

**Evaluation of Phase Three of the New South Wales
Health Impact Assessment Project**

Final Report

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Executive Summary

This report details the findings of an evaluation of the implementation of Phase 3 of the New South Wales Health Impact Assessment Project led by the Centre for Health Equity Training, Research and Evaluation at the University of New South Wales (the project).

The purpose of the project was to integrate Health Impact Assessment (HIA) into the NSW health system as a tool to improve internal planning and decision making, to build capacity within the health system and as a way to engage external partners on initiatives which influence health outcomes.

The evaluation of the project used a mixed-method, qualitative design involving diverse data sources. The methods included:

- a) three case studies involving telephone interviews with eight senior staff from two Area Health Services (AHSs) and three senior staff from the Department of Health
- b) telephone interviews with eight key informants
- c) document analysis.

The summary of findings of the evaluation are reported under the five capacity building domains described in the aims of the project as improvement in capacity in these areas would be seen as key outcomes.

Workforce Development

- The project has had a significant impact on workforce development at the AHS level. It has increased staff members' awareness and understanding of HIA and raised the profile of HIA across the AHSs.
- The learning-by-doing approach that underpins the project is regarded as practical, informative and highly effective.
- CHETRE's involvement, and the provision of a range of useful and informative resources, has been critical to the gains made in workforce development
- Gains in workforce development have been less obvious at the Department of Health.

Resource Development

- The wide range of resources provided by CHETRE was regarded as a key contributor to enhancing staff members' awareness and knowledge of HIA, and informing their use of HIA in practice.
- CHETRE's expertise, support, reliability and general availability was identified as being critical to the success of the practical application of HIA.
- The learning-by-doing training approach was regarded as a key impetus for generating knowledge about HIA and for developing the skills necessary to undertake HIA in practice. The training was also seen as critical for building workforce capacity within health and in partner organisations.
- The funding provided to facilitate rural AHS staff members to attend training was regarded as crucial for their involvement in the project.
- The resources, such as the HIA Manual, website, helpdesk were described as valuable, practical, easy to understand and effective forums for learning about HIA.

Partnership Development

- The consolidation of previously existing relationships, the development of new partnerships, and working in a collaborative way *with* external organisations, was regarded as a key achievement arising from the project.
- Engagement with other departments within the health system, such as Environmental Health, Public Health, Health Promotion and Health Planning, was also noted as an important achievement.
- The HIA process was attributed with having provided a purpose and focus for partnerships and provided a formal structure for communication and relationships to occur.
- The facilitation of closer relationships with external organisations led to a greater interest in health from these partners.
- A key achievement was the development of collaborative relationships between AHSs and local councils.
- Overall the development of partnerships was regarded as useful, positive and durable.

Leadership

- “Champions” at a high level and strong leadership was regarded as one of the key capacity building domains that had led to the achievements of the HIA project within AHSs.
- Staff who have undertaken training are also recognised as effective advocates for HIA.
- The lack of support for HIA at state level is largely attributed to a failure of leadership at the departmental level and to the loss of HIA “champions” within the Department due to personnel changes.
- A lack of leadership and endorsement at state level was perceived as a threat to sustaining the momentum required to embed HIA and to extending its reach beyond those already directly involved in HIA such as Population Health and Public Health.

Organisational Development

- HIA has been included within key strategic documents including the State Health Plan and the Healthy People NSW Population Health Plan. The inclusion of HIA in these documents was considered to be important progress but was described as “aspirational” and yet to be operationalised.
- Area Health Services have included HIA within internal documents but only within Population Health and/or Health Promotion divisions.
- The documents also suggest the AHSs have a greater commitment to the use of HIA than the NSW Department of Health.
- In some AHSs HIA has been incorporated into planning processes, has been used by planners, included in urban planning, has impacted on local environmental and social plans, and used by local councils and other partner organisations.
- While there have been many significant achievements at an organisational level, with a number of staff capable around HIA, systemic capacity across AHSs was considered to be generally at a “low level” relative to total staff numbers.
- Systemic capacity within the Department of Health was thought to be undeveloped.
- Staff at the Department of Health were generally regarded as having a lack understanding of what HIA is about and have not perceived it as relevant to health promotion or policy at departmental level.

Future Action

- Develop support and leadership at the state level.
- CHETRE's continued involvement in the HIA project was widely regarded as critical to ensuring HIA remains on the agenda in health, maintains momentum, and provides ongoing training and professional support to promote and sustain workforce development.
- The continuation of some the training and learning-by-doing approach in some capacity were seen as critical to further build capacity at the state level.
- The majority of participants commented that the HIA project should continue because the culture of HIA was not yet sufficiently embedded.
- There was suggestion that CHETRE needs to further evolve the HIA project, to progress into integrated impact assessment, to involve much more multi-agency work with other partners and to move into areas not previously the focus of HIA.
- It was suggested the project HIA needs to move out of Health Promotion, to become a healthy public policy programme and to prioritise health inequalities.

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1. Introduction

This report details the findings of an evaluation of the implementation of Phase 3 of the New South Wales Health Impact Assessment Project led by the Centre for Health Equity Training, Research and Evaluation at the University of New South Wales). The project is funded by NSW Health. The project uses the following definition of Health Impact Assessment:

a combination of procedures, methods and tools by which a policy, program or project may be assessed for its potential and often unanticipated, effects on the health of the population and the distribution of these impacts within the population (National Health and Medical Research Council, 1994).

Health Impact Assessment (HIA) has been on the public health agenda in Australia for almost two decades. There is an increasing interest both in Australia and internationally in developing systematic approaches to assessing the intended and unintended impact of policies, programs and projects on health. Health Impact Assessment is a structured approach for considering the health impacts for draft projects, plans, programmes and strategies. A more recent focus on health inequality has strengthened the approach, particularly for assessment of health sector proposals. Assessments made by sectors external to health are particularly important as there is often considerable health gain that can be achieved through improved proposals, coupled with significant potential to reduce inequalities as well.

In response to policy recommendations, the Centre for Health Equity Training, Research and Evaluation (CHETRE) has led a three phased intersectoral HIA implementation project in the New South Wales area. Phase 1 of the NSW HIA project (the project) focused on raising awareness and exploring the feasibility for HIA. Phase 2 involved trialling and a focus on “learning by doing” across four main strategies. The aims of phases 1 and 2 were as follows:

Phase 1

- explore the feasibility and mechanisms for the development of HIA
- increase awareness of the purpose and scope of HIA
- identify areas where capacity needed to be developed

Phase 2

- develop a formal communication strategy on the purpose of HIA and its methodology with the aim of promoting organisational commitment to developing HIA
- undertake a limited number of “learning by doing” HIAs by establishing five developmental HIA sites in NSW to provide practical experience to inform policy development and to support the work of the Greater Western Urban Health Development Group (GWUHDG)
- build consensus among stakeholders (within NSW Health and with external stakeholders) on the purpose and range of applications and processes for undertaking HIA.

The breakdown of each phase in terms of process and outcomes is included in Appendix 1. The results of Phase 1 and 2 of the project are reported on CHETRE’s website.

1.1 The NSW HIA Phase 3 Project

The purpose of Phase 3 of the NSW HIA project was to integrate HIA into the NSW health system as a tool to improve internal planning and decision making, to build capacity within the health system and as a way to engage external partners on initiatives which influence health outcomes.¹

The aims of Phase 3 included:

- leading and facilitating opportunities for debate and learning about HIA that can add value to the health system
- embedding the capacity of the health system to undertake HIA
- identifying and fostering key stakeholders within the health system to provide leadership and to embed HIA into current planning and decision making processes
- developing and maintaining up-to-date and relevant resources to support the impact and sustainability of the NSW HIA project
- facilitating intersectoral collaboration with external partners regarding HIA
- building on the “learning by doing” approach developed in Phase 2 through supporting up to 16 more HIA sites over the three year project.

It was anticipated that the activities described above would be delivered through the following five capacity building domains and that improvement in capacity in these areas would be seen as key outcomes of the NSW HIA project.

Five Capacity Building Domains

- Organisational development
- Workforce development
- Resources development
- Leadership
- Partnerships

¹ The CHETRE NSW HIA Phase 3 Project is variously referred to throughout this report as follows: the Phase 3 HIA Project, the HIA Project; the CHETRE project and the project

2. Purpose and Aims

The purpose of this report is to provide an overview of the key findings of an evaluation of the NSW HIA Phase 3 project. The write-up of the report is guided by six key questions from the original tender specifications. The individual case studies and key informant evaluations are reported in accordance with the six key questions that guided the evaluation.

Guiding Evaluation Questions

- what has phase 3 of the NSW HIA project achieved in relation to original tender specifications; at what organisational level have these been achieved; how have these been achieved?
- what has phase 3 of the NSW HIA project not achieved; why?
- what additional outcomes have been undertaken that were not included in the original documentation; what value has this additional work added?
- what systemic capacity has been built?
- what are the benefits and limitations of the NSW approach to building capacity to undertake HIA compared to other Australian jurisdictions?²
- what future action is required to build capacity to undertake HIA in NSW; how sustainable is this capacity?

In response to the six key questions, the evaluation of the HIA project cohered around two stages: a *process* evaluation stage and an *outcome* evaluation stage. Process evaluation refers to an assessment of a) how a programme functions in practice; b) whether there have been any changes in the programme compared with what was originally planned and c) whether appropriate processes are in place for the programme to achieve its stated objectives. The impact of any changes on how the programme has been delivered is considered in relation to its intended outcomes and any additional outcomes that may accrue. The purpose of the outcome evaluation is to assess a) progress towards the programme's stated objectives and b) whether any unintended outcomes have occurred.

In adopting a process and outcome evaluation approach a logic model was used as a reference point for the evaluation process (see Appendix 2). The logic model is used to provide guidance on what the key outcomes for a programme were, the strategies through which they were intended to be achieved and the rationale that linked the strategies to the outcomes. The model was developed in conjunction with CHETRE staff.

² Early in the evaluation process it became apparent that participants' knowledge of HIA extended to the NSW area and that they would not know about other jurisdictions. For this reason the question about benefits and limitations was changed to refer only to the NSW jurisdiction.

The findings of this evaluation are grounded in an analysis of:

- a) three case studies – to provide illustrative examples of how the HIA project has been applied and what difference it has made
- b) key informant interviews – to provide background information, involvement with the HIA project, and perceptions of the project and its outcomes
- c) document analysis – to assess the reach and activities of the HIA project.

3. Methods

The evaluation of the NSW HIA Phase 3 Project involved a mixed-method, qualitative design involving diverse data sources. The methods included:

- a) three case studies involving interviews with eight senior staff from two Area Health Services (AHSs) and three senior staff from the Department of Health
- b) key informant interviews with eight participants
- c) document analysis

The use of a qualitative methodology, and the inclusion of multiple stakeholders coupled with document analysis, was designed to maximise the richness of the research data and maximise the depth of understanding in evaluating the project. The triangulation of data sources and methods of data collection was adopted in this evaluation to enhance the quality and validity of the research findings.

3.1 Interviews

All interviews were undertaken by telephone with individual participants. Each interview was recorded with the consent of the interviewee. The interviews involved the use of a semi-structured interview schedule. The interview schedules for the case studies and key informant interviews differed slightly to allow questioning pertinent to the organisational location of the interviewee. The case study interviews focused on seeking information about participants' perceptions of the CHETRE project in relation to their own organisations whereas the key informant interviews sought more general comment. The interview schedule for CHETRE staff differed slightly from that used for other key informants and one interview was specific to a participant from a local council (see Appendices 3 to 6 respectively).

3.2 Sample - Participant Selection

A key consideration for the evaluation of the NSW HIA project was the identification of priority intervention groups. Organisations involved in increasing HIA within the health system which CHETRE had worked with on the project were identified as the sampling units for this evaluation.

The sample identified includes senior staff from the following sites:

- a) two Area Health Service catchments (one included a council staff member who had participated in a CHETRE learning-by-doing developmental site HIA)

- b) the NSW Department of Health – Centre for Chronic Disease Prevention and Health Advancement
- c) CHETRE
- d) the HIA Steering Committee.

The two AHSs were purposefully selected on the basis of geographical location to include urban and rural areas and on the basis of anecdotal knowledge about the level of uptake (from high to low) of HIA within different AHSs or involvement in the project. The case study interviewees and key informants were identified as stakeholders whose position within a particular organisation, or their involvement with the CHETRE project, meant they would be well placed to comment on the implementation of NSW HIA Phase 3 project.

4. Analysis

The analysis involved coding each data source in accordance with the six key evaluation questions. The data was then thematically analysed, enabling the researchers to identify emergent patterns and themes, as well as contradictions and inconsistencies, in evaluating the NSW HIA project. By combining different methods and sources of data the evaluation captures contextual factors that affect the implementation of HIA. Analysis of the context of the HIA embedding process promotes understanding of what the project has achieved, under what circumstances and why. The findings of each of the three case studies and the key informant interviews are reported as discrete entities in Appendices 7-10 respectively.

4.1 Document Analysis

Documents selected for the documentary analysis included those central to strategic planning, policy and reporting. The findings of the document analysis are reported in Appendix 11.

Document Sources

- strategic plans
- annual plans and reports
- policy documents
- reporting documents
- evaluations
- job descriptions

5. Summary of Evaluation Findings

5.1 Introduction

This section summarises the overarching findings from an evaluation of the NSW HIA Phase 3 project. The summary is based on an evaluation of findings from three case studies, interviews with key informants and documentary analysis. The findings are reported in accordance with the

stated purpose and aims of the project described previously and cohere around the six guiding evaluation questions.

As outlined previously, the three case studies included:

- a) Case Study A Area Health Service, located in a rural geographical area, involved interviews with senior staff members from Population Health, Health Promotion, and the local council.
- b) Case Study B Area Health Service, located in an urban geographical area, involved interviews with senior staff members from Population Health and Health Promotion.
- c) Case Study C is based on interviews with senior staff members from the NSW Department of Health spanning Health Advancement, Strategies and Settings, Epidemiology and Research, and the HIA Steering Committee.

The key informant interviews are based on interviews with senior staff from the Population Health Division within Area Health Services and the NSW Department of Health. Information from these interviews reflects participants' general perceptions of the HIA Phase 3 project from their differing institutional positions and differing locations at regional or state level.

The documentary analysis is based upon documentation within the NSW Department of Health and two Area Health Services that include reference to or illustrate commitment to HIA.

The documents were identified by key informants and other participants involved in the HIA evaluation.

5.2 Summary of Findings

Overall, the evaluation indicates that the NSW HIA Phase 3 project has made significant gains since its inception in 2005 and since a midterm review of the project in 2006.³ These gains have been particularly noticeable at the AHS level of the health system, but less so at state level. At AHS level a range of achievements has been made across the five capacity building domains (workforce, resource, partnership, leadership and organisational development) and participants have identified many strengths of the project. At the same time, the participants have identified areas where achievements have not been made, where there are problems relating to organisational development or systemic capacity building, and factors that have limited the embedding of HIA. A range of recommendations are made by participants to facilitate the integration of HIA across the health system in the future.

6. NSW HIA Project Achievements

In this section, the HIA project achievements are reported under the five capacity building domains outlined previously.

