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REPORT | JUNE 2011

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ABOUT THE NATIONAL COLLABORATING CENTRE FOR HEALTHY PUBLIC POLICY

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

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INTRODUCTION

Health impact assessment (HIA) figures among the practices that encourage the adoption of healthy public policies. The HIA approach is a structured series of steps designed to determine the potential effects, both negative and positive, of a project or policy on a population's health and well-being.[1] HIAs are generally prospective in nature, meaning that they attempt to estimate the future impacts of a policy in order to inform decision makers before decisions are made and policies implemented. They generally address policies developed outside the health sector.

Several models exist for applying the HIA approach. Depending on the purpose of the assessment, the approach may place more emphasis on finding scientific data, encouraging public participation and strengthening local communities, or supporting intersectoral decision making. The HIA pilot project carried out in Montérégie falls more within this last model of practice, which is also the approach adopted at the provincial level.

This practice model has been used by the Québec provincial government for almost 10 years in its application of the Public Health Act. Under section 54 of the Act, all government departments must ensure that their legislative bills and regulations will not have significant negative health impacts on the population. To help different government sectors to meet this obligation, the Ministère de la Santé et des Services sociaux (the provincial department of health and social services, MSSS) has implemented a strategy based on interdepartmental collaboration and searching for situations that may be considered mutually beneficial. The long-term objective of this strategy is to support cultural change that will foster accountability for population health that is shared across all government sectors.[2]

Given the significant influence of municipal policies on the determinants of health and knowing that, internationally, HIA is mostly used at the local level, interest has grown in adapting HIA practice to this decision-making level.

In 2007–2008, a pilot project was launched in one of Québec's health and social services regions. Its objective was to assess the relevance and feasibility of applying a health impact assessment process on policies developed at the municipal level.

This document presents the approach taken by the public health sector in the Montérégie region to interest municipal authorities in HIA and encourage them to make prospective evaluations of policies proposed at the municipal level. It provides a brief description of the different stages in the pilot project, the collaboration mechanisms implemented, the identified objectives, the evaluation strategy and the main conclusions drawn from the experiment.

[1] For more information, consult the introduction to HIA produced by the NCCHPP: http://www.ncchpp.ca/133/publications.ccnpps?id_article=302.

[2] For more information on strategies for implementing section 54 within the Government of Québec, consult the documents produced by the Ministère de la Santé et des Services sociaux (French only): http://politiquespubliques.inspq.qc.ca/fichier.php/60/Bilanarticle54.pdf.

This document is intended to provide information on the process of introducing HIA practice at the municipal level and present the public health sector's main findings on the process. It does not present the results of impact analyses for each of the analyses performed. Furthermore, the nature of the projects studied and, above all, the constraints inherent in a pilot project did not allow the project's team to complete all the steps of the HIA approach with each policy project. However, the lessons learned on the potential influence of the municipal level, the strengthening of policy formulation processes, relations between the health and municipal sectors and knowledge development on both sides led the various partners to conclude that HIA should become a permanent practice, serving as a tool to support healthy public policies. This led to a health impact assessment mechanism being introduced in 2009–2010 as one of the services offered by Montérégie's public health authorities.

1 PRESENTATION OF THE PROJECT SETTING

1.1 ORGANIZATIONAL CONTEXT

Québec is organized into 18 health and social services regions. Each region is administered by a health and social services agency, which includes a regional department of public health. Montérégie's *Direction de santé publique* (department of public health, DSP) serves a region consisting of 11 local areas, each including a *centre de santé et de services sociaux* (health and social services centre, CSSS). The CSSSs represent the local level of health service administration in Québec and, in addition to providing clinical services, are charged with implementing local public health programs. Under the legislative mandates governing public health practice in Québec, local and regional health authorities must work in partnership with various actors in the region to act on health determinants. The DSP saw the HIA pilot project as a way to attain this objective by proposing an approach and tools to CSSSs so that they could work closely with municipal decision makers.

Québec municipalities are not directly responsible for health and social services; however, many of their activities may influence determinants of health. Examples include their obligations with respect to urban planning, economic development, road systems and public transit, water management, and recreation and community life services. Furthermore, many municipalities have adopted social policies designed to foster quality of life for their citizens. This includes family, cultural and social development policies.

Municipalities within a given administrative area are grouped under a supramunicipal entity called a *municipalité régionale de comté* (regional county municipality, MRC). These entities have specific responsibilities, including a responsibility to develop a regional organization plan. In Montérégie, the division of the MRC territories generally corresponds to the health and social services regions.

