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Keywords
Health impact assessment, inter-sectoral partnerships, community participation

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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.

Abstract

This study evaluates the impacts of a locally based health impact assessment (HIA) on community participation, inter-sectoral and inter-agency partnership in local decision and policy-making processes. The methods comprised a series of semi-structured interviews with key informants followed by thematic analysis of transcribed responses. The study revealed a number of positive impacts among both community and service providers. A particularly advantageous impact was the facilitation of community learning through a local action group formed as a recommendation of the HIA that provided community development and HIA training. During the HIA process all participants increased their knowledge of health determinants and recognised a broader range of evidence sources for local decision-making. Participants also developed a greater understanding of each other's roles and perspectives.

Additionally, the study revealed a number of barriers to HIA. Differing views on the role of HIA were evident whereby community members tended to regard HIA as an advocacy tool for local issues impacting on health in their locality while service providers perceived its role more in terms of networking and collaboration. A key area remaining to be tackled in terms of partnership working is the approach of service agencies to enabling meaningful community participation in local decision-making processes. In this respect attention to the cultural dimension of inter-sectoral working, and the need for training for both service agency staff and community members prior to or at the initial stages of HIA are required. Such changes could facilitate more meaningful community inclusion and help to address the current power imbalance between these two sectors.

Introduction

In this article, we provide an evaluation of partnership working and community participation based on the experiences of stakeholders involved in the first HIA in the Republic of Ireland. In the opening section, we briefly describe the core components of HIA and locate it in the context of the Irish policy arena. The dual role of HIA in terms of health promotion, which is closely associated with the formation of Healthy Public Policy (HPP), and community development, which emphasises the value of participation, sets the conceptual parameters for the paper. The background to the study from which this paper was developed is detailed, followed by an account of the methods, sample and data used. The study's results are thematically presented on a two-fold basis in terms of inter-sectoral and inter-agency partnership working through a local level HIA, and the development of learning and understanding regarding the practice of HIA. In the discussion, we illustrate a set of salient issues concerning the perceived value of sustainable partnerships between community members and service providers. The consequences of a series of organisational cultural barriers encountered in the Ballyfermot HIA leading to significant implementation challenges are also reflected on. The potential role of HIA from a community development perspective is outlined in terms of advocacy, knowledge sharing and joint working. Finally, we consider the core impacts of the Ballyfermot HIA and highlight the remaining challenge of adopting a more culturally sensitive approach to the implementation of HIA.

Health impact assessment (HIA) has been described as a tool that supports decision-making by analysing the potential effects of a planned action on health (Scott-Samuel *et al.*, 2001). Over the past decade, HIA has become a widely known tool to assess the impact of policies from either a prospective, concurrent or retrospective perspective in terms of the direct or indirect implications for positively or negatively affecting health and health equity. HIA has three interrelated objectives, to predict the impacts of policies on health, to involve all relevant stakeholders in the assessment process (participation), and to inform the decision-making process (Parry and Kemm, 2005). There has been a strong drive to promote the use of HIA for examining policies, programmes, or projects at both regional and national levels of government (Kemm, 2003; Lock, 2000; Parry and Stevens, 2001). In the Republic of Ireland, at the national level there is a commitment to introducing HIA as part of the public policy development process in the national health strategy 'Quality and Fairness – a health system for you' (Department of Health and Children, 2001). At the local level, the health strategy outlined the requirement for regional-level structures such as local authorities and city or county development boards to consider the impact of their decisions on population health in their areas (Department of Health and Children, 2001).

HIA can be understood from a number of inter-linked perspectives emphasising health enhancement and participatory aspects. The United Nations Scientific Educational and Cultural Organisation (1997) stressed the important role health promotion and health education can play in equipping people with the ability to critically assess and engage in effective social action to bring about change in situations concerning the health of local communities. It noted that this requires an inter-sectoral and community development approach. Such health promotion and community development roles of HIA have been similarly emphasised by a number of authors (Bos, 2006; Cameron *et al.*, 2010; Mittelmark, 2001; Mittelmark *et al.*, 2007). The health promotion role focuses on the enablement of healthy or healthier public policies based on the evidence furnished by HIAs with regards to informing policy makers and health advocates on harmful and/or beneficial factors. HPP, characterised by "an explicit concern for health and equity in all areas of policy and by accountability for health impact" (WHO, 1988), is one of the conceptual roots of HIA (Haigh *et al.*, 2012). HPP was popularised during the late 1980s and early 1990s as a means of broadening the scope of health policy beyond the focus of medical health programmes to cross-sectoral population level health promotion (Mahoney *et al.*, 2007). More recently, the centrality of HIA in the promotion of HPP across local, regional and national levels has been emphasised as a key enabler in the promotion of health (Metcalfe and Higgins, 2009).

