Organizational Conditions Favourable for Health Impact Assessment (HIA)

March 2014

Briefing Note

For up-to-date knowledge relating to healthy public policy

One of the mandates of the National Collaborating Centre for Healthy Public Policy (NCCHPP) is to inform Canadian public health practitioners about effective strategies for fostering the adoption of healthy public policies.

Health impact assessment (HIA) is currently the most structured practice available to public health actors working toward this goal. HIA is applicable to policies developed by sectors other than that of health, which may have significant effects on the determinants of health.
The specific focus of this briefing note is to identify basic organizational conditions necessary for incorporating HIAs into routine practice.

Introduction

The growing interest in health impact assessment (HIA) within Canada is often accompanied by questions of a practical nature: How does one move from theory to practice? What basic organizational conditions are necessary for such a practice to be initiated? Where should one begin?

The aim of this briefing note on the basic conditions needed to initiate the practice of HIA is to provide some answers to these questions. It is intended for local and regional public health authorities that would like to explore the possibility of carrying out HIAs on municipal policies.

> *HIA is a process that combines scientific evidence and stakeholders' knowledge to identify the potential effects of a new proposal (for a policy or a project) on the health of the population and on equity. The goal is to formulate recommendations that can help decision makers to protect and improve health and equity.*

It should be clarified from the outset that the NCCHPP focuses specifically on what is referred to as the *decision-support* model of practice. This type of HIA is conducted on a voluntary basis, in collaboration with decision makers and in the absence of a regulatory framework (Harris-Roxas & Harris, 2011).

This practice is of primary concern to public health organizations. HIA is a tool and process that fosters the implementation of healthy public policies. Although it is flexible and can be adapted to diverse implementation contexts, it nevertheless requires the presence of certain basic organizational conditions to be practised successfully.

By reviewing international HIA experiences, it is possible to identify some common aspects that refer to these basic conditions. These pertain to:

- the way public health is organized (its mission, its mandates);
- available resources and basic skills;
- work methods and tools.

In Canada, regional and local public health structures vary from one province or territory to another, but the majority have the capacity to meet the basic organizational conditions required to initiate the effective practice of HIA. We will examine these seven conditions in the sections below.

Centre de collaboration nationale sur les politiques publiques et la santé
National Collaborating Centre for Healthy Public Policy

Institut national de santé publique Québec

7 organizational conditions

Relating to the organization
Condition 1: Public health mandates that include taking action on healthy public policy
Condition 2: An organizational culture conducive to intersectoral action and a multidisciplinary approach
Condition 3: Strong leadership and support from management

Relating to resources
Condition 4: Organizational mechanisms devoted to HIA
Condition 5: Access to the minimum necessary resources (human, informational and financial)
Condition 6: Skills and workforce development

Relating to methods and tools
Condition 7: Use of a guide and a standardized work method

A supportive organizational environment

Condition 1:
PUBLIC HEALTH MANDATES THAT INCLUDE TAKING ACTION ON HEALTHY PUBLIC POLICY

The first condition is a public health organization's commitment to act on healthy public policies. If the public health organization is clearly in support of developing healthy public policies or working with other political decision-making bodies in its mission and mandates, it is easier for professionals to venture outside the traditional boundaries of the health sector. Some fields of activity in public health, such as the reduction of inequalities, environmental health, community development and the promotion of healthy living habits, naturally tend to involve public health practitioners in an intersectoral work dynamic. These are fields of activity which are favourable to the use of HIA. At the municipal level, the integration of HIA practices could be useful as well. Whether it is for sustainable development, urban planning or territorial development, the health sector can bring added value to municipal decisions, while working to improve the health of the population (Signal, Soeberg, & Quigley, 2013).

Condition 2:
AN ORGANIZATIONAL CULTURE CONDUCIVE TO INTERSECTORAL ACTION AND A MULTIDISCIPLINARY APPROACH

In addition to a clear mandate for healthy public policies, an organizational culture that is conducive to intersectoral and interdisciplinary work are important. Indeed, an issue that was mentioned frequently in the literature from international experiences is difficulty with intersectoral work, including cultural barriers among the various sectors called upon to contribute to the HIA process (Ahmad, B., Chappel, D. Pless-Mulloli, T., & White, M., 2008; Räftegard, 2007; Kearney, 2004). An organization that is accustomed with intersectoral work will be more apt to plan accordingly. To this difficulty we can add the one linked to the presence of subcultures within public health organizations where we can observe the tendency to work in silos (Pursell & Kearns, 2012). HIA is based on a holistic view of health. It takes into consideration the full range of health determinants, whether social, economic, physical or individual; it therefore draws on a broad range of public health knowledge, depending on the nature of the policy proposal being examined. On an organizational level, HIA calls for horizontal management where all the public health expertise can be gathered within a same project. For example, environmental health professionals may be called upon to work with professionals promoting healthy living habits, those responsible for youth programs, or those combating social inequalities of health. They pool their collective knowledge and integrate it into recommendations aimed at improving a policy proposal, from the standpoint of population health.

