Building Healthy Communities

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Building Healthy Communities

I Thematic Report

Indicators and Criteria for a Healthy Sustainable Urban Development

November 2009

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Foreword

Luisa Avedano (BHC Lead Partner) and Marco Santangelo (BHC Lead Expert)

Building Healthy Communities thematic network is now at its top speed.
After its first phase for enlarging partnership and refining objectives and outcomes a 30 months implementation phase has started. In 2009 the 10 partner cities and their Managing Authorities representatives have concretely worked together in order to draw the draft Local Action Plan and tailor possible actions and initiatives.
After the first Steering Group Meeting held in Brussels in February, the already settled Local Support Groups strengthened their links and met periodically in order to achieve a common vision to be then translated into actions. From ideas to actions, involving local stakeholders, residents, local authorities representatives as well as – in some cases – political representatives.
Local actors have met to find a way of introducing health in all policies, trying to find a shared interpretation on how to develop initiatives taking into account residents quality of life and well being. This is not an easy task, but rather a route made by obstacles and inspiring practices where cities can have a driving role despite their almost complete lack of direct competencies on health issues.
BHC journey stopped thus in June, the 8th and 9th, in Łódź (Poland) where the first thematic workshop on indicators on health and quality of life took place: a first important step for building a common understanding of the issue and a cornerstone for the development of a toolkit of indicators to be then adapted to local applications. The debate among the participants clearly showed the need of going even more in depth and for the purpose the first multilateral exchange on HIA (Health Impact Assessment) has been organised and hosted by Belfast City Council in September (28th-30th).
This report represents the first concrete outcome of our network – it has required some more time than what we expected because, as said before, partners' needs and expectations after the Łódź workshop suggested us to include also the Belfast Exchange outcomes in order to put at disposal a more effective product able to mirror a real set of instruments on how to include health and quality of life in local decision making processes.

In the following pages Antonella Cardone, BHC Thematic Expert, has outlined the process of definition of indicators related to health and quality of life in cities and has synthesized the main findings of the Łódź workshop. Besides, a glossary has been attached as annex, to further clarify the contents of the toolkit that represents the main output of the meeting. In the annex section there are also two short articles on the state of the art of the LAPs in our 10 partner cities and on the results of the Belfast Exchange.

It is now time to move on and proceed to the next Thematic Workshop, which will be held in Torino from the 3rd to the 6th of March 2010 and will focus on "Healthy Sustainable Lifestyles". More possibilities for further multi-lateral exchanges will be possible and actively promoted, strictly connected to the implementation and further redefinition of the LAPs in each partner city.
Let's go ahead.

Indicators and Criteria for a Healthy Sustainable Urban Development: main findings from the Łódź Workshop

Antonella Cardone (BHC Thematic Expert)

I. Healthy Sustainable Urban Development

Four out of five European citizens live in urban areas, and their health and quality of life is directly influenced by the state of the urban environment, economical development and socio-cultural cohesion. A high quality urban environment also contributes to the priority of the renewed Lisbon Strategy to '*make Europe a more attractive place to work and invest'.* The attractiveness of European cities will enhance their potential for growth and job creation, and cities are therefore of key importance to the implementation of the Lisbon Agenda.

Ill health worsens poverty and causes socioeconomic decline. Environmental degradation, mismanagement of resources and unhealthy consumption patterns and lifestyles affect health.

In urban areas the environmental, economic and socio-cultural dimensions meet most strongly. Cities are where many health and quality of life problems are concentrated, but they are also the economic drivers, the places where business is done and investments are made, the places where people from different social and cultural background meet most intensively.

However, there are increasing concerns about the state of Europe's urban environment. The environmental challenges facing cities have significant consequences for human health, the quality of life of urban citizens and the economic performance of the cities themselves.

So quality of life, well-being and health are directly influenced by the state of the urban environment, economic and social factors.

Improving quality of life and good health of the citizens is the European Union major goal and has been summarised in "*health needs to be integrated into all policies*" , as it has been agreed by DG SANCO, DG REGIO, World Health Organisation, Council of Europe and the Member States. So the determinants of health need to be studied in an integrated way rather than concentrating on single risk factors, by bringing sectors together to identify potential health effects and to identify interventions to eliminate or minimize negative effects and maximize positive effects.

It is, then, fundamental for all the stakeholders involved in urban regeneration plans to consider the impact on health of public investments. Urban decision makers are exhorted to think about the effects of regeneration plans on the health of the citizens, and in particular, how they can work on reducing health inequality in the urban context.

Cities are aware of the importance of health and quality of life in urban regeneration and development, but there is a clear lack of competences and tools to support healthy sustainable urban development at local level by people in charge.

Keys

Four out of five European citizens live in urban areas.

The Lisbon Strategy: http://ec.europa.eu/growthandjobs

The environmental challenges facing cities have significant consequences for human health, the quality of life of urban citizens and the economic performance of the cities themselves.

II. Indicators and Criteria

Given that health needs to be integrated into all policies and coordinated action is needed among the EU, the national, the regional and the local level, there is a need for a common understanding at different levels, and in various contexts, of what health, quality of life and sustainable urban development are.

There is also the need to inform the general public and to help decision makers to monitor changes and progress, to improve knowledge about the potential impact of a policy, a programme or

a project, to inform decision-makers and affected people, and facilitate adjustments of the proposed policy in order to mitigate the negative impacts and maximize the positive ones.

Those needs are addressed through setting criteria and identifying indicators.

The broad objectives of identifying indicators and criteria for a healthy sustainable urban development are meant to address the key health challenges faced in the coming years, through protecting citizens from health threats, supporting healthy ageing, supporting sustainability of health systems and the wider economy, increasing the focus on global health, working to reduce inequities in health, and supporting a "Health In All Policies" approach.

Improving quality of life and good health is the EU major goal, and it is achievable by approaching it from a broad perspective.

At the first BHC Thematic Workshop in Łódź, (Poland) on the 8 and 9 June 09 participants from the 10 Cities involved in the project have agreed to identify a set of indicators to assess the impact of urban regeneration plans on the health and quality of life of their citizens and to develop a more friendly tool to be easily used by the cities involved at different levels.

During the workshop participants have agreed on a set of indicators having an impact on health focusing on three themes:

1. Economic Development;
2. Cultural and Social Cohesion;
3. Environmental Regeneration.

In order to identify relevant and useful indicators, a commonly understood definition is needed.

Indicators should not be confused with measurements or statistics. Measurements produce raw data; combination and publication of data leads to statistics; statistics are translated and applied as indicators. As such, indicators are much more than data; they involve first the selection of information and then add to this a level of interpretation that provides the users with useful and understandable knowledge that directly addresses their issues of concern. In the process, indicators help to simplify and summarize data, to fill gaps in the existing information base, and to communicate this information to the user.

Indicators are signals for things that cannot be directly seen. They are based on data, but ideally add value to data by expressing them in a way which is more understandable and more relevant to the user. It can be said that monitoring provides data, analysis of data provides statistics, and interpretation of statistics provides indicators that help to inform decision-makers.

Even so there is much confusion about what indicators are. Mistakenly, they are sometimes regarded as the *issues* that we need to address (e.g. indoor air pollution, respiratory health).
Equally misleadingly, they are sometimes defined as the values that we obtain when we try to quantify these issues (e.g. 175ug/m3 PM10, or a respiratory mortality rate of 98.5 per 100 000 births). In practice they are neither.

