



An equity tool for health impact assessments: Reflections from Mongolia

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ABSTRACT

A health impact assessment (HIA) is a tool for assessing the potential effects of a project or policy on a population's health. In this paper, we discuss a tool for successfully integrating equity concerns into HIAs. This discussion is the product of collaboration by Mongolian and Canadian experts, and it incorporates comments and suggestions of participants of a workshop on equity focused HIAs that took place in Mongolia in October, 2010. Our motivation for discussing this tool is based on the observation that existing HIAs tend either to fail to define equity or use problematic accounts of this concept. In this paper we give an overview of socio-demographic and health indicators in Mongolia and briefly discuss its mining industry. We then review three accounts of equity and argue for the importance of developing a consensus understanding of this concept when integrating considerations of equity into an HIA. Finally, we present findings from the workshop in Mongolia and outline a tool, derived from lessons from this workshop, for critically considering and integrating the concept of equity into an HIA.

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1. Introduction

A health impact assessment (HIA) is “a combination of procedures, methods and tools by which a policy, program or project may be judged as to its potential effects on the health of a population, and the distribution of those effects within the population” (WHO, 1999). Using an HIA, government officials, academics, community and industry representatives, and other stakeholders can work to enhance the positive impacts of a policy, program or project and mitigate any negative impacts. Given the explicit focus on distributional concerns in this canonical definition of HIAs, it is clear that they are concerned not only with assessing effects overall, but also with identifying the impacts as they affect different groups. That is, HIAs are, at least implicitly, concerned with equity. Although more detailed discussion is forthcoming in this manuscript, at its most general, equity is about fair shares, in contrast to equality, which is about equal shares (Global Equity Gauge Alliance, 2003). Calls for incorporating explicit assessments of equity, and explicitly health equity, into HIAs have existed since the 1997 Jakarta Declaration (WHO, 1997). These grew out of a concern that that health was rarely being considered in environmental impact assessment processes and when it was inadequately covered with the magnitude and

distribution of health effects within potentially more vulnerable communities rarely assessed (BMA, 1998). Consideration of, in the least, *unequal* distribution of negative health impacts, is now almost universal in HIAs (Mindell et al., 2008; Parry and Scully, 2003). By stressing equity concerns in HIAs, these assessments can also ensure that the distribution of health impacts is also fair to all stakeholders.

HIAs that are explicitly equity-focused, seek to put equity in health on planning and policy agendas. They can be flexible, yet structured, approaches to routinely and consistently identifying the possible impacts of policies and practice on the health of different population groups. They can also provide a means for adding evidence about inequalities and the presence of inequity into decision-making processes (Mahoney et al., 2004).

Currently, HIA mechanisms for assessing equity and the impacts of projects are lacking (Harris-Roxas et al., 2004). Some existing HIAs reference the importance of equity but then fail to incorporate this concept into the assessment of health impacts (Scott-Samuel et al., 2001). In some cases, assessments focus only on inequalities in health without determining which inequalities are morally problematic – and are therefore inequities (Bro Taf Health Authority, 1999; Lester et al., 2001). It has only been recently that any HIA tool explicitly considered equity and integrated this concept into the HIA process (Harris-Roxas et al., 2004).

In this paper, we introduce a tool for equity-focused health impact assessment that we propose as one of four parts in an overall HIA methodology. The equity-focused health impact assessment tool is the result of collaboration by Mongolian and Canadian experts, and it has incorporated comments and suggestions from participants in

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a workshop on equity-focused HIAs that took place in Mongolia in October, 2010. This tool aims to incorporate equity considerations into the HIA process while facilitating a critical consideration by participants as to the meaning of equity in the specific context in which the tool is being used. As we argue, this critical consideration of equity is essential to creating a shared understanding of the concept and its fruitful integration into an HIA.

We begin by introducing the Mongolian context, where concerns were raised regarding the impacts of mining projects on the health of Mongolian people. Next, we provide an overview of the Mongolian workshop, in which we introduced, tested and modified the equity-focused HIA tool. Our larger HIA methodology and the specific equity-focused HIA tool are presented and discussed here. We conclude the paper with reflections on the significance of this contribution, lessons learned and next steps in research and practice.

2. Project/country background

Mongolia is a landlocked, central Asian country situated between Russia and China with a population of approximately 2.7 million and population density of 2 people/km², making it the least densely populated country in the world (World Bank, 2010). Traditionally, livestock herding, agriculture, and, more recently, mining have been its dominant economic activities (CIA World Factbook, 2010). The past decade has seen a virtual explosion of mining exploration and development projects. The mining industry's share of the total GDP tripled in the five-year period 2003–2007, going from 11% to 33% (MNMA, 2008), and the mining and minerals sector contributes around 32% of total government revenue (World Bank, 2010). Mining currently accounts for more than 70% of industrial output, 78% of export revenues (MNMA, 2008), and formally employs more than 45,000 people, or almost 5% of total employment (World Bank, 2010). There is also a large informal mining sector in Mongolia with estimates ranging from 30,000 to 100,000 small-scale and artisanal miners (World Bank, 2006). Mining accounts for a large proportion of foreign direct investment (CIA World Factbook, 2010), which has risen from \$131.5 (million) in 2003 to \$496 (million) in 2009, mainly as a result of inflows to the mining sector (World Bank, 2010). Mongolia's rich mineral deposits include copper, gold, coal, molybdenum, fluorspar, tin, tungsten, silver, and uranium (CIA World Factbook, 2010; MNMA, 2008).

