Health Impact Assessment Quarterly

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Strange Days Indeed[1]

Ben Cave and Francesca Viliani, Health Section Co-Chairs

In this edition of the HIA Quarterly we look at some of the big issues.

We are all affected by the peaks and the low points of global finance . David Stuckler and colleagues show how the current turmoil affects population health and increases inequalities between population groups. Michaela Pfeiffer describes how the World Health Organization is improving the way in which the lending banks take health into account.

Since the industrial revolution in Europe we have steadily and rapidly worked our way through billions of years of geological inheritance. We continue to do so. This will have unprecedented and unknown effects on us and on generations to come. Martin Birley draws our attention to the health effects of climate change and the challenges of peak oil. Robert Bos reports on ways in which HIA is contributing to policy and action for securing water resources.

Photo: Ben Harris-Roxas

The Sydney skyline during the recent dust storm

At times health issues appear to dominate the media and Ana Mensua and colleagues report on the early stages of H1N1 flu pandemic.

Impact assessment provides advice to policy-makers. It draws on scientific information and the public voice. It is part of the process of governance. How can we as IA practitioners best meet these aims? Monica O'Mullane asks whether HIAs are used or ignored and Marleen Bekker takes us off the beaten path and explores what happens when a government provides intersectoral advice on health.

We hear from Francesca Viliani, the new co-Chair of the HIA Section, and Lea den Broeder reports back from IAIA09 in Ghana.

In keeping with the theme of *Strange Days Indeed* Ben Harris-Roxas discusses the potential health impacts of the rather surreal Sydney dust storm that occurred last week.

The HIA section continues to be active. We are keen to hear from members about ideas for the section. We are working with IAIA to find ways to support young and emerging professionals.

In the next Quarterly we will hear back from the HIA conference in Rotterdam. We will update readers on the health discussions and activities planned in Geneva IAIA10 where the conference theme is transitioning to a green economy. We will learn about developments in health and Strategic Environmental Assessment and we will consider the role of impact assessment in conflict zones.

Please contact Ben Harris-Roxas with contributions on these themes and with any other ideas for short articles.

[1] *Nobody Told Me*, John Lennon, 1984.

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In This Issue

The Economic Crisis: Threats and Opportunities to Public Health

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"Social policies can mitigate the negative effects of recession on health. "

How will the financial crisis affect public health, and how should we respond?

Here, we summarize what we know and don't know about the effects of financial crises on health, based on our recent reviews of the literature for the European Commission, European Observatory on Health Systems and Policies, and medical journals.

Financial crisis increases the risks of suicides and homicides

When the economy gets worse, so does mental health (1-4). Rising stress caused by lost jobs and fear of losing jobs increases the risks of depression and mental disorders (5). Suicide attempts rise, as do violence and homicide. Heart attacks (which seem to be associated with stress even if the mechanisms remain unclear), also rise, particularly among working-age men (4). Hazardous drinking also tends to increase.

Traffic accidents and fatalities drop

As the economy slows traffic volume and intensity drops. More people park their cars, opting to save money on fuel, and switch to public transit or walk instead of drive – lifestyle changes benefiting both the environment and health.

Worsening diets increase future risks of chronic disease

Unlike violence or injuries, diabetes and cancer rates do not change in the short-run because they develop after decades of unhealthy diets, smoking, excess alcohol and physical inactivity. During hard times, people buy more calories for less money. They eat out less often (healthier), but buy more snacks and eat at cheaper restaurants (less healthy). Consequently fast food companies have been recording windfall profits despite the overall fall in consumer spending (6).

Depending on which effect is greater, itself influenced by the structure of the market, future risks of obesity and diet-related chronic disease will increase or decrease.

