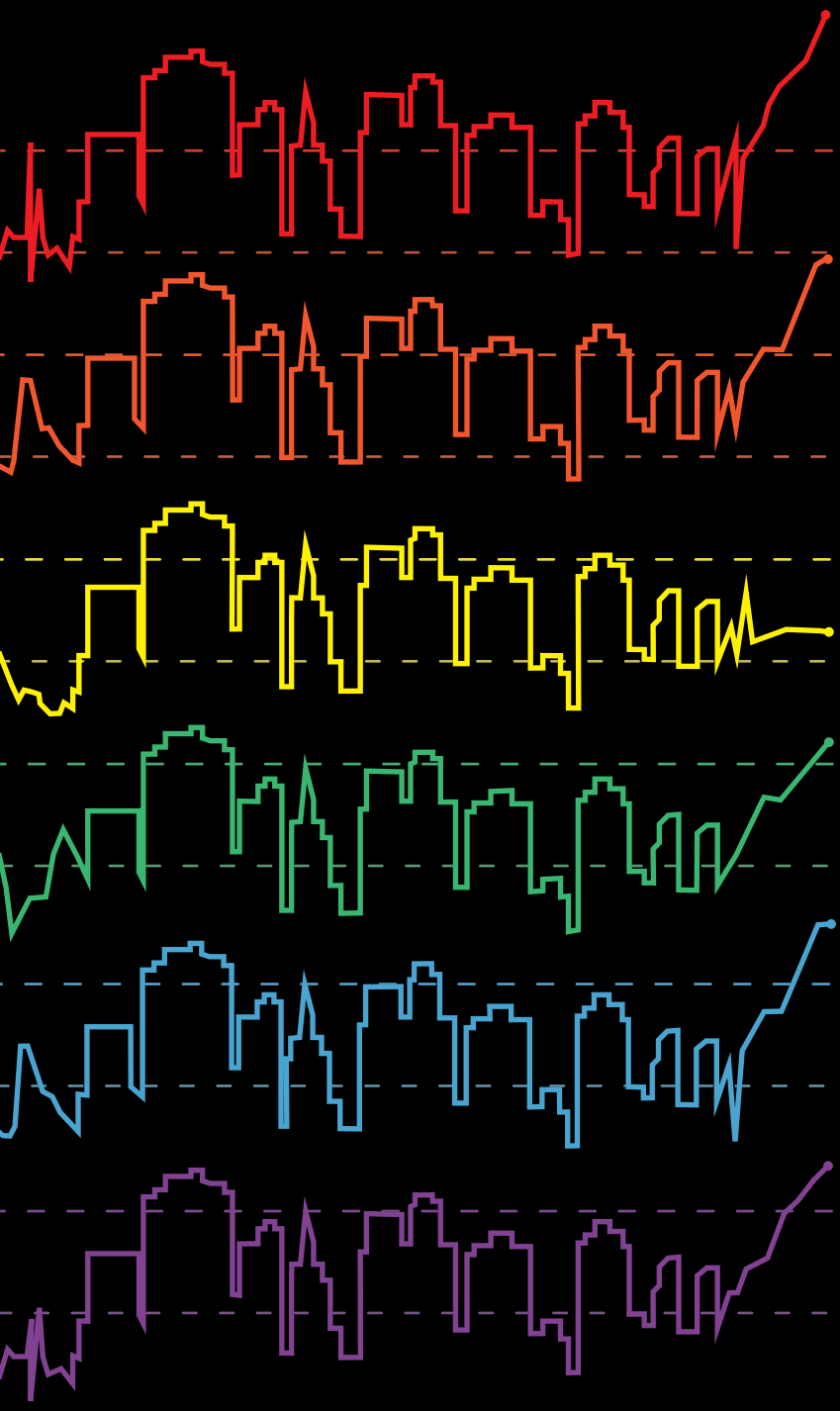
LIFE CHANGING
World Shaping

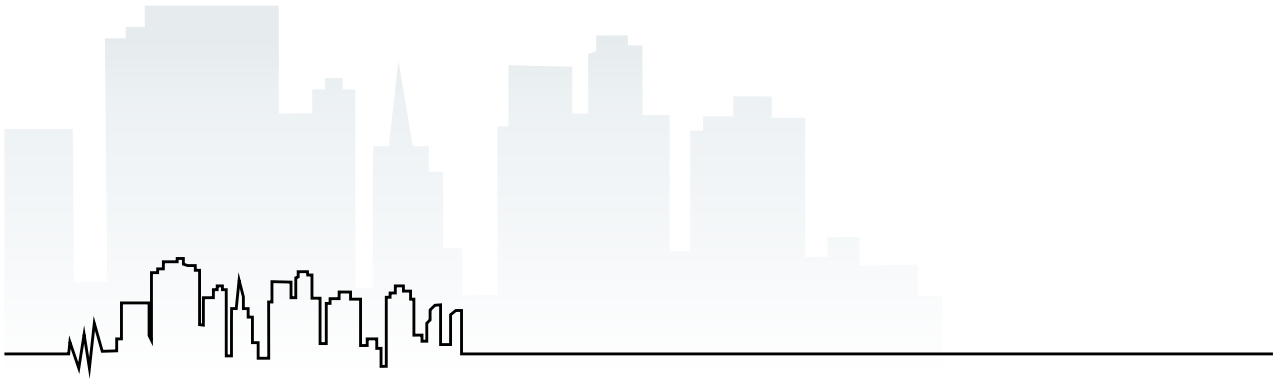


URBAN HEALTH IMPACT ASSESSMENT METHODOLOGY (UrHIA)

UNIVERSITY OF LIVERPOOL

impact

Contents



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This guide has been produced as part of Work Package 7 of the EU funded EURO-URHIS 2 study to develop Urban Health Indicators (UHIs).

We particularly would like to acknowledge the support of the Principal Investigator of the study, Arpana Verma (University of Manchester) and our colleague Dan Pope (University of Liverpool), who have been instrumental in raising the profile of Health Impact Assessment (HIA) throughout the progress of the study.

We would like to thank our former IMPACT colleague Fiona Haigh (University of New South Wales) who contributed to work underpinning the development of this methodology.

This guide is founded on the principles and practice of HIA, in The Merseyside Guidelines for Health Impact Assessment (Scott-Samuel et al, 2001) and the European Policy Health Impact Assessment (EPHIA): A Guide (Abrahams et al, 2004).

We are indebted to our colleagues and friends in the world of HIA, whose work contributed to the synthesis of this methodology, particularly those in the Institute of Public Health in Ireland whose publication: Health Impact Assessment Guidance 2009 (Metcalfe et al, 2009) provided a foundation for the Urban Area HIA Screening Tool (URHIST).

