



**Chapter 11**  
Human Health

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## 11. Human Health

### 11.1 Introduction

This Chapter of the Environmental Impact Assessment Report (EIAR) has considered the potential human health impacts associated with the Construction and Operational Phases of the Swords to City Centre Core Bus Corridor Scheme (hereafter referred to as the Proposed Scheme).

The World Health Organization (WHO) Constitution, which came into force in 1948, defines health as ‘*a state of complete physical, mental and social wellbeing and not merely the absence of disease or infirmity*’ (WHO 1948). This assessment, therefore, includes consideration of potential impacts of the Proposed Scheme on physical, mental and social aspects of health.

As set out in the European Commission’s Environmental Impact Assessment of Projects - Guidance on the Preparation of the Environmental Impact Assessment Report (European Commission 2017), human health is a very broad factor that is highly project dependent. The notion of human health should be considered in the context of other factors in Article 3(1) of Directive 2014/52/EU of the European Parliament and of the Council of 16 April 2014 amending Directive 2011/92/EU on the assessment of the effects of certain public and private projects on the environment (hereafter referred to as the 2014 EIA Directive), and thus, environmentally related health issues should also be considered. Therefore, this Chapter is supported by, and should be read in conjunction with the following EIAR Chapters:

- Chapter 6 (Traffic & Transport);
- Chapter 7 (Air Quality);
- Chapter 8 (Climate);
- Chapter 9 (Noise & Vibration);
- Chapter 10 (Population);
- Chapter 13 (Water); and
- Chapter 14 (Land, Soils, Geology & Hydrogeology).

This assessment has been carried out according to best practice and guidelines relating to human health, and in the context of similar large-scale transport infrastructural projects.

The aim of the Proposed Scheme is to provide enhanced walking, cycling and bus infrastructure on this key access corridor in the Dublin region, which will enable and deliver efficient, safe, and integrated sustainable transport movement along the corridor. The objectives of the Proposed Scheme are described in Chapter 1 (Introduction & Environmental Impact Assessment Process). The Proposed Scheme, which is described in Chapter 4 (Proposed Scheme Description), has been designed to meet these objectives.

The design of the Proposed Scheme has evolved through a comprehensive design iteration process with particular emphasis on minimising the potential for environmental impacts, where practicable, whilst ensuring the objectives of the Proposed Scheme are attained. In addition, feedback received from the comprehensive consultation programme undertaken throughout the option selection and design development have been incorporated, where appropriate.

## 11.2 Methodology

Health is determined by a complex interaction between individual characteristics, lifestyle and the physical, social and economic environment. Most public health experts agree that these ‘wider determinants of health’ are more important than formal healthcare for ensuring a healthy population. (Braveman and Gottlieb 2014). Image 11.1 provides a widely cited illustration of the wider determinants of health.

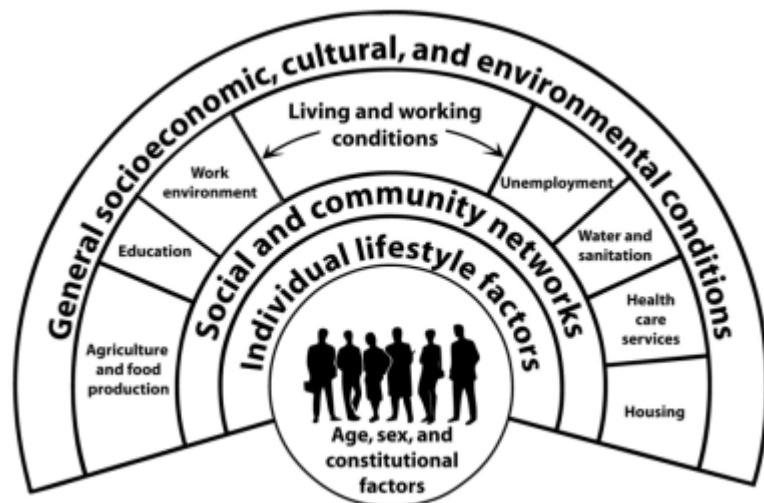


Image 11.1: Wider Determinants of Health (Dahlgren and Whitehead 1991)

A related issue of key importance to public health is the issue of social inequalities of health, which are ‘*the unfair and avoidable differences in health status across groups in society*’ that result from the uneven distribution of wider determinants (WHO *n.d.*). The Marmot Review into health inequalities (Marmot 2010) looked at differences in health and wellbeing between social groups and described how the social gradient on health inequalities is reflected in the social gradient on educational attainment, employment, income, quality of neighbourhood and other issues. Addressing the wider determinants of health is seen as an important means of tackling social inequities of health and improving population health as a whole.

