Report of the Online capacity building on Health Impact Assessment in east and southern Africa, April to July 2025

Regional Network for Equity in Health in East and Southern Africa (EQUINET)

August 2025

Co-ordinated by Training and Research Support Centre (R Loewenson)
in partnership with the East Central and Southern African Health Community (Y Dambisya), Southern African Trade Union Coordination Council (N Banda), TalkAB[M]R (C Walyaro), Nossal Institute of Global Health (S Simpson), and C Dora, with IT support from B Ncube and communications input by JM Gitari

1. Background

Assessing the effect of policies, strategies, corporate and economic activities on health is a core capability to protect public health. Health impact assessment (HIA) helps to identify where changes to project design or operation provide health benefits and mitigate health risks, adding economic value and wellbeing. HIA is a structured process that informs decision makers about the potential effects of a project, programme, economic activity or policy on the health and well-being of populations. It is increasingly a legal requirement in many high and middle income countries globally. In the same way as environmental impact assessment was institutionalized in the ESA region to play a role in this on protecting ecosystems, HIA similarly needs to be institutionalized to embed evidence and health-promoting changes in wider activities, systems and policies that raise health risks[1]. Policy leaders in Africa recognized this in the WHO AFRO Regional multi-sectoral strategy to promote health and well-being, 2023–2030, with a target by 2030 to have institutionalized and integrated health impact assessment (HIA)[2]. Equally Regional health ministers in the ECSA Health Community resolved in 2024 to expand implementation of health impact assessment.

Since 2023, EQUINET -through TARSC with SATUCC and TalkAB[M]R) -in partnership with ECSA Health Community, Nossal Institute of Global Health and C Dora as international partners have been collaborating to provide online training and mentored case study work to build HIA capacities in multi-actor teams in ESA countries. The first online course was held in 2024, separately reported. TARSC through consultant support provided the IT platform for the course, and a media consultant provided input on writing skills. Institutional resources were provided by participating institutions, complemented by support from TARSC, Medico International and the the African Extractivism and the Green Transition (AEGT) research partnership funded by the

[1] EQUINET (2024) Institutionalising health impact assessment in East and Southern Africa, EQUINET, Harare
[2] WHO AFRO (2023) Regional Multisectoral Strategy to Promote Health and Well-Being, 2023–2030 in the WHO African Region AFR/RC73/10, Gaborone.

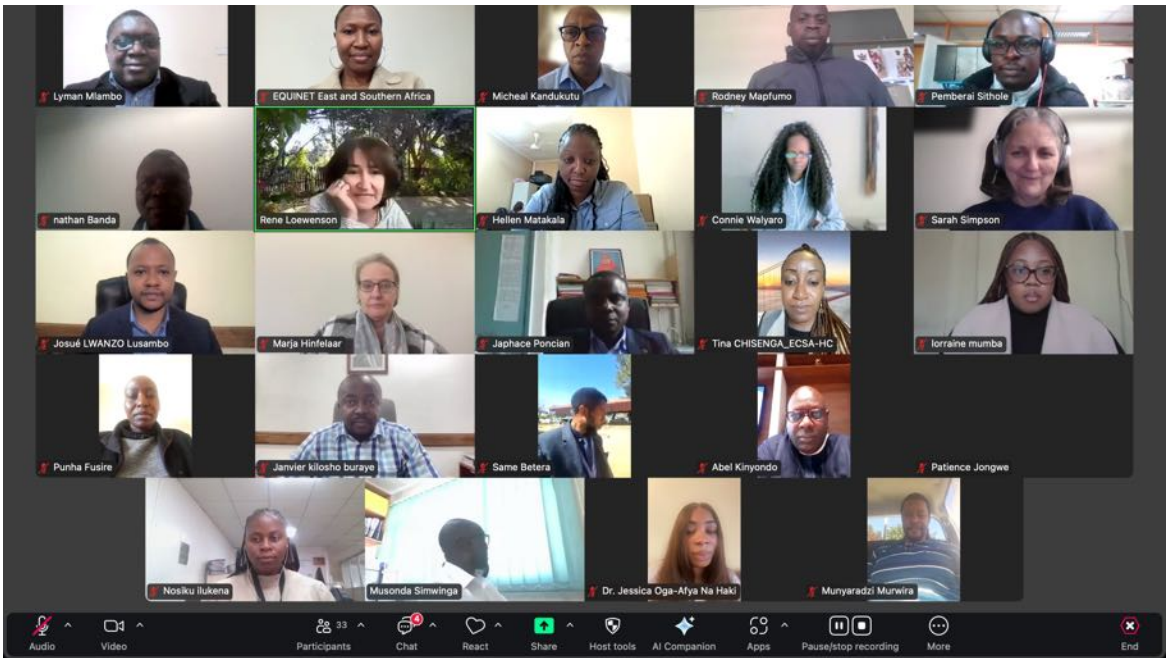
Social Sciences and Humanities Research Council of Canada. This second regional course was held between April and July 2025.

The course built understanding of the theoretical basis of HIA, and knowledge of the methods, evidence, analysis in an HIA, of reporting of and engagement on HIA, and implementation and monitoring of proposed actions. It provided mentored guidance of participant HIA practical work, using real HIA case studies. Towards the end of the course there was discussion on issues and strategies for scaling up and integrating HIA in key sectors and in public health law. This report is prepared by TARSC and briefly summarises the proceedings and issues raised.

Before the course start date, in late 2024/early 2025, the course outline was developed collaboratively between the resource persons, integrating changes based on the participant evaluation and mentor review of the 2024 course. The programme was finalised, shown in *Appendix 1,* and the course was implemented through 10 online sessions between April 28 2025 and July 30 2025. The course training manual was updated and presentations prepared[3].

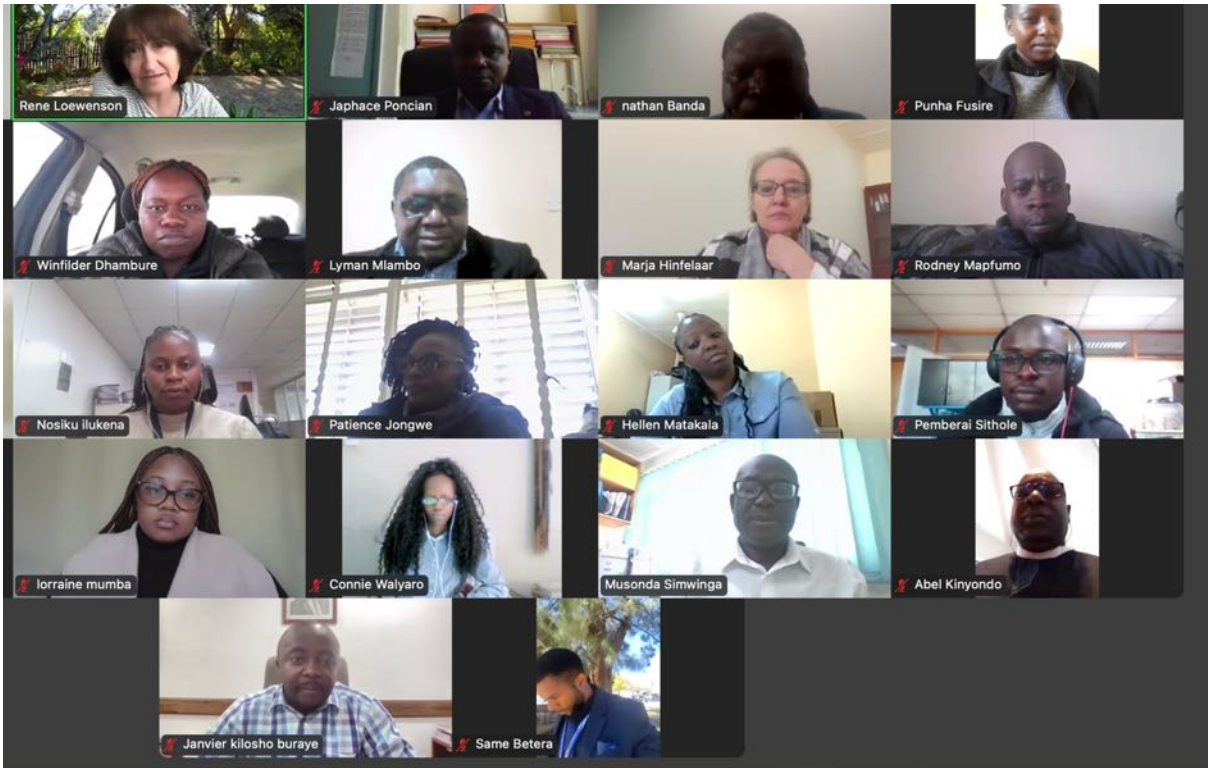
An open call for applicants was circulated, responses reviewed by resource persons, and applicants selected for the course. Applicants were invited to apply from ESA countries, from state, non- state, labour, professional or academic institutions, and requested to have roles in or an intention to implement HIA. Applicants were encouraged to apply as a team of up to 4 people from relevant different disciplines/groups from a country or setting. Individual applicants were also considered and if selected were engaged to include within existing teams, where possible. Applicants were expected to have at least undergraduate level education, and were asked to confirm access to internet, familiarity with zoom, and commitment to participating in the ten online sessions on the dates indicated. Applicant teams/ individuals were asked to identify a positive or negative economic activity or policy innovation that they may wish to focus on to implement a mentored HIA as part of the training. The accepted participants and resource people are shown in *Appendix 2.* A course fee of USd1200 *per team* was levied to part fund the course. About half the participants/teams received full or partial fee sponsorship.