³The CHETRE NSW Health: HIA Capacity Building Program: Mid-term Review. University of New South Wales, 2006.

6.1 Workforce Development

The HIA project is reported to have had a significant impact on workforce development at the AHS level. The project has increased staff members' awareness and understanding of HIA and raised the profile of HIA across AHSs. Many staff members in AHSs have received HIA training and those who have been trained have been involved in undertaking at least one HIA in their area.

The learning-by-doing approach that underpins the project is regarded as practical, informative and highly effective.

Three evaluations of CHETRE's HIA training by staff who have attended their courses indicate that the training meets staff expectations, and the content is appropriate and relevant to their work (see Appendix 12).

Participants agreed that CHETRE's involvement, and their provision of a range of useful and informative resources, has been critical to the gains made in the workforce development domain.

Gains in workforce development have been less obvious at the state health level. Reasons for this are discussed later in the summary of findings in relation to what the HIA project has not achieved.

6.2 Resource Development

The provision of a wide range of resources by CHETRE was regarded as a key contributor to enhancing staff members' awareness and knowledge of HIA, and informing their use of HIA in practice. Participants in all three case studies and the key informants group identified many resources that they considered useful, effective and valuable.

The staff members from CHETRE were regarded as a critical resource for the HIA project.⁴ In particular, participants commented on CHETRE's expertise, support, reliability and general availability to guide them on the use and practical application of HIA. The high quality training, and the learning-by-doing approach, provided by CHETRE was also one of the most widely discussed resources.

The training was regarded as a key impetus for generating knowledge about HIA and for developing the skills necessary to undertake HIA in practice. The training was also seen as critical for building workforce capacity within health and in partner organisations. Moreover, doing the training with staff from other departments within health, and with external partners, was highly regarded. This approach was considered invaluable for developing relationships and making connections within health and with external partner organisations.

Participants commented on many other resources provided by CHETRE. These included: a "how to" manual, guidelines, newsletters, the Public Health Bulletin, listserv, HIA Connect and

⁴ It is noted that some participants did not directly refer to CHETRE staff as a "resource". However information relating to the help CHETRE staff provided is included in this section because it was so significant in participants' feedback on the project.

the HIA helpdesk. These resources were variously described as valuable, practical, easy to understand and effective forums for learning about HIA. Participants valued different resources to varying degrees, depending on their role in the health system. For example in the departmental policy environment a brief document in hard copy format was most accessible and useful, whereas in a practice environment in an AHS more detailed online resources were sometimes more appropriate.

Key informants also referred to the conferences CHETRE had organised as very valuable.

6.3 Partnership Development

The consolidation of previously existing relationships, the development of new partnerships, and working in a collaborative way *with* external organisations, was regarded as a key achievement of the CHETRE HIA project. Likewise, engagement with other departments within the health system, such as Environmental Health, Public Health, Health Promotion and Health Planning, was an important achievement. These different departments gained a better understanding of each others' roles and collaborated in decision making processes.

While some participants reported that relationships with external organisations existed prior to the project, these had strengthened considerably as a result of HIA and the project. The HIA process was attributed with having provided a purpose and focus for these partnerships and provided a formal structure for communication and relationships to occur. The facilitation of closer relationships with external organisations had also led to a greater interest in health from these partners.

A key achievement was the development of collaborative relationships between AHSs and local councils. In one AHS case study the development of a close relationship with the local council had led to the establishment of a project agreement between the two parties. In another, the council had endorsed HIA in the partnership agreement with the AHS and the recommendations from a HIA were included in council plans.

At AHS level the HIA process had facilitated engagement between government organisations, with regional and local organisations, and with communities. The development of partnerships meant greater awareness of HIA within the health sector and intersectorally.

The project also gave legitimacy for staff from sectors outside of health to attend CHETRE HIA training.

The development of partnerships and collaborative ways of working on HIA with external stakeholders was repeatedly commented on by participants and seen as a "highly effective" aspect of the HIA project. Indeed, the HIA process provided an effective mechanism for structuring and formalising partnerships with external stakeholders.

The HIA process also provided transparency in working with other organisations and the community, and this approach had engendered a sense of trust in health that had sometimes not previously existed.

Participants provided several examples where health and external organisations are now working collaboratively and looking forward in terms of developing healthy public policy.

An overall effect of the HIA project was that external organisations were now more interested in and more willing to engage with health and health equity issues.

The development of partnerships was regarded as useful, positive and durable.

6.4 Leadership Development

Having “champions” at a high level and strong leadership was regarded as one of the key capacity building domains that had led to the achievements of the HIA project within AHSs. Leadership at this level has been taken up by directors and/or managers primarily in two key areas - Health Promotion and Population Health. In one AHS the Population Health team is responsible for leading HIA. Particular individuals at senior level in AHSs have also driven HIA through a range of activities such as providing training, and facilitating seminars and workshops.

Staff who have undertaken training are also recognised as effective advocates for HIA.

Area Health Services have had endorsement for HIA from their Chief Executive Officers and this has allowed those at the second tier of management to provide effective leadership. More generally, AHSs were regarded as having a long term vision for the need to address inequalities. They were also considered good at keeping HIA on the agenda even though HIA was still not regarded as “core business” and there were other pressing priorities.

6.5 Organisational Development/Systemic Capacity Building

HIA has been included within key strategic documents including the State Health Plan and the Healthy People NSW, Population Health Plan. Area Health Services have also included HIA within internal documents within Population Health and/or Health Promotion divisions. These include for example service level agreements (in contracts with the Department of Health), business plans, activity reports, work plans for senior staff, performance agreements and job descriptions. However, the documents indicate that while there appears to be an ongoing commitment to HIA within Population Health and/ Health Promotion divisions, HIA is not yet integral to the work of other areas of AHSs.

The documents also suggest the AHSs have a greater commitment to the use of HIA than the NSW Department of Health.

The inclusion of HIA within key state health documents is regarded by participants as critical to organisational and systemic capacity building. However much of the development to date was regarded as “aspirational”.

Participants indicated there have been many organisational achievements within AHSs and evidence of “massive changes” in terms of integrating HIA. In particular there has been good uptake of HIA since the inception of the CHETRE project, visibility and awareness of HIA has increased across AHSs (and amongst partner organisations), many staff have been trained and undertaken HIAs, new HIAs are on the agenda, and staff across the sector have been brought together. In some AHSs several HIAs have been undertaken, including some without CHETRE’s involvement.

Health Impact Assessment is now on the agenda in at least some divisions of AHSs, and staff members are increasingly engaged with HIA both within and beyond the key divisions or teams responsible for leading HIA. In some AHSs HIA has been incorporated into planning processes, has been used by planners, included in urban planning, has impacted on local environmental and social plans, and used by local councils and other partner organisations. Some participants reported that where HIA was well developed within an AHS it was beginning to “trickle” into policy.

There have been considerable developments across key capacity building domains including the workforce, resources, partnerships, and leadership. Both “ground-up” and “top-down” capacity building strategies within AHSs were seen as effective mechanisms that had contributed to organisational development.

The three year funding stream for the HIA Phase 3 project was also regarded as an effective mechanism for building HIA over time and observing the benefits of HIA in the longer term. Many of the organisational achievements were attributed to the combination of the four other capacity building domains, especially leadership and workforce development.

While there have been many significant achievements at an organisational level, with a number of staff capable around HIA, systemic capacity across AHSs was considered to be generally at a “low level”.⁵ Moreover, systemic capacity within the Department of Health is undeveloped. There are a range of reasons why this is the case and these are discussed in the next section in the context of what has not been achieved.

7. What the NSW HIA Project Has Not Achieved

There is wide agreement amongst participants in this evaluation that the Department of Health has not engaged with or adopted HIA. Despite the inclusion of HIA in the NSW State Health Plan there has been little implementation of HIA in state wide projects.

Health Impact Assessment has not been embedded at a macro level, has not been included in a systematic way within the Department of Health, has not been included in planning processes or other policy, and funders have not been successfully engaged with HIA at state level. Within the Department HIA is located in only one department and has not been integrated across the organisation.

Participants indicated that HIA had made only a “tiny difference” at departmental level and only a “sprinkling” of staff have been exposed to or trained in HIA. Although several rapid HIAs have been undertaken in some departmental work, HIA is not regarded as core work. When HIA has been used, its timing in planning processes has been seen as inappropriate and recommendations regarded as criticism.

⁵ The CHETRE NSW HIA Capacity Building Program: Mid-term Review (The University of New South Wales, 2006) indicates that 82 staff have trained in HIA, 72 are on HIA Steering Groups and 25 are involved in the HIA Reference Group.

There has been a perception that HIA delays planning processes. Participants reported that staff at departmental level have generally shown a lack understanding of what HIA is about or how it can be of benefit, have not seen the need for HIA and not perceived it as relevant to health promotion or policy in the Department of Health.

The lack of support for HIA at state level is largely attributed to a change of leadership and the departure of earlier champions of HIA within the Department. Participants indicated that the new leadership has not taken up HIA and a lack of endorsement at state level has meant that HIA remains in the periphery in NSW Health. This situation had been exacerbated by recent budget cuts and a staff freeze. No budget has been set aside for HIA other than the funding for CHETRE to roll out the HIA Phase 3 project.

Further, one participant from within the Department of Health, commented that staff within the Department have a negative view of CHETRE and that there was considerable criticism of the HIA project.

As noted previously, the majority of participants regarded the Department as “the big gap” in terms of embedding HIA in the NSW health system.

At the AHS level, there has been significant leadership and achievement in terms of embedding HIA. However, a lack of leadership from the Department and endorsement at state level has an ongoing impact in terms of sustaining the momentum required to embed HIA and in terms of achieving reach beyond those directly involved in HIA such as Population Health and Public Health.

The lack of funding, or additional staffing or allocation of time for HIA work means staff in some AHSs are undertaking HIA over and above their usual workload. While some AHSs do allocate time, there is no additional funding available to support the embedding of HIA. While a number of staff members have now trained and undertaken HIAs, the large size of the health workforce means that only a small percentage relative to the total workforce are HIA capable. The lack of time and resources, a reliance on a relatively small number of HIA staff trained, and the energy required to build external partnerships and to work collaboratively, all impact on how well HIA has embedded across health and other sectors. These difficulties have been compounded by the reality that other issues, such as obesity and tobacco smoking, have often been regarded by management as a higher priority in AHSs.

There has also been a lack of knowledge about, or understanding and acceptance of the concepts of HIA and the social determinants of health amongst many staff, especially those in the “sharp end” of health. Furthermore, participants reported that some managers in AHSs are not supportive of HIA because it is perceived as resource intensive.

While CHETRE, and key departments and individuals within AHSs, provided excellent leadership it was difficult to maintain the momentum of HIA across the sector without the Department’s support and leadership.

8. Strengths and Limitations of the NSW HIA Project

Participants in this evaluation identified many strengths of the NSW HIA project. They also reported some limitations that were largely attributable to external factors rather than the HIA project itself.

8.1 Strengths

The overwhelming view conveyed by participants was that the CHETRE project was “invaluable” and “absolutely worthwhile”. The HIA project had raised awareness and provided sound evidence for thinking about equity issues and working with social determinants of health. It also brought a focus and context for HIA to occur. The project had encouraged a broader conceptualisation of health and wider applications of HIA principles. It also highlighted the value of evidence and the use of evidence summaries in decision making processes both within health and in other sectors. Health Impact Assessment was regarded as a significant tool and process for addressing health inequalities. The project was regarded as having progressed the integration of HIA much more rapidly than would otherwise have been possible. The participants also identified some particular areas of strength within the HIA project. These relate primarily to CHETRE, their staff and the resources they provided, the training and learning-by- doing method, and the facilitation of intersectoral collaboration with external partners.

8.1.1 CHETRE

The CHETRE Centre, the staff and the resources provided by CHETRE were widely regarded as a key strength of the HIA project. A significant issue raised by participants was CHETRE’s “independence”, both in terms of being at an “arms length” from the politics of health, as well as being seen by other sectors and the community as separate from health and AHSs. It was thought CHETRE’s location at the University of NSW facilitated greater trust when working with partners as CHETRE was regarded as “neutral” and “independent” from health.

Participants spoke about CHETRE’s “expertise”, “authority”, “professionalism” and “flexibility”. These attributes were highly valued and seen as crucial to the success of HIA in terms of dealing with difficult issues and working proactively with external stakeholders. Participants commented that CHETRE’s involvement had improved community and external stakeholders’ perceptions of NSW Health and local AHSs. The academic status and authority associated with CHETRE was influential in developing partnerships and working collaboratively with external partners and the community.

CHETRE’s involvement was also regarded as a vital impetus for change within health and in maintaining momentum through a time of considerable organisational turmoil.

Participants also spoke extremely positively about CHETRE staff members who were typically referred to as “invaluable”. The staff were regarded as “committed”, “timely,” and “supportive”, and interactions with them were always “positive”. CHETRE staff members were described as effective in keeping processes on track, their involvement in resolving challenging group process difficulties was commendable, and they were highly effective in clarifying the purpose and scope of projects and assisting in decision making.

Another strength of the project was the fact staff from CHETRE provided day-do-day support, shared ideas, gave assistance with literature searches and more generally with the HIA process whenever this help was needed. As one participant commented, “if it wasn’t for [CHETRE staff] HIA would have fallen over”.

8.1.2 Training and the Learning-by-Doing Methodology

The training and learning-by-doing methodology was regarded as a key strength of the HIA project and was commended by almost every participant. The training was described as “logical”, it proceeded through “successive steps” and linked theory to practice. Although sometimes challenging, the learning methodology was a critical factor in facilitating the integration of HIA within AHSs. The training forum provided an opportunity for staff from other departments within health and external partners to work alongside one another, to learn together, share ideas, develop skills and get to know one another. Training together meant developing relationships and this provided the groundwork for the later development of collaborative partnerships and a network for support and the exchange of ideas.

8.2 Limitations

A lack of resourcing for HIA, and the resource intensive nature of the HIA process, were identified as significant limitations in terms of integrating HIA. In particular participants reported a lack of time to undertake HIA. In one AHS a team has been established to do HIA, however participants reported that staff members were required to do HIA in addition to their usual workload. In the other AHS additional time was allocated for HIA but the resource intensive nature of the HIA process impacted on what could be achieved. Some participants reported that in some instances senior managers lack awareness of the time involved in facilitating the HIA process. However another participant commented that the time taken to do “intermediate” HIAs was a significant drain on resources compared with the resource required to undertake “rapid” HIAs.

While there was good support for HIA by managers within Health Promotion, Population Health and the directors of Population, Planning and Performance, questions were raised about the commitment and leadership of managers in other areas of AHS. In part this situation was thought to be related to competing priorities within health, especially as other issues are currently prioritised such as obesity and smoking. In addition, HIA was not seen as a priority for those working at the “sharp edge” of health.

The sheer size of AHSs was also raised as a factor limiting the integration of HIA, as only a small percentage of all staff have been trained or used HIA. A lack of resourcing was regarded as a particularly critical issue in rural areas where the workforce is smaller, and more dispersed, which means there are fewer skill sets to draw upon. A lack of resourcing was also raised as an issue for external organisations ability to incorporate HIA into planning and decision making processes.