An aim of this assessment is therefore to identify the wider determinants of health that would likely be affected by the Proposed Scheme and how these effects are associated with health outcomes.

This Chapter also assesses risk to human health from environmental hazards, for example, noise, air pollution and water quality impacts

### 11.2.1 Study Area

A study area covering approximately 500m (metres) on each side of the centreline of the Proposed Scheme has been selected (please refer to Figure 11.1 in Volume 3 of this EIAR). This size of study area captures the main communities within a distance most likely to be affected by the Proposed Scheme (for example, this distance captures people who live and work within easy access of the Proposed Scheme and also encompasses the air quality and noise study areas). The study area has been identified by including all the Small Areas that touch or coincide with the 500m study area from the Proposed Scheme boundary. Small Areas are areas of population generally comprising between 80 to 120 dwellings. They were developed by the National Institute of Regional and Spatial Analysis on behalf of the Ordnance Survey Ireland and in consultation with the Central Statistics Office (CSO). They were designed as the lowest geographical level for the compilation of statistics in line with data protection, and generally comprise either complete or a part of towns or neighbourhoods.

## 11.2.2 Relevant Guidelines, Policy and Legislation

The 2014 EIA Directive introduced 'human health' as a factor to be considered in Environmental Impact Assessment (EIA).

The preparation of this assessment has had regard to the following guidelines and policy documents:

- International Association for Impact Assessment (IAIA) and European Public Health Association (EUPHA) Human Health: Ensuring a High Level of Protection. A reference paper on addressing Human Health in Environmental Impact Assessment (hereafter referred to as the IAIA and EUPHA Guidance) (IAIA and EUPHA 2020);
- Health Impact Assessment in Planning (IEMA 2020);
- A Framework for Improved Health and Wellbeing 2013–2025 (hereafter referred to as the Healthy Ireland Framework) (Department of Health 2019);
- Environmental Noise Guidelines for the European Region (hereafter referred to as the WHO Noise Guidelines) (WHO 2018);
- Environmental Impact Assessment of Projects. Guidance on the Preparation of the Environmental Impact Assessment Report (European Commission 2017);
- Environmental Protection Agency (EPA) Guidelines on the Information to be Contained in Environmental Impact Assessment Reports (hereafter referred to as the EPA Guidelines) (EPA 2022);
- Health in Environmental Impact Assessment – A Primer for a Proportionate Approach (hereafter referred to as the IEMA Primer) (Cave *et al.* 2017 on behalf of IEMA);
- Determining Significance for Human Health in Environmental Impact Assessment (Pyper *et al.* 2022 on behalf of IEMA);
- United States (US) EPA Health Impact Assessment Resource and Tool Compilation (US EPA 2016);
- National Roads Authority (NRA) (now Transport Infrastructure Ireland (TII)) Good Practice Guide for the Treatment of Noise during the Planning of National Road Schemes (referred to as the TII Noise Guidelines) (NRA 2014);
- Institute of Public Health in Ireland (IPH) Health Impact Assessment Guidance (IPH 2009);
- Health Impact Assessment Guidance for Ireland and Northern Ireland (IPH 2021)
- Air Quality Guidelines Global Update 2005. Particulate Matter, Ozone, Nitrogen Dioxide and Sulfur Dioxide (hereafter referred to as the WHO Air Quality Guidelines 2005) (WHO 2005); and
- WHO Global Air Quality Guidelines: Particulate matter (PM<sub>2.5</sub> and PM<sub>10</sub>), ozone, nitrogen dioxide, sulfur dioxide and carbon monoxide (hereafter referred to as the WHO Air Quality Guidelines 2021) (WHO 2021).