1.2 GEOGRAPHICAL AND SOCIAL CONTEXT

Located south of Montréal, Montérégie is Québec's second largest health and social services region (counting approximately 1,370,000 people in 2008). It is characterized by a mix of highly urbanized areas and rural and agricultural zones.

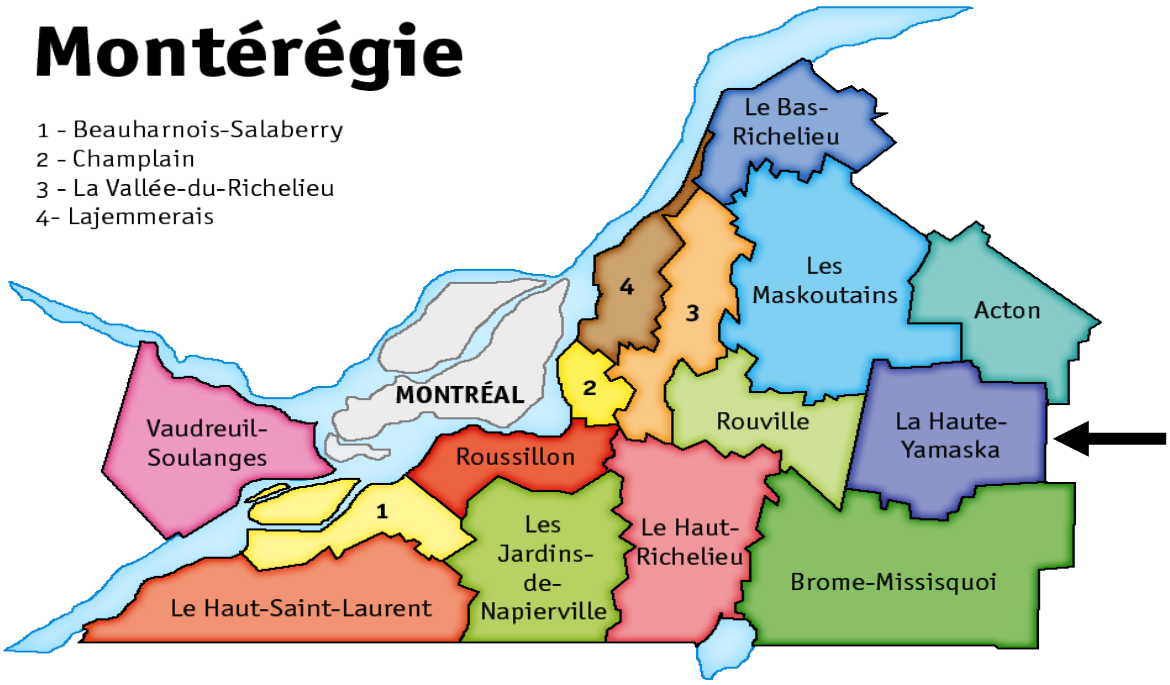


Figure 1 The Montérégie Administrative Region

Source: Wikipédia. (2011). Montérégie. Consulted on June 1, 2011: http://en.wikipedia.org/wiki/Montérégie.

The HIA pilot project took place in Haute-Yamaska (population: 90,237), a region at the eastern extremity of Montérégie and at the outer edge of the MRC. The Haute-Yamaska MRC was selected because it appeared to present favourable conditions for introducing a new practice such as HIA. The MRC's administrators had maintained good relations with the CSSS for many years, and it, as well as most of its eight constituent municipalities, was part of the Réseau québécois des villes et villages en santé (the network of healthy cities and villages). This meant that local elected officials were already sensitive to the links between their actions and health.

2 THE ACTORS INVOLVED

Run by the Montérégie DSP, this project was the product of the collaboration of several partners: the Haute-Yamaska CSSS and the elected officials of the Haute-Yamaska MRC. The MSSS, the Institut national de santé publique du Québec (Québec's public health institute, INSPQ), and the National Collaborating Centre for Healthy Public Policy (NCCHPP) provided support and advice.

The DSP provided leadership in the overall approach taken, while the CSSS served as a liaison with the municipal sector, in particular through its community organizers. The INSPQ, the MSSS and the NCCHPP provided support in their specific areas of expertise. It should therefore be understood that the DSP, as the main leader of the project, played a crucial role in the process by chairing the strategic committee (see below) and by integrating the new project into the workplan of its community development unit.

One of the INSPQ's responsibilities was to hire a project manager who would provide full-time support to the DSP in this one-year pilot project and in its documentation. This project manager's specific role was to: propose a structured approach to the pilot project, plan and facilitate the project's various meetings, adapt and recommend tools for each phase of the HIA approach, draft the HIA reports, and identify training needs as they arose and propose how they should be met. The project manager was also responsible for supporting an evaluation of the entire HIA pilot project.

