 3 includes a checklist of possible resources to consider for the HIA.

Who should be on the steering group?

Identify the main stakeholders and get them involved. Professionals from the relevant policy areas, representatives from affected communities, the voluntary sector and others should be represented. Their input will contribute to informed and balanced results at the end.

Attempt to get a good mix of skills on the steering group

Useful skills include community involvement, public health knowledge and understanding of evidence, research skills (such as literature review, data analysis, qualitative research, stakeholder consultation) negotiation skills, project management and policy analysis. Representatives with access to relevant data could be very useful. Other skills required vary according to the policy type and the depth of the assessment but could include specialist skills in social sciences, epidemiology and health economics

Get the decision makers on board

If possible, get the main decision-makers of the policy or programme to sit on the steering group. If the senior decision makers themselves are not involved ask them to appoint a deputy to attend and keep them up to date. Their involvement will help to demonstrate the added value of HIA to their policy, project or proposal and will make it more likely that the recommendations to maximise health will be accepted.

Explain the health dimensions

Not all participants in the steering group will be familiar with how other policy areas affect health and this should be addressed through awareness raising. Some high level briefings and clearly written promotional material could help foster an understanding of the ideas behind HIA and the process.

Involve somebody with good local knowledge

Involve somebody with good knowledge of local issues who can provide insight into how local population groups might be affected.

Who will manage the HIA process?

The group can determine this. There may sometimes be an advantage to having an outside assessor or facilitator. This person could be used to coordinate the process from beginning to end or to undertake one aspect of it. They could be used for a number of resource-intensive tasks such as documenting decisions, recording the results of appraisal, identifying the impacts missed by stakeholders, finding evidence, prioritising health impacts and helping frame recommendations. An outside HIA facilitator should have public health knowledge and skills, and expertise in conducting HIAs.

Who should chair the group?

A HIA may have the potential for conflicting views so a chair with facilitation skills is very important. The chair should generally not be the same person who is carrying out the bulk of the work in the HIA.

Find out what is open to negotiation

There may be aspects of the policy, programme or project that are not open to negotiation. These should be clearly identified at the outset. Energy might be better spent in mitigating the negative effects on health.

Record decisions for transparency

An archive should be kept and a record of all activity should be documented. This is important to ensure that the assessment is transparent.

Have a work plan or timetable

Have an agreed work plan or programme with clearly defined deadlines and measurable outputs. Find out what the key decision points are, work out how much time there is to make recommendations and decide on what can realistically be achieved by that date.

Decide what methods to use to assess impacts and gather evidence

What communities will be looked at and to what extent can they be involved to get their perspective? For example, will there be surveys, focus groups, meetings or interviews? How will secondary data be collected and how will it be applied to local circumstances? There is a detailed description of methods used to gather evidence in section 3.4.1 below.

Decide how to monitor and evaluate the process

It is important to monitor and evaluate how the HIA was conducted (for example, what worked well, what worked not so well and why –this step is described in more detail in Section 5) and also to assess what impact the HIA had on the policy, programme or project. Decide at the scoping stage how this is going to be done and allocate responsibility for it.

Draw up terms of reference

Draw up and agree the Terms of Reference (TOR) for the HIA. The contents of the TOR will be largely dictated by the elements mentioned above.

3.4 Appraisal

The Appraisal stage is the main part of the HIA. It includes:

- gathering evidence
- assessing and prioritising health impacts
- framing recommendations
- producing a final report
- producing a statement of influence

3.4.1 Methods used to gather evidence

One of the main outputs of the appraisal stage is a set of evidence-based recommendations. The methods used to gather and analyse evidence will vary according to the depth of the HIA. Here is an outline of the main methods used.

Profiling of the population

The population profile helps to establish an overview of the affected population, helps to identify potentially vulnerable groups and can establish a baseline against which possible future health impacts can be assessed.

A profile might include;

- general attributes of the population including size, density, distribution, age and sex breakdown, birth rate, ethnicity, socio-economic status
- health status of the population, particularly the at-risk groups, gained from mortality, disability and morbidity data
- levels of employment or unemployment
- health behaviour indicators
- environmental conditions – transport infrastructure, housing makeup, details on air, water and soil
- geographical location of at-risk groups.

Information for profiles is available from Central Statistics Office (www.cso.ie), the Department of Health and Children (www.doh.ie/statistics), local authorities and the voluntary and community sector.

Analysis of policy proposals

This could consist of the analysis of:

- the proposed policy and supporting documents
- other policies that relate to the policy under investigation
- the social, economic, political, cultural and scientific context of the policy.

Literature review

It may be useful to conduct a review of the literature to search for evidence of the effect of related policy interventions on health.

