出國報告(出國類別：國際會議)

參加第 12 屆健康影響評估國際研討會

服務機關：行政院環境保護署綜合計畫處
姓名職稱：賀志殷技正
派赴國家：加拿大
出國期間：101 年 8 月 27 日起至 9 月 2 日
報告日期：101 年 11 月 28 日

摘要

健康影響評估（HIA，Health Impact Assessment）是世界衛生組織（WHO）近幾年致力提倡的一種計畫評估工具，此項工具發展之目的在於預先發覺各項政策、計畫、方案，可能對民眾健康、生態環境造成的衝擊。茲為了解世界各國健康影響評估政策形成的過程與相關的評估及研究方法，特參加國際影響評估協會辦理之第 12 屆健康影響評估國際研討會，以作為我國環境影響評估制度檢討改進之重要思考方向及參考。

本次研討會主題為「如何將健康影響評估納入所有在健康方面的政策」，主要討論的 4 個議題為健康影響評估政策形成過程、健康影響評估在行政及管理上相關制度、健康影響評估實行的差異性，以及增進健康影響評估實行的相關評估方法及研究等。歐洲地區國家已將健康影響評估技術實際應用於多項國家大型政策的先期評估，以彌補現行環境影響評估（EIA）將重點放在特定的開發案之不足。執行健康影響評估的五個步驟包括：篩選、範疇界定、評價、調整提案的決定或目的、持續性的監控和評價，根據世界衛生組織（WHO）網站調查資料，目前將健康影響評估應用分成 18 種類，其中以交通與運輸領域健康影響評估最為廣泛，其次是開發領域。

歐洲政府組織或其他機構，使用健康影響評估的主要重點是期望在制定政策或決策時，藉由健康影響評估提供的證據，以減少對人類健康之負面衝擊，從歐美推動成果可知，健康風險評估確實可以改善政策執行時所造成的健康衝擊。由於環境影響評估多傾向評估環境方面的衝擊，或部分環境影響評估報告書將致癌風險或非致癌風險等健康風險評估（Health Risk Assessment）被狹隘的進行分析，而諸如其他的死亡率和罹病率的風險、累積影響和隔代影響等廣大的健康影響因素，均未被討論，因此 WHO 歐洲地區分部構想將健康影響評估整合進入環境影響評估流程中，提出環境健康影響評估（EHIA）。另外亦有將健康影響評估整合成為政策環境影響評估（SEA）的一部分，都值得我國未來環境影響評估修正方向之參考。在歐美先進國家已逐漸推動健康影響評估法制化，因目前我國並無專一權責單位統籌執行健康影響評估工作，或跨部門技術整合，因此建議我國朝向立法方式，確認責任歸屬單位，在未來執行健康影響評估工作。

目次

一、目的

(一)緣起

健康影響評估（HIA，Health Impact Assessment）是世界衛生組織（WHO）近幾年致力提倡的一種計畫評估工具，此項工具發展之目的在於預先發覺各項政策、計畫、方案，可能對民眾健康、生態環境造成的衝擊。國際影響評估協會（IAIA，International Association for Impact Assessment）成立於 1980 年，為國際性民間組織，涵括環境、社會、經濟、文化、健康影響及政策環境影響評估等領域，其會員來自 100 個以上國家，歐盟各國、美國、加拿大及亞洲等各國均積極參與其會議及相關研習活動。茲為了解世界各國健康影響評估政策形成的過程與相關的評估及研究方法，特參加該會健康部門辦理之第 12 屆健康影響評估國際研討會，以作為我國環境影響評估制度檢討改進之重要思考方向及參考。

(二)開會目的

本次開會的目的有以下三項：

1. 了解世界各國健康影響評估評估政策形成的過程、實行方式與相關的評估及研究方法之最新的發展議題與趨勢，作為我國推動健康影響評估及環境影響評估相關工作之重要參考。
2. 藉由參加該會議及相關研討，並與會議參與各國人員交流意見。
3. 蒐集探討歐美等先進國家最新健康影響評估政策及相關評估方法。

二、開會行程

本次開會行程自 101 年 8 月 27 日起至 101 年 9 月 2 日共計 7 日，開會地點為加拿大魁北克市，開會行程表如表一，其詳細開會議議程如附件一。

表一、開會行程表

日期	地點	工作內容
101 年 8 月 27 日（星期一）至 8 月 28 日（星期二）	台北至加拿大魁北克市	啟程
100 年 8 月 29 日（星期三）至 31 日（星期五）	加拿大魁北克市	參加會議
100 年 8 月 30 日（星期四）	加拿大魁北克市	參加會議
100 年 8 月 31 日（星期五）	加拿大魁北克市	參加會議
100 年 9 月 1 日（星期六）至 9 月 2 日（星期日）	加拿大魁北克市至台北	返程

三、開會內容

第 12 屆健康風險評估國際研討會主題為「如何將健康影響評估納入所有在健康方面的政策」，主要討論的 4 個議題為健康影響評估政策形成過程、健康影響評估在行政及管理上相關制度、健康影響評估實行的差異性，以及增進健康影響評估實行的相關評估方法及研究等。來自各國不同領域的專家學者就各種領域研究提出發表，部分論文摘要如下：（相關論文摘要資料詳如附件二，其它會議重點資料詳如附件三）

(一) 健康影響評估政策形成過程

本次會議在此議題下主要討論以下分項子題包括：熟悉以健康影響評估為策略之健康政策、對於健康城市及富饒土地之健康影響評估及永續發展。

健康影響評估政策、所有政策中有關健康的議題、健康影響評估的政策制定過程、健康影響評估與政治問題、營養方面的政策、應用到政策的健康影響評估等。

1. 健康影響評估的起源一般被認為在美國 1969 年的全國環境政策法令中所提及，在所有聯邦法律以及影響人們環境的主要行動中，會將健康影響評估(HIA)委託於環境影響報告書中管理，其中包括對人類健康有影響的評估。1981 年世界衛生組織(WHO)成立國際環境管理專家小組，小組目標是在計畫階段時，促進大家對水資源發展計畫環境管理議題的認識；1983 年 WHO 公布功能完整的供水系統所帶來的正向健康影響之評估過程。因此，希望從設計健康獲益的計畫中使衛生設施有所改善。在歐洲共同體之條文第 174 條中有提到：保護人類健康是它們的目標之一，其中阿姆斯特丹之條文內還強調，大眾健康應該在非健康部門的政策中被強調與關心，HIA 就是一個可以幫助達成上述保護健康目標之工具，且對許多轉變中的國家，HIA 可以對其發展政策的永續性上有所貢獻。

2. 傳統上，環境影響評估很少提及人類的健康，或許是因為健康所關心的範圍並不是非常清楚，或是因為政策領域與健康之間的關係，被認知的程序上是較低的。健康應該包含在環境影響評估中，但是不應該只被限制在生物物理學方面。例如在環境影響評估中，健康方面通常只侷限在特定的空氣或水污染物這類毒物學層級中。澳洲的環境管理和污染控制法令於 1996 年宣告，要求環境影響評估中要包括健康的影響評估，要將 HIA 用在所有活動中，藉由法律要求作環境影響評估。HIA 充分整合 EIA 過程，國家架構中為了環境和健康影響評估，其原則視為一致。

3. 健康影響評估(HIA)是已實行之下可能受影響的潛在健康問題，特別是對弱勢團體或非營利族群。HIA 對決策者和掌權者提出建議書，主要針

對提案進行所可能帶來正面衝擊影響的最佳化和負面健康影響之最小化。HIA 是一種程序、方法和工具的組合。用來判斷政策、計畫或專案計畫對人類健康的潛在影響，以及族群中這些影響的分布狀況，目的是為了將健康損失降到最小以獲得最大的健康。HIA 主要的兩個目的是改善群體的健康，以及減少健康的不平等，另外的目的還包括提供資訊決策者，包括任何政策、計畫、企劃實施後會影響人們健康的資訊、嘗試影響決策者去改善計畫、HIA 的基礎促進人們的健康和福址。

4. 為何使用健康影響評估?使用 HIA 的理由，除了要使政策制定所帶來的正面衝擊最大化，將負面衝擊減至最小化，其中還包括促進跨部門的合作工作、重視社區意見的參與方法、健康影響評估提供決策者一個可利用的證據、促進健康和減少不平等、它是一個正向的方法、適用於政策、計畫及專案計畫、合適性、與永續發展及資源管理做連接、許多人皆可使用健康影響評估。

(二) 健康影響評估在行政及管理上相關制度

本次會議在此議題下主要討論以下分項子題包括：健康影響評估的評價、健康影響評估與制度化、健康影響評估與其他程序的整合、分享各國健康影響評估的經驗、有關食物及農業的健康風險評估、健康風險評估與原住民社區等。

1. 在 2005 年 WHO 提及健康影響評估以民主主義、公平性、永續性發展、道德性的證據使用的四個價值為依據以成為一個執行的平台，這將使大眾健康獲得重視，並從事決策過程中將 HIA 觀念引入。HIA 一些重要的核心原因像是帶領公共衛生議程進入主流政策的制定，還包括 HIA 反應出大眾所關心的健康議題、HIA 證明健康的獲得、回應政府的政策優先次序、發展出內外部有效的夥伴關係等特殊重要性。

2. 對於健康影響評估發展經驗案例，在英國對 Finningley 機場開發進行健康影響評估，其主要的衝擊在社會經濟方面包括就業、生活品質等社會經濟衝擊，交通的衝擊、環境污染衝擊進行評估等。另對於威爾斯國家植物花園之計畫開發前進行健康影響評估，評估內容包括對職業、地方經濟的現金收入、旅遊、對參訪者之影響、對志工的影響、對社區的影響、對永續性的貢獻、對健康不平等之衝擊等。在俄羅斯庫頁島發展石油及天然氣開發案，進行建設及營運階段對島上居民進行健康影響評估，評估項目包括對於改善體能、焦躁煩惱、傳染性疾病、身體傷害等之衝擊，這些影響評估都將供決策者做為決策之參考。

(三) 健康影響評估實行的差異性

本次會議在此議題下主要討論以下分項子題包括：健康影響評估過程中利害關係人的參與、健康影響評估程序的公平性、健康影響評估程序中的證據、健康影響評估及所處的生活環境、國家層級的健康影響評估、地方層級的健康影響評估、城市方面的健康影響評估等。

1. 執行健康影響評估的層級包括國際性的層級、國家性的層級、區域性的層級、地方性的層級。執行健康影響評估的時間點包括政策及計畫開發前(預期性)、政策及計畫開發期間(進行性)、政策及計畫開發後(回顧性)的健康影響評估。健康影響評估關係主體包括開發單位、目的事業主管機關、衛生環境主管機關、其他相關主管機關、公共利益團體、當地民眾、開發計畫及評估顧問機構、諮詢學術機構及專家有關團體等。

2. 根據 2005 年世界衛生組織（WHO）網站統計，各國(包括已開發國家之英國、紐西蘭、加拿大、愛爾蘭、澳洲、奧地利、法國、瑞士，開發中國家之泰國、捷克、愛沙尼亞、立陶宛、斯洛伐克、俄羅斯、印度、波蘭)應用健康影響評估於各面向之概況，將目前健康影響評估應用分成

農業、空氣、文化、開發、能源、環境、住宅、整合性衝擊評估、製造業、礦業、噪音、娛樂休閒、社會福利、觀光、交通與通信、廢棄物、水和其他主題 18 種類，其中以交通與運輸領域健康影響評估最為廣泛，其次是開發領域、空氣、重建、能源、住宅、社會福利、健康服務、農業等，其中以英國所進行的 HIA 面向為最多，已開發的國家多有執行交通與通信面向，開發中國家最重視發展面向的 HIA 執行，兩者間的差異也顯示出已開發和開發中國家目前對 HIA 使用的需求並不相同，但其最終目的皆是讓正面衝擊最大化，負面衝擊最小化。

(四) 增進健康影響評估實行的相關評估方法及研究

本次會議在此議題下主要討論以下分項子題包括：健康影響評估與其他程序的整合、以證據為基準之健康影響評估工具、健康影響評估方法分析、有關食物及農業的健康風險評估、健康風險評估與原住民社區等。

1. 執行健康影響評估五個連續性核心步驟篩選（決定是否可以執行健康影響評估）、範疇界定（在一個指定的內容中決定如何執行健康影響評估）、評價（對健康和公平正義的潛在影響作確認並考慮證據之範圍）、調整提案的決定或目的（決策者衡量族群健康利益，調整政策、計畫或專案計畫，使其形式化並排列建議之優先次序）、持續性的監控和評價。

2. 在健康影響評估之發展趨勢，許多國際政策與條例都將健康影響評估成為較廣泛的政策範圍，目前健康影響評估在歐洲屬於一個獨立評估的方式，並不像環境影響評估及政策環境影響評估，有法制化的義務架構來支持，由於健康影響評估與政策環境影響評估有相似之處，因此，在面臨及克服整合性的共識、實行的可能性、評估技術與能力的建立、實證基礎的建立、從經驗中學習等，可逐步將健康影響評估整合為政策環境影響評估的一部分，或將健康影響評估整合至政策環境影響評估中之主

要議題。

四、心得與建議

(一) 本次第 12 屆健康影響評估（HIA，Health Impact Assessment）國際研討會議係國際影響評估協會（IAIA）健康部門所辦理，該會議以「如何將健康影響評估納入所有在健康方面的政策」為主題，並以健康影響評估政策形成過程、健康影響評估在行政及管理上相關制度、健康影響評估實行的差異性，以及增進健康影響評估實行的相關評估方法及研究等四大面向，分享先進國家在健康影響評估執行情形。

(二) 健康影響評估技術是世界衛生組織（WHO）近幾年致力提倡的一種計畫評估工具，此項工具發展之目的在於預先發覺各項政策、計畫、方案，可能對民眾健康、生態環境造成多大的衝擊。歐洲地區國家（例如：英國、荷蘭、德國、澳洲、紐西蘭、加拿大等）已將健康影響評估技術實際應用於多項國家大型政策的先期評估，以彌補現行環境影響評估（EIA）將重點放在特定的開發案之不足。

(三) 健康影響評估兩個主要的目的是改善群體的健康以及減少健康的不平等。執行健康影響評估的五個步驟包括：篩選（決定是否可以執行健康影響評估）、範疇界定（在一個指定的內容中決定如何執行健康影響評估）、評價（對健康和公平正義的潛在影響作確認並考慮證據之範圍）、調整提案的決定或目的（決策者衡量族群健康利益，調整政策、計畫或專案計畫，使其形式化並排列建議之優先次序）、持續性的監控和評價。

(四) 根據世界衛生組織（WHO）網站將目前健康影響評估應用分成 18 種類，包括有農業、空氣、文化、開發、能源、環境、住宅、整合性衝擊評估、製造業、礦業、噪音、娛樂休閒、社會福利、觀光、交通與通信、

廢棄物、水和其他主題，其中以交通與運輸領域健康影響評估最為廣泛，其次是開發領域。

（五）健康影響評估在政策決策中的角色包括：使用於專案計畫、方案和政策、協助政策發展、為決策者提供資訊、同時影響政策和民眾、公眾介入、滿足許多政策制定的要求、確認健康影響評估技術之外亦會影響政策的其他因素、促進正面結果和減少負面結果的前置處理過程等。

（六）在英國，健康影響評估技術已被大量應用於社區總體營造相關實務工作，用以評估該社區所將面臨的各項計畫，預測這些計畫可能對居民健康與生活環境造成的衝擊與影響。

（七）在歐洲，將健康影響評估（HIA）被視為環境影響評估（EIA）的一部分來執行，而德國和荷蘭已經將健康影響評估及環境影響評估之執行進行整合。

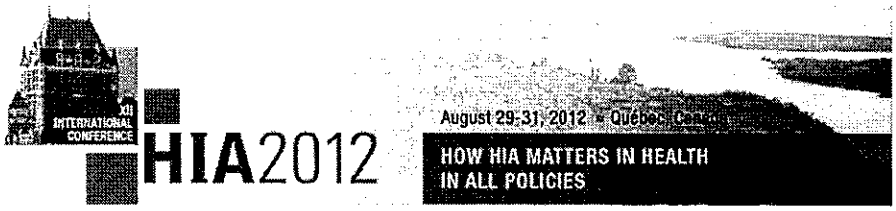
（八）歐洲政府組織或其他機構使用健康影響評估的主要重點是期望在制定政策或決策時，藉由健康影響評估提供的證據以減少開發行為對人類健康之負面衝擊，因健康影響評估發展至今仍是一個新概念，在台灣鮮為人知，從歐美推動成果可知，健康風險評估確實可以改善政策執行時所造成的健康衝擊。因此建議我國可多蒐集相關國外發展的經驗及評估案例，逐漸發展我國健康影響評估制度。

（九）健康影響評估與其他影響評估方法之整合亦為世界先進國家發展趨勢之一，由於環境影響評估多傾向評估環境方面的衝擊，或部分環境影響評估報告書將致癌風險或非致癌風險等健康風險評估（Health Risk Assessment）被狹隘的進行分析，而諸如其他的死亡率和罹病率的風險、累積影響和隔代影響等廣大的健康影響因素，均未被討論，因此WHO 歐洲地區分部構想將健康影響評估整合進入環境影響評估流程

中，提出環境健康影響評估（EHIA）。另外亦有將健康影響評估整合成為政策環境影響評估（SEA）的一部分，都值得我國未來環境影響評估修正方向之參考。

（十）在歐美先進國家已逐漸推動健康影響評估法制化，因目前我國並無專一權責單位統籌執行健康影響評估工作，或跨部門技術整合，因此建議我國朝向立法方式，確認責任歸屬單位，在未來帶領各相關單位執行健康影響評估工作。

附件 1　會議議程



Conference Program

[F] Presentations in French
[E] Presentations in English

Wednesday, August 29, 2012 Thursday, August 30, 2012 Friday, August 31, 2012

Wednesday, August 29, 2012

7:30 to 8:30 a.m.
Arrival and Registration
Grande Place

PRECONFERENCE WORKSHOPS

8:30 to noon
Workshop: *Se familiariser avec l'EIS en tant que stratégie dans toutes les politiques* (workshop in French only) **FULL**
Room Beaumont/Bélair

12:30 to 1:30 p.m.
Arrival and Registration
Grande Place

1:30 to 5:00 p.m.
Workshop: Becoming Familiar with HIA as a Strategy for Health in All Policies (workshop in English only) **FULL**
Room Beaumont/Bélair
National Collaborating Centre for Healthy Public Policy, Institut national de santé publique du Québec, Canada

HIA is a structured process. Within the context of policy development, it allows for an examination of the relationship between a range of elements, thus encouraging decision-making that takes into account potential health effects. This workshop's overall goal is to familiarize participants with the approach of HIA as a means to facilitate the integration of health in all policies. By the end of this session, participants will be able to:

- describe the state of HIA practice in Canada and around the world;
- situate HIA practice within the context of Health in All Policies as compared to other models or ways of understanding of HIA practice;
- identify the standard HIA steps as well as to choose the related tools involved;
- use two tools related to the standard HIA steps;
- recognize the conditions that favor the use of knowledge generated from HIA in decision-making.

How the workshop will proceed

1:30 to 1:45 p.m.
Welcoming Remarks

1:45 to 2:35 p.m.
HIA Overview of HIA Practice
Lecture and exchanges

- State of practice in the world
- Different models of HIA practice
- Classic or standard steps in HIA

2:35 to 3:00 p.m.
Screening Exercise
Exercise in small groups and plenary

3:00 to 3:15 p.m.
Break

3:15 to 4:00 p.m.
Scoping Exercise
Exercise in small groups and plenary

4:00 to 4:55 p.m.
HIA and Policy-Making Processes–Conditions For Using HIA Results in Decision-making
Sharing experiences and exchanges on key issues
[E] Stéphanie Lefebvre, MSW, Manager in Health Equity, Sudbury & District Health Unit, Ontario, Canada

- Policy decision-making processes and the role of evidence
- Favorable factors, according to the literature

4:55 to 5:00 p.m.
Closing Remarks

Trainers:
[E] Louise St-Pierre, MSc, Head of projects, National Collaborating Centre for Healthy Public Policy, Institut national de santé publique du Québec, Canada
[E] François Benoit, Lead, National Collaborating Centre for Healthy Public Policy, Institut national de santé publique du Québec, Canada

1:30 to 5:00 p.m.
Workshop: Healthy Cities, a fertile Ground for HIA and Sustainable Development

Room Beauport
Réseau québécois de Villes et Villages en santé, Québec, Canada
Lectures will be given in French. However, simultaneous translation will be provided in English.

Started and supported by the World Health Organization, the international Healthy Cities movement has existed worldwide for over 25 years. It aims to incorporate health and sustainable development into municipal policies and projects by focusing on strategies such as citizen involvement, cross-sector partnerships, and the commitment of municipal managers. In several European countries, HIA and sustainable development are ingrained in the Healthy Cities movement. Quebec is questioning the practical feasibility of achieving this. This 12th International Conference on Health Impact Assessment offers an ideal setting for reflection, with the participation of all those who work in a municipal context.

The overall goal of this workshop is to establish the interrelationship between HIA, sustainable development, and the Health Cities strategy and to contribute to an overall reflection on the place of HIA and sustainable development in cities and communities. More specifically, at the end of this workshop, participants will be able to:

- summarize the European Healthy Cities model that includes health, sustainable development, and HIA;
- describe approaches and tools to entrench health and sustainable development in municipal policies and projects.

How the workshop will proceed

1:30 to 1:45 p.m.
Welcoming Remarks and Presentation of the Context
Denis Marion, Representative of the Réseau québécois de Villes et Villages en santé; mayor, city Massueville, Québec, Canada
Richard Massé, MD, FCRCP, Chair of the International Scientific Committee of the 12th International Conference on Health Impact Assessment; Public Health Officer, Agence de la santé et des services sociaux de Montréal; Associate Professor, département de médecine sociale et préventive, Université de Montréal, Québec, Canada

Session moderator:
Michel O'Neill, PhD, Associate Professor, Faculté des sciences infirmières, Université Laval; Consultant and Trainer in health promotion, Québec, Canada

1:45 to 2:15 p.m.
Healthy Cities in Europe: An Approach that Integrates Health, Sustainable Development, and HIA
Jean Simos, Dr ès sc., Visiting Professor, Université de Liège ; Project Manager, Groupe de recherche en environnement et santé, Université de Genève; President, S2D, Centre collaborateur OMS pour les Villes-Santé francophones, Switzerland

2:15 to 2:45 p.m.
Overview and Characteristics of Integrated Sustainable Development Approaches in Municipal Organizations in Québec
Stéphane Bouchard, Deputy Director, Direction générale des politiques, Ministère des Affaires municipales, des Régions et de l'Occupation du territoire du Québec, Canada

2:45 to 3:00 p.m.
Questions and exchanges

3:00 to 3:30 p.m.
Break

3:30 to 4:50 p.m.
Interactive panel
The Experience of Municipalities That Have Integrated Sustainable Development and Health in Projects, Processes, and Policies
Éric Charbonneau, Mayor of Acton Vale, Québec, Canada
Gilles Bergeron, Director, Direction de la culture, des sports, des loisirs et du développement social, arrondissement de Côte-des-Neiges–Notre-Dame-de-Grâce, Québec, Canada
[F] Michel Morin, Mayor of Rivière-du-Loup, Québec, Canada
Benoit Ouellet, Director, Service loisirs, culture et communautaire, city Rivière-du-Loup, Québec, Canada

4:50 to 5:00 p.m.
Closing remarks
Discussion Highlights and Future Directions
Denis Marion, Representative of the Réseau québécois de Villes et Villages en santé ; Mayor of Massueville, Québec, Canada

12th International Conference on Health Impact Assessment (HIA)

5:00 to 7:00 p.m.
Arrival and Registration
Grande Place

7:00 to 7:30 p.m.
Official Opening
Salon Palais
Alain Poirier, MD, MSc, FRCPC, Chairman of Local Organizing Committee of the 12th International Conference on Health Impact Assessment, former National Public Health Director and Assistant Deputy Minister, Ministère de la Santé et des Services sociaux du Québec, Canada
Michelle Morin-Doyle, Deputy Mayor, Ville de Québec, Canada
Richard Massé, MD, FCRCP, Chair of the International Scientific Committee of the 12th International Conference on Health Impact Assessment; Public Health Officer, Agence de la santé et des services sociaux de Montréal; Associate Professor, département de médecine sociale et préventive, Université de Montréal, Québec, Canada

7:30 to 8:30 p.m.
Opening Address
Coming of Age of HIA - Current and Future Perspectives
Carlos Dora, Coordinator, Public Health and Environment Department, World Health Organization, Switzerland

(Video presentation mainly in English)

8:30 pm
Opening Reception
Grande Place

Thursday, August 30, 2012

7:30 to 8:30 a.m.
Arrival and Registration
Grande Place

8:30 to 8:40 a.m.
Welcome Remarks
Salon Palais
Richard Massé, MD, FCRCP, Chair of the International Scientific Committee of the 12th International Conference on Health Impact Assessment;Public Health Officer, Agence de la santé et des services sociaux de Montréal; Associate Professor, département de médecine sociale et préventive, Université de Montréal, Québec, Canada
Judith Bossé, PhD, Assistant Deputy Minister, Health Promotion and Chronic Disease Prevention Branch, Public Health Agency of Canada, Ontario, Canada

8:40 to 10:00 a.m.
Plenary Session: **Health in All Policies and HIA**
Salon Palais

Impact Assessments as a Means to Implement Health in All Policies
[E] Timo Ståhl, Technical Officer, Department Noncommunicable Diseases and Mental Health Cluster, World Health Organization ; Adjunct Professor, University of Tempere, Finland

HIA and Health in All Policies
[E] Linda Rudolph, MD, MPH, Consultant in Health in All Policies and Healthy Communities, United States

From HIA to HiAP: The Long March from Project Assessments to Strategic Engagement
[E]Danny Broderick, Principal Policy Officer, South Australian Department of Health, Australia

Moderator:
Luc Boileau, Chief Executive Officer, Institut national de santé publique du Québec, Canada

10:00 to 10:30 a.m.
Break | Poster Session - Visit with the Exhibitors
Grande Place

10:30 to noon
Simultaneous sessions – Block 1

1a The Politics of HIA
Room De Tourny

HIA and Policy-Based Evidence Making
[E] Alex Scott-Samuel, MB, ChB, MCommH, Director, International Health Impact Assessment Consortium, University of Liverpool, United Kingdom

Political Aspects of HIA
[E] Eva Elliot, PhD, Co-Director, Wales Health Impact Assessment Support Unit, School of Social Sciences, Cardiff University, United Kingdom

Popular or Political: Trade-Offs in HIA
Ben Harris-Roxas, Consultant, Harris-Roxas Health; Co-Chair of the International Association for Impact Assessment's Health Section, International Association for Impact Assessment; Conjoint Lecturer, Centre for Primary Health Care and Equity, University of New South Wales, Australia

Moderator:
Alex Scott-Samuel, MB, ChB, MCommH, Director, International Health Impact Assessment Consortium, University of Liverpool, United Kingdom

1b Health in All Policies
Salon Palais

The Health in All Policies Approach: The Visions and Experiences of Different Governments
Danny Broderick, Principal Policy Officer, South Australian Department of Health, Australia
[E] Linda Rudolph, MD, MPH, Consultant in Health in All Policies and Healthy Communities, United States
[E] Timo Ståhl, Technical Officer, Department Noncommunicable Diseases and Mental Health Cluster, World Health Organization; Adjunct Professor, University of Tempere, Finland

Moderator:
Richard Massé, MD, FCRCP, Chair of the International Scientific Committee of the 12th International Conference on Health Impact Assessment; Public Health Officer, Agence de la santé et des services sociaux de Montréal, Associate Professor, département de médecine sociale et préventive, Université de Montréa, Québec, Canada

1c HIA in the Policy Making Process
Room Beauport

People, Environment, Places and Health – 4 Years of Linking Science and Policy-Making in Scotland
[E] Hilary Cowie, BSc, Head of Statistics, Institute of Occupational Medicine, United Kingdom (Edinburgh)

Courses of Action in HIA: Lessons From Québec's Experience
[F] Mélanie Michaud, MSc, Professional Research, École nationale d'administration publique, Québec, Canada

Fill the Gap in Thailand Public Policy Process by Community-HIA
Kritsada Boonchai, PhD, Independent Researcher, Thailand

When Economics Drive Legislation: A Look Into The Methodology of a Casino HIA
[E] Tatiana Lin, MA, J.D., Senior Analyst and Strategy Team Leader, Kansas Health Institute, United States
[E] Catherine Shoults, MPH, Analyst, Kansas Health Institute, United States

Moderator:
Mana Herel, BSc, MA, Manager of Health Equity Integration, Social Determinants and Science Integration Directorate, Public Health Agency of Canada, Ontario, Canada

1d Participation of Stakeholders in the HIA Process
Room Villeray

Community-Driven HIA: Cross-Cultural Perspectives
[E] Mike Tutthill, BA, Planning & Community Engagement Consultant, Health in Common, Manitoba, Canada
Somporn Pengkam, BScN., MEd, Director, Health Impact Assessment Coordinating Unit, National Health Commission Office, Thailand

Moderator:
Mike Tutthill, BA, Planning & Community Engagement Consultant, Health in Common, Manitoba, Canada

1e HIA and Capacity Building
Room Courville/Montmorency

Education, Training, and Materials for Building Capacity in National and International Settings
[E] Martin Birley, PhD, Author, and Principal Consultant, BirleyHIA, United Kingdom
Hilary Dreaves, MPH, Cert.Ed., IMPACT, Research Fellow, University of Liverpool, United Kingdom
Andrew Dannenberg, MD, PhD, Affiliate Professor, Department of Environmental and Occupational Health Sciences, University of Washington School of Public Health, United States
[E] Salim Vohra, PhD, Director, Centre for Health Impact Assessment, Institute of Occupational Medicine, United Kingdom

Building an HIA Program in the United States
[E] Arthur Wendel, MD, MPH, Team Lead, Healthy Community Design Initiative, Centers for Disease Control and Prevention, United States

Moderator:
Martin Birley, PhD, Author, and Principal Consultant, BirleyHIA, United Kingdom

1f Equity in the HIA Process
Room Portneuf/Sainte-Foy

Health Equity Impact Assessment: A User-Friendly Tool for the Integration of Equity Considerations into Health System Delivery and Policy
[E] April MacInnes, MHSc, BA, Senior Policy Advisor in Health Protection Policy Unit, Ministry of Health and Long-Term Care, Ontario, Canada

1g Approaches, Methods and Tools: Evidence in the Assessment Phase (Interactive session in English only)
Room Beaumont/Bélair

Improving Methods in the Assessment Phase: Ideas for Defining and Measuring the Strength of Evidence
Elizabeth Fuller, DrPH, Senior Research Associate, Georgia Health Policy Center, United States

HIA and Evidence Guides by the Scottish HIA Network : Dealing with Uncertainty
Martin Higgins, MA, MSc, Senior PH Researcher, Public Health Department, NHS Lothian; Coordinator, Scottish HIA Network, United Kingdom

A New Model for Conducting Rapid HIA
[E] Jennifer Lucky, MPH, Project Director, Human Impact Partners, United States

Cultural Diversity and the Collection of Evidence for HIAs in Environmental, Social, Health Impact Assessment
[E] Déirdre Treissman, MSc, Technical Specialist, WorleyParsons, Alberta, Canada

Modératrice :
Miriam Fahmy, MA, Chief, Research and Publications, Institut du Nouveau Monde, Québec, Canada

Noon to 1:00 p.m.
Lunch
Salon Kent/Saint-Louis

1:00 to 1:30 p.m.
Poster Session - Visit with the Exhibitors
Grande Place

1:30 to 3:00 p.m.
Plenary Session: Institutionalization of HIA: Addressing Political and Administrative Issues
Salon Palais

HIA Institutionalization: The Québec Experience
[F] Alain Poirier, MD, MSc, FRCPC, Chairman of Local Organizing Committee of the 12th International Conference on Health Impact Assessment, former National Public Health Director and Assistant Deputy Minister, Ministère de la Santé et des Services sociaux du Québec, Canada

HIA Institutionalization in Thailand: From Conference to Constitution and Beyond
[E] Decharut Sukkumnoed, PhD, Professor, Faculty of Economics, Kasesart University and Director, Thailand Healthy Public Policy Foundation, Thailand

HIA Institutionalization in the USA: Status and Prospects at the Local, State, and Federal Level
[E] Aaron Wernham, MD, MS, Director, Health Impact Project, United States

Moderator:
John Kemm, Consultant, JK Public Health Consulting, United Kingdom

(Video presentation mainly in English)

3:00 to 3:30 p.m.
Break | Poster Session - Visit with the Exhibitors
Grande Place

3:30 to 4:30 p.m.
Simultaneous Sessions – Block 2

2a HIA and Political Issues
Room De Tourny

Creating a Rapid-Fire Comprehensive HIA on a Highly Political Topic
[E] Tatiana Lin, MA, J.D., Senior Analyst and Strategy Team Leader, Kansas Health Institute, United States
[E] Ivan Williams, MBA, Senior Analyst, Kansas Health Institute, United States
[E] Catherine Shoults, MPH, Analyst, Kansas Health Institute, United States

Moderator:
Tatiana Lin, MA, J.D., Senior Analyst and Strategy Team Leader, Kansas Health Institute, United States

2b HIA at a Country Scope
Room Beauport

Leveraging Existing Avenues and Exploring New Opportunities in the United States Policy-Making Process to Support HIA Practice

Evaluating Existing Legal Support for HIAs in the United States
[E] Erin C. Fuse Brown, J.D., MPH, Assistant Professor, Georgia State University College of Law, United States

Federal, State, and Local Laws that Require HIA in the USA
Aaron Wernham, MD, MS, Director, Health Impact Project, United States

With:
Rajiv Bhatia, MD, MPH, Director, Occupational and Environmental Health, San Francisco Department of Public Health, United States

Institutionalization of HIA in Thailand
Wiput Phoolcharoen, MD, MPH, Chair, National HIA Commission of Thailand, Thailand National Health Commission, Thailand

Moderator:
Aaron Wernham, MD, MS, Director, Health Impact Project, United States

2c Approaches, Methods and Tools – HIA Integration Within Other Processes
Salon Palais

The Role of HIA in Environmental Review Processes: A Tool for Community and Agency Engagement and Improved Decision-Making
[E] Ruth Lindberg, MPH, MUP, Program Manager, National Center for Healthy Housing, United States
[E] Pilar Lorenzana-Campo, MEP, Senior Associate, Planning and Development Public Health Law and Policy, ChangeLab Solutions, United States
[E] Rebecca Morley, MSPP, Executive Director, National Center for Healthy Housing, United States

Moderator:
Ruth Lindberg, MPH, MUP, Program Manager, National Center for Healthy Housing, United States

2d Participation of Stakeholders in the HIA Process
Room Villeray

Are My Concerns Heard? Stakeholder Perceptions of the HIA Stakeholder Engagement Process
[E] Jen Jones, MPH (c), University of Alaska, Anchorage, United States

Stakeholders Involvement in an HIA of a Proposed Biomass Facility in the Shenandoah Valley, Virginia
[E] Benjamin Evans, M.H.S.A, Policy Researcher Manager, Virginia Commonwealth University, United States

Community Engagement in HIA: The Value of Lay Knowledge
[E] Colleen Cameron, RN, BN, M. AdEd., Instructor, Coady International Institute, School of Nursing, St. Francis Xavier University, Nova Scotia, Canada
Susan L. Eaton, MA, People Assessing Their Health Network, Nova Scotia, Canada
Laura Stymiest, BSc, Student, Dalhousie Medical School, New Brunswick, Canada

Moderator:
Marion Schnebelen, MSc, Interim Coordinator for Environmental Health Unit, Ministère de la Santé et des Services sociaux du Québec, Canada

2e Thematic Cases Studies – Evidence-Based HIA Tools
Room Courville/Montmorency

Evidence-Based HIA Tools to Convey Health and Climate Impacts of Contrasting Community Design Strategies: Lessons From Toronto, Seattle and San Diego
Lawrence Frank, PhD, CIP, ASLA, Professor, Bombardier Chair in Sustainable Transportation, University of British Columbia, Canada
[E] Sudha Sabanadesan, MSc, CPHI(C), Research Consultant, Toronto Public Health, Ontario, Canada

Moderator:
Lawrence Frank, PhD, CIP, ASLA, Professor, Bombardier Chair in Sustainable Transportation, University of British Columbia, Canada

2f **Institutionalization and HIA** (Interactive session in English only)
Room Beaumont/Bélair

HIA Institutionalization in a Regional Context: the Case of the Autonomous Community of Andalusia in Spain
[E] Ana Rivadeneyra, MSc, Researcher, Andalusian School of Public Health, Spain

Institutionalizing the Use of HIAs in Transportation Planning in Massachusetts
Ralph DeNisco, Senior Associate, Nelson Nygaard, United States
Margaret Round, BSc, Senior Environmental Analyst, Bureau of Environmental Health, Department of Public Health, United States

HIA in the Mining Sector – Policy and Practice – A Case Study
[E] Geetha Ramesh, PhD, Director, WorleyParsons Canada, Alberta, Canada

Moderator:
Marie-Laure Landais, BA, Project Manager, Prends ta place; Forum jeunesse de l'île de Montréal, Québec, Canada

4:30 to 5:30 p.m.
Simultaneous sessions – Block 3

3a **HIA and Political Issues** (CONTINUATION of Session 2a)
Room De Tourny

3b **HIA at a Country Scope** (CONTINUATION of Session 2b)
Room Beauport

3c **HIA in the Policy Making Process**
Room Villeray

HIA's Role in Mainstreaming Health in HiAP
[E] Salim Vohra, MBChB , PhD, Director, Centre for Health Impact Assessment, Institute of Occupational Medicine, United Kingdom

HIA: The Montréal Experience and Lessons Learned
Louis Drouin, MD, Lead, Urban Environment and Health Sector, Direction de la santé publique, Agence de la santé et des services sociaux de Montréal, Québec, Canada

New Brighton Healthy Homes – Working in the Political Process
[E] Hilary Dreaves, MPH, Cert.Ed., IMPACT, Research Fellow, University of Liverpool, United Kingdom

Moderator:
Lea den Broeder, MA, MPH, Senior Advisor, National Institute for Public Health and the Environment (RIVM), Netherlands

3d **Evaluation of HIA**
Salon Palais

Quantitative HIA – Where Have We Got to and Where Are We Going?
[E] Hilary Cowie, BSc, Head of Statistics, Research Division, Institute of Occupational Medicine, United Kingdom (Edinburgh)

Incorporating the Concepts of Equity and Vulnerability in the HIA Process
Catherine Olivier, MSc, Trainee, Institut national de santé publique du Québec; Student, Université de Montréal, Québec, Canada

Who Is Afraid of Monitoring and Evaluating HIAs?
[E] Marcus Chilaka, PhD, MBA, Lecturer, University of Salford Manchester, United Kingdom

Moderator:
Michel Désy, PhD, Ethics Advisor, Institut national de santé publique du Québec, Canada

3e **Institutionalization of HIA**
Room Courville/Montmorency

The Institutionalization of HIA: Exploring Applications and Challenges

Integrated Impact Assessment: An Institutionalization Issue
[F] Jean-Sébastien Marchand, Research Officer, École nationale d'administration publique, Québec, Canada

With:
Danny Broderick, Principal Policy Officer, South Australian Department of Health, Australia
John Kemm, Consultant, JK Public Health Consulting, United Kingdom

Moderator:
Clémence Dallaire, PhD, Professor, Faculté des sciences infirmières, Université Laval; Co-Director, Groupe d'étude sur les politiques publiques et la santé, Québec, Canada

3f **Thematic Case Studies – Ports, Trucks, Trains and Health**
Room Portneuf/Sainte-Foy

Ports, Trucks, Trains, and Health: HIA of Goods Movement Infrastructure Projects in the United States

Lessons Learned from the I-710 Freeway Expansion HIA
Jonathan Heller, PhD, Director and Co-Founder, Human Impact Partners, United States

The Baltimore-Washington Rail Intermodal Facility HIA – A Case Study
[E] Ruth Lindberg, MPH, MUP, Program Manager, National Center for Healthy Housing, United States

Food Deserts in Tennessee: Applying HIA in a New Area
[E] Elizabeth Dodson, PhD, MPH, Research Assistant Professor, Washington University in St. Louis, United States

Moderator:
Jonathan Heller, PhD, Director and Co-Founder, Human Impact Partners, United States

3g **Equity in the HIA Process – Is HIA Only for "Easy" Subjects?** (Interactive session in English only)
Room Beaumont/Bélair

Is HIA Only for "Easy" Subjects?
Martin Higgins, MA, MSc, Senior PH Researcher & Scottish HIA Network Coordinator, Public Health Department, NHS Lothian, United Kingdom

Policy Options for Daycare Support: Impact on the Development and Reduction of Social Inequalities in Health
Marie-France Raynault, MD, MSc, FRCP, Head, Département de médecine préventive et santé publique, Centre hospitalier de l'Université de Montréal; Professor, Université de Montréal, Québec, Canada

A Health Equity Impact Assessment Framework Suited for Canadian Immigrants
Maria Benkhalti Jandu, MSc, Student, University of Ottawa, Ontario, Canada

Modératrice :
Miriam Fahmy, MA, Chief, Research and Publications, Institut du Nouveau Monde, Québec, Canada

5:30 to 6:15 p.m.
Leisure Time

6:15 to 7:30 p.m.
Guided walking tour of Old Québec

7:30 to 10:30 p.m.
Cocktail Reception
Québec City's Fascinating History–Sound and light show
Espace 400e Bell

Friday, August 31, 2012

7:30 to 8:30 a.m.
Arrival and Registration
Grande Place

8:30 to 9:30 a.m.
Plenary Session: **Making Sense of Increasingly Diverse Approaches**
Salon Palais

Fit for More Than One Purpose: Typologies, Theory and Evaluation in HIA
[E] Ben Harris-Roxas, Consultant, Harris-Roxas Health; Co-Chair of the International Association for Impact Assessment's Health Section, International Association for Impact Assessment; Conjoint Lecturer, Centre for Primary Health Care and Equity, University of New South Wales, Australia

Investigating HIA From a Politico-Administrative Perspective: A Theoretical Framework
[E] Monica O'Mullane, PhD, MA, Lecturer, Faculty of Health Care and Social Work, Department of Public Health, University of Trnava, Slovakia

HIA in Wales: A Social Science Perspective
[E] Eva Elliot, PhD, Co-Director, Wales Health Impact Assessment Support Unit, School of Social Sciences, Cardiff University, United Kingdom

Moderator:
Louise St-Pierre, MSc, Head of projects, National Collaborating Centre for Healthy Public Policy, Institut national de santé publique du Québec, Canada

9:30 to 10:00 a.m.
Break | Poster Session - Visit with the Exhibitors
Grande Place

10:00 to 11:00 a.m.
Simultaneous sessions – Block 4

4a Approaches and Methods – Tools Analysis
Room Dufferin

"HIAtool.net": A Global Web 2.0 Business Plan for HIA Practitioners and Consultant Experts
[E] Toni Colom-Umbert, MSc, Researcher and Project Promoter, Health Sciences University Institute of the Balearic Islands, Spain

Popular Epidemiology as a Monitoring and Evaluation Tool for Environmental HIA in Thailand
[E] Phongtape Wiwatanadate, MD, PhD, Head of Department of Community Medicine, Faculty of Medicine, Chiang Mai University, Thailand

The Emerging Role of Geographic Information Systems in HIA – The Case Study of the Logan Beaudesert, Queensland, Australia
[E] Ori Gudes, PhD, Research Fellow & Spatial Scientist, Population and Social Health Research Program, Griffith University, Australia

Moderator:
Danny Broderick, Principal Policy Officer, South Australian Department of Health, Australia

4b HIA at a Country Scope
Room Courville/Montmorency

HIA: An Emerging Approach in France
[F] Françoise Jabot, MD, MSc, Professor and Researcher, École des Hautes Études en Santé Publique, France

HIA Methods Used in United States Practice Since 2009
[E] Joseph Schuchter, MCP, MPH, Student, Department of Public Health, University of California, Berkeley, United States

Devolution, Evolution and Expectation: HIA in Wales
[E] Chloe Chadderton, MSc, Research Associate, Wales HIA Support Unit, Cardiff University, United Kingdom

Moderator:
John Kemm, Consultant, JK Public Health Consulting, United Kingdom

4c HIA: Views from Québec
Room De Tourny

Determinants of HIA Use in Québec Government
[F] David Talbot, Research Associate, Groupe d'étude sur les politiques publiques et la santé; Student, Département de management, Université Laval, Québec, Canada

Decision-Making Processes Informed by Institut national de santé publique du Québec Science Advisory Reports Regarding Section 54 of Québec's Public Health Act
[F] Réal Morin, MD, FRCPC, Scientific Director, Direction du développement des individus et des communautés, Institut national de santé publique du Québec, Québec, Canada

HIA Among the Mechanisms in the Development of Healthy Public Policies
[F] Ak'ingabe Guyon, MSc, MD, CCFP, FRCPC, Medical Officer, Agence de la santé et des services sociaux du Bas-Saint-Laurent, Québec, Canada

Moderator:
Louise St-Pierre, MSc, Head of projects, National Collaborating Centre for Healthy Public Policy, Institut national de santé publique du Québec, Canada

4d Evaluation of HIA
Room Villeray

Analytical Framework to Assess the Role of HIA in Public Policy Development
[F] Jean-Louis Denis, PhD, Professor, Chaire de recherche du Canada sur la gouvernance et la transformation des organisations et systèmes de santé, Direction de l'enseignement et de la recherche, École nationale d'administration publique, Québec, Canada

The Role of HIA in Organizational Learning and Practice Changes: Lessons Learned in Québec
[F] Pernelle Smits, PhD, Senior Researcher, Direction de l'enseignement et de la recherche, École nationale d'administration publique, Québec, Canada

The Practice of HIA in Montérégie – Assessment Approach and Preliminary Results
[F] Christian Viens, MSc, Research and Evaluation Officer, Agence de la santé et des services sociaux de la Montérégie, Québec, Canada

Moderator:
Lyne Jobin, M.ps. Director, Direction générale adjointe de la santé publique, ministère de la Santé et des Services sociaux, Québec, Canada