3 OBJECTIVES AND SCOPE OF THE PILOT PROJECT

The general objective of the pilot project was to:

Document the utility of the HIA approach and the conditions for success that would foster its integration in a context of local and regional decision making. The goal was to support a strategy for promoting and supporting this practice in Montérégie and, eventually, in all of Québec's health and social services regions.

The project also had other, more specific objectives to:

- Document the feasibility, acceptability and utility of using HIA in the municipal sector to inform project and policy decision making;
- Determine the conditions required to implement, run, appropriate and sustain HIA in the various institutions represented;
- Define organizational and administrative impacts in each of the partner organizations;
- Identify the roles and responsibilities of the various partners (the CSSS, the DSP, the INSPQ, the MSSS and the NCCHPP);
- Define the support, knowledge and training needs of individuals and the partner organizations;
- Develop an HIA guide and related tools adapted to a municipal context.

4 STRUCTURES IMPLEMENTED

In order to support the various activities associated with the pilot project, the DSP created three different types of committees: a strategic committee, an operational committee made up of members of the strategic committee, and project committees (one for each of the three HIA projects). The project committees were intersectoral, meaning that they were comprised of representatives from the health and municipal sectors.

4.1 STRATEGIC COMMITTEE

Given the fact that HIA was new to Montérégie's regional and local public health authorities, a strategic committee was formed within the health sector. This committee had representatives from various public health partners with an interest in the project: the CSSS, the DSP, the INSPQ, the MSSS and the NCCHPP.

The committee's role was to:

- Establish the project's objectives and the different aspects of the project to be documented;
- Provide advice on how to run the pilot project;
- Provide the support required to operate the project and support the project manager;
- Oversee the quality of the overall approach taken;
- Serve as a liaison between the main actors involved;
- Facilitate collection of the information required for HIA and for documentation of the pilot project;
- Validate the pilot project's process evaluation tools.

4.2 OPERATIONAL COMMITTEE

This committee consisted of public health professionals, some of whom also sat on the strategic committee. They were: the professional responsible for the project within the DSP, two community organizers working at the CSSS, a mid-level manager at the CSSS, and the project manager. Each member of the operational committee was directly involved in one of the HIA projects (for example, by sitting on the project committee).

The committee's role was to:

- Provide a point of contact with municipal authorities;
- Prepare and participate in various meetings organized as part of the HIA approach;
- Provide direction and support to the project manager;
- Report to the strategic committee on progress made in the project.

4.3 PROJECT COMMITTEES

For each of the projects under study, a project committee was also formed to run the HIA. These committees consisted of a project manager, one or two members of the operational committee and designated municipal representatives.

Their role was to actively participate in all stages of the HIA approach by making a contribution commensurate with their respective means.

5 PHASES OF THE PILOT PROJECT

Since the participants were unfamiliar with HIA practice, the pilot project was planned in four phases, including a phase for increasing municipal elected officials' awareness about the HIA approach and choosing municipal policy projects that could benefit from an HIA. Each of these phases is described briefly below.

5.1 THE PREPARATORY PHASE: UNDERSTANDING THE PRACTICE AND ITS POTENTIAL IN THE LOCAL AND REGIONAL CONTEXT

The preparatory phase took place from June to September 2007. For the partners on the strategic committee, the goal was to develop a shared vision of HIA. This was achieved by organizing presentations on the benefits, issues and characteristics of HIA practice. For the partners on the operational committee, the goal of this phase was to develop a more detailed understanding of the decision-making responsibilities of the two levels of municipal administration (MRC and the municipalities) that can affect population health. This phase was also meant to highlight the specific characteristics of the Montérégie region, including the various actors responsible for development in the region. The phase involved developing a shared language for discussing the mandates and skills of the various municipal and supra-municipal actors, and learning how they are linked together and how responsibilities are shared among them and with other actors responsible for development in the region. Informal telephone interviews were also conducted to complete the information collected and better understand the context of the HIA pilot project.

A literature review on international examples of HIA applied at the regional and local levels was conducted in order to highlight those elements that could be applied in Québec's local and regional context.

5.2 THE INTERSECTORAL PARTNER SENSITIZATION AND INVOLVEMENT PHASE: CONTACT WITH MUNICIPAL ACTORS

The CSSS team began by contacting the head of the MRC to present the pilot project and its objectives. Once he had agreed to participate, it was decided that the project should be presented to all the mayors in the MRC at one of their regular business meetings. Members of the strategic committee therefore met with all the mayors during September 2007. The MRC's administration and the group's largest city immediately signed on to the project. A letter was then sent to formalize their collaboration. In addition, the head of the MRC then sent a letter to the mayors of the other seven municipalities in the Haute-Yamaska MRC, officially inviting them to submit one or more projects currently in development in their municipality that would be appropriate for an HIA.