Thus, one of the conditions that facilitate the HIA practice is the presence of an institutional culture which fosters and promotes the value of involving external partners, as well as interdisciplinary work within public health organizations (Ahmad et al., 2008; Bekker, 2007).

Condition 3:
SOLID LEADERSHIP AND SUPPORT FROM MANAGEMENT

A firm commitment on the part of organizational authorities, along with their ongoing support, has also been identified as an element that is pivotal to the successful implementation of HIA within organizations (Cole & Fielding, 2007; Davenport, Mathers, & Parry, 2006). HIA is usually introduced as a new public health practice and is thus considered

an innovation. Therefore, during the early stages of experimentation, managers must demonstrate openness and flexibility, allowing the space necessary for the learning process. They must support those championing the practice, who are often those willing to step off the beaten path and explore new avenues with partners who are sometimes equally new. Thus, leadership needs to occur at multiple levels (Hughes & Kemp, 2007).

KEY QUESTIONS

- To what parts of the mandate/ orientations/ public health program may I refer to, to justify the practice of an HIA? What are the desired objectives?
- What is our knowledge and what are our habits with regards to intersectoral action? What did we learn from our previous experiences that could help us when experimenting with an HIA?
- What are our habits with regards to interdisciplinary work in our organization? What are the anticipated difficulties? What are the successes on which we can capitalize?
- What is the level of support for this initiative at the management level (strong, average, low)? To what extent is this support vital for proceeding? What could be done to increase the level of support (if necessary)?

Supportive resources

Condition 4:
ORGANIZATIONAL MECHANISMS AND CLEARLY DEFINED RESPONSIBILITIES

Organizational leadership also takes the form of establishing a series of measures and mechanisms, which can be fairly simple, intended to support development of the practice. At a minimum, this may involve establishing a work process clarifying and detailing the roles and responsibilities of each person relative to the practice and the factors that would suggest launching an HIA. Identifying a person or a team as the pivotal HIA resource firmly roots it within the organization. Some organizations recommend including HIA in the job description of designated professionals. Others have put in place a more robust mechanism, such as a specific unit responsible for coordinating activities related to HIA.

The existence of this type of structure dedicated to HIA has been found to be particularly useful for ensuring the development and sustainability of the practice (St-Pierre, 2009; Ahmad et al., 2008; Wismar, Blau, Ernst, & Figureras, 2007). These individuals, teams or organizational structures can then be entrusted with tasks related to the development of guides, intersectoral coordination and collaboration, skills development and quality control of HIAs; these are all essential tasks.

Condition 5:
ACCESS TO THE NECESSARY RESOURCES

Among the most frequently-asked questions related to the ability of an organization to conduct an HIA are those concerning the resources required to establish and maintain the practice of high-quality HIA (O'Reilly, Trueman, Redmond, Yi, & Wright, 2006). Such questions often stem from a false conception of HIA as a necessarily long and in-depth study of potential impacts, similar to those produced in the field of environmental impact assessment. Numerous international experiences at the regional and local levels of government have shown that it is possible to conduct good quality HIAs that succeed in modifying the perspective of policy makers, with minimal resources (Wismar et al., 2007; Quigley & Taylor, 2004).

Human resources

Apart from the presence of a pivotal person or unit, the availability of content experts must be ensured. Such persons may be found either within or outside of the organization. Some public health institutions have opted to contract out HIAs. While this way of doing things may make it possible to secure funding for HIA and avoid delays caused by competing organizational priorities, it has the disadvantage of depriving the organization of the secondary benefits of HIA. These include skills development and the building of relationships with intersectoral partners (O'Reilly et al., 2006). Those with the responsibility to undertake HIAs need the time not only to do them but also to develop the relationships needed to make them possible (Harris et al., 2013a).