4e HIA and Intersectoriality
Salon Palais

Understanding and Developing Innovation Through Intersectoral Action in Health
[F] Jessica Amiot, MSc, Student, École nationale d'administration publique, Québec, Canada

Strengthening Implementation of HiAP: A Comparative Analysis of Intersectoral Engagement in Sweden and Québec
[E] Ketan Shankardass, PhD, Assistant Professor, Psychology Department, Wilfrid Laurier University, Ontario, Canada

The Collaborative Approach in HIA: A Process Supporting Population-Based Responsibility in Public Health
[F] Émile Tremblay, MSc, Research Officer, Direction de santé publique, Agence de la santé et des services sociaux de la Montérégie, Québec, Canada

Moderator:
Clémence Dallaire, PhD, Professor, Faculté des sciences infirmières, Université Laval; Co-Director, Groupe d'étude sur les politiques publiques et la santé, Québec, Canada

4f Approaches, Methods and Tools – HIA at a Local Level
Room Beauport

Guidelines for Rapid HIA to Support Decision-Making by Public Health Departments in Italy
[E] Nunzia Linzalone, MSc, Senior Researcher, Institute of Clinical Psychology, Italy

Developing Jurisdiction-Specific HIA Tools for the City of Toronto
[E] Olanna White, MPH, Research Consultant, Healthy Public Policy Directorate, Ontario, Canada

Revitalizing Thailand's Community-HIA
Somporn Pengkam, M.Ed., Director, Health Impact Coordinating Unit, National Health Commission Unit, Thailand

Moderator:
Ana Rivadeneyra, MSc, Researcher, Andalusian School of Public Health, Spain

4g Equity in the HIA Process
Room Portneuf/Sainte-Foy

Building HIA Capacity in the Pacific – Working with Pacific Nations to Promote Health and Reduce Inequities Between Nations
[E] Louise Signal, PhD, Director, HIA Research Unit, University of Otago, New Zealand

A User-Friendly Tool for the Integration of Equity Considerations into Health System Delivery and Policy
[E] April MacInnes, MHSc, BA, Senior Policy Advisor in Health Protection Policy Unit, Ministry of Health and Long-Term Care, Ontario, Canada

Evaluation of an HIA of a Low-Income Housing Redevelopment
[E] Karen Roof, MS, Principal Consultant, EnviroHealth Consulting; Instructor and PhD Student, Design and Planning, University of Colorado Denver, United States

Moderator:
Mana Herel, BSc, MA, Manager of Health Equity Integration, Social Determinants and Science Integration Directorate, Public Health Agency of Canada, Ontario, Canada

4h HIA and the Environment (Interactive session in English only)
Room Beaumont/Bélair

Mitigations for Health Impacts in Natural Resource Development Projects
Marla Orenstein, MSc, President, Habitat Health Impact Consulting, Calgary, Canada
Aaron Wernham, MD, MS, Director, Health Impact Project, United States

Moderator:
Marla Orenstein, MSc, President, Habitat Health Impact Consulting, Calgary, Canada

11:00 to noon
Simultaneous sessions – Block 5

5a HIA and Intersectoriality
Salon Palais

HIA as a Catalyst for Healthy Public Policy: The Role of Cross-Sectoral Collaboration
Rajiv Bhatia, MD, MPH, Director, Occupational and Environmental Health, San Francisco Department of Public Health, United States
Ben Harris-Roxas, Consultant, Harris-Roxas Health; Co-Chair of the International Association for Impact Assessment's Health Section, International Association for Impact Assessment; Conjoint Lecturer, Centre for Primary Health Care and Equity, University of New South Wales, Australia
[E] Rachel J. Thornton, MD, PhD, Assistant Professor, Department of Pediatrics, John Hopkins School of Medicine, United States

Moderator:
Ben Harris-Roxas, Consultant, Harris-Roxas Health; Co-Chair of the International Association for Impact Assessment's Health Section, International Association for Impact Assessment; Conjoint Lecturer, Centre for Primary Health Care and Equity, University of New South Wales, Australia

5b HIA at a Country Scope
Room Courville/Montmorency

HIA: Perspectives in Brazil
[E] Cecilia Balby, Environmental and Social Consultant; Student in Environmental Health Department, Faculty of Public Health, University of Sao Paulo, Brazil

Strategies for Enhancing the Application of HIA in Developing Countries: A Case Study in Nigeria
[E] Marcus Chilaka, PhD, MBA, Lecturer, University of Salford Manchester, United Kingdom

Moderator:
Marla Orenstein, MSc, President, Habitat Health Impact Consulting, Calgary, Canada

5c Approaches, Methods and Tools – HIA Integration Within Other Processes
Room Dufferin

Integrating an HIA into a Transit Draft Environmental Impact Statement
[E] Crystal Myslajek, MPP, Health Impact Assessment Planner, Housing, Community Works, and Transit Department, Hennepin County, United States

HIA in Southern Brazilian Environmental Impact Assessments: Too Far Away from Recommended Practices
[E] Claudia Viegas, PhD, Researcher, Engineering and Knowledge Management Department, Federal University of Santa Catarina, Brazil

Moderator:
Jean Simos, Dr ès sc., Visiting Professor, Université de Liège ; Project Manager, Groupe de recherche en environnement et santé, Université de Genève; President, S2D, Centre collaborateur OMS pour les Villes-Santé francophones, Switzerland

5d Thematic Case Studies – Nutritional Policies
Room Villeray

Think Globally, Act Locally: Assessment of the French "Nutrition santé" Policy that Has Met the Challenge of Conflicts of Interest and Realities in the Field
François Baudier, MD, MSc, Chief, Direction de la stratégie et du pilotage, Agence régionale de santé de Franche-Comté, France

"Shoku-iku" (Food Education): Its Widespread Influence in the State of Nutritional Affairs in Japan
[E] Akira Kanda, PhD, Chief of Nutrition Support Center, HANA Professional Training College of Nutrition, Japan

"NutrientMenuPlan.com" as an Assessment Tool on Quantitative Research Methods in Food Policies, Plans, Programs and Projects
[E] Antoni Colom-Fernandez, MSc, Consultant Technician, Entorn Bioeconomic Sociedad Limitada, Spain

Moderator:
Hélène Valentini, MSc , Coordinator for international collaboration, Vice-présidence aux affaires scientifiques, Institut national de santé publique du Québec, Canada

5e HIA and Capacity Building
Room De Tourny

Teaching HIA Courses in United States Universities: Methods for Engaging Students and Community Partners
[E] Andrew Dannenberg, MD, MPH, Affiliate Professor, Department of Environmental and Occupational Health Sciences, School of Public Health, University of Washington, United States
[E] Keshia Pollack, PhD, MPH, Assistant Professor, John Hopkins Bloomberg School of Public Health, United States
[E] Cynthia L. Stone, DrPH, RN, Associate Professor, School of Medicine, Indiana University, United States

Moderator:
Andrew Dannenberg, MD, MPH, Affiliate Professor, Department of Environmental and Occupational Health Sciences, School of Public Health, University of Washington, United States

5f Approaches, Methods and Tools – HIA at a Local Level
Room Beauport

Impact Assessments: An Appropriate Tool for Supporting Communities and Exercising Population-Based Responsibility in the Québec Context
[F] André-Anne Parent, MSc, Student, Faculté des sciences infirmières, Université Laval, Québec, Canada

A Model of HIA for the Sub-District Municipalities: A Case Study of the Songkhla Lake Basin
[E] Phen Sukmag, MSc, Student, Faculty of Environmental Management, Prince of Songkla University, Thailand

Development of an HIA Screening Tool for Use at the Municipal Level
[E] Tatsuya Ishitake, MD, PhD, Professor, Department of Environmental Medicine, Kurume University School of Medicine, Japan

Moderator:
Marion Schnebelen, MSc, Interim Coordinator for Environmental Health Unit, Ministère de la Santé et des Services sociaux du Québec, Canada

5g Equity in the HIA Process (Interactive session in English only)
Room Beauport/Bélair

Piloting Equity-Focused HIA on the Proposed Teen Triple P Positive Parenting Program: An Intersectoral Collaboration
[E] Beth Jackson, PhD, Manager in Research & Knowledge Development, Strategic & Trends Analysis Division, Strategic & Innovation Directorate, Health Promotion & Chronic Disease Prevention Branch, Public Health Agency of Canada, Ontario, Canada
Benita Cohen, BN, PhD, Associate Professor, Faculty of Nursing, University of Manitoba, Canada
Steven Feldgaier, MA, PhD, Director of Parenting Initiatives, Healthy Child Manitoba Office, Government of Manitoba; Assistant Professor, Department of Clinical Health Psychology, Faculty of Medicine, University of Manitoba, Canada
Karen Serwonka, BA, MHSc, Cert. HIA, Equity Focus HIA Pilot Project Manager, Healthy Child Manitoba Office, Manitoba, Canada

Modératrice :
Miriam Fahmy, MA, Chief, Research and Publications, Institut du Nouveau Monde, Québec, Canada

5h Thematic Case Studies – Food- and Agriculture-Related HIAs
Room Portneuf/Sainte-Foy

Recent Use of HIA to Highlight Linkages among Food, Agriculture, and Nutrition in the United States
[E] Tia Henderson, PhD, Research Manager, Upstream Public Health, United States
Aaron Wernham, MD, MS, Director, Health Impact Project, United States

Moderator:
Aaron Wernham, MD, MS, Director, Health Impact Project, United States

Noon to 1:00 p.m.
Lunch
Salon Kent/Saint-Louis

1:00 to 1:30 p.m.
Poster Session - Visit with the Exhibitors
Grande Place

1:30 to 3:00 p.m.
Simultaneous sessions – Block 6

6a HIA applied to policies: Case Studies
Room Courville/Montmorency

HIA of Ontario's Green Energy and Green Economy Act
Robert Rattle, BSc, Independant Researcher, Ontario, Canada

Healthy Waterways: Health Impacts of Rochester's Local Waterfront Revitalization Program
[E] Katrina Korfmacher, PhD, Associate Professor, Environmental Health Sciences Center, University of Rochester, United States

Child Mental Health and Well-Being and the Physical Environment
[E] Salim Vohra, MBChB, PhD, Director, Centre for Health Impact Assessment, Institute of Occupational Medicine, United Kingdom

Moderator:
Carlos Dora, Coordinator, Public Health and Environment Department, World Health Organization, Switzerland

6b HIA and Aboriginal Communities
Salon Palais

HIA Practice in Aboriginal Contexts in Canada: How, to What End, and by Whom?

The Situation Regarding HIA Practice in Aboriginal Canada
Margo Greenwood, PhD, Academic Leader, National Collaborating Centre for Aboriginal Health, British Columbia, Canada

HIA Mechanisms and Québec Plan Nord
[F] Geneviève Lapointe, Expert, Vice-présidence aux affaires scientifiques, Institut national de santé publique du Québec, Québec, Canada
[F] Lyne Jobin, M.ps. Director, Direction générale adjointe de la santé publique, ministère de la Santé et des Services sociaux, Québec, Canada

Operationalizing Concepts of Health in HIA
[E] Ame-Lia Tamburini, MSc, Project Manager, Habitat Health Impact Consulting, Alberta, Canada

Addressing Tuberculosis in Aboriginal Communities – An HIA Approach
[E] Ginette Thomas, BA, MA, Independant Consultant, Ontario, Canada

Lessons Learned in New Zealand
Robert Quigley, BSc, BCAPSc, PGDipDiet, Director, Quigley and Watts Ltd, New Zealand

Lessons learned in United States
Aaron Wernham, MD, MS, Director, Health Impact Project, United States

Moderator:
François Benoit, Lead, National Collaborating Centre for Healthy Public Policy, Institut national de santé publique du Québec, Canada

6c HIA in an Urban Context: Case Studies
Room Beauport

HIA: An Opportunity to Put People Back Into the Discussions on an Urban Restructuring Project
[F] Anne Roue Le Gall, PhD, Professor and Researcher, École des Hautes Études en Santé Publique, France

Using HIA in the City of Toronto to Review the Official City Plan
[E] Sudha Sabanadesan, MSc, CPHI(C), Research Consultant, Toronto Public Health, Ontario, Canada

HIA of a Residential Neighbourhood – A Constructive Approach to Promote Health and Quality of Life
[F] Émile Tremblay, MSc, Research Officer, Direction de santé publique, Agence de la santé et des services sociaux de la Montérégie, Québec, Canada

Shifting From Car to Bike and Public Transport in the Metropolitan Area of Barcelona: An HIA Study
David Rojas-Rueda, MD, MPH, Student, Center of Research of Environmental Epidemiology, Spain

Moderator:
Marion Schnebelen, MSc, Interim Coordinator for Environmental Health Unit, Ministère de la Santé et des Services sociaux du Québec, Canada

6d Evaluation of HIA
Room Villeray

Evaluating HIA: Lessons From New Zealand
[E] Louise Signal, PhD, Director, HIA Research Unit, University of Otago, New Zealand

HiAP: Development of an Evaluation Framework
[E] Angela Lawless, DrPH, Deputy Director, South Australian Community Health Research Unit, Flinders University, Australia

Advancing the Field by Understanding Impact and Success of HIAs: Design and Conduct of a Large-Scale Evaluation in the United States
[E] Andrew Dannenberg, MD, PhD, Affiliate Professor, Department of Environmental and Occupational Health Sciences, School of Public Health, University of Washington, United States

A Multiple Case Study of the Impacts from HIAs Conducted from 1999 to 2010 in the United States
[E] Gregory Tung, MPH, Student, Department of Health Policy and Management, John Hopkins Bloomberg School of Public Health, United States

Moderator:
Beth Jackson, PhD, Manager in Research & Knowledge Development, Strategic & Trends Analysis Division, Strategic & Innovation Directorate, Health Promotion & Chronic Disease Prevention Branch, Public Health Agency of Canada, Ontario, Canada

6e HIA and Capacity Building
Room De Tourny

Evaluation of HIA Training and Capacity-Building in the United States
Joseph Schuchter, MCP, MPH, Student, Department of Public Health, University of California, Berkeley, United States

Training and Technical Assistance Program for HIA
[E] Jennifer Lucky, MPH, Project Director, Human Impact Partners, United States

Training and Capacity Development for HIA: A Review
[E] Tsogtbaatar Byambaa, MD, MSc, Project Coordinator, Faculty of Health Sciences, Simon Fraser University, British Columbia, Canada

The Mongolian-Canadian Partnership – A Timeline of Progress Towards HIA Methodological Development, Capacity-Building, and Uptake in Mongolia
[E] Colleen Davison, MPH, PhD, Adjunct Assistant Professor, Department of Community Health and Epidemiology, Ontario, Canada

Moderator:
Lea den Broeder, MA, MPH, Senior Advisor, National Institute for Public Health and the Environment (RIVM), Netherlands

6f Equity in the HIA Process
Room Portneuf/Sainte-Foy

Environmental Justice and HIA: From Theory to Practice
[F] Isabelle Goupil-Sormany, MD, MSc, FRCPC, CMFC, Medical Officer, Direction de santé publique, Agence de la santé et des services sociaux du Saguenay–Lac-St-Jean; Clinical Professor, Centre hospitalier universitaire de Québec et Université Laval, Québec, Canada

A Tool for Observing and Assessing Health Inequities in Local Projects

[F] Martine Bantuelle, Director, Association Santé, Communauté, Participation, Belgium

Sustainable Development, Environmental Justice, and HIA From the Perspective of Reducing Social Inequalities in Health
[F] Isabelle Goupil-Sormany, MD, MSc, FRCPC, CMFC, Medical Officer, Direction de santé publique, Agence de la santé et des services sociaux du Saguenay–Lac-St-Jean; Clinical Professor, Centre hospitalier universitaire de Québec et Université Laval, Québec, Canada

The Challenges of Assessing the Impact of Legal and Regulatory Measures on the Social Participation of People with Disabilities
Anne Hébert, deputy director, Office des personnes handicapées du Québec, Canada

Moderator:
Hélène Valentini, MSc , Coordinator for international collaboration, Vice-présidence aux affaires scientifiques, Institut national de santé publique du Québec, Canada

6g HIA and the Environment: Case Studies
Room Dufferin

Application of HIA to Climate Change Policies
Mel Rader, MS, Codirector, Upstream Public Health, United States

HIA and Flood Management – The Challenge for Southeast Asian Cities
[E] Decharut Sukkumnoed, PhD, Professor, Faculty of Economics, Kasesart University and Director, Thailand Healthy Public Policy Foundation, Thailand

Swiss Agriculture, Source of Well-Being and Health: A Multi-Dimensional Perspective
[E] Nicola Cantoreggi, MSc, Project Manager, Groupe de recherche en environnement et santé, Institut des sciences de l'environnement, Université de Genève, Switzerland
[E] Thiemo Diallo, MSc, Project Manager, Equiterre, Switzerland

Moderator:
Marla Orenstein, MSc, President, Habitat Health Impact Consulting, Calgary, Canada

6h L'EIS en contexte de pays en développement (Interactive workshop in French only)
Room Beaumont/Bélair

L'EIS en contexte de pays en voie de développement

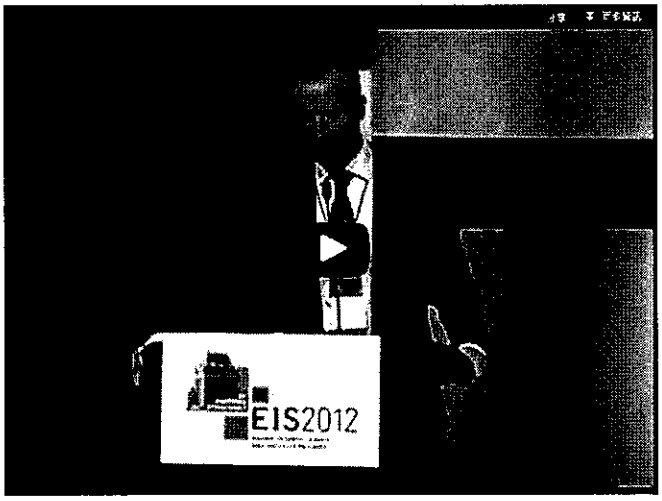
Jean Patrick Alfred, MD, MSc, Deputy Director, unité de programmation et d'évaluation, Ministère de la Santé Publique et de la Population, Haïti
Caroline Druet, MSc, Research and Socio-Economic Planning Officer, Ministère de la Santé et des Services sociaux du Québec, Canada
David Houéto, MD, PhD, chair and président et delegate of the section Sub-Saharan Africa, Réseau francophone international pour la promotion de la santé (Réfips), Bénin
Ginette Lafontaine, MSc, Chair of the Americas section, Réseau international francophone pour la promotion de la santé (Réfips), Québec, Canada
Louise St-Pierre, MSc, Head of projects, National Collaborating Centre for Healthy Public Policy, Institut national de santé publique du Québec, Canada

Moderator:
Marie-Laure Landais, BA, Project Manager, Prends ta place; Forum jeunesse de l'île de Montréal, Québec, Canada

3:00 to 3:30 p.m.
Break | Poster Session - Visit with the Exhibitors
Grande Place

3:30 to 4:30 p.m.
Plenary Session: **HIA in Decision-Making: What We Know and What We Need to Know**
Salon Palais

Informing Decision-Makers and Changing Proposals: HIA's Role
[E] Robert Quigley, BSc, BCAPSc, PGDipDiet, Director, Quigley and Watts Ltd, New Zealand



Understanding Decision-Making and Supporting Better Decisions
[E] Rajiv Bhatia, MD, MPH, Director, Occupational and Environmental Health, San Francisco Department of Public Health, United States

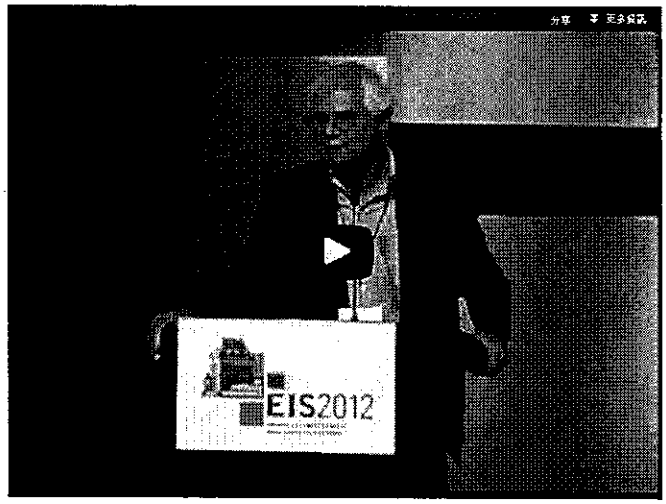
Impact Analysis in the Québec Government's Decision-Making Process
[F] André Fortier, Associate Secretary General, Ministère du Conseil exécutif du Québec, Canada

(Video presentation exclusively in French)

Moderator:
François Benoit, Lead, National Collaborating Centre for Healthy Public Policy, Institut national de santé publique du Québec, Canada

4:30 to 5:00 p.m.
Closing Speech: The Future Challenges for HIA
Salon Palais
[E] Richard Massé, MD, FCRCP, Chair of the International Scientific Committee of the 12th International Conference on Health Impact Assessment;Public Health Officer, Agence de la santé et des services sociaux de Montréal; Associate Professor, département de médecine sociale et préventive, Université de Montréal, Québec, Canada
Alain Poirier, MD, MSc, FRCPC, Chairman of Local Organizing Committee of the 12th International Conference on Health Impact Assessment, former National Public Health Director and Assistant Deputy Minister, Ministère de la Santé et des Services sociaux du Québec, Canada

(Vidéo presentation exclusively in French)



The HIA 2013 Rendezvous

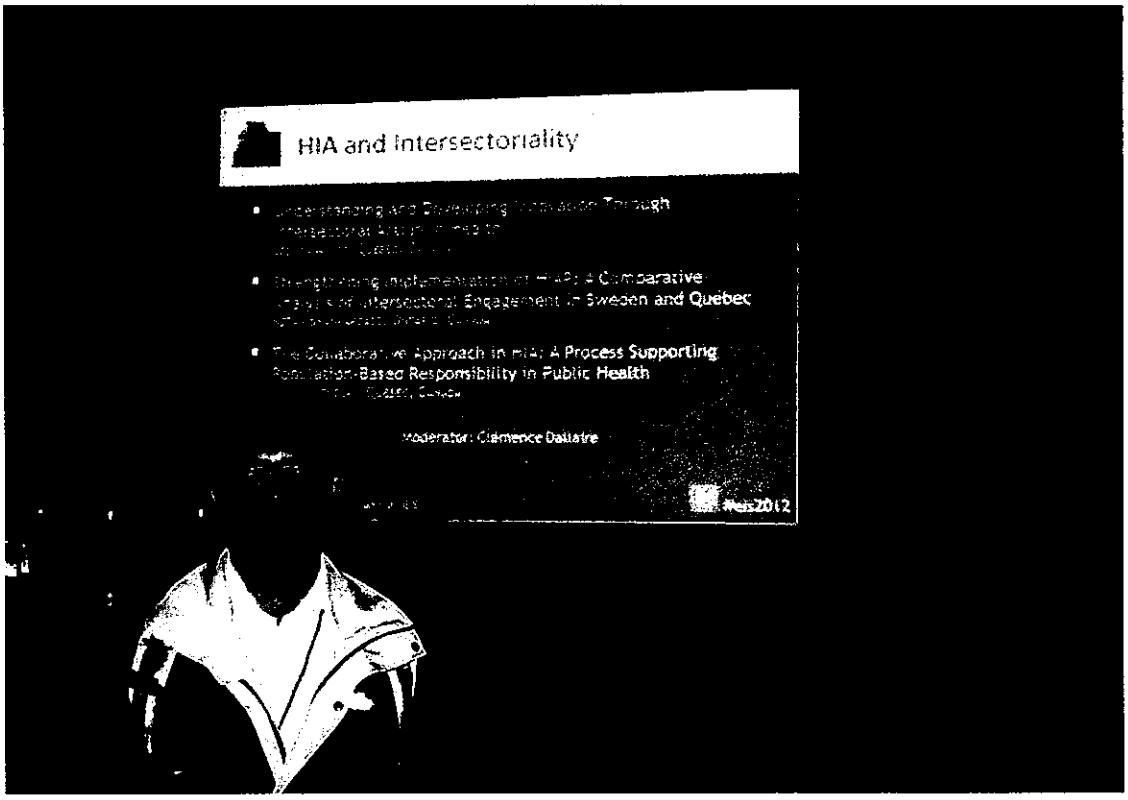
Jean Simos, Dr ès sc., Visiting Professor, Université de Liège; Project Manager, Groupe de recherche en environnement et santé, Université de Genève; President, S2D, Centre collaborateur OMS pour les Villes-Santé francophones, Switzerland

Québec

Photos : Yves Tessier and Luc-Antoine Couturier

附件 2

會場現場相關照片



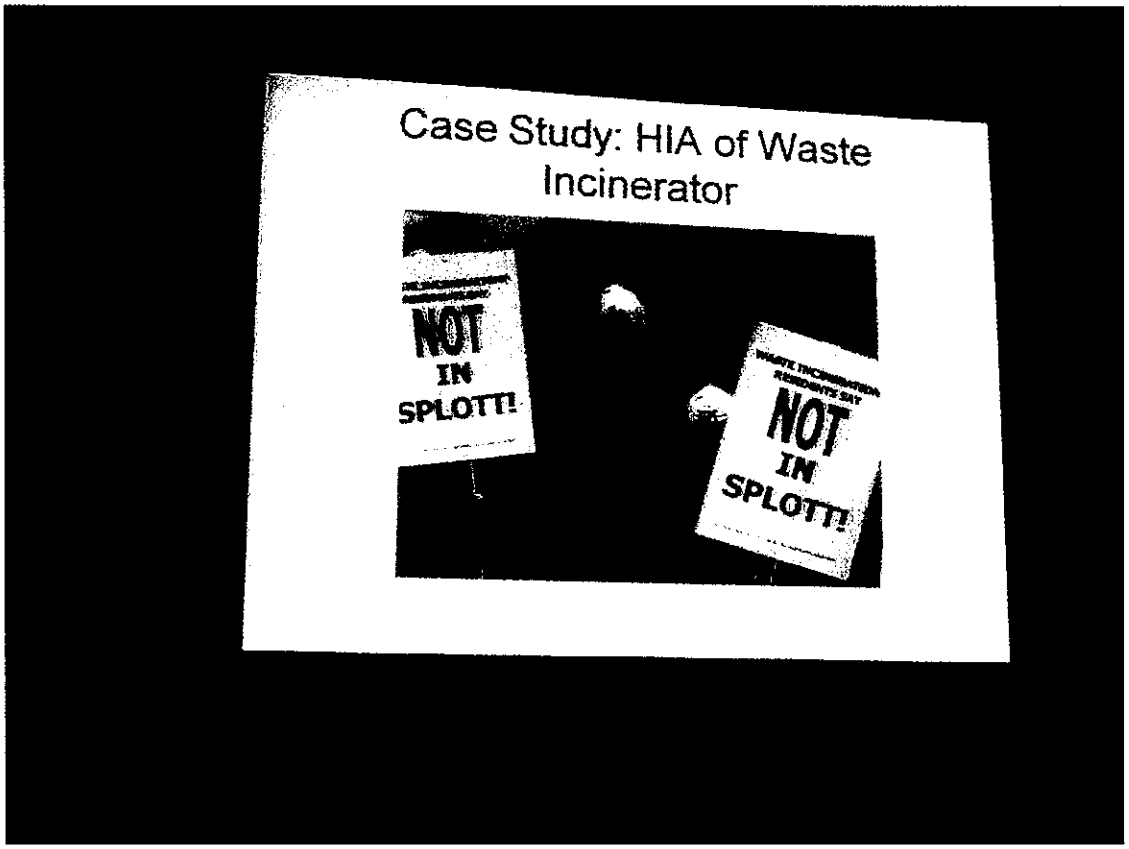
大會現場報告照片一

大會現場報告照片二

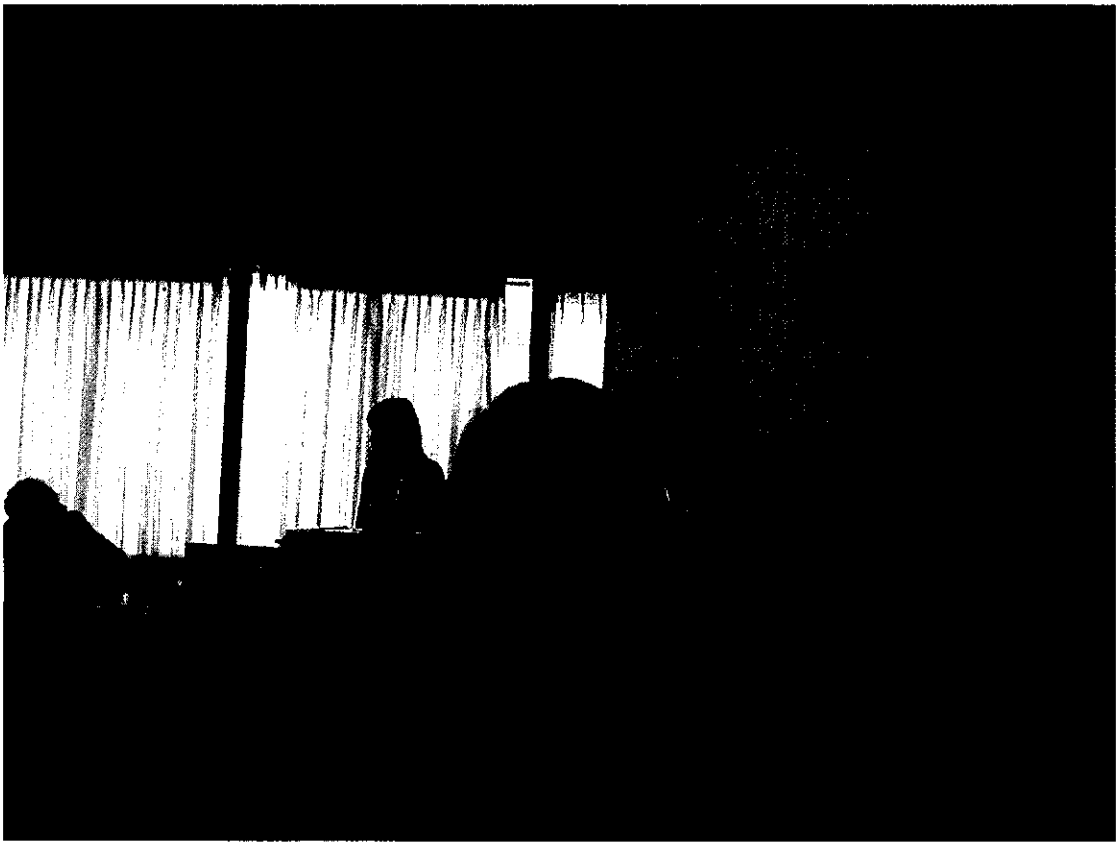
大會現場報告照片三

大會現場報告照片四

大會現場報告照片五



大會現場報告照片六

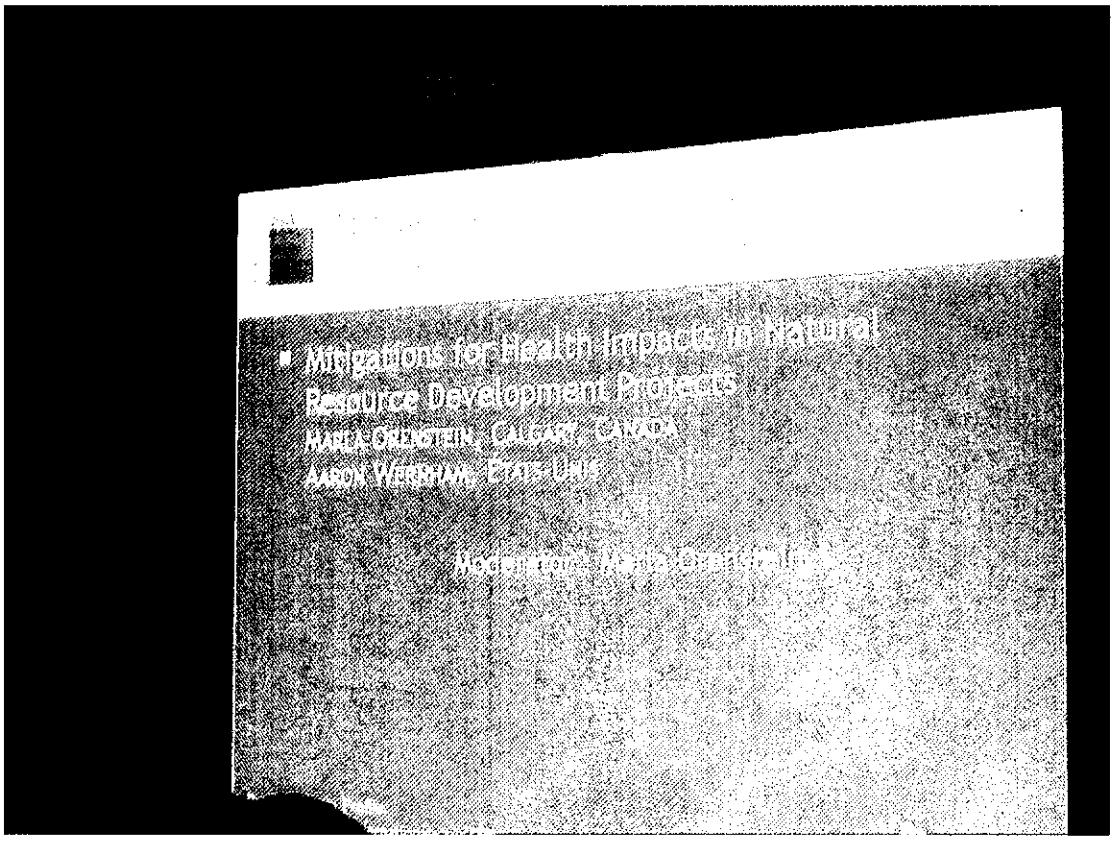


大會現場報告照片七

大會現場報告照片八

大會現場報告照片九

大會現場報告照片十



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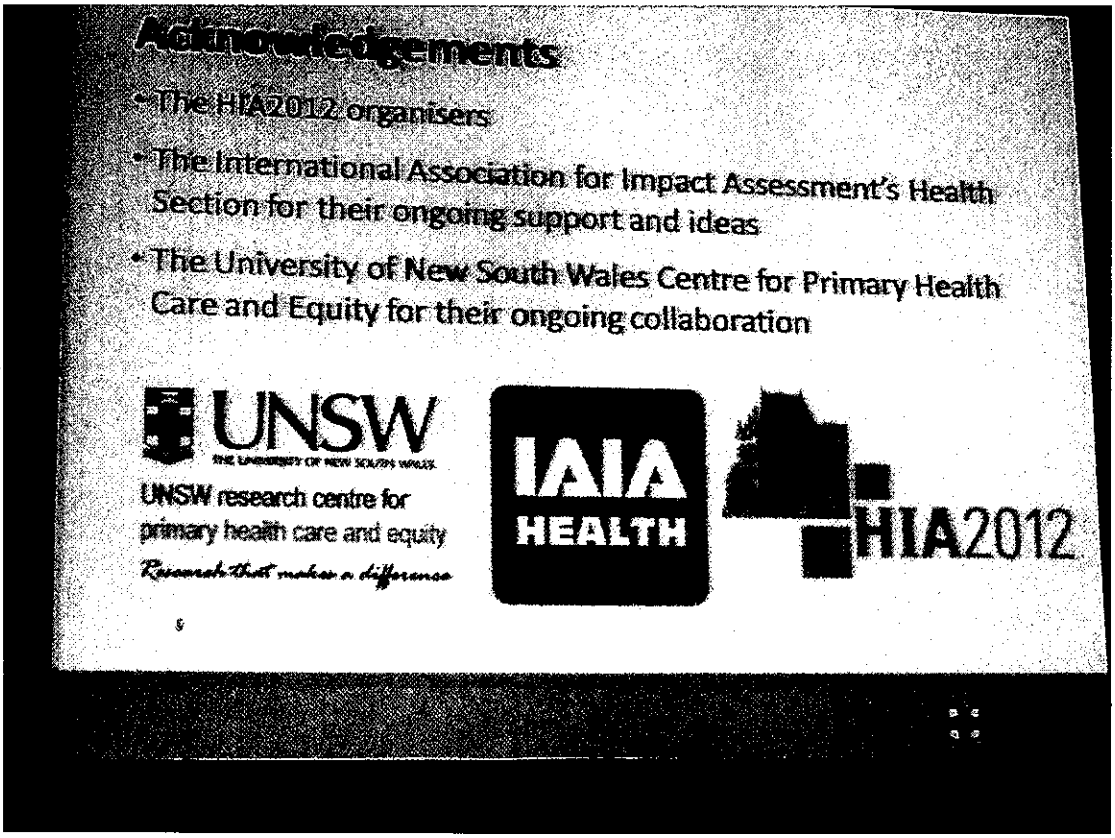


大會現場報告照片十二

附件 3　摘要論文

Posters

17. CREIS: A New HIA Portal in Spanish

Ana Rivadeneyra, Andalusian School of Public Health, Spain

The EASP has launched the CREIS, the first HIA Web site in Spanish. It has been created in the context of the regional administration's interest in promoting new capabilities for implementing HiAP in Andalusia. New partnerships are being established with public health institutions across Spain and Latin America to reach the wider Spanish-speaking community.

Successful implementation of HIA in Spanish-speaking countries strongly depends on resource allocation initiatives facilitating access to key information and operational resources in the form of guidelines, methods, practical tools, and evidence. The Andalusian School of Public Health has recently launched the CREIS, the first dedicated HIA Web site targeting Spanish-speaking audiences. Review of the literature and existing HIA Web sites hosted by public and private institutions to identify key contents and resources for the CREIS. Consultation and piloting of functionality, accessibility, and proposed contents with a group of Spanish public health professionals and HIA practitioners. The CREIS provides easy access to information and practical resources for the planning and delivery of HIAs. It also offers a focal point for the sharing of knowledge and experiences among people interested or already familiar with HIA concepts and methods. New information and tools will be progressively added following new knowledge and experience in HIA development and practice, particularly in Spain and Latin America. The portal was launched in December 2011 and its full functionality will evolve throughout 2012. The CREIS has been created in the context of the regional health authorities' interest in promoting new capabilities to implement HiAP in Andalusia, and in accordance with the HIA-related statutory provisions included in the recently enacted Public Health Law of Andalusia. Nonetheless, new partnerships and collaboration schemes are being established with key public health agencies and relevant institutions across Spain and in Latin America with a view to expanding its scope according to new developments and needs within the Spanish-speaking HIA community.

18. Why Did It Fail? The HIA of Balearic Islands Palma Beach, A Case to be Learned From

Toni Colom-Umbert, Health Sciences University Institute of the Balearic Islands, Spain

To learn from the failure to perform an HIA is the core presentation. Illustrated in a tourist coastal landscape where 40,000 people live. The team in charge of developing the HIA was not considered at the end due the screening test not being well-conducted at decision-makers level and the project should never have been evaluated.

In 2005, the Town Planning Consortium for the improvement and landscaping of Palma Beach was set up with the aim of promoting the refurbishment, including as key issues sustainability, social and residential cohesion, in line with the 21st century. In 2009, the Balearic Islands General Directorate of Public Health designed a multidisciplinary team. In 2010 the elections produced political changes of Government and consequently decision-makers. The previous steps to conducting a Full HIA following the Minimum Elements and Practice Standards for Health Impact Assessment (North American HIA Practice Standard Working Group) were: First a project characterisation considering objectives, reports, complementary studies analysis and regulations affecting the project. Second a set of health objectives was selected from 7 domains. Third, stakeholder identification was done. Screening was based on each objective concern and possibility of project impact after the data availability. Scoping with the alternatives to the decision and the potential health effect were considered. Evidence for causal effect on health was established and forecasting health effects were characterised based on inhabitants baseline conditions. A set of housing refurbishment recommendations were produced and consensus with planners agreed, but not with stakeholders and decision-makers due to the political changes. The entity doing the HIA led the process, but who requested the HIA wasn't clear. At the screening level decision-makers weren't contacted at a formal level and no documents were produced at this point. Finally all collapses when organizational changes affect them.

Posters

15. Un référentiel de compétences en EIS

Doina Malai, Institut national de santé publique du Québec, Canada

Une formation des praticiens en évaluation d'impact sur la santé sera développée à partir d'un référentiel de compétences basé sur des situations professionnelles complexes et authentiques. Ce référentiel est un critère d'assurance qualité.

Dans le cadre de la rédaction d'un cours en ligne, les auteurs ont cherché à produire un relevé des compétences utilisées par les professionnels impliqués dans l'évaluation d'impact sur la santé (EIS). Le résultat, un référentiel de compétence, permettra de construire un cours d'introduction (en ligne), mais pourra servir également à la mise sur pied d'autres cours en présentiel ou en ligne. La démarche adoptée par le groupe s'inscrit dans une approche par compétences, la compétence étant un savoir-agir complexe qui prend appui sur la mobilisation et la combinaison efficace d'une variété de ressources internes et externes à l'intérieur d'une famille de situations (Tardiff, 2006). La démarche repose sur trois principes essentiels : le choix de la définition de la compétence, la collecte d'informations et le traitement et la validation de ces informations. Après avoir procédé à une analyse préliminaire, les auteurs ont consulté différents praticiens pour finalement examiner avec un comité de travail les détails de chaque compétence. Cette analyse a été faite sur une pratique de l'évaluation d'impact sur la santé des politiques publiques. La compétence principale, mener un processus d'EIS en collaboration avec les acteurs du milieu, est composée de cinq éléments. Ce sont : 1) appuyer sa pratique sur les fondements historiques, méthodologiques et scientifiques de l'EIS, 2) gérer efficacement des projets d'EIS, 3) réaliser des processus d'EIS de qualité, 4) communiquer adéquatement avec les divers publics et 5) appuyer sa pratique sur les fondements théoriques de l'élaboration des politiques publiques. Le référentiel présente également l'ensemble des ressources internes (savoirs) et externes (de l'environnement) à mobiliser pour développer la compétence. L'approche par compétences oblige à davantage d'efforts pour apprivoiser à la fois les concepts et les méthodes de travail, mais elle permet de produire des cours de qualité, systématiquement construits et ancrés dans la réalité de la pratique.

16. Competency Framework for Health Impact Assessment

Doina Malai, Institut national de santé publique du Québec, Canada

A training program for health impact assessment practitioners should be developed with reference to a competency framework based on complex and authentic professional situations. This framework is a criterion of quality assurance.

Within the context of preparing an online course, the authors set out to produce an inventory of competencies used by professionals involved in HIA. The result, a competency framework, will enable the development of an introductory course (online) and, in addition, can be used to produce other courses, either for the classroom or online. The process adopted by the group is part of a competency-based approach, with competency being defined as complex knowledge of how to act, supported by the effective mobilization and combination of a variety of internal and external resources within a family of situations (Tardif, 2006). The process is based on three essential principles: the establishment of a definition of competency, the gathering of information and the processing and validation of that information. Having completed a preliminary analysis, the authors consulted various practitioners, and subsequently examined the details of each competency with a work committee. This analysis focused on the health impact assessment of public policies. The core competency – Conduct an HIA in collaboration with relevant stakeholders – comprises five elements. These are: 1) Base one's practice on the historical, methodological and scientific foundations of HIA, 2) Effectively manage HIA projects, 3) Conduct high-quality HIAs, 4) Communicate adequately with various publics, 5) Base one's practice on the theoretical foundations of public policy development. The framework also lists all the internal resources/knowledge and external resources/tools in the community of practice that are mobilized in the development of the competency. Mastering the concepts and work methods specific to the competency-based approach requires extra effort, but this approach allows for the production of high-quality courses that are systematically constructed and firmly anchored in the reality of HIA practice.

Posters

Thème 5
Development of HIA practice

13. Some Challenges Associated with HIA in Developing Countries

Emily Baulk, WorleyParsons, Alberta, Canada

The intention of this talk is to use some real world examples to raise questions and discuss strategies and solutions with members of the HIA community.

Health Impact Assessment is a useful tool for policy development and decision making; however, when health impact assessors come to use HIA in real world scenarios, constraints often become apparent. We must work within these constraints to produce an assessment that is both useful and ethical. Budget is often the most obvious constraint; however, when conducting HIAs in developing countries, there are often other challenges and constraints that may not be immediately apparent. Some examples of challenges encountered while undertaking HIA in countries such as Sierra Leone and Saudi Arabia have included administrative, ethical, and cultural issues. Specifically, 1) where governmental bodies have not functioned as expected due to instability or dysfunction, there have been challenges associated with consultation or with clarity of expectations; 2) ethical challenges have been encountered when performing assessments in developing countries, e.g. procuring food samples for baseline analysis in areas where subsistence farming is prevalent and food is scarce; and 3) there are cultural challenges, e.g. where gender segregation is the norm and there has been difficulty in carrying out proper consultation and information gathering. In order to complete the HIAs associated with these examples, published methodology and approaches from bodies such as the ICMM, WHO, and the IFC were adapted to fit the circumstances. The intention of this talk is to use real world examples to raise questions and discuss strategies and solutions with members of the HIA community.

14. The Society of Practitioners of Health Impact Assessment (SOPHIA): A New Association Supporting the Field

Elizabeth Hodges Snyder: University of Alaska Anchorage, United States

SOPHIA is a newly-formed association of individuals and organizations providing leadership and promoting excellence in the practice of HIA. The presentation will detail the origins of SOPHIA, describe its development and activities to date, discuss how the founders envision the association's future, and solicit feedback.

The Society of Practitioners of Health Impact Assessment (SOPHIA) is a newly-formed association of individuals and organizations providing leadership and promoting excellence in the practice of health impact assessment (HIA). The founders of SOPHIA envision the association becoming a leading network of HIA practitioners in North America and worldwide. By promoting and practising a thorough and systematic consideration of health in policy development and decision making, SOPHIA will work towards achieving better health for all. Priorities of SOPHIA include: 1. Ensuring the continuing high quality of HIAs (e.g. by defining professional values, issuing practice standards, and showcasing exemplary HIAs); 2. Promoting the field of HIA to increase its use (e.g. by publishing HIA information for communities, funding agencies, and clients; and providing a forum for a variety of HIA support/training resources); and 3. Supporting both new and established HIA practitioners (e.g. by maintaining a formalized network of HIA practitioners and hosting an annual meeting). SOPHIA continues to take shape and is currently working to build membership, formalize the network framework, and best design the association to meet the needs of members and of the HIA field. The presentation will detail the origins of SOPHIA, describe its development and activities to date, discuss how the founders envision the association's future, and solicit feedback.