5.3 THE OPERATIONAL PHASE: PROJECT SELECTION

Following this call for proposals, six projects were reviewed for initial selection. A half-day meeting was held with a representative of the CSSS, a representative of the DSP, the project manager and the head and the general manager of the MRC. They used a screening tool that was developed as a list of determinants of health (see Appendix 2). Project selection

was also influenced by contextual considerations, such as the running time of the HIA compared to that of the pilot project, political impacts and strategic considerations. Three projects were retained from this initial screening: a municipal policy initiative for the elderly, a project to build a plant that would convert household waste into compost, and a cooperative project (a multiservice centre) aimed at revitalizing a village.

5.4 THE OPERATIONAL PHASE: APPLYING HIA APPROACHES TO EACH OF THE THREE PROJECTS SELECTED

The HIA process involves five successive stages: screening, scoping, analysis, recommendations and evaluation.

In this pilot project, the HIA process was adapted to each of the three selected projects based on the progress in each project and the results from the screening stage.

As a result, the revitalization project spearheaded by a village cooperative did not get past the screening stage when closer analysis led to the conclusion that the project had virtually no negative impacts. The screening stage involved examining each of the items in the screening table provided in Appendix 2. Screening was performed at a meeting of the project committee, which consisted of three members of the public health sector, the mayor, a member of the administrative staff and a volunteer, the main proponent of the project. The exercise nevertheless underscored positive aspects of the project, and the discussions included potential additions to the project that would improve its ultimate impacts, such as offering healthy foods in the project's restaurant and convenience store. This stage was also used to test some screening tools. The tool recommended by the public health sector proved to be less relevant for a social project such as that proposed by the cooperative. The second tool, based on the Community Health Impact Assessment Tool (CHIAT),[3] a guide developed in Nova Scotia, did not prove conclusive either.

The HIA for the planned policy for elderly people in a major community had to be adjusted to meet deadlines imposed by the development of such a policy and municipal processes. Given that the HIA became part of the policy initiative at the outset of the formulation phase, which was when the citizens were consulted on their expectations of such a policy, the tools for the screening stage were primarily used to guide certain aspects of the citizen consultation and integrate their concerns about health promotion from the very start of the process. The public health sector's most significant contribution to the project was to inform participants about guidelines developed by the World Health Organization (WHO) on how to establish Age-friendly Cities.

Finally, a brief analysis was made of the project to build a plant in the MRC to convert household waste into compost, since the period of time allocated to the pilot project was almost over when all the technical information on the plant model was finally available. As such, the analysis could not be completed. The screening was performed by the head of the MRC, its general manager and a technician. They first examined the project's potential impacts, mainly in terms of the future plant workers' exposure to dust, bioaerosols and noise.

[3] For more information, consult: http://www.antigonishwomenscentre.com/pdfs/Antiognish%20CHIAT.pdf.

The potential impacts for the general population involved an increase in road traffic and the greater economic burden on households living in rental housing. This last point arose because of the substantial tax rate increase that was expected in order to fund the project.

The HIA committee suggested best practices for maximizing potentially positive impacts and minimizing potentially negative impacts on the health of workers and the public. These suggestions are based on findings from the scientific literature.

Table 1 Stages completed for each HIA project

Stage	Project: Cooperative	Elderly policy	Project: Composting plant
Screening	X	X	X
Scoping		X	X
Analysis			X
Recommendations			X
Evaluation	X	X	X

6 HIA RESULTS

The strategic committee adopted an evaluation plan at the start of the pilot project. The evaluation plan developed addressed the project's ability to meet each of the objectives set forth in point 3. Four sources of information were used to collect the data: (1) the logbook kept by the project manager; (2) the strategic committee's minutes from meetings (n=4); (3) the results of a group interview that took place midway through the project with all of the members of the HIA project committees (elected officials, administrative staff, health professionals) directly involved in the HIA projects; and (4) the results of HIA process evaluation meetings for each of the projects.

The results were organized under four main headings: the appropriateness of the HIA approach for each of the organizations involved, the organizational impacts, intersectoral relations and the role of the organizations.

6.1 THE APPROPRIATENESS OF THE HIA APPROACH

6.1.1 Positive aspects

Overall, the HIA approach to intersectoral work on health promotion was considered very appropriate by all the parties involved.