The European Commission's Guidance on the Preparation of the Environmental Impact Assessment Report notes that '*human health is a very broad factor*' that is '*highly project dependent*'. It states that:

*'The notion of human health should be considered in the context of the other factors in Article 3(1) of the EIA Directive and thus environmentally related health issues (such as health effects caused by the release of toxic substances to the environment, health risks arising from major hazards associated with the Project, effects caused by changes in disease vectors caused by the Project, changes in living conditions, effects on vulnerable groups, exposure to traffic noise or air pollutants) are obvious aspects to study.'* (European Commission 2017)

This assessment recognises that human health is interrelated with several other environmental factors. The assessment has sought to identify the potential changes to emissions, health risks, the built environment and traffic that could be caused by the Proposed Scheme, and how these changes may in turn be associated with health outcomes.

The EPA Guidelines state that:

*'The evaluation of effects on these pathways is carried out by reference to accepted standards (usually international) of safety in dose, exposure or risk. These standards are in turn based upon medical and scientific investigation of the direct effects on health of the individual substance, effect or risk. This practice of reliance upon limits, doses and thresholds for environmental pathways, such as air, water or soil, provides robust and reliable health protectors [protection criteria] for analysis relating to the environment.'* (EPA 2022)

This assessment has therefore taken account of the relevant guidelines on limit values and thresholds which are listed in Chapter 7 (Air Quality), Chapter 9 (Noise & Vibration), Chapter 13 (Water) and Chapter 14 (Land, Soils, Geology & Hydrogeology). The assessment draws on the findings of other chapters within this EIAR (see Section 11.1 for a list of relevant chapters).

In 2017, IEMA published the IEMA Primer. The document advocates for a proportionate assessment of health impacts within the EIA process and suggests what should be assessed in this context. Consideration has been given to the general approach put forward in the IEMA Primer when preparing this Chapter. The IEMA Primer notes that Health Impact Assessment (HIA) and EIA are separate processes and that whilst a HIA can inform EIA practice in relation to human health, a HIA alone will not necessarily meet the EIA human health requirement. HIA is not routinely carried out for major infrastructure projects in Ireland.

The Health Impact Assessment Guidance for performing HIA, issued by the IPH in 2009, notes that *'HIA derives its approach and framework from EIA but was developed partly as a consequence of EIA not placing sufficient emphasis on human health'*. In fact, the introductory text in the original Council Directive 85/337/EEC of 27 June 1985 on the assessment of the effects of certain public and private projects on the environment makes it clear that the EIA was designed to address human health impacts, even though this intention was somewhat lost in transposition into national law. The revised wording in the 2014 EIA Directive makes the requirement to consider human health explicit in an attempt to address the gaps in EIA practice which HIA had sought to fill. The IPH issued revised HIA guidance (Health Impact Assessment Guidance for Ireland and Northern Ireland) in November 2021. This guidance states that *'HIA can be done as a standalone assessment, or health outcomes can be considered as part of environmental assessments, such as... Environmental Impact Assessment (EIA)'* (IPH 2021). The IEMA Primer notes that the WHO provides an overview of health in different types of impact assessment and presents the WHO perspective on the relationship of HIA to other types of impact assessment as follows:

*'The health sector, by crafting and promoting HIA, can be regarded as contributing to fragmentation among impact assessments. Given the value of impact assessments from a societal perspective, this is a risk not to be taken lightly... The need... and justification for separate HIA cannot automatically be derived from the universally accepted significance of health; rather, it should be demonstrated whether and how HIA offers a comparative advantage in terms of societal benefits ...*

*Health issues can, and need to, be included [in impact assessment] irrespective of levels of integration. At the same time, from a civic society perspective, it would be unacceptable for HIA to weaken other impact assessments. A prudent attitude suggests optimizing the coverage of health along all three avenues:*

- *better consideration of health in existing impact assessments other than HIA;*
- *dedicated HIA; and*
- *integrated forms of impact assessment'.*

It is clear, therefore, that even the WHO does not support a stand-alone HIA report, unless it could be demonstrated to be of advantage over the EIAR. It is for these reasons, that this assessment of potential human health impacts is part of the EIAR rather than comprised as a stand-alone HIA report.