In 2001, Canada-based Ivanhoe Mines announced the discovery of significant copper and gold reserves at Oyu Tolgoi in the southern Gobi region of Mongolia (IMMI, 2009), spurring exploration that has resulted in a number of additional discoveries of significant coal deposits, gold, copper, uranium, and fluorspar (World Bank, 2006). There are also numerous small to medium sized companies currently in operation in the country (World Bank, 2006) and as of 2008, 24.8% of the country's territory was covered by general mining exploration work (MNMA, 2008). In January of 2011, the Government of Mongolia (GOM) repealed a controversial windfall profits tax on minerals, setting the stage for final approval of several large international mining ventures. As a result, Mongolia will continue to experience a rapid increase in mining exploration and development into the near future (World Bank, 2010).

Unfortunately, mining is occurring against a backdrop of failed rural development, increasing wealth disparities between urban and rural areas, and growing social and economic inequality countrywide (UNDP, 2003, 2005, 2007, 2008). A lower middle-income country, Mongolia's GNI per capita is \$1630 USD (World Bank, 2010). In 2006, it was estimated that over 36% of the population was living below the poverty line; this percentage remains virtually unchanged since the mid-1990s (UNDP, 2000a, 2000b, 2003, 2005, 2007). Approximately half of the country's poor live in rural areas, numbering almost half a million (IFAD, 2010). Mongolian women are more affected by poverty than men (IFAD, 2010). According to the

International Fund for Rural Development, the rural poor of Mongolia include members of female-headed households, members of households with more than four children, families of small herders, the unemployed, people without basic education, and other vulnerable groups (i.e. the elderly, disabled people, orphaned children). In particular, “[h]erders are among the poorest of the poor in Mongolia” (IFAD, 2010). Since the transition from a socialist to a capitalist market economy in the early 1990s, the marked social and economic differences between rural and urban areas has led to large disparities in health outcomes, especially maternal, child, and infant mortality rates; increasing levels of livelihood insecurity in rural areas; and high rates of rural–urban migration, where rural migrants now form a large and highly vulnerable urban underclass (Janes and Chuluundorj, 2004; Janes et al., 2005; Janzen, 2005; Johnston, 2008; UNICEF, 2009) (Table 1).

Mining presents both a promise and a risk for the Mongolian people (UNDP, 2008; World Bank, 2006). As the main driver of the Mongolian economy, mining development has the potential to provide rural employment, shore up deteriorating rural infrastructure, and support local community development. It also poses significant environmental, social, and cultural risks that could exacerbate, rather than mitigate, urban/rural social inequalities (World Bank, 2006). Some of the most substantial potential impacts of mining developments are related to the influx into rural zones of tens of thousands of mine and construction workers, workers' families, entrepreneurs, job seekers, and artisanal miners, which can strain local support systems, and contribute to the spread of communicable diseases and environmental degradation (ICMM, 2010; IFC, 2009). Negative environmental impacts can include: changes in ground and surface water availability; deterioration of water quality; air pollution caused mainly by dust; and grazing-land pollution from unstable and erosion-prone waste-rock piles and tailing repositories (UNDP, 2008; World Bank, 2006). There is now substantial public debate over international investment in the Mongolian mining sector. This has contributed to heightened awareness among the public and policy makers of the need to scrutinize the impact of mining on affected communities and environments.

Table 1
Select socio-demographic and health indicators for Mongolia.

Indicator	Value	Reference
Unemployment rate	The rate is the highest in Ulaan Baatar (14%) and the lowest in the western region (7.5%) of Mongolia	MNSO (2009)
Monthly average income per household	405,000 Mongolian tugriks (Rural – 331,600; Urban – 454,854). Equivalent to about \$321.30 USD (Rural – \$263.07; Urban – \$360.85)	MNSO (2009)
Paved road	2824 km	MNSO (2009)
Alcohol use	40.9% of men and 17.4% of women aged 35–44 reported having consumed 4/5 drinks on a drinking occasion	WHO (2006)
Tobacco use	43% of men and 4% of women aged 15–64 years report smoking	WHO (2006)
Health services	26 physicians and 33 nurses per 10,000 population	MNSO (2009)
Under 5 mortality rate (per 1000 live births)	69 (rural), 31 (urban)	WHO (2010)
Infant mortality rate (per 1000 live births) 2008	41 males, 34 females, 41 both (2008)	WHO (2010)
Population using improved drinking water sources	40 males, 27 females, 33 both	WHO (2010)
Population using improved sanitation facilities	97% urban, 49% rural, 76% overall	WHO GH Observatory
Condom use	64% urban, 32% rural, 50% overall	WHO GH Observatory
	5.4%	UNAIDS (2008)

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