The 43 accepted ESA participants shown in Appendix 2 were organised in eight teams for mentored HIA work, and six individuals. Of the 43 accepted participants, 3 did not attend sufficient sessions to complete the course, and one was an observer participant from ECSA HC. The mentored case study areas and teams are shown in *Section 3.*



Screenshot 1 of some of the resource persons and participants in a session on the online platform, 2025

[3] Loewenson. R, Simpson S, Dora C, Banda N, Walyaro C (2024) EQUINET Training Manual: Capacity building on health impact assessment, Second edition, EQUINET, Harare.



Screenshot 2 of some of the resource persons and participants in a session on the online platform, 2025

All teams produced a final mentored HIA report. The course included 3 blocks of tutorial sessions for teams to obtain review comments – in addition to written reviews- from mentors and to raise questions at different stages of the HIA process. There were also three sessions for teams to present their work on their reports at different stages of the HIA process.

The course was evaluated using an online survey in the week before Session 9 and the findings and views discussed in that session 9. The evaluation results are outlined in *Section 4.* Participants who satisfactorily completed the course were given a certificate of completion by EQUINET.

2. The course proceedings

As shown in the programme in *Appendix 1,* the capacity building was implemented in ten online (zoom) training sessions staggered in 4 blocks of three sessions each day in that week. There were intervals of about a month between blocks for mentored HIA work, review and online tutorials. Sessions were 120 minutes and held at lunch hours Southern African time on Tuesdays, Wednesdays and Thursdays in a block.

Intervals between sessions provided time for practical case study HIA work to apply the knowledge gained in the online training. After sessions covering HIA steps, templates were provided to assist with practical work. Work on mentored case studies was reviewed by at least 2 course resource people for each case study, with teams assigned to the same mentors throughout the course. All case studies were also reviewed by TARSC.

The content of course presentations is largely captured in the training manual and hyperlinked readings. As a development from the 2024 course a case study on HIA in a proposed landfill was provided to participants. The case study was used interactively during HIA methods sessions to show participants how an HIA for that step should be implemented. Slides on this case study HIA used in the session and additional slides demonstrating key teaching points were saved as pdfs and sent to participants after the session.

The three presentation sessions shown in *Appendix 1* provided an opportunity for participants to present and get review feedback on their mentored case studies, of benefit for all teams. The course sessions were recorded to the cloud and the cloud link made available for a period to participants who had not been able to attend the session to catch up. A register was kept of those participating during the actual sessions. Three participants who had caught-up online using the cloud recording for 5 sessions (that was the maximum) were interviewed for their knowledge of the course content to ensure satisfactory completion.

This report does not aim to capture or summarise the full content of what was presented! It indicates the areas covered in sessions and some of the key issues raised in the session discussions.

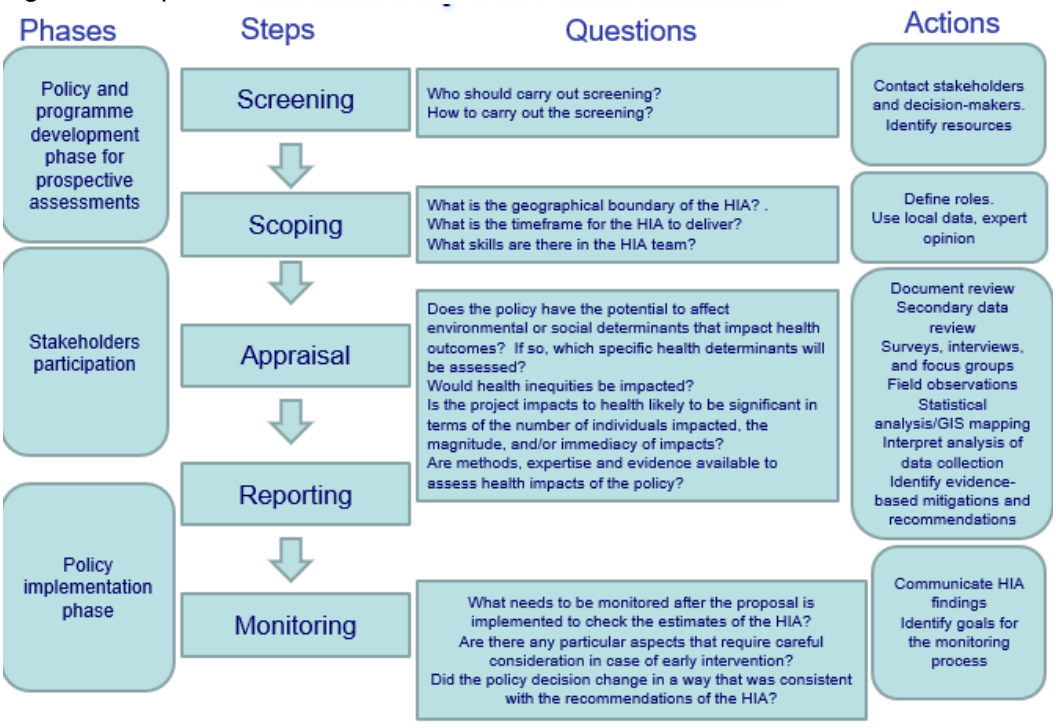
2.1 SESSSION 1: Introducing HIA, principles, equity and social determinants of health in HIA

The first session introduced EQUINET (www.equinetafrica.org), its aims and work, and the convenors, resource people and participants in the course. A document with brief bios for all had been circulated ahead. The session introduced concepts of health equity and social determinants of health as pertinent for public health analysis, including for HIA. This was new information for some participants, as many in the multidisciplinary teams were not health professionals. The session covered the legal basis of HIA and principles applied in HIA practice, including in the Gothenberg consensus. (Other principles such as the precautionary principle were raised in later sessions).

The session introduced and defined HIA as a structured process that informs decision makers about the potential effects of a project, programme, economic activity or policy on the health and well-being of populations, to make recommendations to improve it. It was noted that HIA is often carried out alongside Environmental Impact Assessment (EIA). HIA provides a tool to identify where changes to design or operation of an economic activity, policy, or programme will provide health benefits and mitigate health risks.

There are 5-6 steps in implementing an HIA, summarised in the figure below. While the names of these steps may vary slightly in different tools, the steps are broadly similar.

Figure 1: Steps in HIA[4]



[4] WHO (2023) Health impact assessment (HIA) tools and methods, WHO, Geneva

The session explained and the full course covered sequentially these stages of HIA, viz

1 **Screening,** to determine whether a HIA is feasible, timely, and would add value to the decision-making process, identifying stakeholder interests and positions.
2 **Scoping** to create a plan and timeline for conducting a HIA that defines priority issues, research questions and methods, participant roles and composition of a multi-stakeholder steering group.
3 **Appraisal** in two steps:
   3.1 **Profiling and assessment** to identify existing 'baseline' conditions for a geographic area or population to be able to predict change; and evaluate potential health impacts, including their magnitude, direction, severity, likelihood, and significance, using quantitative and qualitative research methods and data.
   3.2 **Recommendations** to address the identified impacts to improve the project, plan, or policy, and/or to mitigate any negative health impacts.
4. **Reporting** to present and communicate the HIA for decision makers and to media and the public, including on the proposal, policy context, methods, findings and recommendations.
5. **Monitoring** to track the impacts of the HIA on decision-making, to track implementation and health impacts of the adopted recommendations, and identify further areas for response.

The session discussed the levels and timings of HIA and the factors affecting implementation.