Indicators are about the things that lie between the two: they are the entities that we try to measure (e.g. mean annual PM10 concentration or mortality rate) to describe the issues that we are concerned about in a clear and understandable way.
That said, some confusion is inevitable, for there is no clear distinction between data, statistics and indicators. Mortality rate, for example, can be any one of these things. What makes it an indicator in some situations is not the measure itself, but its purpose and the way it is used.

The choice of indicators depends on:

- *Definitions,* which are context dependent;
- *measurement techniques,* which are chosen in terms of level of detail, geographic scale and time period;
- their *compatibility* and *predictive accuracy*;
- and their *purpose*, which is related to the objectives and priorities of those who use them.

Indicators are also used in relation to the kinds of information that are available or that can be obtained, to the pertinence of that information, and to its degree of abstraction in relation to concrete themes or subjects. Given the extreme complexity of human settlements, differences, obstacles, and even conflicts may exist between the definitions, means, and measures used by auth-

orities, institutions, and groups who use indicators of environmental, health, economic, and socio-cultural conditions.

In order to identify relevant indicators and use them appropriately, we have to define first a need to know; and recognizing the need to know means that we are already alerted. Usually, therefore, indicators follow rather than precede awareness, providing answers to questions already posed. They allow an assessment and tracking of known issues but rarely offer a warning of new problems.

Constructed properly, founded on real understanding, based on good data and good science, indicators can be used to monitor situations that might affect us, or to track the effects of specific interventions. Once we have identified an issue, therefore, indicators can reassure or forewarn us; once we have tried to act, they can help us to judge our performance against the goals we hope to achieve. Similarly, they can be used to compare conditions or achievements in our own country or community with those of others. Thus, in the hands of empowered (and especially passionate) people, they can also be powerful symbols: they can be used as a way of highlighting issues and concerns, and of bringing these to the attention of those who need (but often do not want) to know.

Two uses of indicators thus stand out — they are instruments for lobbying and awareness raising, and they are tools for self-judgement and for assessing how well we perform.

No indicator tells us all we need to know: the world and what we need to know are both too complex for that. Nor can we develop indicators for everything. If we were to do so, the huge volume of information — much of it often contradictory and confused — would simply weaken rather than strengthen the message, and overwhelm those concerned. Or the indicators themselves would be so wide-ranging and general that any meaningful interpretation would be impossible. To be effective, information must always be selective: we must target the key issues and communicate concisely.

Selection is not easy. By selecting, of course, we also prioritize. The issues we select as the focus for our indicators, therefore, become the focus for our policy, programme or project. The way we define the issues will inevitably limit the indicators we choose. And, if we use the indicators effectively to guide our actions, then these in turn will skew the way we act. The old adage is true: *we manage what we measure and we measure what we manage*.

We need, therefore, to be clear about how we select the issues for which our indicators are designed, and why we have selected them. We also need to recognize that, in another area, with different problems, or from the perspective of another observer with different interests, this selection may differ, and, with it, the choice of indicators also. Indicators are identified following a need. They are rarely, if ever, universal.

As the need changes, so must the indicators change. Any set of indicators, however 'core' they might be, is limited in its relevance and can easily be made redundant by changes in conditions or concern.

Building indicators — especially indicators that are effective and serve to improve health and quality of life in an urban setting — is not easy. Many different considerations have to be taken into account; many different constraints have to be addressed and resolved. A balance has to be struck between what is needed and what is practicable, between what is ideal and what will work.

Keys

Measurements → raw data
Statistics → combination and publication of data
Indicators → statistics translated and applied

Usually indicators follow rather than precede awareness, providing answers to questions already posed.

Two uses of indicators stand out: they are instruments for lobbying and awareness raising, and they are tools for self-judgement and for assessing how well we perform.

III. Three steps towards the identification of indicators

The process of identifying indicators starts with scoping out the purpose of and need for the regeneration project, the ways in which it might impact on the community, and on which citizens, and the constraints and conditions under which it must be implemented. Based on this understanding, a set of specifications is drawn up to guide the regeneration project design.

The first step in designing indicators is, then, to identify clearly who they are for, and for what purposes they are required. Based on this, the information needs can then be defined.

In an urban regeneration process users of indicators may be the EU, WHO, national governments, Regional governments, the City itself, NGOs, groups of citizens, etc. Each user may use indicators in very different ways. Some require them to help formulate and assess policy at a relatively broad (e.g. national) level, others to help develop more local strategies. Some may use indicators to monitor the impacts of existing actions, others to identify gaps where new action is required. Some will use indicators to advocate, others to challenge; some to negotiate, others to deny.

One of the factors that distinguish most clearly different groups of users is their level of responsibility. Whilst users at the international or national level, for example, are mainly concerned with policy formulation and monitoring, those at a local level often use indicators mainly for lobbying purposes. Governments and international agencies are generally interested in the larger picture and broad patterns and trends; for neighbourhoods and local communities what matters are the specifics that directly affect them. Ministries and public authorities require indicators that are quantitative and reproducible; the public and voluntary agencies often demand indicators that are more intuitive and subjective — and thus more in keeping with the qualities that characterize their own lives. Not surprisingly, therefore, these different groups of users often select and design indicators very differently.

Defining the key issues that need to be tackled is never easy. Priorities also vary depending on where in Europe we are, and on whose behalf we are acting. All of these factors need to be explicitly recognized and sensibly considered before we can realistically define the issues of greatest concern. Different parties with different interests may be involved, the process of identifying and defining these issues may be as much a matter of politics as it is of science. What is clear is that the choice of issues is crucial. The choices we make and the priorities we set at this stage determine many of the decisions we make later.

Several things can be done to ensure an appropriate selection. One such thing is to involve as many as possible of those who have a need or an entitlement to participate, which is all the relevant stakeholders. This means not only the users of the indicators, but also those at whom they are addressed. If the final choice is to be genuine and fair, involvement should also be open and balanced, without undue domination by specific interests. Organizing such participation is never easy. In the specific context of Building Healthy Communities project, a participatory approach is guaranteed by the active involvement of the Local Support Groups also in identifying relevant indicators.

This would help to prioritize urban health and wellbeing issues and to encourage monitoring and surveillance.

The second thing that can be done is to make use of the available scientific knowledge and information. This alone does not define urban health and wellbeing issues, and it certainly cannot prioritize them. On the one hand scientific understanding is itself bounded and sometimes patchy and biased. On the other, setting priorities is a matter of applying value judgements, and though values can never be wholly excluded from science, usually they should at least have been minimized. In any case value judgements are likely to be better if they are informed by the available science.

Providing scientific information, and doing so in an understandable form, is therefore an important part of the process of issue selection. (In this sense, there may be a need for what may be termed ‘pre-indicators’ — preliminary facts and figures, examples, illustrations — that can help those involved make up their minds what the real risks are, and what matters most.)

The third thing that can be done is to use explicit criteria to compare and define the issues. These may not always be strictly quantitative: urban health problems are often too diverse in terms of their effects, and who they touch, to be adequately described simply in terms such as the numbers of schools or average morbidity rate. But there are creative ways of making the necessary comparisons. The use of DALYs is one such method. Multi-criteria assessment provides another method. Other, less formal, methods have been used to help set priorities for instance in *National Environmental Health Action Plans*.

