

Evaluation of the Health Impact Assessment  
of the Canterbury Regional Land Transport  
Strategy

**THIS DOCUMENT HAS BEEN PREPARED BY  
COMMUNITY AND PUBLIC HEALTH**

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# Executive Summary

## Introduction

Effective and accessible transport is important for supporting health. To help ensure that the transport system in Canterbury best supports the health of Cantabrians, a health impact assessment (HIA) was undertaken to support the development of Environment Canterbury's 2012 Canterbury Regional Land Transport Strategy (CRLTS).

The 2012 CRLTS was initially intended for release in 2011, but its development was delayed by the 2010-2011 Canterbury earthquakes. An interim evaluation report covering the processes used in the HIA was completed prior to the earthquake in 2012. This report builds on the interim report by considering what influence the HIA has had on the CRLTS and the capacity of local government and health organisations to improve the health of the community.

## Methods

The HIA project team contained representatives from the Canterbury District Health Board (CDHB), Environment Canterbury, and Christchurch City Council (CCC) with support from consultants Martin Ward and Synergia Ltd. The same team also conducted a parallel HIA of the CCC's Christchurch Transport Plan. The two HIAs utilised joint planning, evidence-gathering and evaluation processes.

A literature review was conducted to provide an evidence base for the links between transport and health (Bidwell, 2010). Key issues and populations of interest were identified at a scoping workshop, and the health impact of population wide changes in transport modes were quantified using a computer simulation (Rees & Field, 2010). To gather community views of the draft CRLTS, appraisal workshops were held in Christchurch, Rangiora, and Timaru with an additional hui for Māori input at Rēhua Marae.

Prior to the earthquakes, an interim evaluation report ([Gourdie, 2010](#)) was produced using feedback data and other information collected by an evaluator attending HIA workshops and team meetings. The original evaluator was no longer employed when the final CRLTS was released, so another evaluator produced this report by drawing on the interim report, the final CRLTS, and notes kept by the original evaluator.

## Findings

The evaluation findings are organised according to the evaluation objectives.

### **The aim and objectives of the HIA have been met**

The HIA successfully identified links between transport, health determinants, and health outcomes; all the links identified in the literature review were addressed in the HIA recommendations, and additional recommendations were generated from the workshops. The recommendations highlight policy changes which may impact health, reduce inequalities, mitigate potential harm, and build sustainable capacity, although some policies supporting Māori equality were not included in the recommendations. Reflective practice was employed throughout the project.

### **The processes used in the HIA for the CRLTS are appropriate**

The HIA used established HIA methodology which was considered appropriate by the project team. In particular, team members felt that having a full-time project officer to lead the HIAs was vital. Team members felt the rigorous literature review was valuable for increasing coverage of cultural expertise and grey literature, but some were concerned that it was expensive and time consuming. Conducting the HIAs for the CRLTS and the CTP in parallel allowed the workshops to contribute to both documents and improved the efficiency of the HIAs.

The appraisal workshops helped identify unexpected ways that transport might affect health. Workshop participants had mixed feelings about the workshops; approximately one third of participants felt the workshops were valuable, one third felt they were let down by poor facilities, and one third felt they did not capture a sufficiently diverse range of views. In particular, there was difficulty obtaining representation for refugees and Māori.

### **The “evaluation criteria for sustainability” have been utilised in the HIA**

The CCC document Health Promotion and Sustainability Through Environmental Design (Billante, 2007) provides fourteen criteria to ensure that determinants of health are adequately considered. The HIA used a determinants of health approach throughout the process and addressed all fourteen criteria.

### **The recommendations made by the HIA were taken into account in the CRLTS**

Changes between the 2008 and 2012 CRLTS which are consistent with HIA recommendations include acknowledging the importance of health in transport policy and committing future funding to policies which support active transport, public transport, and transport demand management. The long term vision and actions scheduled by the CRLTS are consistent with the recommendations of the HIA, but the short term actions are determined largely by pre-allocated funds and many are contrary to the recommendations. Under the current timetable, another CRLTS will be produced before the HIA recommendations begin to be implemented.

The recommendation to “ensure effective representation” was not adopted in the CRLTS. Future HIAs should attempt to identify any recommendations that receive little discussion in the HIA report or are qualitatively different from the majority of recommendations. These exceptional recommendations should be receive additional discussion in the appraisal process and the HIA report.

### **Capacity building has occurred**

Members of the project team felt that undertaking the HIA improved their ability to consider health issues in a transport planning context and that they shared this knowledge with their colleagues. Similarly, workshop participants said the workshops had improved their knowledge of transport and health and they would disseminate the information within their communities. Team members and workshop participants all felt the “learning by doing” approach to capacity building was effective.

The development of the Canterbury Health in All Policies Partnership (CHIAPP) for the HIA has enabled stakeholder organisations to continue to make use of each others’ expertise following the HIA project. However, team members commented that there were limited opportunities to engage stakeholder organisations’ high-level leaders, so little capacity building has occurred at that level.

### **Ongoing monitoring of the health impacts is included in the CRLTS**

The CRLTS specifies that ECAN will produce three-yearly monitoring reports which cover a wide range of indicators, including some health outcomes and many determinants of health. However, there is no provision for health input into the monitoring reports. Without health input there is a risk that the health effects of some indicators will be under-emphasised in monitoring reports. It would be useful for CDHB or Partnership Health to seek, via CHIAPP, to have input into the CRLTS monitoring reports.

Surprisingly, there was no mention of ongoing monitoring in the HIA report. That this evaluation goal was fulfilled seems to have been more the result of good fortune than the HIA process, although the capacity built in ECAN staff members during the HIA process may have contributed.

### **Conclusions and Recommendations**

The HIA of the CRLTS has highlighted the most important ways that transport policy can support public health in Canterbury. The HIA met all of its original objectives and most of the recommendations were adopted in the CRLTS, the only exception being “ensure effective representation”.

It is recommended that CDHB or Partnership Health should seek, via CHIAPP, to have input into the CRLTS monitoring reports. This evaluation identified numerous lessons for future HIA projects, the most important being the value of a full-time project officer and of a “learning by doing” approach.

## Introduction

Effective and accessible transport for people and goods is important for supporting the health of people and communities. To help ensure that the transport system in Canterbury best supports the health of Cantabrians, a health impact assessment (HIA) was undertaken to support the development of the 2012 Canterbury Regional Land Transport Strategy (CRLTS).

CRLTS is a statutory document which provides strategic direction for land transport in Canterbury for the next 30 years. Under the Land Transport Management Act 2003 every regional council must produce a regional land transport strategy every three years (Environment Canterbury, 2012b). The strategy influences how transport funding within the region is allocated and how organisations within the region, such as territorial authorities and the New Zealand Transport Agency, should develop and implement transport projects (Environment Canterbury, 2012a).

The 2012 CRLTS was initially intended for release in 2011, but its development was delayed by the earthquakes which struck Canterbury in September 2010, and February and June 2011. The earthquakes interrupted the process after the completion of the HIA, but before the recommendations of the HIA could be incorporated into the CRLTS. Consequently, this evaluation of the impact of the HIA could not be completed until after the final CRLTS was released in 2012.