Posters

12. L'APPROCHE COLLABORATIVE EN ÉVALUATION D'IMPACT SUR LA SANTÉ : UNE DÉMARCHE FAVORISANT LA RESPONSABILITÉ POPULATIONNELLE EN SANTÉ PUBLIQUE

ÉMILE TREMBLAY, DIRECTION DE SANTÉ PUBLIQUE, AGENCE DE LA SANTÉ ET DES SERVICES SOCIAUX DE LA MONTÉRÉGIE, QUÉBEC, CANADA

L'EIS est une démarche devant impérativement s'ancrer dans le contexte organisationnel dans lequel elle s'inscrit. Au Québec, l'EIS de type collaboratif est une manière adéquate de répondre à la responsabilité populationnelle des établissements et de promouvoir des politiques publiques favorables à la santé et au bien-être en milieu municipal.

Au Québec, en raison du paysage organisationnel du réseau de la santé et des services sociaux, les responsabilités sanitaires reposent sur trois paliers. Outre le niveau ministériel, les paliers régionaux (DSP) et locaux (CSSS) assurent la dispensation des services à la population à des niveaux différents, selon des mandats distincts, mais complémentaires. La responsabilité populationnelle, c'est-à-dire l'obligation de favoriser la santé et le bien-être de l'ensemble de la population, est celle de l'ensemble des établissements d'un territoire et commande des actions concertées afin d'y parvenir. En Montérégie, la pratique de l'EIS s'inscrit dans cette perspective de responsabilité populationnelle et d'approche concertée. Le modèle collaboratif de l'EIS élaboré par la Direction de santé publique (DSP) repose sur le partage de responsabilités entre les paliers régional et local pour informer les autorités municipales des impacts potentiels de leurs politiques et projets sur la santé et la qualité de vie de leur population. En interagissant avec les municipalités volontaires de son territoire, la DSP et le CSSS participant peuvent agir de manière concertée afin de mener une EIS tout en tenant compte du contexte local dans lequel elle s'inscrit. Pour atteindre ses objectifs, l'EIS de type collaboratif repose sur certaines conditions. Par cette communication affichée, nous proposons de les expliciter et de proposer un *modus operandi* favorisant l'utilisation de connaissances transmises.

Posters

Thème 4
Approaches and methods related to HIA

10. Intersectionality-Based Policy Analysis: A New Framework for Understanding Health Inequities

Daniel Grace, Simon Fraser University, British Columbia, Canada

An Intersectionality-Based Policy Analysis (IBPA) framework expands on HIA approaches to understand determinants of health. It includes principles and questions intended to ensure that the most important and relevant information is generated about decision-making priorities, processes, and policy outcomes to reveal the complex contexts and root causes of social and health problems.

Extending beyond gender-focused and social determinants frameworks, intersectionality-based policy analysis (IBPA) draws attention to a variety of multi-level interacting social locations, forces, factors, and structures that shape and influence human life. In the context of health, IBPA can better elucidate how policy constructs citizens' relative power and privileges vis-à-vis their health and well-being. The IBPA framework includes principles and questions intended to ensure that the most important and relevant information is generated about decision-making priorities, processes, and policy outcomes to reveal the complex contexts and root causes of social and health problems.

11. Rapid HIA for Tobacco Control Policy: A Proposed Model

Mark Spires, Johns Hopkins Bloomberg School of Public Health, United States

A tailorable framework methodology for evaluating the health impact of global tobacco control policies at various levels of implementation is presented. Possible approaches to be taken are suggested, along with the weaknesses and strengths of each. The model incorporates existing HIA framework steps and rapid evaluation concepts.

Due to funding partner requirements, the Institute for Global Tobacco Control (IGTC) at the Johns Hopkins Bloomberg School of Public Health required a tailorable, rapid method for evaluating the health impact of tobacco control policies in a variety of global settings. In addition, because policy evaluation work will be conducted in settings where policies are in various stages of implementation (e.g., pre-implementation; implementation; post-implementation; and implementation delay), rapid assessment approaches needed to be tailored accordingly. In order to address policy evaluation needs, a systematic review of peer-reviewed and grey literature was conducted using relevant key words. Consequently, best practices in health impact assessment, rapid evaluation and/or assessment, and tobacco control policy simulation model methodologies were identified, reviewed, and summarized. A framework methodology was developed for the rapid evaluation of health impacts of tobacco control policies. This methodology incorporates existing HIA framework steps and rapid evaluation concepts, and takes into account various stages of policy implementation. Possible approaches to be taken in each circumstance are suggested, along with the weaknesses and strengths of each approach.

Posters

Thème 3
The use of HIA in specific contexts

9. The Development of a Rapid Equity Mental Health Impact Assessment Tool in Canada

Tracey Reynolds, Public Health Agency of Canada, Ontario, Canada

The presentation will inform HIA practitioners and policy makers of the value of conducting mental health impact assessments. MHIA ensures that health, and in particular mental health, impacts are considered especially with respect to non-mental health sectors. Further, it will describe the process undertaken by the Public Health Agency of Canada.

Over the past three years, the Public Health Agency of Canada has been working to develop an equity-based health impact assessment tool that specifically focuses on mental health. The aim of mental health impact assessment (MHIA) is to maximize positive and minimize negative impacts on mental health and well-being. Our MHIA focuses on population groups who may experience health inequalities and social injustice with a particular emphasis on those most at risk of poorer mental well-being. Crucial to the tool is the fact that it also makes the link with social determinants, and can be adapted to be used alongside HIA or as a separate process. The MHIA process enables a shift in thinking to improve mental well-being. It can contribute to re-aligning resources that concentrate on managing the consequences of poor mental well-being to ones that tackle the determinants of good mental well-being: control, resilience, participation, and inclusion.
E.g.: Ensuring existing and new policies, services, programs, or projects have a positive (or at the very least a neutral) impact on mental well-being. The Committee chose to adapt the toolkit of the NHS Northwest Development Centre. This includes using the PHAC definition of positive mental health and the two-continuum model of mental health and mental disorder. We have a draft tool for a rapid assessment and during the year we will have members of our Advisory Group testing the tool in their jurisdictions. We will have evaluation results by the end of 2013.

Posters

Theme 2
The application of HIA to specific areas

7. Integrating HIA and Regeneration: Lessons From Wales

Liz Green, Wales Health Impact Assessment Support Unit, United Kingdom

Using the backdrop of the North Wales Strategic Regeneration Area (SRA) Plan, this paper will discuss how HIA is being integrated into numerous SRA plans and projects. It describes the context and background to the work, who has been involved, and the lessons learned so far.

"One Wales" emphasizes the need to improve and address social, economic, and environmental problems in order to achieve a sustainable future for its people. The Wales Health Impact Support Unit (WHIASU) is funded as part of the Welsh Government's wider strategy to address the health inequalities that continue to persist in Wales. HIA has been used in Wales to consider health in a number of traditionally non-health domains and support a "Health in All Policies" approach to policy making. Regeneration can have significant potential to improve health because it targets one or more determinants of health. HIA can make these connections more explicit. Against the backdrop of the North Wales Coastal Strategic Regeneration Area (SRA), this paper looks at how HIA is being used in some of Wales's most deprived areas as a lever for health improvement in conjunction with regeneration initiatives. This has included joint initiatives for better, more sanitary housing, the improvement of environmental services, and access to open green spaces for physical and social activity. Using two recent HIAs, the presentation describes the context and background to the establishment of the SRA, shows how HIA is being integrated into current SRA regional and local plans and projects, and the impacts identified to date. It highlights how the HIA process has directly involved local stakeholders and harnessed their experiences of living, working, or having free time in these communities. These data have led to the amendment of several proposals — not simply those that target physical and economic redevelopment and improvement, such as retail outlets and housing, but also tourism initiatives, and local community services —and have been used to inform and plan future work. In conclusion, this presentation will discuss lessons learned, and a number of proposals for improving the role of HIA in other regeneration programs will be raised.

8. HIA for Two Intervention-Regeneration Areas in Pasaia Bay

Elena Serrano, Basque Government, Spain

Preliminary results of the HIA of two interventions to regenerate a declining region in which industrial activity is being developed in a built-up urban area will be presented: the screening process, the characterization of the community, the bibliographic review, and the first part of the mixed study with the qualitative analysis.

Pasaia Bay is a commercial and fishing port, whose industry is in decline, in an urban area with 50 000 inhabitants who live around the bay. This area shows signs of economic, social, and environmental decline. In 2010, a project was created to regenerate the bay. The first interventions to be carried out were related to reconstruction of the fish market and urban regeneration of a specific area near the waterfront. As it was a strategic project in Gipuzkoa, it was considered appropriate to assess its impact on population health. The aim of this presentation is to show the screening process, the characterization of the community, the bibliographic review, and the first part of the mixed study with the qualitative analysis. This is a research-action-participation-based HIA approach encouraging the participation of stakeholders. The Merseyside Guidelines are being used, as well as the Devon screening tool to identify potential health impacts. In addition, a mixed approach including qualitative and quantitative methodologies will be conducted to complete the assessment. Triangulation and integrative analysis will then be carried out in order to define and quantify impacts and suggest recommendations for improvement, and procedures for their monitoring. During the screening process some potential impacts on social cohesion, employment, urban quality, connectivity, transport and the environment, as well as risks of gentrification and ghettoization have been identified. The mixed study will be performed shortly, and will provide the population's viewpoint on the impacts that have been identified. The recommendations for improvements will be backed up by the information gathered.

Posters

6. Health Lens for Public Policy – Alberta's Progress

Carol Taylor, Alberta Health and Wellness, Alberta, Canada

The main purpose of the presentation is to discuss the Ministry of Health's Health Lens for Public Policy tools and processes, the evaluation method, and conclusions, along with a discussion of challenges and opportunities associated with the evaluation pilot tests, which resulted in valuable lessons for further developing and proposing its government-wide use.

Among the health priorities of the Alberta Government is to develop a process to assist government policy developers in identifying and understanding the potential health impacts (positive or negative) of a proposed government policy on the health of Albertans. In 2010, the Ministry of Health and Wellness sponsored a Health Lens for Public Policy Project to draft a model, tools, and processes for the Government of Alberta. To increase the appeal to busy policy developers, a draft rapid screening tool to guide the assessment of key factors known to impact health was introduced so that the assessment could be carried out relatively quickly and with minimal impact on resources. The desired outcomes of the project included the following: 1) government policies would systematically consider the potential positive and negative impacts on the health of Albertans in policy decisions, and 2) an increase in government capacity to apply the Health Lens for Public Policy as a tool to support effectiveness and excellence in policy development and decision making. In early 2012, University of Alberta evaluators were contracted to conduct a formative process evaluation to strengthen the evidence base for the Health Lens for Public Policy as an effective government policy development tool. In two pilot tests, diverse policy developers were engaged for orientation and practice sessions to apply the tools to a policy under their development. The policy developers were then asked to evaluate the effectiveness and value of the tools and processes to their stage of the policy development cycle. The Ministry of Health's draft Health Lens for Public Policy tools and processes, the evaluation method, and conclusions will be presented. There will be a discussion of challenges and opportunities associated with the pilot tests, which resulted in valuable lessons for further developing and proposing government-wide use of the Health Lens for Public Policy during policy development.

Posters

4. L'ÉTUDE D'IMPACT EN GOUVERNANCE LOCALE : ENJEUX FAVORABLES, STRATÉGIE D'ÉQUITÉ ET LEVIER SYNERGIQUE DE LUTTE À L'OBÉSITÉ EN SANTÉ PUBLIQUE

JUDITH LAPIERRE, UNIVERSITÉ DU QUÉBEC EN OUTAOUAIS, QUÉBEC, CANADA

Ce sondage a été réalisé auprès des élus et fonctionnaires municipaux dans le cadre d'une recherche subventionnée portant sur les environnements favorables à la prévention de l'obésité et à la promotion de modes de vie sains. L'intégration des études d'impact est une stratégie prometteuse de gouvernance locale pour la santé et le développement.

Alors qu'on reconnaît l'importance capitale des habitudes alimentaires, de la sédentarité et de l'activité physique comme facteurs déterminants dans l'épidémie d'obésité, les environnements physiques, sociaux proximaux et distaux, économiques et culturels comptent de plus en plus dans la balance et tissent largement la toile causale de l'obésité. Il semble que certains quartiers exercent une influence plus ou moins grande sur le poids de ses habitants. Le quartier dans le contexte politique actuel des municipalités offre des leviers inégalés que ce soit en matière de proximité favorisée, d'accessibilité accrue, d'influence du réseautage, de liens de confiance et de pouvoir de mobilisation. Le but de ce projet est de documenter les perceptions des élus et des fonctionnaires de leur influence en matière de saines habitudes de vie et de création d'environnements favorables à la santé et leur évaluation de certaines caractéristiques de leur quartier. Ce sondage quantitatif descriptif a été réalisé auprès des élus et fonctionnaires municipaux du Québec dans le cadre d'une recherche subventionnée. Les résultats présenteront les données sur certaines approches politiques favorables prometteuses comme les politiques familiales, alimentaires et d'urbanisme ainsi que sur l'urbanisation et l'équité, sur des indicateurs de santé et sur l'utilisation de l'évaluation d'impact sur la santé (EIS) par l'administration publique municipale. Le portrait global permet d'articuler l'intégration des études d'impact aux processus décisionnels municipaux. Une nouvelle santé publique émerge, alliant des approches sociales incluant les réseaux familiaux et communautaires et les politiques municipales de développement et d'intégration de la qualité de vie. Certaines municipalités se voient imposer ce nouveau rôle sans avoir tous les outils et expertises. Favoriser l'expression de leurs points de vue pourra permettre une plus grande sensibilisation à leurs besoins, à leurs forces vives et à leurs préoccupations pour optimiser les travaux en actions concertées.

5. EFFICACY OF HIA FROM THE DRIVING FORCE PRESSURE STATE EXPOSURE EFFECT ACTION (DPSEEA) MODEL IN POLICIES AND DEVELOPMENT PROJECTS IN BRAZIL: THE HYDROPOWER PLANTS STUDY CASE

MISSIFANY SILVEIRA, UNIVERSIDADE DE BRASILIA, BRAZIL

This research aims to discuss the development and effectiveness of integrating health impact assessment methodology into the DPSEEA model to enable health impact observations to be taken into account, and thus ensure greater sustainability in the development of strategic projects in Brazil, especially in the case of hydropower plants.

Health issues cannot be separated from socio-environmental changes and their impacts on ecosystems. In view of this, the health sector in Brazil has been strengthening commitments, stressing this essential relationship between health and sustainable development, although it is imperative to create methods capable of building a dialogue regarding social, economic, and environmental policies. There are already several national and international initiatives for the implementation of health impact assessment (HIA), as well as the use of the DPSEEA (Driving Force-Pressure-State-Exposure-Effect-Action) model proposed by WHO, which allows an approximation of the effects on health by connecting them to environmental impacts. The construction of indicators that can identify health problems related to environmental issues is important for priority setting in the evaluation of health policies and programs. It is also important for institutions in charge of development projects, such as the Ministry of the Environment, and the ministries of Mines and Energy, which formulate development policies, plans, and programs pertaining to environmental, mineral, and energy resources. With this in mind, this research aims at discussing the development and effectiveness of integrating health impact assessment methodology into the DPSEEA model to enable health impact observations to be taken into account, and thus ensure greater sustainability in the development of strategic projects in Brazil.

Posters

2. L'UTILITÉ DE L'EIS POUR LES POLITIQUES DE SANTÉ EN AFRIQUE SUBSAHARIENNE : LE CAS DU BÉNIN

ASSOMPTION HOUNSA, MINISTÈRE DE LA SANTÉ, BÉNIN

Les pays africains au sud du Sahara ont intérêt à s'approprier l'approche de l'EIS lors de l'élaboration de leurs politiques de santé dans leur quête d'amélioration des indicateurs de santé et d'atteinte des Objectifs du Millénaire pour le Développement.

Il existe un double fardeau morbide infectieux et chronique dans les pays africains au sud du Sahara. Ce fardeau est aggravé par des problèmes de pauvreté, d'éducation et d'environnement. Ces facteurs ne sont pas bien pris en compte dans la plupart des politiques sanitaires africaines. Cela a conduit à des résultats sanitaires insuffisants dans le passé. Notre méthode a consisté en une analyse de contenu documentaire de l'adéquation entre les stratégies et les problèmes de santé tels que retenus dans le Plan National de Développement Sanitaire (PNDS) et analysés ici selon des paramètres-clés. Le PNDS est un outil recommandé par l'Organisation mondiale de la Santé pour l'opérationnalisation des politiques de santé et couvre souvent une période de dix ans (2009-2018 au Bénin). Un seul des 12 programmes inscrits dans le PNDS du Bénin cible un déterminant social. Les facteurs tels que les mauvaises conditions de vie et d'environnement physique et social, ainsi que la pauvreté, qui contribuent grandement à la survenue de la plupart des maladies citées dans l'analyse situationnelle présentée dans le PNDS, sont ignorés dans les choix stratégiques finaux, de même que la situation des inégalités sanitaires caractérisée par une mortalité infantile de 81 pour 1000 en milieu rural contre 66 pour 1000 en milieu urbain en 2006, inégalités grandissantes en lien avec des disparités évidentes. La notion d'impact anticipé que prône l'EIS reste faiblement évoquée. En somme, l'EIS est d'une grande utilité pour le Bénin et plusieurs pays africains au sud du Sahara dans leur démarche de développement d'une politique de santé et de développement efficace et efficiente.

3. HOW DO WE ESTABLISH THAT A POLICY HAS A DIRECT AND DOCUMENTED EFFECT ON HEALTH?

STELLA KRAEMER, UNIVERSITY OF SOUTHERN DENMARK, DENMARK

The main purpose is to present the results of a survey of international HIA experts and practitioners and interviews with Danish policy makers on the subject of a policy having a direct and documented effect on health.

In HIA, screening is the point at which it is decided whether or not an HIA is needed or wanted; in practice, a decision (political or professional) to conduct screening is required for it to be undertaken. The strengths of HIA are to effectively place health on the political agenda, improve knowledge of health, and increase and define the role of health in policies, strategies, programs, etc. Thus it appears logical that a Danish Disease Prevention Committee recommended in its 2009 final report: "to conduct impact assessments of political decisions on a national level, where a decision is assumed to have a direct and documented effect on the public's health." However, HIA is based on values, and the link between a proposal or bill and its effect on health resembles the two ends of a chain, which also contains determinants of health and risk factors. Thus a direct, straightforward and causal relationship between political decisions and a health outcome is hard to document. The Dahlgren and Whitehead "rainbow" model illustrates the complex relations in a full chain. In order to proceed from the recommendation by the Danish Disease Prevention Committee to assess health impacts of political decisions, it is therefore important to define how and when a political decision has a direct and documented effect on population health. In this presentation, I will present the results of a survey of international HIA experts and practitioners and interviews with Danish policy makers on the subject of a policy having a direct and documented effect on health. Survey participants were identified via established HIA groups or networks and contributors from the 2011 HIA conference. After reviewing the topic trend in HIA reports and articles, stakeholders were identified within the ministries (e.g. Ministry for Food, Agriculture and Fisheries) responsible for policies on these topics.

Posters

The posters were grouped under the main themes to be discussed during the 12th HIA International Conference. Abstracts are presented in the language in which they were submitted.

Theme 1
HIA in the political process

1. The Integration of HIA as Part of the Siting Process for the UK's Geological Disposal Facility for Higher Level Radioactive Waste

Robert Fletton, Nuclear Decommissioning Authority, United Kingdom

Geological disposal is the UK Government's policy for the long-term management of higher-activity radioactive wastes and will be delivered through the Managing Radioactive Waste Safely (MRWS) process. Consideration of human health impacts will be part of the Strategic Environmental Assessment (SEA) for a geological disposal facility (GDF).

Geological disposal is the UK Government's policy for the long-term management of higher-activity radioactive wastes. The principle of geological disposal involves isolating radioactive waste deep inside a suitable rock formation to ensure that no harmful quantities of radioactivity ever reach the surface environment. The Nuclear Decommissioning Authority (NDA) has been tasked by the UK Government with planning and delivering a geological disposal facility (GDF) through the Managing Radioactive Waste Safely (MRWS) process. The Radioactive Waste Management Directorate (RWMD) has been established within the NDA to achieve this. The process of selecting a site for geological disposal is based on the principles of voluntarism and partnership. This means that communities volunteer to participate in the process that will ultimately provide a site for a GDF. The RWMD will work in partnership with volunteer communities to identify and assess potential candidate sites. The RWMD will undertake a Strategic Environmental Assessment (SEA) of proposals for implementing geological disposal in each participating community and a Health Impact Assessment (HIA), integrated with the SEA, will consider the effects on health and well-being. This will be done in keeping with the requirements of the SEA Directive and with reference to UK Department of Health guidance on considering health issues in SEA. Human health is one of a wide range of proposed assessment topics for the SEA and is often overlooked in favour of biophysical criteria such as water resources, air quality, and noise. This paper presents the RWMD's proposed approach to HIA and considers how an integrated environmental and health assessment could achieve a more sustainable outcome and address a wider set of stakeholder concerns.

List of Tables

HIA2012

HOW HIA MATTERS IN HEALTH
IN ALL POLICIES

August 29-31, 2012 • Québec, Canada • www.hia2012.ca

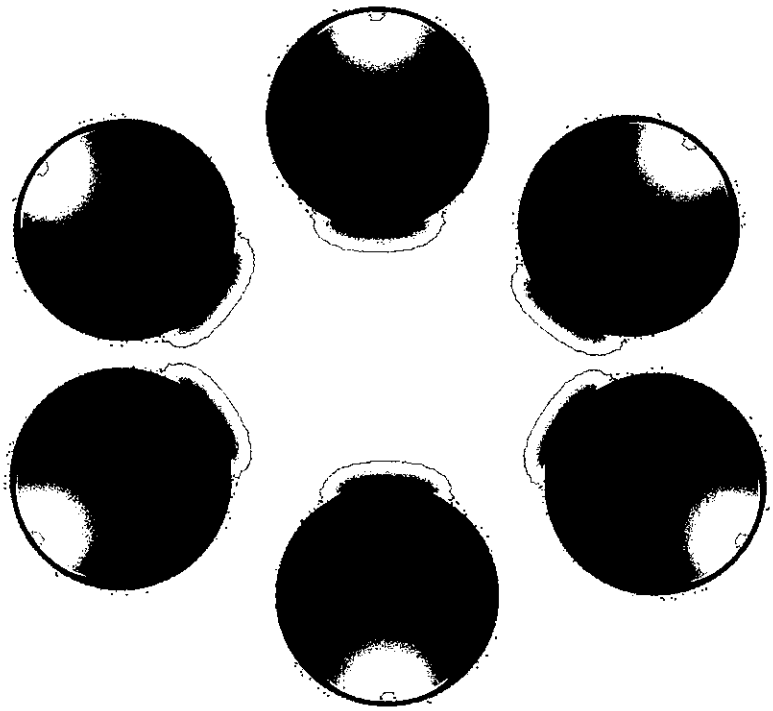
12th HIA International Conference

Posters

附件 4　其它會議重點資料

Health Impact Assessment (HIA):

A tool for public decision-making towards healthy, sustainable and equitable choices



An International Union for Health Promotion and Education (IUHPE) document

IUHPE – UIPES

INTERNATIONAL UNION FOR HEALTH PROMOTION AND EDUCATION
UNION INTERNATIONALE DE PROMOTION DE LA SANTÉ ET D'ÉDUCATION POUR LA SANTÉ
UNIÓN INTERNACIONAL DE PROMOCIÓN DE LA SALUD Y EDUCACIÓN PARA LA SALUD

HEALTH IMPACT ASSESSMENT (HIA): A TOOL FOR PUBLIC DECISION-MAKING TOWARDS HEALTHY, SUSTAINABLE AND EQUITABLE CHOICES

Guiding principles and recommendations for the implementation of Health Impact Assessments at the local level

Forward

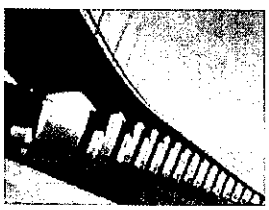
There is a growing interest in Health Impact Assessment globally. Largely inspired by environmental impact assessment of development projects, this method has unfolded over the last ten years based on health promotion principles and values. It is now considered a promising method to promote the establishment of healthy and equitable public policies, as recommended by the Ottawa Charter for Health Promotion (WHO, 1986).

With the multiplication of HIA experiences at all governmental levels (international, national and local), the International Union for Health Promotion and Education (IUHPE) wishes to contribute to efforts supporting the implementation of this practice at the local level, capitalizing on the knowledge of its global working group on HIA.

This document aims to promote the development of HIAs without being a methodological guide (as such tools exist and are available on the web, see "references" and "find out more" sections). It aims to inform stakeholders interested in local HIA, whether from the health sector, from non-governmental organizations or local and territorial authorities, on the conditions which promote HIA establishment, expected benefits from this method as well as the main challenges that impede its implementation.

HIA can

- supply useful data for decision-makers who wish to develop evidence-informed policies
- promote inter-sectoral collaboration
- improve transparency of decision-making processes
- support citizen participation in the development of public policies
- help to improve the health of populations and reduce heath inequities
- contribute to decision-makers' efforts towards sustainable development. (PHAC, 2004)



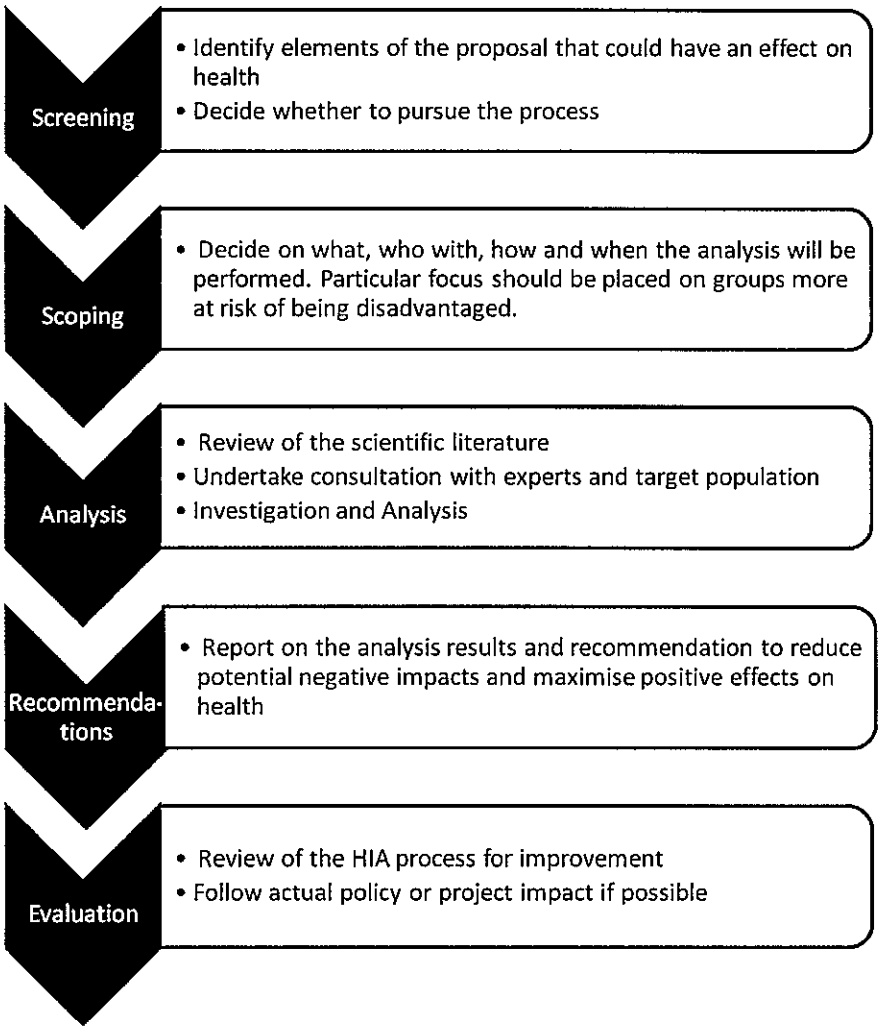
What is a HIA?

HIA refers to an approach structured around successive stages (see below diagram) that aim to identify policy elements that could have positive or negative effects on population health and on the health of various social groups. The approach informs decision-makers on the extent of potential negative effects and the possible ways to avoid them, ideally before the final decision is made. Usually, this process is undertaken for policies or projects that do not have health as their primary objective, and for which the effects on health are not necessarily considered. It therefore aims to enlighten public policy or program decisions in order to avoid negative impacts on health and maximise potential positive effects.

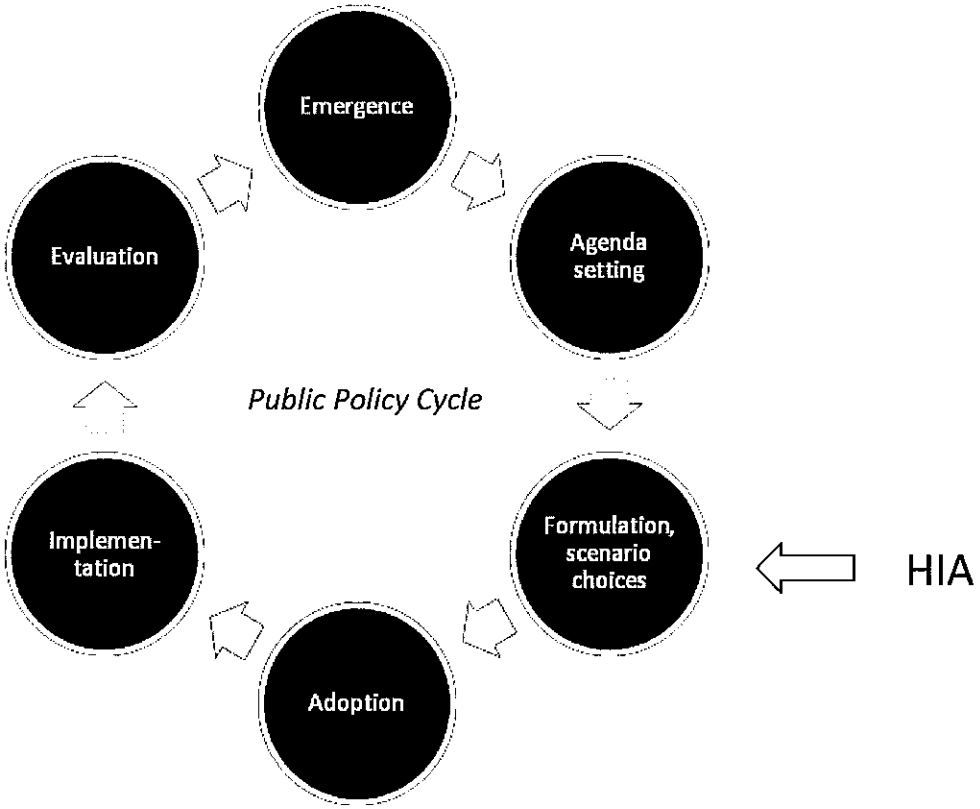
HIA is not only a set of impact analysis methods but also an approach that, when possible, **brings together stakeholders concerned with the proposed policy.** The assessment of the potential impacts takes into accounts both the **scientific data and views from the affected citizens and decision makers.**

Knowledge arising from the field not only allows HIA practitioners to **contextualise information** resulting from research, but can also **facilitate the implementation of policies.**

The five stages of HIA



HIA in the public policy development process



HIA Benefits

The growing interest for HIA can be explained by the potential benefits for all concerned stakeholders engaged in the process.

→ For decision-makers

- HIA supports the decision-making process by providing additional information, founded on evidence of health risks and benefits of a policy or program proposal;
- It links to other concerns or potential impact such as sustainable development, social impact (including equity considerations) or impact on territorial development;
- HIA allows for the prevention of negative consequences on health and well-being, and of developments which are difficult to reverse (e.g. certain infrastructure projects);
- It enables awareness raising and inclusion of citizen concerns with regards to health in a rigorous and impartial manner;
- Inclusion of concerned stakeholders and citizens in the decision-making process facilitates the implementation of final decisions whilst increasing their legitimacy;
- HIA is a great opportunity to promote collaboration between municipal authorities and health authorities as well as with other sectors that could be concerned by the policy, thus promoting its establishment.

→ For the health sector

- HIA enables the adoption of healthy public policies;
- HIA improves understanding amongst the concerned sectors and raises awareness of the social determinants of health;
- It promotes inter-sectoral exchanges and mutual trust;
- It enables action to reduce social inequalities in health;

→ **For other stakeholders and the broader community**

- HIA can contribute to an economic benefit (drop in prices, resource optimization);
- It brings a social benefit (choices that promote a better quality of life and reduce inequities);
- It contributes to a health benefit (reducing negative impact on health and encouraging healthy behaviours and environments;
- It contributes to the development of local democracy by allying stakeholders in the process;
- Through participation, it contributes to increased knowledge and health competencies of target populations.

Examples of projects and policies that have benefited from HIAs

Today, several policies and regional or local projects have benefited from HIAs. Policies around urban development, transportation, housing, leisure, elderly populations, as well as cultural policies or policies on economic development have been evaluated from the perspective of their impact on health. Large projects, such as the holding of the Olympics or the building of a London airport, as well as smaller projects such as the establishment of a new food market in a rural setting have also been subject to HIAs.

Principles and values

Generally accepted values (WHO, 1999) that underpin the practice of HIA include:

- *Democracy*, that recalls the right for citizens to participate in the development, adoption and implementation of policies that influence the course of their lives;
- *Equity* that leads us to consider not only the effects on population health, but also the differential effects on various groups of society;
- *Sustainable development* highlighting the need to consider short-term as well as long-term effects of policies;
- *Ethical use of knowledge* that not only reminds us of the importance of rigour for information / data collection and analysis, but also of the importance of addressing all of the socio-economic determinants of health.

Essential elements for the implementation and sustainability of a HIA approach

- Identify and support key enthusiastic individuals with regard to HIA who can support the experiences of new comers in HIA;
- Create favourable climate for HIA, in particular by sensitizing authorities and the population on the extent and importance of the determinants of health. It is crucial to reach a common understanding on a broad concept of health (beyond health care and individual behaviours) . It may also be necessary to reach a consensus on terminology that suits all (e.g. sustainable development, quality of life, wellbeing, etc.);
- To ensure the timeliness of engaging at the right stage of policy development, be familiar with current local policy processes. The HIA process should be able to follow the rhythm of the policy formulation process; this rhythm can be fast or slow, depending on the decision-making calendar/ timeline;
- Make realistic, practical and evidence-based recommendations to decision-makers;
- Promote collective learning and invest in stakeholders' (health, municipality, partners, etc.) ownership of the HIA process by organizing seminars and workshops prior to launching the HIA process;

- Assess to what extent the HIA process can strengthen or complement existing practices associated with the analysis of policies or other responsibilities of local authorities, such as community development, sustainable development, etc.;
- Ensure support from managers of the organisation leading the HIA process;
- Ensure adequate preparation of people that will be responsible for implementing the process;
- Rely on a HIA steering committee that is sufficiently representative of engaged stakeholders.

How and when to start?

- Begin with a small project or an "easy" policy that is most likely to produce a successful experience
- Chose a situation in which you could have support from other organisations or stakeholders of the concerned field;
- It is better to start on a small scale and to build on success;
- The best way to learn is to get involved in a HIA project and to gain skills from collective learning. Several health agents and other stakeholders engaged can then come to the realisation that they already possess many of the required competencies;
- Several successful experiences in HIA have started with pilot projects that have enabled the development of capacities, the gauging of necessary resources and concrete illustration of the approach and its legitimacy for decision-makers, their partners and the health sector.
- Having a person familiar with the HIA approach within a HIA steering committee during the initial experiences greatly facilitates the required learning.

Necessary resources

The amount of resources necessary to undertake a HIA depends on the nature of the policy/program, the organisational context and the type of HIA favoured (see box below). The resources can include:

- Scientific expertise that uses evidence to assess the health impacts of a policy or project.
- Competencies for evaluating public policies;
- Skills in project management, public participation and communication;
- Necessary logistics for community participation and / or inter-sectoral activities.

Types of HIA

It is common practice to distinguish between three types of HIAs depending on time available to conduct these. Therefore, depending on the scope of the evaluation, available resources and data, potential study of alternative scenarios, and the importance assigned to public consultations, an organization may select one of three types of HIA to conduct: **rapid HIA, intermediate HIA and in-depth/comprehensive HIA**. The latter is usually conducted by a multi-disciplinary team of experts that will use sophisticated analysis tools. Such a HIA can require considerable human, technical and financial resources. However, it is possible to conduct a HIA with limited resources. For example collaboration between a public health unit, a municipal team and community organisations can generate new information that is useful for decision-making by pooling knowledge. A rapid HIA can also provide sufficient information through the simple holding of a meeting between experts and citizens.

Three types of HIA

Rapid HIA	A few days / weeks
Intermediate HIA	2 to 6 months
In-depth HIA	6 months and more

A Few Successful examples

In-depth HIA

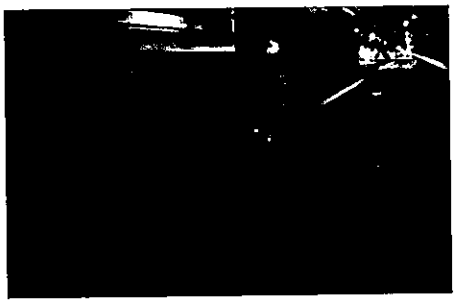
The city of Glasgow, in collaboration with various health partners, carried out a health impact assessment of the holding of the 2014 Commonwealth Games. The HIA was conducted over a period of a little over a year and called upon engagement of eight organizations for the framework coordination, citizen consultations and analysis. A comprehensive literature review was conducted by a university team and almost 3000 people were consulted via questionnaires, electronic surveys and interactive workshops. Of the 13 identified themes, accompanied by concrete measures, five were prioritized by citizens: civil pride, the city's image, housing, public spaces and employment economy. Recommendations were made for each of the potential impacts. For example, it was proposed that public space be designed so that it promotes physical activity and social interaction (Glasgow City Council, 2009)

Intermediate HIA

In 2006, the town of Christchurch in New Zealand decided to lead a HIA on the urban development strategy designed to address the anticipated growth of its population. The HIA was carried out over a two-month period and led by city council and public health staff. The screening stage was conducted as part of a workshop gathering thirty people from the city council and from public health settings. The following six determinants were identified to be further investigated: air quality, water quality and access to clean water, housing, transport, and social connectivity. The analysis was supported by a literature review conducted by a specialist and by four workshops, each focusing on one of the identified determinants. The fact that the analysis was based both on scientific evidence and citizen participation has favored integration of HIA report into the strategy planning process. It helped decision-makers to go beyond traditional concerns related to physical aspects of urban development to focus more on the quality-of-life outcomes (Stevenson et al., 2006).

Rapid HIA

In 2005, the housing development plan of a small town of around 2000 inhabitants in New Zealand was subjected to a rapid HIA. The HIA was mainly led by a small team of two people, one from the city council and one from the health center, each working part-time on the project over a period of twelve weeks. The HIA team was overseen by a steering committee representing health and council authorities as well as the community. The analysis was based on existing literature review and feedback from key informants. The majority of recommendations (9 out of 16) focused on three areas of determinants: physical activity, quality and access to drinkable water and good neighborhoods were integrated in the various city council development plans (Dubois, 2007).



Challenges and suggestions for solutions

There are several different challenges associated with the practice of HIA. They can be methodological, political, linked to inter-sectoral work or to citizen participation. Years of HIA practice have produced suggestions to overcome or reduce the difficulties associated with these challenges.

Challenges	*Reflections and Solutions*
Methodological	
One of the challenges often mentioned is linked to the methodological difficulty of establishing clear links between project or policy elements and population health. This difficulty can come from the complexity of interrelations among multiple health factors, and / or the absence of or difficulty accessing local data. This difficulty is magnified (magnified) by the often short time allocated to conducting these analyses in order to meet decision -making process deadlines.	HIA is a flexible tool that can adapt to many situations. Sometimes, even small amounts of information can be sufficient to inform the decision-making process. It may also be useful to refer to similar case studies. However, it is important that information be relevant for the decision-maker; that it be collected/assembled in a rigorous manner and from reliable sources and that it be conveyed in a transparent manner.
Political	
Various reasons can lead a decision-maker to undertake HIA, all of which are valid (see box). HIA should not be used as an instrument of politics, but neither should it be assumed that "science" alone is the only value that drives political choices. Certain projects or policy proposals can be highly controversial and the subject of high-level political debates, with various interest groups. Caution must be taken to ensure these various groups do not bias the HIA and to ensure the credibility of the process is not jeopardised. The clear objective of a HIA is to influence decision-making. However, the decision-making process is based on a set of sometimes competing considerations including health. HIA aims to shed new light that often adds to the complexity of decision-making. This complexity also arises from the fact that, generally, a decision benefits one group more than another. However, the final decision belongs to decision-makers who must take into account other considerations.	Communicate clearly, from the start, the objectives and principles of HIA. Ensure a good understanding of all stakeholders' expectations For example, if the policy-maker is expecting that the results assist in the acceptance of his / her decisions by citizens or partners, it will be important to discuss different scenarios prior to the process in case the impact analysis does not meet this expectation. A good reading of the political environment is essential. It is possible that the HIA helps to transcend existing conflicts by focusing the debate on health implications. Alternatively, the HIA process may raise unrealistic expectations or provide arguments for opponents of the policy/ program, especially if the extent of potential health impact is unclear. It will therefore be important to judiciously weigh short and long-term advantages and disadvantages of conducting a HIA. A purpose of HIA is to raise awareness around the determinants of health. It is therefore important to consider the knowledge exchanged during the course of the HIA as one of the positive outcomes of the method. Influence on policies can thus be indirect and long-term.

Challenges	*Reflections and Solutions*
Political	
	Making realistic recommendations and adopting a position to support the decision-making process provide greater opportunities for success in terms of impact.
Inter-sectorality	
Though including in the HIA process a broad range of stakeholders helps to broaden viewpoints, facilitate a common understanding and multiply accessible sources of information, it can also rapidly lead to a process that is difficult to manage. HIA can also lead to work with other professional groups (e.g. urban development professionals or community organizers) for whom inclusion of health in their field of responsibility is considered an intrusion or an additional constraint. Health stakeholders must also resist the habit of working in silos and be prepared to share the "ownership" of health.	Restricting the number of members on the HIA steering committee can be a solution. It is wiser to call upon various ad-hoc consultation groups to enlarge the knowledge base according to the various stages of the HIA process. However, in some cases, those in charge of HIA may want to call upon a large group to conduct the screening stage, considered as an important (and sometimes sufficient) step to promote the dialogue on the socio-economic determinants of health and the role of each stakeholder. It is important to be aware of other municipal or territorial obligations and see to what extent HIA can be adapted to these and complement them in a useful manner. It can also be strategic to integrate HIA within environmental and urban planning evaluation processes. Similarly, actions to raise awareness of such groups and decision-makers to the determinants of health interventions can allow for opening fruitful collaboration avenues.
Citizen participation	
Citizen participation in the different stages of HIA is strongly recommended, but can lead to multiple difficulties: • choosing people that are representative of the target groups; • representation of less visible and marginalised groups likely to be affected by the policy; • quality of the consultation process to avoid polarisation and / or the creation of unrealistic expectations with regards to a policy project.	Do not embark on a public consultation process without appropriate experience or skills. Call upon external resources or to join already planned public consultations in the context of policy development. Conduct a preliminary consultation process by meeting certain groups that are representative of the population or by interviewing some key informants.

Bibliography

- Blau, G. & Mahoney, M., (2002). *The Positioning of Health Impact Assessment in Local Government in Victoria*. Health Impact Assessment Unit, Deakin University. Australia.
- Douglas, M., et al., (2001). Developing Principles for Health Impact Assessment. *Journal of Public Health Medicine* 23 (2): 148-54.
- Dubois, L., (2007) *Bungendore Health Impact Assessment Progress Report on Outcomes.* Albury, NSW. Greater Southern Area Health Service.
- Egbutah, C. & Churchill, K., (2002). *An Easy Guide to Health Impact Assessments for Local Authorities*. Luton Borough Council. U.K.
- Finer, D. et al., (2005). Implementation of a Health Impact Assessment (HIA) tool in a regional health organization in Sweden—a feasibility study. *Health Promotion International,* Vol. 20 No. 3. 277-284.
- Glasgow City Council, (2009). 2014 *Commonwealth Games Health Impact Assessment Report: Planning for Legacy*. Glasgow City Council, Chief Executive's Office, Policy Health Team. www.glasgow.gov.uk.
- Kemm, J., (2007). *More than a statement of the crushingly obvious: A critical guide to HIA.* West Midlands Public Health Observatory. Version 1.
- S2D, Ville de Rennes, (2011). *Les Évaluation d'impact sur la santé (ÉIS) : Une méthode simple et des outils pratiques*. Rennes, France.
- Mahoney, M & Durham, G., (2002). *Health Impact Assessment ; a tool for policy development in Australia*. Public Health Education and Research Program Innovations Grants. Deakin University
- *Milner, S., (2004).* Using HIA in local government. In: J. Parry, J. Kemm and S. Palmer, Editors, *Health impact assessment concepts, theory, techniques and applications*. Oxford University Press
- PHAC, (2004*). A Guide to Health Impact Assessment : A Policy Tool for New Zealand.* Public Health
- Stevenson, A. Et al. (2006) *Assessing the impacts on health of an urban development strategy : a case study of the Greater Christchurch urban development strategy Social Policy Journal of New Zealand. 29 ; 146-164.*
- Thackway, S. et al., (2005). Health Impact Assessment Case Study: Working with local government to obtain health benefits. *NSW Public Health Bulletin*. 16 ;7-8, 127-128.
- WHO (1986). *The Ottawa Charter for Health Promotion.* Geneva; World Health Organization.
- WHO (1999). *Health Impact Assessment: main concepts and suggested approach. The Gothenburg Consensus paper.* Brussels; WHO Regional Office for Europe.
- Wismar et al., (2007). *The effectiveness of Health Impact Assessment. Scope and limitations of supporting decision-making in Europe*. European Observatory on Health Systems and Policies.