HIA is defined as a combination of procedures, methods and tools that systematically judges the potential, and sometimes unintended, effects of a policy, plan, programme or project on both the health of a population and the distribution of those effects within the population (IEMA 2017). Human health assessment in the context of EIA focuses the attention on likely significant impacts (i.e. on effects that are deemed likely to occur and, if they were

to occur, would be expected to be significant (as per the requirements of the 2014 EIA Directive)). The IPH Health Impact Assessment Guidance refers to different levels of HIA depending on factors, such as the complexity of the project, potential scale and severity of health impacts and quality of evidence. The levels of HIA vary from desktop HIA (using readily available data), rapid HIA to comprehensive HIA (involving in depth investigation). The approach applied to this assessment draws on guidance for desktop HIA, but adapts the methodology to meet the EIA population and human health assessment requirements.

The most developed guidance on assessing health in EIA, to date, is the IAIA and EUPHA Guidance, issued in December 2020. This has informed the approach to assessing significance, an important requirement of EIA, which is discussed in Section 11.2.4.

IEMA has recently published a guide to determining significance for human health in EIA (Pyper *et al.* 2022). The guide provides separate tables for sensitivity, health magnitude and an indicative EIA significance matrix. The guide makes it clear that the approach may be adapted depending on the scales of matrices used, for example, the criteria could be adapted to fit the 7-point scale for significance suggested in the EPA Guidelines. The IEMA guide provides a further table to support the significance conclusion and reasoning related to public health. The guidelines note that the assessment of significance can be highly contextual and requires the assimilation and consideration of a range of information, for example scientific literature, baseline population health conditions, health priorities and regulatory standards and that professional judgement must be used. This approach reflects the same principles as those applied in the IAIA/EUPHA guidance, which were used to inform the approach in this Human Health assessment. The significance criteria provided in Table 11.1 of this Human Health chapter are consistent with the principles used for determining significance set out in the new IEMA guidance. In terms of policy, the Healthy Ireland Framework provides a roadmap for building a healthier Ireland. The policy framework is based around the following four goals:

- To increase the proportion of people who are healthy at all stages of life;
- To reduce health inequalities;
- To protect the public from threats to health and wellbeing; and
- To create an environment where every individual and sector of society can play their part in achieving a healthy Ireland.

The Healthy Ireland Framework recognises the importance of intersectoral collaboration (for example, involving the health, transport, education, planning and business sectors) to address the social, environmental and economic determinants of health required for health improvement and protection. This assessment has, therefore, taken account of the policy goals when considering the potential significance of the Proposed Scheme in terms of health promotion, reducing health inequalities, health protection, and creating an environment that supports a healthy society.

Taking into account the broad range of health outcomes associated with noise, WHO Europe prepared the WHO Noise Guidelines (WHO 2018). The WHO Noise Guidelines include a recommendation that average daytime road traffic noise exposure should be reduced to below 53dB  $L_{den}$  (i.e. the 24-hour noise rating level) and that night-time traffic noise exposure should be below 45dB  $L_{night}$  (i.e. the long-term average sound level over the night periods of a year, with the eight-hour night-time period between 23:00hrs and 07:00hrs) (WHO 2018). It is noteworthy that WHO Europe provides the rationale for these guideline levels. The 53dB  $L_{den}$  level is based on the annoyance criteria rather than serious health effects. In fact, the WHO Noise Guidelines suggest that, if a level was being set on cardiovascular criteria alone, the level would likely be in the order of 59.3dB  $L_{den}$ . In terms of how this is actually calculated, it is conservatively calculated at the level of noise that may be associated with a 5% increase in relative risk of a cardiovascular event (WHO 2018). For the vast majority of people, the absolute risk of a cardiovascular event in the next year is less than 1%. For an individual who has that risk of 1%, even allowing for the worst exposure to traffic noise effects, the risk is 1.05%. The difference is, therefore, imperceptible on an individual basis. It is a far less significant impact than other risk factors, which is the reason that it is not considered one of the risk factors when calculating an individual's cardiovascular risk. However, when this risk is applied across a large population, such as the population of Europe, even small changes can make a significant difference. This explains why the WHO Noise Guidelines are applicable for populations but not for individuals. The 45dB  $L_{night}$  level is based on sleep disturbance but is somewhat conservative since this level represents only 3% of the population self-reporting as highly sleep disturbed (WHO 2018). To put this further in context, even at levels of 55dB  $L_{night}$ , the percentage of people self-reporting sleep disturbance is still only 6% (WHO 2018).