Policy choices make a difference

Social policies can mitigate the negative effects of

Photo: Daquella manera

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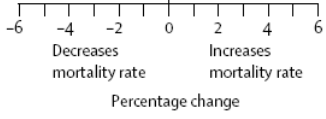
recession on health. During the Post-communist depression, cheap and highly concentrated alcohol gave desperate Russian men an easy means of their own self-destruction, resulting in a devastating rise in suicides, homicides and heart attacks (7). In the US during the Great Depression, Prohibition (albeit widely flouted), appears to have kept alcohol poisoning to a minimum, although suicides rose as much as in 1990s Russia.(8) Cuba's income plummeted in the late 1980s as the Soviet Union broke up; suicides rose, but the US embargo and absence of multi-national food companies ironically meant more affordable options were healthier options, and in the following decades chronic disease rates fell remarkably (9). Governments can make it harder for desperate people to get a hold of hazardous substances through minimum prices for alcohol and better regulating the food and beverage industry, as well as providing stimulus investments in healthy nutrition and physical activity programs.

Job losses and insecurity do not, however, necessarily lead to greater risks of suicide; evidence from across Europe indicate that suicides can be averted when people have access to supportive social networks and institutions, and when programmes are put in place to help those who lose jobs cope with the transition and quickly find new jobs ("active labor market programs") at a cost of

Figure 1: Associations of a 1% rise in unemployment with age-standardised mortality rates, by cause of death, in European Union countries, 1970–2007

	Country-years	Effect size (95% CI)	Potential excess deaths	
			Mean	95% CI
External causes	662	−0·25 (−0·68 to 0·18)	−495·1	−1346·7 to 356·5
Suicide	657	0·49 (−0·04 to 1·02)	247·9	−20·2 to 515·9
Suicide (in people aged 0–64 years)	657	0·79 (0·16 to 1·42)	308·7	62·5 to 554·8
Homicide	496	0·79 (0·06 to 1·52)	40·1	3·0 to 77·2
Drug dependence and toxicomania	261	−3·75 (−7·67 to 0·17)	−107·2	−219·3 to 4·9
Alcohol abuse	203	0·81 (−5·93 to 7·54)	101·8	−745·5 to 947·9
Accidents	516	−0·45 (−0·88 to −0·02)	−574·6	−1123·6 to −25·5
Drowning	506	−0·16 (−1·34 to 1·04)	−10·6	−88·5 to 68·7
Poisoning	504	−0·09 (−1·90 to 1·73)	−10·3	−218·3 to 198·7
Ill-defined causes	611	−1·48 (−3·51 to 0·54)	−1591·3	−3774·1 to 580·6
Transport accidents	515	−1·39 (−2·14 to −0·64)	−633·9	−975·9 to −291·9
Falls	516	0·11 (−0·42 to 0·65)	29·5	−112·6 to 174·3
Cardiovascular disease	662	0·03 (−0·25 to 0·30)	372·6	−3105·3 to 3726·3
Cardiovascular disease (in people aged 0–64 years)	662	0·13 (−0·16 to 0·42)	322·3	−396·7 to 1041·3
Ischaemic heart disease	660	0·31 (−0·15 to 0·77)	1465·9	−709·3 to 3641·2
Cerebrovascular disease	662	−0·16 (−0·45 to 0·14)	−479·6	−1348·8 to 419·6
Psychoactive substance abuse	490	−0·71 (−3·47 to 2·05)	−114·5	−559·4 to 330·5
Liver cirrhosis	662	0·12 (−0·78 to 1·02)	83·4	−542·2 to 709·0
Ulcer	514	0·24 (−0·44 to 0·91)	25·0	−45·8 to 94·7
Neoplasms	662	0·04 (−0·07 to 0·16)	355·4	−621·9 to 1421·5
Lung cancer	661	0·05 (−0·14 to 0·24)	98·5	−275·7 to 472·7
Alzheimer	500	0·12 (−1·71 to 1·96)	39·5	−562·3 to 644·5
Diabetes	655	0·54 (−0·33 to 1·40)	353·3	−215·9 to 915·9
Diabetes (in people aged 15–44 years)	499	0·46 (−1·68 to 2·60)	6·5	−23·9 to 37·0
Maternal mortality	584	−0·17 (−3·06 to 2·73)	−1·0	−18·1 to 16·2
Infant mortality	671	−0·06 (−0·59 to 0·47)	−13·6	−133·8 to 106·6
Infectious diseases	660	−0·31 (−1·18 to 0·56)	−134·5	−511·9 to 243·0
Tuberculosis	462	0·18 (−0·58 to 0·94)	9·6	−30·9 to 50·0
All-cause	521	0·05 (−0·19 to 0·29)	1597·8	−6071·6 to 9267·2