One part of the session introduced the social determinants of health (SDH) and health equity. The underlying causes of health outcomes that often reflect systematic social, political, historical, economic and environmental factors that accumulate across people's lifetimes and are transferred across generations are termed the SDH. Within HIA, understanding causes and the causes of causes of health impacts is important. A conceptual framework for SDH used by the WHO Commission on Social Determinants of Health profiles how SDH relate to and address unfair, avoidable or remediable differences in health among population groups. In implementing HIA, an SDH lens is highly relevant in thinking about the different population groups and the factors affecting health impacts and remedial actions, particularly one that helps to draw attention to distributional outcomes and equity/ inequity.

The session also introduced some foundational principles and norms that apply across all stages of HIAs. The session covered the values and principles underpinning HIA and how they may be applied, such as in equity-focused HIAs, or in integrating consultation and representation in implementing HIA.

It covered the legal frameworks for HIA, and the laws that provide for HIA, including in ESA countries. While many public health laws in the region set a legal duty on everyone, including individuals, companies and institutions, for their activities to avoid harm to health, few have specific laws for HIA. In contrast, HIA is increasingly a legal requirement in many high and middle income countries globally, providing useful legal framing to draw from. The session covered some of these laws, including in ESA, such as South Africa's inclusion of HIA within its EIA laws, Kenya's development of HIA Guidelines and explicit provisions for HIA in Zimbabwe's Public Health Act CH15:18 2018 shown in *Box 1* below.

Box 1: Inclusion of HIA in law

Zimbabwe's Public Health Act 2018 [5] provides in Section 32 Clause 2 under the duty to prevent harm to health for the Minister of Health, by statutory instrument, to specify events, occurrences or things that constitute public health risks; the measures for application of the duty to avoid harm; and the projects and activities which require a health impact assessment to be conducted prior to licensing or implementation; with the procedure for conducting the health impact assessment, the contents of a health impact assessment report; and the time frame for implementing remedies to harm to health.

Session participants in the discussion raised the need for HIA to be more widely implemented in sectors such as the mining sector, infrastructure and energy projects, as well as in the health sector and in relation to challenges such as climate change. A later open webinar is organised for September that includes presentations on health impacts of fossil fuels and implementing HIA in relation to climate change.

[5] Republic of Zimbabwe, Public Health Act CH15:17, 2018,

2.2 SESSION 2: Policy and stakeholder analysis, causal pathways and participation in HIA

The session covered the role of and skills for policy analysis in HIA. HIA was noted in the session to be an instrument to integrate health into decision-making and public policies, not only to judge if policies have integrated health, and how well that was done, but to improve policies and their legitimacy. Examples were shown from other regions on how HIA has been used in decision making, including in Ghana on new developments in the petroleum sector. The session introduced how HIA is used to inform in development financing and investment safeguards. One aspect of this is identifying a causal pathway of how the policy relates to health outcomes that are pertinent for an HIA. It also involves thinking through a theory of change on how implementing an HIA engages with the proposed policy process. HIA is thus a tool to enable strategic public health analysis and collaborative decision-making. It can generate awareness of and support for action on public health risks and benefits in economic activities.

In the discussion, it was noted that some HIAs may need to link to other impact assessments, such as EIA. Not all health determinants are environmental, so HIAs have a different scope to EIAs. Any integration thus needs to accommodate the issues from both. It raises engaging with environmental authority interests and building relationships to support the HIA, so both health and environment actors see mutual benefit.

The session included, as key to the initial analysis, how to implement a stakeholder analysis to identify the stakeholders with an interest in the proposed development being assessed, as people to draw evidence from or consult in the HIA. A template was provided to participants to implement the screening step for their mentored case studies.

The session also covered how to integrate participation by affected communities in the HIA. This is important to deliver on the HIA principles of equity and participation noted earlier. Affected groups can participate in steering committees to review the scope and design of HIAs; and can be included in the gathering and review of evidence. Participation is identified to involve affected communities through genuine representatives in HIA evidence gathering and review, in prior informed consent on the outcome of the process, and in being informed of the monitoring of implementation of recommendations from HIA. In discussion, participants suggested that if communities are more aware of HIA, this would increase their informed participation.

2.3 SESSION 3: Screening and scoping steps in HIA

The first part of this session covered the screening step in HIA. It introduced participants to the definition of and purpose for this step, the evidence to gather and implementation tips. Screening, the first step in the HIA process, is used to decide whether a HIA is feasible, timely, and would add value to the decision-making process. The session noted that projects that benefit from HIA are those that have the potential to result in substantial effects on public health, where such an analysis might significantly protect or promote the health of a population, and where partners engaged in the HIA process will use the results.

The screening step is the time to think through the issues in doing this, given that it engages different decision-making processes and legal frameworks.

The session introduced the process and template for teams to use in implementing the screening step and worked with the hypothetical case study on “Metrozone landfill” (see slides overleaf) to work through screening questions with participants. Teams were guided to use the template with their own mentored HIA case studies, discussed in the next section,

The next part of the session covered the Scoping step in HIA and how to do it. It outlined the different levels and types of evidence to gather and the methods and tools for this, given the resources and time available. Scoping is the second step in HIA. It is focused on planning how the HIA should be done, identifying what health risks and benefits to consider, and who will do what. This step sets the scope and design of the HIA. It involves bringing together the major stakeholders for the HIA, such as in a steering group, with a balance of proponents and opponents of the proposal. The main output for this step is a plan for the HIA, its design, and how it will be conducted. This part of the session also used the ‘Metrozone landfill’ case study to for participants to engage in the session on how they would address questions in the scoping step

for that case study. The template for participants to use in the scoping step was introduced in the session.

Case study: Proposed landfill and waste management plan in Metrozone

The proposal- by the city authorities

- Five more private waste collection vehicles.
- New landfill on a hill in the north west of the city.
- Additional environmental health personnel employed.
- Stricter law enforcement of illegal waste dumping.

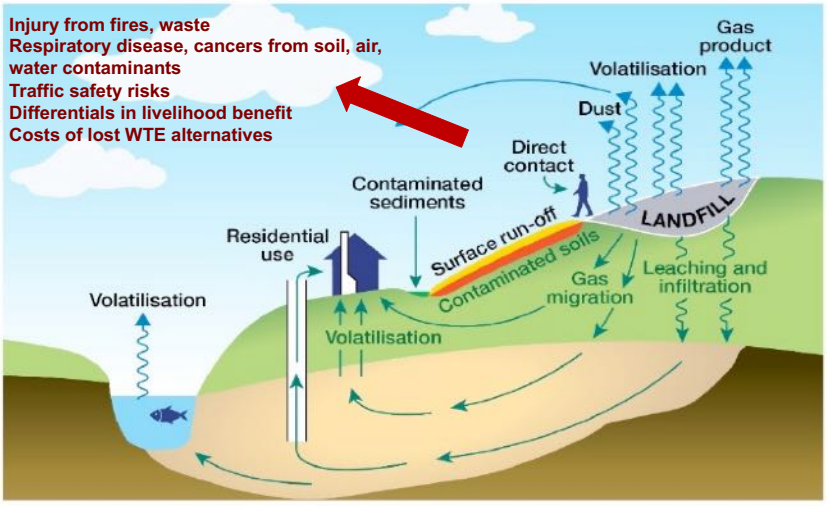
The landfill:

- Late 2025 open tender for management of the landfill.
- 2026 Establish 120 acre landfill site for a shelf life of 30 years
- Receive approximately 1000 tonnes/day of solid waste, 6 days/week
- Weighing and unloading waste, soil cover, leachate treatment.
- 5 km from a new settlement at the base of the hill, 10km from a river, 6km from a main highway, 15 km from the nearest formal urban suburb.
- Wind direction north south (variable); High rainfall May to August.
- **See the case study for details from the current landfill.**

The HIA request:

- Concerns from national health ministry and local residents associations on illness, air pollution, waste picker safety, fires in waste dumps and fires.
- EIA being implemented. Local authority has commissioned you to implement a HIA to complete before closing of the tender call in July 2025.

Proposed landfill and waste management plan in Metrozone



This figure depicts that landfill exposure could come from leaching and infiltration into land and water as well as gas migration and dust emissions. This could lead to a range of pathways of exposure from surface run-off, volatilisation from water or the landfill, or direct human contact with contaminated land, soil, water or air.