An interim evaluation report covering the processes used in the HIA was completed prior to the earthquake in 2012. This report builds on the interim report by considering what influence the HIA has had on the CRLTS and the capacity of local government and health organisations to improve the health of the community.

## Evaluation objectives

The evaluation plan for the HIA contained six objectives (rephrased below for clarity). This report is organised around these objectives.

To assess to what extent:

1. The aim and objectives of the HIA for the CRLTS have been met
2. The processes used in the HIA for the CRLTS are effective
3. The evaluation criteria for sustainability (Billante, 2007) have been utilised in the HIA for the development of the CRLTS
4. The recommendations made by the HIA were taken into account in the CRLTS
5. Capacity building has occurred
6. Appropriate methods for ongoing monitoring of the health impacts are included in the CRLTS

The full evaluation plan is included as Appendix 1 of this report.

## Methods of the HIA

The HIA was led by a project team comprising representatives from the Canterbury District Health Board, Environment Canterbury and Christchurch City Council. In addition, the project team was supported by independent consultant Martin Ward and health consultancy Synergia Ltd. Coinciding with the development of the CRLTS, the Christchurch Transport Plan (CTP) was developed by the Christchurch City Council with a parallel HIA process underway. The two HIAs were designed to link closely together, with some joint planning, evidence-gathering and evaluation activities.

## Literature Review

A literature review was undertaken by the Canterbury District Health Board and peer-reviewed by experts in relevant fields across New Zealand. It was conducted prior to the scoping workshop and used to inform the subsequent stages of the HIA. The literature review provided a key evidence base for the links between transport and health, and provided a basis to validate or critique the issues and potential actions raised through the appraisal workshops. The full report, *Wider Health and Wellbeing Impacts of Transport Planning, 2010*, is available at the Environment Canterbury website [www.ecan.govt.nz/rlltsreview](http://www.ecan.govt.nz/rlltsreview) (Bidwell, 2010).

## Scoping

A key stage of any HIA is the scoping phase, in which stakeholders discuss the policy or project being explored, and decide on the key issues and populations of interest that the HIA should focus on. A scoping workshop for the RLT S was held in December 2009, with representatives from a range of agencies and organisations.

## Focus Areas

Three key issues were identified for detailed exploration in this HIA:

- Making transport safe for people: including increasing safety for all road users and creating environments where active transport (such as walking and cycling) can be fostered.
- Creating real transport mode choice: including planning and delivering urban design and transport options that make active and public transport safe and more appealing; increasing travel choices for commuters; and increasing travel choices in rural areas.
- Building healthier environments: including reducing environmental effects of the transport system (air and water quality, and noise emissions).

## Key Populations of Interest

Consistent with longstanding public health approaches, equity and social inequalities are underlying issues of importance for the HIA. HIAs have proved effective in reducing inequalities in health by ensuring that policies do not exacerbate or maintain existing inequalities for particular population groups. As part of the HIA for the CRLTS, this concept encompassed:

- Consideration of those with greatest social and economic needs;
- Enabling accessibility for all, particularly for those that face the greatest difficulties;
- Ensuring transport disadvantaged people can access services/transport to work; and
- Providing affordable transport options.



The term “transport disadvantaged” was used to define those in the community who have the lowest levels of accessibility to goods, services and activities they need, such as work, education, health care, welfare and food. The Public Transport Management Act 2008 defines transport disadvantage as:

*“people whom the regional council has reasonable grounds to believe are the least able to get to basic community activities and services (for example, work, education, health care, welfare, and food shopping).”*

With this concept of transport disadvantage in mind, the following groups were adopted as key populations of interest for the HIA.

- Older people
- Lower socio-economic populations
- People with disabilities
- People living in isolated rural areas
- Māori
- Children and young people

## Simulation Modelling

To help understand the links between transport and health outcomes, Synergia Ltd were commissioned to develop a computer simulation model to explore the impacts of different transport scenarios. System dynamics modelling, or simulation modelling, is an approach to improve understanding of how a system performs over time. It draws together evidence with expert insight to develop a picture of the overall system, analysis of available data and a causal model to identify what outcomes can emerge. The model itself was developed through a collaborative process of identifying causes, researching connections and critiquing findings.

The model developed for the HIA sought to quantify some of the key linkages between transport choices and health outcomes, and the scale of potential health impacts over time. The analysis, using system dynamics modelling approaches, drew on international evidence, transport and population data for Canterbury. The modelling report is available on the ECAN website <http://ecan.govt.nz/publications/General/HIA%20Model%20Guide%20June%202010.pdf> (Rees & Field, 2010)

## Appraisal

The appraisal stage of an HIA examined the key issues and populations of interest that were identified as the focus of the HIA at the scoping workshop.

### Appraisal Workshops

A series of appraisal workshops were held with a wide range of representatives from the health, transport, government and community sectors. Each workshop sought participants’ feedback on the health and wellbeing impacts of the transport system, and key actions that could be taken to

enhance the positive impacts and reduce the negative impacts. A full day workshop was held in Christchurch with smaller workshops taking place in Rangiora and Timaru.

### **Engagement with Māori**

An important component of undertaking HIAs in New Zealand is to ensure that the principles of the Treaty of Waitangi are upheld. Additionally, local government has the responsibility to provide opportunities for Māori to contribute to decision making processes (required by legislation such as the Local Government Act 2002).

The opportunity for Māori to contribute to the development of this HIA occurred via a number of approaches, including:

- A hui at Rehua Marae;
- Participation of Māori in the project team; and
- Expert independent assistance.

## **Methods used in the evaluation**

Due to the interruption caused by the Canterbury earthquakes, the evaluation is divided into two distinct phases. Before the earthquake, an evaluator collected planning and feedback data about HIA team meetings, the literature review, and the HIA workshops. This data was then used to produce an interim evaluation report (Gourdie, 2010) prior to the release of the HIA. Following the earthquakes and after the release of the HIA, another evaluator used already collected data to produce this final evaluation report.

### **Prior to the Canterbury Earthquakes**

#### **Evaluation team meetings**

An evaluation group, supported by an experienced evaluator, was established to provide oversight for the evaluation of the HIA. The group also accepted responsibility for monitoring the progress of the evaluation according to the evaluation plan. Minuted monthly meetings were organised to review the objectives of the evaluation and to assess progress against each objective.

#### **Literature review**

A number of the peer-reviewers, and some workshop participants, were asked their opinions about the efficacy and usefulness of the literature review. The final evaluation report will include an assessment of the level of consistency between the information provided in the literature review and the final version of the RLTS, as per objective three.

#### **Workshops**

Generic workshop planning and feedback templates (Appendices 2 and 3) were developed during the HIA to facilitate the collection of evaluation data from the workshops. The project team recorded the goals and techniques for the workshop on the planning template, and each participant was asked to provide feedback using the feedback template. The evaluator was then able to determine whether the workshop goals had been met.