Favourable comments on its use made by the municipal actors can be summarized as follows:

- The HIA approach opens new horizons, allowing actors to take into account issues that were not perceived at the start of the project;
- It prepares actors for meetings with citizens;
- It takes citizens' opinions into account by applying a structured approach, and allows discussions to take place that look beyond personal interests or the interests of specific groups;
- The HIA approach and way of working (partnership and consideration of citizens' opinions) are consistent with the approach to strategic planning developed by the MRC;
- It is politically sound, since attention is paid to the health value of municipal projects and policies.

The participants generally felt that the HIA approach adds value to a policy or project development process.

Participants from the health sector also expressed positive opinions of the pilot project. They saw the HIA approach as a new way to work with municipal decision makers, who represent an important group of partners. The point of departure is the municipalities' projects rather than projects initiated in the health sector.

This positive reception given to HIA by both sectors may be explained, in part, by the existence of prior favourable preconditions (see point 1.2 on the cultural context).

6.1.2 Negative aspects

In terms of negative aspects of the HIA approach, participants from both sectors mentioned how it generates additional work (more meetings), confusion about roles due to the presence of an HIA project manager on the teams that were developing the analyzed policies/projects, and the need to adapt the approach and standard tools proposed by the HIA literature to the specific contexts and particularities of the policies under study. The HIA approach needed to be adapted in order to keep it constructive yet ensure that it would be flexible enough to meet the participants' needs.

The additional workload was mentioned several times by the participants in the pilot project. In addition to the intersectoral meetings required to carry out tasks in each stage of the HIA approach, information and project selection meetings were required to introduce the new practice. Adjustments were made along the way. To advance the policy for the elderly, the HIA project manager sat on the committee responsible for policy development created by the municipality, thereby avoiding a parallel process but at the same time generating some confusion in the support roles for this committee.

In the composting project, a compromise was reached on how involved municipal officials would be in the various stages of the HIA. They actively participated in the screening stage but were less present in the other stages. It would appear that it is more difficult to secure the full participation of policy-making officials in every stage of the HIA approach.

The composting project was the one that best satisfied the criteria and tools developed for HIA practice. However, the limited time frame of the pilot project (one-year maximum) affected the quality of the evaluation report, since the analysis could not be completed due to incomplete information. Although the elected officials still considered the report useful, its incomplete nature created some uneasiness when it was tabled, given that public institutions must be transparent. Indeed, this fear proved to be well-founded when a citizen exercised her right to consult the evaluation report.

The project raised the issue of who actually owns the report on the analysis of potential impacts, something that must be determined within a three-way partnership process (the MRC or municipality, the CSSS and the DSP). In the case of the composting project, it had not been clearly determined which of the three authorities would bear the main responsibility for deciding whether or not the analysis report would be released. In fact, no such agreement had been reached when the project began.

For the members of the strategic committee, the issue of the nature of the report on the potential impacts continued to generate discussion. For example, the CSSS believed that the objective of the HIA approach was essentially to sensitize municipal decision makers to the issues and develop their knowledge on the determinants of health. From this perspective, the main deliverable should be the notes taken during the meetings rather than a formal report, which could be contested. In contrast, for the DSP the report must contain evidence-based data and represent a formal point of view from the public health authority, and this point of view should be made public.

6.2 ORGANIZATIONAL IMPACTS

Four different aspects of organizational impacts emerged during the pilot project:

- Access to and processing of information;
- How work is organized within the different authorities;
- Intersectoral relationships; and
- The role of each organization involved in the HIA process.

6.2.1 Access to information and information processing

The project revealed that two types of information are needed to successfully carry out an HIA: information related to health and "technical" information related to the project or the policy analyzed. Technical information was particularly important for the composting project.

As for health information, the three projects analyzed benefited from information and expertise that already existed within the DSP and the CSSS. Information gathered by the department of environmental health, the unit that monitors population health, and a program for the elderly proved helpful in the project screening, scoping and analysis phases.

The degree of precision of the information needed to perform an HIA appears to vary depending on when the HIA is carried out in relation to the progress already made on a policy initiative. In the case of the elderly policy, where the HIA was performed at the beginning of the consultation process (and therefore at the beginning of policy formulation), the information used was more conceptual in nature and came from the grey literature. The health information required for the composting project, which was much more advanced, needed to be more precise and linked to the specific nature of the project (e.g. exposure to noise, compost quality and increase in road traffic). Use of more specialized expertise and more detailed scientific information was therefore necessary, and this required a significant amount of work in terms of finding, analyzing and synthesizing the information.

Technical information on a project or policy proved essential to the successful completion of a health impact assessment. The quality of the report evaluating the potential health impacts of the composting project depended upon technical information held by a private sector actor over which the HIA initiative had no control. This made analysis more difficult and influenced the quality of the report produced.