Participatory, qualitative approaches

Qualitative research gathers evidence from the experience, knowledge, opinions and perceptions of populations affected by the policy (stakeholders) and people with expert knowledge (key informants). This evidence:

- provides a more in-depth picture of the range of health determinants affected by the policy, programme or project
- provides a detailed understanding of how this impacts on health outcomes and why
- contributes to the prioritisation of impacts
- provides a valuable perspective on inequalities

Typical methodology used to consult or incorporate the views of the major stakeholders include;

- community participation
- focus groups
- interviews
- surveys
- workshops

The community is a very important source of evidence, providing insight into how a policy, programme or project may affect their health and community participation forms an important component of many HIAs.

While this kind of resource-intensive evidence gathering and original research may be outsourced to people with research expertise, it is important that the HIA assessor and the steering group keep control of the process and ensure quality control.

For further information and guidance on the principles and structures for effective community participation, see the Health Boards Executive's 'Community Participation Guidelines' (see Appendix 11 for reference information).

Quantitative approaches

Quantitative approaches can be used to estimate changes in health status in the future due to a policy's implementation or estimate changes in health status of some population groups. Surveys are commonly used. Other methods might include forecasting, scenario building, epidemiological analysis and mathematical modelling.

Issues around gathering evidence
The HIA aims to provide a number of evidence-based recommendations but sometimes there is disagreement over what constitutes acceptable evidence. These are some of the issues encountered around evidence and suggested ways of dealing with them.

Lack of evidence
It may be difficult to find evidence to show the direct health impacts of public policy decisions, particularly at a local level. For this reason evidence from other geographical areas is frequently used and applied to local conditions.

Time constraints on gathering evidence
The HIA may not have time to carry out local research and will rely on readily available evidence.

Applying evidence from elsewhere
Local evidence may be difficult to find so you will often need to consider evidence from elsewhere. Where possible, this should be applicable to local circumstances – for example, from a similar geographical area or somewhere with a similar population profile.

Speculative nature of evidence
Where evidence exists, much of it shows associations rather than direct causal connections between policy actions and health impacts. For example, there is an association between poor housing conditions and certain types of illness but there is disagreement about the strength of the association and whether one directly causes the other.

To address this issue, HIA adopts the World Health Organisation approach and applies the **precautionary principle** when dealing with evidence. This means that where there are threats of serious damage to health, a lack of full scientific certainty should not be used as a reason for postponing measures to minimise this damage.

Different views about acceptable evidence
Different views about what is acceptable evidence may lead to challenges to HIA. Some believe only quantitative evidence can apply the required scientific rigour to a HIA while others believe only qualitative research can do justice to the complexity of the social determinants of health. HIA uses the following guiding principles:

Quantitative and qualitative evidence are both important to HIA. The HIA should focus on the quality of the evidence regardless of whether it is quantitative or qualitative. The crucial test of the validity of evidence for HIA should be the quality or robustness of the research design and the validity of its conclusions.

Quantitative and qualitative evidence can complement each other. Qualitative evidence can validate quantitative evidence used from another geographical area and can help shape quantitative surveys and ensure issues of importance to the community are measured.

Decision makers' views on evidence
If the crucial decision makers on the policy, programme or project want to see particular types of evidence used, then highlighting this evidence will improve the chances of the recommendations to maximise health being accepted.

3.4.2 Making recommendations

If prioritisation has not taken place at the screening or scoping stage there may be a large number of potential health impacts of the policy, programme or project identified. To frame recommendations to promote health, these impacts need to be ranked in some way (for example, as high, medium or low).

A tool to help frame recommendations and prioritise them is attached at Appendix 4.

A ranking or prioritisation strategy should be agreed by the steering group. The following criteria and issues should be considered

Strength of the evidence and likelihood of the impact

Is the evidence for the health impact convincing? Is the likelihood of the impact occurring for this particular policy, programme or project definite, probable or speculative?

Some impacts can be measured by direct indicators or quantitatively estimated indirectly by proxy measures. Others are non-quantifiable and are measured instead by opinions or perceptions. Both types of evidence are important to HIA.

Scale of the impacts

If the impact is likely to occur then what will be the likely scale? What proportion of the population might be affected?

The distribution of effects in the population

A policy, programme or project may impact positively on one section of the population and negatively on another. For example, a traffic calming measure will reduce accidents in one part of the community but potentially increase them in another.

Additionally, there may be both negative and positive impacts for the same community from a proposal. For example, a new airport may cause increased traffic and pollution but this may be offset by increased employment opportunities and poverty reduction. The steering group needs to consider how one balances against the other.

