

Report of the Online capacity building on Health Impact Assessment in east and southern Africa, February to June 2024

Regional Network for Equity in Health in East and Southern Africa (EQUINET) July 2024



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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. 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)¹.

In 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 initiated work to provide online training and mentored case study work to build HIA capacities in multi-actor teams in ESA countries. 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 Open Society Policy Centre and Medico International.

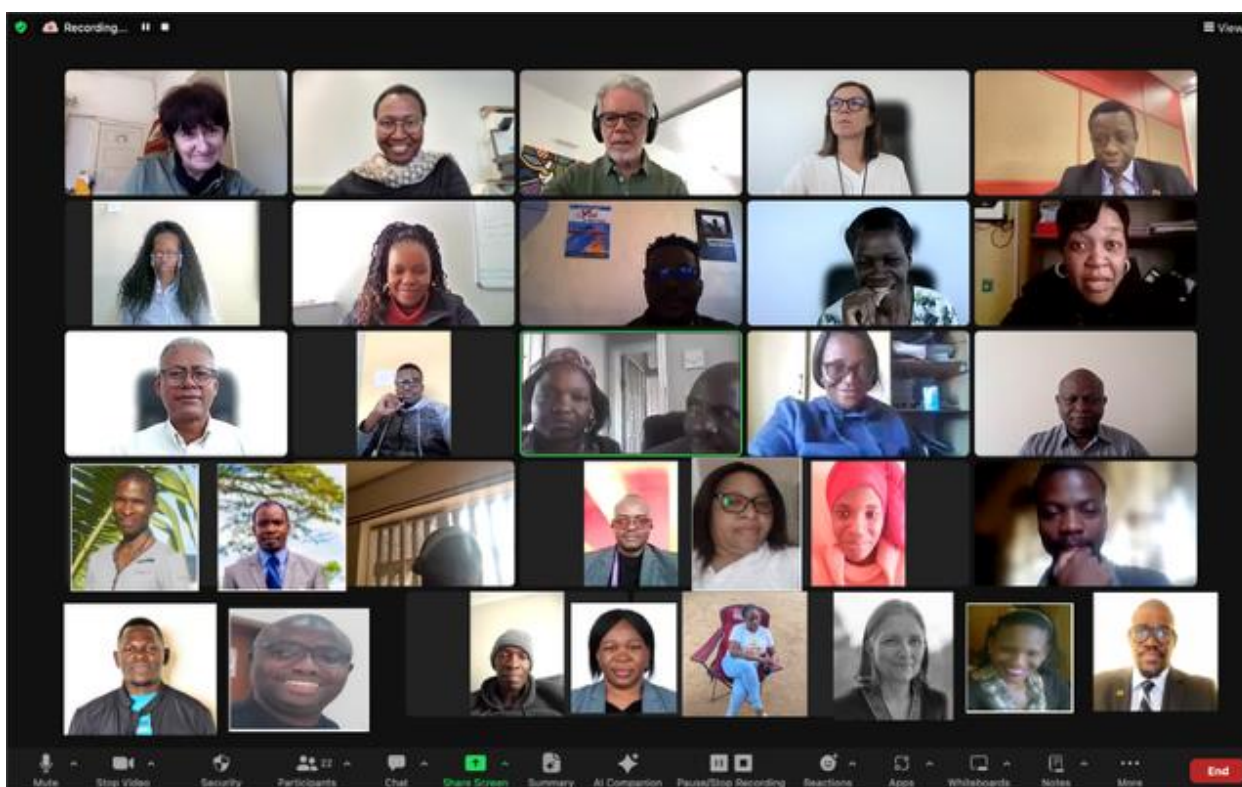
The course built understanding of the theoretical basis of HIA, and knowledge of the methods, evidence, analysis in an HIA, of reporting of and engagement on HIA, and implementation and monitoring of proposed actions. It provided mentored guidance of participant HIA practical work, using real HIA case 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.

¹ WHO AFRO (2023e) [Regional Multisectoral Strategy to Promote Health and Well-Being, 2023–2030 in the WHO African Region](#) AFR/RC73/10, Gaborone.

Before the course start date, in 2023, the course outline was developed collaboratively between the resource persons. The programme was finalised, shown in *Appendix 1*, and the course was implemented through 12 online sessions between February 20 2024 and June 4 2024. A course training manual was developed and individual presentations prepared². The course was held free of any fee cost for participants.

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 the different 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 twelve 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*.

The course organised the 29 ESA participants in eight teams for mentored HIA work, four country teams of different state, non- state, labour and professional actors; two regional teams, and two individuals, each as a team. There were two further participants from outside ESA that did not do mentored case studies, but participated in the course sessions. The mentored case study areas and teams are shown in *Section 3*.



Screenshot of resource persons and participants in a session on the online platform, 2024

All teams produced a final mentored HIA report. The course was evaluated using a zoom poll and discussion in session 6, halfway through, to address any issues raised. It was also evaluated in the final session, also using a zoom poll and discussion. The evaluation results are outlined in *Section 4*. Participants who completed the course were given a certificate of completion by EQUINET.

² Loewenson. R, Simpson S, Dora C, Banda N, Walyaro C (2023) EQUINET Training Manual: Capacity building on health impact assessment, EQUINET, Harare.