Some participants thought greater attention needed to be given to addressing the purpose of HIA and considering questions about where it is best targeted. Some questioned the appropriateness of HIA in the policy context and for work that already had health as its main focus. Another participant also raised issues about where HIA would be most useful, such as

whether it is more effective in working externally with other agencies around urban planning or focusing internally on decision making processes. There was also some evidence that HIA was being targeted on projects that were not necessarily addressing the most pressing health needs, and may not only be failing to address inequalities but exacerbating them. The example given was doing HIA on new land release.

Another issue raised by some participants related to the timing and amenability of HIA. One participant reported that HIA was used too early in the policy planning process and that recommendations were experienced by staff as criticism. However another participant suggested HIA was used too late in the planning process and that there needed to be consideration of the amenability of HIA at an earlier stage. One participant reported that the HIA process was effective in screening out a project that was more suited to a needs assessment methodology.

Another limitation addressed by a minority of participants concerned the nature and targeting of HIA training. One participant regarded it as pitched at too high a level for staff with little previous exposure to HIA. Another participant reported that there needed to be more attention to workforce development needs and use of evidence for organisations outside the health sector. The same person commented that training could be more competency based. A further participant recommended additional, more intensive training after doing an initial HIA.

9. Future Action Required to Build Capacity to Undertake HIA in NSW Health

Participants in this evaluation identified a range of actions required to build capacity to embed HIA within NSW Health. These actions cohere around the following key issues.

- CHETRE's continued involvement
- state leadership
- strategic policies and plans
- workforce development
- resource development

9.1 CHETRE's Involvement

The Centre for Health Equity Training, Research and Evaluation's continued involvement in the HIA project was widely regarded as critical to ensuring that HIA remains on the agenda in health, maintains momentum, and provides ongoing training and professional support to promote and sustain workforce development. Continuation of training and the learning-by-doing approach were seen as critical to further build capacity in NSW Health.

The range of highly effective resources provided by CHETRE was also identified as essential to ensure the ongoing facilitation of learning about HIA and to support staff members' use of HIA in practice.

The majority of participants commented that the HIA project should continue because the culture of HIA was not yet sufficiently embedded. As one participant put it:

A soufflé doesn't rise twice...if it is not quite well enough established and everything falls apart then it is very difficult to reinvigorate it. If you pull the plug too early people move on, people get dispirited...one round more of funding would be really important.

Likewise, another participant who captured the views of many said:

If CHETRE goes the momentum will be lost. If that happens it is a waste of all the investment that has gone into it – a lot of money and work has gone in from all sorts of people.

There was some suggestion that CHETRE needs to further evolve the HIA project, to progress into integrated impact assessment, to involve much more multi-agency work and to move into areas not previously the focus of HIA, such as vulnerable children.

9.2 Leadership

Action at state level was regarded as crucial to the future sustainability of HIA. Participants gave a very clear message that for HIA to be successfully embedded across NSW Health there needs to be champions within the Department of Health and at ministerial level. Commitment and support from the Director General and senior staff within the Department was regarded as critical. The Department was seen as crucial to developing strategies to embed HIA and ensuring its sustained momentum within Area Health Services.

9.3 Strategic Plans and Policies

The future embedding of HIA also depends on the integration of HIA in state-wide strategic plans and policies, and for these to align with the World Health Organisation social determinants of health and link to the core health strategy.

One participant suggested that a national mandate for HIA was necessary to ensure its integration. The recent establishment of a new federal government was regarded as a good opportunity for a national mandate to occur.

Participants were more generally of the view that although the principles of HIA are included in the State Health Plan they need to be operationalised at an organisational level. Health Impact Assessment also needs to be included in health promotion performance agreements.

Participants indicated that HIA needs to be regarded as “core business” and to be kept on the health agenda irrespective of other priorities. Some suggested that HIA needs to move out of Health Promotion, to embed in the healthy public policy programme and take an intersectoral

approach. Indeed, policies and practices within health and non-health sectors need to prioritise health inequalities.

Health Impact Assessment also needs to shift from being a *project* to a *programme*.

Suggestions were made that the approach taken to the London Plan and the New Zealand Ministry of Health HIA unit approach to HIA were useful models for high level integration of HIA.

The participant from the council also suggested that there needs to be a state mandate for HIA to be included in council planning, and in environmental sustainability and development.

9.4 Workforce Development

In terms of workforce development one participant captured the views of others when they commented “we need to build up a critical mass of people who can do HIA in the NSW health system...withdrawing now would not be good...further training is required.” Indeed, participants indicated that workforce development needs to occur in an ongoing manner and to take account of external factors, such as budget constraints, a high staff turn-over, the staff freeze and the small staff numbers in rural areas, that affect workforce capacity over time. This requires ongoing training and support until sufficient workforce capacity is developed for staff to no longer require training and advice from CHETRE.

Opportunities need to be provided for staff across health, throughout the Department and AHSs, from policy to practice, and across a broad range of departments within AHSs, to gain an awareness of HIA, to understand its effectiveness and value, and to have the opportunity to train and undertake HIA.

At policy level staff require a change of perception about HIA to see that once embedded it positively affects the way work is conceptualised and the way policy is developed. Workforce development in the form of developing awareness, ongoing training and building skills, would be required in organisations external to health for effective partnerships to develop and for HIA to occur in a genuinely collaborative way.

9.5 Resourcing

Many of the issues raised in relation to workforce development are intricately linked to resourcing. While the Department has funded CHETRE to implement the HIA Phase 3 project and has covered the costs of travel and accommodation for rural staff to attend HIA training, there has been no additional funding or resourcing for HIA to occur. Participants repeatedly commented that adequate resourcing of HIA including funding, additional staffing and the allocation additional of time was critical to the future of HIA. Engaging funders was also seen as a key issue likely to impact on the future of resourcing of HIA. However, some participants raised issues about the resource intensiveness of HIA and suggested exploring the use of quicker, more efficient and rapid ways of doing HIA especially for small projects. In addition, suggestions were made about being more selective in the use of HIA so that it is used on programmes and interventions that are most amenable and appropriate for HIA.

10. Summary

The NSW HIA Project has been beneficial and worthwhile and HIA has gone some way to being embedded in the NSW health system. As a result of the project HIA has become generally regarded as a useful tool to assist with developing awareness, and methods to achieve, equity in health, to promote health in urban and rural planning and to encourage the development of healthy public policy. More specifically, HIA has become useful in the following ways as a:

- powerful tool to inform planning and decision making and for investigating a range of outcomes
- systematic approach to critically analyse evidence and literature
- means to explore issues from multiple points of view
- useful stocktake of a wide range of impacts
- useful prospective mechanism to assess health impacts
- structured means for taking a whole of government approach
- formal process for engaging external organisations and developing collaborative partnerships.

Some participants considered HIA to be too resource intensive to be used on a regular basis and it has not yet been accepted as a useful tool for developing policy at the state level. A minority of participants were not convinced of the usefulness of HIA within health and suggested it may be more useful if it focused broadly on public health policy and projects outside of health.

The Centre for Health Equity Training, Research and Evaluation has played an important role in the leadership of HIA in NSW. The learning-by-doing methodology, and the training, resources and expertise provided by CHETRE meant that groups of staff within AHSs were now trained and capable of undertaking HIA. The CHETRE project was also attributed with having facilitated the development or consolidation of collaborative intersectoral partnerships. Although CHETRE has made significant gains in integrating HIA, most participants advocated for continued training and support from CHETRE until HIA becomes more securely embedded in the NSW Health system and is more broadly used in the development of healthy public policy.

References

National Health and Medical Research Council. *National Framework for Environmental and Health Impact Assessment*. Canberra: Australian Government Publishing Service, 1994.

NSW Health. *NSW Health and Equity Statement: In all fairness*. Sydney: Department of Health, 2004

Unpublished

The University of New South Wales. NSW Health. *HIA Capacity Building Program: Mid-term Review*. Centre for Primary Health Care and Equity, 2006.

Appendix 1

Phase 1 and 2 Aims

Phase 1 Aims:

- explore the feasibility and mechanisms for the development of HIA
- increase awareness of the purpose and scope of HIA
- identify areas where capacity needed to be developed

Phase 1 Processes and Outcomes:

- establishment of an Advisory Committee
- consultation with experts and key stakeholders
- a review of the literature
- workshops with staff from AHS
- development of an electronic newsletter to build awareness of HIA across the health system.⁶

Phase 2 Aims:

- develop a formal communication strategy for the NSW HIA project with the purpose of promoting organisational commitment to developing health impact assessment
- undertake some HIAs in NSW by establishing five developmental HIA sites in NSW and supporting the work of the Greater Western Urban Health Development Group (GWUHDG)
- build consensus among stakeholders (within NSW Health and with external stakeholders) on the range of HIA applications and processes.

Phase 2 Processes and Outcomes:

- reforming the Advisory Committee from Phase 1 to represent a wider group of stakeholders
- consultation with experts and key stakeholders
- developing national and international links related to capacity development
- establishment of a NSW HIA website
- distribution of electronic newsletters
- training and support for five HIA developmental sites as well as the GWUHDG.

Phase 2 of the project has succeeded in building a greater consensus on the scope and purpose of HIA, developed important links within NSW Health between the HIA project and the Aboriginal Health Branch and the Environmental Health Branch, provided training and experience in undertaking HIA, developed a sophisticated web-based information and support system and provided insights to ways in which HIA can “value add” to existing decision making processes. An overview of the scope of the HIAs undertaken is available on the CHETRE HIA Connect website. See special edition of the HIA E-news on the EFHIA case studies for the two day international capacity building meeting in August 2004.

⁶ A copy of the Phase 1 report is available on the CHETRE website (HIA Connect <https://chetre.med.unsw.edu.au> 2004).

Appendix 2

Logic Model for NSW HIA Project – Phase 3

Simplified Logic Model

Process			Outcome		
Inputs	Activities	Outputs	Short term	Medium term	Long term
<ul style="list-style-type: none"> • CHETRE • Department of Health • Area Health Services • Local Government • Central Government 	<ul style="list-style-type: none"> • Supporting leadership • Reinforcing positive behaviour • Role modelling positive behaviour • Identifying and encouraging key organisations to submit proposals for HIA's • Raising the profile of HIA • Improving skills to deliver HIA • Exploiting opportunities for priority organisations to develop HIA capacity ([experiential learning] / [learning opportunities]) 	<ul style="list-style-type: none"> • Steering Committee • HIA promoted • Awards given to top performing agencies • Top agencies profiled and promoted among key stakeholder organisations • Colloquium and conference held • Educational material developed and disseminated • Promotional material developed and promoted • Steering Committee • Training workshops held (Phase 2) • Development Sites • Organisations submit proposals for HIA's 	<p>Increased capacity</p> <ul style="list-style-type: none"> • Increased motivation among key stakeholders to undertake HIAs • Organisational development (institutionalization of HIA processes) • Improved workforce skills and capacity to deliver HIAs • Improved inter-organisational collaboration and coordination in delivering and implementing HIA findings (Partnerships) • Improved leadership within key organisations to implement HIA processes 	<p>HIA embedded within system</p> <ul style="list-style-type: none"> • HIA embedded within key sectors • HIA embedded within relevant agencies outside the health sector • Improved information to guide decision making for effective courses of action 	<p>Improved interventions and health</p> <ul style="list-style-type: none"> • Improved programme, service and policy planning

Full Logic Model

Process			Outcome		
Inputs	Activities	Outputs	Short term	Medium term	Long term
<ul style="list-style-type: none"> • CHETRE • Department of Health • Area Health Services • Local Government • Central Government 	<ul style="list-style-type: none"> • Supporting leadership <ul style="list-style-type: none"> - Establishment and maintenance of Steering Committee - Providing opportunities to meet, share ideas, experiences and information (colloquium & conference) • Reinforcing positive behaviour <ul style="list-style-type: none"> - Development of award system for 'top' organisations • Role modelling positive behaviour <ul style="list-style-type: none"> - Profiling award organisations among key stakeholders • Identifying and encouraging key organisations to submit proposals for HIA's • Raising the profile of HIA <ul style="list-style-type: none"> - Advocacy to key organisations and stakeholders - Delivery of presentations at key meetings 	<ul style="list-style-type: none"> • Steering Committee <ul style="list-style-type: none"> - Steering formed and regularly meets - Key decisions made - Active promotion of HIA among committee members outside of Committee • HIA promoted <ul style="list-style-type: none"> - Presentations to key groups/organisations - Meetings with key stakeholders - HIA profiled in key media • Awards given to top performing agencies • Top agencies profiled and promoted among key stakeholder organisations • Colloquium and conference held • Educational material developed and disseminated <ul style="list-style-type: none"> - HIA connect - HIA practice guide - Technical reports • Promotional material developed and promoted <ul style="list-style-type: none"> - HIA connect - E-news • Steering Committee <ul style="list-style-type: none"> - Steering formed and regularly meets - Key decisions made - Active promotion of HIA among committee members outside of Committee • Training workshops held (Phase 2) 	<p>Increased capacity</p>	<p>HIA embedded within system</p>	<p>Improved interventions and health</p>
			<ul style="list-style-type: none"> • Increased motivation among key stakeholders to undertake HIAs <ul style="list-style-type: none"> - Good self-efficacy - Positive benefits perceived - Critical awareness of key issues (e.g. equity/upstream) - Recognised responsibilities • Organisational development (institutionalization of HIA processes) <ul style="list-style-type: none"> - HIA integral part of organisational planning and evaluation • Improved workforce skills and capacity to deliver HIAs 	<ul style="list-style-type: none"> • HIA embedded within key sectors <ul style="list-style-type: none"> - Systematic - Efficient - Consistent - Appropriate - Planning processes • HIA embedded within relevant agencies outside the health sector <ul style="list-style-type: none"> - Systematic - Efficient - Consistent - Appropriate - Planning processes • Improved information to guide decision making for effective courses of action 	<ul style="list-style-type: none"> • Improved programme, service and policy planning <ul style="list-style-type: none"> - Better population health - Reduced inequalities

	<ul style="list-style-type: none"> - Meeting with key stakeholders - Development of communications (e.g. e-news) • Improving skills to deliver HIA <ul style="list-style-type: none"> - Delivery of training - Development of educational materials - Development of tertiary course • Exploiting opportunities for priority organisations to develop HIA capacity ([experiential learning] / [learning opportunities]) <ul style="list-style-type: none"> - Development and promotion of training workshops (Phase 2) - Development Sites to support organisations to undertake actual HIAs (reviewed) - Development of supporting educational materials 	<ul style="list-style-type: none"> - Priority organisations participate - HIA's undertaken • Development Sites <ul style="list-style-type: none"> - RFP circulated - 16 Sites identified - Training and follow-up support provided • Organisations submit proposals for HIA's 	<ul style="list-style-type: none"> - Critical mass of HIA practitioners - Resources used - Workshops attended - Tertiary education • Improved inter-organisational collaboration and coordination in delivering and implementing HIA findings (Partnerships) <ul style="list-style-type: none"> - Use of resources - networking • Improved leadership within key organisations to implement HIA processes 		
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Appendix 3

