

# Evaluation of pilot health impact assessments conducted in Ireland

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## Abstract

Health impact assessment (HIA) is based on a socio-economic model of health and provides a transparent framework for the identification and appraisal of health impacts of policies, programmes or projects. The use of HIA with the Republic of Ireland (ROI) is still under development and this study aimed to examine the use of HIA in Ireland within the context of the evaluation of two pilot HIAs. The HIAs were conducted at different assessment levels, one involving a national policy and the other a local development project. Methodologies employed within the HIA process also varied in the two approaches.

Experiences gained from the studies presented suggest that the approach to the project level HIA employed has the potential for enhancing health gains and overall health awareness for local development projects in keeping with healthy principles of sustainable development. At the level of policy development this study suggests that HIA requires further capacity building within the ROI among both stakeholders and policy makers both in terms of awareness building and appreciation of benefits of the transparent and structured approach to assessing impacts of policy development within the HIA process. In addition, endorsement by policy makers appeared crucial to participation in the policy level HIA process, emphasising the necessity to integrate HIA more fully within the public policy development process.

## Introduction

Health impact assessment (HIA) is a process that provides a transparent and structured approach to identify, evaluate and optimise health effects of non-health policy. It is based on a socio-economic model of health covering biological, psychological, economic, sociological and environmental determinants and uses both qualitative and quantitative evidence to focus on the health impacts of a policy, programme or project (Scott-Samuel et al., 1998; Milner, 1999; WHO European Centre for Health Policy, 1999; Ison, 2000; Kemm, 2001; McKintyre, 1999 #95; Ison, 2002; Tay, 2002; Mindell et al., 2003; Mindell and Joffe, 2003; WHO, 2004).

A primary driver for the development of HIA was the general exclusion of health from environmental (EIA) and social (SIA) impact assessments. Other drivers for HIA that have been outlined (Ison, 2000) include: The pursuit of one of the pillars of health promotion, healthy public policy, identified in the Ottawa Charter (WHO, 1986); increasing democratisation of the process of policy formulation; recognition of the importance of equity in the implementation of public policy; and a commitment to sustainable development

While concepts of healthy public policy were enshrined in the Ottawa Charter (WHO, 1986), systematic assessment of the health impacts of public policy is a more recent development (Scott-Samuel, 2002). An integrated approach to health and development has increased the profile of HIA on the agenda of many national governments and international organisations. The World Health Organisation has set targets that all member states of the EU develop HIA processes by 2020 (WHO Regional Office for Europe 1999). Within the EU, Article 192 of the Maastricht Treaty (1992) and Article 152 of the Amsterdam Treaty (1997) require monitoring of public policy proposals for adverse impacts on health.

There have been a number of developments towards integration of impact assessments into public policy development in the Republic of Ireland, however, their current status within Irish policy development processes varies. EIA has been fully institutionalised into policy-making and legislation as part of the Planning And Development Act, of 2000, and Statutory Instruments: (S.I. No. 45 of 2000, ; S.I. No. 538 of 2001). SIA has not been referred to specifically in policy documents however there are references to poverty proofing and impact assessment within the Social Inclusion Strategy of the Department of Social and Family Affairs, (2002).

The use of HIA in Ireland is not yet fully integrated into public policy development and while there is no legislative obligation for its incorporation, the government made a commitment to it in the health strategy, *Quality and Fairness* where it is incorporated as Action 1 in National Goal No 1, *Better health for everyone: promoting and improving everyone's health and reducing health inequalities* (Department of Health and Children, 2001) The Institute of Public Health in Ireland (IPH) is responsible for capacity building for HIA in Ireland and has published

reports summarising HIA process, methodologies and the IPH's approach to HIA (Elliot, 2001b; Elliot, 2001a). The Institute also co-ordinates an email based HIA network for those engaged in or interested in the use of HIA within the island of Ireland.

### Approaches to HIA employed

For this study HIA's were undertaken on two distinct types of prospective change, one involved a change in national policy and legislation governing smoking in the workplace that proposed a complete prohibition of smoking in that setting (SB HIA). The other involved a local development plan for a new sports complex in Bantry (SC HIA). The nature of the changes being assessed led to different overall approaches to the two HIAs, this was true in terms of both the processes and the methods used. With respect to suggested levels of HIA noted by (Milner, 1999): policy level, programme level and project level, the SC HIA was conducted at the project level and the SB HIA at the policy level. Milner (1999) notes that these different levels may require different levels of resources and this was the experience in conducting these two HIA. Table 1 gives a summary of the different approaches of the two HIAs conducted. Full accounts of the SC HIA and SB HIA are reported in O'Keefe, (2003) and Pursell et al., (2004) respectively.

Several approaches to conducting HIAs have been described: **Concurrent HIA** is carried out whilst a policy, programme or project is being implemented; a **comprehensive HIA** is a more detailed process than the rapid or intermediate HIA. It involves the participation of the full range of stakeholders, an extensive literature search, secondary analysis of existing data and the collection of new data; **prospective HIA** is carried out prior to any action being taken, either in terms of drafting a policy, putting together an action plan or implementing it so that steps can be taken, at the planning stage, to maximise the positive health impacts of a policy, programme or project and to minimise the negative effects (Scott-Samuel et al., 1998); a **retrospective HIA** is carried out after the completion of a programme or project. Its use is to inform ongoing development of existing policy or projects (WHO, 1986; WHO, 2004).

The SC HIA was prospective in nature and the HIA framework based on the Merseyside model (Scott-Samuel et al., 1998). The study methodology was based on the Liverpool Public Health Observatory's approach to the HIA of a proposed new sports centre in Parr (Fleeman and Jeffrey, 2000). The SB HIA was also based on the Merseyside model (Scott-Samuel et al., 1998) incorporating the details for workshop preparation and impact matrix use by (Ison, 2000)

### Funding and resources

That policies require a more general approach to assessing impacts than projects (Milner, 1999) was born out in comparison of the experiences gained in conducting the two HIAs piloted in this study. The project level SC HIA was conducted with a smaller range of methodology and fewer resources than the policy level SB HIA. It took place over a 4 month period and documentation over 1 month and was conducted by one researcher.