2. The course proceedings

As shown in the programme in *Appendix 1*, the capacity building was implemented in twelve online (zoom) training sessions staggered at intervals between February 20 and June 4 2024. Sessions were largely 90 minutes, with a few at 120 minutes, and held at lunch hours Southern African time on Tuesdays or Thursdays. Intervals between sessions varied to provide time for practical case study HIA work to apply the knowledge gained in the online training. After each session a summary email capturing discussion points and issues raised in the chat was sent by TARSC (RL) to all participants, together with templates in some cases to assist with practical work. The content of course presentations is largely captured in the training manual and hyperlinked readings, which is now being revised after the course. 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.

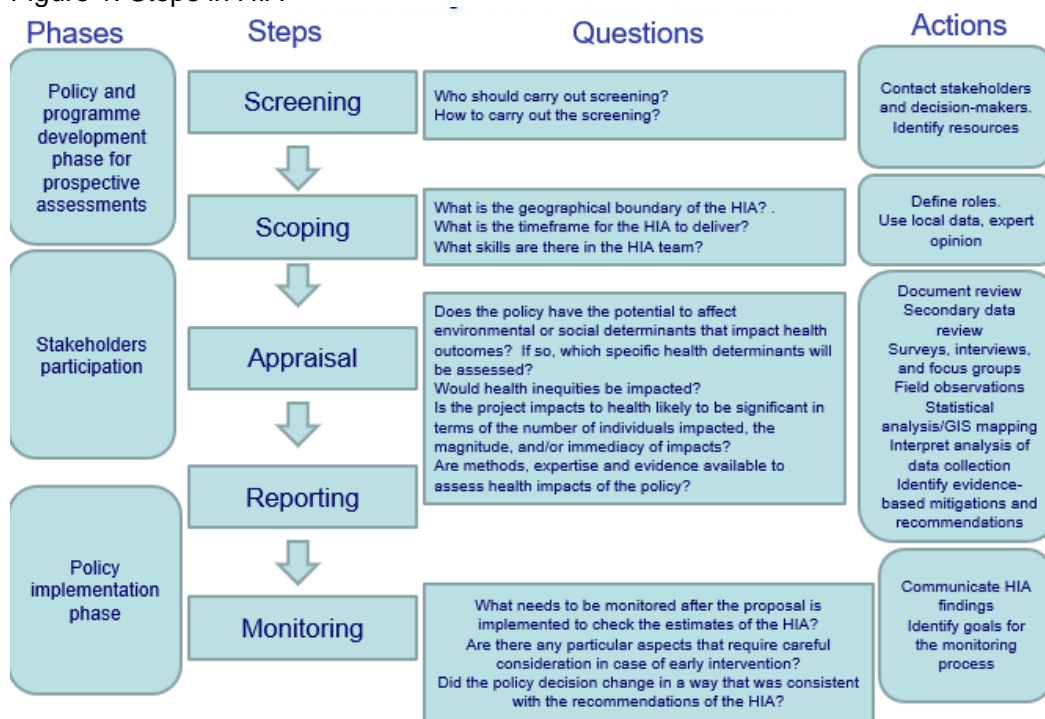
Additional slides were captured as pdfs and attached to the session summary emails sent to participants. Some session presentations were videoed for those who missed elements or for later use. Work on mentored case studies was reviewed by at least 2 course resource people for each case study, with teams assigned to the same mentors throughout the course, and all case studies also reviewed by TARSC. As shown in the programme, some sessions provided an opportunity for participants to present and get review feedback on their mentored case studies, to engage on the work and for other teams to also benefit from the feedback.

2.1 Introduction to the course and to health impact analysis (HIA)

The first session introduced EQUINET (www.equinet africa.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 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 HIA³



³ 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.

Session participants in the discussion welcomed the focus on equity, while noting challenges in measuring and tackling inequities. Many areas were raised that need HIA, such as the mining sector, in road safety, as well as new challenges and opportunities in awareness of the health impacts of and demand for mitigation strategies in climate change. It was also noted that HIA needs to encompass not only the impact of the actions of other sectors on health, but also the impact of the health sector on other sectors. A number of opportunities for implementing HIA in the ESA region were noted in the discussion, including:

- Increasing recognition of and information on public health impacts of policies and economic activities, including in the drive for 'One health approaches', comprehensive Primary health Care as a cornerstone of Universal Health Coverage, the Sustainable development Goals.
- The fact that HIA brings in different institutions and stakeholders; gathers and uses evidence in a systematic process to manage different interests.
- The review of public health law in the region opening space for legal provision of HIA, with HIA practice and capacities adding weight to the opportunities of applying HIA in law.
- The ECSA Health Community strategic plan in 2024 opening an opportunity for inclusion of HIA in assessing and monitoring key regional policy goals and strategies.

Implementing and institutionalising HIA was further discussed in the final session.

2.2. Legal, values and policy basis for HIA

This session introduced some foundational principles and norms that apply across all stages of HIAs. It covered the legal frameworks for HIA, and the laws that provide for HIA, including in ESA countries. A national legal framework helps to institutionalise HIA. There is a legal requirement for EIA in all ESA countries. While health impact assessment can be done using general public health law, not having a specific law requiring HIA in ESA countries was noted to weaken the demand for HIA to be implemented in practice. 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, and also steps 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 2018⁴ 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.

⁴ Republic of Zimbabwe, [Public Health Act CH15:17, 2018](#),

The session also 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 also 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.

The discussion covered the composition of an HIA working/steering group, noting that the composition depends on the policy or project proposal being assessed. Inequities also point to groups who might need to be included, and the issue suggests capacities, resources and experience to involve. Some of the issues raised on what should be measured, on principles guiding participation in an HIA, or ways of evaluating the success of an HIA, were covered in later sessions. Documents on evaluating the HIA itself were shared⁵. Pertinently it was noted and welcomed that the definition of health in HIA covers the wide understanding of physical, mental, social – and ecosystem- wellbeing, and not only absence of disease.