Notes: Coefficients are presented from 29 separate regression models. Models correct for population ageing, past mortality trends, country-specific mortality trends, and country fixed effects. Error bars are 95% CIs based on robust standard errors clustered by country to reflect non-independence of sampling. Country-years are the sample size for every model. Some causes of death are overlapping (eg, poisoning and alcohol abuse). Potential excess deaths were estimated by applying the average effect size of a 1% rise in unemployment to the latest available EU-wide data for age-standardised death rates and population size. Data are from the WHO European Health for All database 2008 edition. Source: Stuckler et al 2009. *Lancet* v374(9686):315-23.

US$150 per capita per year (4, 10). These investments create an opportunity to align sound economic policies with better health. But many countries, especially borrowers from the IMF, are being pressured to cut public spending, including money needed for health systems and social protections, possibly exacerbating the health consequences of financial crisis.(11)

When levels of social support are high, social labor market protections are well-resourced, and hazardous substances are not cheap or widely available, the positive effects of financial crisis on health tends to outweigh the potential risks, as seen during recessions in the United States, Sweden, and Finland. Alternatively, when two out of three of these elements are missing the health consequences can be disastrous, as occurred in 1990s Russia, late-1990s east Asia, and in the mass starvation that has so often devastated populations in East Africa.

Irrespective of the policy responses chosen, vulnerable groups and resource-deprived populations will face the greatest risk, with health inequalities rising as a result. This creates the risk of a downward spiral. Thus, in poor countries, where the Food and Agriculture Organization estimates that an additional 75 million people have gone hungry because of rising food prices between 2003 and 2008, the crisis will further weaken the purchasing power of the poor.(6) Emergency aid from rich countries, devalued by inflation and volatile exchange rates, will not be enough.

Of course, the health consequences of the 2008 crisis could turn out to be altogether different from the others, but it would be remarkable if they differed greatly from what we have learned from consistent public health experiences over the past century. The one thing that may be different is that, this time, we have the ability to learn from the mistakes of the past, if we choose to do so.

Crises have the potential to save many lives or cause more deaths; what happens will ultimately depend on how governments and policymakers choose to respond.

Photo: hira 3

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Early Responses to the H1N1 Flu pandemic
A view from the private sector

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The preparedness for the next flu pandemic offers a good example of the complexity to properly assess impacts and to propose measures to manage those impacts. This article briefly introduces the efforts made by the private sector to respond effectively and efficiently to the next pandemic and it presents some lessons learned, such as the importance and the difficulty of proposing mitigation measures in proportion to the magnitude of the impact indentified and of constantly monitoring an evolving situation.

Photo: Eneas

International bodies, governments, and private organizations alike have been preparing for the next flu pandemic for years. Many were spurred on by the progression of avian flu H5N1 ("bird flu"), which initially appeared in Hong Kong in 1997 and has since killed millions of birds and hundreds of humans. The virus, which kills around 60% of all people it infects, was identified as the most likely candidate to cause the world's next flu pandemic.

Teams involved in preparedness efforts necessarily used a worst-case scenario while making a pandemic plan, to ensure they would address all critical aspects of a *severe* flu pandemic. Most did not consider a pandemic scenario in which a new flu virus would spread worldwide, but only cause mild-to-moderate illness. And yet, this is exactly the situation that evolved beginning in April 2009, when a new strain of H1N1 flu was identified among some people in North America.