The SB HIA process was conducted by one researcher under the supervision of a public health specialist and included analysis of data collected for surveys and submissions. A survey targeting bar patrons conducted within the HIA process was carried out for a Masters dissertation and a community survey was appended to an existing multistage survey. Primary costs were consequently for the salary of a principle researcher, for workshop preparation and venues and for travel. Funding was sourced primarily from a Higher Education Authority grant for the purpose of assessing the process of impact assessments in an Irish context. The SB HIA process took place over an 8 month period after the announcement of prospective legislation. Analysis of surveys and write up took place over a 4 month period that ended with the commencement of the new legislation.

### Boundaries and the scope of health impacts

The boundary of the SB HIA was formed by a specific focus on impacts of the new environmental tobacco smoke (ETS) legislation associated with public houses. Geographically the boundary of the HIA was defined by the national boundary of the Republic of Ireland where the policy was to have jurisdiction. The boundary of the SC

HIA was primarily defined geographically, incorporating the urban area of Bantry and rural District Electoral Divisions of Bantry.

Both HIAs adopted a broad model of health when identifying impacts, defining it as: “a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity.....a resource for everyday life, not the object of living. It is a positive concept emphasising social and personnel resources as well as physical capabilities.” (WHO, 1986).

Using this model of health, HIA incorporates the impacts of many different factors. It does so on the basis that, the more commonly considered factors such as access to and use of health care services, can often have less of an impact on peoples health than their circumstances and environment. These factors termed ‘determinants of health’ have been defined by the World Health Organisation as: “The range of personal, social, economic and environmental factors which determine the health status of individuals or populations” (WHO, 1986).

## **Methods and evidence**

### **Identification of stakeholders and the steering group**

At the start of the SC HIA stakeholders were identified through contact with a local development group. Informants were sought to represent one of five areas that were identified through existing literature to be key themes for a sports centre development project: employment, tourism, health, education and leisure. The HIA steering group comprised sports centre committee members whose responsibilities were to appraise the data collected and decide on priority areas. In the SB HIA stakeholders were identified using a variety of methods including: a review of published literature, news reports in various media including newspapers, television and web sites and observation of a consultation meeting on the smoking ban organised by the Health and Safety Authority, Ireland (HSA). Stakeholder organisations were contacted via telephone and or email inviting representatives to participate in the HIA steering group.

### **Sources of demographic data**

Data for the profiling of the community for the SC HIA was derived from: existing large scale surveys (Centre for Health Promotion Studies, 1999; Centre for Health Promotion Studies, 2002); local surveys (Bantry Integrated Development Group, 2000); and routinely collected data (Central Statistics Office, 2003). The SB HIA derived demographic evidence from a broad range of sources that included: routinely available data (Central Statistics Office, 2002a; Central Statistics Office, 2002b); existing large scale surveys (Centre for Health Promotion Studies, 2002); the media; web based articles from stakeholder organisations and groups; and questionnaire surveys conducted during the HIA.

### **Identifying and analysing impacts**

The SB HIA employed a variety of methods for the identification of impacts, with early sources consisting of: literature review; monitoring of the media; stakeholders’ web based information sites; and observation of a consultation meeting arranged by the Health and Safety Authority, Ireland (HSA). As the HIA progressed other sources comprised: written submissions to the HSA; questionnaire surveys; and community workshops, The SC HIA methodology employed existing published literature, and key informants from the locality as a primary sources for the identification of impacts

Literature reviews served to identify some key issues in both HIAs. In the SB HIA, with respect to physical health impacts, long-term impacts were primarily identified and appraised from the existing published literature, but shorter-term impacts, while initially identified through existing literature, were in part appraised using data collected in new questionnaire surveys. In the SC HIA, physical and mental health impacts associated with physical activity were identified primarily through review of existing literature. Both HIAs in this study identified impacts through consultation with stakeholders but the methods used differed in approach. The SC HIA utilised semi-structured interviews of key informants of stakeholder consultation. Purposive sampling of informants was