The proposed areas for the mentored HIAs were shared and feedback given to ensure a manageable focus, to be clear on context and background, to identify key stakeholders and interests pertinent to the HIA, to avoid focusing only on benefits and not risks, and to consider the feasibility of the proposed HIAs given the available evidence and time for the mentored HIA.

2.3 Screening, stakeholder analysis, and social determinants of health

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 session included, as an element of the screening, 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 final 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.

In the discussion, participants noted that some HIAs need to piggy back on someone else's assessment, such as EIA. The screening step is the time to think through the issues in doing this, given that it engages two different decision-making processes and legal frameworks. 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. Participants also observed that addressing equity raises political dimensions and communication as an element of HIA, including to engage public opinion and understanding, and assess if the momentum or political will is there for the issues HIA will raise.

⁵ Kareen Nour, Astrid Brousselle, Julie Loslier, Mélanie Lepage, Pernelle Smith et al. (2019) Evaluation of the Effects of Health Impact Assessment (Hia) Practice in Monteregie . International Journal of Global Health - 1(1):1-10. <https://doi.org/10.14302/issn.2693-1176.ijgh-18-2523>; Harris E, Haigh F, Baum F, Harris-Roxas B, Kemp L, Ng Chok H, Spickett J, Keleher H, Morgan R, Harris M, Dannenberg AL. The Effectiveness of Health Impact Assessment in New Zealand and Australia 2005-2009. Sydney: Centre for Primary Health Care and Equity, Faculty of Medicine, University of NSW, 2013.

In the subsequent session the mentors gave feedback on the screening reports presented by teams. They suggested that implementers of HIAs not position themselves as advocates for the proposal assessed as it can be read as bias, and 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 start estimating/ quantifying numbers affected in the screening step, as well as the geographical area affected, and the immediacy or long term nature of the impacts, and to identify if concerns had already been raised on the proposal/activity/law, including to mobilise support for the HIA and to inform the scoping stage.

2.4 Scoping, and participation in HIA

The next sessions covered the Scoping step in HIA and how to do it, with 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.

The session also covered how to integrate participation by affected communities in the HIA, 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 observed that we need to keep in mind the power imbalances within engagements, including between the community and the HIA implementers and other stakeholders, as well as to appreciate that community representatives also have vested interests. It was also suggested that we need to popularize HIA. If communities are aware of HIA this would increase their informed participation.

In the discussion on the scoping reports it was suggested that data in UN, local statistics offices and online reports could be useful. Some sources of data on inequalities in health and SDH were shared⁶. 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 not to over-reach.

2.5 Profiling and assessment in HIA

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.

Participants received mentored feedback on their profiling and assessment reports. They 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.

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.

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.

One limitation of impact assessment of specific interventions that was further 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 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.

2.6 Analysis, recommendations, and communicating the findings

The analysis and recommendations step was introduced, 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.

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 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.

In the sessions on reporting there was also 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.

Participants received mentor feedback on their mentored case study reports. 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. It was noted to be useful to indicate if additional resources may be needed to implement the recommendation, or if it will be integrated within existing programmes and budgets, and to point to resource pools that can be used for the recommendation.

Some recommendations made in the HIA reports included improving awareness of affected groups. Mentors suggested that such recommendations need to also include any inputs or conditions that will enable people to act on new information or to change behaviours. Recommendations on law enforcement or penalties should also include measures to inform or incentivise those affected to be compliant, or to adopt changes. Finally it was suggested that recommendations could be sequenced in the text summaries in the reports, so that those that are foundational for other areas of action or that are more immediately applicable appear first.

2.7 Monitoring implementation of the proposals and next steps

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 the final sessions, participants discussed what needed to take place to integrate HIA in public health law 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. They also raised suggestions on how they would use their HIA case studies and ideas for future capacity building courses on HIA. This is reported in *Section 5*.

The session included an online evaluation and discussion to review the course, reported in *Section 4*, raising areas for improvement and any processes, content features to change, keep or strengthen.

Participants who had finalised their HIA reports received certificates of completion in June. In closing remarks Professor Dambisya DG of ECSA HC acknowledged the contributions of mentors, TARSC, EQUINET and the IT support and commended participants for their consistent and active participation and work on their case studies. He noted that the course was a learning experience for all, looked forward to further rounds of training. He indicated that this would be raised also in the future ECSA HC Health Ministers' conference in June 2024.

3. Mentored case studies

The 27 ESA participants were organised in 8 teams. two teams as individuals. Two other participants who were from outside the ESA region participated in the course but did not do a mentored case study. 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: REGIONAL. Team co-ordinator Thulani Ngcamphalala Swaziland Migrant Mineworkers Association Eswatini, with Kgomotso Bhebhe and Lucky Dube Ex-Wenela Miners Association Zimbabwe and Richard Tamva, Ex-miners Association of Malawi.

The policy reviewed in a concurrent HIA is the regional level Cross Border Referral System (CBRS) servicing mineworkers and ex mineworkers to improve diagnosis and treatment of TB and other occupational lung diseases when workers move from one country to another, tracking clients and patients. The HIA assessed the health impacts of selected features of the system drawing secondary evidence and a small number of key informants from Malawi, Eswatini and Zimbabwe.