Interview Schedule – Case Studies

1. Please explain your role in the organisation
2. Can you describe how your organisation has been involved with the CHETRE HIA project
3. Can you briefly describe the HIAs (if any) your organisation has been involved with
 - a) Which ones were related to the CHETRE project
 - b) Any HIAs subsequent to the CHETRE project
4. Do you think HIAs are worthwhile
5. Apart from actually doing HIAs has your organisation done anything else to support the delivery of HIAs within your organisation
 - a) budget/resources set aside for HIA work to be done
 - b) support for staff to do HIA as normal work
6. In general, what would you say are the strengths of the CHETRE project
7. In general, what would you say are the gaps or weaknesses in the CHETRE project
8. At an organisational level what changes have you seen in the following:
 - a) policy
 - b) planning processes
 - c) decision making
 - d) health inequalities/inequities
 - e) capacity
 - f) are these changes sustainable
9. Can you describe any partnerships/collaborations that have developed as a result of undertaking HIAs
 - a) are those relationships ongoing
 - b) are those relationships useful
10. Do you have any comments about your perceptions of changes in the way partners have worked as a result of involvement with the CHETRE project
11. Who are or should be the key people driving HIA in your organisation and in the health system overall
12. How would you describe the skills and capacity of staff within your organisation to manage/deliver HIAs
 - a) how has the CHETRE project contributed to this
 - b) how have the CHETRE workshops, resources, support, communications contributed to this
13. Do you have any recommendations for the future of the project

Appendix 4

Interview Schedule – Key Informants

1. Please describe your role in the organisation
2. How have you been involved with the CHETRE project
 - a) how and when did you first get involved
 - b) what is your ongoing involvement
3. What is your understanding of the CHETRE project
 - a) its key objectives or purpose
 - b) its key activities
4. In general, what do you think about the activities CHETRE has done to achieve these purposes
 - a) the learning by doing approach
 - b) training
 - c) resources
 - d) support
 - e) communications
5. As a result of the project do you think there are more champions or leaders promoting HIA in the NSW health system
 - a) who is driving HIA
 - b) who should be driving HIA
 - c) how well has the CHETRE project contributed to leadership of HIA
6. Do you think HIA is becoming more part of (embedded in) the NSW health system
If so, what contribution has the CHETRE project made to this
7. As a result of the CHETRE project have you seen any changes at an organisational level
 - a) policy
 - b) planning processes
 - c) decision making
 - d) dealing with health inequalities/inequity issues
 - e) resources available for HIA to be done (capacity development)Are these changes sustainable
8. Has your organisation improved the way it works or collaborates with other organisations as a result of the CHETRE project
 - a) are these relationships useful
 - b) are these relationships ongoing
 - c) how has the CHETRE project contributed to the development of those relationships
9. Do you think the CHETRE project has helped increase the skills and capacity of staff to carry out HIA
10. What do you see as the strengths of the CHETRE project
11. Are there any gaps or weaknesses
12. Do you have any recommendations for the future of the project

Appendix 5

Interview Schedule - Key Informants CHETRE

1. Can you describe your involvement with the HIA project?
 - how long have you been involved with the project
2. According to your knowledge, what would you describe as the original purposes of the project?
 - i.e. what were the purposes at the start of phase 2 in 2005
3. In relation to these purposes, what were the key activities that were undertaken to meet these purposes?
 - (e.g the “learning- by-doing” approach, training, resources, support and communications)
 - What activities changed during the course of the project?
 - Have there been any new activities and the rationale for these
 - What is the rationale for change

For each domain can you briefly describe what the domain was about, what the key activities were that CHETRE undertook in relation to those domains and finally what you think the impacts of these activities were.

4. Leadership
 - Rationale for domain; Key activities; Impacts of activities
5. Partnerships
 - Rationale for domain; Key activities; Impacts of activities
6. Workforce skills and capacity
 - Rationale for domain; Key activities; Impacts of activities
7. Organisational development
 - Rationale for domain; Key activities; Impacts of activities
8. Resources
 - Rationale for domain; Key activities; Impacts of activities
9. Thinking back on the activities that we have just discussed:
 - Which worked well?
 - Which did not work well?
 - What do you think should be changed in the future?
10. Apart from those impacts that were discussed in relation to each domain, what other changes have occurred as a result of the CHETRE project?
 - How do you think these indirect/unintended impacts should be taken into account when thinking about the future of the CHETRE project?
11. As the HIA project has progressed do you think that the purposes have changed?
12. In general, what changes, if any, should be made to the HIA project in the future?
 - Overarching purpose (goal)
 - Objectives
 - Activities/strategies
13. Is there anything else that you would like to add?

Appendix 6

Interview Schedule – Case Study: Council Specific

1. Please explain what your role is in your organisation?
2. Can you describe how you and your organisation has been involved with the CHETRE HIA project?
 - how did you first get involved?
3. Can you describe the HIAs (if any) your organisation has been involved with?
 - which ones were related to the CHETRE project?
 - any others not related to the CHETRE Project ?

Did you attend any of the training? Is so, do you have any comments about it?

4. Do you think HIAs are worthwhile?
5. Can you describe any partnerships/collaborations that have developed as a result of undertaking HIAs?
 - are those relationships ongoing?
 - are they useful relationships?
 - do you have any comments about your perceptions of changes in the way partners have worked as result of involvement with CHETRE project
6. What if any effect has your involvement with the CHETRE project made to how your organisation regards health in its work?
7. Who is driving HIA in your area?
8. In general, what would you say are the strengths of the CHETRE project? What would you say are the weaknesses?
9. Is there anything else you would like to add?

Appendix 7

Case Study A – Evaluation Findings

New South Wales Health Impact Assessment Project – Phase 3

Introduction

Case Study A reflects the views of senior staff members in a rural Area Health Service (AHS) characterised by small communities and a high aging population. The participants have diverse roles including a director, manager, senior strategic planner and a programme coordinator. They are located in population health, health promotion, health development and in the local council. The participants have had varying degrees of involvement with the CHETRE NSW HIA project. Their involvement ranged from being integrally involved in all phases of the of the HIA project, having international experience of HIA and undertaking several HIAs, through to having been trained in HIA and involved with or evaluating one HIA. This evaluation is based on interviews with four participants.

NSW HIA project achievements

Participants in the Case Study A indicated that there had been strong leadership within their AHS, with HIA being endorsed and fostered at senior management level. This AHS has made considerable progress in terms of integrating HIA, using HIA in planning and decision making, beginning to build capacity across several capacity building domains and engaging external partners on initiatives that impact on health outcomes.

The success of HIA resulted in the AHS receiving an award from CHETRE for their achievements. The award has had several positive spin-offs including enhancing the profile and legitimacy of HIA, boosting staff morale, and in improving the public image of the AHS which had previously been subject to considerable negative media attention. The positive publicity surrounding the award has reinforced the value of the HIA project.

[The award] made us realise we could do good things. We could see we could do something positive. It was good news for the CE and s/he still sees HIA as a positive thing that we can legitimately do.

Workforce Development

Participants in this case study identified many ways that the HIA project had contributed to workforce development, created awareness and generated a rapid learning curve for the AHS.

Staff members have participated in HIA training, workshops and seminars. The training provided by CHETRE was described as “extremely informative” and had provided practical skills for staff to undertake HIA. The provision of these forms of support coupled with ongoing training meant that workforce development is of such capacity that staff have been able to undertake HIAs both with CHETRE’s involvement and also independently.

Although there have been significant achievements, the sheer size of the AHS (5000-6000 staff) meant only a small percentage of the total workforce were trained in HIA and use it in their work. However, the HIA project was described as having increased knowledge of HIA and all planning issues in the workforce, and is being used to inform decision making processes.

One participant reported that HIA provides staff with another tool to use as well as a process to undertake prospective evaluations. Staff members have now used HIA and health equity perspectives on a number of projects including a rural health service redevelopment. Another participant commented that HIA is now seen as an “integrated part of staff members’ work” and staff are encouraged and enabled to do HIA via the provision of time and management support.

The AHS is currently exploring new planning processes for a new service development within the community and HIA is being used to inform that process.

Resource Development

A range of resources provided by CHETRE was identified as key contributors to the integration of HIA. The learning-by-doing approach, ongoing training, a helpdesk, the day-to-day support, availability and expertise provided by CHETRE, their guidance in applying HIA in practice, newsletters and websites were described as useful and effective resources.

Participants repeatedly commended the training, HIA guide, reading materials, helpdesk, HIA listserv, day-to-day support and sharing of ideas, being able to get help with literature searches and assistance with the HIA process were assets of the project. The website was described as “an absolute boost in terms of the information it has about HIA processes around the world”. Likewise the availability of other demonstration site projects on the website and listserv was termed an “excellent resource”.

The AHS has also allocated time and resources to HIA, however there has been no budget provision.

One participant who is a key driver behind HIA has also organised seminars and workshops to discuss equity issues.

Partnerships Development

The development of relationships within the AHS, and partnerships with local and regional organisations outside of the AHS, has been a significant achievement of the HIA project. Participants reported that having closer relationships meant staff had got to know others in the AHS and now knew who to call in person, and were now involved in joint decision making processes with other departments.

The restructuring of the AHS coincided also with the formation of a new council. The AHS and local council have since developed a close and productive partnership and work together in an ongoing manner on a range of issues. The HIA work provides a focus and proactive way of working together and “before HIA we would not even have known who to ring”. A participant reported that as a result of HIA recommendations on one project, “substantial changes were made to land use, footpaths, connectivity, density of housing – the whole approach.”

Another participant reported that an HIA project that all participants in Case Study A were involved with had led to the establishment of a project agreement which listed responsibilities and agreement on inputs and outcomes which had worked well for all parties involved.

Regional partnerships have also been encouraged such as with the Attorney General's Office, Police, Corrections, Department of Planning and natural resources.

The AHS has also developed closer relationships with the community. As one participant commented, "relationships and collaboration have developed due to the CHETRE project".

More generally, awareness of health issues has increased across sectors. This has been particularly important as health is "a huge issue in rural communities".

Leadership Development

There has been considerable commitment to HIA and leadership amongst senior staff within the AHS and it is endorsed by the Chief Executive Officer. One participant commented that the AHS has had a "top down approach" and that management had been "very supportive". The directors and/or managers of Health Promotion, Population Planning and Performance, and Population Health were described as having been particularly influential in driving HIA. Senior staff members in the Corporate Planning division have also been trained in HIA and are interested in using HIA.

Organisational Development

The inclusion of HIA principles in strategic documents was considered important in terms of embedding HIA. One participant thought that the NSW State Health Plan did not include explicit reference to HIA, but that it was implicitly included in the area of future directions which identifies regional structures and partnerships for health which would meet the requirements of HIA.⁷ The inclusion of HIA in the Health Promotion team business plan was also regarded as an achievement. The AHS has also established a best practice project around the use of HIA.

There has been considerable organisational development since the implementation of the HIA project. Awareness of HIA has grown across the AHS and within the local council, several HIAs have been undertaken and several new HIAs are currently on the agenda. Health Impact Assessment is now being used in planning processes, is used by planners and staff in other areas, and is not restricted to Health Promotion and Health Development. One participant reported that Population Health was actively "expanding its use" and trying to "move it out to other parts of the organisation". Another participant commented that HIA had "changed the way health development addresses planning issues...and had a good effect on the way we access local environmental plans and review social plans." The HIA project had also focused staff member's thinking, gave legitimacy and justification for recommendations that staff may have come up with anyway.

The project has also broadened the local council's vision of ways to look at health in the community, has encouraged more than one way of conceptualising health and is about "people's health into the next generation". As one participant commented "it's more than hospitals and GPs, it's about land use principles and other things". The council aims to

⁷ Analysis of the documents supplied for the evaluation of the HIA project indicate that HIA is explicitly mentioned in the NSW State Health Plan.

incorporate into their planning provisions as many recommendations as possible from a prospective document arising from a HIA.

What the NSW HIA project has not achieved

While participants reported the CHETRE project made many achievements across the five capacity building domains, support from senior staff in the Department of Health was seen as something that had not been achieved. Participants expressed the view that personnel changes meant the new Department staff had not taken on HIA or supported its integration in to the health system. The lack of endorsement at departmental level meant that HIA was “still in the sidelines” in the wider NSW health system. Budget constraints and a staff freeze at Departmental level have also meant that there has not been any budget set aside for HIA.⁸

One participant commented that the AHS is “so big it would take a huge, sustained, ongoing advocacy effort to get HIA through the whole organisation”. Equally, capacity needs to be built across the workforce to impact on policy and planning across the organisation.

Another reported that there needed to be greater education about and acceptance of concepts relating to determinants of health and population health across the AHS, especially in areas that focus on “the sharp end of health”.

A participant who worked for in the local council commented that a lack of resources and time, and a lack of trained training staff across the organisation, meant that the council would not be able to undertake HIA in areas they would be useful.

One participant perceived a lack of commitment and encouragement for HIA by leaders within health but outside of Health Promotion and Population Health. This meant that there still needed to be a lot more staff trained in HIA, that HIA was not fully integrated across the AHS and for example, nurses on wards had “little knowledge of HIA.”

Activities additional to the NSW HIA Project

A senior AHS staff member has presented at the regional coordinators management group, which links to government agencies and the Premiers Department. The same staff member has initiated additional HIA training, workshops and seminars in his AHS. Another colleague who has been a long time advocate had also been successful in getting the social determinants of health on the agenda. The AHS also established a “best practice” project around the use of HIA and that was noted as “highly achieved” in the organisation because it was regarded as such a “contemporary approach for looking at health in the broader sense.

Systemic capacity built to undertake HIA

⁸ It is noted that the Department of Health funded CHETRE to implement phase 3 of the HIA project. However, no additional funding has been allocated for HIA other than to cover the costs of travel and accommodation and travel for rural staff to attend HIA training.

The AHS has made considerable gains in building the systemic capacity to undertake HIA. This is largely attributable to the highly effective leadership within the AHS and endorsement of HIA amongst senior staff across three key departments.

The training provided by CHETRE has also been a key factor in building capacity which, coupled with the training provided a senior staff member within the organisation, has led to the AHS undertaking HIAs independently of CHETRE.

Time and resourcing of HIA within the AHS has also contributed the development of systemic capacity. One participant commented that although staff members are “capable around HIA” there was still need for support to develop systemic capacity.

Strengths and limitations of the NSW HIA Project

Participants in this case study identified many strengths of the HIA project. Other than regarding the project as “absolutely worthwhile” it was described as providing “good evidence around working with social determinants of health.”

The project is regarded as having progressed the integration of HIA much more rapidly than would otherwise have been possible, has been beneficial in terms of informing decision making and has focused the AHS in terms of design and ways a HIA perspective can be incorporated. It has also changed the way Health Development addresses the planning issues and its relationship with one of the local councils.

The project has had a good impact on the way “we access the local environmental plan and the way we review social plans” and “we can transfer HIA principles to other planning processes.”

The methodology of learning-by-doing, involving the pairing of training with an actual HIA project, was identified as a key strength.

The HIA process gives transparency to work with other organisations and the community and was described as “an exciting way forward”. One participant commented that HIA had “raised the ability for us to think about solutions in a different way with the community as opposed to the traditional health view.” This was viewed as highly important in a rural setting where “inequalities are so in your face”.