Health inequalities

The assessment needs to consider the impact on the health of the more vulnerable sections of the population and as outlined in section 2.4 the recommendations should aim at raising the health status of the least healthy population groups to that of the healthiest.

Latency

The steering group needs to distinguish between long-term impacts and medium or short term impacts. For example, a regeneration housing scheme will have longer term positive impacts for the population as a whole but may have short term negative impacts for some due to the disruption caused by construction.

In Appendix 5 there are some examples of recommendations from completed HIAs.

3.4.3. Final Report

Once the appraisal is complete, impacts have been identified and recommendations for policy revision developed, a report describing the process, findings and policy revision options would be produced.

4. Statement of influence on policy/programme/project

Once the proposal has been finalised, a Statement of Influence is written to record how the HIA has influenced both the decision-making process and outcomes. The statement involves a comparison of the HIA's recommendations with the final proposal, commentary on how the HIA influenced the decision-making process and any budget changes. This statement provides important evidence regarding the effectiveness of HIA and is a milestone in the monitoring and evaluation process. It would therefore have a common reporting format. Appendix 6 provides a format that could be used.

5. Monitoring and Evaluation

Monitoring and evaluation is an integral stage of HIA. Ideally, responsibility should be allocated and resources identified at the steering group stage. They are used to assess whether the aims and objectives set at the beginning of the HIA were achieved. Monitoring and evaluation looks at the following areas:

Process

It assesses how the HIA process was undertaken, who was involved, and how useful and valuable the process was. It determines whether the HIA added value to the decision making process.

Impact

The monitoring and evaluation tracks whether recommendations are subsequently accepted and implemented by the decision makers and if not, tries to determine why not.

Monitoring and evaluation of the process and methodology can be conducted by reading output documents, minutes, agendas and other material and getting steering group members points of view through a survey or interview.

Monitoring the longer term impacts of the HIA

Monitoring and evaluation should also consider the health outcomes of a proposal after a HIA has been conducted. It should aim to assess whether the anticipated positive effects on health, well being and equity were in fact enhanced and whether negative ones were minimised.

The health impacts of a policy may take many years to become apparent and the organisers of a HIA may not be available to measure these impacts once the assessment is complete. For this reason, indicators to measure the longer term health impacts of the proposal should be framed while doing the HIA and these should be included as a discrete strand of the ongoing monitoring of the policy or project.

6. Further Information and Advice on HIA

Further information and advice on conducting HIA can be obtained at the Department of Health and Children at 01 635 4000 or from the Institute of Public Health in Ireland at 01 478 6300.

APPENDIX 1 - Screening Tool

1. Title of the policy, programme or project

2. Reference code

3. Description

4. Type

5. Health determinants
Is the initiative affecting any of the following determinants of health?

Lifestyle	Positive Effect	Negative Effect	No effect
Diet			
Physical activity			
Substance use: alcohol, tobacco, illegal substances			
Safe sex			
Other			

Explanation: If there is likely to be a positive or negative effect on lifestyle factors note briefly here what those effects are.

Physical environment	Positive Effect	Negative Effect	No effect
Air			
Built environment and land use			
Noise			
Water			
Other			

Explanation: If there is likely to be a positive or negative effect on the physical environment, note briefly here what those effects might be.

Socio-economic environment	Positive Effect	Negative Effect	No effect
Crime - will the proposal have an effect on crime or the fear of crime?	☐	☐	☐
Education - will the proposal have an effect on educational opportunities?	☐	☐	☐
Employment - will the proposal have an effect on			
Employment opportunities?	☐	☐	☐
The working environment?	☐	☐	☐
Family cohesion - will the proposal have an effect on levels of family contact?	☐	☐	☐
Housing - will the proposal affect the opportunity to live in a decent affordable home?	☐	☐	☐
Income - will the proposal have an effect on poverty levels?	☐	☐	☐
Recreation - will the proposal have an effect on recreational opportunities such as exercise, social contact, cultural activities and other areas?	☐	☐	☐
Social cohesion - will the proposal have an effect on levels of community interaction?	☐	☐	☐
Transport - will the proposal have an effect on:			
Pollution levels?	☐	☐	☐
Exercise levels?	☐	☐	☐
Accident levels?	☐	☐	☐
Other	☐	☐	☐

Explanation: If there is likely to be a positive or negative effect on socio-economic factors, note briefly here what those effects may be.

Health care	Positive Effect	Negative Effect	No effect
Access to health services	☐	☐	☐

Explanation: If there is likely to be a positive or negative effect on access to health services, note briefly here what those effects are.

7. Population affected
Considering the health impacts identified above, which of the following sections of the population will be affected?