The community development role of HIA focuses on participation, making the decision-making process more transparent and inclusive as a result of greater levels of involvement by stakeholders (Kemm, 2000). Participation is a core value of HIA (Parry and Wright, 2003) and community participation is widely regarded as a core aspect of the HIA process (European Centre for Health Policy, 1999; Kearney, 2004; Mittelmark, 2001). From an ethical perspective, participation is considered a means of achieving social justice whereby local concerns are addressed and those affected by policies have a voice in the decision-making process (Parry and Kemm, 2005; Scott-Samuel, et al., 2001). The collection of knowledge and views at the local level from members of affected communities also gives validity to qualitative evidence (Parry and Kemm, 2005). Community participation in policy development and implementation is increasingly recognised in relation to health improvement and social regeneration (Pickin *et al.*, 2002). In this context HIA is based on the principle of individuals and communities coming together to learn from one another, to jointly identify

issues of concern to their health and well-being, and to decide on the appropriate plans and actions to address these issues (Coady, 2010).

Community HIA is regarded as an empowering and educational tool as it places those potentially affected by policies at the centre of the planning and decision-making processes. It equips people with analytical skills to critically assess the potential effect of projects on community well-being and engage in social action to bring about desired change (Cameron, et al., 2010; United Nations Scientific Educational and Cultural Organisation, 1997). Mittelmark *et al.,* (2007) have argued that such a community development approach to HIA can increase the likelihood that policy and decision-makers will listen when citizens raise issues of concern within their community. According to this perspective, HIA may be used as a tool for identifying objectives for action, enabling the community "to then take action through the HIA process, developing its ability to collaborate to solve problems and create opportunities for community improvement" (Mittelmark, et al., 2007). Such local ownership is similarly referred to by Mahoney *et al.,* (2007) in their typology of HIA comprising non-participatory HIA, consultative HIA, participatory HIA, and community HIA. This collaborative aspect of HIA has also been highlighted by Bos (2006) who pointed out that HIA provides a mechanism for the engagement of various actors to promote health while stimulating inter-sectoral actions. Whilst there is a well developed body of literature on the topic of participation, Mahoney *et al*., (2007) point out, despite the rhetoric, there has been little critical examination of the role of community participation in HIA. One exception is an article by (Parry and Wright, 2003) which highlights the practical challenges of attaining community involvement in HIA and questions the extent to which meaningful participatory involvement of community members can actually occur.

A form of HIA most closely aligned to health promotion and community development approaches is the narrative based community HIA tool (CHIAT) developed in The People Assessing Their Health (PATH) project, Nova Scotia, Canada (Cameron, et al., 2010). PATH is an empowering process that seeks to increase peoples control over and improve their health through building their capacity and skills to become active participants in decisions that affect the well-being of their community. The CHIAT is used to ascertain the facilitators of health in order to undertake a community-led HIA (CHIA) (Cameron, et al., 2010). The highly participatory process utilised in PATH enabled a population level perspective on community health and highlighted the value of CHIATs to support community action on health (Mittelmark, 2001). The WHO Healthy Cities networks, operating since 1987, are similarly cited as a means of orienting the policy process towards the community level as a means of helping communities take action to address conditions that need changing to improve health and well-being (Mittelmark, 2001; Pickin, et al., 2002).

Background to the study

The study outlined for the purposes of this paper is based on an evaluation of an HIA on traffic and transport in Ballyfermot (the Ballyfermot HIA), a suburban area of Dublin city. Ballyfermot was chosen from the 10 most disadvantaged areas in Ireland to receive funding under the European Union (EU) URBAN II Community Initiative 2000-2006. URBAN is a Community Initiative of the European Regional Development Fund (ERDF). URBAN I was first launched in 1994 to enable urban districts in crisis within the European Union to design innovative, integrated urban development measures for regeneration. As a follow-up to URBAN I (1994-99), URBAN II focused on promoting the design and implementation of innovative models of development for economic and social regeneration (European

Commission, 2008). As part of this EU programme, URBAN Ballyfermot Ltd. was formed as a social and environmental regeneration programme funded by the European Commission, Ireland's National Development Plan and Dublin City Council (European Commission, 2005).