6.2.2 Work organization

For the DSP, the HIA approach tries to maintain the quality of both intersectoral relationships, with the CSSS as well as with the new municipal partners, and the scientific quality of the impact analyses. With respect to the latter issue, it should be noted that a single team within the DSP cannot have all the information required for the assessments, given the variety of potential subjects and the level of specialized data required. For the team responsible for the HIA practice, the work of structuring the process therefore requires liaising with scientific teams, both within and outside the DSP. This liaison work was in addition to the team's usual responsibilities.

For the three authorities most involved in the pilot project (the DSP, the CSSS and the municipalities), the additional work involved in attending more meetings was considered to be at the limit of what was acceptable; however, they all recognized the value of the results of this intersectoral work. In the municipal sector, the HIA meetings were in addition to those scheduled with other partners to develop the project or the policy proposal. Integrating the pilot project manager into the elderly project development mechanism prevented the overload of work associated with the implementation of a consultation mechanism specifically for the HIA; however, this approach required considerable flexibility on the part of the project manager, both in terms of availability and how the HIA was applied. This said, the context of the pilot project (new lessons learned, activity monitoring and an evaluation of the experience) may have contributed to the high number of meetings.

The municipal sector was open to integrating the HIA approach into its decision-making process, in particular by taking responsibility for the process (organizing meetings) and by using the screening tables (Appendix 2), with support from the health sector. The pilot project did not enable the partners to examine the actual feasibility of this opportunity presented by the municipal sector, nor was it able to look at the amount of support required.

6.2.3 Intersectoral relations

Intersectoral relations served as the foundation for the pilot project's HIA processes. Although the health sector's concerns over the potential impacts of the pilot project on existing relations between the two sectors (in the event that the impact analysis did not favour the proposed project) were not confirmed, they were well-founded. In general, though, the comments received on intersectoral relationships were positive. It appears that the HIA processes brought the sectors, as well as the two authorities from the health sector (the DSP and the CSSS), closer together, giving them a better understanding of each other's roles and responsibilities. Furthermore, the project underscored the links between their missions. For example, at a mid-project review, a municipal participant stated that he increasingly viewed the health sector as an essential partner. One participant from the health sector suggested that more progress had been made in another project undertaken in collaboration with the municipal sector due to better knowledge of the actors and the sector as a result of the HIA approach.

Given the comments made by the municipal participants, this new awareness appears to have had an impact on more general approaches to their work. They explored the idea of using a similar approach with other sectors, such as education. Another participant also suggested using the HIA approach in projects by the *centres locaux de développement* (local development centres, CLDs).

6.2.4 The role of organizational authorities

At the mid-project review, participants identified three different roles associated with HIA practice:

- A role of support for the HIA approach. This includes organizing meetings, using the tables and other process-related tasks;

- A role of research that involves searching for existing scientific information that would be relevant to the project under study. This information is acquired through a quick review of the scientific literature and the grey literature and through interviews with experts;
- A role of synthesis and sharing of the information gathered in order to stimulate discussions and thinking among the people involved in policy development.

These three roles were considered essential in order to provide an effective chain of information (from identification to use). In the case of the pilot project, these three roles were mostly assumed by the project manager. There were discussions at the mid-project review of sharing these roles in the event that HIA practice is institutionalized in local and regional governments. The municipal representatives felt that they would be able to assume the support role associated with the HIA process as long as they could be assured the support of the health sector.

The DSP's role in the HIA approach was not simple, since many objectives were being pursued at the same time. For example, the decision-making support objective and the objective of producing evidence-based data appeared to be at odds, as can be seen in the following comment made by the project manager:

> I feel torn between two logics: the "field logic," with all its constraints in terms of time, scheduling and resources (available or not), which affects planning and the ability to carry out planned HIA activities, and the "research logic," under which everything needs to be prepared and monitored according to a plan that has been developed by researchers and is often difficult to reconcile with the field logic. (Translation from the project manager's log book)

This tension over the DSP's role was also evident in questions raised over the purpose and use of the formal HIA report.

As for the CSSS, participants noted that expertise other than that linked to local knowledge could also be useful to the municipal sector. For example, community organizers can assist municipalities in citizen consultations. One of the advantages of such a contribution is that it could reach people who do not usually have opportunities to be heard by the usual authorities.