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Introduction

Health Impact Assessment (HIA) is defined as "a combination of procedures, methods and tools by which a policy, programme or project may be judged as to its potential effects on the health of a population and the distribution of those effects within the population" (Lehto and Ritsatakis, 1999).

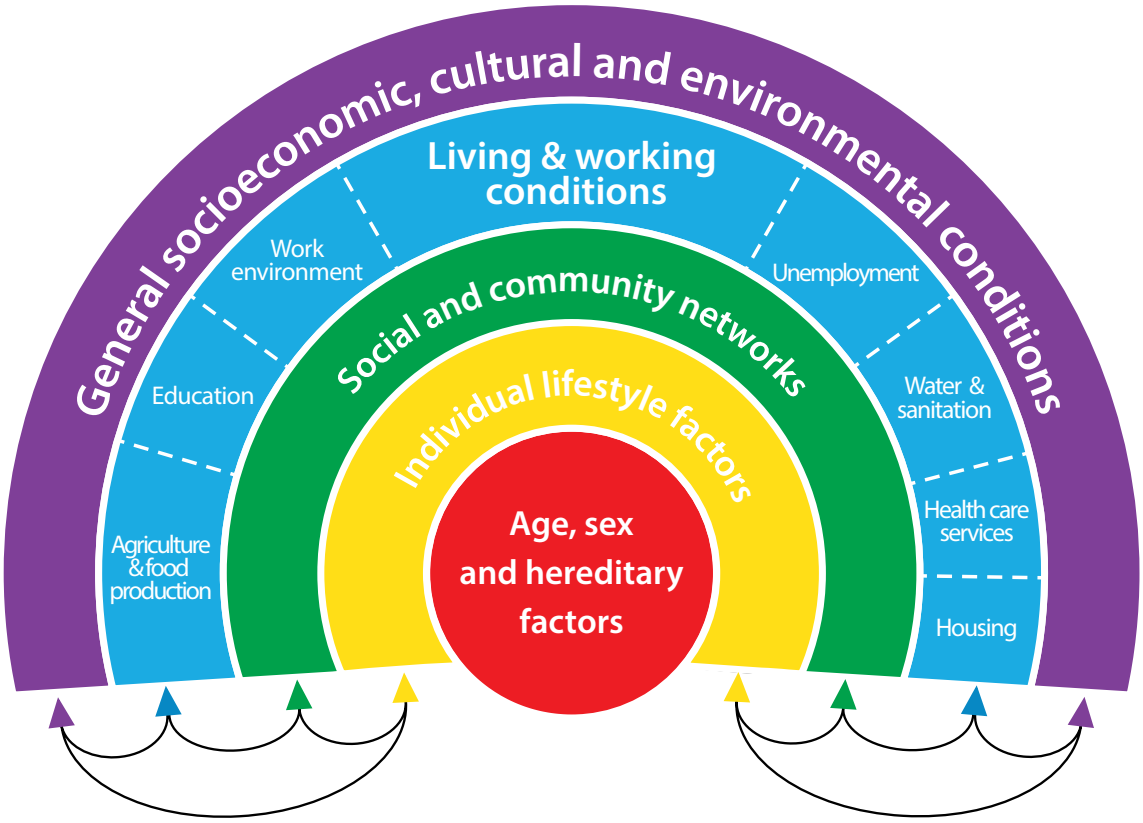
HIA uses qualitative and quantitative research methods to systematically assess potential impacts (both positive and negative) and make evidence-based recommendations to influence policy and decision makers. The purpose of HIA is to improve policies, programmes and projects, ideally prior to their introduction, in order to maximise health gain and eliminate or mitigate any negative health impacts on the population.

There are several methodological approaches to HIA available in the literature, seeking to group HIAs across the very wide continuum of practice. These range from "tight", risk reduction approaches based upon a biomedical model of health, to "broad" HIAs, based upon the socio-environmental model of health (Dahlgren & Whitehead, 1993, Figure 1).

HIA is formally used to reduce health inequalities and strengthen health equity; it is a means of bringing about Health in All Policies. It is a flexible, iterative and collaborative process that promotes shared ownership of its major output – HIA recommendations. It is practical and highly participative with communities playing a crucial role in most HIAs. It should be objective and based upon recognised research quality standards and the ethical use of evidence. Openness and transparency are key values. Recommendations made should as far as possible be SMART, that is, Specific, Measurable, Achievable, Realistic and Time-bound - with consideration given to impacts that occur in the short, medium and long-term.