The development of structured and more formalised partnerships and engagement with organisations outside of health was regarded as a key strength of the project. In part this was attributed to CHETRE’s independence from health. One participant commented that there is “some distrust” of health at a local level, so having the NSW University involved meant “giving people a feeling of comfort, independence and expertise which has been really helpful”. Another participant reported that CHETRE’s neutrality when working with a range of partner agencies, especially when such relationships are challenging, was an important strength of the project.

The development of relationships with other agencies had also improved external stakeholders’ perceptions of health so these were now more positive, and it had increased the profile of health issues in the community.

The development of a close working relationship with the council was a key strength of the project.

The involvement of CHETRE was seen as crucial to the success of a difficult project with a very powerful stakeholder as they provided “independence... authority... professionalism and expertise”. Likewise when working on difficult issues, CHETRE had provided “really valuable advice and support” and the AHS could “share ideas and also the hurdles of HIA” with them. In general the development of partnerships was described as providing “a very proactive view of working together with other organisations.” As one participant commented, “we now know who to call, we know who they are and they know who we are and how they are connected to the organisation”.

Furthermore, the HIA project had enabled rural communities to “move forward with health in a different way...not just the hospital on the hill type view of health, but that health can be improved by the environment”.

The involvement of CHETRE was regarded as a particular strength of the project. The staff members from CHETRE were highly praised by participants in this case study. Staff were described as “always timely...always got back to you...[and] sometimes they intervened to get things back on track when things went off track”. Interactions with CHETRE staff were always “positive” and staff had been invaluable in “resolving group process difficulties regarding the type of group needed to inform and assess a project.” In these circumstances CHETRE had “clarified the purpose of a particular project, the terms of reference, the scope of the project and assisted with decision making”. The involvement of CHETRE during a time of considerable organisational change had also “helped to keep people working on something new at a difficult time”.

A limitation of HIA, although not regarded as a fault of the CHETRE project, was to do with “difficulties getting a team together and introducing new processes, searching for literature the first time and finding cooperative ways for the team to work together”. Sometimes HIA was difficult to apply in practice and there was not the expertise within the AHS to get help. The participant from the council also discussed issues around scoping and the fact many organisations do not have the resources or tools to deliver the recommendations of HIAs.

When doing scoping [HIA staff] need to scope the ability of the people doing the recommendations and also the ability and constraints of other organisations to assist in the delivery of those recommendations...you’ve got to look at both sides of the equation.

Despite some limitations of the project, one participant commented that they could not think of any weaknesses of the project or anything they would have done differently if they had been in “CHETRE’s shoes”.

Future action required to build capacity to undertake HIA in NSW

Participants in Case Study A were of the view that CHETRE’s involvement in the HIA project was vital to keep HIA on the agenda in the health sector, to maintain momentum and to continue providing training, especially the learning-by-doing approach.

One participant reported that they would like to see the HIA website maintained and another commented that staff members need the helpdesk and the professional support provided by CHETRE.

A participant with international experience of HIA said “we are keen to undertake HIA and make them routine but we need CHETRE to further evolve the project or find a way to progress the project in the future.” This person discussed the need to evolve HIA into “an integrated impact assessment and look much more at multi-agency work”, as well as venturing into areas not previously tackled such as vulnerable children. “We need to look at the impact of various agencies and how we can improve communication.” To enhance the profile of HIA, this work needs to be in line with state plans, to be endorsed in policy coming out of the Department of Health and to be included in health promotion performance agreements.

More work also needs to be undertaken to explore environmental sustainability and development with councils. The council participant would like to see councils do a simple rapid HIA when doing their community plans but commented that this would need to be enforced by the state government.

The general view expressed by participants in Case Study A is contained in the following comment:

If CHETRE goes the momentum will be lost. If that happens it is a waste of all the investment that has gone into it – a lot of money and work has gone in from all sorts of people”.

Overall Value of the HIA Project

Participants in Case Study A unanimously regarded the NSW HIA CHETRE project as worthwhile. Participants variously described HIA as “an exciting new area of work”, “a very positive experience” and as providing a “process to do prospective evaluations that seem really valid”. One participant commented on CHETRE in the following way:

[It] gave people the practical skills to undertake HIA. They have been crucial in doing that...I don't have the time...they were a credible organisation that could take it forward and could enable and support [staff]...that has been terrific.

One participant commented that it was “an absolute pleasure for a rural community service to have the opportunity to interact with such smart people [from CHETRE].” Another reported that the CHETRE profile enabled them to convince their Chief Executive Officer that HIA was a “good way to go”.

Health Impact Assessment was described as a “very powerful tool for investigating all kinds of outcomes”.

The above notwithstanding, HIA recommendations need to be pragmatic so they can be delivered.

The collective view of participants in Case Study A is conveyed in the following comment:

Without CHETRE raising [the profile of] HIA, providing support and pushing HIA the AHS would not be where they are now.

Appendix 8

Case Study B – Evaluation Findings

New South Wales Health Impact Assessment Project – Phase 3 [level 2]

Introduction

Case Study B reflects the views of senior staff members in an urban Area Health Service (AHS). The AHS is located in a geographical region regarded as having particularly poor health outcomes. The participants have diverse roles, including a director, deputy director, a manager and an epidemiologist. They are located in the Centre for Population Health within the AHS. The participants have had varying degrees of involvement with the CHETRE NSW HIA project. This evaluation is based on interviews with four participants.

NSW HIA project achievements

Participants in Case Study B indicate that their AHS has made considerable progress towards integrating HIA into the AHS, using HIA as a tool to improve internal planning and decision making, as a means to build capacity within the health system and to facilitate external partnerships to influence health outcomes.

The HIA project has provided an impetus for the AHS to progress their thinking about HIA that had already occurred prior to being involved with the project. The CHETRE project established a formal name and mechanism for HIA to occur and provided a concrete tool for the AHS's decision making processes. The project also provided legitimacy to the use of HIA within the organisation and endorsement for its use with partner organisations.

While the AHS is only in the early stages of the HIA embedding process, the various achievements of the project in this AHS are illustrated in a range of activities that have taken place across several key capacity building domains.

Workforce

Although still in the early stages of development, the CHETRE project has increased workforce capacity, at least in specific areas of the AHS. Staff training has occurred within the organisation including environmental health, epidemiology and health promotion. This process has enhanced staff members' understanding of the work of those in different departments. All trained staff have participated in undertaking a HIA which has reinforced the learning-by-doing approach of the project. Staff are now more clear about what they are doing in terms of HIA and have learnt to use evidence to build proposals and provide critical analysis of plans. Staff training has been enhanced through attendance at CHETRE forums, accessing informal peer support from CHETRE when undertaking HIAs and utilising a range of resources provided by CHETRE. A skill set for undertaking HIA as been established. The general perception was that without CHETRE HIA would not have developed.

Resources

The provision of resources by CHETRE has contributed to the enhancement of staff training in HIA and knowledge about how to undertake HIAs in practise. The most important resource was the provision of training. This was considered a key impetus for 'kick-starting' a commitment to HIA within the AHS. The training was described as useful and an integral resource for building capacity within the AHS and amongst partner organisations. Furthermore, training alongside partners meant they came together, learnt together and established valuable relationships.

Additional resources have included manuals, guidelines and hard copy materials that are easy to understand, and the HIA website, blog, listserv and newsletter.

Staff within the AHS have also been involved in writing an article about HIA which was published in the NSW Public Health Bulletin.

Partnerships

Although the AHS had established a local government partnership group and consultation processes prior to the CHETRE project, the project provided a formal process for this to occur. The HIA project also raised awareness and provided further impetus to develop partnerships and work collaboratively with organisations outside of health. The project provided a purpose and focus for these partnerships to develop, and facilitated the development of trust. The result has been collaborative relationships, with HIAs being undertaken "with" partner organisations rather than "on" them.

The HIA project has also facilitated engagement between government organisations and local communities which was regarded as empowering for communities. In one example the AHS has worked with major stakeholders – the council and regional housing - to progress HIA recommendations on a number of levels.

The AHS has also worked with the Department of Housing which has incorporated HIA recommendations into their regeneration policy frameworks.

HIA has provided a mechanism for working on planning and how to engage and resource this task with partners. The HIA project has provided legitimacy to negotiate with partner organisations for staff to attend HIA training.

The local council has endorsed HIA as part of a formal Partnership Agreement with the AHS, thus allowing HIA to be planned and conducted on a collaborative basis.

The AHS has now established relationships with all of its HIA partners and these relationships are regarded as "useful, positive and long term".

Leadership Development

In Case Study B's AHS HIA is driven by the Centre for Population Health and has a team which holds responsibility for HIA within the organisation. Participants in this AHS reported there was

considerable commitment to the HIA project at a local level and the AHS has a long-term vision regarding the need to address inequalities. While there was initially some leadership from NSW Health at the state level through Health Promotion, there was now little commitment or leadership due to a change of personnel at director level.

Organisational Development

The CHETRE project has brought staff across the organisation together, increased the visibility of HIA within the AHS and facilitated the establishment of a recognised team responsible for HIA. Health Impact Assessment is now an important tool being used within the AHS. These changes have occurred within the AHS rather than at a state health level. It is also noted that although AHS management endorses the project in principle and staff are permitted to undertake HIA, there has been no additional allocation of time resourcing of HIA for most staff. In general, staff undertake HIA in addition to their usual workload. However, one participant reported that their position had been changed so that it was now dedicated to HIA and HIA was included in their job description.

What the NSW HIA project has not achieved

To date the AHS has undertaken relatively small scale HIA and has yet to undertake large scale HIAs. This is due to a reliance on a limited number of staff trained in HIA who are available to resource the process and a lack of additional time. As one participant noted, it takes considerable time to develop new partnerships, especially outside the health sector, to build trust and to develop collaborative working relationships. At the time no additional resources had been committed to HIA and staff were expected to undertake all their usual workload in addition to HIA. One participant reported negative attitudes from some managers within the AHS who thought HIA took too much time to complete.

The restructuring of AHSs has also been a considerable drain on resources for staff trying to establish and progress HIA. Health Impact Assessment was not integrated throughout the AHS and the success of that happening would depend on appropriate funding and time resourcing.

Activities additional to the NSW HIA Project

The AHS has established a healthy environment team that can lead and take responsibility for HIA. Involvement in the project highlighted the need for such a team. The AHS has also renegotiated a different approach to HIA with the local council and Department of Transport.

One participant commented that they were unsure what activities were attributable to the Phase 3 project and what had already been developed prior to engagement with this project. However, they also noted that CHETRE had “done heaps” to develop and formalise HIA within the AHS.

Systemic capacity built to undertake HIA

The AHS has developed an infrastructure to undertake HIA through formal partnerships and intersectoral collaboration. As noted previously, the Centre for Population Health has a new team all of whom are trained in HIA. The team will lead on HIA which means HIA is no longer

dependent on one or two key personnel. However, there has been little systemic capacity developed in terms of funding or human resourcing of HIA across the AHS.

One participant commented that there needs to be a driver behind HIA with two key skill sets. These include research and epidemiology, and strong partnership skills. This person thought the combination of academic staff and population health staff would facilitate the development of the required skill set. This comment is at odds with other participants who regarded the establishment of the in-house team as having the already acquired the skill set.

Strengths and limitations of the NSW HIA Project

A key strength of the NSW HIA project was the funding received from the Department of Health for CHETRE to roll out Phase 3 of the project. The HIA project has brought a focus and context for HIA to occur, has meant several HIAs could be undertaken and staff could see what HIA was like in practice.

One participant regarded the training provided by CHETRE as a strength. This person thought it was logical, proceeded through successive steps and provided a grounding on how to undertake an HIA in practice. The training also provided an opportunity for staff from other departments within the AHS and external partners to learn together, share knowledge and develop skills. The learning-by-doing approach, although sometimes challenging, was regarded by some participants as the most useful way to learn HIA.

The strategies adopted by CHETRE through all three phases of the project, the availability of support and advice from CHETRE, the guidelines and information, and the commitment from CHETRE staff were regarded as particular strengths of the project. One participant commented “if it wasn’t for them HIA would have fallen over”.

Limitations

Participants in this AHS also identified a range of limitations of the HIA project. One of the limitations reported by all participants was a lack of commitment or leadership from NSW Health. This was primarily attributed to a change of leadership.

A lack of resourcing was regarded as a significant limitation in undertaking HIA. Although there was endorsement of HIA from AHS management and a team had been established to do HIA, there was limited resourcing in terms of time or additional staffing. Staff typically undertook HIA on top of their usual work load. One participant described the process of learning as “long, hard and laborious” due to the lack of resourcing. There also seemed to be a lack of awareness by some managers of the time involved in facilitating HIA processes. Participants indicated that the future capacity of HIA is dependent on the commitment of resources within the AHS.

Another limitation reported by some participants concerned the nature of HIA training. One participant regarded it as non-specific, not well targeted and pitched at too high a level for staff with little previous exposure to HIA. Another participant reported that more planning was required prior to HIA training in relation to the workforce development needs of non-health partner organisations. It was thought that training could be more competency based and that there needed to be greater consideration of the use of evidence especially for staff from external agencies. One participant, who did the initial training as participant observer, spoke highly of the training but commented that it would have been useful if the training had been linked to an HIA

relevant to his/her own work .⁹ This person would also have valued additional training (with a more intensive focus) after doing an HIA.

One participant reported a need for some attention to the management of external relationships, especially where partners wanted sensitive issues left out of an HIA. She had questions about the ethics of such processes.

Although participants generally endorsed the learning-by-doing approach, one participant had struggled with it. This person wanted a clearer methodology and more definite approach rather than having to choose from a range of possible ways of doing HIA.

One participant suggested that a communication strategy would have been useful. It would have assisted health staff doing HIA training who were seeking support for HIA from external partners and from senior management within the health system. A communication strategy would have helped as a “managing-up” tool. Use of the mainstream media may also have been an effective strategy in communicating messages about HIA directly to communities.

A limitation of the current approach to HIA was that it was not selective enough and consequently has been used on projects that were not the most worthwhile. The participant who raised this issue mentioned that while many staff members wanted to do HIA training it was of little value unless it was directly linked to an HIA project that the staff member could be involved with.

Although not specific to the HIA project, one participant reported that there were political struggles relating to which department should manage HIA and debates about whether it should sit with environmental health or health promotion.

Future action required to build capacity to undertake HIA in NSW

Participants made various suggestions as to how capacity to undertake HIAs might be built up. One of the key issues raised by participants was the need for state leadership and financial support from the Department of Health.

Adequate resourcing of HIA in terms of time and staffing to enable workforce development and capacity building was noted as a significant issue. It was thought more staff across the AHS and within partner organisations needed training and up-skilling and experience in undertaking HIAs. One participant said “we need to build up a critical mass of people who can do [HIA] in the NSW health system...withdrawing now would not be good...further training is required”.

Action to enhance understanding of HIA within external organisations is also required.

Priorities need to be established to determine what topics should be subject to HIA, to have HIA included in plans and policies across the sector, and to determine where funding for HIA comes from when external partners are involved.

⁹ In some places HIA trainees were participant observers. These trainees were placed on others’ HIA projects during the first round of developmental sites if their own organisations did not have a suitable topic for an HIA. This meant the training was not linked to an HIA project directly related to the staff member ‘s own work..