CONCLUSION

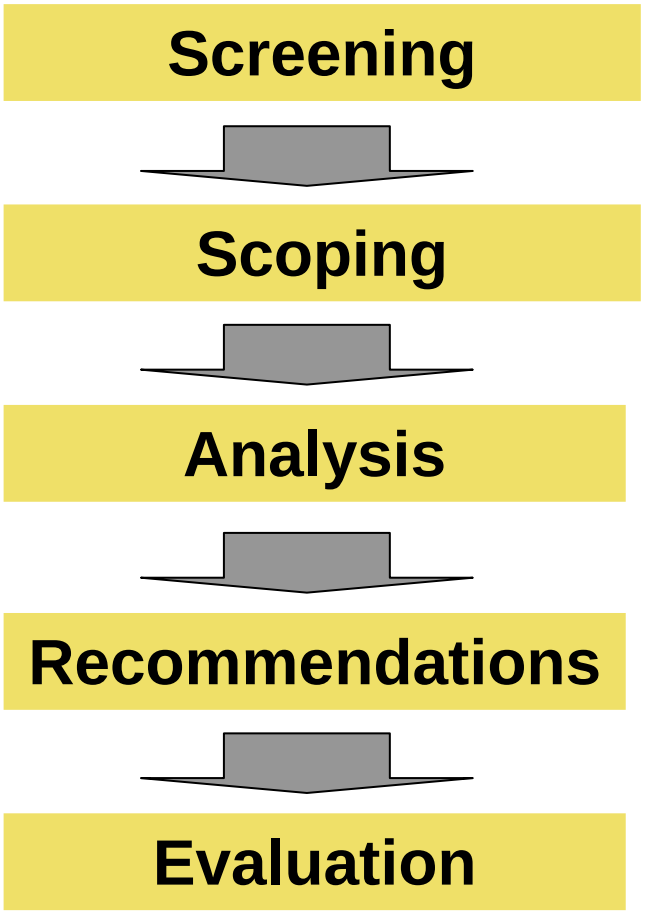
The pilot project ended in June 2008, at the end of the project manager's contract. However, the lessons learned on the potential influence of the municipal sector, on strengthening the policy formulation process, on relations between the health sector and the municipal sector, and on knowledge development on all sides led the various partners to express a desire for permanent implementation of HIA practice in support of healthy public policy. This materialized in 2009. The public health department took concrete action in this regard when it added the HIA approach to its 2009 *Plan d'action régional de santé publique* (regional public health action plan, PAR). The department hired a full-time resource-person to support HIA development at CSSSs interested in this form of practice as a way to collaborate with the municipal sector on the determinants of health.

Finally, when the municipal authorities were consulted on how to follow up on this project, they expressed an interest in continuing this form of collaboration. Several projects have already been proposed in this regard.

APPENDIX 1

CLASSICAL HIA STAGES USED IN MONTÉRÉGIE

CLASSICAL HIA STAGES USED IN MONTÉRÉGIE



APPENDIX 2

SCREENING TABLE USED IN MONTÉRÉGIE DURING THE 2007–2008 PILOT PROJECT

Screening Table[4]: Health Impact Assessment Process

Project:

For each of the following categories,[5] does the project have a potential impact on:		Potential impacts					Comments Specify which aspect of the project was the source of the impact; Describe the nature and scope of the impact (small or large, occasional or frequent, short- or long-term, number of persons affected); Indicate the groups or populations likely to be affected.
		Positive	Neutral	Negative	Don't know	N/A[6]	
Early childhood (0–5 years)	favourable conditions for pregnancy (e.g., proper nutrition)?						
	preventive care (prenatal, postpartum)?						
	parents' and children's level of education?						
	equal access to education?						
	support for families with young children?						
	the accessibility of day care?						
	the accessibility of social and recreational activities for families?						
Diet	healthy eating?						
	the safety of food and consumer products?						
	access to an adequate and varied diet?						

[4] Inspired by: WHO, Réseau québécois des villes et villages en santé (network of health cities and villages, RQVVS) (2004), Swiss model and the Government of Québec (2006).

[5] This list is not exhaustive.

[6] N/A: not applicable.

Screening Table: Health Impact Assessment Process (cont.)

For each of the following categories, does the project have a potential impact on:		Potential impacts					Comments Specify which aspect of the project was the source of the impact; Describe the nature and scope of the impact (small or large, occasional or frequent, short- or long-term, number of persons affected); Indicate the groups or populations likely to be affected.
		Positive	Neutral	Negative	Don't know	N/A	
Dependencies	smoking?						
	alcohol use?						
	drug use?						
	compulsive gambling?						
Behaviours	practice of a physical activity/physical inactivity?						
	use of active transportation (walking, cycling)?						
	risky behaviour?						
	violent behaviour?						
	communicable diseases?						
Stress	the quality of the living environment (e.g., family, school, work, child care, housing, homes for seniors, and arts, cultural and recreation services)?						
	sense of belonging (women, men, young people, etc.)?						
	acculturation, loss of identity?						
	feeling of safety and well-being?						
	sense of self-worth?						
	capacity to confront life's problems?						