Find out More

HIA Gateway (U.K.): http://www.apho.org.uk/default.aspx?RID=44539

HIA Connect (Australia): http://www.hiaconnect.edu.au/

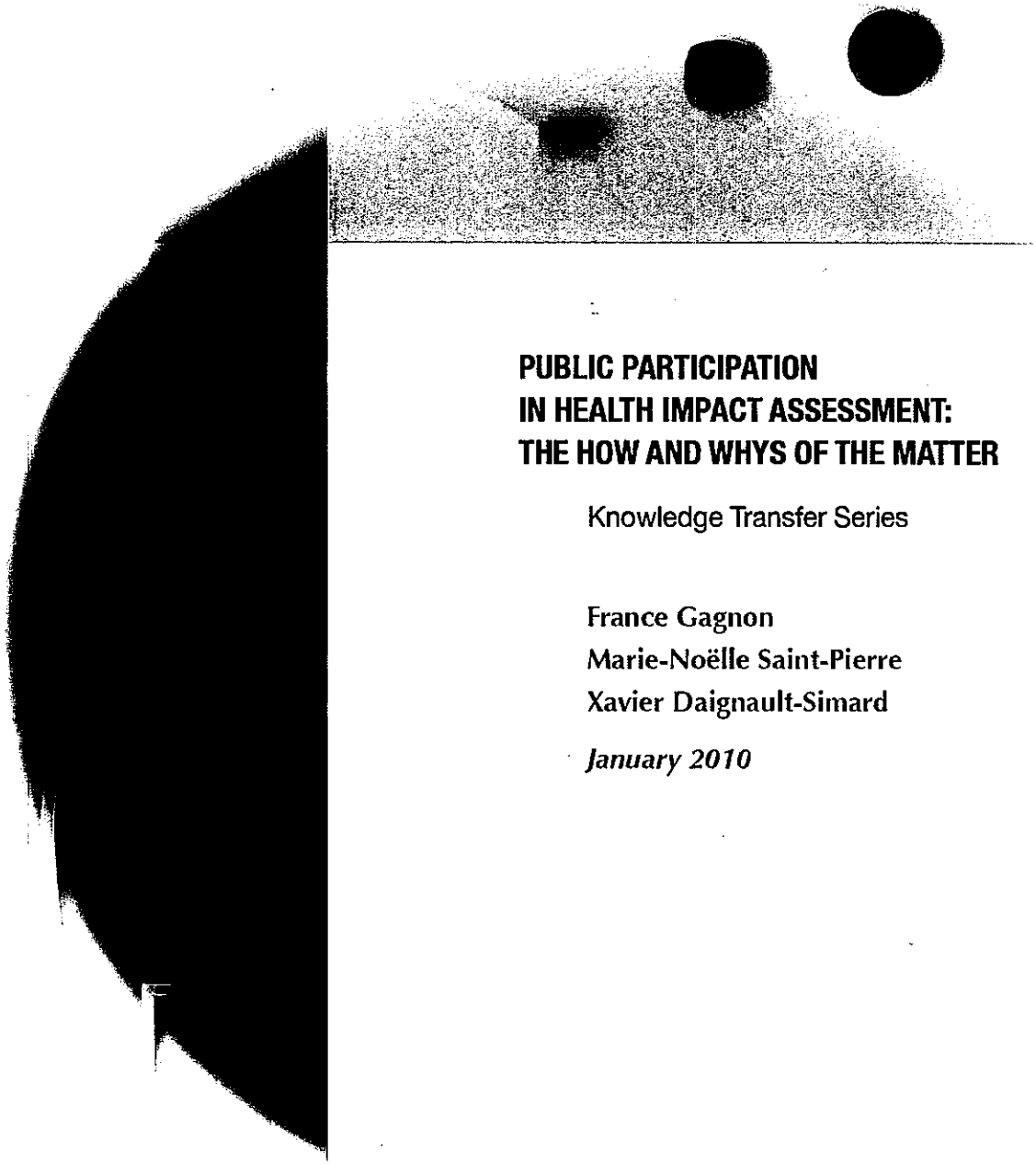
Health Impact project (USA) : http://www.healthimpactproject.org/

National Collaborating Centre for Healthy Public Policy (Canada): http://www.ncchpp.ca

This document results from efforts of a small group of collaborators of the IUHPE for initial dissemination at the 4th international francophone conference on local and regional health programmes / 4e Colloque international francophone sur les programmes locaux et régionaux de santé in June 2011 in Quebec. The document was reviewed and commented on by the participants of the symposium on HIA and Health in All Policy organised by the IUHPE. This is a preliminary version that will be enriched by other collaborators through 2012-2013.

The people that contributed to drafting this document are: Louise St-Pierre, National Collaborating Centre for Healthy Public Policy; Jean Simos, University of Geneva; Nicola Prisse, French Health Directorate; Marie-Claude Lamarre, International Union for Health Promotion and Education and Beth Jackson, Public Health Agency of Canada.

FOR CONSULTATION ONLY



PUBLIC PARTICIPATION IN HEALTH IMPACT ASSESSMENT: THE HOW AND WHYS OF THE MATTER

Knowledge Transfer Series

France Gagnon
Marie-Noëlle Saint-Pierre
Xavier Daignault-Simard

January 2010

GÉPPS
Groupe d'étude sur
les politiques publiques
et la santé

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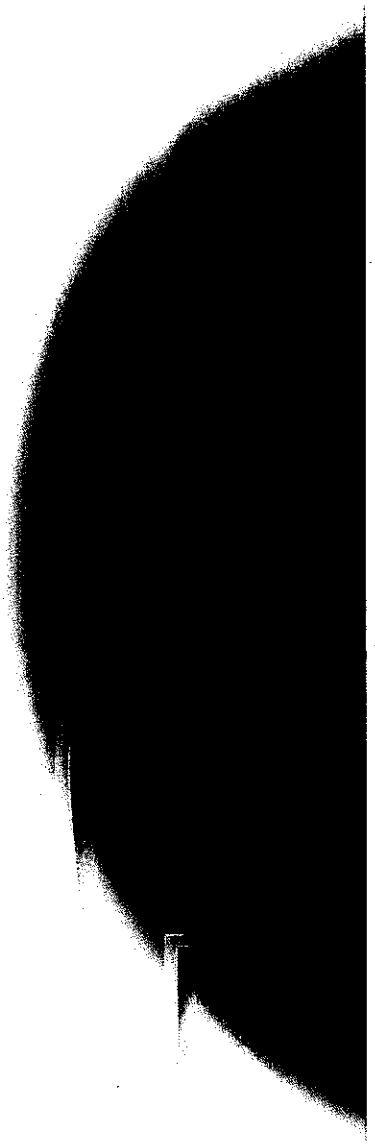
Abstract



Broadly stated, public participation is about increasing the involvement of citizens in policymaking. For several years now, governments have carried out a range of initiatives to bring the public into the decision-making process, particularly in the health sector. The question thus arises as to whether public participation has become firmly anchored in health impact assessment (HIA) process. This document begins by discussing public participation, broadly considered, and then examines the inclusion of public participation in HIA along with the issues that are thus brought into play.

Beginning in the 1970s, Arnstein set out the bases of citizen participation, distinguishing various levels of participation. Where genuine participation is said to occur, citizens should be able to make choices that are effectively taken into consideration. In actuality, however, there are a multitude of reasons for resorting to public participation, with each presenting advantages and disadvantages for citizens and government authorities alike. Furthermore, consultations can be conducted according to any one of several approaches, although no single one is perfect. Thus it is vital to make a wise choice that is adapted to each context in order to obtain conclusive results.

The usefulness of including the community in the HIA process is widely attested to. That being said, carrying out an HIA does not necessarily entail public participation, and the level of public participation in HIA can vary strongly. However, according to various authors, there are numerous benefits to making public participation a part of an HIA. In addition to boosting acceptance for projects and reducing conflicts, public participation also represents a way of building a critical mass of knowledge and promotes mutual learning between citizens and leaders. It is generally acknowledged that no project should be started without first obtaining the approval of the community. Nevertheless, citizens may be excluded from a HIA for a variety of reasons, including the complexity of the HIA process or a lack of time and/or financial resources.

All in all, citizen participation in a HIA is not so different from the generic form of public input in the consultation process. The important thing is thus to appropriately assess the context, determine the extent to which the public can be included, and opt for a consultation approach capable of meeting objectives that have been established in the interest of all.

TABLE OF CONTENTS

LIST OF FIGURES

LIST OF TABLES

Introduction

Over the last several years, a number of countries have carried out wide-ranging initiatives aimed at increasing the involvement of citizens in policymaking (OECD, 2002; Irvin & Stansbury, 2004; Weeks, 2000). Western governments have sought to promote public participation, particularly in decisions concerning the health sector (Abelson et al. 2003a; Rowe & Frewer, 2000). In Canada in 2001, the experience of the Commission on the Future of Health Care in Canada (Romanow Commission) offers an illustration of this interest for having the public participate in setting priorities for national healthcare policy (CHSRF, 2009). In Quebec, the Conseil de la Santé et du Bien-être (Health and welfare board) (2004), the Ministère de la Santé et des Services sociaux (Ministry of health and social services) (2006) as well as the Commissaire à la Santé et au Bien-être (Health and welfare commissioner) (2009) have all taken an interest in public participation in a variety of forms throughout the health system or in relation to various themes such as the ethical issues surrounding prenatal screening for Down's syndrome in Quebec.

The question thus arises as to whether public participation has become firmly anchored in health impact assessment. If so, by what means and in what forms has this occurred? What are the advantages and disadvantages of this participation? These are the questions on which we have focused. We begin by discussing the components of public participation, generally speaking. We then examine public participation in HIA along with the attendant challenges of such participation[1].

1 Public participation

Although governments have been laying increasing stress on public participation in policymaking, the phenomenon is not new in and of itself. Indeed, citizen participation programs were introduced at all levels of government beginning in the 1950s (Irvin & Stansbury, 2004). Despite this record, many questions continue to linger today concerning the how and whys as well as the effectiveness of public participation. From the outset, then, it is worth defining what public participation is assumed to mean.

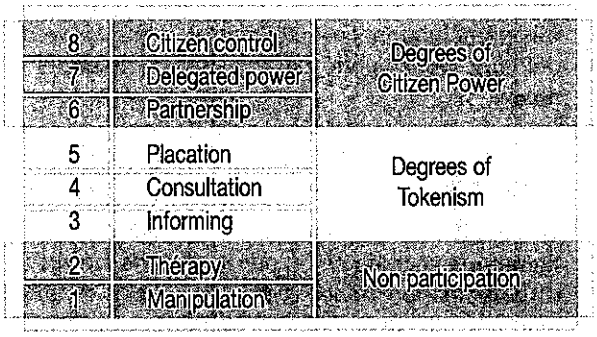
1.1 Definitions

The reality of the situation is that in the scientific literature, a certain ambiguity surrounds the notion of participation (Innes & Booher, 2004). A range of terms, such as "community participation," "public participation," "community involvement" and "citizen involvement" (Mahoney, Potter & Marsh, 2007), are all used without necessarily being defined. "Community participation," for example, takes on a variety of meanings. For some authors (Bauer & Thomas, to mention but one team), community participation denotes the genuine inclusion of the community, whereas for others, such as Kauppinen, Nelimarkka and Perttilä (2006), this form of participation refers as much to the participation of citizens as it does to that of experts from this same community. The question, in short, is what kind of participation is involved? During the 1970s, Arnstein proposed a valuable response to this question, asserting: "Citizen participation is a categorical term for citizen power. It is the redistribution of power that enables the have-not citizens, presently excluded from the political and economic processes, to be deliberately included in the future." [...] "In short, it is the means by which they can induce significant social reform which enables them to share in the benefits of the affluent society" (Arnstein, 1971).

[1] Readers who are less familiar with HIA may consult the document entitled Health Impact Assessment and Public Policy Formulation (Gagnon et al. 2008) at: http://www.gepps.enap.ca/GEPPS/docs/eis14nov08_vfang.pdf

On the basis of this definition, considered to be a "touchstone for policy-makers and practitioners" (Tritter & McCallum, 2006), Arnstein developed a typology in the form of a ladder, in which participation is assessed according to the influence it is able to exert.

FIGURE 1
ARNSTEIN'S LADDER OF PARTICIPATION



Source : Arnstein 1971.

Not only did Arnstein (1971) set out the bases of citizen participation, but her ladder has served as a reference for most research on the subject (Innes & Booher, 2004). As can be seen in Figure 1, its main advantage is to introduce a graduated scale of participation, setting off the highest degree of participation (rungs 6 to 8) from participation having no real impact (rungs 1 and 2). This distinction has been replicated in the literature, and in particular by Rifkin, Lewando-Hundt and Draper (2000), for whom genuine participation should be more than simply taking part in the decision-making process and should indeed involve "activeness, choice and the possibilities of that choice being effected" (in Cornwall & Jewkes, 1995). Arnstein's scale does have its critics, however, with some arguing that its conceptualization of protagonists is simplistic, that it does not evaluate either the process or the results, and that the "rungs" are too few and too static (Tritter & McCallum, 2006). Further, with its emphasis on power, the scale creates the impression that power constitutes a "common basis for users, providers and policymakers and ignores the existence of different relevant forms of knowledge and expertise" (Tritter & McCallum, 2006). In the context of HIA, this reservation is of critical importance, as will be seen below. For the purposes of this document, we will use the generic term of public participation. It nevertheless remains that Arnstein's proposed distinction between various levels of participation appears to be indispensable, since it brings up the question of the finalities of participation.

1.2 The use of public participation

The literature proposes various rationales for public participation. For example, one of the assumptions underlying the value attributed to participation is that if citizens become more involved, then governance – meaning a situation of effective coordination occurring when power, resources and information are broadly distributed (Paquet, 2009) – will be improved as a result. For government authorities, public participation can be viewed either as a basic human right in democratic societies or as a tool for containing public dissatisfaction whenever the implementation of unpopular policies could degenerate into protests or undermine citizens' confidence in their leaders (Rowe & Frewer, 2000). Yang (2005) has highlighted the lack of confidence of public administrators in the public's ability to put forward useful solutions to societal challenges. Other advocates of public participation point to the merits of the process in and of itself; the type of governance resulting from this participation is said to be more democratic and effective (Irvin & Stansbury, 2004).

As shown in Figure 2, Innes and Booher (2004: 422-423) have identified five purposes for public participation, ranging from the interest of decision-makers in ascertaining the public's preferences to complying with a legal requirement of consultation.

figure 2 next page

FIGURE 2
THE PURPOSES OF PUBLIC PARTICIPATION

1	Find out what the public's preferences are so decision makers can play a part in their decisions
2	Improve decisions by incorporating citizens' local knowledge into the calculus
3	Advancing fairness and justice
4	Getting legitimacy for public decisions
5	Participation is something planners and public officials do because the law requires it

Source : Innes et Booher 2004.

Irvin and Stansbury (2004) have focused on the advantages and disadvantages of public participation, both for citizen participants and governments. In short, as is shown in Figure 3, these advantages relate to mutual learning between citizens and government representatives, the building of trust between these same actors, and enhanced legitimacy for decisions. The main disadvantages concern the time and cost of participation. All in all, while several authors acknowledge the importance of involving citizens in the decisions affecting them (Murray, 2004; Rowe & Frewer, 2000; Abelson et al., 2003a, Innes & Booher, 2004), it nevertheless remains that the approach required to achieve this involvement is an ongoing bone of contention (Abelson et al., 2003b).

FIGURE 3
ADVANTAGES AND DISADVANTAGES OF PUBLIC PARTICIPATION IN THE GOVERNMENT DECISION-MAKING PROCESS

	ADVANTAGES TO CITIZEN PARTICIPANTS	ADVANTAGES TO GOVERNMENT
DECISION PROCESS	• Education : learn from and inform government representatives • Persuade and enlighten government • Gain skills for activits citizenship	• Education : learn from and inform citizens • Persuade citizens; build trust and allay anxiety or hostility • Build strategic alliances • Gain legitimacy of decisions
OUTCOMES	• Break gridlock; achieve outcomes • Gain some contril over policy process • Better policy and implementation decisions	• Break gridlock; achieve outcomes • Avoid litigation costs • Better policy and implementation decisions
	ADVANTAGES TO CITIZEN PARTICIPANTS	**ADVANTAGES TO CITIZEN PARTICIPANTS**
DECISION PROCESS	• Time consuming (even dull) • Pointless if decision is ignored	• Time consuming • Costly • May backfire, creating more hostility toward government
OUTCOMES	• Worse policy decision if heavily influenced by opposing interest groups	• Loss of decision-making control • Possibility of bad decision that is politically impossible to ignore • Less budget for implementation of actual projects

Source: Irvin et Stansbury, 2004.

1.3 Public participation: from information to partnership

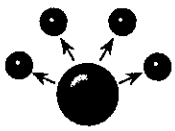
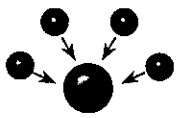
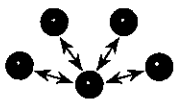
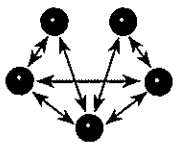
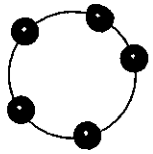
Governments and public administrations take different approaches to participation, which can vary depending on the contexts, issues and main objectives at stake and which must be adapted to each situation in order for the results of such participation to be relevant. Boisvert and Prémont (2003) have classified various participation approaches according to three main categories and five levels (see Table 1).

TABLE 1
CATEGORIES AND LEVELS OF CITIZEN PARTICIPATION

CATEGORIES	LEVELS
1 Communication	1 Information and awareness-building
2 Consultation	2 Gathering of information and opinions
	3 Public discussion and participation
3 Involvement	4 Involvement of citizens
	5 Creation of partnerships

In a report on public participation in British Columbia, the Auditor General notes: "Expectations may be unrealistically raised unless government is clear from the outset about what exactly is being sought and what weight it will place on the input it receives" (Doyle, 2008: 5-6). The same report proposes a «public participation continuum,» linking each level of participation to an objective as well as to an engagement that is expected from those who initiate the consultation process (see Figure 4).

FIGURE 4
THE PUBLIC PARTICIPATION CONTINUUM

	LEVEL 1	LEVEL 2	LEVEL 3	LEVEL 4	LEVEL 5
	Low level of public participation and influence		**Mid level of public participation and influence**		**High level of public participation and influence**
	Inform and Educate	***Gather Information***	***Discuss***	***Engage***	***Partner***
					
OBJECTIVE	To provide balanced and objective information to support understanding by the public.	To obtain feedback on analysis, alternatives and/or decisions.	To work with the public to ensure concerns and aspirations are understood and considered.	To facilitate discussions and agreements between public parties to identify common ground for action and solutions.	To create governance structures to delegate decision-making and/or work directly with the public.
COMMITMENT	To inform the public.	To listen to and acknowledge the public's concerns.	To work with the public to exchange information, ideas and concerns.	To seek advice and innovations from and amongst various public parties.	To work with the public to implement agreed-upon decisions.

Source: Adapted from Health Canada and International Association of Public Participation

On the basis of these distinctions between levels of participation, objectives and engagements, it should be possible to select the appropriate mode of consultation – i.e., one that fits with the main goal to be attained – and to properly inform participants about the outcomes of their participation. The choice can nevertheless be difficult, as consultation methods are diverse and varied. In a document about citizen participation in relation to population health responsibility and accountability, the Quebec Ministère de la Santé et des Services sociaux (2006) inventoried close to 40 methods, specifying the objectives, timescales, costs, advantages and limitations of each.

There would appear to be eight (8) main approaches that are relied on – namely: referenda; public hearings; public opinion surveys; negotiated rule-making; consensus conferences; the citizens' jury or panel; citizens' advisory board; and focus groups.

Rowe and Frewer (2000) evaluated the effectiveness of each of the formal public consultation methods according to two sets of criteria pertaining to acceptance and process. The first set of criteria, which refer to the potential degree of public acceptance for a given consultation method, cover: the representativeness of participants; the independence or unbiased manner in which the consultation is conducted; the early involvement of the public; influence (i.e., the output of the procedure should have a genuine impact on policy); and the transparency of the process from the point of the view of the public. The second set of criteria relate to the building and effective implementation of a method, and refer to: resource accessibility; task definition; structured decision-making; and cost-effectiveness.

After weighing the strengths and weaknesses of each of these approaches on the basis of the above-mentioned criteria, Rowe and Frewer (2000) give the highest ratings to the citizens' jury/panel and the consensus conference. It would appear that these methods offer the best ratio of acceptance to process – in other words, they provide for considerable citizen input while also making reasonable demands on administrative and financial resources.

According to Forest et al. (2000), there is no single perfect consultation approach capable of solving all problems or satisfying all requirements. For this reason, a number of authors argue that it is critical to diversify consultation techniques and to combine different participation approaches (Sénéchal & Piron, 2004; Forest et al., 2000). In the view of Gauvin (2009), it is important to achieve a fit between the type of consultation performed with the specific goals targeted by the consultation process.

Nevertheless, although formal public participation approaches are acknowledged as being essential in modern Western societies, it would appear that they are not provided the funding and time required for them to be conducted effectively (Beresford, 2002 in Newman et al., 2004). As a result, it is difficult to establish crossed techniques or combined approaches to participation, as has been urged by several authors. Thus, the choice of approach must be made with utmost care in order to comply as closely as possible with the demands of "the timescale, resources and issues" (Forest et al., 2000). The question thus arises as to how all these considerations play out in public participation in health impact assessments?

2 Public participation in health impact assessments (HIAs)

Discussing public participation in HIAs is no mean task. To begin with, HIA is implemented in a range of different contexts, being conducted not only by the central authorities but also by regional and local bodies, as is attested to in a number of countries. (Blau et al., 2006). In Quebec, as specified by the provisions of section 54 of the Public Health Act, the central authority is charged with implementing HIA. However, in 2007, a series of pilot projects were conducted jointly with regional and local partners (MSSS, 2008). In short,

the implementation of HIA must be viewed against a background comprising a diversity of political and administrative contexts. Furthermore, authors on the subject agree that this assessment should be conducted on a prospective basis – i.e., be carried out as early as possible in the decision-making process accompanying the design of all government initiatives. It thus comes as no surprise that the challenges surrounding HIA are as numerous as they are varied, touching on scientific, methodological, organizational concerns not to mention political and ethical issues (Gagnon, Turgeon & Dallaire, 2008). The degree of public participation in HIA can vary considerably too.

Public participation – and indeed the participation of a particular group or the community concerned – constitutes an ideal that has been set out in the great majority of contemporary national and international declarations on health (Parry & Wright, 2003). The requirement of including the community in the HIA process has been acknowledged repeatedly (Bauer & Thomas, 2006). At the same time, however, even when this process goes forward at the local level, public participation does not necessarily ensue for all that.

Bauer and Thomas (2006) have noted that as issues become more technical and complicated, participation by average citizens is less likely to occur. In contrast, when the impacts are not of a kind requiring a technical assessment – social impacts, for example – public participation is more likely to occur. These authors even evaluated the level of depth of public involvement according to the type of assessment being conducted. According to their findings, only rarely do environmental impact assessments include the input of citizens. Health impact assessments, on the other hand, make greater room for public participation, but generally during non-critical phases in the decision-making process. Only social impact assessments appear to assign an active role to public participation, even if such recognition appears to hold more in theory than in practice (Bauer & Thomas, 2006). Thus, for example, out of 88 HIAs conducted in England between 1996 and 2004, only 37% included the participation of community members (Davenport, Mathers & Parry, 2006: 198).

Public participation in a HIA amounts to more than a single, once-off event. As a number of different authors have argued, participation should be incorporated into all the steps in a decision-making process (Cook, 2002; Phillips & Orsini, 2002). In reality, however, participation is often absent from critical stages and becomes present only at a time that has been predetermined by leaders or when the public's input is solicited concerning solutions that have already been charted out (Bauer & Thomas, 2006; Monnikhof & Edelenbos, 2001).

2.1 A typology of public participation in HIA

What holds for public participation generally applies equally to participation in HIA, in terms of the general purposes of public participation (shown in Figure 2), the advantages and disadvantages for participants and government actors (outlined in Figure 3), and the levels of participation and engagement (appearing in Figure 4). Nevertheless, some divergences continue to appear in relation to the type of data or evidence used to support the HIA process. According to some authors, the approach of choice should be based on evidence (as this term is used in "evidence-based medicine" (EBM) or "evidence-based management" (EBM)), while others instead emphasize the importance of the qualitative data stemming from consultations with focus groups. At stake, in short, are issues of both a scientific and methodological nature as well as of an organizational, political and ethical character.

Thus, according to Bauer and Thomas (2006), a HIA can favour the perspective that is expounded by experts and supported by evidence over the perspective articulated by community members. Preeminence is thus accorded to "expert" and "research-generated" evidence at the expense of the participatory dimension, thus "reducing the importance attached to the community's experience of empowerment,

ownership and democracy" (Wright, Parry & Mathers, 2005). In addition, experts are likely to have a limited belief in the community's capacity to act responsibly and will focus on the need for professional control throughout the HIA process (Kearny, 2004; Smith et al., 2008). It may also occur that the view of the community is explored, but only after having first been circumscribed and framed such that it will either be of limited interest or altogether useless (Monnikhof & Edelenbos, 2001). These authors recommend taking into account the following "4 Ds" throughout the consultation process:

Demand find out what stakeholders want

Design let stakeholders participate in the creative process of designing solutions

Deal grant participants genuine bargaining power, and

Decide give participants a voice in decisions at every step in the process.

Mahoney, Potter and Marsh (2007) tackled the issues surrounding participation in HIA, considering not only the degree of public involvement but also the gathering and use of evidence. On this basis, they developed a typology of four main approaches, ranging from the non-participatory HIA to the community HIA (see Figure 5). As they have also emphasized, the validity of these approaches varies according to the contexts (specifically, the guiding objectives) in which HIA is carried out; further, the more that priority is given to the participatory approach, the more citizen participation will have an impact. As concerns outcomes, the authors note that the less participatory approaches are focused primarily on producing evidence bases whereas the participatory approaches centre on health promotion and community development.

2.2 The use of public participation

To begin with, public participation helps to **garner greater acceptance for projects**, even when the latter generate negative impacts. Thus, when citizens are encouraged to participate, they are more likely to support a project and to accept an imperfect solution having short-term drawbacks, especially when the long-term benefits of the project in question are apparent to them (Lester & Temple, 2006).

A second benefit of participatory HIAs consists in helping to **reduce conflicts** and increases citizens' ownership of the final decision (Kemm, 2000; Cook & Kemm, 2004). In effect, involving the community in HIA can transform the proponent/participation relationship, evolving the traditional vertical hierarchical relation into a horizontal relation. The result will be to build trust and thereby lay the foundations for a genuine debate over the solutions to be adopted (Elliott & Williams, 2004).

Another rationale for promoting public participation is that it can be of use in **building a critical mass of knowledge** for combination with the "scientific" data that are required in order to carry out some projects. The underlying assumption is that the public concerned can contribute knowledge that experts are otherwise unable to supply, thus helping to create that critical mass of knowledge on which to base the best possible choice under the circumstances. Such are the views of Greig, Parry and Rimmington (2004), who add that a further benefit of public participation in HIA consists in the way that contextual knowledge – i.e., the knowledge provided by the community members concerned – aids in understanding the "complex web of causality and interaction through which differential policy and health impacts could operate." This critical knowledge can only be produced by experts and citizens working together (Greig, Parry & Rimmington, 2004). Elliott and Williams (2004) express similar views, arguing that the usefulness of lay knowledge consists in furthering an understanding of "how the determinants of health interrelate and impinge in the real and meaningful conditions in which people find themselves." Such, in short, are the characteristics of the third main benefit to be had from public participation in HIA.

Furthermore, the literature on public participation highlights the benefit of **a mutual learning process between citizens and policymakers**, a conclusion that also applies to participatory HIA. As was noted by Elliott and Williams (2004) concerning the HIA on which they based their study, local participation makes for a two-way learning-process respecting both evidence and decision-making, serving among other things to: develop a range of skills for the people involved, improve the given appraisal, and facilitate better communication between the local council and the local community. In what amounts to a fourth benefit, Elliott and Williams (2004) have asserted: "This shift towards a more citizen-based policymaking process [...] hints at an emerging recognition of the 'collective intelligence' [...] or 'civic intelligence' [...]."

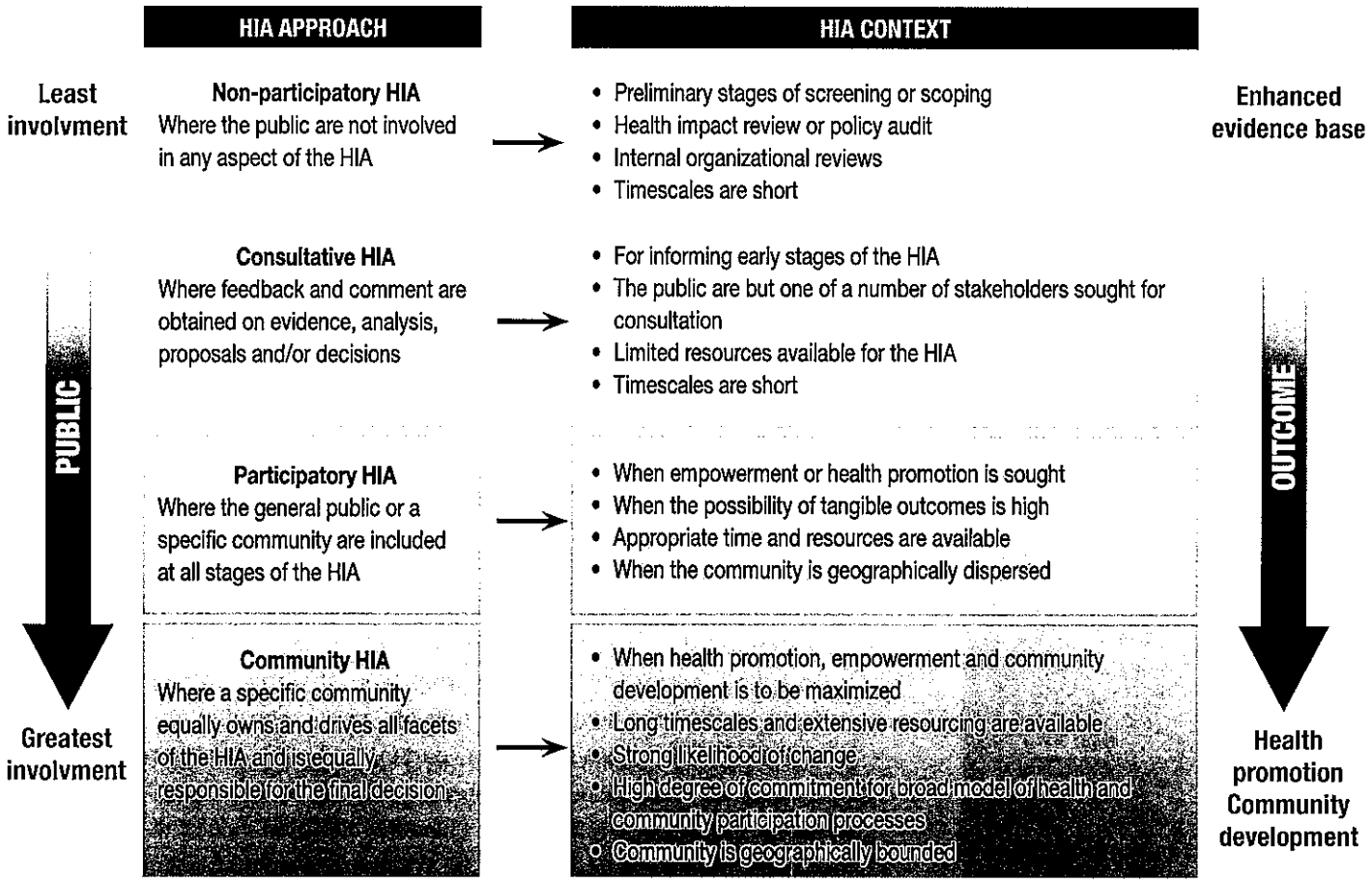
Public participation would also appear to **change or modify perceptions.** In a situation devoid of participation, it would appear that citizens adopt a more individualistic type of perspective. Participatory HIA appears instead to provide a springboard for achieving a more community-based vision and promoting a **decision-making process that is centred on the interest of all.** Finally, from a more hypothetical perspective, participatory HIAs can be of use not only in identifying the integrated solutions supportive of sustainable development, for example, but also in forming the partnerships and alliances required to realize such solutions (Greig, Parry & Rimmington, 2004).

2.3 The challenges of public participation

Thus, for several authors, public participation offers not only a number of clear-cut advantages, it constitutes an indispensable prerequisite for implementing any project, broadly speaking – meaning, no project should be launched without first having obtained the approval of the community. Further still, according to Bauer & Thomas (2006): "If communities are not consulted in their own language, using concepts that they define as core to community life and communication modes that are meaningful to their context, their response can never be accepted as true acceptance." One of the difficulties associated with public participation in HIA lies in the complexity of the HIA process inherited from environmental impact assessments (EIAs). As Mittelmark noted in 2001: "The trend of ever more technical complicated methods of impact assessment threatens to exclude average citizens from participation." And, as Bauer and Thomas (2006) have noted, the prevailing structures, frameworks and concepts used in HIA tend to exclude those who are affected most by planned changes.

Regardless of the framework in which it occurs, participation is a process that requires time and considerable financial resources in order to be of value. The same applies to HIA, where time and money are critical to engaging the public in a genuine, relevant manner; otherwise, for want of such resources, the "likelihood of bringing about genuine ownership and empowerment is small" (Wright, Parry & Mathers, 2005). Thus, even when there is a desire to provide room for participation, the lack of time may well be a factor causing participation to be less extensive than originally expected (Cook & Kemm, 2004).

FIGURE 5
Typology of participatory HIAs



Source : Mahoney, Potter et Marsh, 2007: 236.

Against this backdrop, carrying out a participatory HIA according to the short timescales of development projects (Kearney, 2004) – and particularly in conjunction with the central government – presents a rather daunting challenge. When HIA has to be conducted quickly in order to comply with the policymaking timescale, any participatory component will have to rely on existing people and structures. This means that the scope of consultations among hard-to-reach groups will be compromised and that, in this context, almost all assessments will be predominantly top-down exercises (Parry & Wright, 2003). In other words, the existing participatory structures are likely to favour reliance on established representative groups and traditional consultation activities that many citizens view as being inaccessible or untrustworthy (Kearny, 2004). Bauer and Thomas (2006) arrive at a similar conclusion.

Other factors may play a role in the inability of public participation in HIA to achieve the desired effects. For one, it may be difficult to stimulate participation owing to a climate of conflict that may occur at the local level (Kearney, 2004). The close proximity of elected representatives can be a facilitating factor but also a constraint. Secondly, the public's official representatives sometimes have only limited powers with which to make room for community participation (Kearney, 2004) – not to mention that the staff or managers of some organizations are simply ill prepared or lack the training required to support the participatory process (Smith et al., 2008). In addition, whenever inadequate resources have been earmarked for a participatory HIA process, there is a risk of legitimizing a decision for which a substantial proportion of the public has not made its views heard.

Conclusion

All in all, public participation in HIA is not particularly different from public participation at large, considering how the purposes described by Innes and Booher (2004), as well as most of the advantages and disadvantages mentioned above by Irvin and Stansbury (2004), also apply to HIA. Thus, the process provides evidence of advantages in terms of education and training, legitimacy and conflict resolution. At the same time, constraints of time and resources are readily visible.

For policymakers and experts alike, it is crucial to determine, prior to undertaking a HIA, whether or not it is desirable to seek public participation and, if so, to what extent it is possible to bring the public into the process. As Mahoney, Potter and Marsh (2007) have pointed out, it is vital to consider the context in which one is operating in order to ascertain what type of public involvement is most appropriate under the circumstances – specifically: non-participatory HIA, consultative HIA, participatory HIA or community HIA. While no one consultation approach is perfect, it is critical that whatever approach or approaches ultimately selected indeed fit with the stated objectives (Gauvin, 2009). There are grounds for thinking that the more an issue is complex, the more public participation will be useful for accurately identifying the context of public action.

REFERENCES

Abelson, J. et al. (2003a). Does deliberation make a difference? Results from a citizens panel study of health goals priority setting. *Health Policy, 66*, 95-106.

Abelson, J. et al. (2003b). Deliberations about deliberative methods: Issues in the design and evaluation of public participation processes. *Social Science & Medicine, 57*, 239-251.

Arnstein, S. R. (1971). A ladder of citizen participation. *Journal of the Royal Town Planning Institute, 34*(4), 216-224.

Bauer, I., & Thomas, K. (2006). An evaluation of community and corporate bias in assessment tools. *International Social Science Journal, 58*(189), 501-514.

Boisvert, Y. & Prémont, K. (2003). *Les méthodes de consultations publiques: analyse et description*. Laboratoire d'éthique publique, École nationale d'administration publique; Chaire Fernand-Dumont, Institut national de la recherche scientifique, urbanisation, culture et société, 152 pp.

Blau, J. et al. (2006). The use of health impact assessment across Europe, in T. Ståhl, M. Wismar, E. Ollila, E. Lahtinen & K. Leppo (Eds.), *Health in All Policies: Prospects and Potentials*. Ministry of Social Affairs and Health, pp. 209-230.

Commissaire à la Santé et au Bien-être (2009). *Consultation sur les enjeux du dépistage prénatal de la trisomie 21, ou syndrome de Down au Québec*. Consultation report from the "Consultation sur les enjeux éthiques du dépistage prénatal. " Québec City, Government of Québec, 61 pp.

Conseil de la Santé et du Bien-être (2004). *Participation et consultation des citoyennes et citoyens en matière de santé et de bien-être*. Québec City, Government of Québec, 59 pp.

Cook, A. & Kemm, J. (2004). Health impact assessment of proposal to burn tyres in a cement plant. *Environmental Impact Assessment Review, 24*(2), 207-216.

Cook, D. (2002). Consultation for a change? Engaging users and communities in the policy process. *Social Policy & Administration, 36*(5), 516-531.

Cornwall, A. & Jewkes, R. (1995). What is participatory research? *Social Science and Medicine, 41*(12), 1667-1676.

Davenport, C., Mathers, J. & Parry, J. (2006). Use of health impact assessment in incorporating health considerations in decision making. *Journal Epidemiology and Community Health*, 60, 196-201.

Doyle, J. (2008). *Public Participation: Principles and Best Practices for British Columbia*. Office of the Auditor General of British Columbia, 2008/2009, Report 11.

Elliott, E. & Williams G. (2004). Developing a civic intelligence: Local involvement in HIA. *Environmental Impact Assessment Review, 24*(2), 231-243.

Fondation canadienne de la recherche sur les services de santé (FCRSS) (2009). La participation du public (partie I): incorporer les points de vue de profanes dans la politique des soins de santé. Pourquoi et quels en sont les défis? Saisir et Agir, no. 48, February. FCRSS. (Also published in English as: Canadian Health Services Research Foundation (CHSRF). Public Engagement (Part I) –Engaging the Public in Healthcare Policy: Why Do It? And What Are the Challenges? *Insight and Action*, Issue 48, February 2009.)

Forest, P.-G. et al. (2000). *Rapport – Participation de la population et décision dans le système de santé et de services sociaux au Québec. Québec* City. Conseil de la santé et du bien-être.

Gagnon, F., Turgeon, J. & Dallaire, C. (2008). L'évaluation d'impact sur la santé au Québec: lorsque la loi devient levier d'action, *Télescope*, 14(2), 79-94. (Also published in English as: Health impact assessment in Quebec: When the law becomes a lever for action. Available for viewing online at:

http://www.ncchpp.ca/en/listeresumes.aspx?sortcode=2.1.3&id_article=233&starting=&ending= last retrieved on 2010-05-10.)

Gauvin, F.-P. (2009). La participation du public (partie III): de quelle manière? Comment savoir si elle est efficace? *Saisir et Agir*, no. 53, June. FCRSS. (Also published in English as: Canadian Health Services Research Foundation (CHSRF). Public Engagement (Part I): How Is It Done? How Can We Tell if It Is Effective? *Insight and Action*, Issue 53, June.)

Greig, S., Parry, N. & Rimmington, B. (2004). Promoting sustainable regeneration: Learning from a case study in participatory HIA. Environmental Impact Assessment Review, 24, 255-267.

Innes, J. & Booher, D. (2004). Reframing public participation: Strategies for the 21st century. *Planning Theory & Practice, 5*(4), 419-436.

Irvin, R. A. & Stansbury, J. (2004). Citizen participation in decision making: Is it worth the effort? *Public Administration Review, 64*(1), 55-65.

Kauppinen, T., Nelimarkka, K. & Perttilä, K. (2006). A case study of the role of health impact assessment in implementing welfare strategy at local level. In T. Ståhl, M. Wismar, E. Ollila, E. Lahtinen & K. Leppo (Eds.), *Health in All Policies: Prospects and Potentials* (pp. 253-266): Ministry of Social Affairs and Health (Finland).

Kearny, M. (2004). Walking the walk? Community participation in HIA: A qualitative interview study. *Environmental Impact Assessment Review, 24*(2), 217-229.

Kemm, J.R. (2000). Can health impact assessment fulfill the expectations it raises? *Public Health,114*, 431- 3.

Lester, C. & Temple, M. (2006). Health impact assessment and community involvement in land remediation decisions. *Public Health, 120*(10), 915-922.

Mahoney, M. E., Potter, J.-L. L. & Marsh, R. S. (2007). Community participation in HIA: Discords in teleology and terminology. *Critical Public Health, 17*(3), 229-241.

Ministère de la Santé et des Services sociaux (MSSS, 2008). Bilan et perspectives 2002-2007. À la frontière des responsabilités des ministères et organismes publics: l'application de l'article 54 de la Loi sur la santé publique. Québec City, Government of Québec, 66 pp.

Ministère de la Santé et des Services sociaux (MSSS, 2006). La participation citoyenne au coeur de la responsabilité populationnelle. Support document. Québec, Government of Québec, 45 pp.

Mittelmark, M. B. (2001). Promoting social responsibility for health: Health impact assessment and healthy public policy at the community level. *Health Promotion International, 16*(3), 269-274.

Monnikhof, R. A. H. & Edelenbos, J. (2001). Into the fog? Stakeholder input in participatory impact assessment. *Impact Assessment and Project Appraisal, 19*(1), 29-39.

Murray, Z. (2004). *Community participation in public health planning.* Paper presented at the 8th World Congress on Environmental Health, Durban.

Newman, J. et al. (2004). Public participation and collaborative governance. *Journal of Social Policy, 33*(2), 203-223.

OCDE (2002). Des citoyens partenaires: *Information, consultation et participation à la formulation des politiques publiques.* Paris. Les Éditions de l'OCDE. (Also published in English as: OECD (2002). Citizens as Partners: Information, Consultation and Public Participation in Policy-Making. Paris: OECD Publishing.)

Paquet, G. (2009). *Gouvernance publique.* Text presented at the Forum national sur le management on the theme of "Promouvoir l'avantage compétitif du Canada, " HEC Montréal, September 29 – October 2, 2009.

Parry, J. & Wright, J. (2003). Community participation in health impact assessments: Intuitively appealing but practically difficult. *Bulletin of the World Health Organization, 81*(6), 388.

Parry, J., Mathers, J., Laburn-Peart, C., Orford, J. & Dalton, S. (2007). Improving health in deprived communities: What can residents teach us? *Critical Public Health, 17*(2), 123-136.

Phillips, S. D. & Orsini, M. (2002). *Mapping the Links: Citizen Involvement in Policy Processes,* Discussion Paper No. F 21, Ottawa, Canadian Policy Research Network, Discussion Paper, 48 pp.

Restrepo, H. E. (2000). *Increasing community capacity and empowering communities for promoting health.* Paper presented at the Fifth Global Conference on Health Promotion, Mexico.

Rifkin, S. B., Lewando-Hundt, G. & Draper, A. K. (2000). Participatory approaches in health promotion and health planning: A literature review. In H. D. Agency (Ed.).

Rowe, G. & Frewer, L. J. (2000). Public participation methods: A framework for evaluation. *Science, Technology, & Human Values, 25*(1), 3-29.

Sénéchal, M.-R. & Piron, F. (2004). Participation et consultation des citoyennes et citoyens en matière de santé et de bien-être. Conseil de la santé et du bien-être, Government of Québec.

Smith, N., et al. (2008). Great expectations and hard times: Developing community indicators in a healthy communities initiative in Canada. *Health Promotion International* (Advance access published February 8).