**Table 1 Comparison of HIA case studies**

Topic	Sports centre proposal for Bantry	National ban on smoking in the workplace
Level of HIA	Local development project	National policy
Definition of health	Very broad (WHO, 1986)	Very broad (WHO, 1986)
Time perspective	2 months - HIA process 2 month - analysis and report writing	8 months - HIA process 4 months - analysis of surveys integration of data and report writing
Resources used	Time of assessors	Time of assessors and cost of workshops and attending meetings
Personnel	2 Assessors including: A HIA researcher and a public health specialist	3 assessors including: A specialist HIA researcher, a public health specialist and e health research specialist. Other inputs included methodological advice from social, political and economic specialists
Rationale	A feasibility study by a local development group had revealed that the sporting development of many people in the locality was being restricted by a lack of facilities. The study had been carried out with little informed consultation. The local development group had expressed a keen interest in a HIA to assist in the development for a bid for the funding of the sport complex.	After the announcement of prospective legislation the 'smoking ban' had become a prime issue among lobby groups and the media with much discussion focusing on the effects of the new policy on public houses. Due to a lack of data pertinent to the Republic of Ireland a comprehensive appraisal of the policy was initiated.
Aims	The aim of the SC HIA was to conduct an assessment of the impacts on the health of the local community of Bantry of the presence of a sports centre. Specific objectives were to : i) identify likely health impacts of the construction of a sports centre. ii) identify likely health impacts from the presence of a sports centre iii) make recommendations to aid the sports centre committee in maximising its contribution to tackling obesity and physical inactivity	The aim of the HIA was to conduct an assessment of impacts on health of new legislation governing environmental tobacco smoke (ETS) in the workplace, with specific focus on the impacts associated with public bars. Specific objectives were to : i) identify indicators of health and welfare associated with existing policies governing ETS in the workplace. ii) identify perceptions and attitudes towards the new legislation. iii) predict health and welfare impacts of the smoking ban. iv) form a base line of indicators for a follow-up, post legislation, monitoring and assessment of predicted impacts. v) make recommendation for the monitoring of impacts identified
Scope of policy/project	Local	Nationwide
Boundary of the HIA	Geographical boundary of the local community	Impacts associated with public houses within the Republic of Ireland
HIA Process	Elements of the Merseyside Model (Scott-Samuel, 1998)	Element of the Merseyside model (Scott-Samuel, 1998) plus detailed elements of workshop participation in (Ison, 2000)
Methods used	Literature Review Semi-structured interview of key informants using matrix of health determinants	Literature review Media monitoring Observation of consultation meetings Stakeholder submissions Questionnaire surveys of bar patrons and community members Community workshops using matrix of health determinants
Kind of evidence used	Demographic data: Vital Statistics (Central Statistics Office, 2003); SLÁN (Centre for Health Promotion Studies, 1999). Local evidence: BIDG (Bantry Integrated Development Group, 2000) Qualitative data: Interviews with key informants	Quantitative data: Published literature and questionnaire surveys Qualitative data: Stakeholder submissions, meetings and workshops and from media monitoring Data concerning licenced premises (CERT, 2002) Demographic data: Census (Central Statistics Office, 2002a; Central Statistics Office, 2002b)
Participation	Key informants	Community groups, individuals and national organisations

employed using recommendations from interviews with initial informants from the local development group. Of 25 informants contacted only one did not participate in the interviews.

Workshops have been used in HIA to provide a forum for participation and contribution by a broad range of stakeholders (Ison, 2000). Workshops used in the SB HIA were useful in identifying issues of concern to stakeholders and particularly in highlighting priority impacts. Guidelines for workshop preparation by Ison, (2002) were followed. Polarisation of issues concerning the smoking ban had received extensive media attention since the announcement of the new legislation at the beginning of 2003. There had therefore been some concern during workshop preparation that this polarisation would dominate workshop discussions. In light of this it was made clear throughout the workshop that all issues raised would be assessed equally as potential impacts. In particular it was emphasised that it was not an objective of the process to associate any of the issues raised with particular stakeholders or stakeholder organisations. Establishment of this condition at the beginning of the workshop provided an environment that was safe for expression of issues of concern and did serve to enable much discussion and feedback between participants

In the SB HIA the process of identifying and appraising impacts became iterative in nature such that, while impacts were initially identified from published literature, media monitoring, stakeholders' web based information sites and observation of the HSA consultation meeting, potential impacts emerged as work progressed with later sources comprising the written submissions to the HSA, questionnaire surveys and community workshops. Similarly questionnaire surveys and media searches revealed factors that could be further investigated in the workshop setting.

In order to achieve a wide focus on potential impacts both HIAs used an impact matrix of health determinants during stakeholder consultations. In the SC HIA stakeholder interviews employed a socio-environmental model of health, derived from the work of Lalonde (1974) and Labonte (1993), which acknowledged a broad range of health determinants. This model formed a framework to enable stakeholders to identify potential health impacts In the SB HIA during in the workshop setting. In the SB HIA guidelines from Ison (2002) for using an impact matrix of health determinants during workshops were employed The impact matrix used was comprehensive, listing a broad range of determinants. The intention in using a comprehensive checklist was to elicit an appreciation of the broadness and range of factors that may impact on health. In the SB HIA, in order to initiate this type of focus on health, workshops commenced by focusing on what the participants understood health to be through the use of a graffiti wall. In addition to forming a good introduction to a broad approach to health it also served to introduce the emphasis that all issues arising during the workshop would be considered as valid concerns.

### **Questionnaire based surveys providing new data**

The SB HIA process was based on a comprehensive model and involved the collection of new data to fill gaps in the knowledge base and particularly to provide quantitative data specific to the Republic of Ireland. Initial scoping procedures including the observation of the HSA consultation meeting and media monitoring identified a number of themes for inclusion in cross-sectional questionnaire surveys. The themes investigated comprised the prevalence of behaviours with respect to public bar patronage including: average consumption levels in public bars, smoking behaviour; social use of public bars; attitudes towards the ban; and perceived influence of the ban on future behaviours.

Two specific targets for the questionnaire surveys were public bar patrons and rural communities. The sample for the public bar survey consisted of a total of 30 bars selected according to convenience in the counties of Galway and Offaly. The community-based survey comprised a similar series of questions to that of the bar survey. These were included as a section within a multi-stage interview administered survey examining various aspects of health, safety and well being in rural communities in Ireland. The survey selected rural communities randomly from each of the provinces of the Republic of Ireland with individual participants selected randomly from community samples. The questionnaires comprised a series of questions designed to identify socio-demographic information, social behaviour, current attitudes and perceived influence of the ban on these factors and self-reported symptoms related to respondent's physical health and included questions relating to sensory irritations and duration of exposure to ETS.

## **Media monitoring**

Throughout the SB HIA the media was monitored for articles concerning the ban on smoking. General monitoring was conducted on newspapers, web-based sites, and TV for news and information of the smoking ban. It is well documented that the nature of media coverage can have a significant influence on attitudes to current issues (Chapman and Lupton, 1994) so a more detailed analysis was conducted of two national newspapers for the period from the announcement of the ban in January of 2003 until the commencement of the new legislation in March of 2004. Methodology and coding used in the analysis was adapted from a study by Durrant et al., (2003) of the coverage of tobacco issues in national newspapers in Australia. Outcome measures for the analysis were: the number of articles; month of publication; section in which the article was placed; the dominant theme of the article; event and opinion slant of the article; and whether the main focus of the article was on public houses. This analysis showed trends in media interest in the development of the policy and showed a dominant focus of articles on issues of support or opposition to the policy.