Overall Value of the HIA Project

All participants in Case Study B regarded the HIA project as worthwhile. They reported that considerable capacity had been built within the AHS as a result of the HIA project. Although still in the early stages of being embedded within the AHS the project was perceived as beneficial and worth progressing.

Health Impact Assessment was regarded as a useful tool to inform planning and decision making, a systematic approach to critically analyse evidence and literature, and a mechanism for exploring issues from multiple points of view.

Health Impact Assessment was also seen as a useful way to take stock of a range of impacts and as a prospective means to assess health impacts taking a whole of government approach.

The HIA project was regarded as particularly beneficial in offering a collaborative approach to engage external partners and stakeholders. One participant summed up HIA as follows:

It is a great tool and one of the few approaches that provides for prospective input on a whole of government, whole of community basis, with everyone on a level playing field

Appendix 9

Case Study C – Evaluation Findings

New South Wales Health Impact Assessment Project – Phase 3

Introduction

Case Study C reflects the views of senior staff members in the NSW Department of Health. The participants have diverse roles (or past experience) spanning Health Advancement, Strategies and Settings, Epidemiology and Research, and the HIA steering committee. One participant had a relatively recent role in an Area Health Service (AHS). The participants have had varying degrees of involvement with the HIA project ranging from little involvement to actually undertaking HIAs and being involved in the HIA Steering Committee. This evaluation is based on interviews with three participants. One potential interviewee declined an interview.

NSW HIA project achievements

Participants in Case Study C indicate that there have been considerable gains towards embedding HIA within AHSs and that HIA is well respected at a local area level.

The HIA project was described as achieving “massive change” at the AHS level by taking HIA from being an unknown capability to staff being able to carry out HIA unassisted. These achievements have occurred in the context of considerable political change, the restructuring and amalgamation of AHSs, budget cuts and a staff freeze, all of which were considerable barriers to progress.

The CHETRE project’s ground-up capacity building approach was seen as responsible for the achievements that have been made. The learning-by-doing approach and working within the developmental sites, was seen as an important contributor to these achievements.

The support provided by CHETRE in the AHSs was described as “invaluable”. As the HIA project has shown to be effective it has gained traction and “trickled” into policy and organisational development within AHSs. However, one participant reported that HIA was not yet embedded enough for CHETRE to step back. Another participant commented that the embedding framework has emerged at a micro, meso and macro level, and across the five capacity building domains and that there has been more progress at the micro and meso levels as discussed below.

Participants reported few achievements within the department.

Workforce

The training achievements made by the HIA project at the AHS level were regarded as “really valuable”. Most AHSs have engaged with HIA, have learned about and/or done HIAs and many staff have undertaken HIA training. Health Impact Assessment training, using a “hands-on approach”, was described as a trigger for staff to think differently in terms of how they use evidence and engage with planners.

Workforce development, ongoing training and the knowledge and skills of staff were regarded as important contributors to the HIA embedding process at AHS level.

However staff high staff turn-over meant there was always a need for new staff to be trained in HIA and workforce development was difficult to achieve as staff still have to undertake their core duties in addition to HIA.

The Department of Health’s role in training public health officers who have a Masters Degree in Public Health was seen as one way of fostering the development of an HIA capable workforce. These trainees have received HIA training and would go on to take up positions throughout the health system.

Resources

Participants in Case Study C identified a range of resources that have contributed to the development of HIA within AHSs. These resources, which have been provided by CHETRE, have included staff training, support, a hard copy manual and HIA Connect. However the allocation of funding over and above the CHETRE project, or provision for additional time or staffing in AHSs has not occurred. The resources were seen to have been of less value to departmental staff.

Partnerships

Some participants reported that good partnerships have developed between AHSs and local government as a result of the HIA project. These relationships had encouraged external agencies to engage with health which had not previously been the case. However participants noted that within the Department itself HIA and the project had had little effect on the development of partnerships as relationships with external organisations already existed.

Leadership Development

Having a mandate for HIA to be considered in planning processes, in conjunction with leadership and having a committed director at the AHS level, were regarded as significant contributors to the embedding of HIA in within AHSs. One participant spoke about how a staff member on the HIA Steering Committee who has a broad conceptualisation of HIA, has used HIA in policy and capital works projects, and has been influential in leading HIA within an AHS. Indeed, having champions at a high level of leadership and decision making was regarded as an integral component of the success of HIA in the AHSs.

One participant commented that AHSs were “good at keeping HIA on the agenda” despite recent restructuring and the fact HIAs are not regarded as “core business”.

Organisational Development

Participants indicated that there had been some organisational development but really only at the AHS level. One participant regarded the “ground-up” capacity building approach through the use of the developmental sites as the key contributor to the achievements of HIA within AHSs. In addition, the three year funding stream of Phase 3 has meant the benefits of HIA, and organisational development over time, have been able to be observed. This participant reported that as organisational development was occurring HIA was beginning to “trickle into policy level”. Developments at AHS level were regarded as “highly effective” by another participant who also reported that HIA had been “very successful” in the urban planning area for both health and external agencies.

The third participant commented that organisational development has been at a low level and has not occurred at a planning level of the organisation.

All participants reported there had been no organisational development within the Department of Health.

What the NSW HIA project has not achieved

At the state level, there has been little commitment towards uptake of the HIA project. Embedding has not occurred at a macro level of the Department of Health, in planning processes or in a systematic way. Two participants suggested the Department has done little to support HIA other than the initial funding for CHETRE to undertake HIA. Although HIA is implicit in the State Health Plan, there has been little active implementation of HIA within state-wide projects.

There also seemed to be a negative view of CHETRE and a lot of criticism of HIA at state level. Generally staff within the Department did not think HIA was part of their “real job” but rather an “add on”.

One participant reported that the HIA project had made only a “tiny” difference at department level. Another said that though some rapid HIAs had been undertaken on work within the Department “only a sprinkling” of staff within the Department have been exposed to or trained in HIA. This person noted that as a consequence there is a general lack of understanding of what HIA is about or how it can benefit the Department. At the department level staff members do not see the need for, or value in, HIA within health endeavours and do not consider it relevant to health promotion or policy.

One criticism of HIA was that it was poorly timed in terms of policy planning processes and recommendations on drafts of policy documents were experienced as criticism by staff. There is also a perception that HIA delays the planning process. Health Impact Assessment is not explicitly included in departmental policy guidelines. The existence of a “silo effect” between different departments meant each was advocating for individual issues such as mental health or aged care and not looking at the broader, common issues.

The HIA project is regarded as a “tiny project” located in only one department rather than being across all departments within the Department of Health. One participant reported that it would have been useful if HIA had gained the “high profile” at state level that it did at AHS level.

There appears to be little commitment or enthusiasm for HIA at director level and one participant commented that HIA “has lost its friends”. There are no longer the champions or leaders to progress HIA that were involved at the outset. One participant commented that the “big gap” is in the Department and noted that even as the funder of the HIA project it had not been successfully engaged with HIA.

At the AHS level there have been significant gains despite a turbulent organisational environment and restraints on the budget. However, one participant was not convinced that HIA was embedded enough at AHS level. This person said that ongoing training and the continued provision of evidence summaries would be required to ensure this occurs.

Workforce development and the knowledge and skills of staff are regarded as important to the future of the HIA embedding process at AHS level. Health Impact Assessment also has to compete with other priorities such as obesity and tobacco which are much more fashionable in the current health climate.

Activities additional to the NSW HIA project

The process of learning and doing HIA has led to the development of project management skills amongst staff in AHSs which is regarded as an unintended and positive outcome of the project. The development of more and closer relationships with sectors outside health has also occurred and this has created more engagement from external partners.

Systemic capacity built to undertake HIA

There have been many achievements in terms of integrating HIA and evidence of “massive changes” across AHSs. Staff at AHS level were described as engaged with HIA and it was thought to have gained considerable traction at AHS level. One person said an embedding framework has emerged across the micro, meso and macro levels of AHSs and that there have been significant developments in workforce and leadership capacity building domains. Despite these significant achievements since the beginning of the HIA project, this person thought more needs to be done to build sustainable systemic capacity across all AHSs. Furthermore, HIA should be to be budgeted for at AHS level and staff allocated additional time to undertake HIAs. A lack of systemic capacity means “HIA is not sufficiently embedded to reduce the momentum” at this point in time.

Strengths and limitations of the NSW HIA project

One participant commented there were few benefits to using HIA and did not regard it as sustainable. Another was not convinced of the usefulness of HIA in a policy context but thought it was appropriate to AHSs. Participants identified several limitations of HIA. Health Impact Assessment is regarded as too resource intensive, is inappropriate for use in policy contexts. One participant reported that HIA was used too early in policy planning processes. However another reported that the current HIA screening process means staff have “already gone a fair way down the path once HIA is applied”. This participant said that it would be more useful to consider the amenability of programmes and interventions to HIA at an earlier stage. She suggested the need for the introduction of a step in the process prior to current screening.

Staff in AHSs were regarded by one participant from the Department of Health as “needy” and “dependent” on CHETRE for their use of HIA. Health Impact Assessment Connect was also regarded as inaccessible and an inappropriate resource for policy makers.

CHETRE’s move towards the use of evidence summaries was viewed positively. Summaries are regarded as more time efficient than “reinventing the wheel” each time a literature search has to be undertaken and evidence produced. Further, the use of short summaries rather than long reports saves time.

The use of diverse forums for learning about HIA such as having hard copy materials as well as on-line resources was seen as a strength as staff in different contexts would use these differently. For instance the fast pace and reactivity of policy environments meant staff only have time to read “one page”. However the detail of HIA Connect was considered a more appropriate and a useful tool in a practice environment. However, having both learning forums was seen as “an important strategy” of the HIA project.

The HIA project was seen as having been “highly effective” in facilitating engagement with other agencies who are now more interested and willing to engage with health.

One participant indicated that HIA had been a trigger for staff in AHS to think in a particular way, to consider how they use evidence and how they engage planners. This had meant their work in urban planning was more successful.

Future action required to build capacity to undertake HIA in NSW

The participants highlighted a range of actions required to build capacity to undertake HIA in the future. These cohere around leadership, state-wide policies and plans, the integration of HIA across the Department and within AHSs, the application and timing of HIA, resourcing, educating staff about the value and effectiveness of HIA, and engaging funders. Leadership and workforce development were identified as two core capacity building domains necessary for the future embedding of HIA.

A central issue raised by participants was the need to build leadership, generate advocacy and to have champions at state level, both within the Department of Health and at ministerial level. Commitment from the Director General and the Department is critical. One participant commented that the Department needs to create and maintain an impetus for HIA so that HIA is sustained at AHS level and to develop strategies to embed HIA so that it is no longer dependent on individuals within AHSs. One participant identified the need for advocacy to promote a broader public health agenda. Action at state level is seen as critical to the future of HIA.

Two participants addressed issues relating to health policy, plans and strategies. One commented that there needs to be a national mandate for HIA, that NSW Health needs to join up a national approach using HIA for public health policy, and that this must be practised and not just “enshrined” in policy. The new federal government was seen as a good opportunity for a national mandate for HIA to be developed. State policies and plans need also to be aligned with the World Health Organization social determinants of health statement and should be linked to the core health strategy. This person commented that although the principles of HIA are included in the State Plan they need to be “operationalised” at an organisational level. Another participant echoed these views and identified a need for work on a state-wide plan similar to the way the London Plan had worked to generate a higher profile for HIA.

The integration and embedding of HIA was also identified as a key issue for the future success of HIA and this needs to occur across the Department as well as the AHSs. Participants commented that HIA needs to be regarded as “core business” and kept on the public health agenda irrespective of local AHS needs. One participant suggested the HIA project shift from being a *project* to becoming a *programme*. Otherwise staff members have the attitude that they have “been there, done that” and would not see the continued importance of HIA.

One participant commented that HIA needs to embed within the health public policy programme and to take an intersectoral approach.

Another suggested that HIA needs to move out of health promotion, to be embedded more broadly and have a higher profile across the sector.

Another participant suggested HIA needs to actively link HIA to other health impact assessment processes such as environmental or social impact assessment. The New Zealand approach to HIA, which has involved the establishment of a dedicated HIA department within the Ministry of Health, was recommended as a useful way for NSW to proceed.

Workforce development and the resourcing of HIA were also regarded as central to future capacity building across both health and non-health sectors. Firstly, staff within both AHSs and the Department need to be convinced of the value of HIA, provided with opportunities to facilitate understanding of HIA, and to gain an understanding of its effectiveness. One participant commented that “a lot of work has to be done to get other agencies to understand what HIA is about”. Another commented that ongoing training and support on an “as requested” basis by staff would be necessary for the continued development of HIA. However, another participant commented that the skill base of AHS staff needs to be built up so staff do not require ongoing training and advice from CHETRE.

Opportunities also need to be provided at state government level for staff to see the effects of HIA and HIA needs to be demonstrated at a high level for senior staff to see its value. As a practical measure, one participant recommended the use of evidence summaries and brief research reports at policy level to save time. There is some suggestion that it would be useful to find more rapid ways of incorporating evidence in policy and to find other ways of getting health and equity on the agenda. Indeed, participants generally agreed that strategies need to be developed to more quickly and easily undertake HIA and to do so in a less resource intensive way. Additional allocation of staffing and/or additional time for existing staff within AHSs is also critical to the future of HIA. This issue is particularly problematic at a time of budget restraints and staff freezes. Indeed, engaging those who make the decision about funding in HIA was seen as a key issue for its future development.

In the future HIA may require more selective use and timing. One participant suggested using HIA for “big issues or big developments that you can commit to”. As noted previously, a participant suggested it may be more appropriate to introduce a step before the screening stage of the HIA process and to identify which programmes and interventions are most amenable to HIA. It would also be useful to find more efficient and less resource intensive ways to undertake HIA. For small developments and projects different tools that are quicker and easier to use may be more appropriate. Overall, the future embedding of HIA was seen as reliant on continued effort and momentum. As one participant commented “we have to keep the foot on the pedal”.

Overall Value of the HIA Project

In Case Study C two out of the three participants regarded the HIA project as worthwhile. These participants commented that “CHETRE have played an excellent lead role in putting HIA on the agenda”, “have done an excellent job with the resources provided” and “had been shown to be effective, necessary and worthwhile at an AHS level.” One participant said they were “very pleased and happy” with the training, support, website and activities initiated by CHETRE.

The above notwithstanding one of these two participants regarded HIA as resource intensive, was unconvinced of the usefulness of HIA in policy settings and would prefer to see efforts focused more broadly at public health policy.

The third participant was not convinced HIA was worth doing on health projects. However this participant reported that HIA may be more valuable for projects such as urban planning and local government issues where health was not the sole focus and intent of the work.

Appendix 10

Key Informants – Evaluation Findings

New South Wales Health Impact Assessment Project Phase 3

Introduction

The key informant interviews represent the views of eight people who have been involved with the CHETRE NSW HIA Project. Nine people were approached to be interviewed but one declined to participate. Six interviewees were employed in senior positions in the Population Health Divisions in Area Health Services and the Department of Health. Several had taken part in a learning-by-doing HIA with CHETRE. Three were members of the Steering Committee. Two interviewees were staff members at CHETRE. Four of these people noted they had been involved with the project since its inception and had also been involved in phases one and two. Several had been involved with the project in different capacities as they have changed jobs. The person who declined to be interviewed expressed the view that HIA was not worth doing, not useful, took too much time and added another bureaucratic layer to decisions.