Figure 1. Socio-environmental model of health

Source: Dahlgren & Whitehead, 1993



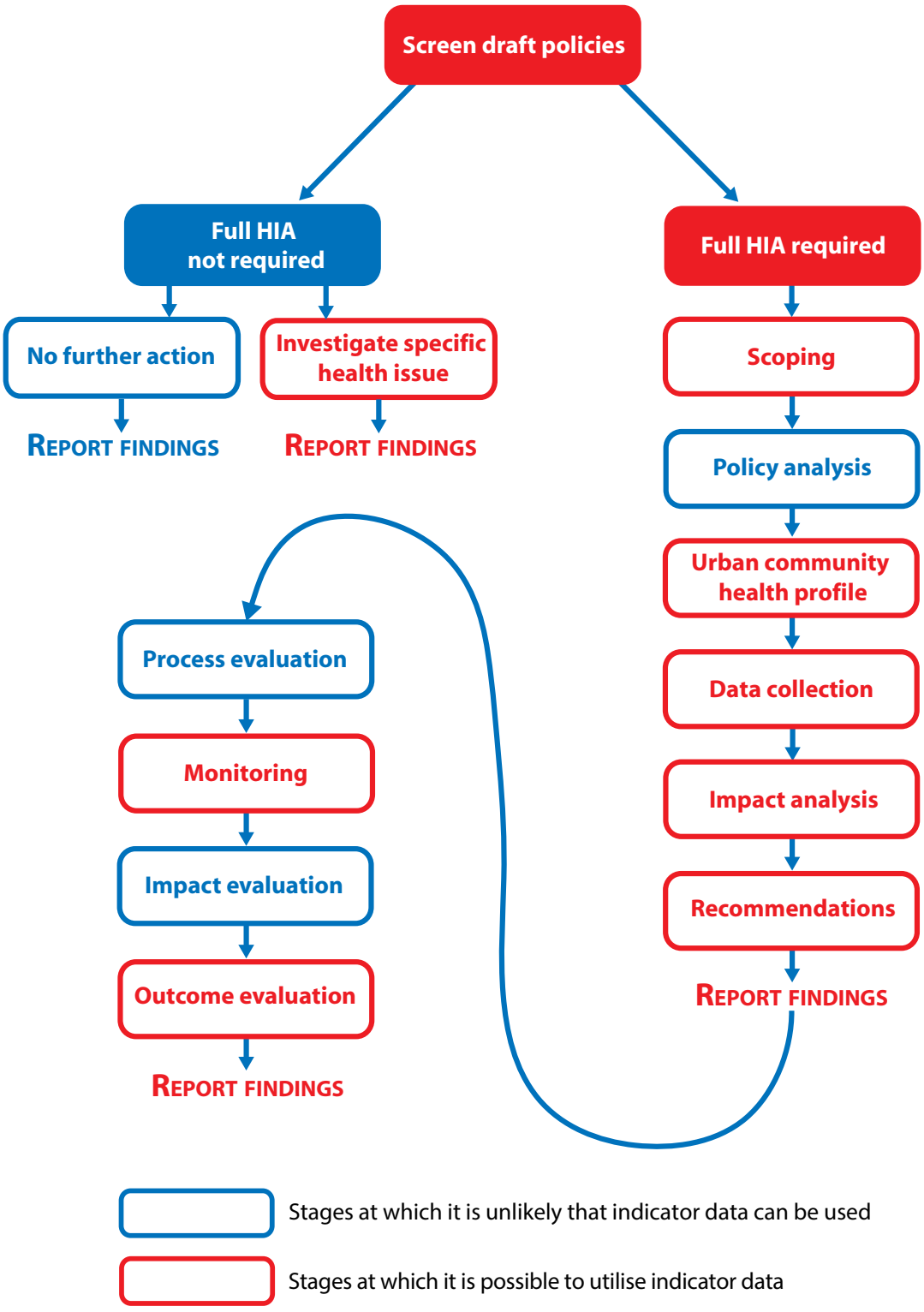
Ideally undertaken prospectively, HIA may also be undertaken concurrently or retrospectively. The intervention-specific, time-bound and iterative nature of HIA as a means of influencing decision making makes each HIA a unique, historically specific piece of work. However, it is possible to discern similarities in process, common themes, findings and recommendations in HIAs on similar subjects and defined populations.

This guide updates IMPACT's HIA methodological guidance published in the Merseyside Guidelines for HIA (Scott-Samuel et al, 2001) and the European Policy Health Impact Assessment (EPHIA) Guide (Abrahams et al, 2004). It describes the procedural and methodological stages of HIA practice and indicates the utility of EURO-URHIS 2 Urban Health Indicators (UHIs) and other data sets, in strengthening HIA practice.

Text boxes throughout the document provide further information on the potential opportunities for utilisation of indicator data.

Figure 2 shows the procedural and methodological stages of UrHIA and highlights potential opportunities for the utilisation of indicator data.

Figure 2. UrHIA methodological framework



HIA screening

Screening is the first procedural stage of HIA. It is not possible, desirable or resource efficient to undertake more detailed HIAs on every policy, plan, programme or project (henceforth 'policy or project' for brevity). Systematic screening, using a robust tool such as the Urban Health Impact Screening Tool (URHIST) (Appendix A) quickly judges which policies or projects should be subject to a more detailed HIA.

There is no formal threshold at which screening becomes a more detailed HIA. Screening may best be carried out by a small multi-sectoral group, with representatives of community, health and municipal authorities, the policy or project proponent and other key stakeholders who have knowledge of the topic under consideration, the defined population or its potential impacts.

Where a HIA policy is in place at a municipal level, regular systematic screening activity may be the responsibility of a constituted committee, reporting at board level.

The output of a HIA screening exercise should be a summary statement of the reasons why a more detailed HIA should, or should not, be undertaken, a record being kept (ideally in the public domain) to ensure good governance.

HIA screening will include preliminary interrogation of available evidence. It may constitute a desktop HIA in itself. When using the EURO-URHIS 2 urban area profiles and urban health indicators (www.urhis.eu) in screening, data on the wider determinants of health and evidence from the literature are likely to be incomplete at this stage; these data will usefully inform the scoping stage when a more detailed HIA takes place. If a more detailed HIA is decided on, the evidence from the screening exercise should provide a robust foundation for taking forward the various stages of the HIA.

HIA scoping

Scoping is the second procedural stage in HIA, concerned with designing and planning the HIA. In all but the smallest HIAs it is carried out by a Steering Group, the purpose of which is to project manage and deliver the HIA. Desktop or small HIAs may not have a full Steering Group, but instead an officer liaising between the assessor carrying out the HIA and the commissioner.

The process of scoping involves:

- Selection of a Steering Group from a wide range of stakeholders
- Definition of role, membership, reporting arrangements of the steering group (terms of reference for the Steering Group)
- Development of the Terms of Reference for the HIA (see below)
- Selection of the HIA assessor/assessment team who will carry out the HIA.

Terms of Reference of HIA

The Terms of Reference (ToR) for the HIA is an explicit statement of the design and scope of the HIA. It captures, usually in one document, both the arrangements for the Steering Group and the scope of the HIA. This should include consideration of all aspects of the HIA that will require time and resources, including decisions on monitoring and evaluation into the future.

These include:

- Design – e.g. aims, objectives, methods – including a definition of what the HIA is assessing
- Depth of HIA – e.g. desk-based, rapid, comprehensive
- Type of HIA – e.g. prospective, concurrent or retrospective
- Duration of the HIA
- Costs and other resources
- Source of funding
- Population groups - e.g. the defined population groups/subgroups likely to be most impacted upon
- Geographical boundaries of the study. These may be defined by the location of relevant population groups (including non-resident ones such as workers and commuters), rather than or in addition to a stated distance from a project location. They may be affected by natural flows of wind, rain, rivers or oceans
- Temporal boundaries, i.e. the amount of time after the commencement of the project over which potential impacts will be estimated
- Outputs - e.g. reports, websites, journal papers, newsletters, videos
- Transparency/confidentiality arrangements
- Valuation of lay (as opposed to expert) evidence and knowledge
- Monitoring and evaluation arrangements.

Policy analysis

The primary purpose of policy analysis is to inform the HIA design (scope) and to illuminate the policy environment in which impacts will occur. It aims to review the key features of content within official documentation from a range of sectors and organisations and the synergy (or divergence) between them, at appropriate levels from local up to international, according to the scope of the HIA.