**Table 2 Summary of impacts identified and their predicted nature**

SC HIA		SB HIA	
<b>Physical and mental health impacts – very positive</b>	There were some concerns for the need for adequate training of personnel in sports injuries and first aid, but data from key informants and published literature predicted an overall positive impact on physical and mental health.	<b>Physical determinants, - very positive impacts</b>	Short-term positive impacts on physical health predicted from literature and bar survey comparison of self-reported symptoms between customers and bar workers. Bars workers reported more respiratory and sensory symptoms than customers. Long-term positive impacts predicted from existing peer-reviewed literature.
<b>Economic impacts - overall positive</b>	Pricing was predicted to be a major factor in access to the facility and its ongoing viability. Limited impact directly on employment other than during construction with a positive contribution to local employment during this phase. Of more importance was thought to be the spin off to be gained by shops and businesses in the town It was also predicted that the centre could attract foreign investment to the town with better facilities for employees	<b>Economic determinants - mixed impacts</b>	As there are few structures in place in Ireland that would enable direct correlation between bar sales and effects of the smoking legislation, economic impacts on public houses were difficult to determine. A survey of customer behaviours and patronage was therefore used as a proxy for predicting economic impacts. Results related to rural bars only and predicted some reduction in patronage levels particularly among current smokers. Literature review of bans elsewhere predicts overall no economic impact.
<b>Social and lifestyle – overall very positive but dependent on specific factors</b>	The centre would provide sporting facilities for the large hinterland surrounding the town. It was predicted it would be a positive influence in combating substance abuse (ie smoking and alcohol consumption among all age groups but particularly young was predicted The centre had the potential to draw the focus away from pubs as the main social venue. Dependant of pricing, the centre was predicted to provide an important facility for the community’s infrastructure, improve social contacts particularly for disabled people and would generally help to alleviate social exclusion (highly dependent of pricing). It was predicted that as a consequence of the better facilities and infrastructure provided by the sports centre there was a greater potential for young people to stay in the area and to come together from different backgrounds through sports	<b>Social and lifestyle impacts - mixed</b>	The rural community survey revealed that the most important use of public bars was for meeting people. A reduction in social use of rural bars after implementation of the smoking ban was predicted. A survey conducted for the statutory body responsible for tobacco control in the Republic of Ireland predicted no overall national change in the social use of public bars. Predicted future social use of bars was dependent on current smoking status. Predicted increases in aggression in the home due to predicted increased drinking of alcohol in that setting could were not supported by existing published literature, which suggest there are no simple causal links between alcohol and aggression.

## Decision making, reporting and recommendations

A report of the SB HIA was produced in draft form comprising: details of the methodology employed; issues identified; appraisal with results of surveys and literature review of issues raised; and recommendations made on the basis of the appraisal. This draft report was sent to participating stakeholders with requests for their responses. At this draft stage of the documentation process decisions concerning predictions and recommendations were carried out by the assessors due to the low level of participation by the steering group members. Decisions and recommendations for the SC were made in conjunction with the sports centre committee and documentation of the process was presented to them as a completed report of the HIA. Table 3 summarises recommendations made in both of the HIAs.

**Table 3 Summary of recommendation from the pilot HIA's**

SC HIA		SB HIA	
<b>Social and economic environment</b>	Minimise social exclusion and discrimination by ensuring access in terms of cost, facilities and transport The venue should be adaptable for other uses including performing arts and for enabling spectators to view games	<b>Amendment issues: Ventilation and designated smoking areas</b>	Existing published studies of ventilation and designated areas, identified as potential amendments to the policy, could not be recommended. Recent research (Kotzias, 2003) of ventilation of ETS found insignificant effects of ventilation on ETS levels in conditions found in residential and commercial indoor environment. Studies of the efficacy of designated areas in controlling exposure to ETS (Cains et al., 2004) showed only partial protection from ETS.
<b>Physical environment</b>	Create a safe environment for the sports centre with adequate lighting, security, and footpaths. Draw attention to possibility of sports injuries and consider first aid training of staff in conjunction with schools	<b>Physical Health</b>	The use of legislation as a control measure had been recommended by the HSA/OTC commissioned report. Studies published since that report have not provided sufficient evidence to change that conclusion. On going research aims to monitor the respiratory health of bar workers
<b>Lifestyle</b>	Link with agencies and organisations targeting vulnerable groups to promote physical activity initiatives (ie asylum seekers, the disabled, the elderly and youth groups). Incorporate indigenous activities	<b>Economic</b>	Rural public bars, identified as potentially the most vulnerable to negative economic effects should be monitored for changes in patronage patterns
<b>Services</b>	Develop links with health services (ie the public health nurse, GP referral schemes , first aid training) Build connections with local schools to encourage physical activity from young age.	<b>Social and cultural</b>	Predicted impacts of the potential for a reduction in public bar focused drinking of alcohol such as elevated drinking in the home and increased drug usage should be monitored
<b>Public policy</b>	Adopt a sports for all policy by ensuring that the facilities cater for all levels of abilities Target groups such as women, lone parents and the elderly to ensure inclusion.		

As an initial aim of the SB HIA was to fill gaps in the knowledge base, the main focus of recommendations was on specifying future monitoring of issues identified. Recommendations made in the SC HIA proved helpful in aiding the sports centre committee to focus on crucial issues for the preparation of a funding bid for the project.