	Positive Effect	Negative Effect	No effect
Whole Population			
Yes	☐	☐	☐
Sub-populations			
Children [0-18 years]	☐	☐	☐
Chronically ill	☐	☐	☐
Economically disadvantaged people	☐	☐	☐
Gender [specify male/female]…………	☐	☐	☐
Homeless	☐	☐	☐
Lesbian, gay and bisexual people	☐	☐	☐
People with disabilities	☐	☐	☐
Racial and ethnic minority groups	☐	☐	☐
Rural population	☐	☐	☐
Older people	☐	☐	☐
Unemployed	☐	☐	☐

(**Note** - there may be other population groups specific to the proposal or policy area being considered not included here (see guidance notes for an example). The exercise may also require one of the above categories to be subdivided further. Additional sub-groups can be added here.)

Explanation: If there is a positive or negative effect on the whole or a section of the population, note briefly here what those effects are. (**Note**, the proposal may have a positive impact on one section of the population and a negative effect on another. Specify where this occurs.)

8. Recommendation
Considering the health impacts, if any, identified above, are these significant enough to warrant a health impact assessment?

Yes ☐

No ☐

(This decision will be based on a judgement of the strength of the available evidence and its applicability to local conditions and the strength of feeling of stakeholders and key informants.)

If No, what are the reasons for not carrying out a HIA?
(Note, possible reasons might include
 - health impacts not considered important enough
 - lack of evidence to show health impacts
 - not enough time to influence decisions on the proposal
 - lack of resources to carry out required level of research

Appendix 2 : Checklist of items to consider when establishing and managing the Steering Group

Include the decision makers of the policy, programme or project on the group ☐

Limit the number on the steering group (generally no more than 12) ☐

Establish the group's values or perspective on health to provide a reference point ☐

Agree how often the group should meet and set dates at the outset ☐

Set up sub-groups to conduct elements of the work if necessary ☐

Find a chair with facilitation skills to deal with potential conflict between group members ☐

Allocate responsibility for different aspects of the HIA and record decisions ☐

Take minutes of each meeting and circulate ☐

Line up potential replacements if members can't attend a meeting ☐

Draw up Terms of reference (TOR) ☐

Details to consider in the TOR include: ☐

Membership ☐

Responsibilities of individual members ☐

Methods of assessment to be used ☐

Expected outputs of the group ☐

Outline of work programme ☐

Deadlines ☐

Budget ☐

Sources of funding ☐

(See checklist of resource items to consider in Appendix 3)

Appendix 3

Checklist of potential HIA resource items to budget for HIA

Office accommodation ☐

Staffing
  Researcher ☐
  Outside validator/Consultant ☐
  Administration staff ☐

Travel
  Agreed Mileage for Car Travel ☐
  Train ☐
  Flights ☐
  Taxis ☐

Equipment
  Computer terminal/laptop ☐
  Tape recorder ☐
  Photocopying ☐
  Mobile phone ☐

Research

  Focus groups/Community meetings
    Hall/room hire ☐
    Transport for participants ☐
    Catering ☐

  Surveys/Interviews
    Survey Design ☐
    Fieldwork ☐
    Analysis and Report ☐
    Statistical software ☐

  Other research costs
    Access to data sources/literature ☐
    Library resources ☐
    Travel costs ☐

Production of HIA report
  Design and printing ☐
  Dissemination/distribution ☐
  Putting report on internet - PDF file ☐

Additional possible steering group expenses
  Room hire ☐
  Catering ☐
  Consultancy fees ☐

Appendix 4 – Tool for Framing Recommendations

This tool suggests one approach to framing recommendations for the HIA. The purpose of the tool is to enable:

1) documentation of the health impacts identified by stakeholders and the steering group.
2) prioritisation of these impacts based on accepted criteria
3) framing of recommendations for the policy, programme or project based on these prioritised health impacts.

Step 1
List in the columns provided both the negative and positive health impacts of the policy, programme or project identified by stakeholders and steering group. Then discuss which of these impacts should be prioritised and indicate in the adjoining columns the reason why.

The criteria for prioritisation will depend on the specific circumstances of the HIA but some of the following could be used.

L = The predicted health impact is likely or very likely and supported by evidence

I = The health impact will have an effect on health inequalities

C = The predicted health impact is considered significant or a cause for concern by the community or population or stakeholders affected by the policy, programme or project.

S = The health impact is speculative

U = The health impact is unlikely in this case

O = Other (Where this is indicated, explain in more detail in the text box provided.)