Policy documents may include, for example, reports, minutes of meetings and strategy and policy documents from government, municipal, industrial and commercial and third sector organisations. They may be found in the public domain, through further searching of the literature, or contact with organisations.

It may be helpful to categorise (perhaps by geographical level) and tabulate the presentation of the policy analysis for ease of managing the documentation, which can be considerable in larger HIAs.

Policy Analysis should also identify through whom, how, where, when and why the policy or project under consideration has come about and how it relates to policies on the wider determinants of health, for example, economic, employment, education, transport, crime, access and availability of services. It should identify whether (or not) there is explicit consideration in the policy of equity dimensions such as social class, gender, ethnicity, sexuality, mental/physical impairment and disability and matters such as urban/rural balance, environmental and economic sustainability.

It is especially important to consider the "fit" with the overall political, cultural, scientific, social, economic, financial and human resource contexts, especially when they are constrained by economic and fiscal conditions.

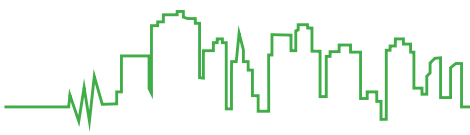
For each of the policies examined, the following criteria may be helpful in forming a conclusion with regard to the overall policy content/context:

Legitimacy - What is the legitimacy of the policy? Is it the right thing to do? Is it morally acceptable? Does it draw on established knowledge and views?

Feasibility – How likely is it that it will achieve what it claims it will and will this change over time?

Affordability – are the measurable costs and benefits for the implementation of the policy realistic?

While most of the methodological stages of HIA can take place simultaneously, policy analysis is the first methodological stage as it can inform the generation of a data map (outline of key information and sources) and a community profile (quantitative data collection); the development of instruments for qualitative data collection (such as a framework for stakeholder workshop groups and key informant interviews), and search terms for literature searching.



Community health profile

The purpose of the health profile is to give a picture of the health and socio-demographic context of the areas covered by a policy or project in order to understand better its potential health impacts and the population groups that may be affected. Its utility in identifying affected population groups is key to understanding both the variation (inequality and/or heterogeneity) within populations and the potential differentiation of impacts (inequities) a policy or project may impose upon them.

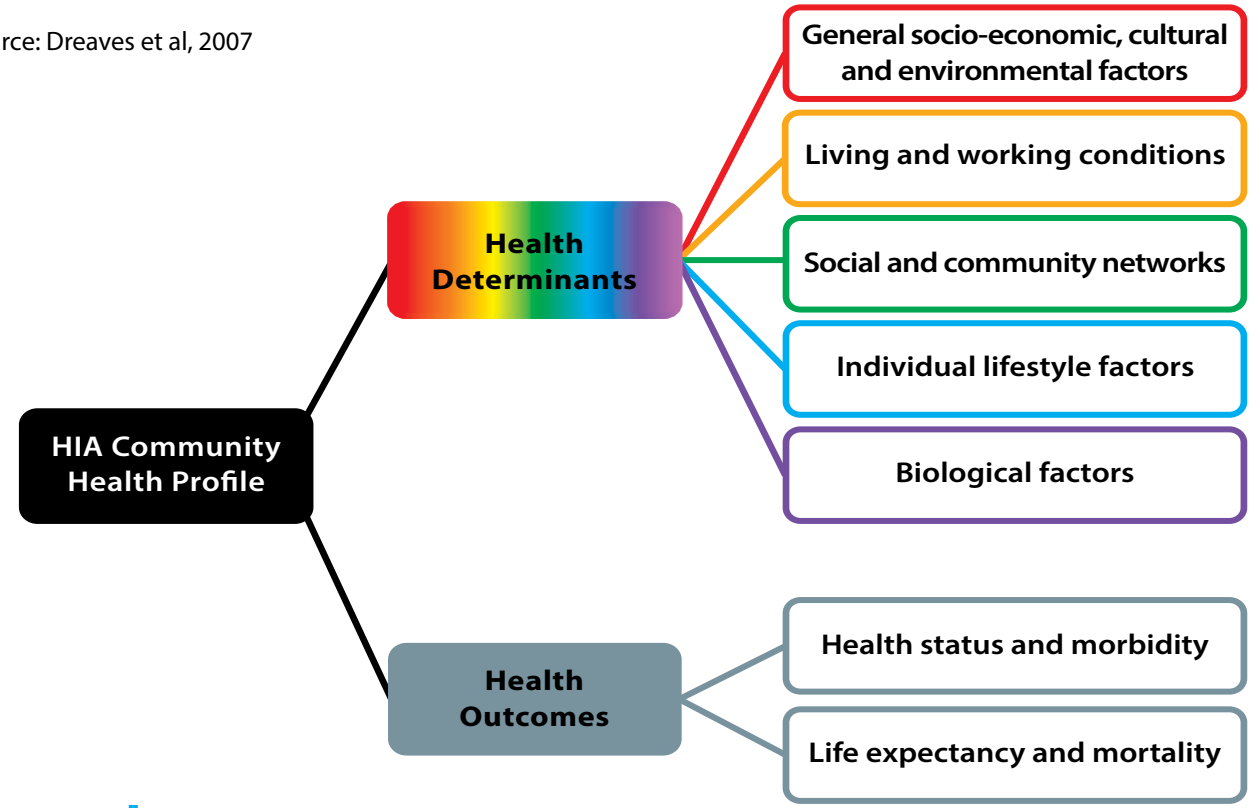
Profiling involves collecting and analysing secondary (existing) data on a range of indicators that relate to the content and context of the policy or project, and its possible impacts on health determinants and health outcomes. Indicators are measurable variables that reflect the state of a community and of persons or groups in a community. Comprehensive HIAs may in addition undertake some primary data collection during profiling.

The profile describes the current status of key health determinants and outcomes including existing inequalities. Where data permit, the profile should also describe historical trends in key indicators and predictions of future trends such as population projections.

The structure of the health profile may be based upon the health determinant categories of the socio-environmental model of health (Dahlgren and Whitehead, 1993) that underpins HIA methodology and practice, and health outcomes. Figure 3 shows a structure for the health profile. The categories are not discrete and some indicators may fall into more than one category.

Figure 3. Structure for a Community Health Profile

Source: Dreaves et al, 2007



The EURO-URHIS 2 Urban Health Indicators provide a core data set around which indicators relating to a specific policy or project can be built. UrHIA does not prescribe a particular set of indicators for use in urban HIA. The selection of indicators should be based on the size, scale and nature of the policy proposal being assessed and its relationship to, and the characteristics of, potentially affected populations. Examples of indicators that are of particular relevance to urban settings might include levels of: population density; greenspace; transport use; air, noise and light pollution; crime; housing energy efficiency; accidents.