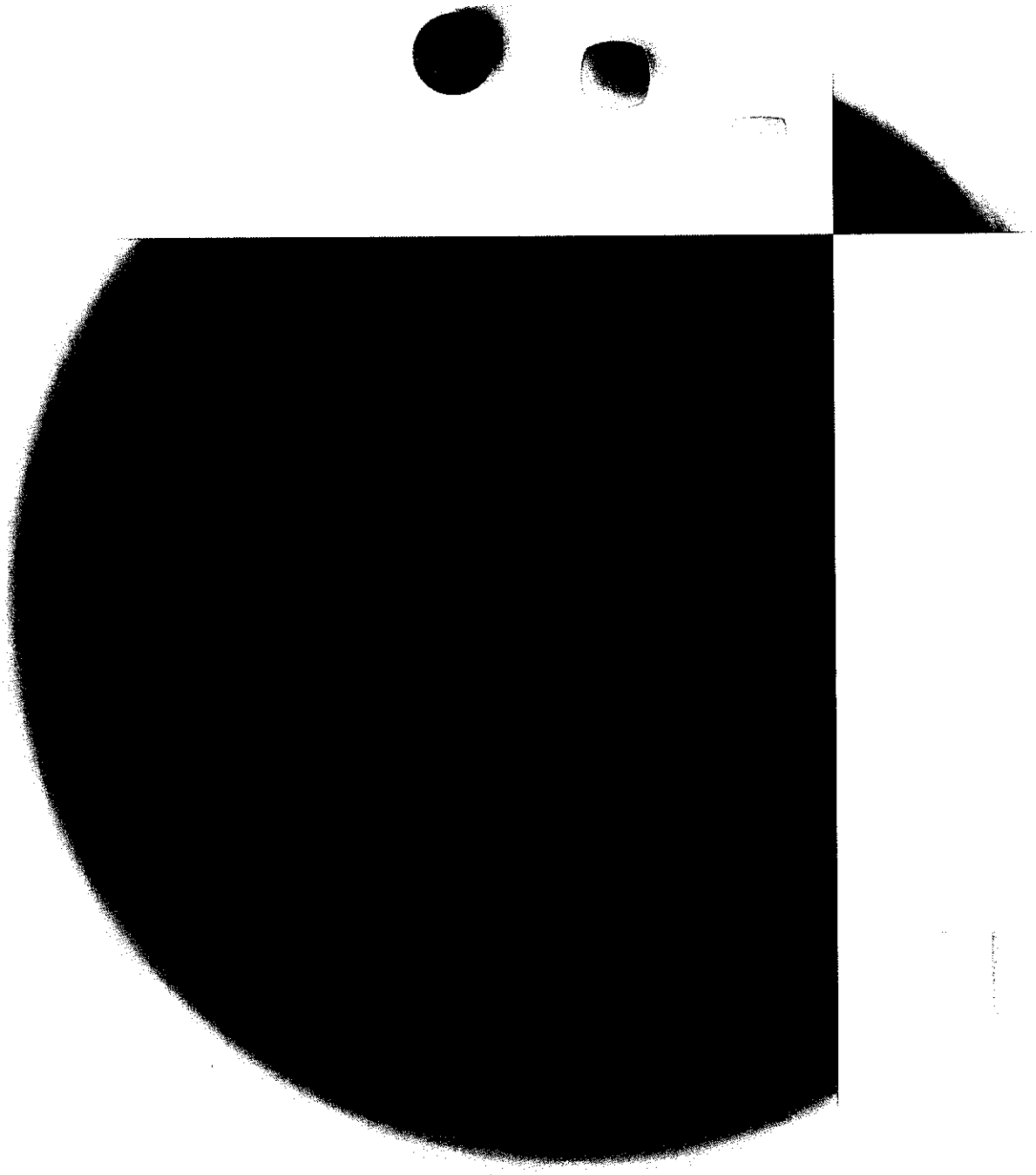
Tritter, J. Q. & McCallum, A. (2006). The snakes and ladders of user involvement: Moving beyond Arnstein. Health Policy, 76, 156-168.

Weeks, E. C. (2000). The practice of deliberative democracy: results from four large-scale trials, *Public Administration Review, 60*(4) (July/Aug.), pp. 360-372.

WHO. (1999). *Health impact assessment: Main concepts and suggested approach Gothenburg consensus paper.*

Wright, J., Parry, J. & Mathers, J. (2005). Participation in health impact assessment: Objectives, methods and core values. *Bulletin of the World Health Organization, 83*(1), 58-64.

Yang, K. (2005). Public administrators' trust in citizens: a missing link in citizen involvement efforts, *Public Administration Review, 65*(3) (May), pp. 273-285



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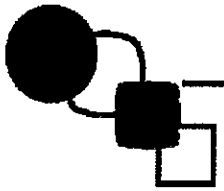

Series ***Transfer of knowledge***

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With the contribution of Stéphane Tremblay and Véronique Turcotte

November 2008

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Table of contents

Introduction

With the idea of integrating the concerns pertaining to health and welfare in public policies, the Quebec National Assembly has adopted, in 2001, Article 54 of the legislation on public health. This article stipulates that:

> "The Minister is by virtue of his or her office the advisor of the Government on any public health issue. The Minister shall give the other ministers any advice he or she considers advisable for health promotion and the adoption of policies capable of fostering the enhancement of the health and welfare of the population.
>
> In the Minister's capacity as government advisor, the Minister shall be consulted in relation to the development of the measures provided for in an Act or regulation that could have significant impact on the health of the population." (2001, c. 60, a. 54)

In reality, the implementation of Article 54 is a true challenge for the public administration stakeholders. The second paragraph in fact stipulates the obligation to consult the Health Minister and implies evaluating the eventual and significant impact of the measures advocated on the health of the population prior to their adoption, namely during their formulation. In the language of the analysis of public policies, the formulation corresponds to the filtering phase between the possible solutions and the means available.

At the Ministère de la Santé et des Services Sociaux (MSSS), the implementation of this article is the responsibility of the public health guidance Department and of the Directorate of the Public Health Program. Since 2002, this department has adopted a two pronged strategy: On the one hand, efforts are deployed to develop an intergovernmental mechanism for the HIA and on the other, emphasis is placed on the development and the transfer of knowledge (for a presentation of this strategy, see MSSS (2008). In order to support those in charge of the application of this article, namely the policy-makers[1], the MSSS has published a Practical guide (2006) on HIA.

This guide presents the generic categories of determinants of health which are lifestyles, the social, physical and economic environments and the societal factors[2], as well as the information on the stages of completion of a HIA. It also contains grids to facilitate the **screening** of the measure involved for its effects on the health influencing factors as well as its **scoping** and **preliminary analysis** which allows evaluating if an in-depth analysis must be recommended.

The goal of this document is essentially to demonstrate the situation regarding the HIA from scientific writings and to present the whys and the wherefores in the political and administrative context. With this in mind, we will first deal with the double origin of the

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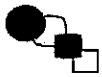
[1] The term policy-maker is used to designate those that formulate public policies, namely analysts, professionals and other individuals more directly mandated to draft these policies.

[2] The MSSS (2007) has also published a brochure on the influencing factors on health : *La santé autrement dit... Pour espérer vivre plus longtemps et en meilleure santé.*

HIA and of its key principles. Then we will examine its development in various countries to concentrate on the five large phases of its completion over which there is consensus.

The spinoffs of this exercise for the stakeholders will be focused upon. Finally, examples are here presented. In conclusion, we will reemphasize the challenges presented by the completion of the HIA during the formulation of public policies and in the political and administrative context.

This document intends to be informative and explanatory. We have sought to make it as practical and as interactive as possible for the reader. Thus, tables, notepads and hyperlinks leading to these documents, websites or presentations are integrated in the text.



1. The double origin of the HIA and its key principles

In general, the emergence of the HIA is attributed to two phenomena (Kemm & Parry, 2004; Banken, 2001; Frankish, 1996). On the one hand, the interest of public health stakeholders for the promotion of health and more precisely for the drafting of public policies favourable to health, would have enhanced the development of this type of evaluation. As we shall see, the search for greater equity between the various social groups underlies this goal. Furthermore, the development of HIA is related to the Environmental Impact Assessment (EIA) which appeared in the sixties in the United States (Blau & Mahoney, 2005; Ison, 2005). In Quebec, the EIA is undertaken by virtue of the regulation respecting environmental impact assessment and review, which is in effect since December 30, 1980. It is defined as follows:

> "A preferred instrument used in the planning of the development and of the employment of the resources and the territory. Its objective is the consideration of environmental concerns at all phases of completion of the project, from its design to its operation including its termination if need be and helps the initiator in the design of a project that is more conscious of the receiving environment, without challenging its technical and economic feasibility." (MDDEP, 2008).

In general and in principle, the EIA includes an evaluation of the impacts on the health of populations. Nevertheless, for different authors, (Ison, 2005; Mindell *et al.*, 2003), the impacts on health are often omitted or are not taken into account in a satisfactory manner. A study by the *British Medical Association* has revealed that approximately two third of the EIAs completed in the United Kingdom did not consider the effects on health or did not consider these effects adequately. Effects on health are thus translated in terms of presence or absence of diseases (biomedical method) or were limited to physical health (Ison, 2005).

In fact, different variables of the evaluations of impact were developed over the last decade. Their goal is to integrate human, social, environmental impacts and more recently the concerns regarding sustainable development. For these various types of evaluations see table 1.

Table 1. Different types of impact assessments

Strategic Environmental Assessment (SEA)	Preceding the EIA, the SEA is intended for the evaluation of the environmental effects of a policy which will determine the framework of any other environmental impact assessment (Wright, 2005).
Integrated Impact Assessment (IIA)	The IIA incorporates at least two types of prospective impact assessments (Milner *et al.*, 2005), among which is the evaluation of the impacts of influencing factors on sustainable development. This type of evaluation supposes that there was initially an integration of the principles and notions of sustainable development in the drafting of public policies (WHO, 2001).
Social Impact Assessment (SIA)	The SIA is intended to estimate prospectively the consequences on society of a specific governmental action. The social impacts refer to the consequences on the population of an action which modifies their way of life, of work, of communicating, of meeting their needs, etc. (Mindell *et al.* 2003).
Human Impact Assessment (HIA)	The HIA combines the HIA and the SIA at the municipal level. This type of assessment was developed in Finland. Sweden on the other hand has integrated in its HIA, the social impact, the environmental aspects, the social economic influencing elements regarding health and their consequences on health and on the population groups affected. Half of the Swedish counties use this methodology developed by the *Swedish Federation of County Councils* (SFCC) (Nilunger, 2004).

The definition of the HIA which is the most frequently used is also selected as well by the MSSS (2006: 9), and is taken from the Gotenburg consensus paper (1999): **"A combination of procedures, methods and tools by means of which a policy, a program or a project may be judged with regard to its potential effects on population health and to the distribution of these effects within the population"**.

This definition which is the result of a discussion between representatives of several countries has garnered a large consensus. It is recognized as one of the best descriptions of the HIA and several authors interested by the HIA refer to it (*European Commission*, 2004). A study by Breeze and associates (2003) reveals that the governments of 19 of the 22 countries having participated in their study have adopted this definition whereas the other three are partially in agreement with it pending clarifications.

For several authors, the ultimate goal of the HIA is to inform the policy-makers in order to influence the decision making process. The HIA intends to allow policy-makers to consider the potential impacts on health of a given proposal on various population groups and when necessary, to recommend changes to enhance the positive impact, minimize or reduce the negative impacts and reach a more equitable distribution of the

impacts. (Doyle, Metcalfe & Devlin, 2003; Health Council, 2001; Ison, 2005; *Public Health Institute of Scotland*, 2006 ; Quigley *et al.*, 2005; Taylor & Blair-Stevens, 2002).

The *National Assembly for Wales* (1999) and the *Swedish National Institute of Public Health* (Lineil, 2005), both lean in this direction. The HIA thus becomes a decision facilitating tool. In relation with this double origin, the key principles of the HIA are worth mentioning. Table 2 presents the key principles of the HIA which result from scientific writings.

Table 2. Key principles of the HIA

Equity and equality According to certain authors, the goal of HIA is equity for all (Elliston, 2003; Ison, 2005). It takes into account the way by which the **vulnerable,** disadvantaged and marginalized **groups** of society could be affected by the advocated proposal (Ison, 2005). It is interested by the **distribution of the impact within the population,** in terms of gender, age, ethnic context and socio-economic status (Letho & Ritsatakis, 1999). For Doyle, Metcalfe and Devlin (2003), who tie HIA with the reduction of the inequalities of health conditions, the decision makers must be informed of the potential impacts of their decisions.
Openness, transparency and participation of the population For several authors, the HIA must be completed in an open and transparent manner (Doyle, Metcalfe & Devlin, 2003; Taylor, Gowman & Quigley *et al.*, 2003). According to Parry and Kemm (2003), the goal of a HIA is to predict in an open and participative manner, the impacts on health and to communicate the results to the decision makers so as to influence the way by which the policy will be implemented. Other authors stress the importance of a full participation of the population likely to be affected by the policy, the program or the project (Samson-Barry *et al.*, 2000). Therefore, the HIA should be guided by principles of democracy which emphasize the **right of citizens to participate**, by means of a **transparent process**, in the **formulation, the implantation and the evaluation of policies** affecting their life, directly or through the policy makers (Elliston, 2003; Letho & Ritsatakis, 1999; WHIASU, 2004; Ison, 2005).
Ethical use of evidence The evidence must not be selected in a way to support a point of view or a special interest (WHIASU, 2004). The HIA should be based on an ethical use of this data (Elliston, 2003; Samson-Barry *et al.*, 2000). The use of **quantitative and qualitative evidence** must be accurate and ideally it must call upon **various scientific and methodological disciplines** to obtain the most complete evaluation possible of the expected impacts (Letho & Ritsatakis, 1999). On the question of the use of evidence, see the presentation of Ouimet (2008) www.gepps.enap.ca

These key principles illustrate therefore the various values which lead the promoters of the HIA and translate the difficulties of its application for the policy-maker. At the time of formulation of a law or of a regulation, the policy-maker is confronted by the evaluation of the potential impacts of this proposal on a given group. He is quickly faced with the issue of the available and accessible data in a short time span.

Furthermore, in Quebec, Articles 19 and 20 of the Act targeting poverty and social exclusion and Article 15 of the Sustainable Development Act introduce the "obligation" for each ministry to take into account the effect of their actions on poverty, on social exclusion and on sustainable development. The law on sustainable development

revolves around the application of 16 principles. One of these essential principles is health.

Thus, the more or less formal obligation to complete impact evaluations may represent a real steeplechase for the policy-makers (Turgeon *et al.*, 2005). The danger is then that the completion of these evaluations becomes a formality without serious analysis of the effect on the environment, sustainable development or health. Wherefrom for a number of authors, it is important to institutionalize this practice (Banken 2001, Morgan, 2008). On the question of institutionalization of the HIA in Europe, see Wismar *et al.* (2006).

***

This reminder of the double origin and of the principles of the HIA allows to better grasp the whys and wherefores of this practice which are, after all at the crossroad of **various rationalities**: normative by its search for greater equity; administrative by its context of completion; political since through the decisional process, the policy-makers are concerned, and cognitive because the HIA call upon available knowledge, namely evidence on a given phenomenon. It should be stated that various countries are interested by the HIA in order to improve the impacts of their policies on the health of their populations at the local, regional or national level.

2. An overview of the development of HIA in various countries

Interest in impact assessment is not a new phenomenon. Since 1980, there exists an international association in matter of evaluation of impact, the *International Association for Impact Assessment* (IAIA). Its objectives are:

(1) To draft approaches and practices for the understanding and integration of the impact assessment;
(2) To improve the procedures of assessment and the method of application;
(3) To promote the education and understanding of Impact assessment;
(4) To provide professional quality assurance through revision by peers and by other means;
(5) To promote the sharing of information networks, for publications for the organisation of professional meetings.

Herein, the development of a community of methods can be noted. Furthermore, since the beginning of the decade, writings on the HIA have increased significantly. Several guides were published; other documents present the intentions of government or refer to experimentation with regard to HIA. The Centre de collaboration nationale sur les politiques publiques et la santé (CCN-PPS) has indexed the various guides, orientation documents and tools on the subject. In this regard, see the document L'évaluation d'impact sur la santé : guides et outils. The following pages provide an overview of the development of HIA in Canada, in the United States, in Europe and in Oceania, at the local, regional or national level.

2.1 In Canada

In 1986, during the first Internal Conference on health promotion, the *Ottawa Charter for Health Promotion* was adopted. This charter presents five strategies. One of them states that the effects on health must be taken into account by policy-makers in all sectors when formulating policies (*First International Conference on Health Promotion*, 1986, referred to in Frankish *et al.*, 1996). The holding of this event on Canadian soil has contributed to Canada's reputation in matters of Health promotion. Canada is often cited as an example for its efforts in integrating HIA within environmental impact assessments (Banken 2004; Kwiatkowski 2004).

However, the management of several key sectors such as Health, Education, Employment and Environment and the resulting policies fall under provincial jurisdiction. Various initiatives were taken by the provinces in order to improve the health of the population. In 2000 for example, the **Manitoba** Government has implemented the *Healthy Child* Manitoba program which is an inter-ministerial long term strategy on behalf of children and their families, in collaboration with partners within the community. In November 2006, the minister responsible for Healthy Living and president of the ministerial committee in charge of *Healthy Child*, presented new legislative measures that officially entrenched, the Manitoban strategy recognized nationally as Healthy Child, by means of an Act (Manitoba, 2006). In **Alberta**, the efforts in terms of Health promotion and prevention are deployed at the regional level (Wilson, 2006). In **Ontario**, a ministry for the promotion of health was created in 2005 and there is an inter-ministerial committee on Healthy living (Sub-committee on the health of populations, 2008). Efforts to develop HIA were deployed in Toronto (CCN-PPS, 2008). The Public Health service in Sudbury is particularly active at the local level to promote the development of policies conducive to Health. Regarding Sudbury, see the Sutcliffe presentation (2008) www.gepps.enap.ca

In **Nova Scotia**, the *People Assessing their Health* (PATH) project is often mentioned as an example for the promotion of Health at the local level. Created in 1996 in the context of the decentralization of the Health system, the goal of this eighteen month project was to allow the population to identify, define and evaluate all the aspects which could influence health. Three communities located North-East of the province were thus able to develop a *Community Health Impact Assessment Tool*, (CHIAT) in the course of this process (Gillis, 1999). Based on determinants of health, this tool intended for community groups and policy-makers, allows evaluating the potential impact of programs or policies on the health of communities. It involves the participation of the population by means of a consultation process at the early stages of the HIA development. (Watts, 2002; Gillis, 1999). The use of this tool has led to an intersectoral cooperation.

To date, two provinces only have formalized their action in terms of HIA at the central level. Aside from Quebec whose experience is more recent, in the early nineties, **British Columbia** has taken steps to promote the development of HIA within its government. In 1993, the Royal Commission on Health Care and Costs published a report, *New Directions for a Healthy British Columbia*, in which it states that HIA will be incorporated in the approval process for any new policy, program or government legislation, for the purpose of insuring that decision makers consider Health, Welfare and influencing factors related to Health. Again in 1993, a new procedure at the office of the prime minister was adopted and requires that the ministers discuss the health impacts of

policies and programs. The Health minister has also published a guide in which a prospective HIA methodology was presented to allow policy makers to identify the health effect of their policies. Guides were also produced for the regional and community health councils. The approach used was very extensive and covered the social, cultural and economic factors likely to affect health (Frankish *et al.*, 1996).

In 1998, an evaluation of the process for the institutionalization of the HIA in the province of British Columbia has demonstrated the failure of this process. Lack of political commitment, a period of political instability and an insufficient involvement of the various public health institutions could in part explain this failure (Banken, 2001).

More recently in March 2005, the British Columbia Government has adopted the *ActNowBC* program intended to promote healthy lifestyles within the population. The program promotes specifically physical exercise, healthy eating, the fight against tobacco use and healthy choices during pregnancy. This is a multi-year initiative involving several ministries, community organizations and companies in the province (*ActNowBC*, 2006). Furthermore, preparation for the 2010 Olympics is seen as an opportunity to maximize the spinoffs on the population, insofar as the environment and the promotion of physical exercise are concerned. In the framework of this event, the objectives of *ActNowBC* is to make British Columbia the healthiest province ever having hosted the Olympics by promoting an intersectoral approach so that all ministries and organizations adopt a prevention plan regarding chronic diseases (*ActNowBC*, 2006). On this subject refer to Curtis, Pederson, Bruce & Frankish (2008).

2.2 In the United States

Interest in the HIA is recent; there seems however to be a gap between the interest manifested and the concrete realization of HIA. In fact, HIA was developed under the influence of EIA (Cole & al., 2004). Since 2001, more than fifteen HIAs were conducted by various organizations, half of which are in California, notably in the sectors of education and agriculture. The American Congress has adopted, in 2006, a law which includes provisions concerning the obligation to perform a HIA for certain types of Federal projects. In spite of the obvious rise in the *momentum* for HIA in the United-States, the benefits of this method are still considered as uncertain and need to be defined (Cole & Fielding, 2007).

2.3 In Europe

In 1997, an important phase regarding HIA was reached when the European Union introduced Article 152 in the *Amsterdam Treaty.* According to this article: *"A high level of human health protection shall be ensured in the definition and implementation of all Community policies and activities"* (*Council of the European Union*, 1997). The *Council Resolution of* June 1999 demands the set-up of procedures to supervise the impact of policies and activities on public health and health care (Letho and Ritsatakis, 1999). In 1999, the European Centre for Health Policy (ECHP) was created to promote HIA in sectors other than health. This centre has published several documents dealing with various aspects of HIA and has developed the *Gothenburg Consensus Paper* which constitutes, somewhat, a starting point and serves as a basis for policy-makers to discuss the development of HIA (*Ibid.*)

In 2006, the European Observatory on Health Systems and Policies, connected to the Regional Office of the World Health Organization published the report *Health in All Policies: Prospects and potentials* which provides a portrait of the evolution of policies promoting health in several European countries. This report presents the results of studies that enumerate the various methods of performing HIAs in 19 European countries. Thus, 158 HIA cases were analyzed (Blau *et al.*, 2006, chapter 11; Wismar *et al.*, 2006, chapiter 12).

Blau *et al.* (2006) deal with the main characteristics of HIAs (definitions, underlying values, moment of completion, levels and sectors of application) and illustrate how these countries use the HIA. The results demonstrate that **England, Wales, Finland** and **the Netherlands** are among the countries that have completed the greatest number of HIAs during the last twelve years. The authors emphasize that the HIAs are mostly performed in the transportation, housing, urban planning and environment sectors. Also, Blau *et al.* (2006) observe that the performance of HIAs at the national level is rather low. For the authors, the lack of technical support or yet the fact that in several countries, the implementation of HIAs is still at the embryonic phase, would explain the situation.

On the other hand, Wismar *et al.* (2006) examine the way by which the HIAs were implemented and institutionalized. Their results demonstrate that institutionalization of HIAs takes various forms and varies significantly from one country to the next. **England, Finland, the Netherlands** and **Wales** have succeeded in institutionalizing the HIAs to various degrees. These countries have several common factors notably a strong governmental commitment. The results demonstrate as well that in most cases, the funds available to complete the HIAs are provided by the local administrations. Only **England, Ireland, the Netherlands, Poland, Slovenia, Switzerland** and **Wales** have budgets allocated at the national level.

In the **United Kingdom**, the Liverpool Public Health Observatory and the Merseyside group were the first to be in favour of using the HIA as was noted in "*The Merseyside Guidelines for Health Impact Assessment*" (Scott-Samuel, 2005). In April 2007, the Impact Assessment (IA) replaces the Regulatory impact assessment (RIA) put in place in the wake of the adoption of the white book *Choosing Health : making healthy choices easier* (Department of health, 2004). The IA is a tool allowing policy-makers to take into account the consequences of their actions during the drafting of policies and allows the government to present the appropriate data of the positive or negative effects of these actions as well as to evaluate their political impact once implemented. As far as the development of HIAs in the United Kingdom is concerned at the national level, see Kemm (2008); as far as the development at the regional level is concerned, see the presentation of Williams (2008) at www.gepps.enap.ca and Mindell *et al.* (2008).

In **Wales**, the National Assembly which, since 1999, has the power to draft and to apply policies dealing with various fields, among which is the health field, is committed to better evaluate the effects of policies and programs. To do so, a process was developed. For a presentation of this process, see *Developing Health Impact Assessment in Wales*. Simultaneously, the Welsh Health Impact Assessment Support Unit (WHIASU) was created. The latter supports the development and the use of HIA and provides its expertise to local authorities. The HIAs are performed more predominantly at the local level and target community development. As far as Wales is concerned, see Elliot, Golby and Williams (2008).

In the **Netherlands**, from 1995 to 2003, the Intersectoral Policy Office funded by the Ministry of Health, Welfare and Sports and located at the National School of public health was responsible of the development of HIAs at the national level, and the development of the methodology and organisation network (Wismar *et al.* 2006; Varela, 2001). Between 1996 and 2003, over twenty HIAs were performed (den Broeder, 2008). However, the Ministry of Health has stopped funding the Intersectoral Policy Office in 2003 and supports to a greater extent the projects at the local level (den Broeder, 2008).

In **Switzerland**, for several years now, the "cantons" of Geneva, of Tessin and of the Jura are committed to the development of methods and activities related to HIA. In spite of the heterogeneity of the political and institutional contexts of the Swiss cantons and of the inherent difficulties in the setup of such a procedure, the HIA experiences have allowed the setup of an intersectoral approach to health in the more global context of health promoting policies (Simos, 2006). The HIA is furthermore integrated in the strategic environmental assessment (Simos and Arrizabalaga, 2006). In July 2007, an agreement was reached between the Département de l'Économie et de la Santé de la République et Canton de Genève and the University of Geneva providing that the unit in charge of HIAs at the Direction de Santé Publique be transferred to the University of Geneva in order to continue the development, the research and the training regarding the HIA. Regarding the case of use of HIAs in the canton de Genève, see Simos and Cantoreggi (2008).

In **Sweden**, tools were developed in the mid nineties by the Swedish Federation of County Councils and the Association of Local Authorities. The HIAs are then mostly performed at the local and regional levels. At the national level, the first HIA was completed in 1995 when Sweden joined the European Union. Since then, several HIAs were performed at this level, notably on the age limit for the sale of tobacco, the European policy on agriculture or the sale of alcohol (Nilunger, Schafer & Pettersson, 2003). Since the beginning of the year 2000, the Sweden National Institute of Public Health (SNIPH) is in charge of the development and of the tools pertaining to HIA. In 2003, a bill emphasizing HIA was adopted by the Swedish government. Since 2005, a sustainable development strategy emphasizing public health and environment quality objectives was also adopted.

2.4 In Oceania

The use of HIA as such is relatively recent in **Australia**, even though the evaluation of health impacts is incorporated in the EIA since the adoption of the *National Environmental Health Strategy* in 1999, which recognizes the importance of the environment on health. All the Australian states and territories recognize the importance of the HIA on the drafting of policies (Government of Western Australia, 2007). Since then, these states and territories have as well developed projects or approaches regarding the HIA. Various initiatives have thus emerged at the national as well as at the local levels. There is a blog solely dedicated to the HIA.

In September 2006, **New Zealand**'s Prime Minister announced a series of initiatives to combat the obesity of youth. The introduction of the HIA in the decisional process is a part of these initiatives. Any new government legislation should be submitted to a HIA. This will be undertaken by the setup of technical support to the HIA within the Public Health Advisory Committee (PHAC, 2007). In February 2007, the PHAC published a

guide on HIAs, which praises the HIA for the evaluation of public policies and makes certain recommendations for its institutionalization. This guide *"An Idea Whose Time Has Come. New opportunities for HIA in New Zealand public policy and planning"* exposes a number of lessons learned with the experience.

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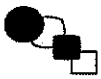
Without being exhaustive, this overview outlines the diversified development of the HIA at the national, regional and local levels. Thus, the HIA should allow meeting governmental priorities at either of these levels, see on the international level (Wright, Parry et *al.*, 2005; Taylor & Blair-Stevens, 2002 ; Samson-Barry *et al.*, 2000). It supports the development of policies and underlines the fact that several factors influence a policy (Wright, Parry *et al.*, 2005). The conditions and the requirements for performance at one or another level are however quite different. Based on a study performed in 2001 in Sweden, the use of the HIA at the national level requires more evaluation and must be performed early at the beginning of the process so as to increase the impact on policy-makers (Nilunger, Schafer & Pettersson, 2003).

Furthermore, even though the existence of legal or institutional constraints are important and tools are available, the development of the HIA may be the result of actors committed in local public health initiatives such as the project of Health Cities of the WHO, as demonstrated by Clavier (2008) in the cases of Denmark and France.

Beyond the diversity noted in the development of the HIA, there is a consensus as to the stages to be completed to perform such an assessment.



3. Stages making consensus

The majority of the authors agree and recognize that the ideal time to perform the HIA is before the implementation of policies, programs or projects[3], when they are in the development process and while the recommendations resulting from the HIA can influence the decision making (Parry & Kemm, 2003; Brown, Shassere & Sengupta, 2005; Doyle, Metcalfe & Devlin, 2003; *Health Council*, 2001; Letho & Ritsatakis, 1999; Linell, 2005; *Public Health Institute of Scotland*, 2006; Quigley *et al.*, 2005). Therefore, **Prospective impact assessment** is advocated by the MSSS (2006).The purpose of the prospective impact assessment is to predict the consequences of the proposal submitted. It would allow bringing adjustments for the purpose of improving the positive impacts forecast and minimizing the negative impacts. (Samson-Barry *et al.*, 2000; Scott-Samuel, Birley & Ardern, 2001; Taylor & Blair-Stevens, 2002). Regarding its characteristics, see the following clipboard.

[3] According to Article 54, the minister must be consulted during the drafting "of measures to be taken as a result of laws and regulations". According to the information obtained from individuals in charge of implementing Article 54 of the MSSS (spring 2008), some ministries extend by themselves the method to strategies, programs or other statements. For the purpose of this document, we will use the term proposal involved or under study to designate the laws, regulations or other political formats that will likely be the subject of consultation or even a HIA in the spirit of Article 54.

CLIPBOARD

Characteristic of the prospective HIA

(according to Mindell *et al.* 2004)

It is based on **prior knowledge and experiences**

In order to benefit from the experience resulting from prior similar decisions of other entities or of other countries, the policy-maker can refer to Policy transfer. In this regard, see Turgeon et al. 2008.

It often deals with policies or interventions that are relatively complex and that have different effects on **determinants of health.**

It requires **evidence** regarding the reversibility of factors that may damage health, and preferably, calls upon a varied spectrum of evidence resulting from various disciplines.

If sufficient knowledge was obtained on the size of the effects on health and the health influencing factors, it is possible to make quantitative predictions (National Assembly For Wales, 1999).

It involves a spectrum of the **stakeholders** originating within different contexts and having varied priorities, concerns, beliefs and values.

On the question of stakeholders see section 4.

It leads to **recommendations** made to policy-makers regarding the quality of the evidence.

It is in the framework of a **tight schedule.**

Most of the authors consider the HIA as a repeated process which includes five (5) stages: 1) the screening; 2) the scoping; 3) the assessment of impacts/effects (*appraisal*); 4) the taking of a decision or the formulation of recommendations; 5) the monitoring and the evaluation (Mindell *et al.*, 2004). It is furthermore to these stages that the practical Guide of the MSSS (2006) refers, by supplying grids to facilitate the completion of the screening and of the scoping, which as mentioned previously lead to the recommendation for an in-depth analysis. In the following pages, we will present each of these stages by emphasizing the tasks to be performed as suggested by various authors.

At the onset, Taylor and Blair-Stevens (2002) suggest proper preparation before performing the HIA, so as to reduce the risk of failure and to increase the probability of reaching the sought objectives. For greater efficiency, it is therefore interesting to ask a few questions in advance. In this regard, see the clipboard. After that, the screening work can be undertaken.

CLIPBOARD

In advance

(according to Taylor and Blair-Stevens(2002)

Identify and use **existing expertise**, i.e. call upon those involved by the proposal so that they can speak their mind, provide their opinion, experiences and expectations.

Is there a committee, a discussion table on the theme which is the subject of the proposal? Was the MSSS summoned to answer? Does the INSPQ have experts on this theme? Have studies already been completed by research groups? Have groups or associations of civil society spoken on the subject?

Improve the **understanding of the HIA**, by the setup of a workshop or the circulation of the HIA guide.

Are the persons involved in the ministry familiar with Article 54, the determinants of health and the HIA. Who should be informed and what is the best way to contact them? Was the person who is a part of the committee of respondents from the MSSS called upon to provide her opinion?

Decide of the **appropriate moment** to introduce the HIA, while taking into account the limited time and resources.

What is the schedule for this bill or regulation? Is it a priority for the ministry in the short, medium or long term? Is there an electoral schedule?

3.1 Screening

Its objective is to identify, from the expertise and from the knowledge available, the proposals for which it will be appropriate or necessary to perform the HIA (Doyle *et al.*, 2003; Letho & Ritsatakis, 1999; Samson-Barry *et al.*, 2000; National Assembly For Wales, 1999). Regarding the factors to consider during the screening, see following clipboard.

CLIPBOARD

To consider during screening

(according to Douglas et al. 2001)

Factors pertaining to the proposal in question (law, regulation or other):

- The scope of the proposal and the resources used;
- The probability of conflict (see actors involved);
- The consciousness of the probable impacts on health;
- The potential of change of the proposal.

Factors pertaining to resources:

- The time available;
- The funds available;
- The knowledge of the area/of the community;
- The knowledge of the subject; - the sources of information/of data available.

According to Doyle, Metcalfe and Devlin (2003), of the *Institute of Public Health in Ireland*, even if it is decided not to use the HIA, the screening would still have been beneficial. In fact it allows for an increasing, insofar as policy-makers are concerned, on their consciousness of the impacts that their decision could have on health and bring them to consider eventually such impacts. This supposes, of course, that they are informed of the results of the screening. Table 3 presents key tasks of the screening.

Table 3. Key screening tasks

Doyle, Metcalfe & Devlin (2003) suggest notably:

- To create a group of key informants and stakeholders involved with the proposal under study, so as to obtain a large perspective and so as to promote a sense of belonging as of the start of the process ;
- To understand the proposal in question (ex : the goals and objectives) ;
- To use a screening tool to structure the discussions or the meetings with the stakeholders (MSSS grid, appendix A) ;
- To document the meetings (ex: establish a population profile).

3.2 Scoping

According to the *National Assembly For Wales* (1999), the goal of the scoping is to browse the potential risks and benefits of the proposal under study and to identify questions that should be considered during the assessment. It allows establishing the work plan and the methods to complete the HIA (Samson-Barry *et al.*, 2000; WHIASU, 2004).

For the *Gothenburg consensus paper*, the scoping helps in determining which factors of the proposals are likely to lead to direct and/or indirect effects on health, which factors need more in-depth study, with regard to which population, by means of which methods and which resources, with the participation of whom and within which timeframe the HIA must be completed (Letho & Ritsatakis, 1999). See its key tasks in table 4.

Table 4. Key scoping tasks

Parry and Kemm (2003) suggest:

- forming a Steering Group (steering committee), by inviting representatives of the responsible organizations, developing and implementing the policy, the program or the project, representative who have already directed the HIA, representatives of the stakeholders, evaluators, local public health practitioners and experts.

  As was suggested by Doyle and his associates for screening, the idea is to assemble the persons concerned and interested by the proposal under study in order to inform them and involve them. The existence of such a committee appears somewhat as a factor of success.

- develop a schedule of completion for the assessment;
- plan the production of the report to be handed to the policy-makers and the way by which feedback will be received by participants who contributed to the HIA.

  Who has the final decision? Who must receive the results of the HIA?
  Is a meeting desirable? Who should participate?

3.3 Impact assessment

The impacts assessment involves identifying and, whenever possible, quantifying the impacts on health and welfare from scientific evidences and knowledge available to date and from the experience and the opinions of the stakeholders. The analysis may be conducted rapidly, semi-rapidly or in depth, depending on the degree of detail and of

quantification required to inform the policymakers (Samson-Barry *et al.*, 2000; Taylor & Blair-Stevens, 2002).

To identify and characterize the potential impacts on health, the *European Commission* (2004) proposes to take into account the determinants of health concerned and their effect on health as suggested in the MSSS Guide as of the screening and scoping phases. For more info, see the following clipboard.

CLIPBOARD

To consider

(according to the European Commission, 2004)

Is the direction of change an advancement or a retreat as far as health is concerned?
It should be noted that health gains as well as losses should be mentioned.
The severity of the impact and the size/proportion of the population
The probability of the impact
The latency period. When will the impact occur?

The time devoted to the assessment of impacts varies. Parry and Kemm (2003) distinguish the evaluations depending on their being mini, standard and maxi. See table 5.

Table 5. Types of HIA

Mini HIA: A desk-top exercise performed from information available and accessible, involves a minimum of quantification of the impacts, as well as a limited consultation, if any exists. **Standard HIA**: A limited review of the literature from routine data already available, involves the full participation of the stakeholders. **Maxi HIA**: An exhaustive review of the literature involves a secondary analysis of the secondary data, the collection of new data, an exhaustive quantification and the full participation of the stakeholders.

The results of the study conducted by the European Observatory of Health Systems and Policies (2006) demonstrate that more standard HIAs are performed at the national and local level, whereas mini HIAs are more numerous at the regional level. On the other hand, maxi HIAs are the ones that are the least used.

In other words, it is possible to distinguish the verification which is made by a professional and which can take approximately two (2) hours; the speedy assessment which calls upon a team and requires an eight (8) hours working session; the detailed assessment which is based on scientific research and requires between four (4) to six (6) months of work (Brisson, 2006). Currently, the tools made available by the MSSS allow the verification of the possible impacts by the professionals.

Furthermore, at the request of the Health minister, or on his own initiative, The INSPQ produces knowledge notices and syntheses based on scientific knowledge in order to support the minister in his role of "advisor to the government on all matters pertaining to public health", as stipulated in Article 54. Table 6 describes the key tasks of this stage.

Table 6. Key tasks of the Impact assessment

Several authors have made suggestions in this regard:
- Evaluate the present health status of the population, including a description of the health inequities between the population sub-groups (Parry & Kemm, 2003) ;
- Identify and characterize Health impacts (nature, size, probability, distribution, etc.) (Samson-Barry *et al.*, 2000 ; Parry & Kemm, 2003 ; WHIASU, 2004) ; prioritize them (Doyle *et al.*, 2003) ;
- Identify the factors affecting the health of the population and the determinants of health which may be affected by the proposal (Parry & Kemm, 2003) ;
- Estimate the subsequent changes to the health of the population, including the effect on health inequities (Parry & Kemm, 2003) ;
- Establish the profile of the population affected (Doyle *et al.*, 2003 ; Samson-Barry *et al.*, 2000);
- Formulate recommendations, by establishing the priorities (Doyle *et al.*, 2003), suggest the means to maximize the health benefits and minimize the health risks, particularly for the underprivileged groups (Samson-Barry *et al.*, 2000 ; WHIASU, 2004) ;
- Produce a final report by describing the way by which the HIA has influenced the process.

3.4 Decision making and formulation of recommendations

This stage involves formulating and prioritizing specific recommendations for the policy makers on the basis of the best available evidence (Taylor & Blair-Stevens, 2002). Decision making involves communicating to the stakeholders the health impacts expected and the way by which the bill or the draft regulation could be modified so as to enhance the positive impacts and minimize the negative impacts in adapted formats to promote their understanding (Samson-Barry et *al.*, 2000). Between the monitoring stage and the stage of evaluation of the HIA, Taylor and Blair-Stevens (2002) identify another stage, namely an additional commitment of the policy makers, which involves reinforcing the value of the recommendations formulated and to encourage their adoption or their adaptation by the decision makers.

3.5 Monitoring and evaluation of the HIA

The monitoring and the evaluation of the HIA occurs after the bill or the draft regulation has been implemented, so as to verify if the effects on health correspond to those that were predicted by the HIA (Parry & Kemm, 2003), if these initial goals and objectives were reached, and if the methodology used was efficient or appropriate (Doyle, Metcalfe & Devlin, 2003). According to Taylor and Blair-Stevens (2002), the purpose of the monitoring is to assess if the recommendations of the HIA were adopted or adapted, and if they had a positive effect on health and on equity.

According to the WHIASU (2004), since the purpose of the HIA is to inform the decision makers, it is important to evaluate the way in which the information was used, the perception of the target public as to the general use of the HIA, the influence which it had on the decision making process and on future developments. This provides as well an opportunity to evaluate the time and the resources that were used, what has worked well and how difficulties were overcome.

According to the *National Assembly For Wales* (1999), the monitoring stage is particularly important when negative consequences are predicted and when their size, their nature and their moment of occurrence are uncertain. A premature detection of negative consequences may allow their effect to be minimized by modifying the way by which the decision will be implemented or mitigated with appropriate measures.

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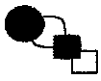
The first stages of screening and of scoping seem to be more documented. The passage to the evaluation stage as such is certainly more demanding and more difficult to document. On these other stages, it is interesting to refer to A Critical guide to HIA de Kemm (2007) that provide information and asks more pertinent questions, notably for the *decision-makers*. However, by having in one's mind the entire process and the main tasks to be performed at each of the stages allows better planning of the action to be undertaken. In this regard, it is interesting to note the various actors who take part in the exercise and to draw their attention to the eventual spinoffs as far as they are concerned.



4. Spinoffs of the HIA for the stakeholders

In theory, all the stakeholders should participate in the HIA, but if all those who are likely to be affected and who have an interest in relation with the decision are involved, the number of participants would be too far-fetched (Kemm, 2004). But the HIA should allow the development of an **efficient and durable work partnership** by bringing actors from various surroundings and having different perspectives to work together to reach a common goal (ex: planners and developer, health experts and members of the local population, etc.) (Lock, 2000; Samson-Barry et *al.*, 2000; Taylor & Blair-Stevens, 2002; Wright, Parry *et al.*, 2005).

The *Public Health Advisory Committee* (PHAC, 2007) of New Zealand states that the HIA is beneficial for the drafting of policies. According to Parry and Kemm (2003), because of the political dimension of the HIA, the early involvement of the policy-makers in the process is desirable, even during the screening phase. According to several authors, the HIA allows the policy-makers to better understand how their decisions could affect health (Brown, Shassere & Sengupta, 2005; Doyle, Metcalfe & Devlin, 2003; WHIASU, 2004). In this regard, a study by Breeze and associates (2003) dealing with data from 22 European countries reveals that the main benefits of the HIA seem to be an increased awareness of health among the civil servants and the organizations of sectors other than the health sector, an improvement of the coordination between the civil servants of various ministries and an increased political conscience of the need for an intersectoral action.

At the other end of the spectrum, the HIA may also be a way of involving the members of a risk group targeted by a given proposal and to respond to the concerns of those who

have questions regarding a given decision (*European Commission*, 2004; WHIASU, 2004 ; Taylor & Blair-Stevens, 2002;).

It highlights the right of individuals to have a clear vision and to participate in the development, the implementation and the evaluation of proposals that affect their life. The constitution of a sample of stakeholders and key informers is important to obtain a large range of perspectives. The political mapping is a method which may be used to identify and create "categories" of stakeholders and to insure having participants from each category (*European Commission*, 2004).

In fact, the population may be involved through various ways, for example, by organizing meetings with representatives of the community and with suppliers of services or yet group discussions with citizens (*focus group*) (*National Assembly For Wales*, 1999). Regarding the benefits of the HIA, see table 7.

Table 7. HIA benefits

For the drafting of policies ... (according to PHAC, 2007)
- Promotes welfare, health and equity among the various intervening sectors; - Identifies the benefits and the potential costs of a political proposal relative to the welfare of the population by allowing the policy to be improved so that it brings about a greater consensus and thus increases its chances of obtaining adequate financing. - May act as a "binding" which encourages the ministries and organizations to work together towards common goals; - Is inclusive and known to encourage the participation of particular groups and other stakeholders; - Uses evidence based data to inform the decision makers; - Increases the mutual understanding of the role of the ministries and organizations;
... and for the community (according to Ison, 2005)
- Better commitment in the formulation and policy adoption process; - A potential to enlarge the democratic process, particularly for the groups of population that are or that feel alienated; - Empowerment; - The development of skills; - A way of reducing sources of inequality.

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This is an overview of the possible spinoffs for some of the stakeholders in the exercise. Needless to say, the spinoffs are not necessarily immediate, but the completion of the HIA seems to call for a minimum of conditions. Three of those appear unavoidable to its success: 1) A strong governmental will which is translated 2) by an institutionalization of the procedure which is not limited to an exercise of verification, but 3) which calls upon an evaluation based on scientific data.

5. Examples to see

Examples of HIAs can be referred to via Internet websites of universities, observatories or public health institutes. We have selected some of the sites where the examples seem to be most pertinent, either because of the sectors or the level presented,or yet because of the effects of the HIA. We thus find on the site of WHO examples of completed HIAs in sectors such as agriculture, environment, transport, etc. The site of the *International Health Impact Assessment Consortium* (IMPACT), a group based in the University of Liverpool (England) and the *HIA Connect* linked to the *University of New South Wales* (Australia) offer several examples of HIAs at the local level, but as well as at the national level. The Gateway HIA, which is hosted by the *West Midlands Public Health Observatory* (England), the *London Health Observatory*, as well as the *Institute of Public Health in Ireland* present a large number of HIA reports dealing with various themes and completed at the local level.

Conclusion

It is yet too soon to conclude on the direct effects on the health of the populations in Article 54. Case studies performed in 2005 by various ministries of the Quebec Government highlight the difficulties which are encountered when integrating HIAs in the formulation of policies (Gagnon,Turgeon and Dallaire 2008).

Two stages seem particularly crucial: First of all, sensitization and awareness of those who produce policies concerning the impact of their choice on health with regard to determinants of health. In this regard, the maxim "Better to be rich and healthy than poor and ill" is worth mentioning. The actions taken by the ministerial team in charge of Article 54 contribute in making public this article, the HIA and the determinants of health more widely among the public administration actors. To this effect, the training and the competence of the policy-makers represent an important asset. The next challenge will be to see that they have, as much as possible, access to pertinent information of good quality, as well as evidence to document the HIAs (Lock, 2008). The methodology used by the Institut national de santé publique du Québec (INSPQ) for the drafting of the reports on the public policies is promising (Groupe de travail sur les politiques publiques de l'INSPQ, 2008). Secondly, the transfer of the knowledge acquired on the impacts on health by the policy-makers represents a compulsory point of passage to promote the adoption of "healthy" policies as advocated by the Ottawa Charter and adopted over twenty years ago.

Bibliographic references

Act Now BC (2006). *Measuring our success: baseline document for ActNow.* [En ligne]. www.health.gov.bc.ca/library/publications/year/2006/ActNowBC_Baseline.pdf consulté le 20 septembre 2007.

Banken, R. (2004). « HIA of policy in Canada ». Health Impact Assessment. Concepts, theory, techniques, and applications. Kemm, J., Parry, J. & S. Palmer (eds.), Oxford, Oxford University Press, p.165-175.

Banken, R. (2001). Strategies for institutionalizing HIA. Copenhagen and Brussels: WHO Regional Office for Europe and European Centre for Health Policy.

Blau, J., *et al.* (2006). « The use of health impact assessment across Europe», dans T. Stahl, M. Wismar, E. Ollila, E. Lahtinen, et K. Leppo (eds), Health in All Policies: Prospect and potential, Ministry of Social Affairs and Health, p. 209-230.

Blau, G., & M. Mahoney. (2005). *The positioning of health impact assessment in local government in Victoria.* Victoria: Health Impact Assessment Unit.

Breeze, C., *et al.* (2003). *Health impact assessment and government policy making in European countries. A position report.* Cardiff : Welsh Assembly Government.