Nevertheless, some of the work involved in conducting an HIA can be assigned to external resources, such as reviewing the literature or consulting with citizens' groups and other stakeholders, for example. This approach allows internal resource people to devote their time to other tasks, such as gathering and analyzing information.

Given that most HIAs carried out at these levels are rapid or intermediate HIAs (Kemm, 2012), the impact on human resources, while real, generally gets distributed among the various existing units. In time, organizations generally find ways of integrating HIA into regular public health practices by reallocating existing resources (Kemm, 2007).

Informational resources

Access to reliable data is fundamental to health impact assessment. Depending on the type of the proposal being examined, these data may be quantitative or qualitative and simple or sophisticated in nature. Given that HIAs are characteristically prospective and will always contain an element of uncertainty, it is important to note that the goal here is to obtain the best information available in the time allotted for the HIA. Since the timeframe of an HIA depends on that of the policy-making process, this element doubtless accounts for one of the greatest difficulties confronting public health actors: that of finding the fulcrum point at which it becomes possible to provide reliable information sufficient to support decision making that promotes health. Usually two levels of knowledge are required for impact analysis. The first level deals with the links between elements of the project in question and the determinants of health. This type of knowledge is usually readily available in the literature. The goal may be, for example, to draw the links between the construction of a new road and road safety, or those between the development of a neighbourhood and its social mixity. The growing availability of HIA reports, which continue to accumulate over time, facilitates the acquisition of this type of knowledge. The second level of knowledge should make it possible to more specifically estimate the potential effects of a policy on a specific population. The knowledge required is that which allows the profile of this population (health and socio-demographic) to be established, as well as that which allows potential risks to be calculated. Ideally, an HIA should succeed in estimating the scope and magnitude of impacts on the health of several population groups (Kemm, 2005). However, there are many instances of situations where the information provided to decision makers did not reach this degree of precision, yet still had an effect on decision making. The central point here is the importance of staying focused on providing precisely the level of information needed to assist decision making and improve the proposed project from a health standpoint.

Financial resources

The cost issue is frequently raised by public health organizations that are unsure of their ability to undertake an HIA. It is difficult to provide answers here, as cost may be influenced by several factors[1]. A few of these are listed below:

- The nature of the policy or project

A project of a technical nature, for example, governed by established standards or subject to predetermined thresholds, can be studied by examining its degree of compliance. A social policy with many ramifications, whose study necessitates the collection of essential information from hard-to-reach people, requires more time and resources.

- The type of HIA

In the same vein, a rapid HIA (that is, one completed in a period of between two weeks and three months), which is based on existing knowledge, is less costly than an in-depth HIA, which usually necessitates the collection of new data and can extend over more than a year. The research method will also affect the total cost.

- The accessibility of necessary resources

If the required information is available and easily accessible by public health organizations and their partners, the cost of acquiring them will be reduced.

An economic study conducted for the UK government found that an HIA carried out by local or regional health authorities costs on average the equivalent of 7,000 Canadian dollars, with the cost ranging from as little as $2,000 to as much as $27,000 CAD (O'Reilly et al., 2006). In the United States, a recent study evaluated the cost of an HIA, whether or not it is done by the private sector, at between 10,000 and 200,000 American dollars. This cost is still considered lower than that normally incurred for environmental impact assessments (Health Impact Project, 2011). In Québec, the average cost of an HIA carried out at the regional public health level has been estimated at $16,000 CAD. This cost is largely attributable to the work time of professionals (Direction de la santé publique de la Montérégie, 2011).

Here again, different possibilities exist. For example, environmental health authorities in San Francisco

[1] A spreadsheet for calculating the costs of HIA is available at the following address: http://www.ccnpps.ca/docs/EIS-HIA_Calculator_EN.xlsx

have established a cost-sharing arrangement with the regional municipality. In addition, internal departmental reorganization has resulted in savings that have been used to hire personnel assigned to HIA (Human Impact Partners, 2012).