A complete profile should include comparative data at different geographic levels so that issues relating to a specific policy or project can be identified, together with any existing inequalities between areas and groups.

Units of analysis are the areas/topics that are the focus of the analysis of the HIA. The profile should describe the geographic units of analysis/comparison areas used and include indicator data and analysis at these levels. To identify inequalities between and within groups the profile should ideally include both geographic and population based units of analysis. The units of analysis will vary according to the policy or project under examination and should be considered at the scoping stage. They may include the following:

Geographic units of analysis

- Sub-urban:
  - Properties occupied by particular population groups affected by a policy or proposal
  - Individual or groups of streets or facilities
  - Neighbourhoods, estates, suburbs or commercial, retail and industrial centres

- Urban:
  - EURO-URHIS 2 urban areas
  - Towns or cities defined by existing administrative boundaries

- Extra-urban
  - States
  - Provinces
  - Regions

- National
  - Countries
  - Nation states

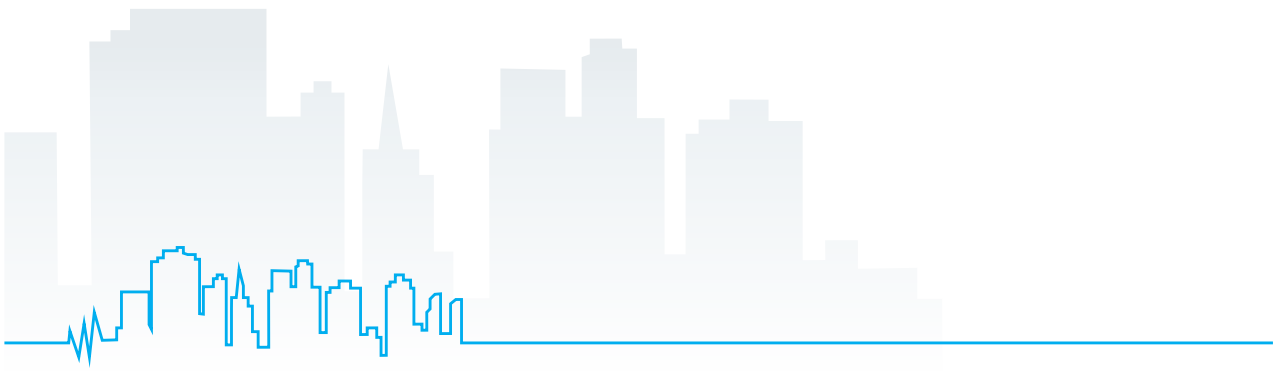
- International
    - European Union
    - Continental
    - Global

Population based units of analysis

Populations by:

- Age
- Sex
- Ethnicity
- Area of residence
- Occupation
- Income
- Socio-economic status or deprivation status
- Marital/partnership status
- Religion
- Physical and mental ability/disability
- Sexual orientation

It is important to be aware of the need to make valid comparisons between indicators. That is, the operational definitions of indicators should be the same wherever possible.



Data collection

HIA uses both qualitative and quantitative data. Qualitative evidence is given similar value to quantitative evidence. There may be some HIAs where qualitative approaches are of greater relevance than quantitative, and vice versa, depending on the nature of the policy or project under consideration.

Qualitative

Primary qualitative data in most forms of HIA is gathered through stakeholder participation. Most HIAs include stakeholder participation. However, desktop HIAs may use (existing) secondary qualitative data as a proxy for stakeholder participation as part of the literature review.

Collection and analysis of qualitative data should be informed by established qualitative research methods. Detailed guidance can be found within Green and Thorogood (2009).

Primary data collection through qualitative surveys is usually only undertaken for the most detailed, comprehensive HIAs. Resources, which may be substantial, need to be identified for this at the scoping stage.

Stakeholder participation

Participation from organisational and community stakeholders (people with vested interests of any sort in the outcome of the HIA, e.g., proponents, public health staff, planners) and key informants (people whose roles give them relevant knowledge of any sort about affected communities, e.g. experts, community nurses, shopkeepers) characterises all forms of HIA, other than desktop HIAs. This can be resource intensive and requires skills in facilitation and appropriate qualitative research methods, as agreed in the scope of the HIA. Gaining the trust and support of those likely to be most affected by the policy or project is important.

The purpose of participatory, qualitative approaches is to gather evidence from the experience, knowledge, opinions and perceptions of the populations affected by the policy or project. This can provide an in depth description of the health determinants affected, an understanding of how they think this impacts on health outcomes, a contribution to the prioritisation of impacts and a perspective on health inequalities and health equity.

Qualitative research methods, such as focus groups, telephone surveys, Delphi exercises, and semi-structured interviews are often used in HIA, according to the scope of the work. Purposive and snowball sampling are often used to establish an appropriate stakeholder map from which representatives and community members can be drawn.

Invitees should ideally be given at least three weeks' notice prior to a stakeholder event. A high number of invitations may yield only a low uptake for workshop events. Every person potentially affected by the policy or project should have an equal chance of meaningful participation. Consideration should be given to the accessibility and appropriateness of venues and techniques, and the capabilities of individuals to participate. Potential access issues for, amongst others, people with learning and organisational difficulties, disabled and older people, parents with children and people on low or fixed incomes should be considered and addressed at the scoping stage of the HIA and through prior consultation with affected individuals.

Instruments (e.g. tables/matrices) for systematically noting the evidence provided by stakeholders should be designed based upon preliminary screening, policy analysis and community profiling work. This will assist thematic analysis of the evidence gathered.

Representative sampling is not essential in HIA, but efforts towards this should be made and evidenced in the full report. There is evidence from the literature regarding the utility of online methods and their appropriateness for some population groups (e.g. older age groups) should be considered at the scoping stage. The use of social media as a means of evidence gathering in scientific research is currently under debate and not yet widely utilised in HIA.

Consent should be noted either in audio or written format and a record kept of anonymised responses. To demonstrate openness and transparency, all responses should be published as appendices in a full HIA report, in the language used by the stakeholders.

Following thematic analysis, it is good practice to feed back initial findings (for example in a consensus building workshop, or through newsletters) to stakeholders and for HIA findings/recommendations to be distributed to them.

Literature review

The literature review presents a summary of the available secondary (existing) evidence from academic and where appropriate "grey" literature. The review should attempt to identify potential pathways between a policy or project and health outcomes via changes in health determinants. The review should also include available evidence on the efficacy of specific interventions including any that are recommended by the HIA itself. The review should identify, retrieve, collate, describe and analyse the available evidence.