Two workshops (the scoping workshop and the first modelling workshop) were conducted prior to the planning and feedback templates being developed. Feedback from these workshops was obtained by key informant interviews with three participants from each workshop.

#### **Data synthesis**

Using a heuristic approach (problem solving by an experimental and/or trial and error approach), a qualitative thematic analysis of information obtained during the various stages of the HIA was undertaken (Gourdie, 2010). An interim evaluation report presenting the findings of this analysis was produced in July 2010.

### **Following the Canterbury Earthquakes**

The eventual impact of the HIA on the CRLTS could not be evaluated until after the CRLTS report was released in 2012. By this time, the original evaluator was no longer available so a different evaluator performed the second half of the evaluation and produced the final report.

Because over two years had passed since the completion of the HIA, each of the objectives in the original HIA evaluation plan was reviewed against existing data sources. The data sources used were:

- The interim evaluation report (Gourdie, 2010)
- The CRLTS report (Environment Canterbury, 2012b)
- The HIA report (Environment Canterbury, Canterbury District Health Board, & Christchurch City Council, 2011)
- The CHIAPP evaluation report (Gawith, 2012)
- Feedback from the Timaru appraisal workshop (which was held after the interim evaluation report was completed)
- Additional review of the original feedback from the workshops

## Findings

### 1. The aim and objectives of the HIA have been met

The main objective of the HIA of the CRLTS was:

- To assess the links between transport planning, health determinants, and health outcomes

This objective was complemented by four supporting objectives

- Highlight policy which may impact health and recommend how to reduce inequalities
- Suggest measures to reduce or mitigate potential harm
- Build sustainable capacity
- Evaluate the process and outcomes of the HIA

### Assess the links between transport, health determinants, and health outcomes

The HIA successfully identified links between transport, health determinants, and health outcomes.

The links between transport, health determinants, and health outcomes were initially assessed by completing a comprehensive literature review of the wider health and wellbeing impacts of transport planning. The findings of the literature review were supplemented with findings from the modelling and appraisal workshops.

A comparison of the findings of the literature review with the recommendations of the HIA showed that the recommendations addressed all the links between transport and health that were identified in the review.

Project team members interviewed after the scoping workshop reported that the workshop resulted in a broader scope for the CRLTS (Gourdie, 2010). This broader scope allowed HIA team members and CRLTS authors to consider additional issues, especially potential effects on public health, in all aspects of transport planning.

The modelling workshop allowed HIA and CRLTS team members to gain a clearer understanding of the effect of changes in the proportion of kilometres travelled by each of the transport modes (walking, cycling, public transport, and private vehicle) in Canterbury. The model provided estimates of the number of people who would use each mode of transport, as well as determinants of health such as the rate of cycle injuries and the number of people meeting physical activity guidelines. However, a few felt that the model was too simplistic; it did not attempt to determine how to change the kilometres travelled using each of the transport modes. Neither did it attempt to account for differential effects on different population groups (e.g. the elderly, children, low income, rural, disabled, and different ethnicities). Despite these limitations, most team members reported that the modelling workshop increased their understanding of the effects of transport interventions on health (Gourdie, 2010).

The appraisal workshops generated key new information about HIA processes, transport planning processes, and the health benefits of transport. All the workshop findings were listed in the HIA

report, and the great majority were integrated into the HIA process or recommendations. There was no discussion of why some workshop findings were not included in the recommendations. A number of appraisal workshop findings made it in to the CRLTS despite not being addressed in the HIA recommendations. Those findings from the workshops which were not integrated into the HIA recommendations or CRLTS are listed below:

- Using international speakers to raise understanding of the issues
- Target adult role models as a priority group
- Regulate mobility scooter use
- Education of youth about etiquette for using public transport
- Community vans used by kaumātua should be given same priority as other buses
- Increase access to Te Reo Māori through signage
- Ensure that whakaaro Māori (Māori thoughts) are visible in the CRLTS and provide opportunity for Māori to provide feedback on the draft CRLTS

To make the process of developing recommendations more transparent, it would be beneficial to discuss the reasons why any workshop findings might not be included as recommendations.

Some members of the HIA team commented that there was a need to make better use of existing routinely collected data to help identify the links between transport and health in a local context, including for the transport disadvantaged. Although existing routine data was not utilised in the HIA, provision for greater use of routine data is included in the CRLTS.

### **Highlight policy which may impact health and recommend how to reduce inequalities**

The recommendations of the HIA effectively highlight policy areas which may impact health and provide broad suggestions on how these policies could support health. Each recommendation is accompanied by an explanation and a list of specific actions. These actions provide suggestions for how the policy might be implemented to reduce inequalities and support public health.

The HIA also notes that “if the CRLTS is to achieve its stated aim to ‘protect and promote public health’ then a concerted package of measures is required to be implemented, and sustained, on a much larger scale than has been previously undertaken”. This statement, although brief, highlights the need for a step-change in transport policy, rather than the small tweaks previously seen, if negative public health consequences are to be avoided.

The HIA report includes the findings of the Rēhua Marae workshop including several practical steps that could be taken to improve equality:

- Community vans used by kaumātua should be given same priority as other buses
- Increase access to Te Reo Māori through signage
- Ensure that whakaaro Māori (Māori thoughts) are visible in the CRLTS and provide opportunity for Māori to provide feedback on the draft CRLTS

However, the HIA fails to make any recommendations based on these findings, instead including only “Ensure Māori representation on the Canterbury Regional Transport Committee which supports recognition of the Treaty of Waitangi”.

With hindsight the HIA team felt they could have devoted more resources to exploring the economic benefits of increased physical activity (Gourdie, 2010). Such analysis could have provided a stronger financial case for transport measures which support public health.

### **Suggest measures to reduce or mitigate potential harm**

The actions associated with each recommendation provide a range of suggestions for how to reduce or mitigate potential harm.

### **Build sustainable capacity**

The HIA was successful in building sustainable capacity within the CCC, ECAN, and C&PH, and to a lesser extent in the wider community. Capacity building is discussed further section five "Capacity building has occurred".

### **Evaluate the process and outcomes of the HIA**

The interim evaluation, and this final evaluation, have contributed to the evaluation of the HIA. These evaluation processes have been generally successful, although some challenges have been encountered.

The evaluation process, along with the development of the HIA, was interrupted by the September 2010 Christchurch earthquake. Once the evaluation was finally resumed in late 2012, the staff member who was responsible for the original evaluation no longer worked for C&PH. The current evaluation therefore had to be performed by another staff member who was not familiar with the HIA project. This situation required the evaluator to spend a lot of time becoming familiar with the project.

## **2. The processes used in the HIA for the CRLTS are appropriate**

The HIA was carried out according to established HIA methodology as outlined in the report (Environment Canterbury, 2012b). The process was generally appropriate, although there were some concerns raised by members of the project team and other workshop participants.