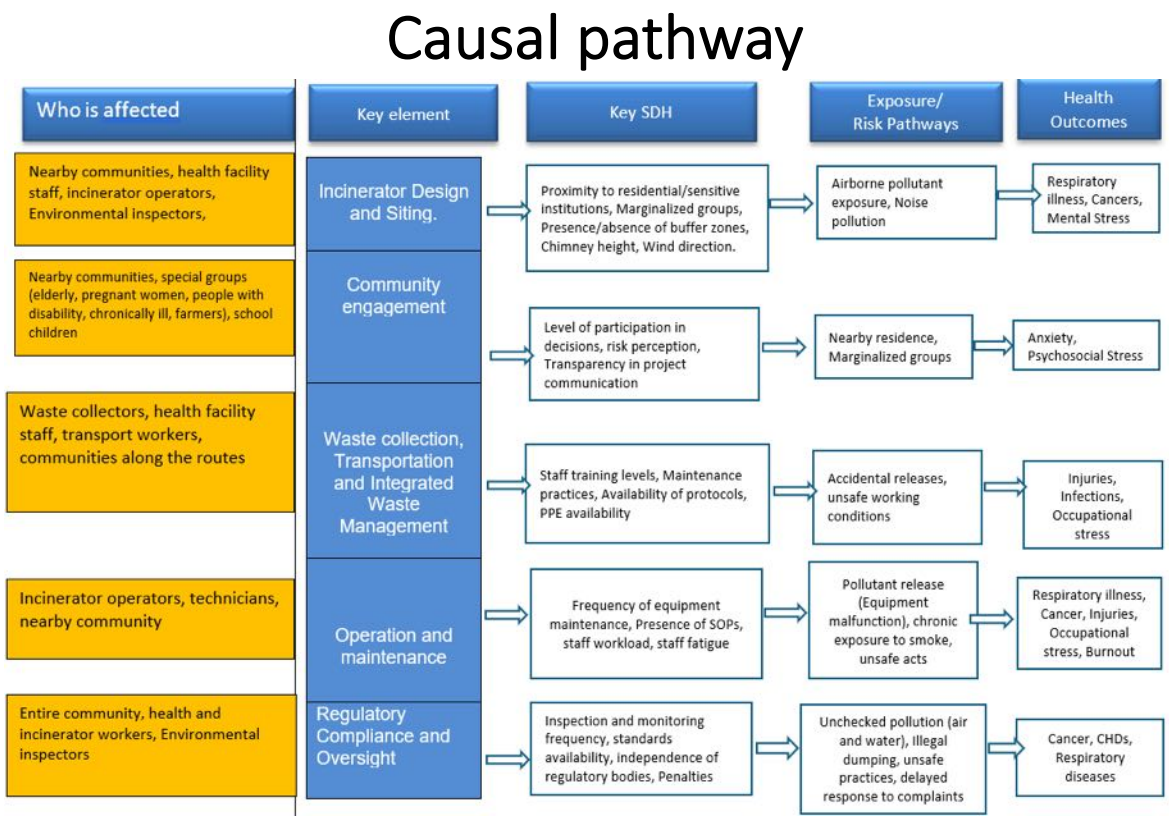
Government of UK 2024, TARSC

Slides from the landfill case study used in interactive methods sessions

2.4 TUTORIALS AND SESSION 4: Screening and scoping reports

In tutorial block 1 teams used the knowledge gained and templates to prepare their own screening and scoping reports. These reports were peer reviewed by mentors, with written review provided, and discussed in the tutorials. Teams found the review feedback and tutorials useful and prepared revised reports. In session 4, each team identified a presenter to present the policy proposal for their HIA, where it is in the policy process, the key stakeholders and proposal elements they have chosen to focus on. In the review discussions team work was appreciated. Teams were guided to be open to identifying both positive and negative impacts of the policy/ activity/ law, including in the different impacts for different groups.

The HIA is an important lever for change, so it can be useful to think about the theory of change and the steps towards the change to be able to focus on what evidence and stakeholders may be important to include in the HIA. Mentors advised to be clear about the geographical area and populations affected, including if a national policy is being reviewed using evidence from a pilot area. To assist teams producing their causal pathways the example from Team 8 (Ministry of Health and Child Care, Zimbabwe) working on a new waste incinerator proposal, shown below, was shared with other teams, with permission from team 8.This was an example of the peer-to-peer learning that took place across many of the course sessions.



In the discussion sources of data on health and SDH were also noted[6]. During the training, given the time available for the mentored HIAs, only desk review of secondary information would be expected. Teams may need to extrapolate for their setting from available data, noting any limitations and gaps in data, and, if possible, using a few focused key informant interviews to fill gaps with qualitative information. Mentors again suggested making very clear the aspects of the law/policy/ activity that are being assessed, focusing the assessment on key issues and the indicators relevant to these, and to not over-reach.

2.5 SESSION 5: Profiling and assessment and making recommendations

Profiling and assessment, (or 'Appraisal' as termed by WHO) in HIA, covered how to implement this stage, with the different levels and types of evidence to gather and estimate, and the methods and tools for this. It included how to forecast and report impacts, with their probability, magnitude, direction, duration, distribution and significance. This step is fundamental to HIA as it assesses the possible impacts on health of the intervention, so that health benefits can be maximized and risks minimized, especially for the most vulnerable social groups to reduce health disparities. This informs the later preparation of recommendations for change.

[6] UN Global SDG Indicators Database. https://unstats.un.org/sdgs/dataportal ; WHO Health Inequality Data Repository https://www.who.int/data/inequality-monitor/data ;WHO Global Health Observatory data repository https://apps.who.int/gho/data/node.main ; World Bank World Development Indicators https://databank.worldbank.org/source/world-development-indicators ;and country National Health Accounts reports and DHS reports available online.

The analysis and recommendations step was aslo introduced in this session, showing how it uses the evidence from the profiling and assessment step to set recommendations to address the impacts, with their roles and time frames. This takes into account the significance of the impacts identified in the prior step. Added to this, identifying recommendations means noting and managing trade-offs and distributional issues in impacts, and the duration of impacts, including long term effects. The recommendations aim to address negative impacts and enhance positive impacts, taking into account their distribution across areas, social groups and time. They cover alternative ways to design the policy, project, plan, or intervention to lessen anticipated adverse health effects, or to improve its health benefits. Once the core team has developed the recommended actions, they can be improved, validated and prioritised through review by the HIA steering committee.

For both the profiling and assessment and the recommendations steps the hypothetical case study, “Metrozone landfill” was used interactively with participants to show how the steps are implemented and to introduce the templates for both steps for participants to use in their own mentored case studies during the next tutorial block.

2.6 SESSION 6: Strategic HIA, writing skills and reporting the findings

One limitation of impact assessment of specific interventions that was discussed in the session is that there are often many activities happening in the same area that affect the same population. The risks or benefits from each may be judged separately and not added up. There are also projects that affect populations in nearby countries, outside the jurisdiction of an HIA. This can understate the real risks or benefits to those populations. Looking at the combined impacts of various projects in the same area, or affecting the same population in a strategic HIA provides a more realistic estimate of impacts. It enhances the prospects of health benefits for all potentially affected people. It is also in the interest of government and economic activities in that area not to leave risks unattended, or ignore ways to maximize benefits. Examples were given to show this of HIA in extractive industries in Ghana and in pulp and paper milling in Argentina.

The session also introduced how HIA is implemented along-side other impact assessments, noting the example of the Strategic Environment Assessment (SEA) protocol that WHO was involved in to integrate HIA in strategic environmental assessments.

The HIA report was noted to be a key document within the process. It describes what type of HIA was done, by whom, with what methods and what consultations. It presents the results, conclusions and recommendations. The report disseminates the HIA findings to different audiences, and allows for evaluation of process and findings by whoever needs to review it.

During this session there was thus a useful presentation on organising and communicating findings and on writing and photography skills. An outline was shared of a structure for HIA reports and links to some examples. There are also examples of HIA reports in the resources pages of the training materials.

2.7 TUTORIALS AND SESSION 7: Reporting profiling and assessment and recommendations

In tutorial block 2 teams used the knowledge gained and templates to prepare their own reports on the profiling and assessment and the recommendations for their areas of focus. These reports were peer reviewed by mentors, with written review provided, and discussed in the tutorials. In session 7, each team identified a presenter to present the policy proposal for their HIA, the causal pathway and selected priority profiling and assessment and recommendations findings.

Participants received mentor feedback on their mentored case study reports. Participants were reminded to make clear for which groups the effects are positive or negative, to directly link impacts to proposal elements and to explain their ratings so that their judgement of impacts is persuasive. If the proposal does not address a pertinent SDH/pathway measure that will have impact, then this can be included with the related element as a gap in the policy/ law / intervention to note for the recommendations. In an HIA, while the profiling and assessment is prepared by the core team, it can be validated and information added by stakeholders in the steering committee.