Literature reviews in HIAs do not normally involve full systematic reviews. Rapid literature reviews can, however, still adopt a systematic approach with an explicit search strategy that records search terms, databases searched and inclusion and exclusion criteria (e.g. publication date ranges, languages and geographies/settings of studies). The review should first attempt to identify strong evidence from the literature in the form of reviews of reviews or systematic reviews before considering, if necessary, findings from other literature reviews, single HIAs and single studies.

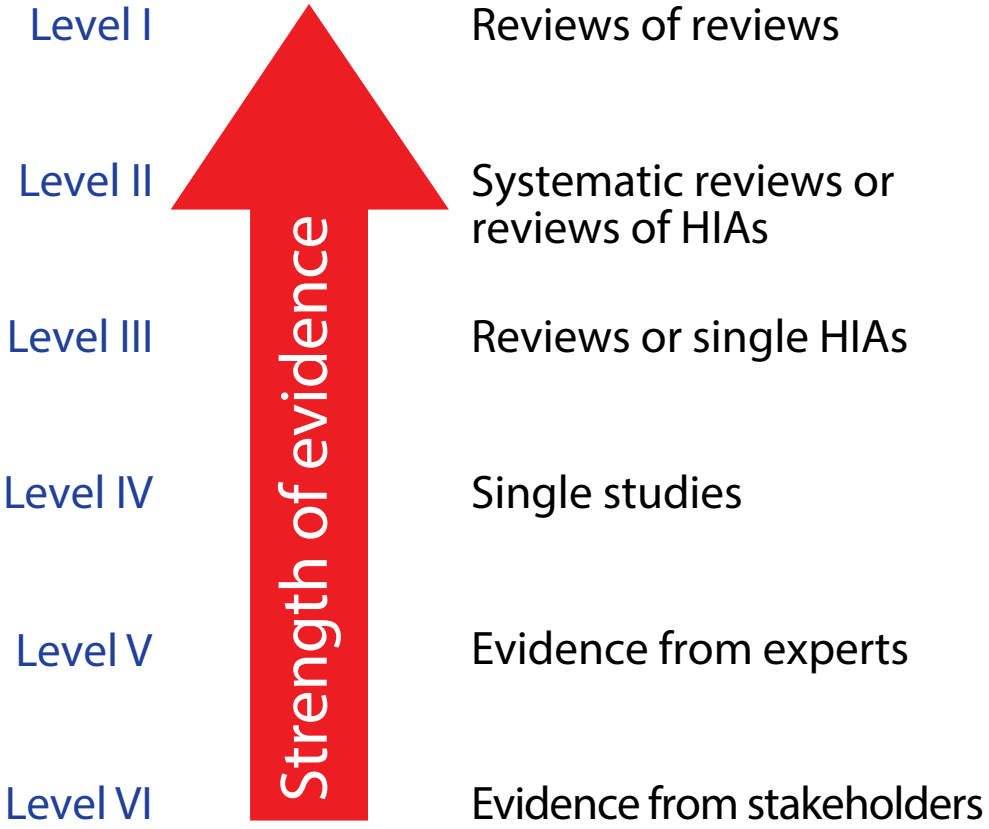
Understanding the strength of the evidence

Evidence from the literature is usually defined in terms of the confidence or "strength" of the findings.

A hierarchy of evidence for use in HIA is shown in Figure 4. The evidence hierarchy, from I to VI, includes evidence from the literature as well as evidence from experts/key informants and stakeholders.

Figure 4. HIA Hierarchy of Evidence

Source: Pennington et al, 2010



While different levels of evidence within a HIA are useful for the purpose of comparison, it should be noted that **lower levels of evidence may still be valid and reliable**. HIA uses and values relevant evidence from all levels, for example a statement from a key informant such as the owner of a corner shop has just as much value as a professional view.

Evidence from the literature should be critically appraised, against specific criteria to establish the rigour of the research evidence. Key (headline) criteria include:

- Is the study relevant to the (HIA) project?
- Does the study address a clearly defined issue?
- Was the research design clearly described and appropriate?
- Was the sample group and size appropriate and representative?
- Were the measures described and appropriate?
- Was the method of analysis appropriate?
- Are confounding and bias considered?
- Were the results clear and adequately reported and discussed?
- Are the limitations of the study presented?
- Can the results be generalised/are the results relevant locally?
- Are the conclusions based on the results?
- Are the implications of the research discussed?
- Were ethical considerations presented, including conflicts of interest of researchers?

Source: based on HEBW, 2008

Published literature, such as previously published HIAs, may contain indicator data or provide useful examples of data sources that can be used to strengthen the community health profile.

Quantitative data collection

Secondary quantitative (numerical) data are collected and used throughout the HIA process, for example, the collection of epidemiological reports within literature searches and the use of indicator data during community profiling. At the data collection stage of a HIA, primary quantitative data collection may involve mathematical prediction/modelling of the health effects of a policy or project. Mathematical prediction is only used in larger scale HIAs because of the data requirements, costs and skills needed. Prediction is generally limited to specific elements of a policy or project, for example, the effects of noise and air pollution on people living near airports, because of limitations in what can usefully be measured. Forecasting, scenario building and mathematical modelling are established methods of prediction. Specific methods should be selected according to the scope of each HIA. Methods of prediction and their scope should be agreed during the scoping stage and a balance should be established between the use of quantitative and qualitative data. Information on specific methods for use in HIA can be found in Fehr and Mekel (2010).

EURO-URHIS 2 indicator data may be a useful source of baseline data for use in mathematical prediction.

Impact analysis

Impact analysis draws together the evidence from all the data collected. It has been described as a triangulation of epidemiological data, stakeholder evidence and evidence from the literature. It identifies and characterises the potential impacts (both positive and negative) on the defined population of interest, with particular regard to health inequalities.

Potential impacts may be characterised as follows:

- **Health impacts** – potential changes in the health determinants affected and (where possible) the subsequent effect on health outcomes
- **Direction of change** in health status – health gain (+) or health loss (-)
- **Scale** – the severity (mortality, scale of morbidity and well-being) and magnitude, where possible (size/proportion of the population affected)
- **Likelihood of impact** – definite, probable, possible or speculative (based on the combined strength of the evidence); these qualitative judgments usually represent the best that is feasible and their use precludes the possibility of 'spurious quantification' of predicted impacts
- **Latency** – when the impact might occur in relation to the exposure to risk of the population (often short, medium and long-term)

For the purpose of impact analysis in HIA, a hierarchy of evidence from level I to VI has been defined describing the relative strength of evidence; this includes evidence from the literature, key informants and stakeholders (see Literature Review section).