Based on these considerations, the key information needs begin to emerge. In broad terms the need is for information that focuses on the health and wellbeing issues identified to help guide, compare and assess policy actions and impacts. To translate these general needs into specific information requirements, however, we need to go much further. We need to be able to identify how these various risks to the citizen's health are actually played out in the real world — what are their causes, how they operate, and what sort of information we therefore require.

This is no easy task, for it is evident that associations between urban environment and health are complex and multi-facetted. So-called environmental causes are not always either immediate or direct; nor do they act in isolation. Many-to-many relationships between environment and health abound. Most health issues also have roots that reach far beyond the physical environment, deep into underlying social circumstances, economic actions and policy.

Health and wellbeing issues are not merely issues of environment and health, but also of the social, economic and policy factors that shape and drive them.

Scoping of the information requirements of the key users provides a basis on which to select the indicators that best meet these needs. Selection, however, cannot be a purely intuitive or random process. Each of the issues on which users need information may be conceptualized in different ways: the indicators we design are likely to vary accordingly. Defining the best indicators (or even those that are merely satisfactory) also implies that we understand how to judge their effectiveness. Before we select indicators, therefore, we need to understand both the conceptual framework in which we are working, and the key criteria that the indicators must satisfy.

Keys

DALYs → Disability Adjusted Life Years. The sum of years of potential life lost due to premature mortality and the years of productive life lost due to disability.

National Environmental Health Action Plans: http://www.euro.who.int/envhealthpolicy/Plans/20020807_1

Steps towards the identification of indicators:
1st Step: Who the indicators are for? For what purpose are they required?
2nd Step: Make use of available scientific knowledge and information.
3rd Step: Use explicit criteria to compare and define the issues.

IV. Criteria to indentify indicators

Given the complexity of environmental health issues, it is clearly useful to have some form of framework to help build and structure indicators. This will not only help ensure the selection of a balanced and relevant range of indicators, but also help to recognize and understand the complicated links between them, and to interpret properly cause and effect.

Common criteria to identify indicators are scientific validity or credibility, clear relevance, utility and practicability (e.g. cost, data availability).

As regards scientific validity, indicators should be:

- credible — *i.e. based on a known linkage between environment and health;*
- sensitive *to changes in the conditions of interest;*
- consistent and comparable *over space and time;*
- robust — *i.e. unaffected by minor changes in methodology, scale or data;*
- representative *of the conditions and area of concern;*
- accurate — *i.e. based on reliable data;*
- scalable — *i.e. capable of being used at different scales.*

As regards utility and practicability, indicators should be:

- relevant *to an issue of policy or practical concern;*
- actionable — *i.e. related to a condition which is amenable to influence or control;*
- understandable *by and acceptable to those at whom it is addressed;*
- timely — *i.e. up-to-date;*
- specific — *i.e. targeted at an explicit phenomenon or issue;*
- measurable — *i.e. based on available data and manageable methods;*
- cost-effective — *i.e. capable of being constructed and used at acceptable cost.*

A primary requirement is that an indicator must be based on a known and interpretable linkage with the phenomenon or condition of concern. Achieving this in the case of urban health indicators is surprisingly difficult.

The problem is that most aspects of urban health are multi-dimensional. Simple one-to-one relationships rarely exist; complex, interlinked associations predominate. As a result, it is often difficult to find indicators that provide a singular and direct measure of a health outcome or exposure. Many are confounded, many uncertain. In these situations, interpretation is extremely difficult. Apparent differences or changes in the indicator might mean one thing or the other, or nothing at all.

There are two main ways of avoiding this difficulty. One — and usually the best — is to be rigorous in defining the indicator in the first place. We should eschew indicators that are inherently uncertain or ambiguous. The other is to use indicators not in isolation, but in combination — as mutually supportive tools. What we cannot deduce with any certainty from a single indicator can often be much more clearly seen if we read the signals of several together. Interpreting a fall in the rate of injuries in road accidents might be difficult, for example. Is it due to reduced levels of road traffic? Is it a result of improved road safety? Or is it an artefact of some change in the classification or reporting of accidents and injuries? If we take the indicator on its own, we can only guess. But if we triangulate — if we compare trends against other indicators — the picture may become clearer.

Comparability and consistency are also important in relation to national indicators.
Comparability over space is crucial if we are to draw meaningful comparisons or contrasts either between different regions within a country, or between different countries. Consistency over time is essential if we are to observe and understand trends. Both require not only that the indicator used is constant in terms of its definition, but also that the methods and data used to construct it are consistent and standardized.

Achieving such consistency is not always easy. One problem is that, internationally, different interests and different standards often prevail. Many countries also have well-established, but different, systems for monitoring and survey: understandably, they are reluctant to compromise these for the sake of international conformity. Indeed, if they do so, they are likely to jeopardize the consistency and continuity of their own time-series data.

To make matters worse, monitoring and survey technologies and practices also change over time. Organizations responsible for monitoring are thus faced with a dilemma. Do they adopt new technologies as they become available, in order to improve the quality of their monitoring and to maintain consistency with their neighbours? Or do they retain old, and increasingly outdated methods in order to keep faith with historic data?

People's perceptions are a rich source of information that should not be neglected. Perceptions of personal health and well-being can tell us a great deal about what matters to people and about the conditions in which they live. Perceptions are also a source of data that can be relatively easily tapped — for example via opinion surveys and questionnaires.

They can therefore help to fill in gaps in data that cannot be obtained by more traditional means. But collecting and using this type of information has another important benefit. It provides a means of involving the public directly in the process of indicator development. This can help to make the indicators seem far more meaningful

and relevant, and encourage their acceptance by the public.

Measurability is another ingredient of good indicators. Indicators, like all forms of information, are only as good as the data on which they are based. If we cannot obtain the necessary data, our indicator remains empty and meaningless.
This is not to say that indicators have to be built on hard data, derived from direct measurements, nor that perception and opinions do not matter. Modelling — as noted above — can be an equally valid basis for indicators. So can softer forms of data, such as those obtained from attitudinal surveys. People's concerns, after all, are often what shape their actions; and anxieties directly impact on quality of life. In many cases, also, people are remarkably perceptive, and detect problems and changes long before more formal monitoring systems.

In some circumstances, we have admittedly little choice, for other forms of data may be unavailable. We should certainly not dismiss such data, therefore, nor be afraid to use them in developing indicators.

Measurability, however, does not stand alone. Given enough resources, we could probably find ways of measuring most things. In the real world, the main consideration is cost, while the second is probably the need for timeliness. For both these reasons, our choices are far more circumscribed. Indicators thus tend to rely on routine data where they can; purpose-designed monitoring or survey campaigns are only carried out as a last resort. It is the limited availability of routine data that consequently represents the real constraint. It is not that we cannot measure what we need to build our indicators, but that it is not affordable to do so.

Cost-effectiveness is thus measurability's twin. Together, they act to define the practicability of many indicators; and they sound the death knell for many a potentially clever idea.

Indicators are tools, and all tools have to fit the purpose for which they are intended. There are thus no absolutes. What makes an indicator good for one purpose in the hands of one user may not be appropriate in the hands of another. The criteria, like the indicators themselves, are dependent on the situation in which they are used.

They need to be recognized and addressed – not only because they may be genuinely held, but also because indicators will only be effective where they are used as part of a listening, open and information-based approach to decision-making. Sometimes, the most valuable benefit of indicators is that they help to generate this way of thinking and working.