The Ballyfermot HIA was the first conducted in the Republic of Ireland and formed part of the initial drive to promote such assessment within the State. It was commissioned by URBAN Ballyfermot Ltd. and carried out by the Department of Public Health at the former Eastern Regional Health Authority (ERHA) between 2003 and 2004 (ERHA, 2004). It was managed by a multi-disciplinary steering group that included representation from the former ERHA, the former South Western Area Health Board (SWAHB), URBAN Ballyfermot Ltd. (which included representatives from the local community), the Institute of Public Health in Ireland (IPHI), Dublin City Council (DCC), and external consultants (ERHA, 2004). The main objectives of the Ballyfermot HIA included: engaging the community to pro-actively participate in decision-making; developing an effective partnership for conjoint working between the community, statutory and voluntary sectors that would influence traffic and transport planning and services in the locality, and promoting learning and understanding across these sectors (ERHA, 2004). A recommendation arising from the HIA was to make the processes sustainable through the establishment of a multi-sectoral local action group (LAG) to oversee the implementation of other recommendations and targeted actions and to address identified issues pertinent to the local area (ERHA, 2004).

As part of the final phase of the Ballyfermot HIA, an evaluation was commissioned by the former ERHA. The evaluation sought to examine process, impact and outcomes of the HIA. HIA procedures used in the Ballyfermot case were evaluated against a set of agreed Terms of Reference (process evaluation), the overall value and the worth of the HIA was evaluated through focusing on its impact on processes such as decision-making, policy and programme developments, and participatory strategies (impact evaluation). Finally, the evaluation compared notional and actual outcomes of the HIA relating to the originally proposed and actually-implemented recommendations and actions (outcome evaluation). The data presented in this paper focuses on the impact evaluation findings of that study.

Methods

The evaluation study of the Ballyfermot HIA utilised a qualitative research design in order to gather in-depth, experiential accounts of the HIA's impacts from the core stakeholders. Two non-probability sampling strategies (purposive and snowball) were employed to access informants (Denscombe, 2010). The purposive strategy consisted of attempts to contact all 20 steering group (SG) members who had knowledge and experience of the HIA as a result of their membership of the Ballyfermot HIA (ERHA, 2004). Eleven of the SG members were available for interview, while nine were not contactable (a number had moved to different positions and/or organisations at the time the evaluation was being undertaken). The snowballing strategy identified other key informants that SG members suggested were of particular relevance to the evaluation. Based on this sampling strategy, contacts for 22 stakeholders were provided including members of: the community, the service provider agencies, the Local Action Group (LAG) (responsible for the implementation of the Ballyfermot HIA recommendations), and other relevant local organisations. Of these, 10 were available for interview. In total, a final sample of 21 was derived, 11 from the initial HIA SG and 10 from the community and other organisations and agencies involved in the HIA.

A series of interviews were conducted to explore participants' perceptions of the impacts of the HIA. The Merseyside Guidelines for HIA (Scott-Samuel, et al., 2001) were used by the Ballyfermot HIA Steering Group (SG) to guide the development and implementation of the HIA. As these guidelines provide an account of conceptual issues and values pertaining to HIA as well as a detailed description of the core procedures and methods for commissioning and undertaking HIA they were used to inform a semi-structured interview schedule for the evaluation. Most interviews were conducted on a face-to-face basis, while a small number were conducted through the telephone and e-mail. In total data were gathered via seven face-to-face interviews, six telephone interviews, two group interviews (n=4 and n=3) and one e-mail. Group interviews were conducted with LAG members. All the face-to-face interviews took place in Dublin. All interviews were audio taped and transcribed in full.

A thematic analytical strategy was employed to analyse the data involving two researchers independently reading the entire verbatim data with themes and patterns identified using a deductive technique (Bryman, 2008; Coffey and Atkinson, 1996; Miles and Huberman, 1994). This involved the use of key values and principles within the Merseyside Guidelines (Scott-Samuel, et al., 2001) and the Gothenburg Consensus Paper (WHO European Centre for Health Policy, 1999), in particular sustainability, participation, equity and the promotion of health, to elicit patterns of meanings from the raw data in the transcripts. An appropriate coding framework was agreed upon to enable the construction of an index of central themes of recurring topics, patterns and connections within the data (Bryman, 2008).