Negative health impacts	Priority	Positive health impacts	Priority

Other - Explanation

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Step 2
Based on the criteria above list again the health impacts prioritised in Step1. Then after discussion list the recommendations to maximise health gain or minimise health loss.

In Appendix 5 there are some examples of recommendations made from completed Health Impact Assessments.

Prioritised Positive Health Impacts	Recommendations to maximise health gain

Prioritised Negative Health Impacts	Recommendations to minimise health loss

Appendix 5 – Examples of recommendations from case studies

These are examples of recommendations made from completed HIAs that would maximise health gain and minimise health loss.

Liverpool Observatory, 1997 – HIA of a Community Safety Initiative

- Involve local people in designing out crime
- Develop opportunities for employment and training in the community
- Carry out a before and after survey of residents to test effectiveness of initiative
- Get children involved in participatory safety education
- Create recreation facilities for local people.

Liverpool Observatory, 1998 - Development of King George V Playing fields

- Make maximum use of established local networks, sporting clubs and national and local associations in the design of facilities
- Give careful thought to the marketing – especially pricing, to ensure maximum use by deprived communities
- Make public transport links and road safety a priority
- Continue to monitor the health status of the community to assess the impact of the development upon all members of the community, especially the vulnerable groups.

Liverpool Observatory, 1999 – Merseyside Integrated Transport Strategy

- Monitor air quality and build data sets for the key traffic-related pollutants
- Link air quality to available health data sets on a geographical basis
- Continue to promote low emission buses
- Consider phasing traffic management measures
- Continue to promote bus patronage and promote accessible buses
- Maintain non-commercial public transport systems and avoid excessive saturation on commercial routes
- Reduce real and perceived dangers of using public transport at night
- Target mitigation methods for communities adjacent to priority traffic routes
- Minimise the impact of construction of transport infrastructure.

Melbourne road by pass
- Noise attenuation – restrict trucks during sleeping hours.

Manchester Airport
- Actively pursue policies that will maximise the percentage of passenger journeys using public transport
- Limit the number of on-site parking spaces
- Plan and control the number of off-site parking places
- Maintain and expand the air quality monitoring system
- Contribute to monitoring of health effects of air pollution and contribute to research and development aimed at minimising adverse health effects
- Action by those responsible for the increase in noise to ameliorate the effects by sponsorship of local schools
- Enforce noise legislation
- Structure job package to include part-time work in hours suitable for single parents and a stated minimum number to be filled by disabled people
- Advertise jobs in media accessible to single parents, disabled people, unemployed and people from deprived areas. Give priority to local people
- Provide affordable crèche facilities with the appropriate number to cater for likely demand
- Provide transport between the airport and local centres of population at times related to staff working hours.

Appendix 6 - Reporting Format for Statement of Influence

What recommendations of the HIA were accepted as part of the policy, programme or project?

How will these recommendations be implemented in the policy, programme or project?

Accepted recommendations	Method of implementation

How will the potential health impact of these accepted recommendations be monitored on an ongoing basis in the policy, programme or project?

Accepted recommendations	Method of Monitoring

What recommendations from the HIA were rejected and why?

Rejected recommendations	Reasons for rejection

Appendix 7 – Overview of Health Impacts of Transport Policies and Projects

"Everyone is exposed to some degree of health risk from transport, but the adverse health effects fall disproportionately on the most vulnerable groups in our societies: people with disabilities or hearing or sight impairments; older people; the socially excluded; children and young people and people living or working in areas of intensified and cumulative air pollution and noise." (WHO, 1999)

Adapted from 'Carrying out a Health Impact Assessment of A Transport Policy – Guidance from the Transport & Health Study Group, Faculty of Public Health Medicine, Stockport Health Authority' – available from www.nhs.uk/transportandhealth

Air pollution
Motor vehicles are responsible for nitrogen dioxide, carbon dioxide and PM emissions. Air pollution episodes are associated with rises in death and hospital admissions. Ambient levels of air pollution are associated with raised morbidity and mortality. Air pollution also contributes to climate change.

Road traffic injuries
The effects include mortality and injury for bicycle users, pedestrians and passengers. Perceived danger from traffic restricts children's independent mobility and reduces the amount children exercise, with long term implications for childrens' physical and mental well-being.

Physical activity
Physical activity reduces the risk of heart disease, stroke, diabetes, hypertension, depressions, cancer and osteoporosis. A transport policy that encourages exercise through cycling or walking will maximise health.

Community Severance
This is caused by major roads being built through a community, with residents cut off from safe access to shops, school and other parts of their social network. Social contact is beneficial to health but studies in the USA show that social contact tends falls as traffic increases.

Noise
Traffic noise contributes to stress-related health problems such as hypertension and minor psychiatric illness. It can also cause loss of sleep and may interfere with concentration.