## Limitations of the HIAs studied

### Timing of the process

With respect to the timing of activities and methods within the HIA process, it has been noted by other HIA pilot evaluation studies that it was difficult to separate the stages of the work in the HIA process as indicated by published frameworks (Scottish Needs Assessment Programme, 2000). This type of difficulty was similarly experienced during the SB HIA and was particularly notable with respect to problems encountered in the amount of

time spent engaging the participation of stakeholders in the HIA steering group and of community members in the workshops. The consequence of these difficulties was that the procedures ran well over their allotted time and intended sequence in the HIA process. Despite the difficulties encountered it was thought important to not omit these procedures entirely and stakeholders were kept informed of progress in the HIA. Figure 1 shows the timing of activities and methods of the SB HIA relative to the steps in the HIA framework.

The timing of the SB HIA relative to the implementation of legislation, enabled analysis of pre-ban the status that can be used as a baseline for assessing post-ban trends. As a primary aim of the HIA this had largely been fulfilled particularly with respect to: the development of baselines for current public bar usage; trends in patronage; and social use of public bars in rural areas. However, the HIA had no effect on final modifications of the policy, Exemptions and modifications to the policy were debated through more traditional consultation procedures between stakeholders and policy makers.

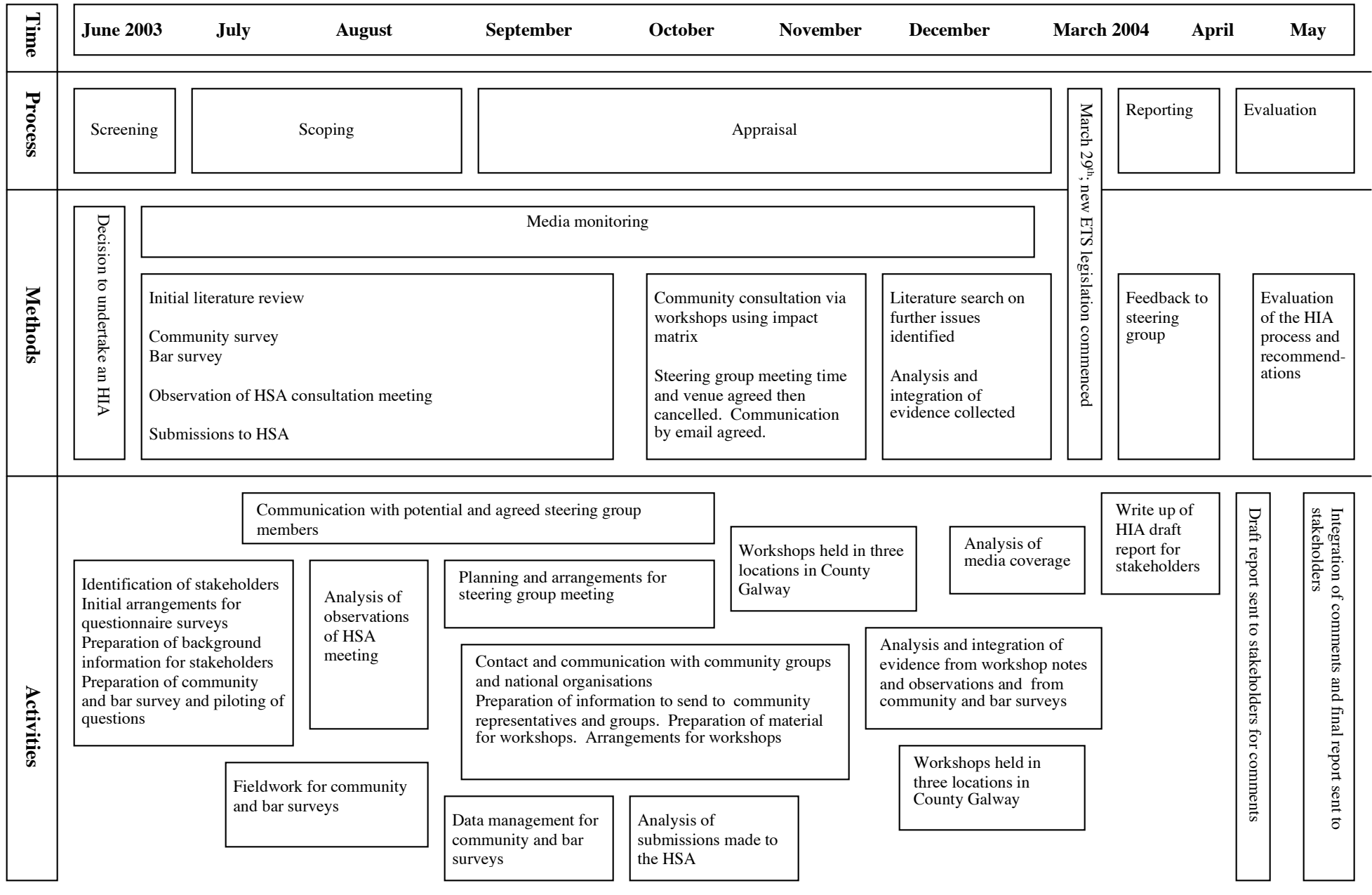
In the SC HIA difficulty was experienced in tackling some key issues due to the timing of the assessment. An example of this was entrance costs to the sport centre, which during interviews had been cited frequently as a contributor to social exclusion and an important determinant of access to the sports centre. However, it was also considered to be an issue that could not be resolved until a much later phase in the development of the project, “it seemed a long way off” from the planning application stage. The timing of an HIA in this respect is crucial and the HIA may perhaps have been more effectively conducted when the project was beyond the planning stage and therefore more secure. At the time of conducting the HIA no site had become available for the sports centre and fundraising activities could not be continued until planning permission had been sought. Therefore, stakeholders may have had some difficulty in conceptualising impacts arising out of the sports centre development. (Mindell et al., 2003) suggests that for a HIA to be influential it needs to be carried out early enough to have an effective input into the decision making process, but late enough for proposals to be sufficiently firm to enable an assessment. Despite this, the timing of the SC HIA did enabled identification of predicted negative and positive impacts of the sports centre and served as part of the planning and bidding process for the sports centre. The process was invaluable in raising awareness of issues present in the locality and helped the sports centre committee focus the rationale for undertaking the development. Figure 2 shows the timing of activities and methods of the SC HIA relative to the steps in the HIA framework.