Keys

Indicators that are inherently uncertain or ambiguous should be eschewed. Indicators should be used in combination, not in isolation, as mutually supportive tools.

Perception of personal health and well being can tell us a great deal about what matters to people and about the conditions in which they live.

V. Urban health indicators

Urban Health Indicators can be used to harmonize criteria on how to measure environmental health issues, to monitor environmental health policies and programs, to facilitate the systematic exchange of information between countries, to forecast trends, to facilitate the identification of risk factors, to measure the impact and effectiveness of interventions or policies.

Monitoring Urban Health is implemented through:

1. Definition of the problem. To define the problem, a relation should be known between a specific environmental factor and its impact on health. The data and information required to measure each component of this relation should be defined at this stage by diverse groups of actors.
2. Definition and measurement of relevant urban health indicators bearing in mind the availability of data from routine sources and their reliability and comparability over time.
3. Formulation and implementation of appropriate policies that are meant to continue as part of an ongoing cycle of monitoring and policy review.

Urban health indicators are coupled to analysis, assessment and reporting methods.

A number of urban health-related indicators are difficult to measure. The main reasons for these difficulties are that:

- some urban health indicators include more than one entity to be measured;
- some urban health indicators are not disaggregated for the population groups most affected by or vulnerable to the targeted issue, or most in need of a specific intervention;
- some urban health indicators have a numerator and/or a denominator which needs to be better defined.

A common rule is that the more we have to use extrapolation procedures, the more the uncertainty increases and the weaker the final estimate will be. Additionally, the weaker that figure is, the more limiting the capacity is to use it for different purposes.

Evidence can be used for at least four distinct purposes:

- strategic decision-making;
- programme implementation or management;
- monitoring of outcomes or achievements;
- and evaluation of what works and what does not.

Indicators are identified based on the urban regeneration project that is going to be assessed. After the proposal, population and community are analysed, the assessment of the impact on health and quality of life can start. Drawing conclusions directly from the content in the proposal to health outcome is difficult and complex. The analysis thus determines the likely effects of the proposal on the determinants of health and then how the determinants of health affect health outcomes. The process follows these questions:

- How does the proposal affect the determinants of health?
- Which determinants?
- How strongly are they affected?
- How are these determinants of health likely to affect the health outcome in the population?

These factors show that appraisal should use both qualitative and quantitative evidence. Qualitative data describe and explain the content of the proposal, whereas quantitative data estimate the size of the relationship. Both methods are usually valuable and necessary to provide a full picture.

Qualitative research involves gathering evidence from experience, knowledge, opinions and perceptions of research such as surveys, interviews, focus groups, workshops and citizens' juries.

This type of evidence is of great value and the HIA (Health Impact Assessment), a methodology that is of great interest for us, helps to show for which reasons. This evidence:

- It provides more insight and detail into how a proposal is likely to affect the determinants of health;
- It provides more insight and detail into how the determinants of health are likely to affect the health outcome;
- It gives information about the population's opinions and feelings about the proposal and its outcome;
- It gives insight into the likely effects on inequality in health, which population groups may be affected and how.

Quantitative data and methods provide the magnitude and direction of the effects. Several quantitative methods can be used, such as population analysis, regional analysis, identifying and classifying health hazards, health monitoring, environmental monitoring and health risk assessment.

Quantitative data are of great value to the HIA process for the same reasons as above, plus because quantitative data could also be used to monitor effects over time and thereby provide information about how the effects are likely to increase or decline over time.

A mix of both qualitative and quantitative is then preferable.

So, when assessing the urban health and quality of life we need the following information:

- Size;
- Age and sex structure;
- Vital statistics;
- Health Status;
- Inequality (identification of vulnerable or deprived groups);

- Lifestyles;
- Living conditions;
- Socioeconomic conditions;
- Physical environment;
- Physical and social infrastructure;
- Public health services and policies (including the quality of and access to services).

And the set of core indicators identified should:

- provide relevant and robust measures of progress towards achieving the goals agreed;
- be clear and straightforward to interpret, and provide a basis for national and international comparison between cities;
- be based to the greatest extent possible on international standards, recommendations and best practices; and
- be constructed from well-established data sources, be quantifiable and reliable to enable measurement over time.

When assessing the impact on health and quality of life of an urban regeneration project, we have to aim at:

- Improving health and quality of life of the citizens;
- Reducing health Inequalities;
- Increasing attractiveness of the urban area.

The indicators presented here are intended to serve the purpose of:

- providing a basis for assessing the impact of a project, a change, a programme within a major urban regeneration plan on health and well being of the citizens in that urban area;
- acting as a basis for monitoring and evaluating the effectiveness of a project, a change, a programme within a major urban regeneration plan on reducing health and well being risks on the citizens in that urban area;
- providing a template for developing other indicators as needed to address issues of specific local concerns.

Nevertheless, it is evident that different issues matter in different places. So individual cities may wish to select and adapt these indicators to meet their own needs.
Both exposures and health outcomes – as well as the associations between them - are affected by contextual conditions, such as social, economic or demographic factors.
In the following pages is provided a provisional list of indicators addressing identified objectives by issue per each theme: economic development, cultural and social cohesion, environmental regeneration.

Keys

Appraisal should use both qualitative and quantitative evidence.

When assessing the impact on health and quality of life of an urban regeneration project, we have to aim at improving health and quality of life of the citizens, reducing health inequalities, increasing the attractiveness of the urban area.

A. Economic development

There is a clear link between a healthy population and economic prosperity. Enhanced development of cross-sectoral synergies could lead to a positive impact on the economy through better understanding of, for example, the impact of health on the labour force and the impact of innovation on health systems.
The link between health and economic prosperity would be better understood, supporting sustainable health systems and economic gains in the long term.

Theme: **Healthy sustainable urban development focusing on economic development**

Issues	Objectives	Indicators
Economic status and wealth	Improve the economic status and decrease the level of poverty	*Income per capita* *Rate of poverty by gender* *Rate of poverty by ethnic group* *N. of births by teenage parent* *Dependency ratio*
	Attract more investments from other regions and from abroad	*Rate of local investments* *Rate of international investments* *Economic activity composition*
Employment and working conditions	Maintain high and stable levels of employment	*Rate of local unemployment* *Labour force participation*
	Improve working conditions	*Level of employees satisfaction*
	Increase employability	*Level of attainment* *Rate of professional education compared to availability of jobs*
Living conditions	Reduce/Increase/Maintain the cost of living	*Cost of living* *Cost of households per square metre*

B. Cultural and Social Cohesion

Building on existing cross-sectoral synergies could lead to a positive social impact particularly in fields like employment and health, social capital and health, safety and quality of life and emotional wellbeing.