Even the leading international health body, the World Health Organization (WHO), had not fully accounted for variable virus severity when creating its recommendations and policies. As a result, they refined their Pandemic Phases several times during the early period of uncertainty. As more information became available about the H1N1 flu virus and its spread, it began meeting more and more criteria to be called a "pandemic " flu. WHO elevated the virus through its six Pandemic Phases fairly quickly and declared a full pandemic (Phase 6) on June 11. Since the illness caused by H1N1 was overwhelmingly similar to a "regular" seasonal flu infection, WHO officials declared it a "moderate" pandemic (http://bit.ly/11GFWB).

As WHO was working through definitions prior to declaring a pandemic, many national governments and companies within the private sector activated their pandemic plans. Many had identified WHO Phase changes – from Pandemic Phase 4, to 5, to 6 – as "trigger points". Actions indicated in most plans – and implemented in some cases – included travel restrictions and quarantine periods, aggressive screening procedures, mask distribution and use, and mobilization of efforts to obtain antiviral medication. Companies struggled to decide whether their planned actions, designed to address *severe* pandemics, were too aggressive. In

some cases, the size of the response would have been disproportionate to that of the threat.

Response teams within businesses have a clear responsibility to respond quickly to situations which threaten the business and its employees. However, the very employees they are supposed to protect can grow resentful if the response is viewed as an "overreaction". This is especially true if the responses are disruptive, intrusive or expensive. Responses need to match the magnitude of the actual threat. Travel restrictions are one example of a potential mismatch between threat and action and can greatly impact global companies, where reduced travel could result in reduced business output.

Response planners can learn from the world's response during the initial wave of the H1N1 flu pandemic. These experts are experienced in examining the different factors that an unexpected event will have upon a population. When organizations are creating and implementing pandemic plans, they are forced to consider the needs of two "populations": their employees and their business. Although the latter is not a population per se, it is a "living" entity that requires protection. Employees need to be kept healthy and alive during an emergency – so, too, does the business. Thus business continuity must be considered when designing effective pandemic plans – especially since the interests and needs of the business may conflict with those of the employee population..

The pandemic response of the private sector provides an opportunity to look at the competing needs of a business and a personnel population. It also highlights the importance of considering *magnitude*, among other factors, of both the problem (here, the pandemic) and the impacts of measures enacted against the problem (elements of the pandemic plan). Plans need to be kept alive and adequate triggers need to be identified to prompt planners to revise and update plans to a changing scenario (e.g. changes on the virulence of virus). Such might be crucial to mitigate the impact of a potential aggravation of the pandemic during the coming winter months.

New Section Co-Chair: Francesca Viliani

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Francesca, an Italian national, is a public health specialist with extensive experience in designing and managing HIA, epidemiological surveys, monitoring and evaluation activities, and communicable disease control programs. She has been working for over 10 years in the field of public health in contexts as different as Europe, Balkans, Central America, South East Asia, and Africa.

She has a Master in Public Health in Developing Countries from the London School of Hygiene and Topical Medicine with a dissertation on the role of HIA of extractive industries in addressing risk factors for HIV/AIDS.

Francesca is currently the Group Manager for Public Health Programs for International SOS. She is responsible for the management of Health Impact Assessment of industrial development in low and middle income countries. Francesca is also interested in policy development and advocacy activities with focus on HIA and public health interventions in low income countries and in complex emergencies.

She is presently based in Denmark but travels quite extensively. Francesca is looking very much forward to her new role as co-chair of the HIA section.

Climate change, Peak Oil and HIA

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Recent estimates suggest that 300,000 people are currently dying each year as a result of climate change and that some 500 million are extremely vulnerable. Governments are moving towards a planned reduction in GHGs emissions of at least 80% by 2050.

It is unlikely that this reduction is sufficient to ensure that concentrations remain below the unacceptable risk threshold.

There is growing evidence that the production of conventional oil is peaking. This implies that in a growing economy there will be less oil available each year than the year before.