### **Stakeholder consultation and participation**

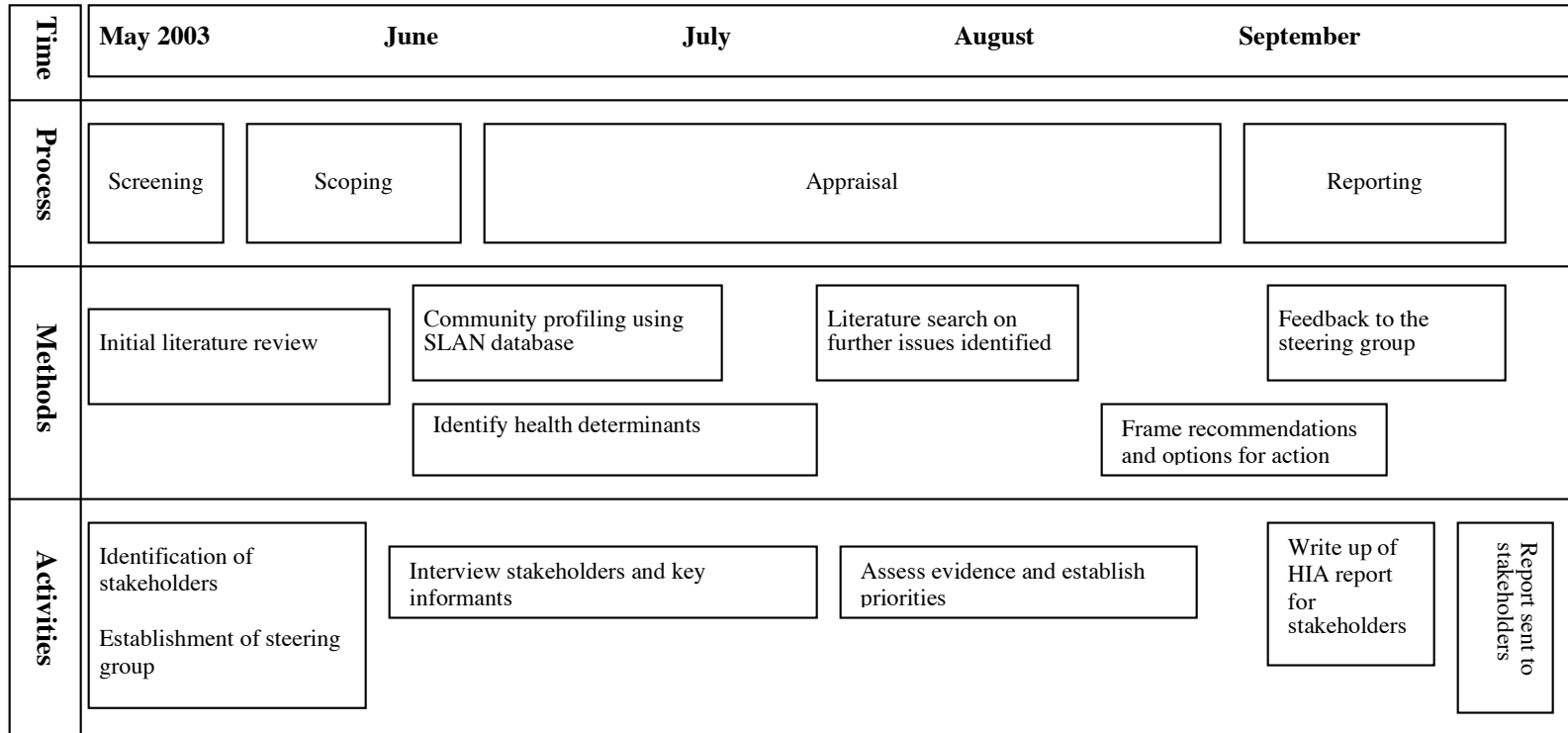
The SB HIA incorporated a range of methods for participation but it was evident that the level of participation varied according to the method used. In the first activity to engage participation, representatives from stakeholder organisations were invited to take part the HIA steering group. Initial contact with stakeholder organisations brought much expression of interest in HIA process and in its subject, the smoking ban. However, invariably, this did not extend to actual participation and arrangements for a steering group involved prolonged communication with various potential participants. Next two aspects of the public consultation process of the statutory body, the HSA, were incorporated into the HIA (the consultation meetings and written submissions to the HSA). The consultation meetings raised many issues but were largely dominated by lobby-groups, a situation that may have proved intimidating to individual community members. Finally workshops were arranged to invite community members to give their perspectives in a semi-structured forum. For this workshop guidelines developed by (Ison, 2002) were used. Representatives from organisations participated through the various methods of, consultation meetings, written submissions and workshops. Submission of depositions to the HSA was utilised by individuals to a much greater extent than either the workshops or the HSA consultation meeting, suggestive that convenience played a role in the manner in which individuals chose to participate. However, it may also be that presenting a written submission to a statutory body was perceived by stakeholders as having more weight than taking part in either a consultation meeting or a workshop.