Generally, mentors noted the need to be specific, succinct and concrete on the recommendations, who should implement them, what the action is and any specific groups or distribution of impacts that recommendations should pay attention to. Recommendations on law enforcement or penalties should also include measures to inform or incentivise those affected to be compliant, or to adopt changes.

2.8 SESSION 8 AND TUTORIALS: Communicating the HIA and monitoring implementation of the recommendations

In the sessions on reporting there was presentation on how to set up a communication strategy/ plan for the HIA to disseminate, engage and negotiate on the recommendations and action plans, with different target groups; document agreed changes, and where needed integrate these in public health management plans/ policies. It was recommended that the HIA report first be sent to decision makers, then to all stakeholders, put in public domain and provided to media, noting that once the findings are in the media it is difficult for decision makers to ignore them.

In the last part of the training, monitoring was introduced as the final step in an HIA. It involves setting measures, processes and roles for monitoring implementation of the project/policy/ intervention to track implementation of agreed recommendations. Monitoring thus builds accountability and also assists to test assumptions and assess population outcomes.

In tutorial block 3 teams used the knowledge gained and templates to prepare their full HIA reports in line with the guidance provided on the structure. These reports were peer reviewed by mentors, and each report was also reviewed for writing style by the media consultant. Suggestions for improvements were given by all reviewers. The reviews were discussed in the tutorials. Teams revised their reports and resubmitted them. A further round of direct technical edit was implemented by TARSC on each to bring them in line with the required structure. In session 9, each team identified a presenter to present their final reports as detailed below.

2.9 SESSIONS 9-10: Presenting the final reports, evaluation and next steps

In Session 9 each team presented a brief summary of their HIA reports and their immediate next steps to the course participants, mentors and invited delegates. The latter included people from the previous course, personnel from institutions of the current 2025 participants, and people from the AEGT project, WHO AFRO and ECSA HC. The presentations were well received and comments were made on each, both to commend and to improve them. Mentors present congratulated the teams for their work and presentations. Invited guests appreciated that the HIA was done as a desk review during the training and relied on reported community views and noted that a field survey based HIA could add more community level information. One invited delegate observed that the presentations were “clear” as well as “compelling and sometimes distressing”, with actionable recommendations, especially when presented in specific detail. Another observed ”…this has been a very impressive and eye-opening presentation. This is my first time, and I've learnt a lot”. The specific comments on particular HIA case studies were used in the final round of revisions and all the HIA reports were finalised.

After the open part of the session and departure of the invited delegates, the results of the online evaluation were discussed by course participants, raising improvements and any processes, content features to change, keep or strengthen. The results are discussed in *Section 4.*

In the final session, Session 10, participants discussed what needed to take place to integrate HIA in public health law, training and practice at country and regional level in ESA. They discussed the actions and key sectors for strategic engagement to widen skills for and areas covered by HIA. This is reported in *Section 5.*

In closing remarks Dr Chissenga, ECSA HC noted the progress made in building a critical mass of capacities on HIA in the region and proposed that the HIA studies and recommendations relevant for regional level could be presented at the 2026 ECSA HC Best Practices Forum for key recommendations to be taken forward to the subsequent Directors Consultative and Regional Ministers meetings. This was widely supported and TARSC/EQUINET and ECSA HC will have follow up dialogue to take it forward. Participants who had finalised their HIA reports received certificates of completion.

3. Mentored case studies

The 40 ESA participants who completed the course were organised in 8 teams, with 3 further participants joining as individuals. The teams came from different countries, disciplines and organisational backgrounds, reflecting HIA as a multi-actor and multi-disciplinary process. The teams, their members and the broad areas of focus of the case studies are outlined below.

Team 1: UGANDA and ZIMBABWE: HIA of the implications of the High Court's ruling on Section 2(1) of Zimbabwe's Termination of Pregnancy Act [Chapter 15:10].
Team co-ordinator Oga Jessica (Team Lead)- Head of Regionalism, Afya na Haki, Uganda, Maria Birungi- Research Officer, Afya na Haki, Uganda, Ivy Chimedza-Legal Officer, Community Working Group, Zimbabwe, Lorraine Mumba-Legal Desk Officer, Community Working Group, Zimbabwe, Betty Balisalamu- Executive Director, Women with a Mission, Uganda. This HIA assessed the health impacts of the implementation of the Zimbabwe High court decision expanding grounds for abortion to include marital rape and the rape of minors. The HIA assessed consistency with constitutional and regional human rights standards, particularly under the Maputo Protocol and equity in its implementation.

Team 2: ZIMBABWE. HIA of a planned private cemetry project (Monavlei cemetery), northwest of the Prince Edward Water Treatment Plant in Harare, Zimbabwe. Team Co-ordinator. Victor K. Nyamandi Director Environmental Health Services, Ministry of Health and Child Care (MoHCC); Margaret Tawodzera Food Safety Manager MoHCC, Winfilder Dhambure Environmental Health Officer MoHCC, Rodney Mapfumo Environmental Health Officer, MoHCC, Zimbabwe. This HIA assessed plans for a Monovlei private cemetery project with a capacity of 75,450 graves northwest of the Prince Edward Water Treatment Plant along Seke Road, and less than 200 meters from a stream feeding into the raw water source, raising concerns about potential contamination of the Seke Dam water source. Noting provisions of the Public Health Act and WHO guidelines the HIA assessed siting, layout, waste management, and other public health impacts to make recommendations in these areas.

Team 3: ZAMBIA. HIA of the health, safety, and environmental impact in mining activities of the Zambia Minerals Regulation Commission Act 2024 Team Co-ordinator. Marja Hinfelaar, Director of Research and Programs, Southern African Institute for Policy and Research (SAIPAR) and AEGT country manager Zambia; Derrick Tembo Bwalya. SAIPAR Research Associate; Milanzi Moyo, SAIPAR Legal Intern; Benedict Matongo Environmental Health Officer, Ministry of Health Lukulu District Health Office; Zambia.. The HIA assessed how far the above Act integrates key areas of health impacts, including the institutional capacities needed for implementation, noting that the regulations to implement the Act are still to be passed and can integrate HIA recommendations.

Team 4: TANZANIA. HIA of the integration of health impacts in the draft Critical and Strategic Minerals Strategy Team Co-ordinator: Japhace Poncian, Mkwawa University College of Education and AEGT Country Manager for Tanzania, Chakupewa Joseph Mpambije Mkwawa University College of Education; Lucy Linus Shao, HakiRasilimali and AEGT project; Abel Kinyondo, Dar es Salaam University College of Education, Tanzania**.** The HIA focused on Tanzania's critical mining sub-sector and specifically Tanzania's draft Critical and Strategic Minerals Strategy currently under development. The HIA examined whether direct and indirect health impacts of critical and strategic minerals extraction are integrated in the strategy, including the required implementation capacities, particularly in the artisanal mining sector.

Team 5: ZIMBABWE: HIA of a small-scale mining operation and onsite milling Bubi District, Matabeleland North Province Team Co-ordinator, Lyman Mlambo, University of Zimbabwe and AEGT country manager. Zimbabwe; Perez Livias Moyo, Lecturer, National University of Science and Technology, Zimbabwe; Paul Matshona, Zimbabwe School of Mines, Farai Mutondoro, Manager for Regional Programmes, Africa Institute of Environmental Law, Zimbabwe; Pemberai Sithole, Zimbabwe, AEGT Researcher, Zimbabwe. The HIA of the small-scale gold mining operation and onsite milling in Bubi District, Matabeleland North Province, Zimbabwe assessed public health impacts of the mining and the milling activities, including health impacts of environmental effluents into downstream population water supplies.

TEAM 6: ZAMBIA: HIA of the scale up of the expanded Total Facility Approach (TFA), an evidence-based HIV stigma and discrimination reduction model for health systems within the Zambia national health strategy Team Co-ordinator, Dr Musonda Simwinga, deputy director research, Zambart, Hellen Matakala, MRT study manager, Macha Research Trust, Dr James Mulilo, eTFA Zambian study manager, Nosiku Ilukena, eTFA health economist, Zambart**.** The HIA assessed the health, health worker and institutional impacts of the national implementation of the Expanded Total Facility Approach (eTFA) piloted in one area of Zambia, in relation to the provisions of the Zambia national health strategy.