Theme: **Healthy sustainable urban development focusing on Cultural and Social Cohesion**

Issues	Objectives	Indicators
	Demographic issues	
Age	Attract younger people population Improve elderly people living conditions	*Aging index* *Rate of elderly people in need of social and health care* *Growth rate*
Ethnicity	Increase/reduce/maintain the migrant population	*Density of migrants by country of origin* *Rate of family integration or reintegration*
Family	Improve family living conditions	*Rate of single parent families* *Rate of single teenager parents*
	Living Conditions issues	
Housing	Improve the conditions of homeless	*Rate of homeless people by ethnic group, gender and age*
	Increase/reduce/maintain social homes	*Rate of social homes*
	Reduce the proportion of unfit (housing) stock	*Rate of homes judged unfit to live in*
Leisure time	Increase leisure time opportunities for all Improve access to recreational opportunities	*Level of attractiveness of parks, green areas and playgrounds* *Level of satisfaction of the cultural activities implemented by season in the area*
Access to services	Improve health of the population	*Healthy Life Expectancy at birth*
	Improve accessibility to health services	*Proximity of health services* *Level of satisfaction of the health services in the area* *Rate of health services accessible to disabled* *Proximity to pharmacies in the area* *Self reported health status*
	Improve accessibility to social services	*Proximity of social services* *Level of satisfaction of the social services in the area* *Rate of people using social services by gender, age, ethnic group* *Rate of social services accessible to disabled* *Rate of voluntary organisations providing social services* *Rate of volunteers by age, gender and ethnic group*
	Improve accessibility to education and vocational training opportunities	*Illiteracy rate* *Rate of education attainment by age, gender and ethnic group* *Proximity of schools by grade* *Proximity of vocational training venues* *Rate of schools accessible to disabled* *Rate of vocational training venues accessible to disabled*
	Improve/maintain accessibility to private services	*Proximity of shops*
Safety	Increase the level of safety	*Level of crime* *Rate of reported domestic violence* *Self reported level of safety by age, gender and ethnic group*
Mental health and emotional wellbeing	Improve mental health, quality of life and emotional wellbeing	*Rate of death by suicide* *Rate of hospitalisations for intentional self-harm* *Residents' rating of how happy they are* *Residents' satisfaction with their own lives in general* *Residents' rating of experiencing negative stress over the past 12 months*

C. Environmental regeneration

Environmental health indicators have been defined as: *an expression of the link between environment and health, targeted as an issue of specific policy or management concern and presented in a form which facilitates interpretation for effective decision-making.*

"Environment" is a concept that means many different things to different people. In reality, the environment has no clear bounds. It simply means the context within which things happen: "the conditions or influences under which any person or thing lives or is developed" in the words of the *Oxford English Dictionary.*

In terms of environmental health, the environment thus includes not only the natural world, but also the anthropogenic world of the home, school, workplace and neighbourhood. It includes not only physical and chemical influences, but also the social and other factors that affect our health. This is an expansive definition. We need to define a focus for our attention. This focus is provided by the physical contexts within which urban citizens interact: the ambient environment (the wider world of air, water, land and living creatures); the community (the social environment or neighbourhood within which they live); and the home environment.

Theme: **Healthy sustainable urban development focusing on environmental regeneration**

Issues	Objectives	Indicators
	Environmental issues	
Air Quality	Reduce air pollution and improve air quality	*Contamination per capita*
Indoor Air Quality	Improve Indoor Air Quality	*Contamination per capita*
Noise	Reduce noise	*Contamination per capita*
Contaminated land	Reduce/treat/isolate contaminated land	*Contamination per capita*
Radiation	Reduce/isolate radiated area	*Contamination per capita*
Waste	Promote recycling	*Rate of recycled waste per total kg of waste produced*
	Reduce generation of waste	*Rate of waste produced per capita*
Greenhouse gas emissions	Reduce greenhouse gas emissions	*Greenhouse gas emission per capita*
	Planning and transportation issues	
Energy usage	Reduce energy usage increasing the usage of energy saving materials for new buildings	*Used electricity per household/person*
Traffic and congestions	Improve choice in transport; improve access to education, jobs leisure and services; and reduce the need to travel by private cars	*Road traffic*
Parks, green areas and playgrounds	Increase the number of green areas and playgrounds, improve accessibility to parks, playgrounds and green areas.	*Green areas square metres per capita* *Playground square metres per child under 15*

ANNEXES

1. Glossary of Indicators

Antonella Cardone (BHC Thematic Expert)

A. Economic development

A1. Income per capita - The total value of goods and services available to citizens, expressed in inflation-adjusted Euros, per head of population, also known as real gross national disposable income (RGNDI) per person

A2. Rate of poverty by gender - Percentage of individuals,(divided by men and women) living in households where the total equivalised household income is below 60% of national equivalised median income, after social transfers. In order to understand the link between poverty and gender inequalities in Europe we can consider three aspects of gender inequalities in the labour market. First, women have a markedly lower rate of economic activity than men. Second, rates of female unemployment are usually higher than those for men. Third, women receive lower hourly remuneration. Promoting women's participation in the labour market is the aspect with the greatest potential to promote pro-poor growth. Hence improving women's (particularly poor women's) access to the labour market is an essential element of public polices. Since caring for children increases the probability of women being economically inactive, one important means of increasing female participation might be to provide childcare facilities, especially to poor women.

A3. Rate of poverty by ethnic group - Percentage of individuals, by ethnic group, living in households where the total equivalised household income is below 60% of national equivalised median income, after social transfers.

A4. N. of births by teenage parent - Teenage parenthood is regarded as a significant disadvantage in countries that increasingly demand an extended education and in which delayed childbearing, smaller families, two-income households and careers for women are increasingly becoming the norm. Women who become mothers at a young age are likely to have reduced educational attainment, limited opportunity to complete tertiary education and reduced participation in paid work. There are also several physical and mental health risks associated with teenage pregnancy. Some research indicates that pregnant teens are at greater risk of health problems, including anaemia, hypertension, renal disease and depressive disorders. There are risks of serious health consequences for babies born to mothers still in their teens. Children of teenagers are more likely to have low birth weights and to suffer from associated health problems.
Two measures are used to assess this indicator:

- Births to teenage mothers
- Teenage sole parents earning less than xxxx per year.

Births to teenage mothers
This measure looks at the rate of live births to females aged between 13 and 17 years, as a rate per 1,000 of all females aged between 13 and 17 years.
Teenage sole parents earning less than xxxxx per year
Socio-economic status is a key determinant of people's ability to access health care services for themselves and their children. This measure investigates the links between income and young parents. It shows the number of sole parents aged 15 to 19 years who earned less than xxxx per year.

A5. Dependency ratio - The total dependency ratio is the number of persons under age 15 plus persons aged 65 or older per one hundred persons 15 to 64. It is the sum of the youth dependency ratio and the old-age dependency ratio.

1. The youth dependency ratio is the number of persons 0 to 14 years per one hundred persons 15 to 64 years.
2. The old-age dependency ratio is the number of persons 65 years and over per one hundred persons 15 to 64 years.

A6. Rate of local investments - Number of new investments made by people living in the area by year. The rate of local investments is influenced by local taxations, infrastructures available, safety in the area, vicinity to other relevant services, etc.

A7. Rate of international investments - Number of new investments made by foreigners in the area by year. The rate of international investments is influenced by local taxations, infrastructures available, safety in the area, vicinity to other relevant services, etc.

A8. Economic activity composition - Number of different categories of businesses in the urban area considered.

A9. Rate of local unemployment - Individuals registered unemployed at the local employment office (or equivalent, according to national standards) as a percentage of the total potentially employed local population (all employed and unemployed citizens).

A10. Labour force participation - The labour force participation rate consists of the economically active popula-

tion in a particular age group as a percentage of the total population of that same age group. The active population (or labour force) is defined as the sum of persons in employment and unemployed persons seeking employment. This definition of employment is the one adopted by the Thirteenth International Conference of Labour Statisticians (Geneva, 1982). National definitions may in some cases differ. For information on the differences in scope, definitions and methods of calculation used for the various national series, see International Labour Organization.