Table 1 Estimated cost of HIAs (in Canadian dollars)

Country	Minimum	Maximum
UK	2,000	70,000
USA	10,000	200,000
Canada (Québec)	Average: 16,000	

Condition 6:
SKILLS DEVELOPMENT

It has been clearly demonstrated that initiating HIA practice is greatly facilitated by activities that build knowledge and develop skills associated with different aspects of HIA (Harris et al., 2013a; Berensson, 2004). Many skills are required to successfully carry out an HIA. In addition to methodological skills, skills tied to project management, writing, negotiation, citizen participation and interdisciplinary work, among others, must be considered (Kemm, 2007). Recent studies show that people who understand the broader policy context and who are good at crossing organizational boundaries are well placed to undertake HIAs (Harris, Kemp, & Sainsbury, 2012; Harris, Harris-Roxas, Harris et Kemp, 2013b). Such abilities are possessed in varying degrees by professionals called upon to conduct HIAs. Training allows these skills to be channelled toward fulfillment of the specific objectives and values of HIA.

HIA could be seen as an innovative approach to organizational practices. In this respect, the organization developing an HIA practice will benefit from the collective learning opportunities that an HIA implies. Indeed, a study by Mindell and Boltong (2005) of the conditions supporting integration of the practice concludes that the most important step is to allocate time and resources to staff for testing the process and the proposed tools, and for discussing these. Thus, taking the time needed to train, to build relationships and to do the work is considered as an important success condition for HIA (Harris et al, 2013b). The same approach is also considered appropriate for partners who will be called on to participate in HIAs (Hughes & Kemp, 2007). This is the path that was adopted in Sweden, for example, where major efforts have been devoted to training project partners (Räftegard, 2007).

KEY QUESTIONS

- What kind of HIA practice do we want to develop? A thorough one (with emphasis on the evidence base and researching new data)? An intermediate one (using existing data and information)? A quick one (in response to ad hoc requests)? Mainly with experts? In association with stakeholders, citizens or decision makers?
- What are the processes that we would like to implement to insure good practice? In the short term? In the longer term?
- Do we have experience regarding citizen participation? If not, are there organizations, in our environment that have this experience?
- What internal or external resources (people, units, and/or teams) could be used?
- What conditions would facilitate the involvement of these people or groups?
- To what types of data do we have easy access? Internally? Externally?
- Is it necessary to plan for additional financing or is it possible to undertake HIAs (or a part of them) with internal resources?
- What could be the potential sources of funding?
- Do we need training? If yes, what are the options (courses, people, and/or organizations)?
- What mechanisms are we planning to use to look back at our HIA experience to discuss what we learned and what our difficulties were?

Methods and tools that provide guidance

Condition 7:
USE OF A GUIDE AND A STANDARDIZED METHOD

The field of HIA has developed through a standardized method for structuring the overall

process. Over the course of time, several guides and tools have been created by governments and by the various organizations that support HIA practice. These have proven essential to establishing HIA and its spread throughout the world (Davenport et al., 2006; Harris et al., 2013b). Not only do they ensure that work can be carried out in a consistent and rigorous manner, but they also serve as vehicles for sharing the vision and objectives underlying HIA. Guides thus become important tools for communication both within public health organizations and within the broader community involved in the HIA process, which includes policy makers, the prime users of the results of HIAs. The NCCHPP has identified and classified the various HIA tools that have been published to date[2]. Many organizations use existing guides and tools as the basis for the development of their own tools, adapted to their specific contexts.

And now, where to start?

The seven conditions described above have proven to be important to ensuring the sustainable practice of HIA. However, many practitioners say that it is not necessarily best to wait until all these conditions are met before first attempting to experiment with HIA. These conditions can gradually be established during the experimentation process.

For public health organizations interested in initiating the practice of HIA, the International Union for Health Promotion and Education (International Union for Health Promotion and Education, 2011) has formulated the following recommendations:

- Be on the lookout for opportunities which arise in the environment and that would be convenient for a first experiment;
- Choose a small project with strong support to begin with, and make it a pilot project. It is better to start small and build on your successes;
- Make sure that you have someone on the team with some knowledge of HIA, or that you can rely on a knowledgeable organization for mentoring;
- Choose a situation where it would be possible to enlist help from other organizations or from key community stakeholders;
- Rely on an existing practice guide, choosing the one that best suits your needs;
- And dive in. We learn mostly by doing.

KEY QUESTIONS

- What tools could help us structure our HIA initiatives?
- Is there an existing HIA guide that meets our needs?
- What model of the determinants of the health do we want to use to frame our approach?
- To what extent will our tools (guide, model of the determinants of health, screening tool, framework, etc.) be used as a communication tool in addition to being a work tool?
- To what extent do we want these tools to be understandable for our partners (tools specifically for analysts or communication tools)?