Where evidence collected from multiple research methods converges, this adds extra strength to the evidence and the likelihood of impact. Definition of the likelihood of the impacts is described in the following qualitative terms (next page). The likelihood of the impact is based on the assessed strength of evidence. For clarity throughout the impact analysis section of a HIA report, potential impacts may be shown in **bold**, while the likelihood of an impact may be <u>underlined</u>.

Definite =	Will happen. Overwhelming strong evidence from a range of data sources collected using different methods (level I)
Probable =	Very likely to happen. Direct strong evidence from a range of data sources collected using different methods (levels II/III)
Possible =	More likely to happen than not. Direct evidence but from limited sources (levels IV/V)
Speculative =	May or may not happen. No direct evidence to support (level VI)

To help assure the quality of a HIA report, it is good practice to state the assumptions upon which the impact analysis is made.

Impact analysis is likely to be undertaken by either the assessor or by members of an assessment team, who have sought and gathered the evidence collected.

Impact analysis may be presented as text (sometimes tabulated), with cross references made to the sections of the HIA from which the supporting evidence comes.

Establishing priority impacts

Many valid methods are available for use in ranking impacts and achieving consensus among stakeholders in HIA. These range from simple anonymised visual "voting" methods at workshops, to Delphi approaches and the use of exclusion criteria. Appropriate methods and resources should be agreed at the scoping stage of the HIA.

Developing recommendations

HIA recommendations are proposals for alternative and/or additional actions that are designed to maximise health gain and to mitigate against adverse health effects. They are the key output of any HIA.

Recommendations emerge at various stages of the HIA and they should be recorded, along with their source. The presentation of recommendations should be clear and succinct. Summaries of findings and recommendations are useful aids to decision making.

Wherever possible, recommendations should be **SMART**. That is:

1. **S**pecific – who is going to do what, when, how and how much of it?

2. **M**easurable – is it possible to enumerate or assess qualitatively?

3. **A**chievable – is it "do-able"? Are the resources available?

4. **R**ealistic – is it grounded in practical reality, or merely an aspiration? Relates to timescales and organisational constraints

5. **T**ime bound – does it say when the recommendation will occur? Usually short, medium and long-term.

HIA report

The main output of a HIA is a set of evidence based recommendations designed to influence policy and decision makers.

The findings of a HIA may be reported in a number of ways, appropriate to the population of interest. For example, mixed media and visual presentations, either graphically or a drama, may be suitable for projects involving children and young people, or those with literacy or numeracy issues. There will usually be a full technical report for the commissioners of the work, with a separate executive summary and/or a short report or summary of findings and recommendations. The nature of the output, including the number and type of reports and a strategy for their dissemination, should be agreed at the scoping stage of the HIA.

A first draft report, structured similarly to that shown in Figure 5, should be presented to the HIA Steering Group or commissioner of the work and to the stakeholders for their comments.

For larger more comprehensive HIAs, it is good practice to have a draft HIA report peer reviewed by an external expert/independent HIA practitioner, in order to assess the rigour of the HIA methodology and process. Resources for this should be identified at the scoping stage of a HIA.

Negotiation of the language and presentation of the recommendations is very important to ensure that the recommendations have the best possible chance of being taken up and acted on. These negotiations may inform an implementation plan, usually beyond the scope of a HIA itself, but very helpful in establishing future pathways for monitoring and evaluation.

Figure 5. HIA Draft Report Structure Outline

Section	10. Policy Analysis
1. Acknowledgements	11. Health Profile
2. Table of Contents	12. Evidence from the Literature
3. List of Figures	13. Evidence from Stakeholders and Key Informants
4. List of Tables	
5. Executive Summary	14. Impact Analysis
6. Introduction	15. Conclusion and Recommendations
7. Summary of the Project	16. Monitoring and Evaluation
8. Methodology used	17. Bibliography
9. Scope of the HIA	18. Appendices

Monitoring and evaluation

Negotiation of the language and presentation of the recommendations is very important to ensure that the recommendations have the best possible chance of being taken up and acted on. These negotiations may inform an implementation plan, usually beyond the scope of a HIA itself, but very helpful in establishing future pathways for monitoring and evaluation.

The scoping stage of the HIA should identify the resources and approaches that will be required for monitoring and evaluating both the outcomes of the policy or project and the process and impacts of the HIA itself. It is uncommon for an external HIA assessor to be commissioned to carry out monitoring or evaluation (with the exception of process evaluation), since these are events that will happen into the future, after the conclusion of a HIA. The costs associated with monitoring and evaluation may be considerable. The costs (time, skills and resources) of outcome monitoring and evaluation, in particular, can potentially be greater than the cost of conducting the HIA itself. These factors need to be taken into consideration during scoping, and a realistic monitoring and evaluation plan developed. It is good practice, at the very least, to resource and conduct a process evaluation. Evaluation provides a means of accountability to stakeholders and valuable information for practitioners and decision makers conducting future HIAs.

Process evaluation

Process evaluation involves critical appraisal of the HIA process. Assessors should keep a record of relevant information while conducting the HIA, for example:

- How all aspects of the HIA process were undertaken
- Who was involved (or dropped out)
- Any barriers to the HIA process, e.g. issues accessing data
- Any facilitators of the HIA process, e.g. useful sources of data

Achievement of the Terms of Reference is the key focus of process evaluation. The evaluation should also attempt to identify how useful and valuable the HIA process was. Informed by the assessors' records, the process and methodology of the HIA can be evaluated using HIA output documents, minutes, agendas and other materials and by obtaining steering group members' and other stakeholders opinions through interviews or questionnaires. Assessors may also keep diaries of the HIA process.

Monitoring recommendations

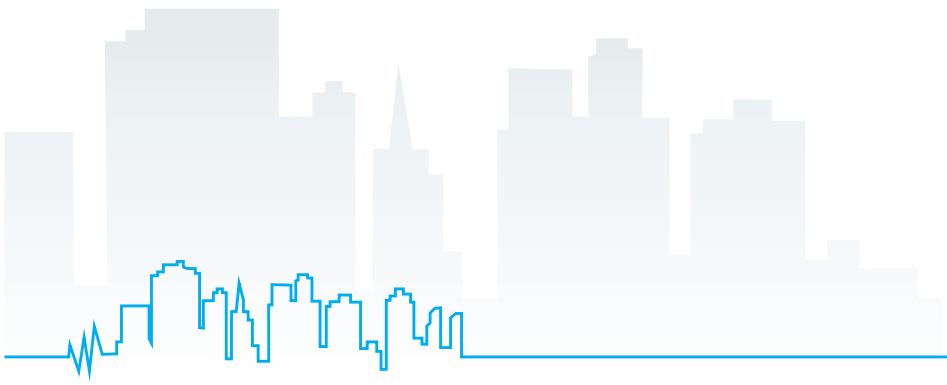
Monitoring, recording and reporting what happens to the recommendations (who they are presented to, when they are/are not taken up, who takes them up and how they are implemented) underpin impact and health outcome evaluation.