Climate change and peak oil interact in an unfortunate way. As oil becomes more scarce, unconventional sources are exploited such as the tar sands in Canada. The unconventional sources require a much higher emission of greenhouse gases in order to exploit them. For example, 10 times as much CO2 is emitted to obtain a barrel of oil from tar sands as is required for conventional Saudi oil. So peak oil accelerates climate change.

There are no credible alternative sources of energy to fossil fuels. We are faced with the need to reduce our energy consumption individually, communally, nationally and globally. Every new policy, programme, project, or plan that is in preparation today will have to operate under increasing energy constraint.

This has many implications for impact assessment in general and health impact assessment in particular. We are at an early stage in understanding the implications. We held a workshop at the IAIA conference in Ghana this year. There will be opportunities for discussing the issues at the Rotterdam meeting in October and at the IAIA annual conference in Geneva next April.

There are many health co-benefits of energy constraint but also many risks and challenges. The very act of attending an international meeting produces GHGs emissions. For example, a flight halfway round the world is equivalent to about 5 tonnes of CO2 per individual which is greater than a reasonable per capita annual emission. What kind of rationing and offsetting are needed?

Photo: *Thirsty for Oil* by hrmmsfrfr

IAIA09 Conference in Ghana

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The conference proved to be very interesting and showed clearly that Health Impact Assessment (HIA) in an African context has to deal with issues such as malaria, other vector-borne diseases and HIV/AIDS, that are not as often addressed by HIA in industrialized parts of the world. These issues were among others discussed in relation to impacts of the mining industries. Other issues, such as the impact of transport policies on obesity, seem to be more important in other parts of the world and less relevant in the African setting.

Perhaps that was the reason why there were few HIA practitioners at the conference, unlike other years when the HIA group has been very present. This should make us, HIA and public health practitioners, reflect on how to apply HIA principles in practice given the various physical, social and cultural contexts.

The conference also taught us that HIA is not that well-known in African countries. It was therefore important that the IAIA conference was held in Ghana: this may be boost deeper reflection about what HIA could entail for the population's health, and how implementation could take place. At the same time it raise questions on the most appropriate way forward: would it be a good idea, in the African context to focus foremost in the integration of health issues in EIA or SEA? Or is important to advocate for HIA to ensure that the health aspects are not overshadowed by other issues?

I have visited the IAIA conferences since 2002 and have never before seen so many African delegates at the conference. Many of these of course, were Ghanaian, but many also came from other countries on the continent. This clearly shows how important it is for IAIA to move around the world: many practitioners or interested colleagues would otherwise never visit an IAIA meeting.

The IAIA09 Conference Proceedings are now available online http://www.iaia.org/iaia09ghana

What I missed in the conference was attention on topics such as health impacts of international trade and the Great Financial Crisis (GFC, not to be confused with the Giant Freshwater Crayfish). I would have expected that they were important and actual issues. The relations between crisis, war, disasters and health were not referred to although they might be important issues on the African continent. Perhaps these topics could become more central in the HIA section's work at future conferences.

Health Impact Assessment Research in Ireland Are HIAs used in policy or left to gather dust on shelves?

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HIA was first advocated in national policy in the Republic of Ireland in the Health Strategy 'Quality and Fairness: A Health System for You.' This policy document stated that "HIA will be introduced as part of the public policy development process." Regional authorities were called upon to "consider the impact of their decisions on population health in their area" (2001: 61). In the Health Services Executive (HSE) Population Health Strategy (2008) a reference was made to the need for 'health-proofing' policies, without explicit mention of the HIA tool. In Northern Ireland, the public health strategy (Investing for Health, 2002) recognises HIA as a mechanism to reduce health inequalities and as a means of promoting health and wellbeing. Northern Ireland's regional health

strategy (A Healthier Future, 2005) also advocates the use of HIA as a policy-support tool. Currently a HIA is being conducted on the new Mental Health and Wellbeing Promotion strategy by the Department of Health in Northern Ireland. Although HIA has been acknowledged as a worthwhile tool to inform decision-makers, the extent to which it is used in policy in Ireland is subject to scrutiny.