### **Leadership**

The HIA process was led by an HIA project officer and ECAN's Principal Regional Transport Planner. The project officer is a full time role jointly funded by ECAN, CCC, CDHB and Partnership Health Canterbury. The project officer is responsible for building capacity within all four organisations to undertake HIAs. Feedback from project team members suggests that a comprehensive HIA would not have been achieved without the presence of a project officer in a dedicated leadership role (Gourdie, 2010).

The project team consisted of staff from the three participating organisations (ECAN, CCC and CDHB) with assistance from independent health consultancy Synergia Ltd. In addition to building capacity within all three organisations, including staff from each created a strong feeling of ownership of the HIA within each organisation. Importantly, some of ECAN staff responsible for drafting the CRLTS were part of the HIA project team, so were able to directly transfer the insights gained during the HIA process.

### **Literature review**

The literature review for the HIA underwent an online peer review process to allow for feedback on each section from a broad group of national experts. Feedback from reviewers and HIA project team members highlighted the system's ability to capture cultural expertise and local grey literature. (Gourdie, 2010). Completing the literature review before the scoping workshop enabled the scope of the HIA to be widened to include all the determinants of health.

Conversely, some project staff commented that the peer review process used a great deal of resources, including the technological resources and the time of the IT staff and expert reviewers. Some team members were uncertain whether the additional information identified was worth the resources invested.

### **Evaluation and reflective practice**

Prior to the September 2010 earthquake, the HIA evaluation was carried out concurrently with the HIA. Furthermore, the HIA project team and evaluation team employed reflective practice throughout the project. Using concurrent evaluation and reflective practice enabled the teams to quickly identify when things could be done better and adapt their processes to suit. For example, it was difficult to get quality feedback from the scoping workshop participants so generic workshop feedback templates were developed for use in subsequent workshops (Appendix Three, Gourdie, 2010).

### **Workshops**

The appraisal workshops involved the community in the HIA process, helping to improve community buy-in and knowledge transfer. The new information generated at the workshops helped the HIA team to identify unexpected ways that transport might affect the health of various population groups.



Participant feedback from the workshops showed a mixed response. Approximately one third of participants from all workshops felt that the workshops would have been improved by including a more diverse group of people.

The appraisal workshops were intended to include representation from all the identified stakeholder groups. While the workshops certainly achieved broad representation, and considerable effort was made to get representation from all identified stakeholder groups, there were some important gaps. The four appraisal workshops combined included representatives for older people, Māori, Pacific people, people with disabilities, non-English speaking people, people from areas of high deprivation, and people from isolated rural areas. However, no representation was sought for children and young people, despite them being identified as one of the key populations of interest. A representative for refugee communities was sought, but no refugee representative actually attended. Additionally, some population groups were represented by people who were accepted spokespeople for the group, but were not members of the group (e.g. district councillors representing people from isolated rural areas). The importance of these gaps is reinforced by workshop participant feedback; approximately one third of participants commented that the workshops could have been improved by including a more diverse group of people (Gourdie, 2010). We cannot know the impact of these gaps in representation, but it is possible that some important health effects were not identified because the affected groups were not present. When conducting future HIAs, substantial resources should be devoted to ensuring that representation is as broad as possible.

There was good attendance at the Christchurch, Timaru, and Rangiora workshops, but there was poor attendance at the hui at Rēhua Marae. A panui was sent to 47 people with 25 indicating they would attend, but only nine people eventually attended, some of whom had to leave early. Participants commented that it was difficult for kaumātua to travel to the marae, and that attendance would have been better if transport was provided. Similar transport problems could have also contributed to there being no members of refugee communities or people from isolated rural areas at any workshops (although there were some urban residents representing rural residents). To obtain adequate representation for disadvantaged groups, it is important to ensure that all invited participants are able to travel to the workshop location.

A further one third of participants commented that the workshops could be improved with better facilities, such as having breakout rooms and better heating. While it is difficult to estimate what effect these facilities may have had on the outcomes of the workshops, these comments imply that these participants will be less willing to participate in future HIA consultation unless they are able to remain comfortable.

Feedback from the remaining third of workshop participants was positive (Gourdie, 2010). Participants said that the meetings were well facilitated, that they had increased their understanding of the ways transport can affect health, and which health supporting policies were most practical to implement. Participants reported that they would disseminate the information they had learned via newsletters, school councils, local councils, colleagues, public meetings, and advocacy groups.

The generic templates (Appendix 2 and 3) developed to plan workshops and obtain participant feedback proved very useful. By using a consistent planning and feedback mechanism for every workshop, the evaluator was able to obtain useful information which could be fed back into the HIA

process to improve future workshops. As noted in the “evaluation and reflective practice” section, the planning and feedback templates were not developed until after the scoping workshop and the first modelling workshop. When conducting future HIAs, a preliminary evaluation plan including feedback templates should be prepared prior to any workshops being held. The evaluation plan should draw on the information contained in previous HIA evaluation reports.

### Resources used

To facilitate planning of future HIAs, the resources required for the CRLTS HIA are listed here:

- Skills of a transport analyst to compile and interpret transport data and trends
- Facilitators and presenters for workshops
- Project team commitment of 5-8 people covering transport planning and health professions, each with a time commitment of between two and four hours per week
- Support from senior management, elected representatives, and other key stakeholders
- Evaluation expertise and evaluator time
- E-mail and internet access (including access to peer-reviewed literature databases)
- IT expertise and technology for online peer review process
- Time of expert peer reviewers
- Catering for screening, scoping, and appraisal workshops
- Meeting room(s) access
- Access to population profiling and transport monitoring information
- Project management and leadership skills

Although these funding requirements were primarily met by the Ministry of Health, some financial assistance was provided by ECAN, CCC, CDHB, and Partnership Health Canterbury. As discussion around the funding was not one of the HIA evaluation objectives, a financial analysis was not undertaken and has therefore not been included in this report.

It is important to note that because the HIA of the CRLTS was conducted in conjunction with the HIA of the Christchurch Transport Plan, many of the workshops, discussions, and evaluation processes were able to contribute to both HIAs. This approach has allowed each of the HIAs to be completed using substantially less resource than would have been required otherwise.

### **3. The evaluation criteria for sustainability have been utilised in the HIA for the development of the CRLTS**

The Christchurch City Council document Health Promotion and Sustainability Through Environmental Design (Billante, 2007) provides fourteen “evaluation criteria for sustainability” which are an effective checklist to ensure that determinants of health are adequately considered. The HIA report addresses all the evaluation criteria for sustainability. The HIA used a determinants of health approach throughout the process, which was facilitated by utilising the evaluation criteria for sustainability.

## 4. The recommendations made by the HIA were taken into account in the CRLTS

### The CRLTS is consistent with the recommendations

In general, CRLTS is consistent with the overriding recommendation of the HIA, that “the CRLTS supports a strategic direction that enhances active and public transport and reduces car dependency”. The CRLTS addresses almost all the key recommendations of the HIA and public health is a prominent theme throughout the document.