NSW HIA Project Achievements

Key informant participants without exception noted CHETRE's learning-by-doing approach to HIA has been a very practical way of building capacity and getting HIA incorporated into the work of the NSW Health system. One participant noted that people who have been involved directly through training or doing an HIA, and indirectly through Steering Group memberships had gained an understanding that HIA is not just theory but "grounded in practice". Another participant said "It has been a fantastic way of engaging other sectors in practical work."

Participants noted the project has had some success in working towards achieving the overall aim of capacity development at an individual and organisational level. As one participant noted the situation has gone from there being no capacity and no experience of HIA in the NSW workforce to almost every AHS having staff who can carry out an HIA and a "pretty long list" of examples where people have not only learnt the theory of HIA but also completed an HIA. The fact that a number of areas are now doing second and third HIAs and some without the assistance of CHETRE was noted as a good indication that workforce skills and organisational capacity had started to be built up.

Several people expressed the view that the CHETRE project helped to focus where HIAs could be used and acted as the catalyst getting it working on appropriate processes.

The CHETRE project was also credited with having built very useful networks both within the public health workforce in NSW and with partners in other agencies outside the health system.

Workforce Development

Interviewees attributed the learning-by-doing approach as being a key success factor in creating a workforce capable of carrying out HIA. “The whole process worked really well. Very professional, very tailored to our needs. It was a very good workforce development exercise.”

One of the advantages of the project’s state-wide approach has been the networks of workers in Population Health departments. As one participant noted “there is always someone you can go to get help and discuss things.”

Training public health officer trainees was considered to be an important factor in HIA having a future in the health system. It was noted that these people went on to work in relatively senior positions in the system and were a useful way of “getting HIA out there.”

Participants who worked AHSs said they had small teams of staff well versed in HIA and that some were doing HIAs regularly. One participant said “ It would not have worked if we had needed to employ 6 extra staff to do this [the HIAs]. It works because we were able to use people already in the community health service and population health areas.” Using these staff has worked because it has focused on the normal work that these people do.

Resources

Resources provided by CHETRE – the published material, website, blog, newsletter, helpdesk, seminars, presentations and conferences were well received and considered to be valuable. The HIA manual was noted as very practical and those who worked with CHETRE during its development found assisting with piloting the resource a useful learning exercise. The funding to assist rural staff to get to training was noted as a factor in the success of the project. One interviewee from one of the rural AHSs said that staff from her organisation would not have been able to attend the training without that assistance. Another noted the difficulties for rural AHS staff because they were “... more dispersed, had smaller work force, and fewer skills in the workforce which made it more difficult to do something new.”

CHETRE staff was regarded as a resource because of their availability to support and assist with the HIAs. Participants were very complimentary of the role played by CHETRE staff “It is difficult to imagine how we could have made so much progress without an organisation like CHETRE taking the lead they have. ”

The two editions of the Public Health Bulletin which covered HIA and with which CHETRE staff were involved were also noted as a valuable resource. Two participants noted that these helped to extend the reach of information about HIA and were an important way of “...disseminating the ideas across the system.”

The training, the associated resources and the Public Health Bulletin were both identified as very good levers for integrating theory into practice.

Partnerships

Participants thought HIA, as promoted by the CHETRE project, had contributed to progress in the development of working partnerships with other agencies. Several commented that though

HIA provided “a real tool” and a “really concrete way of working together” with other agencies that HIA was not the only thing that facilitated these relationships. It was noted that those relationships were not only useful but also had spinoffs such as other planning activities that would not have otherwise happened. CHETRE’s efforts in actively facilitating these relationships was commended but as one participant put it “ ... There are multiple factors, so improvements are not all due to this project but it has been a major contributor...” In a similar vein another suggested that though the improved opportunities to engage with councils and other organisations might have happened anyway as public health people became more aware of healthy community issues, HIA provided a focus and process to do it.

One person commented relationships within the health system had been improved and a better understanding that environmental health, public health, health promotion and health planning all need to work together on issues had developed. Another noted the developmental site HIA in the area had made links with local governments that proved useful but that the relationships had already started prior to involvement with the project and HIA. This person and several others noted that the HIA process added “a structure” to relationships. It was also noted that the HIA process helps work with local government planners particularly as it uses a “common language”. Other beneficial partnerships participants noted as having developed as a result of the project included those with the Department of Housing, inter-jurisdictional and international partners.

Leadership Development

Most participants felt CHETRE had shown very good leadership for HIA but had struggled to get sustained traction from the Department of Health. “Pushing leadership from the outside can be fraught”. There was agreement among participants that there were more “champions” for HIA in the AHSs than in the Department of Health. While there was support at the chief executive level in most of the AHSs the leadership had come from second tier management, especially the Directors of Population, Planning and Performance.

Staff who had done the training and were involved with the HIAs were seen as effective advocates for HIA.

Two participants interpreted the commitment of the Department of Health to fund the project for more than three years as leadership but acknowledged that enthusiasm for the project had “waned” more recently. Political pressures, funding cuts, a staff freeze and changing personnel were identified as reasons for the Department’s change in attitude. One participant commented that while his/her area had a small team of people with experience in HIA they were all middle level staff and not the decision makers. This meant there was no “ongoing leverage” and consequently HIA had not been adopted as policy but approached opportunistically.

Organisational Development

The inclusion of HIA in the NSW State Health Plan and the Public Health Plan for NSW were seen as significant progress in the process of embedding HIA. Although one participant commented that the inclusion of HIA in these documents was only “aspirational” it was still considered to be important. Population Health performance agreements in all AHS contracts with the Department of Health in 2006 and 2007 included a requirement for an HIA to be carried out. Several participants noted that while this was not one of the key performance measures it still provided impetus for the AHS to use HIA.

In the AHSs where there has been good uptake of HIA it has been included in the Population and the Public Health department work plans and in individual work plans. This was seen as developing the 'bottom up approach'. The fact that some organisations had done second and third HIAs and additional ones without assistance from CHETRE was considered to be a good indication that workforce skills and organisational capacity had started to be built up. One participant said "for a long while it [HIA] was just theory but the CHETRE project has facilitated good practical experience with it."

What the NSW HIA Project Has Not Achieved

All of the participants expressed their reservations about the degree to which HIA had been "embedded" into the system. Two expressed their concern in the same way noting that they did not think the project had achieved "reach" beyond those who had been directly involved with training and the HIAs carried out. Several noted that even where HIA had gained traction it had not moved out of population and public health areas. Another participant expressed it slightly differently, "if you wanted to run an HIA on a particular piece of health services planning you'd have to argue the case...there is not general acceptance that it is a good idea." None of the participants thought it had become an intrinsic part of the way people work or "assess things".

Only a small number of staff (relative to the large staff numbers in the health service) have the skills and these almost all have come from the Population Health area. One person noted that in his/her area staff turnover and loss of confidence through not practising meant there would be very few staff who could carry out an HIA without guidance. "Whether they would choose to without it being suggested to them is another matter."

Of special note was the Department of Health's failure to adopt and engage with HIA. Several participants noted that early support for HIA had faded away with changes in personnel. One person thought NSW Health had "dropped the ball".

The time intensive nature of HIA was noted as a limiting factor by several people. The extensive resources required to carry out HIA meant that it could not be applied routinely. There was some discussion regarding the confusion about when HIA should be applied and what projects were most suitable. Participants said some of the developmental site projects were not good examples of HIA and that there was still not enough knowledge about where and when to apply HIA appropriately.

Strengths and Limitations of the NSW HIA Project

Strengths

All the participants were positive about the learning-by-doing approach. The "hands on" method of teaching meant people learned the principles and theory and achieved the work of an HIA. The following statement sums up most participants views. "There are so many instances where people go off and get training in something and then don't get an opportunity to implement it or apply that learning... this [learning-by-doing approach] has worked particularly well."

The use of developmental sites led to some very positive, unanticipated opportunities. The focus on urban planning, for example, emerged though HIAs carried out on urban development

plans. It provided an opportunity to contribute to the debate about urban development independently of HIA, but based on HIA experiences.

CHETRE's academic status was mentioned as having had a positive influence on several different levels. CHETRE's academic base allowed staff to keep up with research and publish papers which helped spread the knowledge further. One participant described CHETRE's academic base as having authority and independence which was useful. On a slightly different tack another participant made the following comment:

There was great advantage in having CHETRE do this work as it keeps it at arms length from the Department which is very open to arbitrary influences like political influences and changes of personnel. The value in contracting this work out for three years means you know you are going to get a good, solid academically based approach.

A common theme among participant's comments about the strengths of the project was the wide variety and high level of support that CHETRE had provided to those working in the developmental sites. CHETRE's flexibility and continual looking forward for the next step – in terms of disseminating the skills and/or getting senior people in AHS involved was praised. One participant noted that CHETRE was ... "always seeking our views on how HIA can help. CHETRE has not looked at it as – let's run another course or do more HIAs – it was more practical than that...and [CHETRE] worked hard to meet the needs of NSW Health and AHSs."

Most participants agreed HIA increased awareness of equity issues and provided a useful tool for doing something about equity in health. "Everybody talks about the problem of inequity but what they need is ways of making decisions differently that address inequity. Health Impact Assessment is one of the tools to help us do that."

Both HIA and the learning-by-doing approach were cited as very positive ways of engaging other sectors in practical work. One interviewee cited the example of the Department of Housing which having completed an HIA "...then started talking about how they could go upstream into a healthy public policy context."

Another participant also gave the example of working with the Department of Housing on an HIA and establishing an ongoing relationship – "now they're working on different research projects and getting health involved in some of their design assessment phases and things like that". Health Impact Assessment is seen as a positive way of moving towards developing healthy public policy more broadly.

It's opened a window of opportunity for us and advocates within the department to put the issue of healthy public policy on the agenda... HIA [has the ability] to actually engage other sectors at the level I didn't anticipate. I didn't really appreciate how powerful a tool of engagement it was because it moves around all this talking about sharing problems into a very focused activity.

The project has highlighted the value of the use of evidence. "HIA has highlighted for a lot of people in health that they have something to offer in terms of their evidence base to other sectors such as local government." It was thought that this extended beyond HIA into much broader issues.

Another positive outcome of the project has been that HIA has given people an action to take which can make a difference on a number of public/population health issues and especially equity. "It's shifted them from talking about problems to thinking that there's something they can do about it."

Limitations

Intensive time and resource allocation is needed to do HIA and that can make them difficult to fit into the work programme and plans. Several participants said they thought HIA required too much investment for them to be repeated on a regular basis. For many in the health system there are always more pressing priorities. "...the health system here is so politically driven around front page crises and so on that it is difficult to think strategically about stuff they're not going to be held accountable for in the short term."

Many of the participants shared concerns about leadership. They thought leadership was the critical domain and the most difficult to get action on because leadership has to come from within the Department of Health. No matter how much leadership CHETRE could provide the Department needed to take a stronger role to see how HIA could fit into the departmental work and in negotiating with other sectors. The sentiment expressed by one participant was shared by several others.

NSW Health is such a complex organisation and at the moment this is a project that's being driven from within the Population Health division. For it to get fully embedded it probably needs to get greater traction in other parts of the organisation, for example State-wide Services Development through which a lot of health planning projects get adopted. Having said that it probably depends what we want to use HIA for. If it's more around working with other agencies around urban planning then maybe it's not so important for other bits of NSW Health to be involved. If we want to use it internally within NSW Health to assess our decision - making then we need to get more traction with other parts of the organisation. If it's more about how we work with local government, Department of Planning, other government agencies that can probably happen with it being driven from the Population Health Division where it is currently.

One participant noted that in the beginning of the HIA project there was more enthusiasm from the Department of Health and scepticism from Area Health Services and local councils because they were worried about the resource implications. However, as time has gone on the operational people have seen the usefulness of HIA and have been convinced of its value. At the same time the Department of Health has had personnel changes, staff numbers reduced, budget cuts and political pressures which have made it difficult to work on intersectoral engagement and the "higher level stuff has been an up-hill battle".

The issue of health inequalities was also regarded as controversial and there appeared to be internal struggles at state level. State leadership was regarded as critical to future capacity building and the sustainability of HIA.

A participant noted there had not been enough attention paid to the barriers and impediments that prevented some AHSs from participating in the project and committing to HIA. This person noted that rural areas generally struggle more than the urban areas because staff are more

dispersed, there is a smaller work force and fewer skills, all of which make it more difficult to take up something new and especially something which requires intensive resourcing.

One participant noted a concern that HIA had “gone places” that were not necessarily addressing the most pressing health needs and was failing to address inequalities. “One of my concerns is that we’re often talking about new land release issues or growth issues and it’s not the people who have the worst health status that live in these new areas. I’m concerned that improving the health of those people living in those areas actually increases inequalities.” Avoiding this “trap” may require shifting the focus to state renewal and working with local governments on things other than new land release.

Future Action Required to Build Capacity to Undertake HIA in NSW

All participants commented that the project should continue in some form because they perceived the culture of HIA was not sufficiently embedded for it to be left to its own devices. The general view was that without continued support the progress in embedding HIA made so far would fade away. “... there would be a serious risk that it would fizzle.” Participants noted that even in the AHSs where there was presently significant support for HIA that staff turnover, competing priorities and lack of resources put the continued use of HIA at risk. Four participants commented that there has been a history “great ideas” failing because funding was withdrawn before they were sufficiently integrated into practice. As one participant put it:

A soufflé doesn’t rise twice ... if it is not quite well enough established and everything falls apart then it is very difficult to re- invigorate it. If you pull the plug too early people move on, people get dispirited...one round more of funding would be really important. I don’t consider this to be an optional extra.”

Another participant noted “while I don’t think we need to be focused on capacity building for HIA forever, there is a role to resource activities to make sure the capacity doesn’t evaporate.” Several participants thought continuing the learning-by-doing approach and the support role which CHETRE has carried out via activities such as the helpdesk, website and publications should be continued.

Four of the interviewees recommended future work should have a broader focus on healthy public policy and for HIA to be just one part of that. Health Impact Assessment was regarded as an important tool in the development of healthy public policy but interviewees noted that there is a need for a wider range of activities around problem identification, healthy public policy, healthy planning and equity. This broader focus could facilitate more “upstream” interventions and intersectoral policy and activities. One participant suggested this work could be renamed as “environments for health or healthy public policy” but also noted that HIA should be maintained as part of that because “it’s transparent and structured and it’s a good way of engaging a wide range of people in something very practical and tangible.”

One participant noted the value in continuing to promote HIA because of its value as a “very useful and powerful tool for getting people thinking differently” about prevention, healthy public policy and equity issues. Two participants mentioned that future work could usefully clarify the issues around Equity Focused HIA and develop the concept of community based HIAs. Several participants recommended investigating ways to streamline HIA and to reduce its costs.

Two participants noted the value of continuing HIA training for the public health officers as a way of “systematising” learning in a group who are subsequently likely to take on senior roles in the health system. “It is like a long term investment.”