Access/Mobility
Access to education, work, shops, health care and social networks are important determinants of health. A transport policy needs to ensure that access is enabled for all these for all sectors of the community, not just car users.

Inequalities
The effects of a transport policy do not fall evenly on all sectors of society. Pedestrians and cyclists are more prone to injuries than drivers. People with higher incomes can live away from a main road and will not suffer as much from air pollution, noise or community severance. Those with easier access to leisure facilities will exercise more.

Checklist of potential health impacts of transport proposals

Health Promoting	Health Damaging
Access to : employment shops recreation social support networks health services countryside Recreation Exercise Economic Development	Road traffic injuries Pollution: particulates carbon monoxide nitrogen oxides hydrcarbons ozones carbon dioxide lead Noise Stress and anxiety Danger Loss of land and planning blight Community severance by road Constraints on mobility, access and independence Reduced social use of outdoor space

Example transport HIAs

HIA of a Local Transport Plan (LTP) for West Yorkshire
HIA of the City of Edinburgh Council's Urban Transport Strategy
On the move: Informing transport health impact assessment in London
(http://www.hiagateway.org.uk/Resources/)

Carrying out a health impact assessment of a transport policy: Published jointly by the Transport & Health Study Group and Faculty of Public Health Medicine (http://www.ihia.org.uk/)

A Prospective Health Impact Assessment of the Merseyside Integrated Transport Strategy (MERITS), Liverpool Health Observatory, 1999 (Available at a charge of £5)
(http://www.liv.ac.uk/PublicHealth/)

Some sources of evidence on transport and health

The European Centre for Environment and Health - Gives information on the WHO work programme around transport, environment and health, provides evidence on the links between transport and health and discusses policy options. http://www.euro.who.int/ecehrome

World Health Organisation, Regional Office for Europe – Website on Transport and Health:http://www.who.dk/healthy-cities/UrbanHealthTopics/20010912_1

HIA Gateway Website, Health Development Agency, U.K., http://www.hiagateway.org.uk/Resources/

Appendix 8 – Overview of Health Impacts of Employment

This document is adapted from the work of a European Commission DG Sanco funded project 'Policy Health Impact Assessment for the European Union' involving research partners in the UK, Germany, The Netherlands and Ireland.

Unemployment and low income
Unemployment tends to affect both physical and mental health and is an important determinant of health inequalities in adults of working age. Unemployment carries a higher risk of morbidity and premature mortality. In England & Wales, mortality from all causes is higher than average for unemployed men. Unemployed women in England & Wales have higher mortality from coronary heart disease and injuries and poisonings, including suicide. Unemployed people tend to have lower levels of psychological well-being ranging from symptoms of depression and anxiety to self harm and suicide. Unemployment affects family income levels that impact on other health determinants, for example, housing or nutrition.

Job insecurity
Job insecurity is associated with negative attitudes to work and negative impacts on health – for example, mild depression and self-reported health status tends to deteriorate among those anticipating a job loss. Insecure jobs also tend to involve high exposure to work hazards of various kinds.

Less skilled, manual workers tend to be most exposed to low paid, temporary or insecure jobs. Downsizing, which can lead to increased job insecurity, has been shown to be associated with long periods of sick leave.

Working conditions
Working conditions of non-permanent workers are worse than those of permanent workers. They have a greater exposure to vibrations, loud noise, hazardous products and repetitive tasks.

Type of work
Jobs involving a high psychological demand but with low control over working conditions are associated with health-related harm. High demand, low control work is more common with lower socio-economic groups and non-permanent workers and is associated with increased risk of heart disease, musculo-skeletal disorders, mental illness and sickness absence. Social support in the workplace has been shown to mitigate this job strain. There is some evidence showing an association between effort-reward imbalance and incidence of coronary heart disease, and precursors of cardiovascular disease.

Employment interventions and health
Improvements in psychological health have been demonstrated with workplace changes. These include workforce participation in planning and problem-solving and altering shift patterns to accommodate worker needs.

Explicit commitment and leadership at a national level also promotes good practice
High-levels of perceived co-worker, supervisor or trade union support can help offset negative effects of job insecurity

A longer term study of Whitehall civil servants in the UK suggests that health could be improved by giving workers in low control environments a greater variety of tasks and a stronger say in decisions related to the workplace.