TEAM 7: DEMOCRATIC REPUBLIC OF CONGO (DRC) HIA of legal formalization of artisanal mining of critical minerals in the DRC. Team Co-ordinator: Francine Iragi Mukotanyi, Centre d'Expertise en Gestion Minière (CEGEMI)/Université Catholique de Bukavu (UCB) and AEGT Country manager; Janvier Kilosho Buraye, CEGEMI)/UCB; Philippe Dunia Kabunga, junior researcher, CEGEMI; Christian Kamala Kaghoma, CEGEMI)/UCB; Emmanuel Lurhangire Ongezi, Ecole Régionale de Santé Publique (ERSP)/ UCB. This HIA assessed the Ministerial decree 19/15 provisions to set up institutions and processes to formalize artisanal small-scale mining (ASM). The HIA assessed this in relation to the integration of health impacts of ASM in cobalt mining and the institutional capacities and mechanisms to address the health impacts.

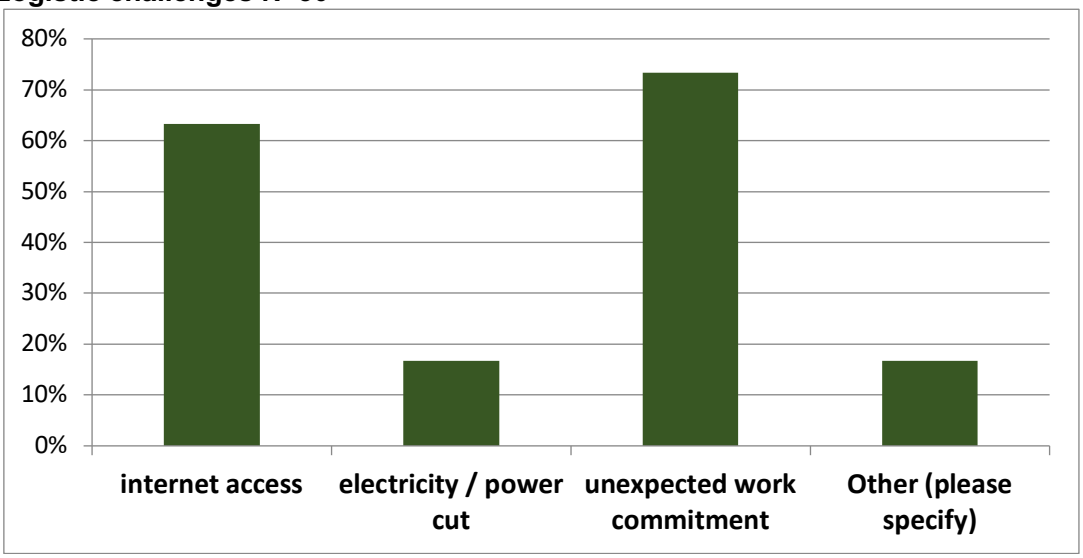
TEAM 8: ZIMABWE. HIA of a proposed construction of an incinerator in Mberengwa District in the Midlands Province, Zimbabwe. Team Co-ordinator: Punha Fusire, Envirinmental health office, Manicaland Province, MoHCC Zimbabwe; Temba Moyo, Provincial Environmental Health Officer, Midlands Province, MoHCC, Zimbabwe; Same Betera, District Environmental Health Officer, Zvishavane District, Midlands Province, MoHCC, Zimbabwe; Tafadzwa Chivasa, District Environmental Health Officer, Mberengwa District, MoHCC, Zimbabwe; Munyaradzi Murwira, Director of Health Services, Kwekwe City, Midlands Province, Zimbabwe. This HIA assessed the construction of a state-of-the-art incinerator at Mberengwa District Hospital, Midlands Province, Zimbabwe that will manage medical waste generated from the thirty-eight (38) health institutions. The HIA assessed the. incinerator design, operation, legal compliance and other factors linked to the public health risks and benefits.

4. Course evaluations

The results of the online course evaluations and follow up discussions implemented in Session 9 assessed participation, logistic challenges, the training materials, case study work, tutorials and other elements of the 2025 course.

In the evaluation, 30 people (75%) responded. The findings indicated that participants largely attended in person. They reported some logistic challenges, primarily difficulties with internet access and unexpected work commitments (see figure below).

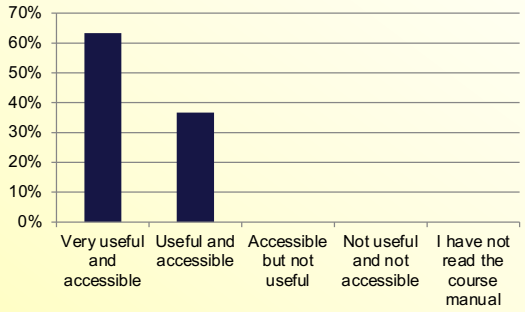
Logistic challenges N=30



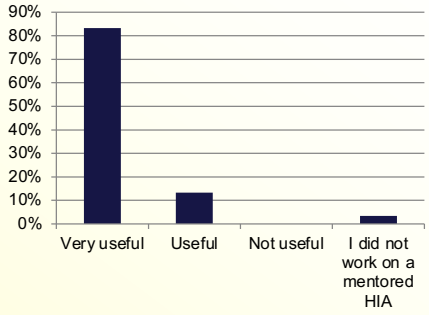
Three quarters of respondents (74%) saw no disadvantage in watching the catch up sessions online when they faced these challenges.

Poll results 3: How useful, accessible, understandable…

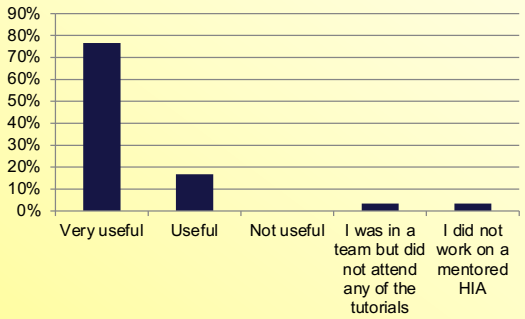
Were the training materials?



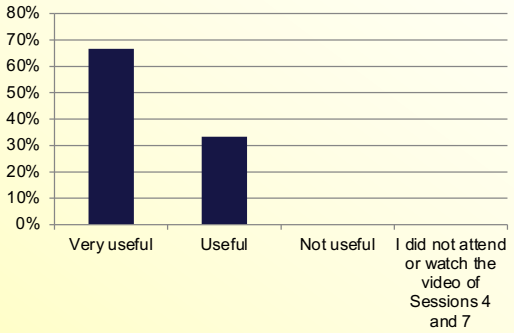
Was doing a mentored HIA?



Were the tutorials?



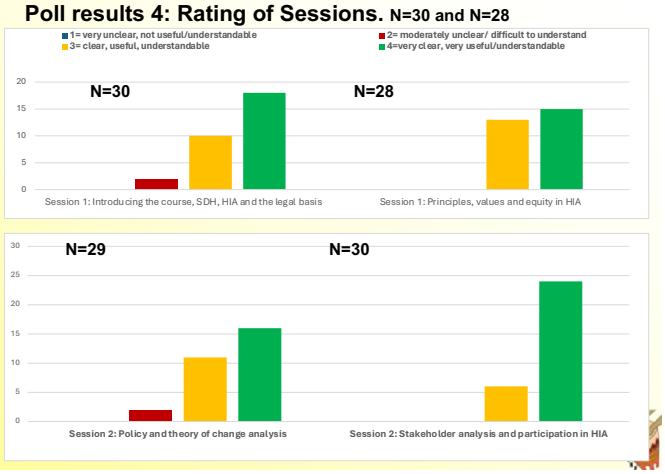
Were the HIA presentations?



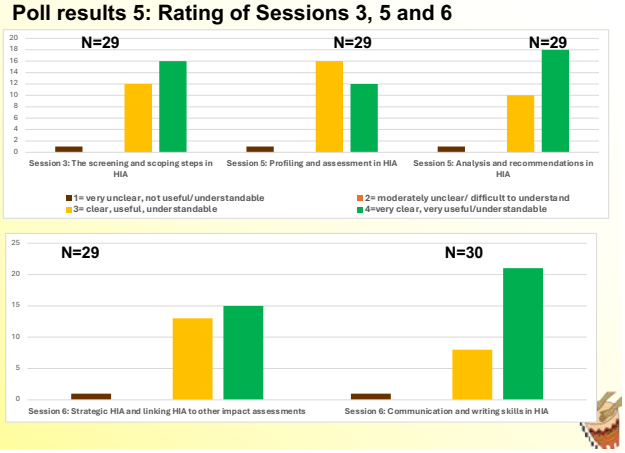
The training materials were viewed as use and accessible, the tutorials and mentored HIAs as useful or very useful, as were the presentations by participants of their HIAs for review in Sessions 4,7, and 9 (see graphs above). Participants found the work on the mentored HIA and presentations and review of this as the most valuable learning experience in the course. The inclusion of interactive work on the Metrozone landfill case study in the sessions to show the methods in practice was also appreciated.