Although the long term vision and actions scheduled by the CRLTS are largely consistent with the recommendations of the HIA, the short term actions are not. The CRLTS defines the short term as 1-3 years, medium term as 4-12 years, and long term as 13-30 years. In the short term, the strategy is to continue with the existing programme of road building and upgrades. Most health promoting interventions are scheduled to begin in the medium term, and many programmes will not be fully funded until the long term.

The CRLTS states

*“Current transport system maintenance, and programmed improvement and management practices will continue over the next three years. Many activities are already committed over the short term with limited funding available to introduce new activities. However, some planning and investigations can now begin, to enable a change in strategic direction and investment over the medium term” (Environment Canterbury, 2012b)*

The current schedule means that another CRLTS will be produced before most of the initiatives recommended by the HIA begin. It will be important for public health to ensure that the schedule for change in strategic direction in the current CRLTS is carried forward into subsequent versions.

### The HIA improved the CRLTS

To be effective, the HIA should improve the effect that the CRLTS will have on health. In fact, the HIA report stated that “if the CRLTS is to achieve its stated aim to ‘protect and promote public health’ then a concerted package of measures is required to be implemented, and sustained, on a much larger scale than has been previously undertaken”. An estimate of the improvement in the health effects can be made by comparing the differences between the 2012 CRLTS and the previous version published in 2008.

The marked difference between the 2008 and 2012 versions of the CRLTS is that public health objectives receive more prominent and explicit acknowledgement in the more recent strategy. Some examples of the differences between the 2008 and 2012 versions of the CRLTS are:

- The 2012 CRLTS identifies “managing the negative and supporting the positive impacts of transport on health” as one of the key challenges facing the region. Other key challenges important to supporting public health (transport accessibility, transport options, growth of private vehicle traffic, road safety, environmental impacts, and transport for dispersed communities) are included in both strategies.

- Effects on health are explicitly included among the rationale for many specific interventions in the 2012 CRLTS (e.g. increasing use of public transport), alongside other benefits included in both strategies such as improved access, equity, fuel economy, and traffic volumes.
- The 2012 CRLTS commits to a defined time frame for shifting a specified proportion of transport funding from policies which support private car use to policies which support active and public transport and transport demand management. The 2008 strategy also included increased funding for active and public transport and demand management, but did not commit to a specific proportion of total transport funding or a defined time frame.

Despite these differences in the rationale and funding commitments, there is very little difference between the stated strategic directions of the two strategies. In other words, both strategies encourage similar transport planning decisions which are likely to have similar health effects. However, health effects certainly receive greater consideration in the 2012 CRLTS, and the commitment to future funding changes may result in better implementation of health-supporting policies.

### **Ensure effective representation**

The CRLTS does not adopt the HIA recommendation to “Ensure effective representation” or the associated actions “ensure Māori representation on the Canterbury Regional Transport Committee which supports recognition of the Treaty of Waitangi” and “continue to support the involvement of a public health representative on the Canterbury Regional Transport Committee”. In fact, there is no mention of representation from Māori or Public Health on the Canterbury Regional Transport Committee, or of any kind of consultation or advocacy to be used during planning.

There are a number of possible reasons which could account for why this recommendation was not adopted.

The actions included in the “ensure effective representation” recommendation are concerned only with the Canterbury Regional Transport Committee process. Other findings of the Rēhua Marae hui which could have been part of this recommendation were not included (see the section “highlight policy which may impact health and recommend how to reduce inequalities”). It is possible that the committee resolved amongst themselves that they would continue to have a Māori representative and a public health representative, and did not consider it necessary to include issues of committee process in the public strategy.

“Ensure effective representation” is not easily classified into one of the three focus areas identified by the HIA (“making transport safe for people”, “Creating real transport mode choice”, and “building healthier environments”). While the rationale behind the other HIA recommendations are discussed extensively in the HIA report as part of the focus areas, the rationale behind effective representation are provided only in two paragraphs in section 4.3.12. With so little discussion, it would be easy for a reader to assume that effective representation was of lesser importance than the other recommendations.

Finally, “ensure effective representation” is concerned with the process by which planning decisions are made. It would be understandable if transport planning professionals may be disinclined to place constraints how they are allowed to come to a decision.

To avoid similar problems when conducting future HIAs, project teams should attempt to identify any recommendations that receive little discussion or are qualitatively different from the majority of recommendations. These exceptional recommendations should be receive additional discussion in the appraisal process and the HIA report to ensure that it is easy for the report’s audience to understand how they will improve health outcomes. A better understanding of all recommendations will increase the chances that they will be adopted.

### **Current political environment**

During the HIA process, there was some concern that the “current political environment” (i.e. the replacement of the elected Canterbury Regional Council with government appointed commissioners) could reduce the uptake of the HIA recommendations. The interim evaluation report said that the project team would attempt to identify where there was a risk that current political environment might reduce uptake of the recommendations, and plan to manage that risk. As that almost all the recommendations of the HIA have been included in the CRLTS, it seems likely that the anticipated risks were adequately managed or did not eventuate.

## **5. Capacity building has occurred**

The HIA project provided four main opportunities for capacity building:

- Transport planning professionals were able to learn about how their work affects health
- Public health professionals were able to learn about the practicalities of implementing healthy transport policy and to improve their health impact assessment skills
- Members of the public attending workshops were able to learn how transport policy and behaviour can affect the health of individuals and groups
- Local government and health organisations were able to learn how to cooperate to support public wellbeing

The HIA used a “learning by doing” approach to capacity building, and received a portion of its funding from the New Zealand Ministry of Health’s HIA Learning by Doing Fund (New Zealand Ministry of Health – Manatū Hauora, 2011). The learning by doing approach was strengthened by the involvement of expert reviewers; Māori representatives; representatives of other key populations of interest; and staff from CCC, ECAN, and CDHB. This broad range of experience meant that every person involved with the HIA was exposed to challenging new ideas from outside their area of expertise and gained greater understanding of the complex relationships between transport and health.

The learning by doing approach was also supported by outside expertise from independent health consultant Martin Ward and health consultancy Synergia Ltd. The specialised expertise brought by the consultants ensured that suitable HIA and modelling processes were applied. Only by “doing” appropriate processes could “the learning by doing” approach be effective.

### **Transport planning professionals**

Reports from project team members suggest that substantial capacity building has occurred amongst transport planning professionals at ECAN and CCC.

The scope for improvement in the ability of transport planning professionals to increase their ability to consider public health was illustrated by comments from the scoping workshop. After the workshop, some ECAN and CCC staff members said they only then understood the purpose of using HIA for transport issues (Gourdie, 2010).

Other comments show that transport planning professionals feel that the information gained from the HIA process will be useful in their work. Some team members stated that they will take new knowledge about determinants of health and transport back to their own organisation to use to improve their service. Some participants in the modelling workshops reported that they had discussed the content of the first workshop with colleagues, and after the second workshop planned to do this again. Furthermore, peer reviewers and project team members reported that the literature review quickly propagated right throughout their organisations. A comparison of the original distribution list for the literature review with the list of people who provided feedback showed that more than three times the number of people initially targeted had read the review by the end of the peer review process. (Gourdie, 2010).