The workshops venues were kept local (ie in County Galway), partly because of the difficulty that had been encountered in arranging more distant venues for the steering group, but also due to the identification of the ban having potentially negative social and economic impacts on rural public bars. Again there was much enthusiasm for the HIA and its subject during initial contact but attendance was nether-the-less low with only one of the workshops successfully drawing attendance from community representatives

**Figure 1 Time line of methods and activities relative to the HIA process in the SB HIA**



**Figure 2 Time line of methods and activities relative to the HIA process in the SC HIA**



Especially problematic was the low level of participation both among those invited from stakeholder organisations and from the community to the steering group and the workshops. Guidelines for participatory processes in policy development have been produced by a project co-funded by the European Commission under the (Programme for preparatory actions to combat and prevent social exclusion, 2000). Within the concept of the ‘process of participation’ the project highlighted various elements that are crucial for the achievement of effective participation. These elements include: i) Establishment of terms of participation; ii) Ensuring topics and exercise are relevant to those invited to be involved; iii) Building the capacity of the stakeholders to participate; iv) Building organisational commitment to the process; v) Developing an ongoing process through the various stages of policy development, implementation and evaluation.

While elements (i) and (ii) of the participatory guidelines were addressed during the SB HIA other elements such as, capacity building (iii) and endorsement by policy makers (iv), were not fulfilled. The HIA process itself provides for element (v), as a methodological process for participation in policy development. However, in the absence of explicit official endorsement of the SB HIA, a lack of commitment may well have been perceived by stakeholders to be evident.

A number of reasons may be posited for the relatively low level of direct participation in the SB HIA. Time demands and inconvenience may have played a role in low participation. Stakeholders that hold relevant positions within their organisations, enabling them to make important decisions for those organisations within the HIA process, tend to have very busy schedules. They need to see their participation in the HIA process as a worthwhile task. Endorsement of policy level HIA by the policy makers is most likely an important factor in conveying the relevance and usefulness of the process.

Timing of the SB HIA relative to the announcement of the policy may also have been an issue in participation levels. Prior consultation is a fundamental tenet of the HIA process. While the time between the announcement of the new legislation and its implementation was over one year it was felt by some stakeholders that consultation was made available only after the legislation had become “a done deal”. Comments during the HSA consultation meeting suggested that many thought that these meetings would provide a chance to influence the choice of control strategy for ETS. As this was not the case it may be that some stakeholders had become cynical about their involvement in any consultation process for the ban.

The low level of direct participation in the policy level SB HIA is interesting when compared to participation in the project level, SC HIA, where all but one stakeholder approached, participated in the process. This difference in the levels of direct participation in the two HIA processes may, possibly, be explained by a greater impetus to participate when issues are more local and perhaps perceived as more accessible

The issue of the complexity of participation in the HIA process has been highlighted by (Parry and Scully, 2003) who noted that while community participation may be intuitively appealing its use was not as straight forward as may seem. Experience from these HIAs highlights the necessity of using as varied an approach to consultation as resources permit, particularly where policy level HIAs require a broad, heterogeneous definition of community.

### **Appraising the issues**

Criticism of HIA has cited an over reliance on expert opinion as a major limitation of the process (McKintyre and Petticrew, 1999). Certainly, the SC HIA drew the majority of its evidence from key informants, however, many of the issues raised were appraised through a review of existing published studies. A problem that arose from this strategy has been recognised by (Milner, 1999) who noted that information obtained at project level may be more precise than that of other levels but is often of a more localised relevance. In the SC HIA the use of key informants enabled many specific local issues to be identified, however, linking identified impacts to existing published evidence on a local level was problematic in that issues and especially potential solutions from studies derived elsewhere were not appropriate for local circumstances. Equally, lack of available local baseline health data made it difficult to monitor and assess specific health impacts. For example during stakeholder interviews there had been concern expressed about a high rate of suicide in the area, however without quantitative evidence to validate this, it was

difficult to know if this perception was correct. Similarly in the SB HIA data analysed from surveys of public bar patrons and rural communities were only applicable to rural areas. Existing published studies relevant to the issues surveyed were derived from other countries or even continents making appraisal of issues using these sources difficult.

### **Health advocacy v's impartial assessment**

(Kemmer, 2001) has argued that while the practice of HIA creates a favourable climate for health advocacy by putting health high on the agenda, there is a tension between HIA that seeks to make an impartial assessment of the health consequences of different policy options and health advocacy that is normally committed to one option.

In conducting the SB HIA some conflict in the underlying principles of HIA did become apparent. The SB HIA was conducted on a policy, the aim of which is to improve physical health. The use of a very broad definition of health within the HIA required assessment of many determinants of health. This necessitated an examination of the potential for social and economic factors to be impacted, some of which conflicted with the physical health aims of the policy. The process raised the question of whether in some circumstances, when using a wider socio-economic definition of health, the HIA principles of health promotion and health advocacy can fit comfortably within the principle of objective assessment of impacts.

In response to the SB HIA report some participants stated that they felt the document did not present a clear position on the policy. While these comments indicate that further capacity building among stakeholders is required in terms of awareness of HIAs' principle of impartial assessment, naming the process 'health' impact assessment may not be helpful in this respect, as it can give the impression that the process is primarily concerned with health advocacy. (Kemmer, 2001) noted that HIA could be interpreted as an attempt to make all policy areas subordinate to health with the wording of the Ottawa Charter with respect to health promotion, reinforcing such concerns. In response to this (Tay, 2002) advocated a process termed 'human impact assessment' be used, eliminating any connotation with health imperialism that may be associated with HIA. The process of human impact assessment, Tay argued, should also enlarge the conceptual focus of HIA towards sustainable development, further integrating the social and biophysical determinants of health.