Some sources of evidence on Employment and health
The European Foundation for the Improvement of Living and Working is a European Union body that contributes to the planning and establishment of better living and working conditions. Its work includes substantial research on the impacts of health on employment.
www.eurofound.ie

The National Institute for Working Life - a Swedish Institute that carries out research and development on working life including links with health. To access the English version use http://www.niwl.se/en

Appendix 9 - The Health Impacts of Housing

This is a brief summary of some of the main impacts of housing on health. Much of this has been adapted from the document 'Housing Improvement and Health Gain: A summary and systematic review' by Hilary Thomson, Mark Petticrew, David Morrison, MRC Social & Public Health Paper No 5, January 2002. This report is available for download at :
http://www.hiagateway.org.uk/Resources/evidence_and_hia_resources

Temperature and warmth
Research in the UK shows a 30% increase in death rates between the summer and winter months and suggests that these variations are related to indoor rather than outdoor temperature. The elderly and the very young are most at risk in the cold weather and helping them reduce exposure by tackling fuel poverty and improving insulation will improve health. Health problems associated with cold indoor temperatures are often linked to the ability to pay fuel bills, rather than the condition of the home itself.

Indoor air quality
The most common airborne particles arise from environmental tobacco smoke, cooking, certain heating appliances and human activity. Hazards associated with the highest health risks (identified by the Building Research Establishment) were hygro-thermal conditions, radon, house dust mites, environmental tobacco smoke and carbon monoxide.   Short term elevations in ambient particles are strongly associated with increased mortality and morbidity (especially acute cardio-pulmonary impairment) Vulnerable groups such as the elderly and asthmatics are most at risk.

Dampness and Hygrothermal growth
If a home is damp or mouldy there is a small increase in the risk to respiratory health. Housing should be designed to prevent the proliferation of indoor allergens.

Home ownership
Home ownership may generate a degree of security and control and in some cases may be associated with good health. However, health (in particular mental health) may be negatively affected by insecure home ownership and mortgage arrears.

House type and design
Poor quality housing and overcrowded housing are associated with low levels of mental health and well-being.   Flat dwelling has been linked to social isolation, crime and reduced privacy. These stressful conditions can affect physical and mental health. With flat dwelling there are also fewer opportunities for safe play for children.

Moving and relocation
Moving to a new area may have health benefits if the relocation leads to an improved social environment with better educational and employment opportunities. On the other hand, moving to another area can lead to a loss of community or social networks, with negative health impacts. Moving is stressful and can also lead to uncertainty and lack of control over changes and living circumstances, particularly in the case of social housing where tenants have limited relocation choices.

Housing costs
High housing costs can negatively affect health. For example, high rents can affect people's budget for an adequate, nutritious diet. Expensive or inefficient heating systems will discourage people on low incomes from using them leading to health risks associated with fuel poverty.

Displacement during regeneration projects
While housing regeneration and improvement projects will generally have longer term health benefits, residents may suffer shorter term negative health impacts through displacement.

Further sources of information and evidence on Housing and Health

In addition to the document mentioned above, the following are useful sources of information:

World Health Organisation source of evidence and information
http://www.who.dk/eprise/main/WHO/Progs/HOH/Home

The following completed HIAs on Housing available for download at:
http://www.hiagateway.org.uk/Resources/completed_hia_database/

Health Impact Assessment of the NEAR Housing Strategy: Scottish Needs Assessment Programme

Housing, Health and Wellbeing in Llangeinor, Garw Valley: HIA

Shepherds Bush Housing Association – Assessing the health impact of housing policy … work in progress

Targeting Housing Improvement Grant HIA

Preliminary Health Impact Assessment of Housing Policies in the Netherlands

Appendix 10 - Information Resources on HIA

The World Health Organisation Regional Office for Europe
The WHO European Office reviews information, models and experience in HIA, discusses the results of international workshops, develops practical tools for policy makers to apply HIA and tests and evaluates these tools in pilot HIA projects. There is also a HIA email discussion group.
www.who.dk

The European Centre for Health Policy gathers information, develops models and methodology and shares experience with HIA. It uses meetings, workshops and an international email network to develop and evaluate practical tools for policy making.
www.who.dk/echp

HIA Gateway Website, Health Development Agency, U.K.,
Developed by the Health Development Agency in England, this website includes information about HIA in England and globally. It includes a database of resources (completed HIAs, toolkits, evidence and other related material), a database of HIA contacts, on-line forms for adding contact details and resources and details of HIA activities in other nations
http://www.hiagateway.org.uk/Resources/

International Health Impact Assessment Consortium
The International Health Impact Assessment Consortium (IMPACT) is a multi-agency partnership formed to help further research, study and practice of HIA. The site includes a searchable database of resources, the Merseyside Guidelines HIA methodology and information on training and events.
http://www.ihia.org.uk/

The Federation of Swedish County Councils
This site includes a general introduction to HIA, a discussion on how policy decisions impact on public health, HIA toolkits and examples of how to implement HIA.
http://www.lf.se/lfenglish/

The International Association for Impact Assessment
The International Association of Impact Assessment (IAIA) supports individuals and organisations involved in different forms of impact assessment by providing a forum for the exchange of ideas and opportunities for collaboration. The IAIA has a health impact assessment email discussion group.
http://www.ihia.org.uk/

The Welsh Health Impact Assessment Support Unit
www.whiasu.cardiff.ac.uk
This site outlines the work of the Welsh Health Impact Support Unit and HIA activity in Wales.