The all-island Institute of Public Health (IPH) supports the development of HIA in Ireland, by building capacity in the tool by providing training for health professionals, community representatives and public sector officials employed in national government ministries.

Doctoral research examined the use of HIA evidence in policy (2005-2008). The conclusions of this study pertain to whether or not evidence was used directly or indirectly. It was hypothesised that HIAs would inform the policy process, although the extent to which it would was central to this examination. HIA utilisation was investigated from a policy scientific perspective, building on the work of Kemm (2001), Putters (2005), Davenport *et al.* (2005), Bekker (2007) and Wismar *et al.* (2007). Are HIAs being produced to 'gather dust on the shelves of local authorities? (This statement has been freely expressed by at least one interviewee in each case study, while discussing their experiences on the HIA steering groups (2007/2008). What influences the use of HIA evidence?

Four case studies, where HIA had been conducted, were analysed in this study. All projects were located within the local government policy-making tier. These HIAs were conducted on traffic and transport in Dublin; Traveller accommodation in Donegal; a draft air quality action plan in Belfast; and on a social housing regeneration project in Derry. HIA aims to identify intended and unintended consequences that a project, policy or programme will have on the affected population's health.

A theoretical framework, drawing from institutionalist, impact assessment and knowledge utilisation theories and schools of literature, underpin this study. The investigation involves an examination of the unit of analysis which consists of the HIA steering groups. These are made up of local authority decision makers, statutory health practitioners and community representatives. The overarching structure and underlying values which are hypothesized as present in each HIA case are investigated in this research. Building on the work of Rossi *et al* (2004) it was found that Dublin, Belfast and Derry HIAs were used instrumentally (directly) in local policy while all four cases were used to inform the conceptual process of policy making (indirectly). Donegal, Belfast and Derry were found to be used as for a political means (small 'p'); the HIAs were used by one stakeholder to persuade one side of an argument over another (indirect use).

Pragmatic recommendations from this study primarily relate to the need for local government planning officials to be on the HIA for it to maximise its use in policy. The Integrated Impact Assessment (IIA) option is deemed a practical route for HIA to be incorporated into policy making in the future in Ireland, especially given the non-statutory status of the tool.

For the integration of the tool, this study suggests that a local network of interested representatives from key statutory, community and voluntary agencies is required in advancing HIA on the ground. Since the completion of this thesis, the author has co-founded the Southern Health Impact Assessment Network in Ireland, comprising membership mainly the Munster counties. With the encouragement and support from the IPH, the Network meets quarterly. It aims to progress the development of the tool locally by holding informative presentations on local HIAs, disseminating information on use of the tool, providing a network of support to those conducting HIAs and by advocating to the relevant authorities the pertinence of such a policy-proofing instrument. HIA is also being advanced within the Cork Healthy City Project.

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Dutch Intersectoral Policy Advice Off the beaten path

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On May 19, The Dutch Advisory Councils of Public Health and Healthcare, Education, and Public Administration jointly published an innovative government advice on intersectoral health policies called *Off the Beaten Path*.

In the advice, they elaborate the concept of 'parallel interests' between different policy sectors, highlighting the role and interest of other policy sectors in creating healthy public policy. Again, the HIA is recommended as an appropriate instrument. The Councils' call for integration of these ambitions in the Coalition Agreement, and establishing a separate department to coordinate the initiatives at the Ministry of Public Health.

The English translation of the report is available (http://bit.ly/imREX), along with the background study on 'Governance tools and framework' by the Canadian National Collaborating Centre for Healthy Public Policy.