Brisson, G. (2006). *Document de réflexion sur les domaines liés aux politiques publiques favorables à la santé. L'évaluation de l'impact des politiques publiques sur la santé.* Institut national de santé publique du Québec : 42 p. Document non-publié.

Brown, J., Shassere, E. & S.Sengupta. (2005). *Health in regional public policy: Using assessment techniques to improve the impact of policy on health.* Durham : Health Development Agency.

Centre de collaboration nationale sur les politiques publiques et la santé (CCN-PPS). 2008. *Table ronde canadienne portant sur l'évaluation d'impact sur la santé (ÉIS).*Québec, 24 p.

Clavier, C. (2008). « Entre initiatives locales et contraintes législatives, l'émergence comparée des études d'impact sur la santé en France et au Danemark ». *Télescope*, 14(2): 38-50.

Cole, F. & J.E. Fielding. (2007). « Health Impact Assessment : A tool to help policy makers understand health beyond health care». *Annual review of public health*, (28): 393-412.

Cole, B., Wilhem, M., Long, P.V., Fielding, J.E., Kominski, G. & H. Morgenstern (2004). « Prospects for health impact assessment in the United States: new and improved environmental impact assessment or something different? ». *Journal of Health Politics, Policy and Law*, 29(6):1153-1186.

Council of the European Union. (1997). *Amsterdam Treaty - Article 152.* Ministry of Foreign Affairs. EU Commissioner: Markos Kyprianou.

Curtis, S. et collaborateurs (2008). « Pour des politiques publiques favorables à la santé dans le contexte de la préparation de grands événements internationaux : l'exemple des jeux olympiques ». *Télescope*, 14(2):95-106.

Den Broeder (2008). « Health impact assessment in the Netherlands. An overview. » *Health Impact Assessment Quarterly.* International Association for the Impact Assessement. [en ligne]

www.iaia.org/modx/assets/files/HIA_Quaterly_September_2008.pdf consulté le 15 septembre 2008.

Department of Health (2004). *Choosing health: making healthy choices easier*. Londres: The Stationery Office.

Douglas, M.J., Conway, L., Gorman, D., Gavin, S. & P. Hanlon (2001). « Achieving better health through health impact assessmen t». *Health Bulletin*, 59(5):300-305.

Doyle, C., Metcalfe, O. & J. Devlin. (2003). *Health impact assessment: a pratical guidance manual*. Dublin: The Institute of Public Health in Ireland.

Elliot, E., Golby A. & G. Williams (2008). « La situation des évaluations d'impact sur la santé au pays de Galles». *Télescope*, 14(2):15-25.

Elliston, K. (2003). *Health impact assessment: A strategy for Plymouth*. Plymouth: Public Health Development Unit.

European Commission. (2004). *European policy health impact assessment - a guide*. Liverpool: European Commission.

Frankish, C. J., *et al.* (1996). *Health impact assessment as a tool for population health promotion and public policy*. Institute of Health Promotion Research, University of British Columbia.

Gagnon, F., Turgeon, J. et C. Dallaire (2008). « L'évaluation d'impact sur la santé au Québec : lorsque la loi devient levier d'action ». *Télescope*, 14(2), 79-94.

Gillis, D. (1999). « The people assessing their health (PATH) project: Tools for community health impact assessment ». *Canadian Journal of Public Health*, 90 (suppl): S53-S56.

Government of Western Australia. (2007) *Health impact assessment in Western Australia*. Discussion paper. Departement of health. [en ligne]. http://www.health.wa.gov.au/envirohealth/planning/docs/Health_Impact_Assessment_in_WADiscussion_Paper.pdf consulté le 1er octobre 2007.

Groupe de travail sur les politiques publiques de l'INSPQ (2008). *Guide méthodologique - Élaboration des rapports sur les politiques publiques et la santé*. Institut national de santé publique du Québec.

Health Council. (2001). *Health impact assessment guidelines*. Canberra : National Public Health Partnership.

Ison, E. (2005). Health impact assessment toolkit for cities (No. Document 3). Copenhagen, Danemark: WHO Regional Office for Europe.

Kemm, J. (2008). « Les expériences d'évaluation d'impact sur la santé au Royaume-Uni et leur traduction dans les politiques publiques. » *Télescope*, 14(2):1-14.

Kemm, J. (2007). *More than a statement of the crushingly obvious : A critical guide to HIA*. West midlands public health Observatory. Version 1 October, 27 p.

Kemm, J. (2004). « What is health impact assessment and what can it learn form EAI? » *Environmental Impact Assessment Review*, 24:131-134.

Kemm, J. et J. Parry (2004). « The development of HIA ». Health Impact Assessment. Concepts, theory, techniques, and applications. Kemm, J., Parry, J. and S. Palmer (eds.), Oxford, Oxford University Press, p.15-23.

Kwiatkowski, R. E. (2004). « Impact Assessment in Canada : an evolutionary process ». Health Impact Assessment. Concepts, theory, techniques, and applications. Kemm, J., Parry, J. and S. Palmer (eds.), Oxford, Oxford University Press, p.309-316.

Letho, J. et A. Ritsatakis. (1999). *Health impact assessment. Main concepts and suggested approach. A Gothenburg consensus paper.* European Center for Health Policy. [en ligne] http://www.euro.who.int/document/PAE/Gothenburgpaper.pdf

Linell, A. (2005). *A guide to health impact assessments: Focussing on social and environmental sustainability.*Stockholm: Swedish National Institute of Public Health.

Lock, K. (2000). « Health impact assessment ». *British Medical Journal*, 20(7246):1395-1398.

Lock, K. (2008). « Les outils pour améliorer les politiques de santé publiques fondées sur des preuves avérées : les rôles potentiels de l'évaluation d'impact sur la santé, de l'analyse de décision et des techniques de prévision». *Télescope*, 14(2):107-117.

Manitoba (Page consultée le 29 octobre 2008) Site du gouvernement du Manitoba. [en ligne], http://news.gov.mb.ca/news/index.fr.html?archive=2006-11-01&item=456.

Milner, S. J., C. Bailey, *et al.* (2005). « Integrated impact assessment in the UK - Use, efficacy and future development ». *Environmental Impact Assessment Review*, 25(1): 47-61.

Mindell, J. et collaborateurs (2008). « L'évaluation d'impact sur la santé: un instrument de santé publique dans le développement de stratégies régionales ». *Télescope*, 14(2):26-37.

Mindell, J., Boaz, A. & M. Birley (2004). « Enhancing the evidence base for health impact assessment ». *Journal of epidemiology and community health*, 58(7): 546-551.

Mindell, J., Ison, E. & M. Joffe (2003). « A glossary for health impact assessment ». *Journal of Epidemiology and community health*, 57(9): 647-651.

Mindell, J., Joffe, M. & Ison, E. (2004). « Planning an HIA », dans Kemm, J., Parry, J., et S. Palmer, Health impact assessment. Oxford: Oxford University Press, pp 91-102.

Ministère de la Santé et des Services sociaux du Québec (MSSS) (2008). *À la frontière des responsabilités des ministères et organismes publics : l'application de l'Article 54 de la Loi sur la santé publique. Bilan et perspectives.* Québec, Gouvernement du Québec, 70 pages. (à paraître).

MSSS (2007). *La santé, autrement dit ... Pour espérer vivre plus longtemps et en meilleure santé*. Québec, Gouvernement du Québec, 21 pages.

MSSS (2006). *Guide pratique: Évaluation d'impact sur la santé lors de l'élaboration des projets de loi et règlement au Québec.* Direction générale de la santé publique. [en ligne] http://msssa4.msss.gouv.qc.ca/fr/document/publication.nsf/961885cb24e4e9fd85256b1e00641a29/fdeb9f49b9032ac98525726400698644?OpenDocumet

Ministère du Développement durable, de l'Environnement et des Parcs (MDDEP) (2008). *Guide de réalisation d'une étude d'impact sur l'environnement.* [en ligne] http://www.mddep.gouv.qc.ca/evaluations/guide_realisation/introduction.htm#Introduction, consulté le 26 juin 2008.

National Assembly For Wales (1999). *Developing health impact assessment in Wales.* Cardiff: National Assembly for Wales.

Nilunger, L., *et al.* (2004). *The need for health impact assessment: Screening the terms of reference of swedish official government reports.* Stockholm: National Institute of Public Health.

Nilunger, L., Schafer Elinder, L. & B. Pettersson (2003). « Health impact assessment: screening of Swedish governemental inquiries». *Eurohealth*, 8(5), 30-32.

Parry, J. M., & J. Kemm. (2003). *HIA training manual.* Birmingham: University of Burmingham

Public Health Advisory Committe (2007). *An idea whose time has come. New opportuities for HIA in New Zealand public policy and planning.* [en ligne] http://www.phac.health.govt.nz/moh.nsf/indexcm/phac-idea-whose-time-has-come?Open consulté le 2 octobre 2007.

Public Health Institute of Scotland. (2006). *Health impact assessment: A guide for local authorities.* Glasgow: Public Health Institute of Scotland.

Quigley, R. *et al.* (2005). *Clarifying approaches to: Health needs assessment, health impact assessment, integrated impact assessment, health equity audit, and race equality impact assessment.* Londres: Health Development Agency.

Quigley, R. *et al.* (2003). *Clarifying health impact assessment, integrated impact assessment and health needs assessment.* Yorkshire (Angleterre): Health Development Agency.

Samson-Barry, H. *et al.* (2000). *A short guide to health-impact assessment: Informing healthy decisions.* London: London Health Commission.

Scott-Samuel, A., Birley, M. & K. Ardern. (2001). *The Merseyside guidelines for health impact assessment.* Liverpool: International Health Impact Consortium.

Scott-Samuel, A. (2005). « Health impact assessment: An international perspective ». *NSW Public Health Bulletin*, 16(7-8): 110-113.

Simos, J. et N. Cantoreggi (2008). «Les évaluations d'impact sur la santé à Genève et l'utilisation de leurs résultats dans le processus législatif : l'exemple de l'interdiction de fumer dans les lieux publics ». *Télescope*, 14(2), 51-63.

Simos, J. et P. Arrizabalaga (2006). « Utiliser les synergies entre l'évaluation environnementale stratégique et l'évaluation d'impact sur la santé pour promouvoir la prise en compte de l'environnement et de la santé dans les processus décisionnels publics. » *Sozial Und Praventivmedizin*, 51(3):133-136.

Simos, J. *et al.* (2006). «L'ÉIS en Suisse: considérations sur l'expérience des cantons de Genève, Jura et du Tessin», *Italian Journal of Public Health.*

Simpson *et al.* (2004). *Health impact assessment in Australia: context and diversity.* [en ligne] http://www.hiaconnect.edu.au/files/Simpson_S_(2004)_EFHIA_UK_Conf_Poster.pdf consulté le 26 septembre 07.

Sous-comité sénatorial permanent des affaires sociales, sciences et technologie (2008). *Politiques sur la santé de la population: perspective fédérale, provinciale et territoriale.* Avril 2008, 120 p.

Taylor, L. & C. Blair-Stevens. (2002). *Introducing health impact assessment (HIA): Informing the decision-making process.* London: Health Development Agency.

Taylor, L., Gowman, N. & R. Quigley (2003). *Influencing the decision-making process through health impact assessment (6 p.). Learning from practice bulletin.* London : Health Development Agency.

Turgeon, J. *et al.* (2005) « Politiques publiques et santé : Les dilemmes de l'évaluation prospective. » *Administration publique du Canada.* 48(3) : 328-347.

Varela, P., Broeder, den L., Penris, M. & E. W. R.Abbing. (2001). *Experience with HIA at national level in Netherlands: A case study.* Copenhague et Brussel: WHO Regional Office for Europe et European Centre for Health Policy. [en ligne] http://www.euro.who.int/document/e75556.pdf

Watts, T. (2002). Assessing the impact of the People Assessing Their Health (PATH) Project. Path Network.

Welsh Health Impact Assessment Support Unit (2004). *Improving health and reducing inequalities: A practical guide to health impact assessment.* Cardiff: Cardiff University, 33 pages.

Wismar, M., *et al.* (2006). «Implementing and institutionalizing health impact assessment in Europe», dans T.Stahl, M. Wismar, E. Ollila, E. Lahtinen, et K. Leppo (eds), Health in All Policies: Prospects and potential, Ministry of Social Affairs and Health, p. 231-252.

Wilson, D. (2006). « La promotion de la santé en Alberta : beaucoup de chemin parcouru mais la route est encore longue », dans M. O'Neill, S. Dupéré, A. Pederson et I. Rootman (dir.), Promotion de la santé au Canada et au Québec. Perspectives critiques, Québec : Les Presses de l'Université Laval : 240-244.

World Health Organization (2001). *Health impact assessment in development policy and planning.* Genève (Suisse): Department of Health and Development, WHO. Report of an informal WHO consultative meeting (Cartagena, Colombie, 28 mai), 28 pages.

Wright, J., J. Parry, *et al.* (2005). « Institutionalizing policy-level health impact assessment in Europe: is coupling health impact assessment with strategic environmental assessment the next step forward?» *Bulletin of the World Health Organization*, 83(6): 472-477.

XII INTERNATIONAL CONFERENCE

HIA2012

HOW HIA MATTERS IN HEALTH IN ALL POLICIES

August 29-31, 2012 • Québec, Canada • hia2012.ca

Mitigations for health impacts in natural resource development projects

Facilitated by Aaron Wernham and Marla Orenstein

Examples of common health impacts in natural resource development projects

Natural resource development projects exert a strong influence on social, economic and biophysical environments. A common set of health impacts have been identified, including:

- Changes in infectious disease rates and distribution, such as malaria, tuberculosis and sexually transmitted infections related to demographic shifts, in-migration, and environmental changes such as standing water.
- Dietary change related to altered patterns of farming and harvesting of wild foods
- Health effects related to real or perceived changes in air and water quality and other environmental media
- Health effects related to opportunities created by income, revenue and employment
- Increases in social pathologies such as crime, violence, and alcohol / substance misuse
- Changes in stress and mental wellbeing

For more examples and explanation, see:

- International Council on Mining and Metals (ICMM). 2010. Good Practice Guidance on Health Impact Assessment (2010)
  http://www.icmm.com/document/792
- Health Effects Assessment Tool (HEAT): An Innovative Guide for HIA in Resource Development Projects.
  http://www.apho.org.uk/resource/item.aspx?RID=83805
- Canadian Handbook on Health Impact Assessment (4 volumes – several hundred pages but not really a practitioner's guide)
  http://www.hc-sc.gc.ca/ewh-semt/pubs/eval/
- Technical Guidance for Health Impact Assessment (HIA) in Alaska (Alaska Department of Health and Social Services)
  http://www.epi.hss.state.ak.us/hia/AlaskaHIAToolkit.pdf

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Small group exercise instructions

15 minutes: Please go around the group. Each person should describe:

- **An example of a mitigation you developed or used for a natural resource development project**
    - You can also describe any interesting features around the justification for, utility of or success of the mitigation, such as:
        - Did you like the mitigation or not? Why?
        - How did you come up with it? What evidence base did you draw on?
        - Was it actually used: that is, was it included in the HIA and implemented? Is implementation pending? Was it rejected by the decision-maker?

3 minutes: After listening to the examples, you should decide (as a group) on one example that you will report back to the workshop.

What is Health Impact Assessment (HIA)?

June 2009

Fact sheet

For up-to-date knowledge relating to healthy public policy

Definition

The most common definition of Health Impact Assessment (HIA) is the one set forth by the European Office of the World Health Organization (WHO) in 1999 in what is known as the "Gothenburg consensus paper." HIA is presented as "a combination of procedures, methods and tools by which a policy, program 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" (WHO Regional Office for Europe, 1999).

The application of HIA to policies is supported by a social model of health which assumes that the health of a population is closely tied to the conditions in which people live and work and that these conditions are influenced by decisions made in all government sectors (Whitehead & Dahlgren, 1991). HIA also rests on the idea that all sectors are responsible for the health of the population. Thus, HIA is generally applied to policies, programs and projects developed in sectors other than health services and generally comes under the responsibility of health departments.

5 Steps

HIA offers a systematic five-step process for structuring actions aimed at identifying which health determinants a proposal will affect, at planning and conducting a study of the potential repercussions on a given population's health, and at interacting with policy developers on the basis of the results. In addition to drawing on public health information produced through research, the HIA process is designed to accompany the process of public policy development, encouraging decision makers and groups within the population to take part in identifying potential health effects. Thus, HIA must be seen as part of a larger process that involves more than following a procedure and producing a scientific report, because it presupposes interaction between the public health sector, those responsible for the proposed policy and the population, whenever possible.

The 5 steps of HIA

- Screening
- Scoping
- Appraisal
- Reporting
- Monitoring

Origins

The application of HIA to policies is a field that developed from two sources of influence: the environmental impact assessment of development projects, which generally includes consideration of their impacts on human health, and the health determinants approach developed in the area of health promotion. The latter influence gave rise to a type of HIA that is practised outside of environmental impact assessments and relies on a broader definition of health, which includes concern for health inequalities. This approach assigns as much importance to the process of influencing policy as to the production and use of evidence.

This approach to HIA is developing significant support throughout the world, particularly in Europe where a wealth of experience and a variety of tools are now being shared on the internet. Recently, a large-scale study on the effectiveness of HIA carried out in 19 European countries confirmed the ability of this practice to influence the decision-making process and to raise decision makers' awareness of the broad determinants of health (Wismar, Blau, Ernst, & Figueras, 2007). In addition, an independent British study established a positive cost-benefit relationship for the practice of HIA (O'Reilly, Trueman, Redmon, Yi, & Wright, 2006).

Centre de collaboration nationale sur les politiques publiques et la santé
National Collaborating Centre for Healthy Public Policy

Institut national de santé publique Québec

The National Collaborating Centre for Healthy Public Policy and HIA

The National Collaborating Centre for Healthy Public Policy (NCCHPP) has a mandate to identify effective strategies for promoting healthy public policy.

Health impact assessment is one such strategy. This practice is enriched by the extensive experience gained in the environmental health sector, from which it is possible to draw useful lessons for the application of HIA to local and national policies. Moreover, its use on an international scale helps create a body of knowledge that can be used beneficially in the Canadian context. The Canadian Round Table on HIA held in February 2008 (St-Pierre, 2008) made it possible to define the role that the NCCHPP can play in supporting the development of this practice in Canada. Thus, the Centre intends to promote the establishment of a pan-Canadian network of users interested in this approach, to produce an inventory of Canadian HIA initiatives, to make these known, and to ensure the existence of training in this area. The goal is to create an environment favourable to this practice by, among other things, raising awareness among partners and decision makers about the important role public health actors play in the development of socially sustainable public policy. In addition to focusing on these areas of intervention, the NCCHPP intends to develop tools and documents not only to support this practice in Canada, but also, more generally, to further reflection in this field of practice.

More HIA resources can be accessed on the NCCHPP website at: http://www.ncchpp.ca.

References

O'Reilly, J., Trueman, P., Redmon, S., Yi, Y., & Wright, D. (2006). *Cost benefit analysis of Health Impact Assessment.* England. York Health Economics Consortium. Department of Health. Retrieved from: http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_063158.pdf.

St-Pierre, L. (2008). *Report on the Canadian Round Table on Health Impact Assessment.* Québec: National Collaborating Centre for Healthy Public Policy. Retrieved from: http://www.ncchpp.ca/docs/ReportRoundTableHIA.pdf.

Whitehead, M. & Dahlgren, G. (1991). What can we do about inequalities in health? *The Lancet, 338*, 1059-1063.

WHO Regional Office for Europe. (1999). *Health Impact Assessment: Main concepts and suggested approach. (Gothenburg consensus paper).* Brussels: European Centre for Health Policy. Retrieved from: http://www.hiaconnect.edu.au/files/Gothenburg_Consensus_Paper.pdf.

Wismar, M., Blau, J., Ernst, K., & Figueras, J. (Eds.) (2007). *The Effectiveness of Health Impact Assessment. Scope and limitations of supporting decision-making in Europe.* Copenhagen: European Observatory on Health Systems and Policies. Retrieved from: http://www.euro.who.int/__data/assets/pdf_file/0003/98283/E90794.pdf.

September 2006
Special Publication Series No. 5

Health Impact Assessment
International Best Practice Principles

HEALTH IMPACT ASSESSMENT MAY BE DEFINED AS A COMBINATION OF PROCEDURES, METHODS AND TOOLS THAT SYSTEMATICALLY JUDGES THE POTENTIAL, AND SOMETIMES UNINTENDED, EFFECTS OF A POLICY, PLAN, PROGRAMME OR PROJECT ON THE HEALTH OF A POPULATION AND THE DISTRIBUTION OF THOSE EFFECTS WITHIN THE POPULATION. HIA IDENTIFIES APPROPRIATE ACTIONS TO MANAGE THOSE EFFECTS.
(ADAPTED FROM WORLD HEALTH ORGANIZATION, 1999)

PURPOSE
These principles are intended to promote health impact assessment (HIA), to lead to better consideration of the health implications of decisions and render them more sustainable.

They should help practitioners to integrate health into impact assessment (IA), decision-makers to commission and review IAs and other stakeholders to ensure that health concerns and aspirations are addressed in development planning.

BACKGROUND
Health is a cross-cutting theme relevant to all fields of IA. These principles should therefore be read in conjunction with the other principles of best practice provided by IAIA.

IAIA and the World Health Organization (WHO) have a Memorandum of Understanding for collaboration in the area of HIA.

IAIA is actively developing a comprehensive series of Principles and Practice papers covering a wide range of important issues which need to be covered in IA. Many of the papers produced are devised by the IAIA Sections and this one is no exception. IAIA has an active Health Section, members of which have been instrumental in both requesting and developing these principles.

The principles were prepared by the Health Section of IAIA; comments are welcome at any time and should be forwarded to the current Chair of the Health Section via info@iaia.org.

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The underpinning concept of HIA

Individual and population health status is largely the result of the social, cultural and physical environment in which we live. Factors such as the state of our environment, access to resources to meet our basic needs, our exposure to risks and capacity to cope with these, our income and education level, and our social network of relationships with friends, family and neighbors all have considerable impacts on health and well-being.

Human health and the physical and social environment are intricately linked. Human health has a number of *determinants* that go beyond individual lifestyle choices (examples in Table 1):

1. Determinants related to the **individual**: genetic, biological, lifestyle/behavioral and/or circumstantial.
2. **Social and environmental** determinants: physical, community conditions and/or economic/financial.
3. **Institutional** determinants: the capacity, capabilities and jurisdiction of public sector institutions and the wider public policy framework supporting the services they provide.

What is Health Impact Assessment?

Health Impact Assessment (HIA) aims to identify how development induces unintended changes in health determinants and resulting changes in health outcomes. HIA provides a basis to proactively address any risks associated with health hazards. HIA also addresses health improvement opportunities in development. Health hazards, risks and opportunities also may be addressed explicitly in environmental assessment.

Development planning is typically conducted outside the health sector and is concerned with social and economic development, for example, energy, agriculture, industry and transport. With a considerably larger proportion of resources at their disposal, and with a responsibility for action that may change environmental and social health determinants significantly, these other sectors outstrip the health sector in the potential to affect, protect and promote population health.

Development planning without adequate consideration of human health may pass hidden "costs" on to affected communities, in the form of an increased burden of disease and reduced well-being. From an equity point of view, it is often marginalized and disadvantaged groups who experience most of these adverse health effects. From an institutional point of view, it is the health sector that must cope with development-induced health problems and to which the costs are incurred of dealing with an increased disease burden.

HIA provides a systematic process through which health hazards, risks and opportunities can be identified and addressed upstream in the development planning process, to avoid the transfer of these hidden costs and to promote multisectoral responsibility for health and well-being. The production of public health management plans with safeguards, mitigating measures and health promotional activities is an integral part of HIA.

Key principles of HIA are presented in the three sections that follow:

1. **"What is HIA"** provides a definition of its scope, indicates the key determinants to be considered and outlines the main functions and purpose of the HIA process.
2. **"Guiding principles"** apply to all stages and types of IA; this section explains the basic values and how a desired outcome can be achieved for health and well-being.
3. **"Operating principles"** explains how health concerns and aspirations are best addressed in the main stages of the IA process.

What is HIA?

HIA systematically reviews the health hazards and health promoters associated with a development policy or project. It assesses risk factors associated with hazards and opportunities associated with promoters as they change in the course of a development activity, and it develops evidence-based recommendations to inform the decision making process on health protection and promotion.

The recommended measures should be technically sound, socially acceptable and economically feasible.

The appropriate actions, which are identified in an HIA, may be presented as a *Public Health Management Plan*. This intersectoral management plan explicitly includes safeguards to health and mitigating measures which may fall outside the remit of the health sector. The *Public Health Management Plan* can also include provision for adapted health services. Most importantly it provides for the monitoring of compliance and the evolution of health status.

HIA attempts to clarify health implications by disaggregating the **determinants of health and well-being** (examples listed in Table 1) (Public Health Advisory Committee, 2005).

HIA investigates the pathways of how the inter-related determinants may be affected by a proposed policy, programme or project. It aims to trace the changes through to their impact on health status. Some of the pathways are direct (such as pollution and asthma admissions to hospitals); others may be indirect (such as traffic density and community severance, leading to changes in several health outcomes) (Dahlgren, 1995).

The dimensions of HIAs (scope and time frame) will vary. Each HIA must be suitable for the context within which it is undertaken, it must be affordable and its costs must be proportional to the overall project budget. Supporting flexibility in approach is critical for maintaining the practical use of HIA. The size of a team carrying out a given HIA will vary accordingly.

Table 1. Examples of the determinants of health

Categories of determinants of health	Examples of specific health determinants
Individual factors: genetic, biological, lifestyle/behavioral and/or circumstantial. Some of these factors can be influenced by proposals and plans, others cannot.	Gender, age, dietary intake, level of physical activity, tobacco use, alcohol intake, personal safety, sense of control over own life, employment status, educational attainment, self esteem, life skills, stress levels, etc.
Social and environmental factors: physical, community and/or economic/financial conditions.	Access to services and community (health, shopping, support, etc.); social support or isolation; quality of air, water and soil; housing; income; distribution of wealth; access to safe drinking water and adequate sanitation; disease vector breeding places; sexual customs and tolerance; racism; attitudes to disability; trust; land use; urban design; sites of cultural and spiritual significance; local transport options available; etc.
Institutional factors: the capacity, capabilities and jurisdiction of public sector services.	Availability of services, including health, transport and communication networks; educational and employment; environmental and public health legislation; environmental and health monitoring systems; laboratory facilities; etc.

Purpose and functions of HIA

The purpose of all HIA is to inform and influence decision making on proposals and plans, so health protection and promotion are effectively integrated into them.

Linked to this central purpose, HIA has an important function contributing to healthy projects and healthy public policy. Some examples:

1. HIA involves and engages health experts, project proponents, other key players and the community affected by the proposal, and facilitates public participation in decision making[1].
2. HIA attempts to identify health inequalities that may arise from a proposal.
3. HIA addresses cross-cutting health issues with repercussions for sustainability.
4. HIA helps place public health on the agenda of many different agencies and individuals and increases awareness of what determines health status, thereby providing a basis for improved collaboration within and between agencies.
5. HIA provides a "license to operate," not only for public bodies, but also for private sector companies who incorporate social and health responsibility into their activities.
6. HIA is a tool for intersectoral action for health.
7. HIA focuses on the health status of vulnerable groups.
8. HIA may reduce the burden on health sector services.

[1] The attempt to involve communities in an HIA is seen as a strength. IAIA has a public participation principles and practice paper (Special Publications Series No. 4, 2006)

Who does HIA?

HIAs are typically commissioned by:

- Local, regional and national governments
- Local, regional and national health authorities/departments
- Local, regional and national planning authorities/departments
- National and international development banks/ bi- and multilateral donors
- Private industry

Practitioners usually have a diverse background of skills and experiences. There are no accreditation schemes for practitioners as yet, and a mix of skills is often developed and used. There is currently more experience of HIA at the program and at the project level than at the strategic level.

Training courses exist in some countries to assist practitioners and to develop capacity (particularly since capacity to undertake HIA is low in most countries). The skills required to undertake HIA are many, but they need not be held by one individual and should instead be present across the team of people undertaking the HIA. As an individual, the best way to develop HIA skills is to participate in or undertake an HIA.

Writing Terms of Reference (TOR) for full scale HIAs should be undertaken collaboratively by the Ministry of Health (MOH) (central or peripheral levels) and other relevant authorities. The MOH may also be in charge of the critical appraisal of the consultants' HIA report with its recommendations for mitigation of negative health impacts and enhancement of positive impacts. There is currently a lack of capacity among authorities on how to develop TOR and critically appraise the quality of HIA reports. The agreed procedures for HIA should reflect the responsibilities of different actors at different stages.

Generally, the leader of an HIA team would be a professional with a broad public health outlook rather than one with a narrow medical area of expertise. The expertise of an HIA team should reflect the complexity of the health determinants associated with a given project, programme or plan (e.g., public health, natural and social science, economics) and the key health issues identified at the screening phase.

Guiding principles for HIA

The Gothenburg consensus paper (World Health Organization, 1999) indicates that values are framed by society, the government in power, the sector and the people working in the sector within which a proposal is placed. These values of HIA are:

- Democracy – emphasizing the right of people to participate in the formulation and decisions of proposals that affect their life, both directly and through elected decision makers. In adhering to this value, the HIA method should involve and engage the public, and inform and influence decision makers. A distinction should be made between those who take risks voluntarily and those who are exposed to risks involuntarily (World Health Organization, 2001).
- Equity – emphasizing the desire to reduce inequity that results from avoidable differences in the health determinants and/or health status within and between different population groups[2]. In adhering to this value, HIA should consider the distribution of health impacts across the population, paying specific attention to vulnerable groups[3] and recommend ways to improve the proposed development for affected groups.
- Sustainable development – emphasizing that development meets the needs of the present generation without compromising the ability of future generations to meet their own needs. In adhering to this value, the HIA method should judge short- and long-term impacts of a proposal and provide those judgements within a time frame to inform decision makers. Good health is the basis of resilience in the human communities that support development.
- Ethical use of evidence – emphasizing that transparent and rigorous processes are used to synthesise and interpret the evidence, that the best available evidence from different disciplines and methodologies is utilized, that all evidence is valued, and that recommendations are developed impartially. In adhering to this value, the HIA method should use evidence to judge impacts and inform recommendations; it should not set out to support or refute any proposal, and it should be rigorous and transparent.
- Comprehensive approach to health – emphasizing that physical, mental and social well-being is determined by a broad range of factors from all sectors of society (known as the wider determinants of health). In adhering to this value, the HIA method should be guided by the wider determinants of health.

Operating principles for HIA

HIA process

The following represents key steps in the HIA process and suggested responsibilities for each step:

1. Screening: deciding what scale, if any, HIA is required (desk exercise by ministry/authority).
2. Scoping: setting the boundaries in time and space for the assessment and formulating TOR for a full scale HIA accordingly (usually by MOH (central, province and/or district) and key stakeholders).
3. Full scale HIA (by HIA team according to specifications in TOR).
4. Public engagement and dialogue (initiated by MOH or other relevant authority).
5. Appraisal of the HIA report (compliance with TOR, quality control of independent criteria) and the feasibility/soundness/acceptability of its recommendations (MOH or another MOH-assigned independent consultant).
6. Establishment of a framework for intersectoral action (MOH and relevant ministries).
7. Negotiation of resource allocations for health safeguard measures (Ministry of Finance and relevant ministries).
8. Monitoring (of compliance and of pertinent health indicators), evaluation and appropriate follow-up (MOH and line ministries).

[2] For example, across ages, genders, ethnic groups and geographic locations, etc.

[3] Groups can be vulnerable due to their physical status (e.g., children, older people, disabled people) or due to their social positions (e.g., people with low socioeconomic status, ethnic minorities, women).

HIA methods

The HIA team works according to specific TOR for the assignment in question. The TOR may suggest specific methods to be used by the assessor and emphasize the need to share information produced by environmental and social IA teams working in parallel with the HIA team. Examples of methods include:

- Collection and analysis of appropriate secondary data from relevant authorities (e.g., national or district health statistics, environmental and demographic data).
- Interviewing key informants and conducting focus group discussions in stakeholder groups (participatory approaches).
- Direct field observations in the bio-physical, social and institutional environments.
- Mapping using Geographical Information Systems.
- Review of relevant scientific and "gray" literature.

In most cases, there is no time for cross-sectional epidemiological surveys, but these may be carried out as part of the assessment in projects with exceptionally long planning stages, such as large dams. Where appropriate, integrated assessment may be introduced to benefit from a joint methodological approach saving time and reducing cost of the assessment.

Policy HIA

Although HIA is often carried out on a project level, broader policies, such as employment, trade, education and strategic spatial planning policies can, and are, also assessed for health impacts. The aim of HIA of policies is, again, to prevent health damage and enhance opportunities for health improvement. As such, HIA is a tool for the development of healthy public policy, guaranteeing a "Health in All Policies" approach.

Health in Environmental Assessment

Strategic Environmental Assessment (SEA) at the strategy, policy and programme level and environmental impact assessment (EIA) at the project level have traditionally addressed health issues. Human health is, however, often a single bullet point on an EIA or SEA check list. The assessment of health effects is likely to be biased towards bio-physical health determinants rather than a holistic view that also includes important wider determinants. The scope of health issues covered may reflect the industrial country roots of EIA, and therefore lack the level of comprehensiveness necessary to make the assessment fully relevant to local health conditions.

Most importantly, EIA procedures frequently do not recognize the fact that the ultimate authority for health pertains to Ministries of Health (central or peripheral levels), which should have the regulatory responsibilities for the planning, quality control and final approval of any assessment of the impact on health and its follow-up. In that case, care needs to be taken:

- To ensure health is covered comprehensively.
- To strike an acceptable balance between strengthening of health services and design and operational measures by other sectors to safeguard health and well-being.
- To adequately address the wider determinants of health.
- To anchor the final authority for the health component with the Ministry of Health.

Glossary

Health: A state of complete physical, mental and social well-being and not merely the absence of disease or infirmity (World Health Organization, 1948).

Health hazard: An agent with a potential to create ill health (e.g., bacteria, toxins, chemicals).

Health risk: Indicates the extent to which the potential of a hazard may be realized.

Health promoter: An agent with a potential to enhance health status (e.g., anti-oxidants, constituents of medicinal plants).

Health determinants: The range of personal, social, economic and environmental factors which determine the health status of individuals or populations (NIHCE, 2006).

Health outcome: A change in the health status of an individual, group or population which is attributable to a planned intervention or series of interventions, regardless of whether such an intervention was intended to change health status.

Health inequality: Differences in health status or in the distribution of health determinants between different groups of a population. They occur as a consequence of differences in social and educational opportunities, financial resources, housing conditions, nutrition, work patterns and occupational conditions and unequal access to health services (NIHCE, 2006).

Health inequity: Is a term that has a moral and ethical dimension – where inequities can result from avoidable and unjust differences in health status (Scott-Samuel, 1996).

Methods and tools web sites

http://www.who.int/hia
http://www.who.int/water_sanitation_health/resources/hia/en/index.html
http://www.hiagateway.org.uk
http://www.hiadatabase.net
http://www.who.dk/eprise/main/WHO/Progs/HMS/Home
http://www.hc-sc.gc.ca/ewh-semt/pubs/eval/index_e.html

References

Dahlgren, G .1995. *European health policy conference: Opportunities for the future. Vol 11 – Intersectoral action for health.* Copenhagen: WHO Regional Office for Europe.

National Institute for Health and Clinical Excellence 2006 HIA Gateway web site (2006). Available at http://www.hiagateway.org.uk. Last accessed 26/09/06.

André, P., B. Enserink, D. Connor and P. Croal 2006 *Public Participation International Best Practice Principles. Special Publication Series No. 4.* Fargo, USA: International Association for Impact Assessment.

Public Health Advisory Committee 2005. A guide to health impact assessment: A policy tool for New Zealand. Wellington: Public Health Advisory Committee.

Scott-Samuel, A. 1996 Health impact assessment: An idea whose time has come. BMJ, 313:(27 July), pages 183-4.

World Health Organization 1948 Constitution of the World Health Organization. Geneva: World Health Organization.

World Health Organization 1999 *Health impact assessment: main concepts and suggested approach* European Centre for Health Policy, Copenhagen: WHO Regional Office for Europe.

World Health Organization 2001 Health Impact Assessment. Harmonization, mainstreaming and capacity building. Report of a WHO inter-regional meeting (Arusha, 31 October-3 November 2000), *WHO/SDE/WSH/01.07. Geneva:* World Health Organization.

COMPETENCY FRAMEWORK FOR HEALTH IMPACT ASSESSMENT (HIA)

DOINA MALAI [1,2,3], ANIKA MENDELL [1], FRANÇOIS BENOIT [1], RICHARD MASSÉ [3,4]

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[2] Institut national de santé publique du Québec,
[3] Université de Montréal,
[4] Direction de la santé publique, Agence de la santé et des services sociaux de Montréal.

CONTEXT

HIA – WHY TAKE AN INTEREST?

- Growing popularity of the social determinants of health approach and increasing importance of health equity and of the development of healthy public policies.

HIA – HOW CAN THE NEEDS OF THE PROFESSIONALS INVOLVED BE MET?

- Competency-based approach essential to providing a high-quality process.
- Preliminary step: identification of professional situations and resources to be mobilized.

METHOD

Concept of competency according to Tardif (2006): complex knowledge of how to act, supported by the effective mobilization and combination of a variety of internal and external resources within the context of a family of situations. Translation: six-step process, based on three essential principles:

- establishing a definition of competency;
- gathering information;
- processing and validating information.

STEP 1

CLARIFY THE PURPOSE OF THE FRAMEWORK

Goals:

- introductory academic course on the HIA of public policies;
- analysis of needs in the field;
- plan for developing competencies.

STEP 2 AND 3

USE THE REFERENCE DEFINITION OF THE CONCEPT OF COMPETENCY AND ESTABLISH THE FORMAT OF THE FRAMEWORK

Common understanding of working group:

- reference definition (Tardif, 2006);
- format: context of framework and inventory of resources (table).

STEP 4

GATHER THE EXISTING MATERIAL

Preliminary analysis:

- reading;
- consultation with experts in HIA and pedagogy;
- first draft.

STEP 5

GATHER AND PROCESS COMPLEMENTARY DATA

Consultation sessions:

- 1 core competency;
- 5 competency elements;
- 11 families of professional situations;
- inventory of internal and external resources.

STEP 6

VALIDATE THE FRAMEWORK

Program committee:

- improvement of framework.

RESULTS

CORE COMPETENCY: CONDUCT AN HIA IN COLLABORATION WITH RELEVANT STAKEHOLDERS.

11 families of professional situations	5 competency elements	Inventory of resources: Internal resource (property of the individual)	Inventory of resources: External resource (property of the environment)
Professional situation: - problem (requires action or intervention) and, - emblematic (representative).	- Base one's practice on the historical, methodological and scientific foundations of HIA, - effectively manage HIA projects, - conduct high-quality HIAs, - communicate adequately with various publics, - base one's practice on the theoretical foundations of public policy development.	- Knowledge, - know-how, - self-management skills.	- Research reports, - guides, - laws, - networks, - experts…

EXAMPLE

CORE COMPETENCY: CONDUCT AN HIA IN COLLABORATION WITH RELEVANT STAKEHOLDERS.

Families of professional situations	Competency elements	Inventory of resources: Internal resource	Inventory of resources: External resource
Explain the nature of health promotion and the social determinants of health approach	Base one's practice on the historical, methodological and scientific foundations of HIA	- Basic population health and public health concepts, - HIA expertise, - critical awareness, rigorousness, open-mindedness…	Essential reference documents: - Ottawa Charter - Commission for the Social Determinants of Health, - Section 54 of Québec's *Public Health Act*…

CONCLUSION

1. Mastering the concepts and methods specific to the competency-based approach takes time, but…
2. This approach makes it possible to produce high-quality training programs firmly anchored in the reality of HIA practice.

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summary

For up-to-date knowledge relating to healthy public policy

Poster

12th HIA International Conference
August 29-31, 2012 – Québec city, Canada

Context

Within the context of preparing an online course, the authors set out to produce an inventory of competencies used by professionals involved in HIA. The result, a competency framework, will enable the development of an introductory course (online) and, in addition, can be used to produce other courses, either for the classroom or online.

Method

The process adopted by the group is part of a competency-based approach, with competency being defined as complex knowledge of how to act, supported by the effective mobilization and combination of a variety of internal and external resources within a family of situations (Tardif, 2006). The process is based on three essential principles: the establishment of a definition of competency, the gathering of information and the processing and validation of that information. Having completed a preliminary analysis, the authors consulted various practitioners, and subsequently examined the details of each competency with a work committee. This analysis focused on the health impact assessment of public policies.

Results

The core competency – Conduct an HIA in collaboration with relevant stakeholders – comprises five elements: 1) Base one's practice on the historical, methodological and scientific foundations of HIA, 2) Effectively manage HIA projects, 3) Conduct high-quality HIAs, 4) Communicate adequately with various publics, 5) Base one's practice on the theoretical foundations of public policy development. The framework also lists all the internal resources (knowledge) and external resources (tools in the community of practice) that are mobilized in the development of the competency.

Conclusion

Mastering the concepts and work methods specific to the competency-based approach requires extra effort, but this approach allows for the production of high-quality courses that are systematically constructed and firmly anchored in the reality of HIA practice.

For more information, please feel free to contact Doina Malai (doina.malai@inspq.qc.ca).

The National Collaborating Centre for Healthy Public Policy (NCCHPP) seeks to increase the expertise of public health actors across Canada in healthy public policy through the development, sharing and use of knowledge. The NCCHPP is one of six centres financed by the Public Health Agency of Canada. The six centres form a network across Canada, each hosted by a different institution and each focusing on a specific topic linked to public health. In addition to the Centres' individual contributions, the network of Collaborating Centres provides focal points for the exchange and common production of knowledge relating to these topics. The National Collaborating Centre for Healthy Public Policy is hosted by the Institut national de santé publique du Québec (INSPQ), a leading centre in public health in Canada.

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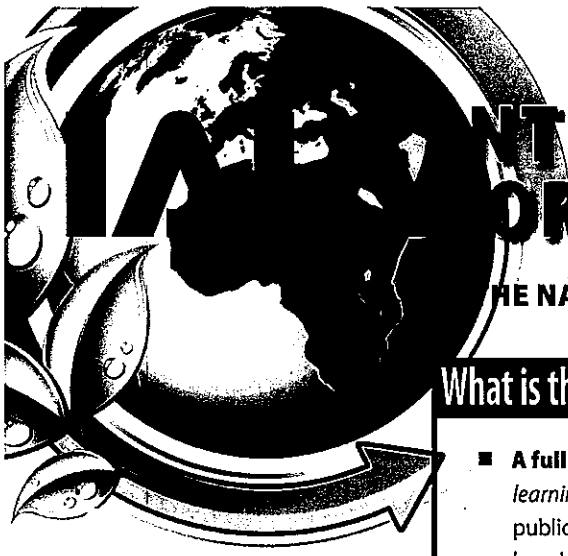

INTERNATIONAL ASSOCIATION FOR IMPACT ASSESSMENT

THE NATURAL HOME FOR HIA PROFESSIONALS AROUND THE WORLD

What is the Health Section planning for the next IAIA conference?

- **A full health day within the IAIA conference.** *"The science and art of international HIA practice: learning from what works to inform future HIAs."* The objective of the health day is to get HIA and public health practitioners to reflect on what we have learned through the application of HIA and how HIA has to evolve to be better fit for the new challenges ahead. The health day will start with a theme forum with invited guest speakers who are prestigious public health figures. The theme forum will set the discussion, followed by two sessions dedicated to specific topics such as equity and effectiveness. The day will then finish with an open session for discussion with the aim is to collect the reflections and input of the day and move the HIA field forward. The conclusions of the health day will then be represented in Geneva at the International HIA conference 2013.
- **A 2-day Health Impact Assessment Master Class.** The purpose of this course is to address topics of concern for experienced HIA practitioners in order to move the field forward and promote the use of best practice.
- **A theme forum on "Health in Impact Assessment."** Co-organised with WHO and EUPHA, the theme forum will invite IAIA specialists from other Sections to present how health is addressed in different types of impact assessment.
- **Several other sessions will be co-organised with other IAIA Sections.** Different topics will be addressed, such as baseline data in ESHIA; climate change and HIA; negotiating community responses to renewable energy through impact assessment; partnerships to improve community health programs; and scoping fear: how HIA assesses, alleviates and perpetuates the perception of harm. Social events will also be held, in addition to the technical sessions.

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About IAIA

IAIA is the leading global network on best practice in the use of impact assessment for informed decision making regarding policies, programs, plans and projects. IAIA seeks to:

1. Develop approaches and practices for comprehensive and integrated impact assessment.
2. Improve assessment procedures and methods for practical application.
3. Promote training of impact assessment and public understanding of the field.
4. Provide professional quality assurance by peer review and other means.
5. Share information networks, timely publications and professional meetings.

Who are the members of the Health Section of IAIA?

IAIA has a special-interest Section for Health which has over 140 members from all around the world. Members of the Health Section have different backgrounds and experiences and the exchange among members is one of the additional values of the IAIA membership. Members come from governmental institutions, ministries, regional or local departments, public health institutes, universities, private companies, consultancy firms, etc. We welcome your input.

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- Access the latest topical news on environmental, social and health impact assessment.
- Get a 12 month subscription to IAIA's journal, *Impact Assessment and Project Appraisal.*
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The Health Section is chaired by Ben Harris Roxas of Harris Roxas (ben@harrisroxashealth.com) and Francesca Viliani of International SOS (francesca.viliani@internationalsos.com).