While it seems likely that the HIA built capacity right throughout the organisations involved, the greatest effect is likely to have been on the staff included in the project team. Two and a half years after the project began, all the project staff from CCC have remained working for their organisation. The staff member from ECAN is now working for Dairy New Zealand, an industry organisation with important opportunities to influence public health outcomes. Furthermore, there were other staff from the ECAN, CCC and CDHB involved with the HIA who will also have built capacity despite not being involved with the project team. The understanding and skills gained by these staff members during the HIA will still be having a positive effect on public health today.

### **Public health professionals**

Public health professionals involved in the HIA reported that they felt their own capacity had been built, especially their understanding of the practicalities of implementing different health promoting transport policies (Gourdie, 2010).

Project team members felt that support from experienced consultants was particularly important for capacity building in public health professionals (Gourdie, 2010). Use of consultants ensured public health professionals used best practice HIA methodology, and avoided common HIA pitfalls resulting from inexperience.

As with transport planning professionals, public health professionals reported that they had shared information from the workshops with their colleagues, and that the literature review circulated throughout the whole organisation.

Five of the six public health professionals involved in the HIA project are still working for the CDHB.

### **Members of the public**

The appraisal workshops not only extended the involvement of the community in the CRLTS, but also helped to transfer knowledge to the community. Workshop participants reported they would disseminate the information they learned at the workshops via newsletters, school councils, local councils, marae, colleagues, public meetings, and advocacy groups (Gourdie, 2010). Building the capacity of the community to understand the links between transport and health will help to make health promoting transport policies politically acceptable in the future. However, if public education about transport and health were a primary goal of the HIA then other techniques may reach a wider audience and be less expensive than the workshops used in this project.

In the case of this HIA, the participation of members of the public and Māori in workshops was also important for building the capacity of public health and transport planning professionals. Team members reported that workshop participants introduced perspectives, ideas and relationships between health and transport that they had not previously considered (Gourdie, 2010).

### **Local government and health organisations**

Capacity building has occurred at an organisational and leadership level amongst CCC, ECAN, and CDHB.

The CRLTS and Christchurch Transport Plan HIA projects were essential seed projects for the establishment of the Canterbury Health in All Policies Partnership (CHIAPP), a collaborative partnership between CCC, ECAN, CDHB and Partnership Health Canterbury which aims to ensure that potential health impacts are routinely considered in all policy decisions. Establishing CHIAPP required support from high-level leaders within each organisation and the development of a memorandum of understanding amongst the organisations. These actions allowed the organisations to collaborate more closely and share information more freely, and have enabled the non-health sector member organisations to make better use of the determinants of health expertise within the other member organisations. CHIAPP has now become business as usual for all four member organisations (Gawith, 2012). The contribution of the HIA to developing a self-sustaining CHIAPP is likely to be an important effect of the HIA over the long term.

Conversely, CRLTS HIA project team members commented that there were limited opportunities to engage high-level leaders in the HIA itself, and consequently little chance for the high-level leaders to develop a real understanding of a determinants of health approach to policy (Gourdie, 2010). However, the HIA has allowed many non-management staff members to gain an improved understanding of a determinants of health approach, which in turn allows them to promote this approach within their organisations over time (Gawith, 2012).

## **6. Appropriate methods for ongoing monitoring of the health impacts are included in the CRLTS**

The CRLTS specifies little direct monitoring of health outcomes, but it does specify monitoring of the most important transport-related determinants of health. This position is appropriate as most transport-related health outcomes are impossible to attribute to the effects of a single policy,

whereas determinants of health are often much easier to attribute. However, the HIA report contains no recommendations about monitoring, and the CRLTS contains no provision for health organisations to contribute to the monitoring reports.

The CRLTS specifies that ECAN will produce three-yearly implementation monitoring reports. The great majority of indicators monitored are related to determinants of health. These reports are to cover:

Health outcomes:

- Deaths per annum on region's roads
- Serious injuries per annum on region's roads
- Casualties per annum – deaths plus serious injuries – by transport mode

Indicators related to determinants of health:

- % of Greater Christchurch population who can reach work or education by public transport
- % of population in small urban areas who can reach key services by active modes
- Average trip length for all trips – Canterbury Region
- Public perceptions of safety of using each transport mode in Canterbury
- Time spent walking and cycling – hours per capita per annum – Christchurch City and small urban areas
- Number of residents who walk or cycle for 30 minutes or more each day – Christchurch City and small urban areas
- Mode share of different transport modes for all trip legs – Greater Christchurch
- % of single occupancy vehicle trips in Greater Christchurch
- % of households in Greater Christchurch and small urban areas within 10 minutes walk, 10 minutes cycle, or 30 minutes public transport ride of a Key Activity Centre
- Number of Cantabrians reporting that they experienced transport disadvantage due to disability
- Number of Cantabrians who do not have access to at least one mode of transport on a regular basis
- Tonnes of CO<sub>2</sub> from domestic land transport per capita
- Fuel sales
- Alternative fuel usage

Other transport indicators:

- Projects completed per annum in the Canterbury RLTP that increase network resilience in the region
- Regional private vehicle fleet mix
- Travel time variability and levels of service on the strategic road network

The organisations responsible for monitoring each of these indicators are specified in the CRLTS. Monitoring organisations include the local and regional councils, the New Zealand Transport Agency, the Ministry of Transport, the Energy Efficiency and Conservation Authority, and KiwiRail, but do not include any health agencies. With no health organisations involved there is a risk that the health



effects of some indicators will be under-emphasised in monitoring reports. To help ensure the CRLTS is implemented as planned, it would be useful for CDHB or Partnership Health to seek, via CHIAPP, to have input into the CRLTS monitoring reports.

Surprisingly, ongoing monitoring is not mentioned in the HIA, despite it being included as an evaluation goal of the HIA project. Furthermore, one of the HIA recommendations is “to make better use of existing data to help develop better understandings on the links between transport and health”, which will only be achieved if there is both health and transport expertise involved in interpreting the data. That this evaluation goal was for the most part successfully achieved seems to have been more the result of good fortune than of the HIA process, although the capacity built in ECAN staff members by the HIA may have contributed.

## Conclusions and Recommendations

The HIA of the CRLTS has highlighted the most important ways that transport policy can support public health in Canterbury. The HIA met all of its original objectives, successfully identifying the links between transport, health determinants and health outcomes; highlighting policy which might impact health and how to mitigate harm; building workforce capacity to consider health issues; and conducting an evaluation.

The HIA was conducted using established HIA methodologies which were appropriate to the HIA's objectives. Of particular importance was the use of a full time project officer whose primary responsibility was to drive the HIA process. Other useful practices included the use of experienced consultants to provide specialist expertise, online peer review of literature review, concurrent evaluation and reflective practice, and the use of generic workshop planning and feedback templates. There were also some methodological weaknesses, primarily that representation was not sought for some key populations of interest, and that transport difficulties prevented some of the most vulnerable workshop invitees from attending.