Team 2: MALAWI. Team Co-ordinator. Wilson Asibu, Country Minders for Peoples Development, with Ndizi Machilika, Malawi Network of Community Health Workers, Levison Masamba and Blessings Sabao, CMPD.

The retrospective HIA assessed using secondary and photographic evidence, and selected key informant interviews features particularly related to urban environments (waste management, access to safe water) of the 2019 Malawi National Urban Policy in sites in Lilongwe. It particularly focused on health impacts of the implementation provisions for the identified areas of the policy, and the relevant legal rights and duties.

Team 3: KENYA. Pascal Mukanga and Allan Ouko K'oyoo, both Kounkuey Design Initiative The prospective HIA implemented in Mukuru informal settlement Nairobi assessed health impacts related to pollution of the Ngong river (solid waste and sewage from households and untreated liquid waste from industry) in relation to the County Environmental Health and Sanitation Bill 2016. It used a range of secondary and mapping evidence to assess the distribution and scale of impacts.

Team 4: SOUTH AFRICA. Nosimilo Mlangeni Institute for Occupational Health, working with Boledi Susan Moraba and Collen Jolobe Social and Environmental Justice in Action This prospective HIA assessed a proposed draft occupational health and safety (OHS) policy for farm workers in South Africa, covering also HIV and TB. The policy development is being done in

collaboration with tripartite parties, ie the government (Department of Employment and Labor, Department of Agriculture, National Institute for Occupational Health), the employer (s), and the labor representatives. Identified elements of the draft policy document were assessed using secondary evidence to inform the policy development process.

Team 5: ZIMBABWE: Team Co-ordinator, Nonjabulo Mahlangu, Community Working Group on Health (CWGH) working with Mandy Mathias, Mongie Khumalo, CWGH, Racheal Mafura, Food Federation and Allied Workers Union, Benice Maluleke Zimbabwe Banks and Allied Workers Union and Jokoniah Mawopa, Food Federation of Trade Unions Zimbabwe.

This team assessed informal sector activity is food handling in the preparation, processing, storage, and sale of food items in Bulawayo as set in local by-laws under the Public Health Act, the Food and Food Standards Act. Local by laws are under review and the HIA assessed the health impacts of the standards and their implementation on informal food vending to inform current policy dialogue in the city and at national level.

TEAM 6: REGIONAL: Team Co-ordinator, Adelheid Onyango, World Health Organisation (WHO) AFRO region working with Chiara Retis, Fikru Tullu, Doris Kirigia, Laetitia Ouedraogo, and Jeremiah Mushosho, all of WHO AFRO

WHO has partnered with other UN agencies and governments in an initiative to assist farmers in shifting from tobacco growing to alternative crops that are nutritious and economically viable. This prospective HIA covered the proposed initiative in Zambia to assess the impact of the proposed interventions on food and nutrition security, school attendance by children from farming households, economic benefits and exposure to health risks and recommend changes to improve the initiative.

TEAM 7: UGANDA Florence Bukenya, Youth Alive Uganda;

The Uganda Value Added Tax (Amendment) Act, 2023 applied an 18% Value Added Tax on diapers for both adults and children. This retrospective HIA assessed the health impact of the 18% Value added tax on child and adult diapers, drawing evidence from national level and from Kampala City to inform policy engagement on future reviews of the Act.

TEAM 8: SOUTH AFRICA Moeketsi Modisenyane, Department of Health, South Africa;

This prospective HIA assessed selected areas of intended and unintended positive and negative health and health service impacts of the inclusion/ exclusion of asylum seekers in the provisions of the National Health Insurance (NHI) Bill in South Africa. The HIA drew on evidence from the ILO and UNHCR, South African government data and other secondary documents. The HIA aims to inform policy dialogue on inclusion of asylum seekers in the NHI scheme and its implementation.

4. Course evaluations

Online course evaluations and follow up discussions were implemented in Session 6 and Session 12. In Session 6 the evaluation assessed participation, logistic challenges, the training materials, team work and the first 5 sessions. The Session 12 evaluation assessed similar issues and the information shared in Sessions 7-10. This section of the report combines the information from both evaluations.

In the Session 6 interim evaluation, 23 people responded. Participants reported some logistic challenges, primarily difficulties with internet access (48%) and unexpected work commitments (48%). The training materials were viewed as easy or very easy to understand by 78% of respondents.

The sessions (see the programme in *Appendix 1* for details) were largely rated as clear / very clear and understandable: Session 1 (Introduction to HIA) by 91% of respondents; Session 2 (law and policy on HIA) by 70%; Session 3 (Screening) by 74%; Session 4 (Screening review and SDH) by 78% and Session 5 (Scoping) by 52%. The scoping session thus presented the most difficulty for participants with 48% finding it less clear and understandable. For the 19 respondents actually working in a team, 84% found it easy or very easy to work in a team.

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

- a. On timing: holding sessions later in the day, or holding two sessions in the day for people who have timing difficulties to join; and having more time between sessions when participants need to do or revise assignments on their HIA.
- b. Keeping the teams, as it means that if one member misses the team members can brief them.
- c. Keeping the training manual as it provides a lot of the useful information, but using more graphics in the materials, and including the reporting templates but making them shorter where possible.
- d. Having opportunities to engage with mentors between the sessions, with participants noting that mentor feedback is clear and useful.