A11. Level of employees satisfaction - Level of employees satisfaction is measured through a survey and it's mainly a qualitative indicator. Employees are reconsidering their priorities, their performance and how much they should really expect from employers. Four major aspects of employee satisfaction have risen sharply in the past 4 years:

1. Number of hours worked (up 12 points).
2. Opportunities to learn new things (up 13 points).
3. Amount of work expected to handle (up 8 points).
4. Level of compensation (up 8 points).

A12. Level of attainment - Level of attainment is mainly used in the British education system. It's one of ten groupings, each with its own attainment criteria based on pupil age and ability, within which a pupil is assessed. Attainment Levels describe exactly what a child working at that level will be achieving. Your child's teachers will assess the level your child is working at in each subject on a regular basis. At the end of each Key Stage, children are assessed formally in Standard Attainment Tests (SATs). The results for each school could be reported nationally. Attainment Levels for all subjects range between 1 and 7, with 1 being the lowest. High-performing children may be awarded a Level 8 or Exceptional Performance. The levels are also subdivided, so sometimes you may hear teachers talk about Level 6c, 2b or 4a. In this case, 'c' means the lowest achievement at any one level, 'b' the middle and 'a' the top. So a child working at Level 2b is in the middle of that level, just above Level 2c, but working up to Level 2a. This may seem confusing, but subdividing levels helps teachers to monitor how children are progressing from term to term. For example, a child who moves from Level 3c to 3a over a year is clearly making progress, even though s/he has stayed at the same level. One who moves from Level 3a to 4c will not have progressed as much, despite moving from one level to the next.

A13. Rate of professional education compared to availability of jobs - It is the percentage of the overall population over 18 years of age with a professional qualification within the qualifications required by open job opportunities in the labour market.

A14. Cost of living - Can be defined in different ways, two of which are:

1. The average cost of the basic necessities of life, such as food, shelter, and clothing.
2. The cost of basic necessities as defined by an accepted standard.

A15. Cost of households per square metre - It's an average estimated cost of households per square metre in a given neighbourhood.

B. Cultural and Social Cohesion development

B1. Aging index - The ageing index is calculated as the number of persons 60 years old or over per hundred persons under age 15.

B2. Rate of elderly people in need of social and health care - It's the percentage of over 60 years old people in need of social and health care on the total number of over 60 years old.

B3. Growth rate - A population's growth rate is the increase (or decrease) in the number of persons in the population during a certain period of time, expressed as a percentage of the population at the beginning of the time period. The average annual growth rates for all ages as well as for particular age groups are calculated on the assumption that growth is continuous.

B4. Density of migrants by country of origin - Number of migrants by country of origin per square kilometre.

B5. Rate of family integration or reintegration - Percentage of family integrated or reintegrated on the total number of immigrants present in that specific urban area.

B6. Rate of single parent families - It's the percentage of single parent families over the total number of families. Globally, one-quarter to one-third of all families are headed by single mothers, calling into question the normativeness of couple headed families. Developed countries, in particular, are experiencing an increase in single-parent families as divorce becomes more common. The United States has the highest percentage of single-parent families (34% in 1998) among developed countries, followed by Canada (22%), Australia (20%), and Denmark (19%). In developing countries, divorce is not as common, but desertion, death, and imprisonment

produce single-parent families, primarily headed by women (Kinnear 1999).

B7. Rate of single teenager parents - It's the percentage of single teenager parent over the total number of teenagers. One segment of the single parent population that I have not highlighted before are teenage single parents. They have unique needs and challenges when they become parents, and in the majority of cases are totally unprepared for parenting on their own. Teen parents have additional roadblocks such as trying to finish high school, lack of job skills, lower income, and lack of transportation. All of these issues and more can really hinder a teen parent's ability to effectively parent her child. Single parenting is difficult without having the additional disadvantage of being a young adult.

B8. Rate of homeless people by ethnic group, gender and age - It's the percentage of homeless people by ethnic group, gender and age over the total population of that specific urban area.

B9. Rate of social homes - It's the number of social homes per a given number of inhabitants in that specific urban area.

B10. Rate of homes judged unfit to live in - It's the number of homes judged to be under the minimum level of safety conditions per a given number of inhabitants in that specific urban area.

B11. Level of attractiveness of parks, green areas and playgrounds - The level of attractiveness can be measured in different ways:

- Number of people attending the park in a given period of time (daily, weekly, monthly, yearly) over the total population of that specific urban area;
- A survey through a questionnaire done to the overall population of the urban area.

B12. Level of satisfaction of the cultural activities implemented by season in the area - The level of satisfaction of the cultural activities implemented by season in the area can be measured in different ways:

- Number of people attending the cultural activities by season over the total population of that specific urban area;
- A survey through a questionnaire done to the overall population of the urban area.

B13. Healthy Life Expectancy at birth - Life expectancy is a key indicator of the general health of the population. Improvements in overall life expectancy reflect improvements in social and economic conditions, lifestyle, access to health services and medical advances. This indicator uses estimated life expectancy at birth.

B14. Proximity of health services - General practitioners (GPs) are part of the front line of primary health care provision. Accessibility to a GP is an important issue in both treatment and prevention of poor health. The number of GPs per city may reflect accessibility to health services. A lower rate of GPs per head of population may result in difficulty accessing primary health care and is associated with higher rates of hospitalisation. Two measures are used to examine access to general practitioners:

- Rate of general practitioners per 100,000 population
- Barriers to accessing a general practitioner. This indicator can be measured through a questionnaire given to the entire population of that specific urban area.

B15. Level of satisfaction of the health services in the area - This indicator is a qualitative one and can be measured through a survey based on a questionnaire to the overall population.

B16. Rate of health services accessible to disabled - Percentage of health services accessible to disabled on the overall health services in that specific urban area.

B17. Proximity to pharmacies in the area - It can be measured as:

1. Average distance between households and local pharmacies
2. The longest distance between households and the local pharmacy.

B18. Self reported health status - Self-reported health is a global measure of health. It is subjective and complements the findings from more objective and direct health outcome measures. It's normally measured through a survey using a questionnaire.

B19. Proximity of social services - It can be measured as:

1. Average distance between households and local social services
2. The longest distance between households and the local social service.

B20. Level of satisfaction of the social services in the area - This indicator is a qualitative one and can be measured through a survey based on a questionnaire to the overall population.

B21. Rate of people using social services by gender, age, ethnic group - It's the percentage of people using social services by gender, age, ethnic group on the overall population of that specific urban area.

B22. Rate of social services accessible to disabled - Percentage of social services which are accessible to disabled on the overall social services in that specific urban area.

B23. Rate of Voluntary Organisations providing social services - Number of Voluntary Organisation providing social services by xxxx number of people living in the area.

B24. Rate of volunteers by age, gender and ethnic group - Percentage of volunteers on the overall active popula-

tion of the area by age, gender and ethnic group.

B25. Illiteracy rate - The illiteracy rate of a particular age group indicates the proportion of persons in that group who cannot read with understanding and cannot write a short simple statement on their everyday life.

B26. Rate of education attainment by age, gender and ethnic group - Level of attainment is mainly used in the British education system. It's one of ten groupings, each with its own attainment criteria based on pupil age and ability, within which a pupil is assessed. Attainment Levels describe exactly what a child working at that level will be achieving. Your child's teachers will assess the level your child is working at in each subject on a regular basis. At the end of each Key Stage, children are assessed formally in Standard Attainment Tests (SATs). The results for each school could be reported nationally.