The sessions (see the programme in *Appendix 1* for details) were largely rated as clear / very clear and understandable (See below).

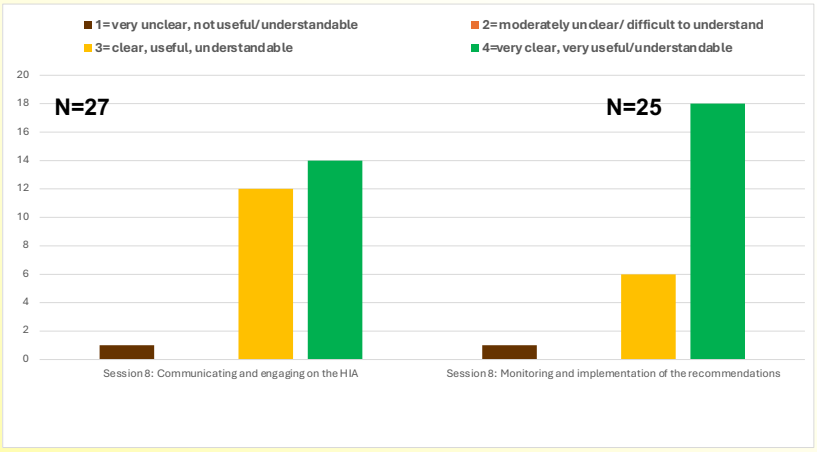
Poll results 4: Rating of Sessions. N=30 and N=28



Poll results 5: Rating of Sessions 3, 5 and 6



Poll results 6: Rating of Session 8



The profiling and assessment session presented the most difficulty for participants, albeit with the majority still finding it clear or very clear and understandable. Nearly all participants (81%) found the timing of sessions and tutorials to be appropriate.

Some comments made by participants to consider for future courses included:

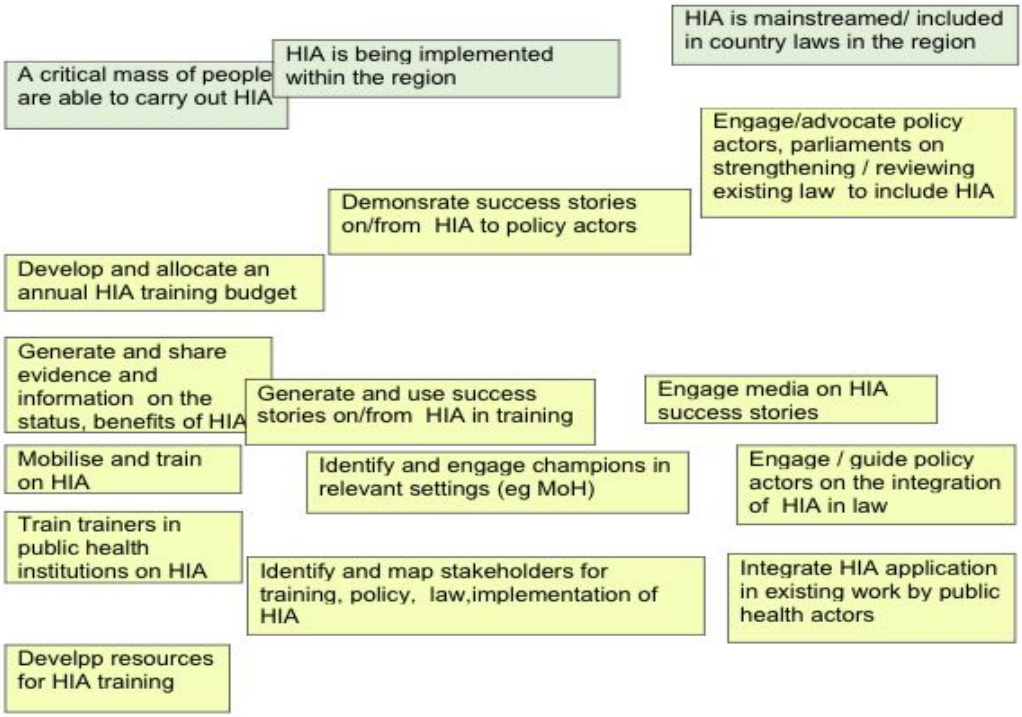
a. Participants felt that team work was extremely valuable. As one participant noted, “One finger cannot lice (Zambian proverb)”. Working as a team was seen to allow for interaction and sharing knowledge and practice, to bring diversity in the process, and cross pollination of ideas. It enables a division of labour, notwithstanding the challenges. The overall consensus was that the course should continue to involve teams doing mentored HIAs as participants
b. The consensus from discussion was that the manual and presentations were important and a resource for later use, and that the interactive case study helped in the presentations. It was suggested that more examples could be included in the materials.
c. On unexpected areas of learning from the course, delegates noted that it helped participants to learn about the value of group work and assigning each other tasks; to discover some unexpected talents from group members. It also built a new appreciation of health issues in non health sector personnel in teams.
d. It was suggested that while the course times are circulated well ahead for individuals to confirm participation before acceptance, it would be important to get the employer/ institutional director to acknowledge and confirm the participation for the sessions to avoid other work conflicts. It was noted that having access to the cloud link helped when unexpected work commitments made it difficult to attend.

All participants (100%) said they would. recommend HIA to colleagues, and would recommend *this* HIA course to colleagues. All felt that they can apply the knowledge gained in their work.

5. Next steps for HIA work

In. Session 10, a theory of change developed in 2024 was presented to trigger discussion from participants on how to institutionalise HIA in the region. The theory of change developed by the 2024 group is shown overleaf. The proposed steps were supported by 2025 participants as reflecting their own assessment of what needed to be done to institutionalise and widen HIA practice in the ESA region, while noting further issues raised below.

The theory of change to institutionalise HIA in the region



There are few people with capacity to implement HIA	EIA experts do not see the need for HIA	HIA not housed in the relevant Ministry/department	Dearth of evidence on impacts of CDOH
Limited awareness and knowledge on HIA	Policy actors do not understand HIA	Technical institutions do not understand HIA	Public health laws weak on CDOH
			Only 3 ESA countries have law / guidance institutionalising HIA

Participants made a number of suggestions for widening uptake of HIA in the region:

a. There was some discussion on the presence of and need for more sustained intersectoral forums that bring different government ministries and other agencies together for review of HIA findings and actions. Examples were given of these at local government level and on specific issues nationally (eg water, sanitation and hygiene WASH). There was, however, less certainty on whether they exist in all countries at national level as regular, sustained and more holistic platforms. Teams agreed to. follow up on whether they exist in their country at national level and to engage with them if present.
b. Stakeholder engagement could also take place through regional and/or national forums where researchers, CSOs, government agencies, and the business sector can engage in discussion on HIA and its inclusion in laws. The example was given in Tanzania of the annual National Extractive Conference (Jukwaa la Uziduaji) organised by HakiRasilimali. Another example at regional level is the ECSA HC Best Practices Forum. Key outcomes from a national meeting in Zimbabwe in August 2025 on advancing implementation of HIA can be shared.
c. HIA can be expanded if there is wider public awareness and if citizens note health challenges and trade unions can campaign to have HIA in law. Sharing the studies and stories of where HIA recommendations were implemented as this will encourage uptake, including in law. EQUINET has been supporting photojournalism to report on such success stories and invites more.
d. HIA can also be integrated into existing programmes and interventions supported by capacity building. Participants noted the opportunity to influence university curricula in health and other sectors at degree or masters levels to include a module on HIA. Zimbabwe has for example integrated a 4 week module on EIAthat builds proficiency in

this area and the same can be done with HIA. It was noted that NUST Zimbabwe has course content on HIA (and follow up will be made to obtain it). A Kemri Graduate School HIA Course (https://kgs.ac.ke/event/health-impact-assessment-hia/) was flagged. It may be useful to collect any existing course curricula and work on a regional 'model' course guideline for inclusion as a module in training programmes.

e. There was a proposal supported by the group to develop model guidelines for implementing HIA that can be modified / adapted for different sectors. TARSC/EQUINET will follow up on this and share a draft with mentors and teams for input. (This is one of the outputs that can also be tabled at the ECSA platform for policy uptake). There was discussion on integrating HIA in regional standards for the mining sector, including the SADC aim to have harmonised regional health standards.
f. A number of areas for specific research were raised. TARSC/EQUINET proposed research to assess how far EIAs include health in selected countries in the region (Zimbabwe, Zambia, Tanzania and South Africa). A protocol will be developed for this that other mentors agreed to review. There was also discussion in applying HIA in specific high investment areas.