Results

The findings from this study identified two broad areas that were consistently reported by the participants. These related to inter-sectoral and interagency partnership working, and the development of learning and understanding among the HIA stakeholders. Firstly, with respect to partnership working the manner in which community members and service providers experienced interactions both during and after the HIA and their perceptions of changes to these relationships are reported. On this basis, a series of noteworthy sub-themes arose concerning communication, information sharing, hierarchy, and organisational culture. Secondly, the extent of skills development and capacity building, in terms of knowledge and learning derived from the participation in the HIA and implementation of its recommendations are outlined.

Inter-sectoral and inter-agency partnership working

The significance of community participation, both in the HIA and in the implementation of its recommendations, was stressed by interviewees as a means of achieving the desired outcomes of the Ballyfermot HIA. Participants explained that a LAG group was formed in January 2005 and comprised service agency and residents living and/or working in the Ballyfermot area. The former included Dublin City Council, the Heath Service Executive and the Gardaí. However, it became clear in the early stages of the LAG that the group was not functioning optimally as an inter-sectoral entity. The main reason given was that members of the local community lacked the skills and confidence to fully participate and interact with agency providers in such a working group. It was pointed out that whilst local residents were very knowledgeable in relation to needs and wants in the area, they did not possess the necessary skills to articulate these in the formal forum of a working group. As one of the service agency members of the LAG explained,

> *"….. they have never been able to articulate it [local knowledge]. There was always that kind of fear of you know, the authority figures if you like…....... the community*

> *themselves felt that they weren't able to fully participate with service providers….you have the service providers at one end working on a strategic level and you've the community element working on the group at local level".*

Another specific issue which led to difficulties within the group was the contrasting discourse or *"speak that was being used"* by different sectors. Contrasting discourses used at the LAG meetings were described in terms of anecdotal, experiential language used by the residents compared with formal, scientific language used by service/professional members. The latter form of communication that predominated within the group was highlighted by local community members as alienating. In essence, the two groupings were speaking different '*languages*'. A perception of tension in the working relationship therefore arose, whereby it was noted by one community LAG interviewee that,

> "*One is not always compatible with the other, so you're disempowered in a way sometimes by what you can achieve*".

As a result of these issues arising within the LAG, it was sub-divided into two, one group comprised local community members (community LAG) and the other, professionals who were responsible for service delivery across a range of sectors including health, transport, justice, safety and policing in the locality (service provider LAG).

Mixed views were expressed by participants on perceived changes in working relationships during the early stages of the LAGs implementation of the HIAs recommendations. Some members of the community LAG noted the importance of the development of the group and its potential:

> "*We have formed coalitions now with people alright…..we have something to offer and they* [service agencies] *are going to listen to us*".

A member of the service LAG noted the advantage of "*having local people represented on the group* [LAG] *was good, as they know what happens on the ground*".

While these advantages were appreciated a sense arose among some community members that the HIA was somewhat hierarchical, as the following quotes illustrate:

> "*All the information came from the experts…..while there were some local issues raised about traffic and traffic lights, but not very in-depth*".
>
> *"A lot of the public* [sector] *is very hierarchical isn't it really you know? And when you're coming from community development hat on you, you have a totally different approach".*

Similarly other interviewees from the community noted the contrasting organisational cultures with respect to ways of working amongst the different stakeholder groups. It was pointed out that, "*They* [service agencies] *work from the top-down*" and in the community sector, "*we work from the bottom up*".

Another concern identified in interviews was the perceived lack of dissemination of past research information gathered by various bodies to the Ballyfermot community. To quote one community LAG member:

> "*There are a lot of surveys done by* [public sector agencies] *and other outside bodies for some reason in Ballyfermot, but they never come back to us with the result. The local people give up their time, and its almost impossible to get the*

> *results, they never come back to you to say this is what we found*".

It was felt that HIA processes such as sharing of information should be a core part of the research process and would prevent the same type of research being repeated. As one community interviewee LAG commented, "*it could save us all that work and we could move on*".