The WHO Noise Guidelines specifically state that:

*'to reduce health effects, the GDG (Guideline Development Group) strongly recommends that policymakers implement suitable measures to reduce noise exposure from road traffic in the population exposed to levels above the guideline values for average and night noise exposure. For specific interventions, the GDG recommends reducing noise both at the source and on the route between the source and the affected population by changes in infrastructure.'*

The guidelines are conservative and are not environment-specific. The Proposed Scheme will operate in an urban traffic environment, and the guidelines therefore must be reconciled with the existing baseline. In carrying out this exercise, the assessment in this Chapter recognises that these guidelines were drafted with an abstract population in mind. The WHO readily acknowledges that the WHO Noise Guidelines cannot be reasonably achieved at every individual residence. However, the question in relation to the assessment of the impact on health will be determined by the overall impact on the population. Where it is demonstrated that the Operational Phase would have an overall positive effect on population due to environmental noise, the public transport development would be in keeping with the WHO Noise Guidelines.

The WHO has prepared Air Quality Guidelines, which were updated in September 2021. The WHO has recommended guideline levels for annual and short-term exposure for various air pollutants. Some of these are more conservative than the EU Limits set in Directive 2008/50/EC of the European Parliament and of the Council of 21 May 2008 on ambient air quality and cleaner air for Europe (hereafter referred to as the CAFE Directive). However, the WHO has also set recommended interim targets to:

*'serve as incremental steps in the progressive reduction of air pollution towards the air quality guideline levels and are intended for use in areas where air pollution is high. In other words, they are air pollutant levels that are higher than the air quality guideline levels, but which authorities in highly polluted areas can use to develop pollution reduction policies that are achievable within realistic time frames. The interim targets should be regarded as steps towards ultimately achieving air quality guideline levels, rather than as end targets.'* (WHO 2021)

### **11.2.3 Data Collection and Collation**

Spatial statistical data relating to the population within the study area have been obtained from the CSO.

Further information on health profiles and health research have also been obtained from publicly available sources, including those produced by Lenus – a central source for open access health research in Ireland (Lenus 2021), the Health Service Executive (HSE) and the IPH. Evidence for associations between health outcomes and certain determinants has been drawn from a wide range of published health literature and is referenced throughout the assessment.

Health data used to inform this assessment are generally 'at population level' rather than clinical level. Since the assessment is reliant on aggregated data for the 'at population level', it cannot be used to infer potential impacts on health outcomes at individual (clinical) levels.

### **11.2.4 Appraisal Method for the Assessment of Impacts**

The assessment has been undertaken in the following stages:

#### **11.2.4.1 Develop Baseline Understanding of Population Health Profiles and Determinants of Health**

A desk study of the available data has been undertaken to identify the populations of interest and characterise them in terms of their population size, socio-economic status, burden of disease and the distribution of those existing factors.

Baseline data from the assessments of other chapters in this EIAR was then reviewed to understand baseline determinants of health. Issues such as the location and distribution of services and community amenities were obtained from Chapter 10 (Population). Information on air pollution levels and existing noise was obtained from Chapter 7 (Air Quality) and Chapter 9 (Noise & Vibration), respectively. Other relevant information, such as traffic



and travel patterns, was obtained from Chapter 6 (Traffic & Transport). These were considered the most relevant aspects of the environment to understand in terms of human health. However, there is an interaction between human health and several other environmental topics assessed (refer to Section 21.4.3 in Chapter 21 (Cumulative Impacts & Environmental Interactions) for further information).