USEFUL LINKS

Documents:

- HIA Practice Standards Document http://www.ncchpp.ca/133/publications.ccnpps?id_article=268
- Health Impact Assessment. Tool Kit for cities. 43 pages http://www.euro.who.int/__data/assets/pdf_file/0007/101500/HIA_Toolkit_1.pdf
- Health Impact Assessment. A guide for practice http://www.healthimpactproject.org/resources/document/Bhatia-2011_HIA-Guide-for-Practice.pdf
- Health Impact Assessment: Guides and Tools http://www.ncchpp.ca/133/publications.ccnpps?id_article=391

Portals:

- Health Impact Project (USA) http://www.healthimpactproject.org/
- HIA Connect (Australia) http://hiaconnect.edu.au/

[2] This inventory can be consulted at the following address: http://www.ncchpp.ca/133/Publications.ccnpps?id_article=391

References

Ahmad, B., Chappel, D. Pless-Mulloli, T., & White, M. (2008). Enabling factors and barriers for the use of health impact assessment in decision-making processes. *Public Health, 122*(5), 452-457.

Bekker, M.P.M (2007). *The politics of healthy policies. Redesigning health impact assessment to integrate health in public policy*. Delft: Eburon.

Berensson, K. (2004). HIA at the local level in Sweden. In Kemm, J., Parry, J. & Palmer, S. (Eds.), *Health Impact Assessment: Concepts, theory, techniques, and applications.* (pp. 213-222). Oxford: Oxford University Press.

Cole, B. L. & Fielding, J. E. (2007). Health impact assessment: A tool to help policy makers understand health beyond health care. *Annual Review of Public Health, 28*(1), 393-412. doi: 10.1146/annurev.publhealth.28.083006.131942

Davenport, C., Mathers, J., & Parry, J. (2006). Use of health impact assessment in incorporating health considerations in decision making. *Journal of Epidemiology and Community Health, 60*(3), 196-201. doi: 10.1136/jech.2005.040105

Direction de la santé publique de la Montérégie (2011). Internal document. Québec, Canada : Agence de la Santé et des Services sociaux de la Montérégie. Unpublished.

Harris, P., Kemp, L. A., & Sainsbury, P. (2012). The essential elements of health impact assessment and healthy public policy: a qualitative study of practitioner perspectives. *BMJ Open, 2*(6).

Harris, E., Haigh, F., Baum, F., Harris-Roxas, B., Kemp, L., Ng Chok, H., ... Dannenberg, A.L. (2013a). *The Effectiveness of Health Impact Assessment in New Zealand and Australia 2005-2009*. Sydney: NSW Centre for Primary Health Care and Equity.

Harris, E., Harris-Roxas, B., Harris, P., & Kemp, L. (2013b). Learning by doing, building workforce capacity to undertake health impact assessment: an Australian case study. In Monica O'Mullane (Ed.), *Integrating Health Impact Assessment with the Policy Process. Lessons and experiences from around the world.* (pp. 99-108). Oxford: Oxford University Press.

Harris-Roxas, B. & Harris, E. (2011). Differing forms, differing purposes: a typology of health impact assessment. *Environmental Impact Assessment Review, 31*(4), 396-403. doi:10.1016/j.eiar.2010.03.003

Health Impact Project. (2011). Health impact assessment: bringing public health data to decision making. Consulted on November 8, 2013: http://www.healthimpactproject.org/resources

Hughes, J. L. & Kemp, L. A. (2007). Building health impact assessment capacity as a lever for healthy public policy in urban planning. *New South Wales Public Health Bulletin, 18,* 192-194.

Human Impact Partners. (2012). Completed HIA Projects, Consulted on November 29, 2012: http://www.humanimpact.org/projects/past-projects/

International Union for Health Promotion and Education. (2011). *Health Impact Assessment (HIA): A tool for public decision-making towards healthy, sustainable and equitable choices.* 4th international francophone conference on local and regional health programmes, June 2011. Québec: International Union for Health Promotion and Education. Retrieved from: http://www.iuhpe.org/images/GWG/HIA/2012 08_HIA_GuidingPrinciples_ENG.pdf

Kearney, M. (2004). Walking the walk? Community participation in HIA: A qualitative interview study. *Environmental Impact Assessment Review, 24,* 217-229.