Generally service agency interviewees expressed satisfaction with inter-agency and inter-sectoral working arising from the HIA and participation in the LAG. Several pointed out that useful connections and networks were made in the various health, transport and other local authority agencies. As one service LAG member explained "*we now know where to go for the data*". Some noted that the relationship among the different agencies had changed as a result of the HIA, since they subsequently met together with the aim of "*trying to progress the recommendations*" of the Ballyfermot HIA. They reported that different agencies and community members also held monthly meetings in relation to making public transport safer in the area.

However, other service agency interviewees questioned the specific contribution of HIA to collaboration. These interviewees contested the notion that inter-agency work was something new that came about as a result of the HIA process. They explained that while there may have been "*a bit more interaction*" between the different agencies resulting from the HIA process, a lot of this type of inter-agency work would have been on-going in the community anyway. Similarly, while familiarity with the workings of the other agencies as a result of participation in the HIA was positively referred to, one interviewee noted that, "[We] *are involved in working with these sectors and agencies anyhow as part of* [our] *job*".

Development of learning and understanding

Another theme emerging from the study centred on the development of learning around the practice of HIA. Interviewees noted the value of the HIA process in terms of providing baseline information concerning a perceived rise in the levels of air pollution resulting from heavy traffic congestion on the main road in Ballyfermot and creating an awareness amongst the various stakeholders of the main issues and problems that needed to be dealt with in the local area.

Furthermore, participants reported the provision of HIA and community development training to members of the community LAG after the HIA had been completed. It was explained that this training was funded jointly by local service agencies in the community and health sectors, and coordinated by Dublin City Council. The training was accredited by a statutory body for further education and training (Further Education and Training Awards Council). At the centre of this move was the provision of the necessary skills and expertise to local residents in order to articulate and report their ideas, suggestions, concerns and needs through the gathering of relevant information to those working at the strategic level (Service LAG). As one service LAG member stated:

> "*The reason for that* [the training] *is that the community themselves felt that they weren't able to participate fully with the service providers…..and this is where the HIA training came in. It [the training] was …… to build up the skills within the group, but also to empower them to be able to articulate at that level, with those people* [service providers]*, and not be scared of doing it*".

From the perspective of this service provider the purpose of the training was to enable members of the community to engage with service providers on a more equal basis. The reported aim being, to educate local people about recognising the various assets and services already existing in their area, thereby addressing the lack of information and knowledge amongst some members of the community. In order to encourage the Ballyfermot residents on the Community LAG to participate in the training it was explained that incentives were put in place by Dublin City Council such as the provision of payment for attending the training course, and the organisation of the training on a flexible basis to assist with childcare responsibilities.

In terms of outcomes of the training, from the perspective of those who received it, significant benefits were reported such as increased confidence and understanding of the intricacies of policy-making, decision-making, the research processes, and evidence gathering. Some members of the Community LAG who participated in the training subsequently described themselves as '*active citizens*'. Their confidence and sense of empowerment is evident from the following quote from one community LAG member:

> *"I think this group [Community LAG] is great, in that we are all members of the community and we obviously can see that we have something to offer and that they [service providers] are going to listen to us"*.

Similarly, one service LAG member pointed out that the training that was provided to members of the community has:

> *"….empower[ed] them to take part more…... All those things can add to a person's ability to participate and I think it has provided an opportunity…"*

In this way, it was envisaged that the Community LAG would take on the role of a lobbying group using HIA, as service interviewee stressed, in order to, *"get these services in or enhance the services that are already there [in Ballyfermot]"*.

In addition to the educational aspect of the training provided to members of the Community LAG, several interviewees from both the community and service sector noted that the HIA had lead to a broader level awareness about what the various agencies and service providers were doing in their local area. In particular, knowledge of how services were planned, and the types of difficulties faced by the various agencies when making strategic decisions was highlighted as a beneficial impact of participation in the HIA process. It was also pointed out by interviewees from both sectors that the HIA had increased their awareness of the more obvious issues regarding transport and health such as road safety, the inconvenience and danger of traffic, the length of journey times, and pollution. In addition to these health issues related to transport the HIA highlighted less obvious effects that were only revealed as a result of the HIA such as mental health issues, quality of life and social isolation. As one interviewee explained:

> "*We started out with expecting to examine and focus on the physical effect of transport on health. However, the main outcomes in relation to stress, anxiety, security of transport, access to transport etc. are not so much about the physical as quality of life issues. These came up in the focus groups*".