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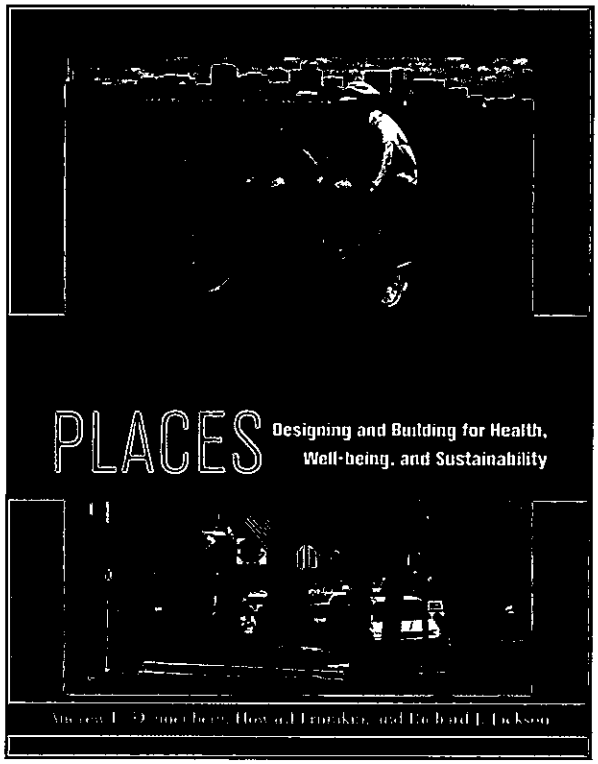

Making Healthy Places

Designing and Building for Health, Well-being, and Sustainability

Edited by Andrew L. Dannenberg, Howard Frumkin, and Richard J. Jackson

The environment that we construct affects both humans and our natural world in myriad ways. There is a pressing need to create healthy places and to reduce the health threats inherent in places already built. However, there has been little awareness of the adverse effects of what we have constructed-or the positive benefits of well designed built environments.

This book provides a far-reaching follow-up to the pathbreaking *Urban Sprawl and Public Health*, published in 2004. That book sparked a range of inquiries into the connections between constructed environments, particularly cities and suburbs, and the health of residents, especially humans. Since then, numerous studies have extended and refined the book's research and reporting. Making Healthy Places offers a fresh and comprehensive look at this vital subject today.

There is no other book with the depth, breadth, vision, and accessibility that this book offers. In addition to being of particular interest to undergraduate and graduate students in public health and urban planning, it will be essential reading for public health officials, planners, architects, landscape architects, environmentalists, and all those who care about the design of their communities.

Like a well-trained doctor, *Making Healthy Places* presents a diagnosis of-and offers treatment for-problems related to the built environment. Drawing on the latest scientific evidence, with contributions from experts in a range of fields, it imparts a wealth of practical information, with an emphasis on demonstrated and promising solutions to commonly occurring problems.

Andrew Dannenberg, M.D., M.P.H., serves as a consultant to and formerly was Team Leader of the Healthy Community Design Initiative in the National Center for Environmental Health at the Centers for Disease Control and Prevention (CDC).Â He holds affiliate faculty appointments in the Department of Environmental and Occupational Health Sciences and in the Department of Urban Design and Planning at the University of Washington in Seattle.

Howard Frumkin, M.D., Dr.P.H., is Dean of the School of Public Health at the University of Washington. He previously served as Director of the National Center for Environmental Health/Agency for Toxic Substances and Disease Registry at CDC, where he established programs in climate change and in the built environment. He is co-author of *Urban Sprawl and Public Health* (Island Press, 2004).

Richard Jackson, M.D., M.P.H., is Professor and Chair of the Department of Environmental Health Sciences at the University of California, Los Angeles. He is a pediatrician, and previously served as director of the National Center for Environmental Health at CDC and as the State Public Health Officer for California. He is co-author of *Urban Sprawl and Public Health* (Island Press, 2004).

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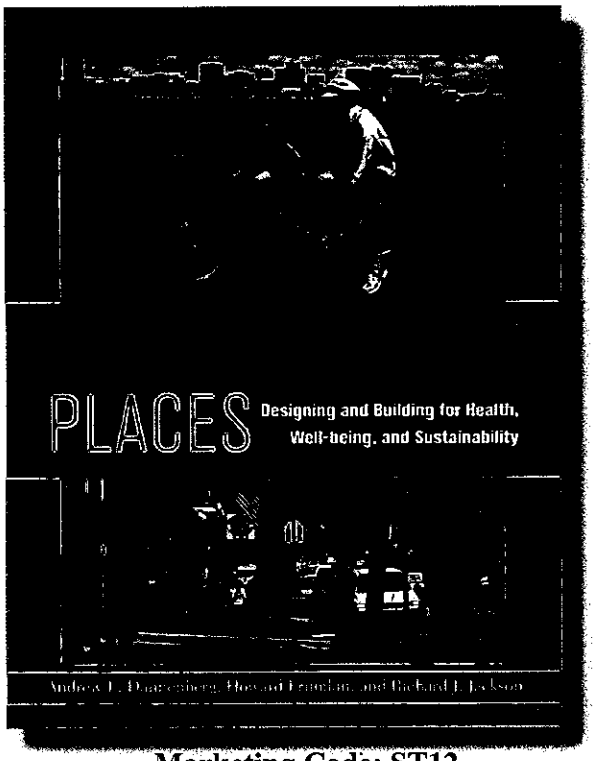

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HIA IN THE INTERNATIONAL ASSOCIATION FOR IMPACT ASSESSMENT

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IAIA seeks to...

1. develop approaches and practices for comprehensive and integrated impact assessment;
2. improve assessment procedures and methods for practical application;
3. promote training of impact assessment and public understanding of the field;
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5. share information networks, timely publications and professional meetings.

Who are the members of the HIA section of IAIA?

IAIA has a special interest section for Health Impact Assessment (HIA) which has members from twenty five countries. Members of the HIA section have different backgrounds and experiences and the exchange among members is one of the additional values of the IAIA membership. Members come from governmental institutions, ministries, regional or local departments, public health institutes, universities, private companies, consultancy firms, etc ... We welcome your input!

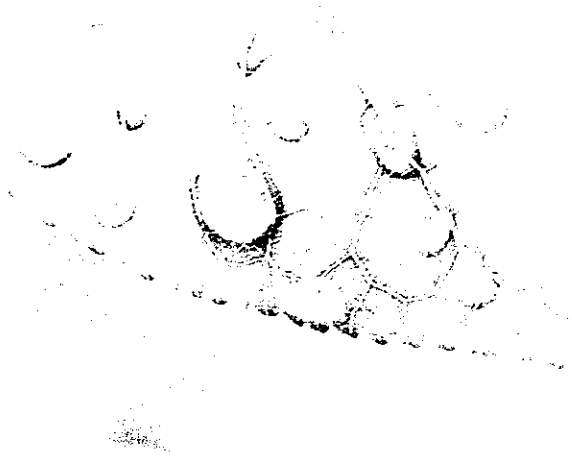
What the HIA section does...

The HIA section and its members are very active: the section produces a regular newsletter, members run training courses in HIA and the section works closely with other sections. For example with the Social Impact Assessment section on opportunities for integrating the two forms of impact assessment and with the Strategic Environmental Assessment section to further include human health and address equity in SEA. IAIA has a memorandum of understanding with WHO that recognizes the ways in which each organization's work on HIA complements each other.

The President and the Chief Executive Officer of IAIA meet with the HIA section chair and WHO each year to review progress. The HIA section and its members have been consulted on, or have contributed to, many guidance documents in HIA. In 2006 the HIA section published a paper on principles and practice for Health Impact Assessment (Quigley et al, 2006).

What is the HIA section working on right now?

- Organizing and coordinating health activities and discussions for the Geneva IAIA10 conference where the theme is transitioning to a green economy.
- Preparing a side event on SEA and health at the Fifth Ministerial Conference on Environment and Health, Parma, Italy, 2010. In discussion with WHO Rome and with IAIA affiliate in Italy.
- Organizing a tutoring and mentoring system for young practitioners with a special attention to those active in countries where it is difficult to access information.



Further information about IAIA and resources for impact assessment can be found at **www.iaia.org**

The HIA section is chaired by Ben Cave of Ben Cave Associates Ltd **ben.cave@bcahealth.co.uk** and Francesca Viliani of International SOS **francescav@internationalsos.com**
Comments or questions regarding the HIA section? Send an email to the section chairs.
Or join the HIA section by becoming a member of IAIA.

IAIA
International Association for Impact Assessment

Implementation of Section 54 of Québec's Public Health Act

August 2012

Preliminary version – for discussion

Since 2002, the Government of Québec's ministries and agencies proposing laws or regulations must first undertake a health impact assessment (HIA).

This briefing note describes the context of the adoption of this law, the procedures introduced by the Québec government to help in its implementation, and some of the results achieved to date.

Specifically, the paper addresses the following questions:

1. **How did HIA come to be adopted in Québec?**
   - Its history
   - Its formulation
2. **How has the measure been implemented?**
   - The role of the Ministère de la Santé et des Services sociaux (MSSS) (Ministry of Health and Social Services)
   - The role of the government ministries and agencies
   - The role of the Institut national de santé publique du Québec (INSPQ)
3. **What results have been achieved in the past ten years?**

The information presented in this paper is drawn from various studies of section 54 and on the issue of HIA in Québec by the Ministry of Health and Social Services. This review was supplemented by semi-structured interviews with key actors directly involved in the development and implementation of section 54 of the *Public Health Act* (PHA).

At this stage, the review of the first five years of implementation of section 54 of the PHA, produced by the MSSS in 2008, as well as the results of various studies carried out on this subject have mainly focused on procedural aspects.

A mandate to evaluate HIA practices adopted at the central level and, more broadly, to assess how health issues are taken into account in the development of public policies generated by other sectors of the government was given to the École nationale d'administration publique du Québec in 2012. The results are expected in 2013. This study makes it possible to measure the progress of organizational learning within ministries and partner agencies.

Why health impact assessment in the public policy sector?

Public policies, no matter the sector of government in which they are adopted, can directly or indirectly affect the health and well-being of the population.

From a public health perspective, it is therefore important that governments adopt measures to ensure that the potential impacts of policies on the determinants of health are taken into account by all sectors of government.

Health impact assessment is a process that allows policy makers to do this. Internationally, various governments already use this approach to ensure the development of healthy public policies. At present, HIA is not widely practiced in Canada. However, several provincial governments have adopted or plan to adopt HIA provisions.

Similarly, at the regional level, initiatives aimed at ensuring a more systematic use of HIA have been introduced. This is the case, for example, in Montérégie, in Québec, as well as in the Sudbury region of Ontario,

Section 54 of the *Public Health Act*

Section 54 of Québec's 2001 *Public Health Act* was implemented in June 2002. This section obliges government ministries and agencies to ensure that the legislative provisions they adopt

Briefing Note

For up-to-date knowledge relating to healthy public policy

Centre de collaboration nationale sur les politiques publiques et la santé
National Collaborating Centre for Healthy Public Policy

Institut national de santé publique Québec

do not adversely affect the health of the population. It also gives the Minister of Health and Social Services the capacity to provide advice promoting health to other government ministries or agencies upon his or her own initiative.

HOW DID SECTION 54 COME TO BE ADOPTED?

In 1992, the policy document *Politique de santé et de bien-être* (MSSS, 1992) recognized that intersectoral initiatives were necessary to improve the health of the population. This idea served as a guiding principle in the public health document, *Priorités nationales de santé publique: 1997-2002* (MSSS, 1997).

In 2000, the *Commission d'étude sur les services de santé et les services sociaux* (Clair Commission) explicitly recommended the systematic assessment of the impacts of public policies on health (Commission d'étude sur les services de santé et les services sociaux, 2000).

A further catalyst for change was that, by 2001, the existing law on public health was over 30 years old. It was, therefore, necessary to update it to reflect more recent public health priorities and strategies.

In order to propose guidelines for the amendment of the Act and to formulate new provisions, the Ministry of Health and Social Services created the *Groupe de travail sur l'élaboration de la loi sur la santé publique*, (The public health act working group). The new legislation that this group would recommend had to encompass all of the essential facets of public health: protection, promotion, prevention and monitoring. Section 54 is a measure aimed at establishing a legal basis for the promotion and prevention facets.

For measures relying on intersectoral initiatives (MSSS, 1999), the working group turned to the Ottawa Charter for Health Promotion and the priorities stipulated in the Jakarta Declaration on Leading Health Promotion into the 21st Century.

The working group also reviewed existing legislative provisions at the international level. It found few examples of legislation devoted specifically to prevention and health promotion but discovered an extensive body of literature on HIA initiatives, undertaken by a number of countries, targeting the promotion of healthy public policy.

Some examples used by the working group are British Columbia's experience, as well as initiatives in the environmental health sector which, for several years, has sought to include health impact assessments in environmental impact assessments.

The working group also used the Gothenburg Consensus (European Centre for Health Policy, 1999)[1] as the underlying reference for its proposal, specifically concerning the legal obligation of government ministries to consult the Ministry of Health and Social Services when they draft legislation and regulations.

WHAT DOES SECTION 54 STIPULATE?

Section 54 of the *Public Health Act* stipulates that:

> The Minister is by virtue of his or her office the advisor of the Government on any public health issue. The Minister shall give the other ministers any advice he or she considers advisable for health promotion and the adoption of policies capable of fostering the enhancement of the health and welfare of the population.
>
> In the Minister's capacity as government advisor, the Minister shall be consulted in relation to the development of the measures provided for in an Act or regulation that could have significant impact on the health of the population (*Public Health Act*, 2001).

The first subsection of section 54 confirms the Minister of Health and Social Services' role as an advisor to the government. However, it adds an additional dimension by making official the Minister's power of initiative to proactively issue advice to colleagues in all branches of government. He or she may invoke this power with the aim of fostering the development and adoption of healthy public policies (MSSS, 2005a).

Subsection 2 establishes the obligation of all government ministries and agencies to consult the Minister when they develop legislation or regulations that may significantly affect the health and well-being of the population.

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[1] The Gothenburg Consensus was established by European countries that shared their experience in the area of health impact assessment, as well as in the more established field of environmental impact assessment of projects or programs.

How has the measure been implemented?

A MULTIFACETED STRATEGY

In order to implement section 54, the MSSS has developed a strategy with two main thrusts:

- The establishment of an intragovernmental health impact assessment (HIA) mechanism; and
- The development and transfer of knowledge about healthy public policies.

Fulfillment of these objectives has required:

- The creation of two full-time positions;
- The establishment and leadership of a network of ministerial representatives;
- The development and dissemination of support tools;
- The implementation of an internal procedure for processing requests for assessments from ministries proposing legislation and regulations;
- The establishment and monitoring of a research program on healthy public policies; and
- The establishment of a collaborative agreement between the MSSS and the Institut national de santé publique du Québec (INSPQ) (MSSS, 2002).

SUPPORT TO THE MINISTRY CONDUCTING THE HIA

According to this model, the ministry or agency responsible for the draft legislation or regulations is obliged to carry out health impact assessments.

The MSSS supports the ministry or agency conducting the HIA and provides the technical support and necessary tools

NETWORK OF DEPARTMENTAL REPRESENTATIVES

To support ministries in this new role, the MSSS established a network of ministerial representatives who promote awareness of the existing impact assessment tools in their respective ministries, and support the use of these tools.

The representatives inform the MSSS of problems encountered in the application of section 54 as it relates to their ministry's set of tools, and recommend adjustments that may be required. The representatives meet approximately twice per year.

More specifically, the representatives are called upon to:

- Act as the resource person for requests for general information regarding the implementation of section 54 of the PHA (legal aspects, documentation, tools, etc.);
- Act as the resource person for the promotion of healthy public policy (HPP) among managers and personnel and promote the health impact assessment of legislation and regulations;
- Collaborate in gathering relevant information within their organization and its affiliated agencies, to guide research on HHP;
- Participate, on a periodic basis, in network meetings and in work on specific projects related to HPP or health impact assessment;
- Ensure the dissemination, within their department, of information on events and knowledge-sharing activities related to healthy public policy (forum of representatives, Journées annuelles de santé publique, etc.).

Ministerial representatives ideally belong to their ministry's administrative secretariat, or strategic planning or policy planning divisions.

TOOLS AND GUIDES

The MSSS produced its own HIA guide based on impact assessment models developed in Europe and adapted to an intragovernmental context (MSSS, 2006a).

This guide describes the five stages of the HIA process:

1. Screening
2. Scoping and summary analysis
3. In-depth analysis
4. Decision-making
5. Evaluation

The first two stages, screening, and scoping & summary analysis, are the responsibility of the government ministries and agencies proposing the legislation or regulation in question.

If the initial screening stage shows that an adverse impact on health is likely, further stages are carried out. If a positive impact on health is anticipated, the ministry or agency may pursue an abridged form of

the analysis, in order to justify or give priority to a measure.

When no impact is anticipated, the process is taken no further.

The second stage, scoping and summary analysis is intended to clarify:

- The potential impact of the proposed measure,
- The groups concerned, and
- The sources of information used in the analysis.

Ministries or agencies carry out this stage, using the tools that the MSSS provides.

They may request assistance from the MSSS or from the health care network. If a broader analysis is required, a request is submitted to the Deputy Minister's office which sends it to the appropriate experts in the MSSS, the INSPQ or other organizations that offer the requisite expertise.

EVOLUTION OF TOOLS AND METHODS

Since its implementation in 2002, the impact assessment guide has been modified, on the basis of consultations with ministerial representatives and of a knowledge synthesis of the various tools developed in Europe (MSSS, 2004a).

In addition, the MSSS has produced a document on the determinants of health, in order to heighten awareness in all government departments and agencies of the non-medical determinants of health and the link between their respective missions and the health of the population (MSSS, 2006b, MSSS, 2012).

A review of the first five years of implementation of section 54 (2002-2007) was also published in 2008. This report assesses the progress of both aspects of the implementation strategy: the establishment of the intragovernmental HIA mechanism and the development and transfer of knowledge about healthy public policy (MSSS, 2008). A new report is expected in 2013 on the 2008-2012 period.

In addition, a synthesis of a conceptual framework of health determinants, developed by the MSSS's health status monitoring division, was published in 2012. This document, intended not only for other sectors, but also for the general public, leads to a better understanding of the social determinants of health (MSSS, 2012).

RESEARCH PROGRAM

To broaden knowledge with respect to healthy public policy and to the processes involved, the MSSS has allocated funds for research.

In 2002, the MSSS jointly designed a research program with the *Fonds de la recherche en santé du Québec* (FRSQ)[2] and the *Fonds québécois de la recherche sur la société et la culture* (FQRSC).[3]

The research program:

- Supports the development of tools to assess the impact of public policy;
- Consolidates and broadens the capacity for interdisciplinary and multidisciplinary research and expertise in Québec;
- Supports applied research to evaluate, *a priori* and *a posteriori*, the impact of policies, legislation and regulations on health and well-being;
- Supports the development of collaboration between researchers, the INSPQ, research program partners and other government ministries and agencies; and
- Fosters the transfer of knowledge to decision-makers.

The MSSS and its partners have selected four areas of research:

1. Public policy and lifestyle habits[4];
2. An assessment of the impact of government initiatives on health and well-being[5];

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[2] The *Fonds de la recherche en santé du Québec* (FRSQ) implements government strategies regarding health research as defined by the Québec Research and Innovation Strategy. It plays a key role in the planning and coordination of health research in Québec. Source: http://www.frsq.gouv.qc.ca/en/index.shtml.

[3] The *Fonds québécois de la recherche sur la société et la culture* (FQRSC) is devoted to the development of research and innovation in Québec, in the humanities, social sciences, arts and literature. To this end, the FQRSC provides funding for research and the training of researchers in these fields and fosters the dissemination and transfer of knowledge. It also establishes the partnerships necessary for the advancement of scientific knowledge focusing on social problems. Source: http://www.fqrsc.gouv.qc.ca./fr/accueil.php.

[4] This area of study comprises three research projects, funding for which began in January 2006 and ended in December 2007.

3. Concepts and methods[6]; and
4. Poverty and social exclusion[7].

A call for research proposals was launched in each area of research. This stimulated the development of new research capacity through, among other things, the establishment of a research group dedicated to healthy public policy, which received funding for a period of six years. The final report published in 2011 stated that the use of "HIA as a decision-making tool constituted an important step toward the formulation of healthy public policies" [Translation] (Gagnon, Turgeon, Michaud & Dallaire, 2011, p. 15). The report's other conclusions focus on decision making within ministry sub-systems, the pragmatic aspects of implementing this practice and the use of knowledge in a decision-making context.

In addition, it was possible to fund certain projects outside these areas of study, as was the case in 2009 for a specific project on the social inequalities of health, for example.

At the time of publication of this update, the partners in the research program were considering the possibility of developing new areas of study based on an examination of issues, such as the aging problematic.

AGREEMENT WITH THE INSPQ

The INSPQ was established in 1998 to support the MSSS and regional public health authorities in fulfilling their public health mandates.[8] The INSPQ is a public health expertise and reference centre in Québec with over 500 employees. It offers training and consulting services and provides screening, laboratory and research services.

One facet of the INSPQ's mission focuses specifically on the assessment of the impact of public policy on the health of the population, and the submission of such findings to the Minister of Health and Social Services.

From the outset, the INSPQ has participated in the MSSS' deliberations on section 54 and has participated in reviewing the tools developed by the MSSS. It is a member of the steering and follow-up committee that oversees the research groups that obtain funding, participates in the development of areas of research, and collaborates in the drafting of reports.

The MSSS and the INSPQ have an agreement specifically devoted to the application of section 54. This agreement covers both of its subsections: support for the MSSS' advisory role with respect to other government ministries, and support for the process to evaluate the impact of legislation and regulations on health. More specifically, the agreement focuses on:

- Supporting the role of the MSSS with respect to the intragovernmental impact assessment process and to the research program;
- Developing tools to facilitate access to expertise and knowledge; and
- Monitoring healthy public policy.

In addition, a second agreement between the MSSS and the INSPQ was concluded in 2011, this one specifically tied to the Plan Nord,[9] and comprising a focus on health and social services. The aim of the agreement, which is to extend over five years is to support the development and implementation of a health impact assessment mechanism applicable to the projects and policies initiated within the context of the Plan Nord.

The INSPQ's mandate centres mainly on work related to:

- Supporting the strengthening and linking of existing impact assessment procedures, namely:

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[5] This area of study also comprises three research projects, funding for which began in December 2007 and ended in December 2009. A new call for proposals was issued in 2011-2012. The new projects will be launched in 2013.

[6] Funding for this research team started in December 2004 and ended in November 2010.

[7] This area of study includes an initial phase comprising 11 research projects, funded from 2007 to 2009, and a second phase, subsequent to a new call for proposals issued in 2010, of eight projects, funding for which began in 2011.

[8] Legislation stipulates that the mission of the Institut national de santé publique du Québec is to provide support to the MSSS, to regional public health authorities and to other institutions, by making available its expertise and specialized laboratory and screening services. See the INSPQ Website at: http://www.inspq.qc.ca/english/about/default.asp.

[9] The **Plan Nord** is an economic development plan for Québec's northern regions put forth by the government of Québec in May 2011. It includes plans to invest approximately 80 billion dollars in public and private funding over a period of 25 years. The plan, purported to be based on sustainable development, includes the opening of mines, the development of renewable energy projects and the construction of transportation infrastructure.

  - The environmental impact procedure (EIA)[10]; and
  - The health impact procedure (HIA);
- Supporting policy makers through the production of specific information (documentation and knowledge specifically relevant to the context of the Plan Nord).

SUPPORT FOR THE MINISTER'S ADVISORY ROLE

One of the INSPQ's key roles is to produce advisory notices and knowledge syntheses on public health problems that can be modified through public policy, and on the policies, themselves. The MSSS chooses the subject of advisory notices and syntheses, and submits them for discussion with the INSPQ through a committee comprised of the directors of both organizations. In addition, for several years now, ministerial representatives have been invited to join these committees, based on the subject of the reports. Moreover, all the ministerial representatives are invited to share their suggestions for advisories and syntheses by means of surveys.

The professional and scientific researchers at the INSPQ are responsible for drafting the notices and an inter-branch body, including the CEO, examines issues related to this mandate. Upon completion, the advisory notices are submitted by the CEO of the INSPQ directly to the Minister of Health and Social Services. The advisory notices are then published after a delay of 90 days.

SUPPORT FOR THE HIA PROCESS

The INSPQ plays a key role with respect to HIA, centred on monitoring and knowledge transfer, to both the MSSS and to ministerial representatives. Funding from the MSSS has supported the establishment and operation of a web portal devoted to public policy, and a newsletter, which produces an environmental scan of healthy public policy initiatives.[11]

Finally, the INSPQ hosts the National Collaborating Centre for Healthy Public Policy (NCCHPP),[12] a pan-Canadian knowledge-transfer centre. This centre has developed a work stream focused specifically on HIA, which has led to the production of several documents on the theory and practice of HIA. This work has also made it possible to share Quebec's expertise in this area with the other provinces and with the international community and, in so doing, has helped build on the INSPQ's expertise, thus furthering the objectives of section 54.

How has the implementation been achieved?

CERTAIN MINISTRIES INITIALLY EXPRESSED RESERVATIONS

In 2003, one year after section 54 came into effect, the MSSS asked the *Observatoire de l'administration publique* at the École nationale d'administration publique (ENAP) to conduct a study of all of the government ministries and agencies covered by section 54 (*Observatoire de l'administration publique de l'ENAP*, 2003).

The study's objectives were to analyze the extent to which the impact assessment process had been implemented, and to gauge overall receptiveness to this new measure, by means of interviews with senior civil servants in 18 government ministries and agencies.

The study revealed that some ministries and agencies showed limited adherence to the principles covered by section 54, and that they demonstrated a lack of knowledge with respect to both the impact assessment process and to determinants of health and well-being (the main obstacles to implementation). Moreover, in line with the existing literature on the subject, it confirmed that ministries and agencies with a social mission adhered more extensively to the approach than those with an economic mission.

This information enabled the MSSS to adjust its strategies; for example, by producing an awareness and information handbook on health determinants, geared to different government ministries.

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[10] A procedure, established in compliance with the *Environment Quality Act*, which allows the impact of development projects on ecosystems, resources and the quality of life of individuals to be measured.

[11] See http://politiquespubliques.inspq.qc.ca/.

[12] This Centre is one of six public health collaborating centres funded by the Public Health Agency of Canada; it seeks to support the development of the skills of public health actors in Canada.

The handbook, launched in 2006 by the *Directeur national de santé publique* (Chief Medical Officer of Health), constitutes the first report on health determinants, the *Rapport national sur l'état de santé de la population du Québec: Produire la santé*, that is accessible to a wider audience (MSSS, 2005b).

IMPACT ASSESSMENTS

The MSSS's efforts to heighten awareness within and provide support for government ministries and agencies by means of intragovernmental tools and procedures have facilitated the implementation of the impact assessment process. Thus, between 2002 and 2012, the MSSS recorded 519 requests for consultations from other ministries.[13]

The following characteristics of the above requests are noteworthy:

- A large portion of the requests for consultation focused on draft legislation or draft regulations, as stipulated by section 54 of the PHA. However, other types of projects were also submitted to the MSSS: government policies, action plans, certificates of authorization, etc.
- Government ministries and agencies were asked to amend about 20% of the 528 proposals.
- The vast majority of the requests (over 90%) came directly from the *Conseil exécutif* (Executive Council).
- An internal survey, conducted by the MSSS, of a sampling of projects revealed that half of the requests had been the topic of prior discussion with the ministries and agencies concerned.
- Other HIAs were carried out without the MSSS being formally notified.

A TREND TOWARDS EARLIER, PROACTIVE CONSULTATION

During the first few years in which requests were recorded, it was noted that the majority came from one of the three Cabinet secretariats dealing respectively with social development, education and culture (the Secrétariat du développement social, de l'éducation and de la culture) which, having examined the reports submitted by the ministries and agencies, concluded that health impact assessments were warranted. Today, requests also come from secretariats dealing with economic prosperity, sustainable development and regulatory streamlining the Secrétariat à la prospérité économique, the Secrétariat au développement durable and the Secrétariat à l'allègement réglementaire et administratif.

In addition, the Direction générale de la santé publique of the MSSS has observed that, with increasing frequency, some ministries are consulting the MSSS earlier on in the policy development process. For example, the Ministère de l'Agriculture, des Pêcheries et de l'Alimentation du Québec (Ministry of Agriculture, Fisheries and Food) consulted the MSSS concerning a document for public consultation within the context of a commission on the future of agriculture and agri-business in Québec, the *Commission sur l'avenir de l'agriculture et de l'agroalimentaire québécois* (2007). And, more recently, the Ministère des Affaires municipales, des Régions et de l'Occupation du territoire (MAMROT) (Ministry of Municipal Affairs, Regions and Land Occupancy) consulted the MSSS on its draft proposal for the *Loi sur l'aménagement durable du territoire et l'urbanisme* (2010), an act regulating sustainable development of the land and urban planning.

This suggests a trend towards acceptance and integration of the process.

[13] A consultation is requested for the purpose of obtaining a formal or informal opinion of draft legislation or regulations.

Bibliography

Commission d'étude sur les services de santé et les services sociaux. (2000). *Rapport et recommandations : les solutions émergentes.* Québec: Government of Québec. Retrieved from: http://msssa4.msss.gouv.qc.ca/fr/document/publication.nsf/0/6c397fad530bc545852569d6006ef6ef?OpenDocument.

European Centre for Health Policy. (1999). *Health Impact Assessment: Main concepts and suggested approach.* Gothenburg consensus paper. Brussels: WHO-Regional Office for Europe. Retrieved from: http://www.hiaconnect.edu.au/files/Gothenburg_Consensus_Paper.pdf.

Gagnon, F., Turgeon, J., Michaud, M. & C. Dallaire. (2011). *L'adoption de politiques publiques favorables à la santé pour le Québec.* Groupe d'étude sur les politiques publiques et la santé. Québec. Retrieved from: http://www.gepps.enap.ca/cerberus/files/nouvelles/documents/GEPPS/Nouvelle/Bilan%20Final%20avec%20annexes_AC%202005-SP95622.pdf.

Institut national de santé publique du Québec. (2006). *Bilan annuel d'activité : réalisation de l'entente de services MSSS-INSPQ concernant l'application de l'article 54 de la Loi sur la santé publique.* Internal document. Québec: Government of Québec.

Ministère de la Santé et des Services sociaux. (1992). *Politique de santé et de bien-être.* Québec: Government of Québec. Retrieved from: http://publications.msss.gouv.qc.ca/acrobat/f/documentation/1992/92_713.pdf.

Ministère de la Santé et des Services sociaux. (1997). *Priorités nationales de santé publique 1997 – 2002.* Québec: Government of Québec. Retrieved from: http://publications.msss.gouv.qc.ca/acrobat/f/documentation/1996/96_203.pdf.

Ministère de la Santé et des Services sociaux. (1998). *La santé publique à l'aube de l'an 2000 : action et concertation.* Québec: Government of Québec

Ministère de la Santé et des Services sociaux. (1999). *Des pistes en vue de l'élaboration de la loi sur la santé publique: Working document of the Groupe de travail sur l'élaboration de la Loi sur la santé publique.* Québec: Government of Québec.

Ministère de la Santé et des Services sociaux. (2002). *Stratégie pour soutenir le développement de politiques publiques favorables à la santé.* Internal document. Québec: Government of Québec.

Ministère de la Santé et des Services sociaux. (2004a). *L'évaluation des impacts sur la santé : synthèse des connaissances et orientations pour l'action.* Internal document. Québec: Government of Québec.

Ministère de la Santé et des Services sociaux. (2004b). *Programme national de santé publique 2003-2012 : version abrégée.* Québec: Government of Québec. Retrieved from: http://publications.msss.gouv.qc.ca/acrobat/f/documentation/2004/04-216-01.pdf.

Ministère de la Santé et des Services sociaux. (2005a). *Article 54 de la Loi de santé publique du Québec : Bilan de mise en œuvre (juin 2002 à janvier 2005).* Internal document. Québec: Government of Québec.

Ministère de la Santé et des Services sociaux (2005b). *Rapport national sur l'état de santé de la population du Québec : Produire la santé.* Québec : Gouvernement du Québec. Retrieved from: http://publications.msss.gouv.qc.ca/acrobat/f/documentation/2004/04-228-01.pdf.

Ministère de la Santé et des Services sociaux. (2006a). *Guide pratique : Évaluation d'impact sur la santé lors de l'élaboration de projet de loi et de règlement au Québec.* Québec: Government of Québec. Retrieved from: http://publications.msss.gouv.qc.ca/acrobat/f/documentation/2006/06-245-01.pdf.

Ministère de la Santé et des Services sociaux. (2006b). *La santé, autrement dit… Pour espérer vivre plus longtemps et en meilleure santé*. Québec: Government of Québec. Retrieved from: http://publications.msss.gouv.qc.ca/acrobat/f/documentation/2006/06-245-02.pdf.

Ministère de la Santé et des Services sociaux. (2008). *Bilan et perspectives 2002-2007. À la frontière des responsabilités des ministères et des organismes publics : l'application de l'article 54 de la Loi sur la santé publique*. Québec. Government of Québec. Retrieved from: http://publications.msss.gouv.qc.ca/acrobat/f/documentation/2008/08-245-02.pdf.

Ministère de la Santé et des Services sociaux. (2012) *La santé et ses déterminants : Mieux comprendre pour mieux agir*. Québec. Government of Québec. Retrieved from: http://msssa4.msss.gouv.qc.ca/fr/document/publication.nsf/fb143c75e0c27b69852566aa0064b01c/18ad57eaf514abbe852579d70064c864?OpenDocument&Highlight=0,determinants.

Observatoire de l'administration publique de l'ENAP. (2003). *Identification des enjeux sociétaux et sectoriels pour l'opérationnalisation du programme de transfert de connaissance et de recherche sur les politiques publiques favorables à la santé et au bien-être*. Québec: Government of Québec. Retrieved from: http://collections.banq.qc.ca/ark:/52327/bs53263.

Public Health Act, R.S.Q. c. S-2.2, c.60 a.54. (2001). Retrieved from: http://www2.publicationsduquebec.gouv.qc.ca/dynamicSearch/telecharge.php?type=2&file=/S_2_2/S2_2_A.html.

St-Pierre, L. (2004). *Réflexion sur le mécanisme d'analyse d'impact sur la santé des lois et règlements au Québec; à partir des points de vue des principaux acteurs concernés.* PhD seminar in health promotion. Québec: Université Laval.

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The National Collaborating Centre for Healthy Public Policy (NCCHPP) seeks to increase the expertise of public health actors across Canada in healthy public policy through the development, sharing and use of knowledge. The NCCHPP is one of six centres financed by the Public Health Agency of Canada. The six centres form a network across Canada, each hosted by a different institution and each focusing on a specific topic linked to public health. In addition to the Centres' individual contributions, the Collaborating network of Collaborating Centres provides focal points for the exchange and common production of knowledge relating to these topics. The National Collaborating Centre for Healthy Public Policy is hosted by the Institut national de santé publique du Québec (INSPQ), a leading centre in public health in Canada.

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La version française est disponible sur le site Web du Centre de collaboration nationale sur les politiques publiques et la santé CCNPPS) au : www.ccnpps.ca.

Citizen Participation in Health Impact Assessment: An Overview of the Risks and Obstacles

November 2011

Fact sheet

For up-to-date knowledge relating to healthy public policy

One of the mandates of the National Collaborating Centre for Healthy Public Policy (NCCHPP) is to inform Canadian public health practitioners about effective strategies for promoting the adoption of healthy public policies. Health Impact Assessment (HIA) currently represents one of the most structured practices available to public health actors. It is applied to policies developed by sectors other than that of health that can significantly affect health determinants. This fact sheet focuses on one of the methodological aspects of implementing health impact assessments, namely the role that can be assigned to citizen participation.

Definitions

Health Impact Assessment

Health Impact Assessment (HIA) can be defined as a combination of procedures, methods and tools by which a policy, program or project may be judged as to its potential effects on the health of a population (European Centre for Health Policy, 1999).

Citizen Participation

Citizen participation refers to all of the means that are used to involve, whether actively or passively, citizens or their representatives in an HIA process.

Risks/Obstacles to Citizen Participation

The founding documents of HIA, and in particular the Gothenburg Consensus paper (European Centre for Health Policy, 1999), identify citizen participation as one of the cornerstones of HIA. In fact, some practitioners and researchers maintain that an HIA remains incomplete without the effective and concrete participation of the community (Dannenberg, Bhatia et al., 2006, p. 266). However, participatory practices in HIA are still limited in scope and number (Gagnon, St-Pierre et al., 2010). In addition, even the idea of citizen participation in HIA seems poorly articulated and is sometimes called into question (Mahoney, Potter et al., 2007; Wright, Parry et al., 2005).

Basing our discussion on a review of the literature on HIA[1] carried out using predetermined terms,[2] we will explore, in this fact sheet, five categories of factors that can explain the significant gap between the participatory rhetoric attached to HIA, and actual practices. It should be noted that these factors can be simultaneously viewed as risks or obstacles. In fact, strong advocates for citizen participation see them as obstacles that can and must be overcome. Others see them more as real risks that serve to explain these actors' mitigated interest in, perhaps even their opposition to, citizen participation in HIA.

[1] Four databases indexing scientific journals covering public health and the social sciences were consulted for our literature review: PubMed, OvidSP, EBSCO Host and CSA Illumina. Searches were carried out using predetermined terms and were aimed at identifying all of the relevant publications published before July 2009, in both French and in English. Initial searches led to the identification of 443 potentially relevant articles. The title and abstract of each article were analyzed to determine their relevance and duplications were eliminated. All articles examining citizen participation in other sectors were eliminated (e.g.: environmental impact assessment). The relevant articles were then analyzed in greater depth, along with their references, so as to identify other publications of interest. Our final inventory included 51 articles focused on citizen participation in HIA.

[2] Searches carried out using PubMed and OvidSP used the following terms and boolean operators: "health impact assessment" AND "consumer participation". The searches carried out in EBSCO Host and CSA Illumina used the following terms and boolean operators: (Public OR Communit* OR Citizen* Or Stakeholder*) AND (Particip* OR Consult* OR Involv* OR Engag*).

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1) Organizational Risks/Obstacles

Public organizations that are called on to conduct HIAs (e.g.: public health branches, regional health authorities, or municipalities) have limited human and financial resources with which to support citizen participation strategies (Kearney, 2004). In addition, establishing participatory processes can prove incompatible with decision-making timeframes, which are often very short (Wright et al., 2005; Mahoney et al., 2007). Thus, tension continues to exist between the time and resources available to meet decision makers' demands with respect to HIA, and the time and resources required to establish a citizen participation strategy.

2) Community Risks/Obstacles

Some HIA practitioners appear to doubt the desire of citizens to invest time and energy in an HIA process; citizens already being quite busy fulfilling their own daily obligations (Parry & Wright, 2003, p. 388). Moreover, some excluded or marginalized groups might be difficult to mobilize (Wright et al., 2005, p. 61). It is also possible that citizens' mistrust of governmental institutions makes the participatory methods used in HIA appear untrustworthy to them (Kearney, 2004, p. 227).

The Five Risks/Obstacles to Citizen Participation

1. Organizational
2. Community
3. Political
4. Theoretical
5. Methodological

3) Political Risks/Obstacles

Decision makers can also themselves be mistrustful, and may associate certain risks with citizen participation in HIA. Unlike some authors who see the participatory approach as consensual and cooperative (Lester & Temple, 2006, p. 916), others, like Kearney (2004, p. 227), point out that it can spark controversy within a community or reignite a latent conflict, which will impede the decision-making process. Some government authorities also fear that citizens could mount systematic opposition toward any large-scale project and that the decision-making process could thus be held hostage (Kearney, 2004, p. 225). Still according to Kearney (2004), decision makers are generally risk-averse. They could be hesitant to commit to a participatory process that risks undermining their ability to implement projects, programs or policies.

4) Theoretical Risks/Obstacles

Some authors contend that the idea of citizen participation is poorly articulated in the founding documents of HIA; these documents evoke the notion without, however, making explicit what is meant (Mahoney et al., 2007). Thus, it seems that the meaning of "citizen participation" remains rather ambiguous, as does the way to integrate it into the science of HIA. Some even argue that the theoretical foundations of HIA have not yet reached a level of maturity that allows for the risk-free involvement of citizens (Cole, Shimkhada et al., 2005, p. 385).

5) Methodological Risks/Obstacles

The literature on HIA offers few clear answers to the questions that concern practitioners: Which citizens should be involved? At which point in the HIA process should they be involved? What should be their level of involvement in (or degree of influence on) the HIA process? The absence of a proven method thus seems to feed a certain amount of scepticism toward citizen participation. Some view it as an intangible practice and an unattainable goal (Elliott & Williams, 2008, p. 1112).

Conclusion

The rhetoric of participatory HIA is confronted with several significant risks and obstacles. These reflect, in large part, the fact that citizen participation in HIA is an emerging practice. This novelty gives rise to concerns and uncertainty about the effects citizen participation might have on HIA and on the decision-making process. However, it seems important to place these risks and obstacles in perspective, by examining the considerable arguments in favour of involving citizens in an HIA process, which we have documented in another fact sheet. One must also consider the fact that citizen participation can rely on a variety of means to help mitigate some of the risks and obstacles identified above, regardless of the goals one has in undertaking the HIA. Thus, a final fact sheet in this series documents the practical dimensions of implementing a participatory approach.

Bibliography

Cole, B. L., Shimkhada, R. et al. (2005). Methodologies for realizing the potential of health impact assessment. *American Journal of Preventive Medicine, 28,* 382-389.

Dannenberg, A. L., Bhatia, R. et al. (2006). Growing the field of health impact assessment in the United States: an agenda for research and practice. *American Journal of Public Health, 96,* 262-270.

Elliott, E. & Williams, G. (2008). Developing public sociology through health impact assessment. *Sociology of Health & Illness, 30,* 1101-1116.

European Centre for Health Policy. (1999). *Health Impact Assessment: Main concepts and suggested approach. Gothenburg consensus paper.* Brussels: WHO-Regional Office for Europe. Retrieved from: http://www.hiaconnect.edu.au/files/Gothenburg_Consensus_Paper.pdf.

Gagnon, F., St-Pierre, M.-N., & Daigtnault-Simard, X. (2010). *La participation du public dans l'évaluation d'impact sur la santé : Pourquoi et comment?* Québec: Groupe d'étude sur les politiques publiques et la santé. Retrieved from: http://www.gepps.enap.ca/GEPPS/docs/Serietransfertdeconnaissances/GEPPS_participationcitoyenne.pdf.

Kearney, M. (2004). Walking the walk? Community participation in HIA A qualitative interview study. *Environmental Impact Assessment Review, 24,* 217-229.

Lester, C. & Temple, M. (2006). Health impact assessment and community involvement in land remediation decisions. *Public Health, 120,* 915-922.

Mahoney, M. E., Potter, J. L., & Marsh, R. S. (2007). Community participation in HIA: Discords in teleology and terminology. *Critical Public Health, 17,* 229-241.

Parry, J. & Wright, J. (2003). Community participation in health impact assessments: intuitively appealing but practically difficult. *Bulletin of the World Health Organization, 81,* 388. Retrieved from: http://www.who.int/bulletin/volumes/81/6/parry.pdf.

Wright, J., Parry, J., & Mathers, J. (2005). Participation in health impact assessment: objectives, methods and core values. *Bulletin of the World Health Organization, 83,* 58-63. Retrieved from: http://www.who.int/bulletin/volumes/83/1/58.pdf.

November 2011

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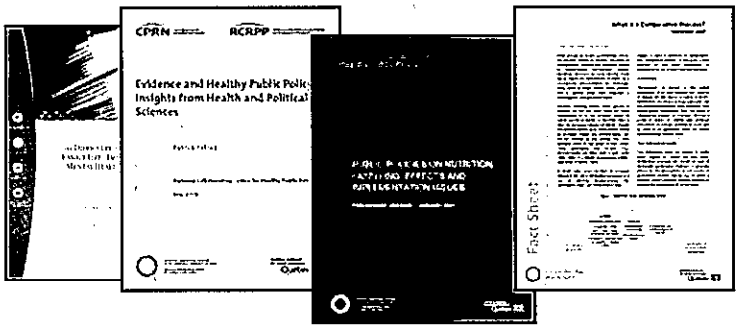

Selected Resources

Selected Publications from 2008-2010

- Interactive Timeline on Tobacco Policy in Canada 1900-2000
- Structural Profile of Public Health in Canada
- Method for Synthesizing Knowledge about Public Policies
- Integrated Governance and Healthy Public Policy: Two Canadian Examples
- Comprehensive Policies to Combat Poverty Across Canada, by Province
- Deliberative Processes: Inventory of Resources
- Health Impact Assessment: Guides and Tools
- Assessing the Role of Evidence in Developing Healthy Public Policy
- The Quebec Public Health Act's Section 54

Selected 2011-2012 Publications

- Urban Traffic Calming and Health: A Review of Literature
- The Use of Health Knowledge by Not-for-profit Organizations: Taking a Look at Their Policy-influencing Practice
- Public Policies on Nutrition Labelling: Effects and Implementation Issues - A Knowledge Synthesis
- Citizen Participation and HIA: The Principal Arguments Supporting It, and the Risks and Obstacles (2 documents)
- A Workshop on Inequalities Using the Escalators Metaphor: Presentation Kit
- Built Environment – Public Policy, Actors, Barriers and Levers
- Framing the Core: Health Inequalities and Poverty in Saskatoon's Low-income Neighbourhoods

Work in Progress for 2012

- Development of more tools and resources in Health Impact Assessment
- Development of resources for working with public policy processes to produce healthy public policies
- Development of additional resources focusing on traffic calming
- Workshops and training on how to use our new knowledge synthesis method applicable to public policies

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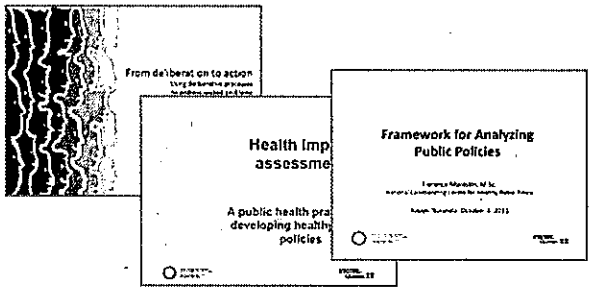

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- Method for Synthesizing Knowledge about Public Policies
- Health Impact Assessment: Practical Applications at the Local and Regional Levels

Themes

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- Deliberative Processes: What, Why and How?
- Ethics and Public Health: Key Reference Points and Applications
- Communication and Public Health Actions
- Wicked Problems and Deliberations: A Method for Establishing Dialogue
- Problem Framing: Implications for Policy Making

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- Transportation Policies and Health Inequalities: Avenues for Intervention
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Citizen Participation in Health Impact Assessment: An Overview of the Principal Arguments Supporting It

November 2011

Fact sheet
For up-to-date knowledge relating to healthy public policy

One of the mandates of the National Collaborating Centre for Healthy Public Policy (NCCHPP) is to inform Canadian public health practitioners about effective strategies for promoting the adoption of healthy public policies. Health Impact Assessment (HIA) currently represents one of the most structured practices available to public health actors. It is applied to policies developed by sectors other than that of health that can significantly affect health determinants. This fact sheet focuses on one of the methodological aspects of implementing health impact assessments, namely the role that can be assigned to citizen participation.