Kemm, J. (2005). The future challenges for HIA. *Environmental Impact Assessment Review, 25*(7-8), 799-807. doi: 10.1016/j.eiar.2005.07.012

Kemm, J. (2007). What is HIA and why might it be useful? In M. Wismar, J. Blau, K. Ernst & J. Figueras (Eds.), *The effectiveness of health impact assessment: Scope and limitations of supporting decision-making in Europe*. (pp. 3-13) Brussels: European Observatory on Health Systems and Policies. Retrieved from: www.euro.who.int/document/e90794.pdf

Kemm, J. (2012). *Health Impact Assessment. Past Achievements, Current Understanding and Future Progress.* London: Oxford University Press.

Mindell, J. & Boltong, A. (2005). Supporting health impact assessment in practice. *Public Health, 119*(4), 246-252.

O'Reilly, J., Trueman, P., Redmond, S., Yi, Y., & Wright, D. (2006). *Cost benefit analysis of health impact assessment – final report.* London: York Health Economics Consortium and London Department of Health. Retrieved from: http://hiaconnect.edu.au/old/files/Cost_Benefit_Analysis_of_HIA.pdf

Pursell, L. & Kearns, N. (2012). Impacts of an HIA on inter-agency and inter-sectoral partnerships and community participation: lessons from a local level HIA in the Republic of Ireland. *Health Promotion International, 28*(4), 522-532. doi: 10.1093/heapro/das032

Quigley, R. J. & Taylor, L. C. (2004). Evaluating health impact assessment. *Public Health, 118*(8), 544-552. doi: 10.1016/j.puhe.2003.10.012

Räftegard, T. (2007). *Health Impact Assessment. Barriers and Facilitators. A systematic review and suggestion on a future study*. Stockholm: Departement of Public Health Sciences, Karolinska Institute.

Signal, L., Soeberg, M., & Quigley, R. (2013). Health impact assessment in local government. In M. O'Mullane (Ed.), *Integrating Health Impact Assessment with the Policy Process. Lessons and experiences from around the world*. Oxford : Oxford University Press.

St-Pierre, L. (2009). *Governance tools and framework for health in all policies*. European Observatory on Health Systems and Policies. Retrieved from: http://www.rvz.net/uploads/docs/Achtergrondstudie_-_Governance_tools_and_framework1.pdf

Wismar, M., Blau, J., Ernst, K., & Figueras, J. (Eds.). (2007). *The effectiveness of Health Impact Assessment: Scope and limitations of supporting decision-making in Europe.* Copenhagen: World Health Organization (on behalf of the European Observatory on Health Systems and Policies). Retrieved from: http://www.euro.who.int/document/E90794.pdf

March 2014

Author: Louise St-Pierre, National Collaborating Centre for Healthy Public Policy

Editing: Alima Alibhay and Michael Keeling, National Collaborating Centre for Healthy Public Policy

SUGGESTED CITATION

St-Pierre, L. (2014). *Organizational Conditions Favourable for Health Impact Assessment (HIA)*. Montréal, Québec: National Collaborating Centre for Healthy Public Policy

ACKNOWLEDGMENTS

The NCCHPP would like to thank Elizabeth Harris, Kari Barkhouse, Emile Tremblay and one anonymous reviewer for their comments on an earlier version of this document.

The National Collaborating Centre for Healthy Public Policy (NCCHPP) seeks to increase the expertise of public health actors across Canada in healthy public policy through the development, sharing and use of knowledge. The NCCHPP is one of six centres financed by the Public Health Agency of Canada. The six centres form a network across Canada, each hosted by a different institution and each focusing on a specific topic linked to public health. In addition to the Centres' individual contributions, the network of Collaborating Centres provides focal points for the exchange and common production of knowledge relating to these topics. The National Collaborating Centre for Healthy Public Policy is hosted by the Institut national de santé publique du Québec (INSPQ), a leading centre in public health in Canada.

Production of this document has been made possible through a financial contribution from the Public Health Agency of Canada through funding for the National Collaborating Centre for Healthy Public Policy (NCCHPP). The views expressed herein do not necessarily represent the views of the Public Health Agency of Canada.

Publication N°: XXXX

This document is available in its entirety in electronic format (PDF) on the National Collaborating Centre for Healthy Public Policy website at: www.ncchpp.ca.

La version française est disponible sur le site Web du Centre de collaboration nationale sur les politiques publiques et la santé au : www.ccnpps.ca.

Centre de collaboration nationale sur les politiques publiques et la santé

National Collaborating Centre for Healthy Public Policy

Institut national de santé publique Québec