Discussion

Community participation and inter-sectoral collaboration are core concepts in the present view of health promotion (WHO, 1986; WHO, 2005). This theme was a key aspect of the current study that sought to consider the impact of the Ballyfermot HIA on community participation and collaborative inter-sectoral and inter-agency working. It has been argued

that HIA should be adopted as a key tool to facilitate effective working partnerships between organisations and sectors and to improve community engagement (Bos, 2006; O'Reilly *et al.*, 2006; Tugwell and Johnson, 2011). The study found that the Ballyfermot HIA to some extent developed and/or enhanced both formal and informal working relationships amongst community members and service providers. Additionally, all participants agreed that the use of HIA gave this interaction a specific focus on enhancing health and well-being. These factors were a primary aim of the Ballyfermot HIA which sought to facilitate sustainable working partnerships between the community and key service providers in the area in relation to local transport and health (ERHA, 2004). However, a number of service providers reported that while their involvement in the HIA had led to a little more interaction with other agencies and the community, they considered inter-sectoral working to have already been a normal part of their working activities.

The inter-sectoral nature of HIA has been highlighted by Bos (2006) as positively contributing to a widening of the basis for the promotion of health. Moreover, in line with Kemm's (2000) discussion of the added value of HIA in terms of enhanced transparency and participation, service agency and community participants reported that the HIA process had led to both a greater insight and awareness of issues and of procedures involved in decision-making processes. The Ballyfermot HIA was also credited by several interviewees with leading to greater understanding concerning what various sectors, agencies and service providers were doing in the local area, especially regarding the different roles and responsibilities of individuals within agencies. Cameron (2010) argues that HIA facilitates the development of HPP by providing a process through which decision-makers at various levels can value local knowledge. Of particular note in the current study was the opportunity the HIA provided to observe and gain a better understanding of the roles various agencies had in the local area in relation to addressing the social determinants of health.

A salient theme outlined in the literature is organisational cultural barriers encountered in inter-sectoral working (Ahmad *et al.*, 2008; Kearney, 2004; Kearns and Pursell, 2011; Pickin, et al., 2002). For instance Kearney (2004) reported institutional barriers to ensuring community participation in the HIA process. Ahmad *et al.,* (2008) in a study mapping the capacity of HIA in England reported that a lack of understanding of other organisations' cultures and targets could act as a challenge to inter-sectoral partnerships. Unique cultures and sub-cultures within organisations have also been highlighted by Kearns and Pursell (2011) as a barrier to the institutionalisation of HIA in the Republic of Ireland. In the current study, whilst interviewees from service agencies considered community participation to be an important part of the decision-making process and the development of the LAG was generally viewed as a positive impact of the HIA, significant barriers were encountered. Participants' reflexive accounts revealed a number of cultural challenges which further emphasised the divide between both sectors including: contrasting top-down versus bottom-up ways of working; expert led information exchanges; a lack of community capacity and appropriate skills on the part of community members to engage fully with professionals in the process; and a discourse divide that hampered common understanding between agency and community members. These challenges resulted in the splitting of the LAG into separate community and service agency groups. Such a development was significant in light of Pickin *et al*'s (2002) assertion that the power balance between individual community members and between statutory organisations is crucial to promoting community health. Similar findings were reported by Kearney (2004) who has argued that there is a gap between rhetoric highlighting

the advantages of community participation and the reality of achieving genuine and effective participation based on work on the ground.

Another related theme that emerged from the study was the facilitation of community learning through HIA. As Coady (2010) argued, the process of participating in a HIA can promote adult and community learning. This in turn can lead to community members expanding their thinking beyond disease oriented health issues towards how policies can support community health. Reported experiences in the current study demonstrated learning through participation in the HIA involved increased awareness of the structures and processes of decision-making. However, this in itself was not sufficient to sustain input by community members who lacked required skills to interact with service providers during this process. To remedy this situation the local service agencies subsequently funded a training course on community development and HIA for community members of the LAG. It is noteworthy that there was no mention of the need for training on the part of service providers to enhance collaborative working with the community. These findings emphasise the necessity for training for all sectors in order to facilitate community inclusion at the strategic level in the decision-making process. Ideally this needs to be in place prior to or at the early stages of conducting a HIA.