Attainment Levels for all subjects range between 1 and 7, with 1 being the lowest. High-performing children may be awarded a Level 8 or Exceptional Performance. The levels are also subdivided, so sometimes you may hear teachers talk about Level 6c, 2b or 4a. In this case, 'c' means the lowest achievement at any one level, 'b' the middle and 'a' the top. So a child working at Level 2b is in the middle of that level, just above Level 2c, but working up to Level 2a. This may seem confusing, but subdividing levels helps teachers to monitor how children are progressing from term to term. For example, a child who moves from Level 3c to 3a over a year is clearly making progress, even though s/he has stayed at the same level. One who moves from Level 3a to 4c will not have progressed as much, despite moving from one level to the next.

B27. Proximity of schools by grade - It can be measured as:

1. Average distance between households and local schools by grade
2. The longest distance between households and the local school by grade.

B28. Proximity of vocational training venues - It can be measured as:

1. Average distance between households and local vocational training venues
2. The longest distance between households and the local vocational training venue.

B29. Rate of schools accessible to disabled - Number of schools accessible to disabled on the overall number of schools in that specific urban area.

B30. Rate of vocational training venues accessible to disabled - Number of vocational training venues accessible to disabled on the overall number of vocational training venues in that specific urban area.

B31. Proximity of shops - It can be measured as:

1. Average distance between households and local shops
2. The longest distance between households and the local shop.

B32. Level of crime - The rate of crime in a particular neighbourhood. It can be measured as:

1. n. of crimes per month or year
2. n. of crimes a year per 100,000 number of people.

B33. Rate of reported domestic violence - The rate of reported domestic violence in a particular neighbourhood. It can be measured as:

1. n. of reported domestic violence per month or year;
2. n. of reported domestic violence a year per 100,000 number of people.

Around the world at least one woman in every three has been beaten, coerced into sex, or otherwise abused in her lifetime. Most often the abuser is a member of her own family. Nearly one in every three adult women experiences at least one physical assault by a partner during adulthood.

B34. Self reported level of safety by age, gender and ethnic group - Self-reported level of safety by age, gender and ethnic group is a global measure of safety. It is subjective and complements the findings from more objective and direct safety measures. It's normally measured through a survey using a questionnaire.

B35. Rate of death by suicide - The number of suicide deaths per 100,000 population, expressed as a three-year moving average age-standardised rate, for the population aged 5 years and over. Suicide is an indicator of the mental health and social wellbeing of society and a major cause of injury-related death in the population.

B36. Rate of hospitalisations for intentional self-harm - It's the number of hospitalisations for intentional self-harm over the total number of hospitalisations. Significantly increased age- and sex-adjusted relative risks for suicide were associated with previous hospitalization for self-injury, injuries of undetermined causes, and assault. Also, elevated risks were associated with these causes of hospitalization in the case of subsequent self-injury hospitalizations. Results indicate that identifiable subgroups of individuals hospitalized for injuries are at marked risk for serious suicidal behaviour and suggest the potential of targeted suicide prevention for these individuals.

B37. Residents' rating of how happy they are - It's a qualitative measure done through a survey using a questionnaire. It's a subjective measure.

B38. Residents' satisfaction with their own lives in general - It's a qualitative measure done through a survey using a questionnaire. It's a subjective measure.

B39. Residents' rating of experiencing negative stress over the past 12 months - It's a qualitative measure done through a survey using a questionnaire. It's a subjective measure.

C. Environmental regeneration

C1. Contamination per capita - Includes:

1. The deposit, absorption, or adsorption of radioactive material, or of biological or chemical agents on or by structures, areas, personnel, or objects. See also fallout; induced radiation; residual radiation;
2. Food and/or water made unfit for consumption by humans or animals because of the presence of environmental chemicals, radioactive elements, bacteria or organisms, the by product of the growth of bacteria or organisms, the decomposing material (to include the food substance itself), or waste in the food or water.

C2. Rate of recycled waste per total kg of waste produced - Self explained.

C3. Rate of waste produced per capita - Self explained.

C4. Greenhouse gas emission per capita - Emissions of greenhouse gases, primarily carbon dioxide (CO_2), methane and water vapour contribute to global warming. It's calculated in particles of gases emission by day/week/month or year per person living in that specific urban area.

C5. Used electricity per household/person - Self explained.

C6. Road traffic - It can be measured in different ways:

- N. of vehicles along roads by day/week/month or year;
- N. of vehicles along roads by people leaving in that specific urban area.

C7. Green areas square metres per capita - Self explained.

C8. Playground square metres per child under 15 - Self explained.

2. The Belfast Exchange: BHC partners meet in Belfast for Health Impact Assessment workshop

Adele Keys (Belfast City Council)

A two day Health Impact Assessment workshop was hosted by Belfast on 28-30 September 2009. The purpose of the workshop was to give partner cities an understanding of the concept and process of HIA and to see how it has been applied in Belfast.

The workshop was organised by Belfast's local support group which is chaired by Joan Devlin from Belfast Healthy Cities project managed by Adele Keys, Belfast City Council.

The training was provided by Erica Ison, an HIA specialist who has a wide range of experience in doing HIA's in Belfast. The training included HIA theory and also had a practical focus including HIA case-studies of the Regeneration Strategy of the Lower Shankill and site visits to the Shankill and East Belfast. In Belfast, health impact assessment is strongly endorsed in the interdepartmental public health strategy, Investing for Health. Belfast Healthy Cities have led several HIA's in Northern Ireland and have produced some general introduction information to introduce HIA.

What is Health Impact Assessment (HIA)?

WHO define HIA as "a combination of procedures, methods and tools by which a policy, programme or project may be judged as to its potential effects on the health of a population and the distribution of those effects within the population". HIA is undertaken with the purpose of giving decision-makers information about the effects on health and well-being of a specific proposal, and supporting that information with suggestions about how to change and modify the proposal in order to achieve or optimise health gain.

HIA has two purposes:

- to predict the likely health effects of a proposal on a specific population group or groups and;
- to inform policy-makers to improve evidence-based recommendations in the decision-making process.

It can also recommend changes that can reduce inequality in health and can lead to better policy-making through its values and principles. HIA provides increased opportunities for intersectoral cooperation and action for health.

Stages of Health Impact Assessment

Screening: Identifies if a proposal should be subject to HIA and identifies potential effects on the determinants of health, health outcome and population groups.

Scoping: This will include establishing a steering group, setting boundaries, methods of appraisal, designing and planning the HIA, time scale, the steering group's role, membership and reporting arrangements.

Appraisal: Gathers evidence for the HIA and appraises the information to make a judgment about the health impacts of the proposal.

Reporting and dissemination: Reporting includes collecting and presenting the results from the analysis and input from stakeholders.

Supporting decision-makers: This task explores the main influences on decision-making.

Monitoring and evaluation: Monitoring and evaluation follow the results of the HIA and evaluate the process and the effectiveness of the HIA.

Types of Health Impact Assessments

There are two main types of HIA appraisal that are normally carried out: Desk top HIA and Rapid HIA:

- Rapid appraisal does not collect new data but only compiles information or data already available;
- Desk top HIA appraisals involve literature reviews and access to the internet to identify relevant evidence base.