The CRLTS is consistent with most of the recommendations in the HIA, although work on most recommendations is not scheduled to begin until 2015. The only recommendation which was not adopted in the CRLTS was to ensure effective representation.

Compared to the 2008 version, the 2012 CRLTS has some important changes which could be attributed to the HIA. Most concrete is that the 2012 CRLTS contains a commitment and timetable to increase funding for active and public transport to a specified proportion of total transport funding – almost double the current level. The increased profile of health issues and greater discussion of determinants of health in the 2012 CRLTS is also important.

The HIA successfully utilised a “learning by doing” approach to build capacity to consider health issues outside the health sector. Planning staff at ECAN and CCC gained experience at using determinants of health approach, while health professionals at CDHB gained insight into the practicalities of policy planning work. The ability of health and non-health organisations to work together was also improved, especially via the HIA's contribution to the CHIAPP partnership.

The CRLTS contains provision for ongoing monitoring and reporting of many transport-related determinants of health and health outcomes. However, as there was no recommendation in the HIA related to ongoing monitoring, the monitoring cannot be attributed to the HIA. Furthermore, there is no health oversight of the reporting process, so there is a risk that health indicators may be under-emphasised when reports are produced.

### Recommendations for this HIA

- Public health professionals from CDHB or Partnership Health should seek, via CHIAPP, to have input into the CRLTS monitoring reports

### Lessons for future HIAs

- Future HIA should seek to make use of existing routinely collected data whenever possible
- Where findings from workshops are not included in the recommendations, the reasons they were not included should be discussed in the HIA report

- Having a full time project officer whose primary responsibility is guiding the HIA will help to ensure the HIA project remains on track
- Well resourced HIA projects where a literature review is conducted should consider conducting peer review by distributing the review widely to a range of expert reviewers. However, this approach is very resource intensive, so may not be appropriate for less well resourced HIA projects
- Instruments for gathering evaluation feedback from workshops and project team members be developed or adapted early in the HIA process, before any workshops are conducted. The feedback templates used in the CRLTS HIA are included in Appendix 3 of this report
- The appraisal process should include input from a wide range of interests, but particularly any population groups identified as “key populations of interest”
- To ensure adequate representation for vulnerable populations, consideration should be given to avoiding barriers to attendance such as lack of access to transport
- Presenting the economic benefits of policies which support health will help strengthen the case for adopting these policies
- HIA reports should include enough discussion for a casual reader to understand the rationale behind each HIA recommendation. Where one recommendation has substantially different rationale from the other recommendations, it is important to ensure the rationale is still adequately presented.

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## Appendices

### Appendix 1: Canterbury Regional Land Transport Strategy - Health Impact Assessment - Evaluation Plan

#### Introductory Notes:

- The following evaluation plan outlines the objectives of the evaluation of the HIA for the RLTS, as opposed to the objectives of the HIA of the RLTS.
- The plan provides guidelines to approaches needed to answer questions for the evaluation of an HIA such as are outlined in “A Guide to Health Impact Assessment”. These evaluation objectives provide a framework for the evaluation plan.
- The tools mentioned under the resource section have not yet been included and will require further consultation with key stakeholders prior to development.
- Where the term “evaluator” has been used this does not necessarily mean that it needs to be the same person throughout the process.
- The timeframes that have been provided are flexible, although in most instances could be expected to be the maximum.
- The time required by the evaluator to write the final evaluation report for the HIA of the RLTS has not been included, but could be expected to be approximately 15 to a maximum of 20 working days.
- The information obtained from the approaches outlined in the evaluation plan is expected to inform the efficacy of the process(es) undertaken throughout the HIA.
- Some of the approaches will also provide information about the level at which an objective(s) of the HIA for the RLTS were met.
- The planned approaches will inform of the level at which the HIA recommendations contributed to the RLTS.
- It is anticipated that use of the approaches below will provide sufficient information for formative evaluation. Hence, information obtained during the evaluation should be useful in refining and improving HIA processes generally, especially with regard to the use of the evaluation criteria for sustainability.
- Mention of ongoing monitoring process is an ‘ideal’ rather than a necessity and it is possible to address this at a later stage.

### **Significant Timelines:**

- The Ministry of Health Health Impact Assessment (HIA) Support Unit funding deadline for the 2010 version of ECAN's HIA for the RLTS is 30 June 2010
- The HIA for the RLTS will be done in conjunction with the HIA for the Christchurch Transport Plan (CPT), in particular Stage 1 due June 2010.
- The evaluation of the HIA for both the RLTS, and for the first stage of the CPT, will as far as practicable be done concurrently.

### **Objectives for the Evaluation of the HIA for the Regional Land Transport Strategy (RLTS):**

- (i) To evaluate the level at which the aim and objectives of the HIA for the RLTS have been met.
- (ii) To review the effectiveness, and assess the impact, of the process used in the HIA for the RLTS.
- (iii) To assess the level at which the evaluation criteria for sustainability (refer 'Health Promotion and Sustainability through Environmental Design') have been utilised in the HIA for the development of the RLTS.
- (iv) To analyse the extent to which the recommendations made by the HIA were taken into account in the stage 1 version of the RLTS.
- (v) To assess the level of capacity building that has occurred, and ascertain whether the current political environment may have had an impact on the HIA process for the RLTS.
- (vi) To ascertain appropriate methods for ongoing monitoring of the health impacts of the transport strategy

### **Aim and Objectives of the HIA of the RLTS (as at 21 January 2010)**

1. The aim of this HIA is to assess the links between transport, health determinants, and health outcomes for the Canterbury RLTS. It has four supporting objectives:
  - Highlight areas of policy which may impact on the health of the Canterbury regional population and make recommendations on how to reduce health inequalities which will be taken into account when developing RLTS policies so as not to exacerbate or continue existing inequalities in different geographical areas
  - Suggest measures to be incorporated into the RLTS 2011-41 that seek to reduce or mitigate the potential harm identified
  - To evaluate the process and outcomes of this HIA for the purpose of contributing to the development and the building of an evidence base for HIAs
  - To assist in building sustainable capacity within the organisation (Environment Canterbury) to perform HIAs on future policies and embed this approach into good practice

The HIA is primarily intended to help inform assessment of the strategic options. The options are expected to be formulated mid 2010, and the HIA process will be undertaken immediately afterwards.