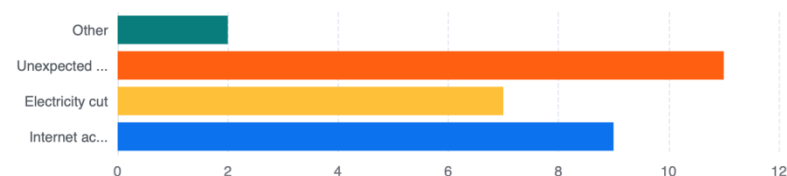
A comment was “The team is doing extraordinary work and follow-up and support is very helpful”.

In the end of course Session 12 zoom evaluation, 19 people responded. In addition to the questions in the interim evaluation, participants rated sessions 7-10; how useful the process of working on and getting feedback on a mentored HIA was; and what they found most useful for their learning skills on HIA in the course. Participants were also asked if they would recommend learning how to do an HIA to colleagues; whether they would recommend this HIA course to colleagues and whether they felt they could apply the knowledge gained from the course in their work.

Course participation was high, with 84% of participants actively attending nine or more of the 12 sessions. The adjacent graph shows the issues faced with participation, with the greatest challenge from unexpected work commitments, followed by internet access and electricity cuts affecting internet and laptops.

2. Have you faced any of the following logistic problems? (Multiple choice) *

(19/19) 100% answered



All respondents found the training materials easy / very useful and accessible. In terms of the rating of the sessions, the percent finding the sessions as clear / very clear and understandable were

- Session 7: Profiling and Assessment step in HIA 68%
- Session 8: Reporting HIA findings 64%
- Session 9: Analysis and recommendations in HIA 84%
- Session 10: Reporting, engaging and monitoring in HIA 63%

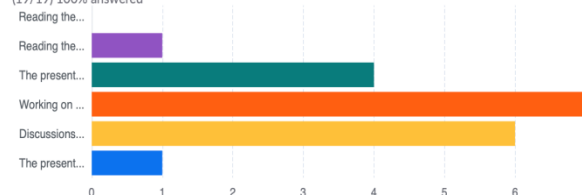
Almost all (95%) of respondents found working on and getting feedback on a mentored HIA useful or very useful.

The adjacent figure and percentages below indicate the areas respondents found most useful for their learning skills on HIA in the course (participants could choose only one)

- The presentations of key topic areas – 5%
- Discussions and working with examples during presentations – 32%
- Working on a mentored case study and getting mentor feedback – 37%
- The presentations and discussion of mentored case studies – 21%
- Reading the training manual – 5%
- Reading the resources in the reading list – 0%

9. What did you find most useful for your learning skills on HIA in the course? (Single choice) *

(19/19) 100% answered



All participants (100%) said they would recommend learning how to do an HIA to colleagues; and all (100%) said they would recommend this HIA course to colleagues. In terms of applying the knowledge gained from the course in their work, 63% felt that they could, while 37% said that they partially could. In the discussion the latter felt they needed to read more and implement more HIAs to build experience and confidence.

5. Next steps for HIA work

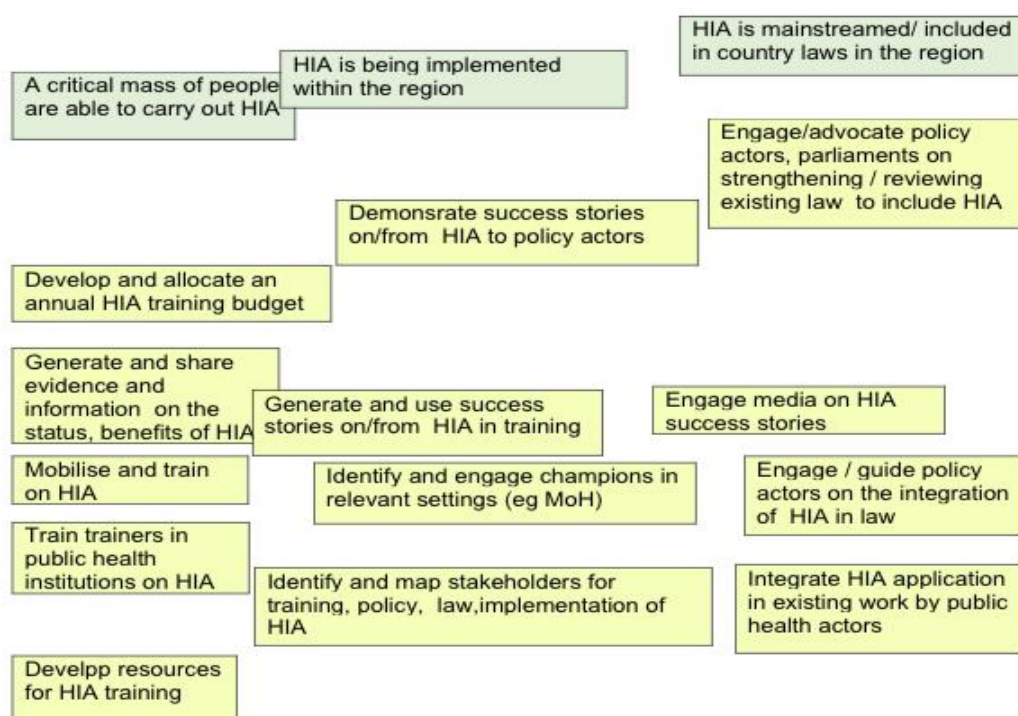
In the discussion in the last sessions a number of suggestions were made collectively for widening uptake of HIA in the region:

- On key sectors/ areas for HIA implementation, those noted included the mining/extractives sector, large infrastructures, including energy infrastructures; development and commercial investments including those related to climate; and trade and investment agreements, including within the AfCFTA, African Commodities Strategy
- It was noted that for earlier uptake it will be important to engage key sectors and connect HIA with other areas of impact assessment where legal frameworks for impact assessment already exist, eg environment impact assessment, economic impact assessment, social impact assessment. This implies that the health sector understand and engage the role of other sectors/actors as encouraged in the HIA methods, while being clear on the health-related issues, principles, duties and methods.
- In the medium term (longer/shorter in different countries) it will be important to amend public health law to include HIA to ensure / mandate this practice.
- To take HIA forward we need improved skills in those engaging on policy or potential implementers in the health community, including public health actors in government (health ministries and field personnel such as environmental health practitioners), local government, in key health-related sectors eg mining, agriculture; in civil society, trade unions, and those in academia who train others. HIA could target staff within the national and county government public health department as many laws and by-laws come out of those departments, and target NGOs working in the health sector, particularly in the underserved neighbourhoods.
- Creating the critical mass at academic institutions would be important for widening skills, and for policy advocacy. HIA should be integrated in public health training at universities, technical and vocational colleges. While raising awareness may need shorter inputs, deeper skills training benefits from practical work.
- It is important to widen awareness and benefits of HIA as a tool for health and others. Those that need to be reached for this are those actors noted above, and those in parliamentary committees and policy forums, including in related sectors (mining, environment, economic, trade) and in the academic sector. Forums such as the climate COP, Mining Indaba and other forums can be used to widen awareness.
- Those in the course were seen to represent a first step in building a critical mass. In moving forward as a region, participants noted the key role of WHO, as well as institutions involved in investments, such as African Union, African Development Bank, COMESA, SADC, EAC, and ECSCA HC. EQUINET remains committed to advancing HIA, and appreciates the partnerships with others on this, such as in this course.

During the May 2024 EQUINET Regional meeting on urban health and commercial determinants of health participants with experience of HIA carried out an exercise to develop a theory of change for widening capacities in HIA and inclusion of HIA in law in the ESA region. (See adjacent photos of the group preparing and explaining the HIA). The theory of change developed by the group is shown overleaf. It was presented to the course participants in Session 12 and the proposed steps supported by participants as reflecting their own assessment of what needed to be done to institutionalise and widen HIA practice in the ESA region.



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

It was generally agreed that having a critical mass of people with capabilities to implement HIA will enable practice. It would also enable scientific and technical peer review of HIA findings and reports to strengthen their quality and validity. The quality of HIA work would be further strengthened by regional exchange of experience and information. Widening capacities was noted to help to identify the sectors where HIA needs to be more routinely implemented, due to the level of health risks or potential for improvement of health. In ESA countries, this may include mining, energy, service and infrastructure projects, amongst others.

The WHO Regional Committee strategy on Multisectoral Action for Health noted earlier includes a commitment to widen assessment of health impacts. In 2024, the ECSA Regional Health Ministers Conference resolved to institutionalise health impact assessment, as shown in *Box 2* below. Countries would need to translate this regional policy support into national health strategies and plans.

Box 2: The formal resolutions of the 2024 ECSA Regional Health Ministers Conference included the following on HIA:

EXTRACTED from Recommendation 8 taken from Resolutions of the 73rd ECSA Health Ministers Conference, 20-21 June 2024 ECSA/HMC73/R8: Mitigating the effects of climate change on health

Now therefore,

Urges the Member States to:-

7. Harmonize local and national laws, policies and regulations by integrating and institutionalizing relevant evidence, including health impact assessments to strengthen public health systems.

Directs the Secretariat to:-

1. Support the member states to develop metrics and implement health impact assessment to monitor the effectiveness of climate and health interventions and regularly report on progress.

Experience in other regions indicates that having an identified focal point/leadership within health ministries and a multi-actor national working group is important to support the implementation of HIA. In the session discussion, participants said that health sectors can link to and begin to implement HIA alongside or in co-operation with other sectors implementing impact assessments, including EIAs and economic impact assessments, such the economic impact assessments implemented by the African Development Bank, or as was implemented on oil extraction in Ghana⁷.

This was seen to call for a wider level of institutional and professional capacities on HIA methods than currently exist in many ESA countries and key institutions. However, it was felt that HIA capacities can be easily built in those with public health capacities, already widespread in most ESA countries, particularly if integrated in existing training, including in-service training, within the state, academia and various sections of civil society. This will be particularly facilitated by those teaching in public health schools, medical schools, technical colleges, universities and other institutions integrating HIA skill-building as part of the professional training.

A national legal framework was also seen to help to institutionalise HIA. There is a legal requirement for EIA in all ESA countries. There is a lot that can be done as above using general public health law. However, not having a specific law requiring HIA in ESA countries weakens the demand for HIA to be implemented in practice. 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.

Finally, some follow up steps were agreed at the end of the course, including:

- a. For mentors to have a review meeting to discuss how to improve future iterations of the course;
- b. To produce a short information brief on HIA, what it is and why do it that can be used in various places to raise awareness on HIA, and stimulate interests and follow up;
- c. To hold a review meeting in late August with all participants to see what follow up they have made on their case studies and/or HIA skills;
- d. For the core team to revise the training manual based on the inputs and learning of what worked and what didn't from the training in 2024.

As EQUINET, there is a commitment to continue further online HIA training taking note of the review and feedback raised and to liaise with partners and policy actors, including WHO AFRO and ECSA HC in moving forward.