In terms of priority sectors to be covered by HIA, the meeting noted mining to be a key sector, as well as energy, infrastructure, and the health sector. The food sector was also raised, including food processing, particularly of ultra-processed foods or of commercial monocropping reducing land for domestic food production. Waste management was also suggested as a potential area.

Climate is a key area for HIA if focused on specific activities that have climate-related impacts. EQUINET noted further that it will be hosting an online meeting on Climate, fossil fuels and health impacts with the Global Climate and Health Alliance, Federal University of Rio Grande do Sul in end September 2025. It was also proposed that HIA be included into the COP 30 climate and Health Plan that Brazil will propose to other countries as part of the COP negotiations.

It was agreed that mentors have a follow-up debrief after the course closing and that mentors and participants will meet in October 2025 to hear how the HIA reports were received/acted on within countries, and to discuss progress in proposed regional follow up.

As EQUINET, there is a commitment to continue further regional online HIA training in 2026, taking note of the review and feedback raised, and to continue to liaise with partners and policy actors in the region in moving forward.

Appendix 1: Course programme 2025

The course blocks and timings are shown below, given in Southern African time.

Timing of course block	Contents of course block and session	Facilitators
SESSION BLOCK 1 Session 1 April 28 12-2pm	Introducing the course, SDH, HIA and its legal basis. Principles, values and equity in HIA	R Loewenson (RL), S Simpson (SS)
Session 2 April 29 12-2pm	Policy and theory of change analysis, stakeholder analysis and participation in HIA	C Dora (CD), C Walyaro (CW), N Banda (NB)
Session 3 April 30 12-2pm	The screening and scoping steps in HIA, Introducing the mentored HIA work, templates and tutorials	RL, SS RL
TEAM PRACTICAL WORK & TUTORIALS 1 and 2 May 2 –May 23	Mentored HIA work on the screening and scoping steps with two 1-hour tutorials in the period 1. Clarifying the proposal being assessed and the screening and TOC 2. The scoping, policy and stakeholder analysis	Teams and their mentors
SESSION BLOCK 2 Session 4 May 28 12-2pm	Team presentation of their HIAs, group review comments and mentor comment on issues raised in the tutorials. Interim evaluation.	All mentors, delegated team presenters
Session 5 May 29 12-2pm	Profiling and assessment in HIA; Analysis and recommendations in HIA	RL, SS
Session 6 May 30 12-2pm	Strategic HIA; Linking HIA to EIA, economic impact assessment; Organising the findings and reporting the HIA; Communication / writing skills	CD RL, JM Gitari
TEAM PRACTICAL WORK & TUTORIALS 3 and 4 June 2– June 30	Mentored HIA work on (i) the profiling and assessment step and (ii) the recommendations step with two 1-hour tutorials in the period 3. Implementing the profiling and assessment 4. Implementing the analysis and recommendations and feedback on writing/ communication style	Teams and their mentors
SESSION BLOCK 3 Session 7 July 8 12-2pm	Team presentation of their HIAs, group review comments and mentor comment on issues raised in the tutorials.	All mentors, delegated team presenters
Session 8 July 9 12-2pm	Communicating and engaging on the HIA; Monitoring implementation of the recommendations,	SS RL
TEAM PRACTICAL WORK & TUTORIALS 5 and 6 July 10-25	Mentored HIA work on the monitoring and communication plan and full HIA report with two 1-hour tutorials in the period 5. Implementing the monitoring and communication plan and draft report 6. The full final report	Teams and their mentors
SESSION BLOCK 4 Session 9 July 29 12-2pm	Team presentation of their HIAs, group review comments. Final evaluation.	All mentors, team presenters
Session 10 July 30 12-2pm	Follow up – integrating HIA in public health, next steps, certification and closing	RL, all mentors, teams

Appendix 2: Delegate and Resource Person list

	NAME	INSTITUTION AND COUNTRY
	Resource persons	
1	Rene Loewenson	Training and Research Support Centre., cluster lead EQUINET
2	Belinda Ncube	Consultant, IT support, Training and Research Support Centre
3	Nathan Banda	Representative, SATUCC
4	Carlos Dora	Consultant, Brazil
5	John Mwenda Gitari	Journalist, communication and media consultant, Kenya
6	Sara Simpson	Nossal Institute of global public health, Australia
7	Connie Walyaro	Executive Director of Talk AB[M]R, Kenya
	Registered participants	
1	Jessica Oga	Afya na Haki, Uganda
2	Maria Birungi Kakinda	Afya na Haki, Uganda
3	Marja Hinfelaar	SAIPAR, and AEGT, Zambia
4	Lorraine Mumba	Community Working Group on Health, Zimbabwe
5	Betty Balisalamu	Women with a Mission, Uganda
6	Paxina Phiri	Centre for Primary Care Research, Zambia
7	Margret Zulu (*)	Centre for Primary Care Research, Zambia
8	Tina Chissenga (ECSA) (**))	East, Central and Southern Africa Health Community
9	Victor K. Nyamandi	Ministry pf Health and Child Care, Zimbabwe
10	Margaret Tawodzera	Ministry pf Health and Child Care, Zimbabwe
11	Winfilder Dhambure	Ministry pf Health and Child Care, Zimbabwe
12	Rodney Mapfumo	Ministry pf Health and Child Care, Zimbabwe
13	Michael Kandukutu	Zimbabwe Congress of Trade Unions, Zimbabwe
14	Patience Jongwe	Zimbabwe Congress of Trade Unions, Zimbabwe
15	Musonda Simwinga	Zambart, Zambia
16	Hellen Matakala	Zambart, Zambia
17	James Mulilo	Zambart, Zambia
18	Nosiku Ilukena	Zambart, Zambia
19	Matongo Benedict	Lukulu District Health office, Zambia
20	Ivonne Nkhata. (*)	Disaabled Women in Development, Malawi
21	Lyman Mlambo	University of Zimbabwe and AEGT, Zimbabwe
22	Paul Matshona	Zimbabwe School of Mines, Zimbabwe
23	Pemberai Sithole	AEGT project, Zimbabwe
24	Farai Mtondoro (*)	Africa Institute of Environmental Law, Zimbabwe
25	Perez Livias Moyo	National University of Science and Technology, Zimbabwe
26	Punha Fusire	Ministry pf Health and Child Care, Zimbabwe
27	Temba Moyo	Ministry pf Health and Child Care, Zimbabwe
28	Same Betera	Ministry pf Health and Child Care, Zimbabwe
29	Tafadzwa Chivasa	Ministry pf Health and Child Care, Zimbabwe
30	Munyaradzi Murwira	Kwekwe City Council Health Services department, Zimbabwe
31	Francine Iragi Mukotanyi	Centre d'Expertise en Gestion Miniere, AEGT, DRC
32	Janvier Kilosho Buraye	Centre d'Expertise en Gestion Miniere, AEGT, DRC
33	Christian Kamala Kaghoma	Centre d'Expertise en Gestion Miniere, AEGT, DRC
34	Philippe Dunia Kabunga	Centre d'Expertise en Gestion Miniere, AEGT, DRC
35	Emmanuel Lurhangire Ongezi	Ecole Regionale de Sante Publique, DRC
36	Japhace Poncian	Mkwawa University College of Education, AEGT, Tanzania
37	Lucy Linus Shao	HakiRasilimali and AEGT, Tanzaniaa
38	Abel Kinyondo	Dar es Salaam University College of Education, Tanzania
39	Chakupewa Joseph Mpambije	Mkwawa University College of Education, AEGT, Tanzania
40	Derrick Tembo Bwalya	SAIPAR, Zambia
41	Milanzi Moyo	SAIPAR, and AEGT, Zambia
42	Ivy Chimedza	Community Working Group on Health, Zimbabwe
43	Josue Lusambo	Centre d'Expertise en Gestion Miniere, AEGT, DRC

(*) Three participants enrolled but did not attend sufficient sessions to complete the course
(**) As an observer of the course