**Objectives for the Evaluation of the HIA for the Canterbury Regional Land Transport Strategy (RLTS)**

1. To evaluate the level at which the aim and objectives of the HIA for the RLTS have been met.

Methods and associated details	Resources	Dates	Weekly review of progress (Include date, update and link for report/overview/summary)
<p>(A) Evaluator reviews the HIA report for the RLTS against the <u>goal</u> of the HIA</p> <p>(B) Evaluator reviews the HIA report for the RLTS against the <u>objectives</u> of the HIA</p> <p>Evaluator to ascertain at what level</p> <ul style="list-style-type: none"> <li>(i) the goals and</li> <li>(ii) the objectives were met?</li> </ul>	<p>Copy of the goal and objectives of the HIA for the RLTS</p> <p>Evaluator (alongside those for CPT at their stage 1 level – 8 hours</p>	<p>On completion of HIA</p>	<p>20 January 2010</p> <p>Objectives for HIA for RLTS available in Draft document from scoping workshop.</p>

2. To review the effectiveness, and assess the impact of the process used in the HIA for the RLTS.

Methods and associated details	Resources	Dates	Weekly review of progress (Include date, update and link for report/overview/summary)
<p>Dawn will maintain ongoing contact with members of the evaluation team throughout the HIA process. Dawn will consult/discuss progress on a fortnightly basis and/or as needed basis</p> <p>Evaluator to be familiar with literature review process</p> <ul style="list-style-type: none"> <li>- Assess the distribution and feedback process of the literature review</li> <li>- Analyse the use of the literature review, and the contributions it made, towards the HIA of the RLTS</li> </ul> <p>using survey and telephone/e-mail contact with recipients of the literature review</p> <p>Evaluator to summarise examples in which aspects of the literature review has been referred to, or utilised, during the HIA process</p>	<p>Literature review</p> <p>Final version of the RLTS</p> <p>Survey questions (constructed by evaluator)</p> <p>Recipients of the literature review</p> <p>Evaluator 30 mins fortnightly</p>	<p>Minimum of fortnightly review with evaluation team</p>	<p>20 January 2010</p> <p>Dawn met with evaluation team to discuss the evaluation plan 12/11/10 and with Alison as coordinator 14/01/10.</p> <p>Dawn agreed to present modifications to plan by 25 January 2010.</p> <p>Dawn will consult with Alison and Susan re literature review distribution and feedback processes by 29/01/10</p> <p>Modifications made to literature review as a result of feedback are due end of January 2010. (Minutes 13/01/10)</p>
<p>Evaluate all key stakeholder meetings using a range of tools depending on suitability</p> <ul style="list-style-type: none"> <li>▪ oral feedback opportunities</li> <li>▪ formal written evaluation sheets</li> <li>▪ meeting records/copies of presentations</li> <li>▪ survey process (written and/or oral) towards end of planning stage</li> </ul> <p>In consultation with facilitator, the evaluator will develop Guidelines for oral feedback against Objectives for the meeting(s)</p> <p>Similarly a written evaluation form(s) is developed for attendees to complete</p>	<p>Oral feedback guidelines</p> <p>Evaluation sheet for attendees</p> <p>Evaluator 8 hours (4 hours for any additional meetings)</p> <p>Facilitator/key stakeholder 4 hours (2 hours any additional meetings)</p> <p>Facilitator 10 -15 mins per meeting</p>	<p>Ongoing</p>	<p>12 January 2010 Alison will attempt to develop a standardised template of questions for various meetings</p> <p>Dawn will approach 2-3 attendees following each meeting (that have been identified by the facilitator, or associates), for their feedback.</p> <p>Alison will provide names and contacts of 3 from the scoping workshop.</p>



<p>Meeting facilitator requests oral feedback from attendees Meeting facilitator distributes and collects written evaluations</p> <p>Records of meeting that include, number and roles of attendees; organisations involved; topics discussed; decisions made and action points, or proposed developments, are made Evaluator/Dawn will collate and analyse the information; compare the meeting outcomes against their objectives and of those of the HIA. Summary of achievements of progress from meetings developed</p>	<p>Key stakeholder – meeting records <i>(Depends on length of meetings – currently unknown)</i></p> <p>Collation; analysis; comparisons and summary by evaluator 8 -12 hours per meeting</p>		
<p>To assess the utilisation of resources, evaluation team members will record relevant details that include:</p> <ul style="list-style-type: none"> <li>- Staff time in hours and associated expenditure of those immediately involved</li> <li>- Time and any associated expenditure for persons consulted</li> <li>- Time and any associated expenditure for others who assisted with duties e.g. secretarial</li> <li>- Other organisational and associated costs e.g. Catering; Technology; Facilities; Vehicles; Sundries e.g. printing</li> </ul> <p>Evaluation report writer will collate the information, overview the resources utilised and identify key issues around them – the range, extent of use and levels of contribution to the outcome.</p>	<p>Evaluation team members 12 hours total</p>	<p>Ongoing from commencement of HIA</p> <p>Overview/summary on completion of HIA report/recommendations</p>	<p>12 January 2010 Janes, Ruth and Alison will pull together information and start a running record of the various resources, including personnel, that contribute to the HIA for the CPT</p>
<p>Interviews of at least 4 key stakeholders by</p>	<p>Develop interview guidelines</p>	<p>On completion of HIA report</p>	

<p>evaluator – aimed at seeking information as to what they saw was useful in the process; what they thought was less useful and how they think things might be done differently in future such circumstances</p> <p>Anonymous written evaluation questionnaire/survey (refer Objective 5) developed by evaluator for completion by all key stakeholders.</p> <p>Evaluator to analyse responses from both interviews and written evaluations and develop a summary</p>	<p>and Develop evaluation sheet Evaluator 4 hours</p> <p>Analysis and summary – Evaluator 8 hours</p>		
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3. To analyse the extent to which the recommendations made by the HIA were taken into account in both the stage 1 and stage 2 documents for the RLTS.

<b>Methods and associated details</b>	<b>Resources</b>	<b>Dates</b>	<b>Weekly review of progress (Include date, update and link for report/overview/summary)</b>
The evaluator and the evaluation team analyse the extent to which the recommendations made in the HIA have been included in the RLTS	Final version of RLTS  Key stakeholder 4 hours for review  Evaluator 1 day for review and summary	On completion of the RLTS	

4. To assess the level of capacity building that has occurred, and ascertain whether the current political environment may have had an impact on the HIA process for the RLTS.

<b>Methods and associated details</b>	<b>Resources</b>	<b>Dates</b>	<b>Weekly review of progress (Include date, update and link for report/overview/summary)</b>
<p>Evaluator develops a questionnaire/survey (Refer Objective 2) that also includes questions about:</p> <ul style="list-style-type: none"> <li>- self-perceived personal and work related achievements that may have occurred as a result of their involvement in the HIA processes</li> <li>- perceptions of the influence of the political environment on the HIA process</li> </ul> <p>Distribute questionnaire to all involved personnel (aim for 60% return)</p> <p>Evaluator analyses survey responses</p>	<p>Questionnaire</p> <p>IS expertise</p> <p>Evaluator</p>	<p>At end of HIA for RLTS</p>	

5. To ascertain appropriate methods for ongoing monitoring of the health impacts of the RLTS.

<b>Methods and associated details</b>	<b>Resources</b>	<b>Dates</b>	<b>Weekly review of progress (Include date, update and link for report/overview/summary)</b>
In consultation with the wider project team, the evaluation team use the recommendations and content of the HIA, the RLTS documents (as appropriate) to develop appropriate methods for the ongoing monitoring of health impacts during the implementation of the RLTS.	Final version of HIA report/recommendations  Final version of RLTS  Evaluation team  Key stakeholders (e.g. project team)	By commencement of the implementation of the RLTS    Ongoing from then	