### **Issues and recommendations for conducting HIA in Ireland**

The two HIAs discussed in this study have highlighted a number of issues that relate to the conducting of HIAs in an Irish context. These fall into three main areas:

- Availability of a coordinated evidence base
- Traditional approaches to consultation at policy level and the need for capacity building with both policy makers and stakeholders
- Need for an integrated approach to impact assessments

#### **Co-ordinated evidence base**

Experience with the two case studies presented here has shown that evidence is available at both local and national levels within the ROI for use in HIAs. Major national and international surveys such as the SLÁN surveys (Centre for Health Promotion Studies, 1999; Centre for Health Promotion Studies, 2002) and HBSC (Eds: Currie et al., 2004) contain local and national demographic data for the profiling of communities. However, the SB HIA demonstrated the need for a greater coordination of the evidence base with many gaps within the baseline data needed for determining future impacts, particularly with respect to economic and social determinants. For specific issues concerning the focus on impacts associated with public houses, new data was required and did therefore necessitate additional resources for the HIA. At a local level the in the SC HIA a lack of available local baseline physical health data made assessment of the nature of health impacts difficult.

Whilst the experience base is likely to be unique for any given HIA, whether at national policy or local project level, the evidence base is likely to contain many elements that reoccur from one HIA to another. In this respect a coordinated evidence base could prove an extremely useful resource for impact assessments. (Joffe and Mindell,

2002) have highlighted the need for greater coordination of a sound evidence base for use in HIAs, proposing a framework that could be used to collate and evaluate existing data. Such a coordinated evidence base could be used to identify gaps in the data requiring research and enable informed judgements about health impacts for various policy options.

A review of existing data sets carried out by the (National Statistics Board 2003) indicates that preliminary work has been undertaken to evaluate existing non commercial datasets in the State with respect to meeting future policy needs. Additionally the development and the recent publication of Health Information: A National Strategy Department of Health and Children (2004) promises the establishment of a national, integrated and accessible set of health related data.

### **Consultation, participation and transparency**

During the SB HIA, there had been a considerable amount of consultation between the policy-makers and various stakeholders during the one-year period between the announcement of prospective legislation and its eventual commencement at the end of March of 2004. These consultations had been referred to widely in the media and in press releases from statutory organisations (Brennock, 2003; Donnallan, 2003; O'Halloran, 2003; O'Regan, 2003; O'Regan et al., 2003; OTC, 2003). However, HIA was not employed by policy-makers during this phase and the consultation process was conducted in the traditional 'behind closed doors' manner where various lobby-groups and organisations consulted in private sessions with policy makers. In terms of public participation, measures had been taken by the policy makers to enable public involvement in the policy development process. This included a series of public consultation meetings arranged by the Health and Safety Authority in several locations across the country, and invitations for written submissions were invited from stakeholders. The outcome of the various consultation measures arranged by the policy-makers was the incorporation of a number of amendments to the original proposed legislation into the final Act, Public Health (Tobacco) (Amendment) Act, 2004). While this process was widely reported in the media during that period, the overall approach lacked what are the major aims of HIA, to provide a fully transparent, structured and documented approach to policy development.

### **Integration of HIA into the policy development process**

Ison, (2000) notes that when embarking on HIA it should be born in mind that the process is iterative rather than a one off activity and it needs to be integrated into the culture of all organisations in a manner that makes considerations of health and health gain become routine. Experience during the SB HIA with respect to engaging participation in the HIA process would suggest that at both the level of the stakeholder and the policy maker HIA is not fully integrated into the culture of organisations. However, recent publication of a white paper, *Regulating Better*, issued by the Department of the Taoiseach, (2004) does indicate that an integrated impact assessment model (regulatory impact assessment, or RIA) is set to become incorporated into the development phase of public policy. It has been suggested by Kemm, (2001) that there are political advantages to a more integrated approach to impact assessments that do not reframe social and economic goals as determinants of health. Kemm argued that governments are keen for policy goals, with varying political, social, economic and health aims, to be formulated in an integrated manner, that will not disturb the balance of influence between the various branches of the policy-making organisation. As the RIA model is still under development it is not certain how HIA will be integrated into such a process within Irish public policy development.

### **Conclusions**

The SC HIA met its objective of identifying potential health impacts from the presence of a sports centre in Bantry. The assessment also served in making recommendations to aid the sports centre committee in its application for planning for the sports centre, focusing the rationale for the development. There was a unanimous belief among participants in the SC HIA that the presence of a sports complex in their area would improve the health of locals and provide an impetus to create a new healthier lifestyle in their town. The HIA process served to highlight for the participants the important role that a policy and environmental approach to tackling physical inactivity could play. The added value of this approach to enabling people to adopt a healthy lifestyle through the provision of sports

facilities is that the Ottawa Charter (WHO, 1986) principle of creating supportive environments for health in can be realised at a local level.

The SB HIA was able to identified perception and attitudes towards the new legislation and a range of potential impacts. A primary aim of the process to fill gaps in the knowledge base with respect to impacts of the ban on public bars in the ROI was successful in terms of providing baseline indicators for the potential impacts for follow-up post legislation assessment of the policy. The HIA was useful for outlining areas of uncertainty and recommendations were made for future monitoring of these issues.

Both studies made an important contribution to the practice of HIA in the ROI as no previous literature exists for either policy or project level HIAs in the State. Experiences gained from the two HIAs highlighted a number of issues that are relevant to their development within an Irish context.

- Stakeholder participation levels were problematic at policy level HIA
- Further capacity building is required to increase awareness of the principles of HIA
- A coordination of evidence and baseline data is required and an assessment of data that is likely to re-occur in a wide range of impact assessments is necessary
- Further integration of impact assessment processes is needed and further integration within the development of public policy

Issues that have arisen during these studies have significance for the process of HIA at policy level in general. They serve to illustrate that HIA requires further capacity building, with both stakeholders and policy makers, to enable it to become fully incorporated into policy development within the ROI. In particular, endorsement by policy makers is a necessary prerequisite in order for the process to have relevance for stakeholders.

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