After the Cabinet Vision document on Public health and Prevention, in which the Cabinet explicitly prioritised Healthy Public Policy and the importance of explicating parallel interests, we now have to wait and see if government is really ready for taking up this advice. First of all, in the evaluation studies we conducted of HIA practices in the Netherlands, 'bureaucratic politics' explains why intersectoral policies are not adopted at a large scale. The senior civil officers have to protect the Minister of public Health against the negative impacts of political accountability on his/her reputation. Furthermore, establishing a separate department, without real leadership, power and capacity, runs the risk that other departments will pass their responsibilities on. Nevertheless, it will enhance public visibility of parallel interests.

At the implementation level, however, project leaders and professionals, the actual leaders of intersectoral *practices*, are impeded by polarised science and education as well as polarised policies. Persistent conflicts between 'hard' and 'soft' scientific health disciplines are often reproduced in separate community health service units instead of tailoring the organisation to a problem-based cross-discipline approach. Additionally, many project leaders and professionals are in need of process- and network management skills to anticipate, recognise and manage potential contradictions between parties involved in intersectoral policies. They have to create a safe environment and trust by rendering the process of interactions in a closed setting before making the whole process transparent. They realize at what moments the introduction of experts and scientific research can be helpful or harmful to the process, and they tailor the presentation of their findings in different ways to different audiences.

Nevertheless, I fully endorse the message of the Government Advice that we should not wait for those conditions to be established but rather keep on experimenting. Because leaving the *beaten path* is the only way to learn from experience and improve the interaction processes behind intersectoral health policies.

Photo: Jenny Downing

Off the beaten path

"Persistent conflicts between 'hard' and 'soft' scientific health disciplines are often reproduced in separate community health service units instead of tailoring the organisation to a problem-based cross-discipline approach."

WHO's Activity on Health and Development Lending

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Large-scale development projects can have significant impacts on public health, safety and community well-being. Within the last three years, several banks (including the IFC, EBRD, and Equator Principle Banks) have explicitly integrated community health and safety requirements into their lending criteria.

The implementation of this requirement provides a major opportunity for the development finance sector to promote measures that favour health and reduce vulnerability.

WHO is preparing guidance for development lending institutions on how to integrate public health and safety considerations into bank lending policies and practices. This guidance is being prepared in response to a request for technical advice from some of the development banks who were either considering or implementing new lending criteria that made explicit reference to community health, safety and security issues.

The WHO guide *Health in Development Lending* has been reviewed by impact assessment practitioners and development banks specialists and should be finalised by end 2009.

As a follow-up and in continuation of this initiative, WHO and some of the development banks are discussing the possibility of convening a theme forum on health and development lending at the forthcoming IAIA Conference which will be held in Geneva in April 2010. Key aims of this forum will be to bring together IFIs, WHO and impact assessment practitioners, to share experiences with community health/health impact assessment in the context of development investments (projects), identify good practice examples, and highlight key areas for future action.

Additional activities related to HIA planned by WHO for upcoming conferences:

HIA Conference in Rotterdam - October 2009

Workshop/panel session on "Globalising HIA" - key aims of this session are to discuss current developments in HIA and to identify key areas for action

Proposals for IAIA2010 in Geneva

1. Panel session on the community health aspects of development bank performance requirements and the role that international finance institutions can play to promote and protect health as part of the financial sector's response to the economic crisis.

2. Theme session or other session on health and the new green deal. What are the health co-benefits associated with a green economy and how can health arguments be used to facilitate and promote the transition?

Photo: Chuckumentary

HIA and Water Resources

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World Week is an annual Conference in Stockholm, organized by the Stockholm International Environment Institute SIWI. Last year's WWW was held from 17 to 23 August under the theme *Progress and Prospects on Water: for a clean and healthy world*.

With a strong focus on sanitation, the Conference programme left room to cover other health/water issues. WHO and DBL/Centre for Health Research and Development at the University of Copenhagen jointly organized a three hour seminar on HIA that was well attended by water professionals.

Given the trends in water resources (contextual scarcity, changing rainfall patterns, increased production of wastewater) there is an increased need for HIA in water resources development. Awareness creation and capacity building among professionals from non-health sectors is essential – the recent IWA publication *Health Impact Assessment for Sustainable Water Management* (Fewtrell and Kay 2008) brings the subject to the attention of water resources professionals.