The purpose was to build up a baseline understanding of where the health-related environmental and social issues may be and the characteristics of the communities affected to enable an assessment as to whether these could be exacerbated or relieved by the Proposed Scheme.

#### **11.2.4.2 Identification of Potential Impacts**

The characteristics of the Proposed Scheme have been considered and the potential pathways between aspects of the construction and operation of the Proposed Scheme and health outcomes (beneficial and adverse) have been mapped out. Image 11.2 presents several pathways to health outcomes from transport policies and projects. Due to the nature of impacts on human health, many of these are indirect. The assessment of the Operational Phase of the Proposed Scheme has focused on those potential impacts most likely to be influenced by the Proposed Scheme, namely air quality, noise, community severance, social use of outdoor space, physical activity levels, access and risk of injuries. For the identification of construction impacts, reference has been made to the other environmental topic assessments to identify the aspects of the environment likely to be affected, and then a further consideration has been made as to whether there is a likely pathway between those impacts and human health outcomes.

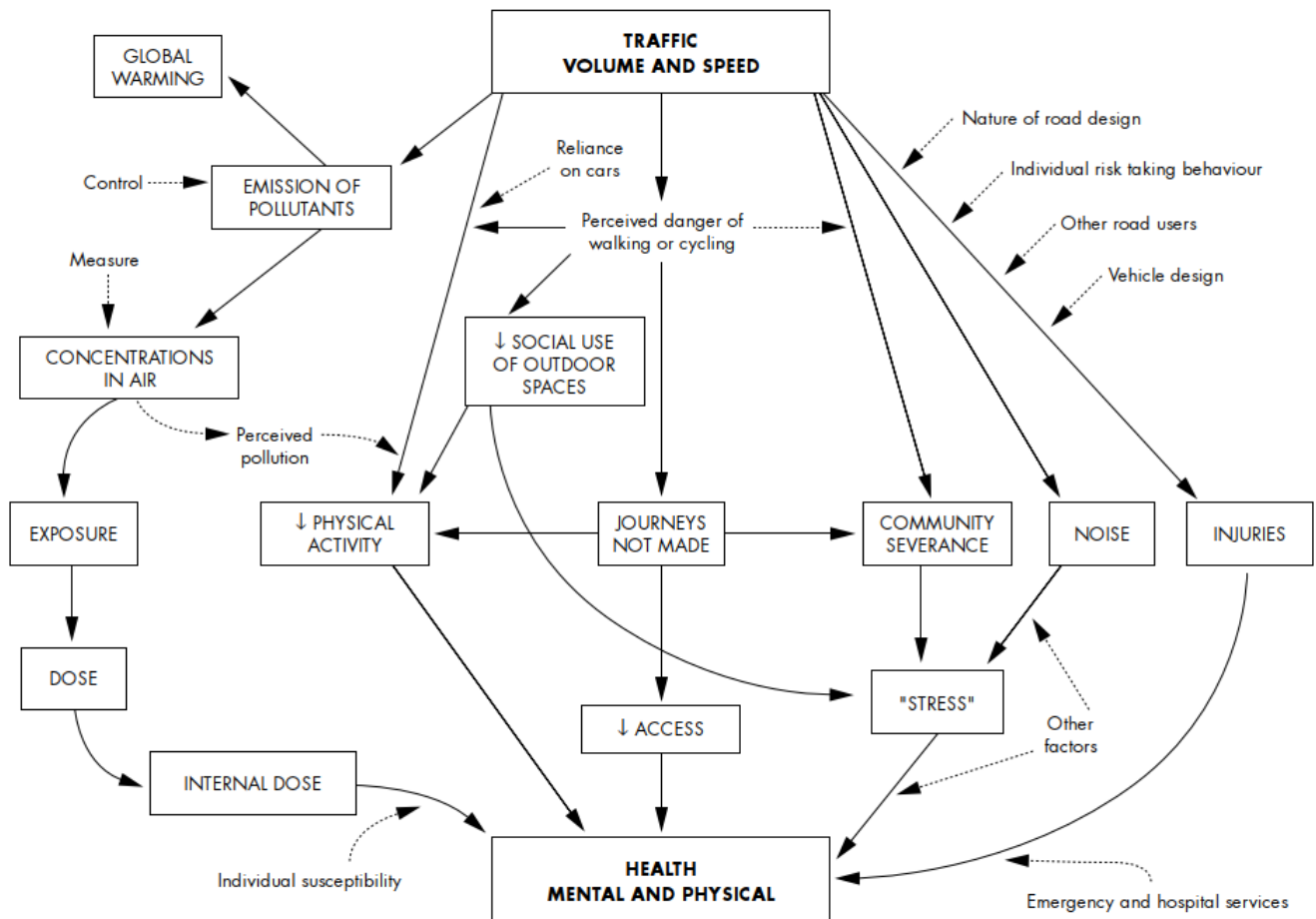


Image 11.2: Pathways from Transport Policy to Health Outcomes (Source: Joffe and Mindell 2002)

### 11.2.4.3 Literature Review

A literature review was undertaken to identify the strength of evidence for associations between impacts on various determinants of health and health outcomes. The issues targeted for the literature review related to the mapping out of potential health impact pathways above. The literature review has critically evaluated the evidence and whether the evidence is substantial, weak or speculative. The review has taken into account, whether the available research is likely to be generalisable to the populations in the study area for the Proposed Scheme. The literature review has been important in supporting the assessment with the best available evidence. The results of the literature review are integrated in the reporting of the baseline and assessment of this Chapter, rather than presented as a standalone section, so that the findings are presented within the context of the assessment for the Proposed Scheme. Full references for the sources of research consulted are provided in Section 11.7.

### 11.2.4.4 Assessment of Impacts

The assessment considers the potential influence of the Proposed Scheme in terms of health protection, health promotion and health inequalities. The assessment describes how the Proposed Scheme could impact on baseline environmental and social factors (determinants of health), whether these impacts are associated with health outcomes (using evidence from the literature review), and whether those outcomes are considered to be positive or negative.