Other websites in development
In 2003, The World Health Organisation is in the process of developing a comprehensive website to enable capacity building on HIA activity worldwide.
The Netherlands School of Public Health is also currently developing a HIA website.
(http://www.hiadatabase.net/)

Appendix 11 - Documents and other Sources of Information for this Publication

Elements of the document are adapted from the ongoing work of the European Commission DG Sanco funded project 'Policy Health Impact Assessment for the European Union'

Training Courses:
Some of the guidance in this document was adapted from advice and written material provided in the following training courses:

Health Impact Assessment in Practice, A four day course about Health Impact Assessment, London Health Observatory, February 12th-13th and March 12th-13th 2003

Health Impact Assessment Training Course, 10-14th March 2003, International Health Impact Assessment Consortium, University of Liverpool

Documents:
(Many of these documents are available for electronic download from the Health Development Agency website: http://www.hiagateway.org.uk.

Health Impact Assessment - an introductory paper. Iris Elliott, The Institute of Public Health in Ireland 2001

An easy guide to HIA for Local Authorities; Chimeme Egbutah and Keith Churchill, Luton, Luton Borough Council, Oct 2002

Carrying out a Health Impact Assessment of A Transport Policy – Guidance from the Transport & Health Study Group, Faculty of Public Health Medicine, Stockport Health Authority – www.nhs.uk/transportandhealth

Community Participation Guidelines, Health Strategy Implementation Project, The Health Boards Executive, Ireland, December 2002

Focusing on health: How can the health impact of policy decisions be assessed; Landstings Forbundet, Svenska Kommunforbundet, Sweden; 1998

Health Impact Assessment: Main concepts and suggested approaches. European Centre for Health Policy (1999). The Gothenburg Consensus Paper, Dec 199. WHO Regional Office for Europe

Health Impact Assessments, A review of reviews, Lorraine Taylor and Rob Quigley, Health Development Agency, London, Oct 2002

Health Impact Assessment, Piloting the Process in Scotland, Scottish Needs Assessment Program

Health Impact Assessment Guidelines, Enhealth, National Public Health Partnership, Canberra, Australia, Sep 2001

Health Impact Assessment of the Near Housing Strategy, Scottish Needs Assessment Programme, Scottish Executive, 1999

HIA of the City of Edinburgh Council's Urban Transport Strategy, Scottish Needs Assessment Programme, May 2000

Housing Improvement and Health Gain: A summary and systematic review, Hilary Thomson, Mark Petticrew, David Morrison, Medical Research Council, Social & Public Health Sciences Unit, Occasional Paper No 5, January 2002

Housing, Health and Well Being in Llangeinor, Garw Valley: A Health Impact Assessment, Eva Elliot, Gareth Williams, School of Social Sciences and Regeneration Institute, Cardiff University, 2002

Independent Inquiry into Inequalities in Health (The Acheson Report). 1998, The Stationery Office, U.K.

Introducing Health Impact Assessment: Informing the decision-making process, Health Development Agency, NHS, 2002

Investing for Health, Department of Health Social Services & Public Safety, Belfast, March 2002

Methods of Health Impact Assessment: a literature review; Linda McIntyre, Mark Petticrew, Medical Research Council, Social & Public Health Sciences Unit, Occasional Paper, December 1999

On the move: Informing transport health impact assessment in London, NHS Executive, London, October 2000

Prospective Health Impact Assessment: Pitfalls, problems and possible ways forward: Jayne Parry & Andrew Stevens, BMJ, Vol 323, Nov 17 2001.

Rapid Appraisal Tool for Health Impact Assessment in the context of Participatory Stakeholder Workshops: A Task Based Approach, Erica Ison, Institute of Health Sciences, Oxford, 2001

Resource for Health Impact Assessment. Erica Ison, Oct 2001, NHS Executive, London – available for electronic download from www.londonshealth.gov.uk

Wraparound: The Health Impact Assessment of the All-Inclusive Wraparound Scheme,
The Southern Health and Social Services Board & The Institute of Public Health in Ireland, August 2002