National governments and multi/bilateral donor agencies have their specific roles to play in ensuring effective and efficient HIAs of water resources development. Critically important is the establishment of a national HIA policy framework that defines decision-making criteria and procedures. Other capacity building efforts should focus on the essential HIA functions of the health sector, and the development of skills in intersectoral negotiation for professionals in all sectors. Recent WHO/DBL/InWEnt efforts in the Mekong countries illustrate the feasibility of delivering integrated HIA capacity building packages; the Nam Theun 2 dam case study from Lao illustrates the need for sound HIA.

The efforts by the International Finance Corporation (IFC, the private sector arm of the World Bank Group) were highlighted as an example of positive action. They include: expansion of "Guidance Notes" covering IFC Performance Standard #4 Community Health, development and expansion of environmental health areas methodology, development of "HIA Toolkit" and HIA training for Equator Principles financial institutions. A plea was made to develop *Equator Principles Plus*, that take into consideration specific health issues and adopt HIA as a key planning tool.

Health Impacts of the Sydney Dust Storm

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Sydney-siders awoke to a red glow on Wednesday 23 September and opened their curtains to find that the city had been shrouded in the biggest dust storm in 70 years, blown in from South Australia and western New South Wales by strong winds. Our clothesline was covered in red muddy lumps that were similar in shape to the clothes I'd hung out the day before.

My mother-in-law called up to instruct me not to take the baby outside. "You don't want her breathing that stuff!"

I'm no respiratory expert, but I know that one-off exposure to dust of this nature was unlikely to cause enduring respiratory problems. A precautionary response doesn't hurt however, and state health agencies recommended that people stay inside.

This did make me wonder, what are the health impacts of dust storms?

The first concern is naturally the dust itself. The principal impact of the dust in the Sydney case was exacerbating existing respiratory problems, such as asthma, and causing upper airway irritation. There was a substantial increase in ambulance call-outs and emergency department presentations.

Photo: Ben Harris-Roxas

The view over my back fence at 8:15am

Another concern is what the dust may contain - plant pollens, fungal spores, dried animal faeces, minerals, chemicals from fires and industry, bacteria and pesticide residues. These all have the potential to impact on human health.

This is of particular concern in countries where there is increasing desertification and weak government regulation of the use of pesticides and the storage and burying of toxins. In the case of the Sydney dust storm there were also largely unfounded reports that the dust may have contained radioactive material. This is because much of the dust was from the Woomera Prohibited Area in South Australia, which includes a former British nuclear testing site, and the Olympic Dam uranium mine site.

Dust storms have also led to algal blooms in some parts of the world, which in turn have a number of environmental and health impacts (though these should not be confused with blue-green algae blooms, which are actually caused by the cyanobacteria).

The psychological impacts of dust storms are worth mentioning as well. I noticed on the day that there was a flurry of exclamations about the "end of the world" amongst my friends on facebook this morning. I think that if the storm went on for several days, some of these exclamations may have become semi-serious.

Of course Sydney's little dust storm pales in significance next to the dust and sand storms experienced in many parts of the world, that are so ferocious that they can scour paint from buildings. Many of the potential health impacts are similar however.

As impact assessors we should be mindful of the potential for projects to increase dust and the potential for dust storms. Though the direct physical health impacts may not be drastic in nature, they are significant, particularly if we consider ongoing psychological impacts and risk communication issues.

The Sydney dust storm also reminds us that what happens elsewhere in paces like the outback can have a very real effect on cities and coastal populations, as much as we might like to pretend it doesn't. I lived in a rural town called Bourke when I was a kid and dust storms were not an uncommon event. Maybe they'll become semi-regular events in Sydney in the future as well.

I'll have to start bringing the washing in.

This story is based on a piece that was first published on Croakey, the Crikey health blog
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