⁷ Nyonator F, Clark E (2012) [Oil and gas development and health in Ghana](#), GHS,

Appendix 1: Course programme

February 20 2024 to June 4 2024

(*all times shown as Southern African time

Resource persons: Dr Rene Loewenson, TARSC; Ms Sarah Simpson, NIGH; Dr Carlos Dora, Mr Nathan Banda, SATUCC, Ms Constance Walyaro, TalkAB[M]R and Prof Yoswa Dambisya, ECSA Health Community

Session	Content and process	Presenter/ facilitator	Timing(*)
SESSION 1 Introduction to the course and to HIA	<p>Introductions Introduction to the course, EQUINET, participant teams, resource people course aims, process, resource materials, and communications</p> <p>Introducing HIA Definition of, motivations for and key steps in an HIA Different forms/ types and levels of HIA</p> <p>Discussion on HIAs, enablers and barriers to doing them</p>	<p>Rene Loewenson All Other resource persons will also join the session</p> <p>Rene Loewenson</p> <p>All</p>	<p>Tuesday February 20th 1pm- 230pm</p>
SESSION 2 Legal, values and policy basis for HIA	<p>Legal, policy and public health basis for doing HIA</p> <p>Principles, values and equity in HIA</p> <p>Policy analysis for HIA</p>	<p>Rene Loewenson</p> <p>Sarah Simpson</p> <p>Carlos Dora</p>	<p>Thursday February 22nd 1pm-3pm</p>
Policy analysis on HIA	<p>Participant team 5 minutes introduction (each) of their mentored HIA, expected result from doing it, the policy basis and intended audience. Review feedback</p>	<p>Nathan Banda Participants With R Loewenson, S Simpson, C Dora</p>	<p>5-minute break at 2.10pm</p>
SESSION 3 Screening in HIA	<p>Introduction to the Screening step in HIA. Interactive session</p> <p>Associated skills area- Stakeholder analysis</p>	<p>Rene Loewenson</p> <p>Connie Walyaro</p>	<p>Tuesday February 27th 1pm- 215pm</p>
Stakeholder analysis	<p>Introduction to participant assignment on applying the screening step to the team HIA [purpose, response to screening questions, decision on HIA type, target group, evidence sources]</p>	<p>Rene Loewenson <i>Team to submit written report 7 March and to present 12 March</i></p>	
SESSION 4 Screening in HIA	<p>Team presentation and review feedback on HIA Screening reports. Discussion</p>	<p>Connie Walyaro Team presenters All resource persons reviewing</p>	<p>Tuesday March 12th 1pm- 230pm</p>
Social determinants of health and health equity	<p>Associated skills area: Social determinants of health and health equity</p> <p>Follow up participant assignment: Strengthen HIA screening step reports integrating review feedback, health equity and SDH analysis</p>	<p>Rene Loewenson</p> <p>Rene Loewenson <i>Team to submit revisions with scoping stage report 22 March</i></p>	
SESSION 5 Scoping in HIA	<p>Introduction to the Scoping step in HIA Interactive session</p>	<p>Sarah Simpson</p>	<p>Thursday March 14th 1pm- 230pm</p>
Community participation in HIA	<p>Associated skills area- Community participation in HIA</p> <p>Introduction to participant assignment to carry out the scoping step for their HIA (SS 5 minutes)</p>	<p>Nathan Banda</p> <p>Sarah Simpson <i>Team to submit written report 22 March and to present 26 March</i></p>	

Session	Content and process	Presenter/ facilitator	Timing(*)
SESSION 6 Scoping in HIA	<p>Team presentation and review feedback on HIA Scoping reports. Discussion</p> <p>Brief check on participant evaluation of the course to date. Discussion</p> <p>Follow up participant assignment: Strengthen HIA scoping reports integrating review feedback and community participation inputs</p>	<p>Sarah Simpson Team presenters All resource persons reviewing</p> <p>Rene Loewenson</p> <p>Rene Loewenson <i>Team to submit revisions with profiling stage report by 16 April</i></p>	<p>Tuesday March 26th 1pm-230pm</p>
SESSION 7 Profiling and assessment in HIA	<p>Introduction to the Profiling and Assessment step in HIA Interactive session</p> <p>Profiling and assessment in a strategic framework Interactive session</p> <p>Follow up participant assignment: Carry out the profiling and assessment step for their HIA</p>	<p>Rene Loewenson</p> <p>Carlos Dora</p> <p>Rene Loewenson <i>Team to submit written report 16 April and to present 23 April</i></p>	<p>Thursday April 4th 1pm-3pm</p> <p>5 minute break at 2pm</p>
SESSION 8 Profiling and assessment in HIA	<p>Team presentation and review feedback on their HIA Profiling reports. Discussion</p> <p>Introduction to reporting the HIA</p> <p>Associated skills area: Reporting the HIA, organising and communicating findings</p> <p>Follow up participant assignment: Strengthen HIA profiling and assessment reports integrating review and reporting skills input.</p>	<p>Rene Loewenson Team presenters All resource persons reviewing</p> <p>Carlos Dora John Mwenda</p> <p>Rene Loewenson <i>Team to submit revisions with analysis report 2 May</i></p>	<p>Tuesday April 23rd 1pm-3pm</p> <p>5 minute break 1.55pm</p>
SESSION 9 Analysis and recommendations in HIA	<p>Introduction to the Analysis and Recommendations step in HIA Interactive session Discussion on implementation issues</p> <p>Follow up participant assignment: Carry out the Analysis and recommendations step for their HIA</p>	<p>Sarah Simpson</p> <p>Sarah Simpson <i>Team to submit full written report 2 May and to present 7 May</i></p>	<p>Thursday April 25th 1pm-230pm</p>
SESSION 10 Reporting and engaging on and Monitoring actions in an HIA	<p>Team presentation and review feedback on their HIA profiling, assessment, analysis and recommendations report. Discussion</p> <p>Communicating and engaging on the HIA Discussion</p> <p>Monitoring the implementation of the proposal Discussion</p> <p>Follow up participant assignment: Finalise team HIA reports including reporting / review targets, a communication plan and areas for monitoring implementation</p>	<p>Yoswa Dambisya Team presenters All resource persons reviewing</p> <p>Sarah Simpson Carlos Dora</p> <p>Rene Loewenson Nathan Banda</p> <p>Rene Loewenson <i>Team to submit full reports 16 May and to present 21 May</i></p>	<p>Tuesday May 7th 1pm-3pm</p> <p>5 minute interval at 1.55pm</p>