Further details on HIA can be found at:
www.belfasthealthycities.com
www.publichealth.ie/eventsandresources/hiatools
www.euro.who.int/healthy-cities/UHT/20050201_10
www.hiagateway.org.uk/

For information concerning the workshop please contact:
Adele Keys at <KeysA@BelfastCity.gov.uk>

3. An overview of the Local Action Plans

Marco Santangelo (BHC Lead Expert)

During the last months the BHC Thematic Network activities have focused on the definition of draft Local Action Plans. Considering the importance of what has been achieved in the URBACT II programme as a whole, the experience of one of the pilot thematic networks, i.e. MILE, has been exploited to define the structure of the plans to be designed at local level.
For this purpose, the 10 partner cities of BHC have filled a template based on the LAPs that have been produced as final outputs of the MILE experience.
The adapted LAP is as follow (document provided in advance to have the LAPs ready for the first thematic workshop):

Local Action Plan Draft

The LAP Draft is made of 2 parts: the first to describe the context, the local situation and the organisational activities that each LSG is undertaking; the second to provide a synthetic framework of the actions that would form the final LAP.

1. **Descriptive part**: describe the context (also referring to the already provided Local Mapping in the Baseline Study), provide data if needed, outline a selection of priorities/needs/challenges that will constitute actions in the following scheme (part 2).
   Please also describe the LSG and its activities (e.g. composition of the LSG, presence of a coordinator, calendar of the meetings, strategy of communication, organised events etc.).
   Please, use brief paragraphs, lists and few tables and figures, if needed and useful to present data in a clear way.
   Max 3 pages.
2. **LAP Scheme** for the First Thematic Workshop, to be held in Łodz on the 8th-9th of June 2009 (there could be as many schemes as there are foreseen actions).

Local Action Plan Scheme elaborated by the name of the city BHC Local Support Group

(dd-mm-yyyy)

	LAP priorities	*Projects related to the LAP priorities*	*Funding Programme*	*Funding Procedure*	*Timing*
1. XXX (here the action that needs to be tackled/the project that has to be implemented)	In this column should be reported the specific priorities/needs/ challenges related to the main LAP objective as described beside.	Other projects that have already been implemented or have been designed and that could provide synergies with our LAP.	Report the programmes that could fund each priority (the main source should be the Regional Operational Programme, but also other programmes should be reported).	Report deadlines related to the funding programmes reported in the previous column.	Dates and deadline of the LAP related action (according to deadlines of the funding procedures and the LSG scheduled activities and expected outputs).
	…	…	…	…	…
	…	…	…	…	…
	…	…	…	…	…

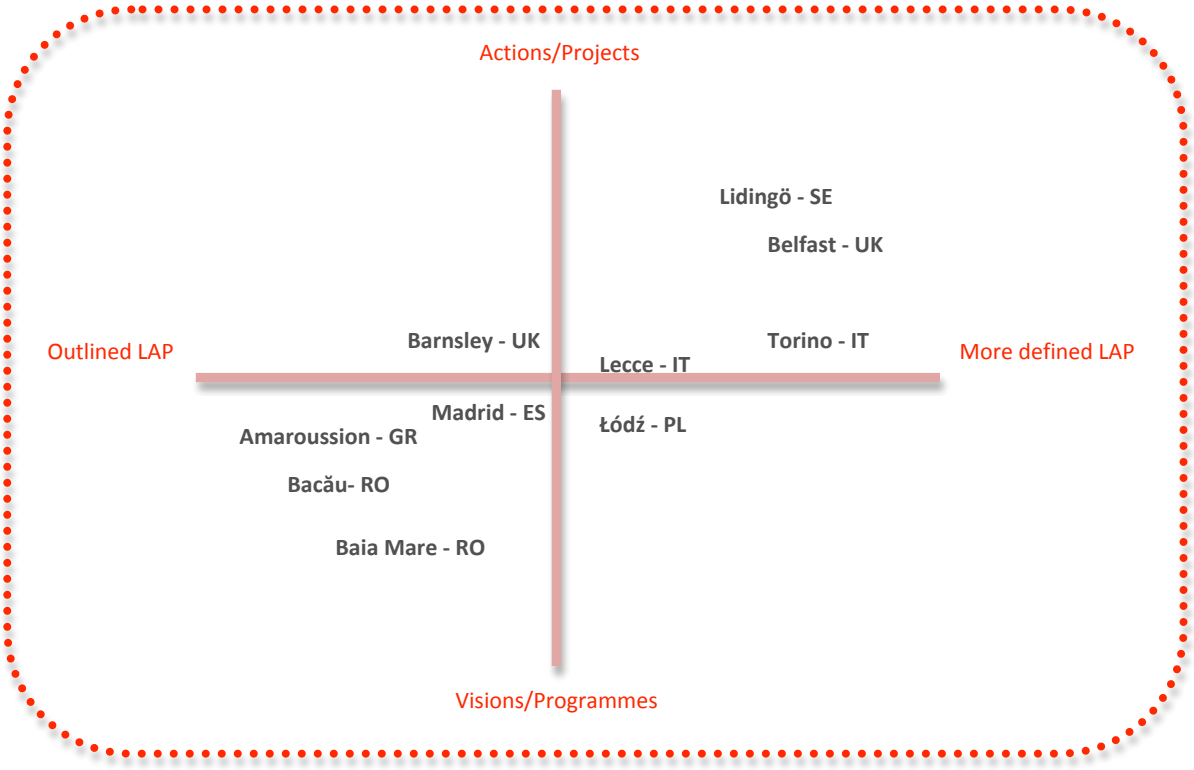
N.B.: The scheme refers to the LAP scheme used in the MILE Fast Track Pilot Thematic Network.

The partners cities filled the template, adapting it to the very different contexts and expectations, thus allowing to identify two main families of LAPs, into which the different approaches and – to a certain extent – some already defined actions are visible.
The main families into which the ten LAPS can be divided are:

- LAPs which focus on specific needs and problems and that, therefore, result in actions and projects. Being so clearly targeted, these actions and projects demand for a better definition of the funding possibilities and this will be the main task in the next months;
- LAPS which outline wider urban regeneration strategies and that, therefore, result in strategic visions or programmes that need to be better specified in the next months.

The figure below gives a quick glance at the different types of LAPs that have been produced by the ten partner cities. The two families of LAPs can be seen according to their position close to "actions/projects" or "visions/programmes", while the definition of the presented initiatives can be seen according to their position close to "outlined" or "more defined".

Fig. 1 – Different types of LAPs according to the definition of the initiatives to be implemented



The position of the different cities is not to be considered – of course – as something fixed. It represents, in fact, just what has been stated in the LAPs and, thus, will change in the next months thanks to the confrontation at local and transnational level, taking into account opinions and facts, new deadlines of the possible funding, the implementation of the toolkit with indicators and criteria for a healthy sustainable urban development.
The two families are clearly linked to the local social, economic, cultural and political conditions, while a major opportunity is to have Managing Authorities working in – or directly supporting – the Local Support Groups: in such cases the link between the definition of the initiative and the (possible) access to funds is more evident.

It is also to be highlighted that those cities that have preferred to engage the LSGs in defining a vision for future developments and transformation of the urban area are less focused in designing actions or projects, at least for the moment.
An important issue that is common to all the cities regards the capacity to address, design and monitor policies through the introduction of the “health in all policies” principle and the consequent adoption of a system of indicators that helps to bring health and quality of life at the centre of the local debate.