A further dimension of shared learning frequently mentioned in the current study was the difficulty of inter-sectoral working due to the cultural gap associated with the lack of a common language amongst the community members and service professionals engaged in the HIA. Mittelmark (2001) has noted that the use of complex inaccessible jargon only serves to increase inequity by excluding people from participation. He advocated a health promoting perspective to community level HIA that is understandable to any person or group with an average level of education (Mittelmark, 2001). In this respect the necessity for training for both community and local service agency members engaging in HIA is evident. Huxham and Vangan (2004) argued that structural relationships between partners form a source of power imbalance, with those possessing a formal source of authority clearly having a source of power over those who do not. This is particularly evidenced in the current study through the service providers' perspectives on the provision of training to only community members of the LAG and in their lack of attention to their use of technical jargon in discourse with community members. The requirement for training has also been noted by Kearney (2004) who stated that if HIA is to fulfil its potential, it is essential to recognise that professionals as well as community stakeholders require training and support in order to engage effectively. In considering institutional and organisational barriers to HIA in relation to genuine community participation, a similar argument is made by Pickin *et al.,* (2002) and the Health Development Agency (2000).

Important lessons could be learnt from the PATH approach to community HIA which uses a narrative based methodology to create a vision of a healthy community that acts as a tool to assess the impact of a policy. This inclusive approach has been used to bridge the cultural divide between the community and professional perspectives by increasing community participants' capacity to articulate and validate their needs and priorities with relevant decision-makers in the policy arena (Cameron, et al., 2010; Coady, 2010). This is in line with a move away from the deficit model of health which focuses on the problems and needs of local communities which require professional input and resources towards a more positive assets based approach which identifies capabilities and skills which individuals and communities have in order to make improvements in their lives and environment (Morgan and Ziglio, 2007).

Perspectives on the potential role that HIA can play within the community setting emerged as the final theme in the current study. Interviewees from both sectors perceived the HIA as increasing knowledge of the determinants of health and providing a greater understanding of the significance of health in all policy areas. The social model of health is primarily interested in the relationship between health and the physical and social environment in which people live (Judd *et al.*, 2001) and the health assets and resources individual and communities have to promote health and well-being. Cameron *et al*., (2010) have noted that broadening the understanding of the social determinants of health among all sectors can act as a basis for communities to advocate for specific issues to be considered in policy-making and programme interventions within their locality. In the current study community members in particular perceived HIA as an advocacy and lobbying tool for local issues and conditions concerning health. They reported a growing confidence that their voices could be heard through this route. This perception of HIA as an advocacy tool is also in keeping with the definitions of it for 'community development HIA-CD' described by Mittelmark *et al*., (2007) and the 'community HIA' defined by Mahoney (Mahoney, et al., 2007). Additionally, Coady (Coady, 2010) has reported that this approach can foster adult and community learning thus increasing a community's capacity to improve local conditions for a healthier community. Such learning was evident in the current study, but came after the HIA rather than preceding or during it. Therefore, the timing was not optimal to promote full use of the HIA process as an advocacy tool. In contrast to the community participants' perspective, the service provider interviewees' perceptions were more focused on the HIA as facilitating wider inter-agency interactions and increasing knowledge of resources and information outside of their usual remit. However, these participants did feel the highlighting of problems addressing transport and pollution issues within the locality was an important outcome of the HIA.

Conclusion

This study shows that as an attempt to implement HIA within a community initiative in the Republic of Ireland, the process that was used in Ballyfermot has had a number of beneficial impacts including enhanced inter-agency interactions and the facilitation of community learning. Participants from both the community and service agencies increased their knowledge and understanding of the determinants of health and recognised a broader range of information sources. The development of the LAGs as a major outcome of the Ballyfermot HIA played a key role in implementing its recommendations. Participation in these groups also provided community members with the opportunity to acquire community development and HIA implementation skills. This HIA embedded within a community initiative led to increased understanding of roles and perspectives within and between service agencies and the community.

Learning from this study also revealed that there is still work to be done in relation to the cultural dimension of inter-sectoral working within service agencies and on capacity-building to enable meaningful community participation. Addressing the power discrepancies and cultural and language barriers between service agencies and the community as well as the timing of learning, training and skills development within both of these sectors requires a shift towards a more culturally sensitive approach to the implementation of HIA.

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