Session	Content and process	Presenter/ facilitator	Timing(*)
SESSION 11 Reporting and engaging on and monitoring actions in an HIA Integrating HIA in public health law and practice	Team presentation and review feedback on HIA reports, reporting targets, communication and monitoring plans Discussion Discussion: Integrating HIA in public health law and practice at country and regional level and widening HIA skills Next steps for HIA case studies and teams.	Rene Loewenson Team presenters All resource persons reviewing Rene Loewenson All Yoswa Dambisya All	Monday May 20th 1pm-3pm 5 minute interval at 1.55pm
SESSION 12 Next steps Moving from capacities to practice Course evaluation Certificates and closing	Course evaluation (RL 20 minutes) Discussion: Review and reflection on the course. Areas for improvement Discussion: Next steps for the team reports, future courses and law Presentation of participant certificates Acknowledgements, Final comments Course closing	Rene Loewenson All Yoswa Dambisya, Connie Walyaro, All Rene Loewenson Nathan Banda, All Rene Loewenson Yoswa Dambisya	Tuesday June 4 th 1pm-2pm

Appendix 2: Participant and Resource Person list

	NAME	INSTITUTION AND COUNTRY
	Resource persons	
1	Rene Loewenson	Director Training and Research Support Centre., cluster lead EQUINET
2	Belinda Ncube	Consultant, IT support, Training and Research Support Centre
3	Nathan Banda	Occupational Safety and Health Officer, Zimbabwe Chemical Plastics and Allied Workers Union, and Representative, SATUCC
4	Yoswa Dambisya	Director General of the East, Central and Southern Africa Health Community (ECSA-HC)
5	Carlos Dora	Consultant, Brazil
6	John Mwenda Gitari	Journalist, communication and media consultant, Kenya
7	Sara Simpson	Nossal Institute of global public health, Australia
8	Connie Walyaro	Executive Director of Talk AB[M]R, Kenya
	Registered participants	
9	Wilson Asibu	Executive Director, Country Minders for Peoples Development, Malawi
10	Kgomotso Bhebhe	Finance and Administration officer, Ex Wenela Miners Association, Zimbabwe
11	Francis Mugote Bukonya	Planning, Monitoring, Research, Learning, Evaluation, Quality Assurance practitioner, Uganda
12	Lucky Dube	Ex-Wenela Miners Association Zimbabwe
13	Collen Jolobe	Environmental activist, Witbank South Africa.
14	Zelalem Kebede	Associate Researcher, Ethiopian Public Health Institute
15	Doris Kirigia	Health equity, social determinants of health, WHO AFRO
16	Allan Ouko K'oyoo	Research Associate, Kounkuey Design Initiative, Kenya
17	Mongi Khumalo	Adolescent Sexual Reproductive Health, Community Working Group on Health, Zimbabwe
18	Ndizi Machilika	Projects Coordinator, Malawi Network of Community Health Workers
19	Racheal Mafura	Project Coordinator, Food Federation and Allied Workers Union, Zimbabwe
20	Nonjabulo Mahlangu	Community Working Group on Health, Zimbabwe
21	Benice Maluleke	Gender Coordinator, Zimbabwe Banks and Allied Workers Union
22	Levison Masamba	Community Development Practitioner, Malawi
23	Mandy Mathias	Community Working Group on Health, Zimbabwe
24	Jokoniah Mawopa	Safety and Health Officer, Food Federation of Trade Unions, Zimbabwe
25	Nosimilo Mlangeni	Public Health Practitioner, National Institute for Occupational Health, South Africa
26	Moeketsi Modisenyane	Director: Africa and Middle East Relations, National Department of Health, South Africa
27	Boledi Susan Moraba	Social and Environmental Justice in Action, South Africa
28	Olalekan Raimi Morufu	Lecturer, Federal University Otuoke, Nigeria
29	Pascal Mukanga	Planning Associate, Kounkuey Design Initiative, Kenya
30	Jeremiah Mushosho	Climate Change, Health and Environment, WHO AFRO
31	Thulani Ngcamphalala	Programs Manager. Swaziland Migrant Mineworkers Association, Eswatini.
32	Adelheid Onyango	Director , Universal Health Coverage Healthier Populations Cluster, WHO AFRO
33	Laetitia Ouedraogo	Nutrition and food safety, WHO AFRO
34	Chiara Retis	Violence, Injuries and Disability, WHO AFRO
35	Blessings Sabao	Social worker, Zomba district. Malawi
36	Richard Andrew Tamva	Programmes manager, Ex-miners Association of Malawi
37	Fikru Tullu	Non Communicable diseases, WHO AFRO