Definitions

Health Impact Assessment

Health Impact Assessment (HIA) can be defined as a combination of procedures, methods and tools by which a policy, program or project may be judged as to its potential effects on the health of a population (European Centre for Health Policy, 1999).

Citizen Participation

Citizen participation refers to all of the means that are used to involve, whether actively or passively, citizens or their representatives in an HIA process.

Arguments Favouring Citizen Participation

The founding documents of HIA, and in particular the Gothenburg Consensus paper (European Centre for Health Policy, 1999), identify citizen participation as one of the cornerstones of HIA. In fact, some practitioners and researchers maintain that an HIA remains incomplete without the effective and concrete participation of the community (Dannenberg, Bhatia et al., 2006, p. 266).

Basing our discussion on a review of the literature on HIA[1] carried out using predetermined terms,[2] we will explore, in this fact sheet, the four main arguments favouring citizen participation in HIA.

1) Supporting the Development of a Democratic Society

Authors writing about HIA stress that citizens have the right to express their view regarding the potential impacts of policies, programs and projects on their health. It is they who will have to cope with the consequences of decisions on a daily basis (Bauer & Thomas, 2006, p. 501). In and of itself, citizen participation can help correct a certain democratic deficit (Wright, Parry et al., 2005, p. 58), which is characterized by authors as the lack of transparency and legitimacy that plagues current governments, and which they attribute to the complex functioning of institutions and to decision-making processes that are often inaccessible to citizens. Citizen participation in HIA would also make it possible to highlight concerns about equity and social justice by involving individuals or groups that are often excluded or marginalized.

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1 Four databases indexing scientific journals covering public health and the social sciences were consulted for our literature review: PubMed, OvidSP, EBSCO Host and CSA Illumina. Searches were carried out using predetermined terms and were aimed at identifying all of the relevant publications published before July 2009, in both French and in English. Initial searches led to the identification of 443 potentially relevant articles. The title and abstract of each article were analyzed to determine their relevance and duplications were eliminated. All articles examining citizen participation in other sectors were eliminated (e.g.: environmental impact assessment). The relevant articles were then analyzed in greater depth, along with their references, so as to identify other publications of interest. Our final inventory included 51 articles focused on citizen participation in HIA.

2 Searches carried out using PubMed and OvidSP used the following terms and boolean operators: "health impact assessment" AND "consumer participation". The searches carried out in EBSCO Host and CSA Illumina used the following terms and boolean operators: (Public OR Communit* OR Citizen* Or Stakeholder*) AND (Participat* OR Consult* OR Involv* OR Engag*).

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2) Empowering Communities

This second argument constitutes one of the central ideas of contemporary declarations on health promotion, whether one considers the Declaration of Alma Ata (1978), the Ottawa Charter (1986), the Jakarta Declaration (1997) or, again, the Bangkok Charter (2005).

All of these declarations highlight the need for greater devolution of decision-making powers to communities. In this way, citizens can become the authors or co-authors of the political, social and economic transformations that are likely to affect their lives (Elliott & Williams, 2008, p. 1112).

The Four Benefits of Citizen Participation

1. Supporting the development of a democratic society
2. Empowering communities
3. Integrating citizens' knowledge and values into HIA
4. Formulating more sustainable recommendations

3) Integrating Citizens' Knowledge and Values into HIA

There is growing recognition that citizens possess a form of expertise that can greatly contribute to HIA (Elliott & Williams, 2008). It is they who are most knowledgeable about the values, needs, preferences, and dynamics that define their communities. Moreover, several authors maintain that a participatory approach would make HIA more scientifically robust by integrating the knowledge of citizens into the assessment process (Kjellstrom et al., 2003, p. 455). This is all the more pertinent given that practitioners and decision makers must often function in a very uncertain grey zone. Evidence produced by scientific research concerning the potential impacts of a policy is often insufficient, inconclusive, or subject to scientific controversy. Thus, decision makers cannot base their decisions strictly on scientific considerations and are confronted with complex social and ethical dilemmas (Elliott & Williams, 2008). Participatory HIA would provide decision makers with a citizen-based perspective on dilemmas for which science can provide only partial answers.

4) Formulating More Sustainable Recommendations

The participatory approach to HIA is intended to be consensual and cooperative (Lester & Temple, 2006, p. 916). Its aim is to give a voice to various stakeholders and thus identify changes that could be made to a policy (or program, or project) so it can meet the needs of the community involved. Such an approach would ensure wider acceptability of the recommendations generated by an HIA and thus prevent policy "boomerangs" (Mittelmark, 2001, p. 270) .

Conclusion

The arguments in favour of involving citizens in the HIA process are considerable, which explains why citizen participation is an integral part of the type of health impact assessment defined, among others, by the Gothenburg Consensus paper. HIA practitioners do not necessarily appeal to all of these arguments when they engage in citizen participation processes. For example, some emphasize the democratic value of citizen participation while others focus on participation as a means to gather information relevant to the evaluation. That said, whatever ends are sought, there remains a gap between the ideal of optimal participation described by the authors and the reality of implementation. In another fact sheet in this series, we have documented the risks and obstacles that impede its implementation. It is also important to consider that citizen participation can take many different forms; this might reduce some of the risks and obstacles identified in that fact sheet. One final fact sheet in this series documents some practical aspects relating to implementation.

Bibliography

Bauer, I. & Thomas, K. (2006). An evaluation of community and corporate bias in assessment tools. *International Social Science Journal, 58,* 501-514.

Dannenberg, A. L., Bhatia, R. et al. (2006). Growing the field of health impact assessment in the United States: an agenda for research and practice. *American Journal of Public Health, 96,* 262-270.

Elliott, E. & Williams, G. (2008). Developing public sociology through health impact assessment. *Sociology of Health & Illness, 30,* 1101-1116.

European Centre for Health Policy. (1999). *Health Impact Assessment: Main concepts and suggested approach. Gothenburg consensus paper.* Brussels: WHO-Regional Office for Europe. Retrieved from: http://www.hiaconnect.edu.au/files/Gothenburg_Consensus_Paper.pdf.

Kjellstrom, T., van, K. L. et al. (2003). Comparative assessment of transport risks-how it can contribute to health impact assessment of transport policies. *Bulletin of the World Health Organization, 81,* 451-457. Retrieved from: http://www.who.int/bulletin/volumes/81/6/kjellstrom0603.pdf.

Lester, C. & Temple, M. (2006). Health impact assessment and community involvement in land remediation decisions. *Public Health, 120,* 915-922.

Mittelmark, M. B. (2001). Promoting social responsibility for health: health impact assessment and healthy public policy at the community level. *Health Promotion International, 16,* 269-274.

Wright, J., Parry, J., & Mathers, J. (2005). Participation in health impact assessment: objectives, methods and core values. *Bulletin of the World Health Organization, 83,* 58-63. Retrieved from: http://www.who.int/bulletin/volumes/83/1/58.pdf.

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HIA and Inequities

HIA Series

March 2010

Preliminary version – for discussion

One of the mandates of the National Collaborating Centre for Healthy Public Policy (NCCHPP) is to inform Canadian public health actors[1] about effective strategies for promoting the adoption of healthy public policies. Health Impact Assessment (HIA) is currently the most structured practice available to actors in this field. It is applied to policies developed by sectors other than that of health that can significantly affect health determinants.

This brief document is the second of a series that examines the practice of HIA from various perspectives. The web-based versions of these documents include hyperlinks to other resources that can be accessed through the NCCHPP website.

Briefing Note

For up-to-date knowledge relating to healthy public policy

Introduction

Health Impact Assessment (HIA) is defined by the World Health Organization as *"a combination of procedures, methods and tools by which a policy, program 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"* (WHO, 1999).

This definition invites health practitioners to take not only the impacts on the health of the population into consideration, but also how these impacts could have differential effects on some groups of the population.

This brief paper intends to expand more specifically on this aspect of HIA.

What do we mean by health inequities?

Before going further on the topic of health inequities in the HIA process, it is useful to review certain distinctions in the definitions related to the concept.

- The literature on the topic generally distinguishes the notions of inequality and inequity. Inequality refers to unequal distribution in terms of health status within the population. Inequity refers to the fact that in some situations these differences are unnecessary and unjust (Hogstedt, Moberg, Lundgren & Backhans, 2008).
- Some disparities in the health status of individuals can be due to biological or genetic factors, or to chance. In these cases, we refer to the notion of inequality, However, we refer to inequity when these disparities are persistent and systematically affect specific groups of people (for example, ethnic groups, Indigenous peoples, or low-income persons) and because they are often due to structural factors such as unhealthy physical and social environments, poor working conditions, or lack of access to good jobs and education (Butler-Jones, 2008).
- As such, inequalities in health that are systematically associated with underlying social disadvantages and that reflect unequal opportunities for better health are considered to be unjust, unfair and avoidable, and are commonly referred to as 'health inequities'
- Equity in health refers to the absence of avoidable health differences among populations or population groups defined socially, economically, demographically, or geographically (WHO, 2009).

The distinction between the terms "inequality" and "inequity" is not always the subject of consensus, and these terms are sometimes

[1] Here, the term 'actors' refers to people working in the health field at whatever level (practitioners, health promoters, etc).

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used interchangeably, whether explicitly or not. The World Health Organization (WHO) uses the term "health inequity," to designate avoidable and, thus, unfair, differences in health among population groups (WHO, 2008). It is this term, understood in this way, which will be used here.

The role of HIA in combating health inequities

Concern among public health actors for health inequities stems from the fact that improvements in health status at the population level usually involve a reduction in health disparities between sub-groups in the population. In order to reduce these disparities, particular attention must thus be paid to the most vulnerable individuals and groups if we wish to improve their health status. At the policy level, three broad types of strategies are used:

- those that call for the allocation of specific resources to these groups (for example, a program that targets the homeless);
- those aimed at making existing resources more accessible (for example, subsidies to extend access to daycare);
- those aimed at reducing the negative effects of programs and policies designed for the general population but which have the potential to create, maintain or widen existing gaps.

HIA acts mainly on the last strategic level by estimating the effects on health as well as the distribution of these effects within the population.

The HIA process has sometimes been adapted so that it would account exclusively for impacts on health inequities, resulting in guides and tools for addressing this issue (For example see, Lester, Griffiths, Smith & Lowe, 2001). It has been observed that HIA practitioners do not always take an equity focus into account in a satisfactory manner (Harris-Roxas, Simpson & Harris, 2004). This was discussed by an international round table of HIA practitioners, and it was generally agreed that it would be better to strengthen the equity dimension within a generic HIA framework rather than to develop a parallel practice focused solely on how policies affect inequities (Douglas & Scott-Samuel, 2001). This document has been written following this perspective.

Considering health inequities in the HIA process

As its definition implies, HIA aims to make explicit the potentially differential effects of a policy or program on various population groups. Thus, the practice of HIA can help reduce health inequities by informing policy makers of the probable negative effects (increased disparities) or positive effects (decreased disparities) of a proposed policy or program.

For this reason, it has been introduced by many governments (for example, those of Norway and New Zealand) as a means of combating health inequities. Moreover, it is supported by the WHO, which, in a follow-up to the report by the Commission on Social Determinants of Health, urged member states to take health equity into account in all policies aimed at acting on the social determinants of health (WHO, 2009). In Canada, the report of the Senate Subcommittee on Population Health also suggested that this practice be applied to Canadian public policies (Keon & Pépin, 2008).

Concern about inequities as a core element of HIA

The practice of HIA, which is based on health promotion principles, automatically incorporates concern for health inequities. This is done by ensuring that the differential effects of a proposed policy on groups within a population are systematically identified through inquiry into how the policy's effects disadvantage certain vulnerable groups. It is important, also, to investigate the cumulative effects of these policies. Indeed, a single policy may produce minor effects, but an

accumulation of minor effects can have major repercussions for the continuation or growth of health disparities.

Integrating equity considerations into each stage of the HIA process

The best way to systematically take health inequities into account is to integrate this concern into each stage of the HIA process, and to do this for all proposed policies or programs being analyzed.

At the screening stage

The screening stage is a systematic process that aims to determine if aspects of a policy or program can potentially affect the health of the population and whether conducting an HIA is appropriate or not for a particular project or policy. Tools developed for carrying out this stage generally incorporate analysis grids listing the determinants of health in relation to which the public policy in question should be examined. Analysis grids that integrate concern for health inequities can simultaneously examine the effects of a proposal on the determinants of health and the distribution of these effects within vulnerable groups, sometimes through the use of two separate columns (see, for example, *An Easy Guide to Health Impact Assessment for Local Authorities* (Egbutah & Churchill, 2002)). Sub-groups may be defined geographically, economically, according to cultural identity, or based on other factors linked to age or to mental or physical condition, for example, that may result in fragility.

At the scoping stage

The scoping stage serves two main functions: identification of the type of information needed for the impact analysis and of the method to be used to gather that information. Thus, taking health inequities into account means identifying the sub-groups about which specific information is needed as well as the nature of the information needed, if this differs from that which will be relevant to the overall population. Including concern for health inequities throughout the HIA process also implies considering the feasibility of seeking input from persons in sub-groups that may be negatively affected by the proposed policy under study, to get their perspective on how the policy might affect their health.

At the appraisal stage

At this stage, health impacts are analyzed on the basis of the results obtained during the previous stages in order to evaluate the scope and scale of these impacts. At the epidemiological level, it may be difficult to clearly establish the potential effects of a policy on specific groups within the population. Faced with this difficulty, it is sometimes suggested that the direction rather than the magnitude of effects be identified (Parry & Scully, 2003). It can also be very difficult to identify all sub-groups, and to make appropriate choices between groups considered vulnerable and the general population. It is sometimes necessary to make compromises when choosing between improving the health status of the general population, improving the health of the most vulnerable people and reducing disparities. The formation of a multidisciplinary scientific committee, including partners from a variety of backgrounds, is therefore recommended as a way to resolve the dilemmas associated with these choices (Ison, 2000).

At the reporting stage

Reporting involves identifying potential health effects and their distribution within the population. Reporting also includes suggesting possible changes. This stage should be guided by transparency. Thus, the report lays out the rationale behind the choice of sub-groups analyzed, as well as any uncertainty surrounding the results reported, if applicable. It is sometimes suggested that results be presented in the form of matrices, which makes it possible to illustrate various trends within sub-groups and within the population in general (Mahoney, Simpson, Harris, Aldrich & Stewart-Williams, 2004). (See, for example, the guide entitled *Improving Health and Reducing*

Inequalities, Welsh Health Impact Assessment Support Unit).

At the evaluation stage

In the literature, this stage is presented in three ways (Ison, 2000). The first stresses the importance of monitoring the effects of implementing the policy whose health impacts were assessed. In this case, it is necessary to identify indicators that will be monitored to assess the real effects on inequities of the policy choice. Alternatively, this stage is conceptualized as a reflective exercise, whose purpose is to review the process as a whole. This involves a critical analysis of the efforts made to take into account the differential effects of the proposed policy. Finally, the third approach advises practitioners to assess the influence the process has had on decision making. To this end, the question of how decision makers reacted to the information about differential effects and to the proposed changes should be examined.

For further information

HIA guides that consider health inequities

- Equity-Focused HIA Framework (Australia)
- A Health Equity Assessment Tool (Equity Lens) for Tackling Inequalities in Health (New Zealand)
- Whanau Ora Health Impact Assessment (New Zealand)
- Health Inequalities Impact Assessment: Screening; Rapid Appraisal Guidance and Notes (United Kingdom)

References

Butler-Jones, D. (2008). *The Chief Public Health Officer's Report on the State of Public Health in Canada, 2008*. Ottawa. Public Health Agency of Canada.

Douglas, M. & Scott-Samuel, A. (2001). Addressing health inequalities in health impact assessment. *Journal of Epidemiology and Community Health*, 55, 450-451.

Egbutah, C. & Churchill, K. (2002). *An Easy Guide to Health Impact Assessments for Local Authorities.* Luton, Bedfordshire Luton Borough Council. 61 p.

Harris-Roxas, B., Simpson, S., & Harris, E. (2004). *Equity Focused Health Impact Assessment: a literature review*. Sydney Centre for Health Equity Training Research and Evaluation (CHETRE) on behalf of the Australasian Collaboration for Health Equity Impact Assessment (ACHEIA). 74 p.

Hogstedt, C., Moberg, H., Lundgren, B. & Backhans, M.(2008). *Health for all? A critical analysis of public health policies in eight European countries*. Stockolm: Swedish National Institute of Public Health.

Ison, E. (2000). *Resource for Health Impact Assessment. Volume I: The Main Resource.* London NHS Executive London. 198 p.

Keon, W. J. & Pépin, L. (2008). *Population Health Policy: Issues and Options.* Fourth Report of the Subcommittee on Population Health of the Standing Senate Committee on Social Affairs, Science and Technology Ottawa. Senate of Canada.

Lester, C., Griffiths, S., Smith, K., & Lowe, G. (2001). Priority setting with Health Inequality Impact Assessment. *Public Health, 115,* 272-276.

Mahoney, M., Simpson, S., Harris, E., Aldrich, R., & Stewart-Williams, J. (2004). *Equity-Focused Health Impact Assessment Framework.* Australasian Collaboration for Health Equity Impact Assessment (ACHEIA). 45 p.

Ministry of Health (2002). *Reducing Inequalities in Health.* Wellington Ministry of Health, New Zealand.

Parry, J. & Scully, E. (2003). Health impact assessment and the consideration of health inequalities. *Journal of Public Health Medicine, 25,* 243-245.

Quigley, R., Cave, B. et al. (2005). *Practical lessons for dealing with inequalities in health impact assessment.* London NHS National Institute for Health and Clinical Excellence. 20 p.

World Health Organization (WHO) - Regional Office for Europe, European Centre for Health Policy (1999). *Health Impact Assessment: Main concepts and suggested approach (Gothenburg consensus paper).*

World Health Organization (WHO) (2008). *Closing the Gap in a Generation. Health equity through action on the social determinants of health (Final Report Executive Summary).* Geneva. World Health Organization.

World Health Organization (WHO) (1-23-2009). Reducing health inequities through action on the social determinants of health. EB124.R6. 124th Session. Agenda item 4.6.

Further reading

Quigley, R., Cave, B., Elliston, K., Pratt, A., Vohra, S., & Taylor, L. (2005). *Practical lessons for dealing with inequalities in health impact assessment.* London: National Institute for Health and Clinical Excellence.

Simpson, S., Mahoney, M., Harris, E., Aldrich, R., & Stewart-Williams, J. (2005). Equity-focused health impact assessment: A tool to assist policy makers in addressing health inequalities. *Environmental Impact Assessment Review, 25,* 772-782.

Taylor, L., Gowman, N., & Quigley, R. (2003). *Addressing inequalities through health impact assessment.* Learning from Practice Bulletin, Health Development Agency.

Mackenbach, J. P., Veerman, J. L., Barendregt, J. J. M., & Kunst, A. E. (2004). Health inequalities and HIA. In J. Kemm, J. Parry, & S. Palmer (Eds.), *Health Impact Assessment,* pp. 25-37. Oxford: Oxford University Press.

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La version française est disponible sur le site Internet du CCNPPS au www.ccnpps.ca
This document is a preliminary version. We invite reader feedback, which can be sent to ncchpp@inspq.qc.ca

Online Introductory Course on the Health Impact Assessment (HIA) of Public Policies

July 2012 version

Fact sheet

For up-to-date knowledge relating to healthy public policy

This short document outlines the main parameters of a new online course, available in French and in English, devoted to the health impact assessment (HIA) of public policies.

The course will provide practitioners in the public health field and other related sectors, as well as decision makers intent on becoming involved in this sector, with access to resources for developing and improving their competencies related to the health impact assessment of public policies. Most of the modules presented are equally relevant to the analysis of programs and projects.

HIA is most commonly defined as a combination of procedures, methods and tools by which a policy, program or project may be judged as to its potential effects on the health and well-being of a population (European Centre for Health Policy, 1999). The effective practice of HIA makes it possible to minimize negative and maximize positive health effects.

Despite the growing popularity of HIA throughout the world, few training opportunities are offered in North America and none are offered in French. It is within this context that a training project has been undertaken by the National Collaborating Centre for Healthy Public Policy in partnership with the Département de médecine sociale et préventive at the Université de Montréal, and with the assistance of the Unité de développement des compétences of the Institut national de santé publique du Québec.

This bilingual course has been designed using a competency-based approach. Its aim is to provide professionals with the know-how required to properly conduct a high-quality HIA in collaboration with relevant stakeholders.

To define the course's contents, the course development work group first produced an inventory of required competencies, in consultation with HIA theoreticians and practitioners. Next the group outlined the course structure to allow for assimilation of the various elements of knowledge required for the practice of HIA. Various specialists were then mandated to write the course material.

The course includes four mediatized modules, comprising a combination of pedagogical strategies. These include the reading of online material and scientific articles, the use of discussion forums, situational scenarios, role playing and a final training project. Throughout the course, students benefit from an instructor's support.

Offering this course online presents several advantages that make it particularly well-suited to adult practitioners. These include geographic accessibility, adaptation to individual work rhythms and the opportunity to achieve specific objectives without requiring the presence of an instructor.

The course's pedagogical structure may be consulted on the reverse of this page. For more information about the course, please feel free to contact Doina Malai (doina.malai@inspq.qc.ca).

The National Collaborating Centre for Healthy Public Policy (NCCHPP) seeks to increase the expertise of public health actors in the area of healthy public policy through the development, transfer and exchange of knowledge. The NCCHPP is part of a Canadian network of six centres financed by the Public Health Agency of Canada. Located across Canada, each National Collaborating Centre for Public Health is specialized in a specific area, but all share a common mandate to promote knowledge synthesis, transfer and exchange. The network of Centres not only serves to disseminate the specific contributions of the Centres, but also provides focal points for the exchange and common production of knowledge. The NCCHPP is hosted by the Institut national de santé publique du Québec, a Canadian leader in the field of public health.

Production of this document was made possible through financial support from the Public Health Agency of Canada in the form of funding for the NCCHPP. The views expressed here do not necessarily reflect the official position of the Public Health Agency of Canada.

Centre de collaboration nationale sur les politiques publiques et la santé

National Collaborating Centre for Healthy Public Policy

Institut national de santé publique Québec

ONLINE INTRODUCTORY COURSE ON THE HEALTH IMPACT ASSESSMENT (HIA) OF PUBLIC POLICIES

Preliminary information
- Basic concepts of population health
- Available sources of public health information

Time required
- 15 hours online
- 30 hours of individual work
- For a total of 45 hours

Evaluation of coursework
- 10% discussion forums focused on health determinants
- 15% multiple choice questionnaire at the end of module 2
- 25% role playing focused on knowledge brokering
- 50% on final integrative project based on a simulated scenario

Module 1
Introduction
Approx. 1h

- **Unit 1** General information and round of introduction of participants

Module 2
Historical, methodological and scientific bases of HIA
Approx. 10h

- **Unit 1** History of HIA
- **Unit 2** Health determinants, inequalities and inequities
- **Unit 3** Public policy development process
- **Unit 4** Types of IA HIA models

Module 3
Carrying out high-quality HIAs
Approx. 13h

- **Unit 1** Screening
- **Unit 2** Scoping
- **Unit 3** Analysis
- **Unit 4** Recommendations
- **Unit 5** Evaluation & monitoring
- **Unit 6** Quality standards and principles
- **Unit 7** Implementation conditions Project management

Module 4
Knowledge transfer and decision making
Approx. 11h

- **Unit 1** Intersectoral collaboration Role of the community and the population
- **Unit 2** Decision-making process
- **Unit 3** Knowledge brokering concepts
- **Unit 4** Knowledge sharing

Final project
Approx. 10h

KANSAS HEALTH INSTITUTE

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ISSUE BRIEF

August

2012

HEALTH IMPACT ASSESSMENTS HELP LINK POLICY DECISIONS WITH EFFECTS ON PUBLIC WELL-BEING

Introduction

Chronic conditions like heart disease, stroke, cancer and diabetes are among the most common, costly and preventable of all health problems in the United States. According to the Centers for Disease Control and Prevention (CDC), chronic diseases cause more than seven out of 10 deaths among Americans each year. Like the rest of the United States, Kansas has seen an increase in the rate of chronic conditions among its residents that contribute to higher health care costs and poor quality of life. In 2010, about one-third of Kansas adults were obese and more than one in four adults in Kansas had arthritis.

To address the prevalence of chronic disease, policymakers can start to think about health in a new way. Helping Kansans achieve good health requires a multifaceted approach, such as improving access to affordable, quality health care services and creating an environment that helps them make healthy choices.

As discussed in this brief, health impact assessments (HIAs) can be a valuable tool for policymakers seeking to understand the health impacts of the policies they consider.

The National HIA Landscape

Because various factors affect well-being — including behavior, education, genetics and environment — policymakers can try new strategies to address chronic disease. The Health in All Policies approach encourages policymakers to collaborate across sectors to create social and physical environments to promote health. HIAs are a practical way to implement Health in All Policies because they bring health into policy discussions and offer a reasonable projection of health effects. HIAs have been used in other countries for some time but are a rapidly emerging practice in the United States.

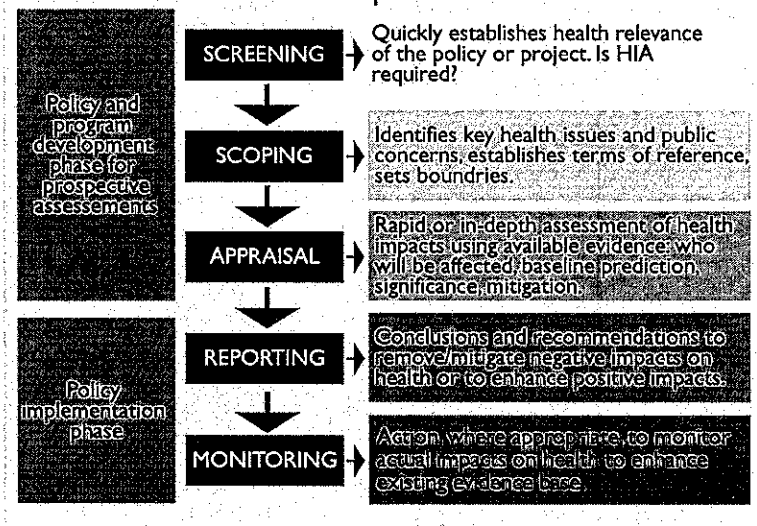
As seen in Figure 1 (page 2), HIAs involve steps that are similar to those used in other types of decision-making tools, including environmental

KEY POINTS

- A health impact assessment (HIA) is an informational tool designed to help decision-makers consider the health implications of proposed policies, especially those that don't appear to have direct connections to health.
- HIAs encourage collaboration among sectors, allow policymakers to use resources effectively and help officials identify hidden factors that affect health.
- Since 1999, policymakers in more than 30 states have used HIAs to inform many decisions, including policies related to transportation, housing, agriculture, energy and environment.
- Kansas policymakers could use HIAs to bring health into the state and local decision-making process.
- The Kansas Health Institute and research partners conducted the first HIA in Kansas in 2012. The HIA examined the potential health effects associated with casino development in southeast Kansas — from benefits associated with more jobs and tourism to drawbacks associated with pathological gambling.

Figure 1. Health Impact Assessment Steps

HIA follows the same basic steps.



The HIA process varies in scale and scope.

Mini, desktop	Maxi, comprehensive, inclusive
Rapid	Lengthy
Single health outcome	Multiple outcomes
One person	A range of stakeholders, including community
Simple model	A range of models and tools
Quick decision	In-depth, consensus-based decision
Inexpensive	Expensive

Source: Adapted from WHO, Health Impact Assessment Tools and Methods.

impact assessments. The HIA process can include different research methods, such as literature review, data analysis and community engagement. This process is flexible for each HIA and depends on the amount of time and resources available to effectively inform policymakers.

In the United States, the CDC and other nationally recognized health agencies support the use of HIAs. In addition, the Robert Wood Johnson Foundation and The Pew Charitable Trusts collaborated to create the Health Impact Project, a national initiative designed to promote the use of HIAs as a decision-making tool for policymakers.

Since this national HIA initiative launched in 2009, several states — including Washington, Colorado, Oregon and Maryland — have used HIAs as part of their policymaking process. For example, an HIA analyzed the redevelopment of the Derby District in Colorado's Commerce City commercial core. Policymakers used the HIA findings while planning the district to create an area that encouraged physical activity and increased access to healthy foods.

HIA Development in Kansas

Three bills considered in the 2012 Kansas legislative session were in part designed to clear the way for construction of a casino in Crawford County or Cherokee County in southeast Kansas. The Kansas Health Institute, in partnership with the University of Kansas School of Medicine–Wichita, launched the state's first HIA in January 2012 to identify the potential health impacts of developing a southeast Kansas casino. The project, funded with a grant from the Health Impact Project, considered health issues within a framework of social, economic and physical factors. It also focused on building capacity to conduct future HIAs in Kansas and showing state and local policymakers the benefits of using HIAs.

Policymakers may find it challenging to recognize how some of their decisions might affect the health of Kansans, particularly when those decisions do not seem to have direct health consequences. As shown in Table 1, the HIA findings outline how a new casino could affect the health of southeast Kansans. The Kansas HIA uncovered potential health benefits — such as reduced likelihood of premature death and increased life quality and expectancy associated with job creation — and health risks — including injury, chronic fatigue and obesity associated with pathological gambling — that were not part of previous discussions of casino development.

Concerns about the economy and health are not new for southeast Kansas residents. More than

27 percent of Crawford County and Cherokee County children live in poverty, compared to 18 percent of all Kansas children. As the 2012 County Health Rankings show, Crawford and Cherokee counties lag behind many other Kansas counties. The result is that many residents are sicker during their lifetimes and die younger than their counterparts in other parts of the state.

HIA Research, Findings and Recommendations

The HIA used multiple information sources — including a review of relevant literature, interviews with key local and state leaders, focus groups with community members and secondary data analysis — to project potential health impacts of a southeast Kansas casino.

The HIA findings focus on three main casino impacts: employment, tourism and access to gambling. Based on these, the HIA research team developed recommendations with input from community members to maximize the potential benefits of a casino development. Selected recommendations follow.

Employment

The presence of a casino in Cherokee County or Crawford County could increase local employment levels. Tangible benefits (such as insurance and income) and intangible benefits (such as a sense of meaning) of employment may have positive impacts on health. But the extent of positive health effects depends largely on the physical, psychological and social job environment. Several negative effects have been associated with casino employment, including shift work and secondhand smoke exposure.

Table 1. Summary Health Impacts of a Casino in the Southeast Kansas Gaming Zone (Crawford and Cherokee Counties)

Health Factor or Outcome	Expected Health Impact	Quality of Evidence
EMPLOYMENT		
Casino jobs	Positive	****
Health insurance	Positive	****
Income	Positive	****
Public assistance	Mixed	**
Shift work and sleep disturbance	Negative	**
Secondhand smoke exposure	Negative	****
Risk behaviors	Negative	***
Unemployment rate	No effect	***
TOURISM		
Leisure and hospitality industry jobs	Positive	****
Health insurance	Positive	***
Income	Positive	***
Per capita income	Positive	**
Population growth	Mixed	***
Property crime, violent crime	Negative	***
Traffic volume	Negative	**
ACCESS TO GAMBLING		
Entertainment value	Positive	***
Divorce	Mixed	**
Child abuse and neglect, domestic violence	Negative	****
Unsafe sex and STDs	Negative	***
Alcohol (ab)use, alcohol-related motor vehicle injuries and fatalities	Negative	****
Suicide	Negative	***

Source: Kansas Casino Health Impact Project, KHI 2012.

Legend

Expected Health Impact
Positive: Changes that may improve health
Mixed: Changes can be positive as well as negative
Negative: Changes that may worsen health
No effect: No identified effect on health

Quality of Evidence
**** 10 + strong studies
*** Five to 10 strong studies and data analysis
** Five or more weak or moderate studies or mixed results
* Fewer than five studies

Recommendations:

- Provide health insurance to employees.
- Eliminate smoking in and around the casino.

- Create workforce development programs and educational opportunities.
- Provide workplace wellness services, especially for late-shift employees.

Tourism

Tourism can have a number of benefits for rural communities, especially related to revenue and job creation. The casino HIA found that Cherokee and Crawford counties may experience an 11 percent increase in overnight tourism and related transient guest tax receipts following the opening of a casino. However, tourism also can mean population growth that can have positive and negative effects. An increase in income per capita and population growth may attract new health care providers and improve access to health care services. But population growth in Cherokee and Crawford counties may lead to increases in crime and traffic volume.

Recommendations:

- Ensure that the casino functions as a destination by creating an array of complementary attractions.
- Monitor and respond to any potential increase in crime.
- Enhance DUI enforcement on major roads.
- Discourage crime through facility design, such as safe entrances, adequate lighting and video surveillance.

Access to Gambling

Access to gambling can lead to problem or pathological gambling, which is related to nicotine dependence, substance use disorders, depression and insomnia. Pathological gambling also has been associated with higher rates of child abuse and neglect, domestic violence, unsafe sex and divorce.

Recommendations:

- Implement a tracking and exclusion system for gambling addicts.
- Educate new students at schools in the region about problem/pathological gambling.
- Train primary care physicians to screen for problem gambling behaviors at medical homes.
- Strengthen local addiction services to treat and prevent gambling addictions and comorbidities.

Conclusion

In recent decades, health practitioners and researchers have realized that health should be more broadly factored into the policymaking process, although the link between public policies and factors affecting health is not always clear. HIAs help by providing in-depth analysis of the policies' potential effects on health so policymakers can make decisions that more effectively promote well-being and address health problems.

Legislation related to a new casino in southeast Kansas may not seem to have direct connections to health, making the issue a good fit for the Kansas research team. The casino project introduced Kansas to HIAs, and the team will build on this experience during two upcoming HIAs in Kansas communities.

As more communities are involved with HIAs, more Kansas policymakers will be able to recognize their value and use them to inform their policy decisions. They also may consider asking state agencies to conduct HIAs on policies with possible health implications. When health is considered in all policies, it is more likely that policies put in place will result in safer and healthier communities.

About the Issue Brief
This publication is based on work done by Tatiana Y. Lin, M.A., Catherine C. Shoults, M.P.H., and Sida Niu. It is available online at www.khi.org. The opinions expressed are those of the authors and do not necessarily reflect the views of the Health Impact Project, Robert Wood Johnson Foundation or The Pew Charitable Trusts.

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Introduction to HIA

HIA Series

November 2009

Preliminary version – for discussion

One of the mandates of the National Collaborating Centre for Healthy Public Policy (NCCHPP) is to inform Canadian public health actors[1] about effective strategies for promoting the adoption of healthy public policies. Health Impact Assessment (HIA) is currently the most structured practice available to actors in this field. It is applied to policies developed by sectors other than that of health that can significantly affect health determinants.

This brief document is the first of a series that examine the practice of HIA from various perspectives. The online versions of these documents include hyperlinks to other resources that can be accessed through the NCCHPP website.

What is HIA?

History

Since the mid-1990s, the practice of using Health Impact Assessments to influence public policies has been gaining in popularity throughout the world. HIA was built on the success in the field of environmental protection, where Environmental Impact Assessments (EIA) for large infrastructure projects is now standard practice in most industrialized countries, including Canada. HIA was first developed as a complementary tool within EIAs to examine the potential impacts of a project on human health. In recent years, the practice of HIA has evolved and may now be applied to any policy proposal with potentially significant impacts on the socio-economic and physical determinants of the health of the population, regardless of its presumed impact on the environment.

Foundations

HIA is often presented as a way to take action in one of the priority areas mentioned in the *Ottawa Charter for Health Promotion*, namely: Promoting healthy public policy (WHO, 1986). Indeed, the principles and values set forth in the *Ottawa Charter,* such as promoting a holistic approach to health, the values associated with democracy, equity, sustainable development and the ethical use of evidence are the cornerstones of HIA (International Association for Impact Assessment, 2006). Literature on HIA traces its origins back to the convergence of the two trends we have just mentioned: Environmental Impact Assessment and Health Promotion (Kemm *et al.*, 2004).

Goals

In the area of public policy, HIA is both a process and a tool that provides non-public health sector policy- and decision-makers with information about the possible consequences of their decisions on the overall health of a population or on specific groups within that population.

The WHO defines HIA as *a combination of procedures, methods and tools by which a policy, program 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. (WHO, 2005)*

In the field of public policy, HIA may be defined as follows:

- HIA is a process that aims to provide prospective predictions regarding the potential impacts of a proposed project/policy on the health of the population.

[1] Here, the term 'actors' refers to people working in the health field at whatever level (practitioners, health promoters, etc).

Briefing Note

For up-to-date knowledge relating to healthy public policy

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- HIA may be used as soon as a policy proposal has been developed to the point that its potential impacts may be analyzed, but before decisions about it have been made, so that policy content may be influenced accordingly.
- HIA aims to add value to the decision-making process by identifying unexpected and unwanted health impacts, which would be overlooked by other policy planning mechanisms.
- The HIA process integrates information from scientific literature into information provided by stakeholders who are affected by the adoption and implementation of a project/policy (including decision-makers, stakeholders and the general public) so that a broader context may be considered.
- Taking health inequities into account is an inherent part of the HIA process.

While it remains an evaluative research activity, HIA is a method that helps make public health information available during the decisional processes of non-public health policy development (Kemm, 2001).

HIA — A five-step process

HIA practice guides generally call for a five-step process. These steps (and the related tools that have been developed over the years by a variety of countries and public health organizations[2]) provide a framework and structure for HIA implementation. The HIA process is conducted as follows:

Step 1: Screening

The screening process addresses two central questions:

- Does the project/policy proposal contain elements that could have a negative impact (to be avoided) or positive effects impact (to be fostered) on the health of the population?
- If so, are these impacts substantial enough to warrant an in-depth analysis?

If the answer to these two questions is "yes," the process continues and proceeds to the second step, Scoping.

As part of the screening process, some practitioners include questions to ascertain the relevance of conducting an HIA based on their project/policy context. In some situations, it may be wise to ascertain whether allotted time is sufficient, whether key resources are available and/or whether there is a realistic potential to influence decision making (Mahoney *et al.*, 2004).

Several tools have been established by the HIA community of practice to facilitate and systematize the tasks related to the screening process. The tool most often used is a grid to assess the social, economic and physical determinants of health, these determinants being used to review the elements of a proposal. In this way, the impact (positive or negative) of a proposed project/policy on the determinants of health and the scope/magnitude of that impact may be determined, while also considering which sub-groups of the population are most likely to be affected.

It is generally recommended that this step be conducted with a multi-disciplinary team comprised of representatives from decision-making milieus and from the population group that will be affected by the proposed project/policy. Including a variety of participants at this point allows for a more comprehensive preliminary perspective on the policy, which is vital, as this exercise will influence the rest of the process.

Step 2: Scoping

Scoping consists in planning the subsequent step of HIA (Appraisal), in which the impacts predicted during Screening will be examined. Scoping addresses the following questions:

[2] Many such resources (e.g., guides, courses, analytical tools, assessment reports) from government and academic organizations are available online. Some of these reference sites may be accessed through the NCCHPP website at the following address: http://ncchpp.ca/en/contenu.aspx?sortcode=2.1.6.7.

- What information will be needed to estimate the scope and potential impacts of the elements identified during Screening?
- How, when, by whom, and with whom will the collection and analysis of the information be conducted?
- How much time will be available to study the predicted impacts?

The answers to these questions will provide clear markers for the various actors participating in the appraisal stage in addition to determining expectations regarding the nature and scope of the outcomes.

Step 3: Appraisal

During this step, the impacts themselves are appraised. Two activities are carried out at this time: the collection of information and its analysis.

There are generally four types of information to collect:

- Precise information about the characteristics of a project/policy. This type of information is usually not readily available to public health actors.
- Scientific publications, obtained through a literature review and consultations with experts.
- The profile of the population that will be affected by the proposed project/policy. This information is generally obtained from administrative sources.
- Information from the population is obtained during consultation activities (such as discussion groups and deliberative dialogues). The objective here is not so much to measure the social acceptability of the proposal as to determine indications of the probable impacts involved in implementing a given project/policy in the targeted milieus. These impacts may differ from those typically found in HIA literature.

It is recommended that after the data has been collected, the analysis and interpretation of the findings be conducted by a multi-disciplinary team composed of (social, epidemiological, environmental and other) experts from different scientific backgrounds.

A group of authors (Mindell *et al.*, 2006) has developed a guide for collecting scientific information, which takes into account the time constraints that must be dealt with during an HIA. These authors found it was possible to obtain valuable information working within limited timeframes by following a rigorous process.

Step 4: Report

In the interest of transparency, it is generally recommended that the findings from Screening, Scoping and Appraisal be compiled in a written report.

The report will also contain recommendations from the HIA team. The team may recommend removing certain elements of the project/policy that could have negative impacts; suggest changing certain aspects to avoid negative impacts or foster the positive impacts on health; and/or make provision for protection measures to be established if it is impossible to remove or change measures that will likely generate negative impacts. Since HIA is a process that supports decision-making, it is important to consider the economic, social and political feasibility of any proposed changes.

Step 5: Monitoring

Two areas of monitoring operations are highlighted in HIA literature. The first area of monitoring is a preliminary follow-up to measure the real impacts of implementing a project/policy. The idea here is to measure the extent to which predicted health impacts have materialized while gauging the efficacy of mitigation measures, as required.

However, this type of follow-up is not always possible, since it is dependent on the nature and scope of a project/policy, the contexts in which its implementation takes place and the capabilities of the team conducting the HIA. An HIA team may recommend that a

project/policy include a clause about monitoring for health impacts.

The second area of operations in monitoring is evaluating the HIA process. This evaluation reviews all of the activities undertaken, the usefulness of the tools deployed, the participation of the various actors involved and the degree to which HIA information was used by decision-makers. This step may be viewed as a reflexive exercise in that improvements regarding current practices are considered in tandem with an evaluation of the HIA's potential to influence the decision-making process in the future.

HIA: Strengths and Weaknesses

HIA is often presented as a process that promotes the implementation of healthy public policy. But despite the advantages of this process, undertaking HIA is not without its challenges. Literature on HIA lists a number of strengths and weaknesses, including those mentioned below:

Adaptability

The HIA process is adaptable. Despite its standardized procedure, it may be used for a variety of purposes and adapted to different levels of decision making (local, national or international). This adaptability means that HIA is may be used to generate health-related data, to promote citizen participation and to facilitate public administration (Bekker, 2007).

Structured and systematic planning

By adopting HIA as a common process, a community of practice has been established, within which it is possible to discuss concrete experiences and the effectiveness of tools in use. The resulting improvement in practices and tools promotes a systematized, rigorous and easy means of communicating with partners and peers alike.

Contextualized feasibility

Because HIA is conducted parallel to the decision-making process, it more fully contextualizes the implementation of a project/policy and thereby generates recommendations that take the real feasibility of the project/policy into account.

Variable accuracy

One of the HIA's greatest challenges is to precisely predict a policy's health impacts (Mindell *et al.*, 2001). The nature and scope of a project/policy studied influences the accuracy of predictions. For example, in the case of social policies whose impacts are likely to result from a series of chain reactions, it is difficult to make precise predictions. Impacts on health determinants, the strength of the links between them and the state of health described in the literature are generally the most useful data.

Constraints on adaptability

For the HIA process to be useful, its practitioners must adapt it to the decision-making process of the policy being assessed and not expect decision-making to adapt to the HIA (Putters, 2005). Political considerations surrounding the choice of a policy, such as opposing interests, the dominant ideology or fluctuations in demand, are further constraints that must be given due consideration by HIA practitioners.

Dependency on resources and capacities

For decision-makers, HIA adds value by providing information that would otherwise be impossible to obtain from the usual policy analysis process. To obtain this information, access to certain resources (human, financial and technological) in addition to multiple skills and complementarities (e.g., reviewing literature, facilitating groups, generating reader-friendly scientific information for the general public) are required.

Despite these issues, HIA remains, to date, one of the best structured practices available when working on public policies. It supports decision-making by taking into account a wide range of scientific and contextual data. Awareness vis-à-

vis the determinants of health has been demonstrably improved through HIAs, especially among decision-makers who work outside the health sector (Wismar, 2007). Indeed, the popularity of current HIA practice the world over has resulted in the generation of vast constellations of knowledge, which can be used by any new practitioner in his practice.

References

Bekker, M. (2007). *The politics of healthy policies. Redesigning Health Impact Assessment to integrate health in public policy*. Delft: Eburon.

Kemm, J. (2001). Health Impact Assessment: a tool for Healthy Public Policy. *Health Promotion International,* 16, 79-85.

Kemm, J., Parry, J., & Palmer, S. (Eds.) (2004), *Health impact assessment*. Oxford: Oxford University Press.

Mahoney, M., Simpson, S. *et al.* (2004). *Equity-Focused Health Impact Assessment Framework.* Newcastle: Australian Collaboration for Health Equity Impact Assessment (ACHEIA).

Mindell, J., Biddulph, J. P. *et al.* (2006). *A Guide to Reviewing Published Evidence for Use in Health Impact Assessment.* London: London Health Observatory.

Mindell, J., Hansell, A. *et al.* (2001). What do we need for robust, quantitative health impact assessment? *Journal of Public Health Medicine,* 23, 173-178.

World Health Organization (WHO) (1986). *Ottawa Charter for Health Promotion.* Ottawa: Health and Welfare Canada.

World Health Organization (WHO) (1999). *Health Impact Assessment: main concepts and suggested approach. The Gothenburg Consensus paper.* Brussels: WHO Regional Office for Europe (European Centre for Health Policy).

Putters, K. (2005). HIA, the next step: Defining models and roles. *Environmental Impact Assessment Review,* 25, 693-701.

Wismar, M., Blau, J.; Ernst, K., & Figueras, J. (Eds.) (2007), The Effectiveness of Health Impact Assessment. Scope and limitations of supporting decision-making in Europe. Copenhagen: European Observatory on Health Systems and Policies, World Health Organization.

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