Screening Table: Health Impact Assessment Process (cont.)

For each of the following categories, does the project have a potential impact on:		Potential impacts					Comments Specify which aspect of the project was the source of the impact; Describe the nature and scope of the impact (small or large, occasional or frequent, short- or long-term, number of persons affected); Indicate the groups or populations likely to be affected.
		Positive	Neutral	Negative	Don't know	N/A	
Stress (cont.)	stress?						
	disposable income?						
	material security?						
Social support	social cohesion?						
	social interactions between people?						
	preserving the social support network?						
	support for people with dependents?						
	support for social activities?						
	opportunities to volunteer?						
Social exclusion	access to goods and services (e.g., diet, health services, employment, education, social and recreational activities)?						
	social participation?						
	people's isolation?						
	discrimination (social status, income, ethnic origin, sex, age, capabilities, opinions, religion)?						
	equity between groups of persons (children, young people, the elderly, workers, people with low incomes, immigrants, women, disabled people, etc.)?						

Screening Table: Health Impact Assessment Process (cont.)

For each of the following categories, does the project have a potential impact on:		Potential impacts					Comments Specify which aspect of the project was the source of the impact; Describe the nature and scope of the impact (small or large, occasional or frequent, short- or long-term, number of persons affected); Indicate the groups or populations likely to be affected.
		Positive	Neutral	Negative	Don't know	N/A	
Social exclusion (cont.)	the social integration of different groups of people?						
	people's ability to have access to information and understand it?						
Housing	access to quality housing (safe and healthy)?						
	the availability of affordable housing?						
Employment	job access?						
	unemployment?						
	long-term job creation?						
	the viability of businesses and companies?						
	the quality and safety of the workplace (e.g., stress, responsibilities, decision-making power)?						
	return to the labour force?						
	work-family balance?						
	skill development?						
	the physical accessibility of the workplace?						
	practice of physical activity at work?						
	adequate income?						

Screening Table: Health Impact Assessment Process (cont.)

For each of the following categories, does the project have a potential impact on:		Potential impacts					Comments Specify which aspect of the project was the source of the impact; Describe the nature and scope of the impact (small or large, occasional or frequent, short- or long-term, number of persons affected); Indicate the groups or populations likely to be affected.
		Positive	Neutral	Negative	Don't know	N/A	
Employment (cont.)	income inequality?						
	purchasing power?						
	distribution of benefits among groups of people?						
Education	citizen education?						
	accessibility of a basic education (primary and secondary)?						
	being able to continue education?						
	educational achievement?						
	opportunities for training and education?						
	literacy?						
Transportation	the type of transportation used (walking, cycling, motor vehicle, public transit, carpooling, etc.)?						
	availability and access to public transit?						
	physical accessibility of services?						
	road safety (road traumas)?						
	amount of road traffic?						
Physical environment	water quality?						
	air quality?						
	soil quality?						

Screening Table: Health Impact Assessment Process (cont.)

For each of the following categories, does the project have a potential impact on:		Potential impacts					Comments Specify which aspect of the project was the source of the impact; Describe the nature and scope of the impact (small or large, occasional or frequent, short- or long-term, number of persons affected); Indicate the groups or populations likely to be affected.
		Positive	Neutral	Negative	Don't know	N/A	
Physical environment (cont.)	noise?						
	odours?						
	safe disposal of hazardous waste?						
	waste recycling, recovery and reclamation?						
	sound use of natural resources (water, forests (paper), energy)?						
	land use (planning, mix of functions)?						
	safety of physical amenities (roads, sidewalks, bike trails, lighting)?						
	interior environment?						
	landscape?						
	climate, climate change?						
Societal factors	the efficiency and quality of public services?						
	equitable access to resources and public services?						
	equitable distribution of project benefits in the community?						
	equitable distribution of wealth?						
	the local and regional economy?						
	poverty reduction?						

Screening Table: Health Impact Assessment Process (cont.)

For each of the following categories, does the project have a potential impact on:		Potential impacts					Comments
		Positive	Neutral	Negative	Don't know	N/A	Specify which aspect of the project was the source of the impact; Describe the nature and scope of the impact (small or large, occasional or frequent, short- or long-term, number of persons affected); Indicate the groups or populations likely to be affected.
Societal factors (cont.)	respect for diversity?						
	crime prevention?						
	active participation of citizens in collective decisions?						
	local and regional vitality?						
	people leaving the community?						
	the aging population?						

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