Impact evaluation

Impact evaluation considers the influence a HIA had on decision making. This may be evidenced by modifications to the draft policy or project under consideration. It is generally qualitative and descriptive in nature.

The output of a HIA, a set of evidence based recommendations, is presented to a Steering Group and their uptake and progress is followed through monitoring. It is the subsequent uptake and implementation (or not) of the recommendations that will bring about any changes in the distribution of impacts. Each recommendation may therefore require specific monitoring and evaluation.

There may be unintended impacts on decision making, for example through improved partnership working or though raising the profile of health in non-health settings and these should be included in the evaluation.



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Appendix A

Urban Health Impact Assessment Screening Tool (URHIST)

Health Impact Assessment (HIA): Screening for health impacts

This HIA screening tool is based on Metcalfe et al (2009)[1]. It has been modified for use within an urban policy context.

Introduction

Health is determined not only by access to quality healthcare services and lifestyle choices but also by the social and economic conditions in which people live. These include many factors which lie outside the healthcare sector, such as housing, employment, transport and access to fresh food. Policies and actions formulated in these non-healthcare sectors can have a significant impact on people's health and wellbeing.

Assessment of the potential impacts on health of a policy should include consideration of physical, mental and social health. Health Impact Assessment (HIA) is a combination of procedures, methods and tools that systematically assesses the potential effects of a policy on the health of a population. It also considers the distribution of those effects within the population and can be a useful mechanism for highlighting where the health of some groups may be affected more than others if the policy is implemented[2].

Screening

Screening is the first step in a HIA and its purpose is to determine whether or not to proceed further with HIA. It does so by quickly and systematically highlighting the potential impacts of the policy, plan, programme or project - henceforth 'policy' for brevity - on health. Screening may be undertaken by a single person or as a group exercise. The length of time required for screening will depend on the scale of the policy and the amount of information available. If screening is undertaken by a group, this should ideally include stakeholders (those with a vested interest in or likely to be affected by the policy) and decision-makers.

The screening tool comprises three sections:

1. Section one records background and context.
2. Section two considers the potential impact of the policy on a range of health determinants, for the population as a whole and for groups within the population.
3. Section three documents the outcome of screening.

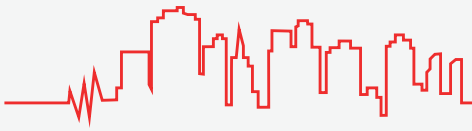
1 Metcalfe O, Higgins C, Lavin T (2009) Health Impact Assessment Guidance. Institute of Public Health in Ireland. http://tinyurl.com/8qmp3uj

2 International Association for Impact Assessment. Best practice guidelines for HIA 2005. www.iaia.org

HIA screening tool

Section One: Background and context

Title of policy being screened
Date screening conducted
Person(s) involved in the screening process (name, organisation represented and job title if applicable)
What stage of development is the policy at?
Can the policy be changed as a result of the recommendations of the HIA?



Section Two: Potential impacts on health determinants

Instructions for completing the table (next page)
The left-hand column contains a list of issues that are known to influence health (health determinants). These are grouped into social and economic conditions, structural issues, and individual and family issues.

STEP 1:
Assess the likelihood of the policy impacting on this health determinant and record as:

Likely (it is likely that the policy will impact on this health determinant).
Code as L

Unlikely (it is unlikely that the policy will impact on this health determinant).
Code as U

Not known (there is insufficient information in the policy to assess whether or not it will impact on this health determinant).
Code as NK

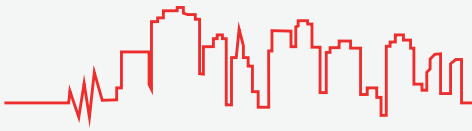
If the health impact is considered **likely** (L), continue to step 2.

If the health impact is considered **unlikely** (U) or is **not known** (NK), move on to the next health determinant.

STEP 2:
List the groups most likely to be affected by the policy. Examples of different population groups are given below (this is not intended to be a complete list).

• Infants and toddlers	• People with particular religious beliefs
• Children and adolescents	• People with particular political beliefs
• Working age people	• People with disabilities
• Older people	• Chronically ill people
• Males/ females	• Homeless people
• Single/ married people	• Unemployed people
• Gay/ lesbian people	• Economically disadvantaged people
• People with dependants	• Gypsies and travellers
• Racial and ethnic groups	• Others (specify)

Social and economic conditions that influence health		
Likelihood that the policy will impact on this health determinant	(L/U/UK)	Groups most likely to be affected by the policy
Education		
Employment		
Childcare		
Crime and fear of crime		
Community interaction		
Access to fresh food		
Access to sports and other opportunities for physical activity		
Access to cultural and other recreational activities		
Access to healthcare services		
Access to social welfare services		
Access to other community services		
Access to public transport		
Other social or economic conditions (list)		



Structural issues that influence health		
Likelihood that the policy will impact on this health determinant	(L/U/UK)	Groups most likely to be affected by the policy
Housing		
Public buildings		
Commercial buildings		
Green space (including parks)		
Other public spaces		
Road safety		
Transport infrastructure		
Communications infrastructure (internet/telephone)		
Energy sources		
Waste management infrastructure		
Water quality		
Air quality (indoor and outdoor)		
Soil quality		
Noise		
Light		
Other structural issues (list)		

Individual and family issues that influence health		
Likelihood that the policy will impact on this health determinant	(L/U/UK)	Groups most likely to be affected by the policy
Diet		
Physical activity		
Substance use (legal and illegal)		
Sexual activity		
Household income		
Family cohesion		
Other individual and family issues (list)		

Section three: Screening outcome

Tick the appropriate outcome

Outcome	Action	Tick
Overall, health impacts of the policy are unlikely or relatively minor and easy to address.	Where appropriate, make recommendations to decision-makers on how such impacts may be addressed. Do not proceed with HIA.	
Overall, health impacts are likely or unknown.	Taking into account issues raised in section one, proceed with HIA.	

IMPACT

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EURO-URHIS 2
European Urban Health Indicators System Part 2
Urban Health Monitoring and Analysis System to Inform Policy