One participant discussed the need to focus on the AHSs that have been less successful than others in adopting HIA and stressed the need to build up state-wide skills.

Overall Value of the HIA Project

Generally interviewees thought CHETRE had made a big difference to the capacity within the NSW health system for HIA to be carried out. As a result of the project groups of people, particularly in the AHSs, are capable of, and experienced in, running HIAs.

A set of resources and good networks have been established to assist people to carry out HIA.

The learning-by-doing model has been successful in changing practice and integrating theory into practice. There are now sites that are using HIA that would not necessarily be using it if it had not been for the project.

Participants thought HIA had become better embedded in the AHSs than in the Department of Health. In the AHSs it has been used to approach issues like an urban design or service delivery but it has not been systematically used in policy evaluation.

The project has brought people together who might otherwise have not worked together and it has helped intersectoral working relationships across councils and health. However HIA has only a small reach into the health system and many within the system have been unconvinced of its value – in part because they do not see it as a cost effective measure.

Appendix 11

Document Review

Document Details

Case Study A

Document 1

Service Level Agreement (Draft document)

Schedule Two: Centre for Chronic Disease Prevention & Health Advancement

Priority issues for 2006/07

Better practice and Workforce alignment

2. Support the implementation of Phase 3 of the NSW Health Impact Assessment project.

Document 2

Health Development Team Business Plan 2007-2008

Key Strategies	Tasks
Further develop HIA capacity within Case Study B AHS, including participating in 2007 developmental site round.	Submit a proposal for the 2007 developmental site round. Explore the feasibility of developing an organisational structure for HIA in Case Study B AHS Work with X Shire Council student on an identified HIA

Document 3

Case Study B AHS Population Health Annual Report 2006/07

E1 Ensure population health capability

E1.1 Develop and maintain the population health force

- Convened a two day HIA workshop with CHETRE in Y
- Sponsored two additional staff to attend HIA training at UNSW

Document 4

Health Development Team Annual Activity Report 2006-2007

Priority: Equity, Social Determinants and Capacity Building

- Continued to promote Health Impact Assessment across Case Study B AHS , including
 - Completing a formal process and interim impact evaluation of the Z.HIA;
 - Convening a two day HIA workshop with CHETRE if Y
 - Sponsoring two additional staff to attend HIA training at UNSW

Document 5

Health Development Plan 2006 -2009

Key Result Area 4: Equity, Social Determinants and Capacity Building				
Aim 1: To build the capacity of staff and the community to influence health equity and the social determinants of health.				
Objective	Intended Action	Rationale	Evidence	Time Frame
To increase the number of staff who are familiar with Health Impact Assessment methodology	Selected staff to participate in the Leadership Development Program of the 2006 NSW HIA Project. Evaluate the Z HIA.	HIA holds great promise to enhance recognition of the social and environmental determinants of health.	Corbett, S. "The Art of the Possible: The Experience and Practice of HIA in NSW" in NSW Public Health Bulletin, 2005	July 2006 – June 2008

Case Study B

Document 1 (Draft document)

Work Plan Case Study A AHS Human Services Senior Officers Group

State Plan Activity: Delivering better services				
Goal	Initiative	Priority	Action	Responsibility
Healthy Communities	Health Impact Assessment	S3 improved health through reduce obesity, smoking	Conduct & evaluate HIAs on agreed major plans/policies that will have a large impact on communities in Case Study A AHS	Lead agency – health Partners – will depend on policy/plan

Document 2

Centre for Population Health Business Plan – July 2007 to June 2008

SD1 Make Prevention Everybody's Business				
Preventing falls in older people				
Objective	Outcomes	Performance Indicators	Strategies:	Risk:
Promote urban planning outcomes that facilitate active ageing	Improved urban environments that facilitate active ageing	Recommendation incorporated into LG plans	Provide recommendations for relevant LG plans, HIAs etc, explore revision of SEP	The urban environmental continues to be a threat & reduces older peoples ability to be physically active
SD4 Building regional and other partnerships for health				
Building regional and other partnerships for health				
Identify strategies to address healthy weight, falls & tobacco control that can be addressed across all Councils collaboratively with D [organisation]	Reduction in ETS & Healthier urban environments for Case Study A communities	Councils working towards smoke free alfresco dining & other outside venues HIAs conducted on any major new plans	Work with D [organisation] to take a regional approach to address smoke free environments in alfresco dining, playgrounds etc across all Councils & to address urban planning in the region	Capabilities for working on relevant issues with each individual Council will be too stretched
SD5 Make smart choices about costs and benefits of health services				
Equity				
Develop recommendations for improving the health of the E community	Improved health outcomes for E community	HIA completed & recommendations developed & implemented	Conduct HIA on E Council's Strategic Plan. Feed recommendations into E Councils Management & Social Plans etc &	Positive health outcomes of people in E [community] will remain disproportionately lower requiring greater health

			provide directions for A's response	resources than those in Case Study A AHS & the state
Build a sustainable workforce				
Build Capacity				
Build capacity for CPH staff & relevant partners to conduct HIAs	Improved health outcomes with particular attention to equity for the community	HIAs conducted to a high standard on appropriate regional/local plans & policies	Conduct HIA workforce development workshop in collaboration with CHETRE and Case Study A AHS	Staff will not keep up to date with contemporary practice

Document 3

Job Description

Centre for Population Health - Senior Research and Evaluation Officer

Primary Objectives (of role)

- Participating in or leading Health Impact Assessments.

Document 4

Job Description

Centre for Population Health – Population Health Program Officer

The initial key accountability for this position is contributing to a body of work that will improve environments that impact on health. This will include:

- Working collaboratively and building capacity with Local Government and other stakeholders to apply available tools and evidence for healthier environments, in particular, applying 'Health Impact Assessment' methodology.

Document 5

Population Health Plan

Making Prevention Everyone's business		
Future Directions	Healthy People 2010 Strategic Directions (Functions and drivers)	Population Health Strategies at Case Study A AHS
Build regional partnerships for health	Recognition of the public health role of other government agencies and NGOs Ensures that communities are partners in work undertaken	Partnership agreement with local government in Case Study A AHS and the Department of Education Health Impact Assessments

2.Reduce health inequalities to the lowest possible level	
Target	To achieve this target by 2011 we will:
Issues of social disadvantage explicitly considered and prioritised in population health plans and programme	Where applicable utilise health impact assessment as a means of gauging the broad impacts of government policies and programs in Case Study A AHS

8. Create and sustain healthy environments	
The development of healthy environments in Case Study A area supported and sustained	<p>Establish a healthy Urban Environment Team in Case Study A AHS</p> <p>Build capacity and experience in the conduct of Risk and Health Impact Assessment</p> <p>Develop tools to monitor the impacts of urban development on health in Sydney</p> <p>Review regulatory performance and outcomes in Case Study A AHS</p>

Case Study C

NSW State Documents

Document 1

A New Direction for NSW

NSW State Plan

Towards 2010

NSW Government

February 2007

Strategic Direction 1

Make prevention everyone's business

Re-investment

Identify and realign resources to promote the health of the community by supporting lifestyle changes through measures including legislation, regulation, incentives, pricing and health impact assessments of policy. Shift resources to support prevention activity.

Document 2

Healthy People NSW

Improving the health of the population

Population Health Division

NSW Department of Health

February 2007

Section Two

P1 Priorities for action and enablers to achieve them

P1.2 Assess health inequalities

Current actions

Health Impact Assessment (HIA): The Third Phase of the NSW HIA project is underway. The project has supported 15 HIAs to be undertaken in NSW and trained 82 people in the methodology.

What we will do

P1.2.5 Implement equity focused Health Impact Assessments as relevant.

P3 Promote health and prevent disease, disability and injury

P3.1 Implement strategies to promote health and wellbeing

Focus on the social determinants of health

P3.1.20 Ensure that all population health services undertake appropriate planning measures to address equity issues (such as equity-based Health Impact Assessments for all programs and the use of tools such as the *Four Steps Towards Equity*).²⁶

E1.2 Develop and Maintain Population Health Infrastructure

E1.3 Build Population Health Partnerships

E1.3.8 Establish partnerships at a state, regional and local level enhanced and coupled with the development of resources that support best practice, such as guidelines on Health Impact Assessment in Local Government.

Appendix 12

Evaluation of Training

CHETRE supplied summaries of three evaluations from those attending 3 training workshops held in 2007. These evaluations represent the views of 63 people. CHETRE asked trainees to rate their understanding and knowledge of HIA before and after training, if their expectations were met during the training, the relevance of the training for their work and their opinion on the appropriateness of the content detail of the training.

Overall the evaluations showed that most trainees had increased their knowledge and understanding of HIA (from average scores of 2.8 – 3.5 out of 7 to 4.8 – 5.3 out of 7). On average ratings showed that more than 80 percent of trainees felt their expectations had been met, more than 75 percent considered the detail in the course was “just right” and more than 75 percent said it was relevant to their work. Comments on the evaluation forms were generally complimentary though a few people noted some reservations.

Appendix 13

Activities Additional to the HIA Project Activities Additional to the HIA Project

CHETRE staff identified activities which were additional to the original contact. These include;

- a third round of developmental sites, including training and support (only two rounds were originally planned)
- broadened the scope and size of the HIA conference to recognise the work going on in NSW, to bring those working in HIA in NSW together and highlight how HIA was working in other places.
- offered a course on healthy planning
- increased the ways information about HIA was disseminated eg provided hardcopies of the electronic newsletter and introduced blogs
- commissioned a report on HIA in local government (paid for by an external grant but added value to the NSW HIA Project)
- worked on a second issue of the Public Health Bulletin on HIA as a means of extending the reach of HIA information to health practitioners
- worked with other agencies on developing research activities on urban health and ran a one day workshop on healthy urban development
- provided funding for each area health service to send a person to courses run by the Faculty of the Built Environment on development, the environment and health
- developed and taught an HIA case method tutorial as part of the University of NSW Medicine program
- supervised an AHS staff person with writing up of an HIA for Masters of Public Health at University of NSW
- co-developed and facilitated a workshop run by an AHS
- participated in meetings with Department of Planning and Department of health regarding a project to investigate wellbeing in Major Projects Environmental Assessments.

Appendix 14

Developmental Sites NSW HIA Project Developmental Sites

Location	Key Stakeholders	HIA Title
2005		
North Coast	<ul style="list-style-type: none"> • NCAHS Public Health • NCAHS Health Promotion • Environmental Health Branch, NSW Department of Health • Kempsey Council (Local Government) • Commonwealth Indigenous Coordination Centre 	HIA of the NCAHS Indigenous Environmental Health Workers Proposal
Hunter/ New England	<ul style="list-style-type: none"> • Auspiced by the Hunter Regional Coordination Management Group (all human service agencies) • HNEAHS • NSW Department of Health • NSW Premiers Department • NSW Department of Education • NSW Police Force • NSW Department of Community Services • NSW Department of Planning 	Lower Hunter Regional Strategy HSIA
Greater Southern	<ul style="list-style-type: none"> ▪ Palerang Council ▪ GSAHS Health Promotion ▪ Quenbeyan City Council (as observers) ▪ Local community representatives ▪ Palerang Councillor ▪ GSAHS Public Health ▪ GSAHS Health Service Planning 	Bungendore HIA
Sydney South West	<ul style="list-style-type: none"> • WSROC • SSWAHS • SWHAS • CHETRE • NSW Department of Health 	Growth in Western Sydney HIA (WSROC)

	<ul style="list-style-type: none"> • NSW Department of Planning • NSW Ministry of Transport • Around 20 other agencies 	
North Sydney / Central Coast	<ul style="list-style-type: none"> • NSCCAHS Health Promotion • NSCCAHS Families First • Other agencies indirectly 	Health Home Visiting in NSCCAHS HIA
Sydney West	Not supplied	Greater Granville Regeneration Scheme HIA
South Eastern Sydney / Illawarra	<ul style="list-style-type: none"> • SESIAHS Health Promotion • Wollongong City Council 	Wollongong Foreshore Precinct Plan HIA
2006		
Great Southern	<ul style="list-style-type: none"> • GSAHS Health Service Planning • Jerilderie MPS Board • GSAHS Western Cluster Managers • Jerilderie MPS Management 	Health Service Planning in GSAHS HIA
Sydney South West	<ul style="list-style-type: none"> • SSWAHS Population Health • Liverpool Health Service • SSWAHS Health Service Planning 	Liverpool Hospital Capital Works HIA
Hunter / New England	<ul style="list-style-type: none"> • HNEAHS Aboriginal Health • HNEAHS Population Health • University of Newcastle Department of Rural Health • Tamworth Aboriginal Medical Service • NSW Department of Education • NSW Department of Community Services • Several other agencies - Scott will be able to advise 	Good for Kids, Good for Life Aboriginal Childhood Obesity Prevention Strategy EFHIA
NSW Department of health	<ul style="list-style-type: none"> ▪ Centre for Chronic Disease Prevention and Health Advancement, NSW Department of Health ▪ CHETRE ▪ New South Wales Council for Social Services ▪ NSW Centre for Overweight and Obesity, University of Sydney 	Rapid EFHIA of the Australian Better Health Initiative (NSW)

	<ul style="list-style-type: none"> ▪ UNSW Research Centre for Primary Health Care and Equity (Chronic Disease Prevention and Management Program) ▪ Victorian Department of Human Services (observer) 	
2007		
North Coast	<ul style="list-style-type: none"> • NCAHS Population Health • Coffs Harbour City Council 	Coffs Harbour Our Living City Settlement Strategy HIA
Sydney South West	<ul style="list-style-type: none"> • Camden City Council • SSWAHS Population Health • SSWAHS Public Health • SSWAHS Population Health • SSWAHS Health Service Planning 	Oran Park and Turner Road Land Release HIA
Sydney West	<ul style="list-style-type: none"> • SWAHS Population Health • Lithgow City Council 	Lithgow 25 Year Strategic Plan HIA
NSW Department of health	<ul style="list-style-type: none"> • NSW Centre for Oral Health Strategies, NSW Department of Health • New South Wales Council for Social Services • Australian Dental Association • CHETRE UNSW 	Desk Based EFHIA of the Every Brushes Twice a Day Project
Greater Southern	<ul style="list-style-type: none"> • GSAHS Health Promotion 	Physical Activity Leader Program (HIA Screened Out)

Annexure 1:

NSW HIA project Phase Three Activity Report

1.1 Events

Event		Overall Attendance	NSW Health attendance
<i>Developmental sites training</i>		91	78
<i>Master of Public Health at UNSW</i>		54	3
<i>HIA colloquium</i>		72	29
<i>HIA 2007 conference</i>		181	46
<i>Health Promotion Symposium Workshop</i>		35	35
<i>Workshops</i>	<i>GSAHS screening and scoping workshop</i>	38	15
	<i>SWAHS / SSWAHS HIA workshop</i>	60	38
	<i>Urban Development. Workshops</i>	78	57
Total attendance		609	301 (of 609)

1.2. HIA guide dissemination since November 2007

Source	Total
<i>Hard copy</i>	1000
<i>Downloads from HIA connect</i>	700

1.3. HIA connect visits

There was an average of 1059 'hits' per month on HIA connect in 2007.