The reporting of impacts takes a descriptive approach so that the evidence and assumptions underpinning the judgement of significance can be explained. The judgement of sensitivity, magnitude and significance takes into account several factors, including:

- Health status of the population;

- Social inequalities;
- Likely level of exposure to a health risk;
- Likely size of population affected;
- Level of evidence in scientific literature for an association between an environmental impact and health outcomes; and
- Existing health policy and priorities.

These considerations have been developed with regard to the IAIA and EUPHA Guidance (IAIA and EUPHA 2020).

Where appropriate, the assessment takes account of evidence for dose-response relationships to certain pollutants (i.e. air pollution) and the likely duration of exposure to those pollutants, using information from the relevant assessment chapters in this EIAR, as well as from the literature review. Since health evidence normally underpins the limits set for certain pollutants (e.g. air quality objectives), it can be determined that significant impacts on human health are not likely, provided that these limits are not exceeded.

Table 11.1 sets out the criteria used to guide the description of significance for health impacts, after considering the range of issues described above. These criteria have been aligned to terminology for level of significance set out in the EPA Guidelines (EPA 2022).

**Table 11.1: Significance Criteria for Health Impacts**

Impact Level	Significance Criteria
Imperceptible	The Proposed Scheme will have an impact on a determinant of health of a type and degree which is not associated with any population health outcomes.
Not Significant	The Proposed Scheme will have an impact on a determinant of health of a type and degree where no health outcomes are attributable. Example considerations for assigning this level of significance are: <ul style="list-style-type: none"> <li>• Level of exposure to impact is sufficiently low to pose no likelihood of developing an associated health outcome.</li> </ul>
Slight	The Proposed Scheme will have an impact on a determinant of health of a type and degree where there may be a small impact on individual reported symptoms but no change in population health status can be attributed. Example considerations for assigning this level of significance include whether: <ul style="list-style-type: none"> <li>• The level of risk of developing a health outcome attributed to impact is extremely low (for example where there is limited and inconsistent evidence for an association with a health outcome, or the risk of exposure to impact is very unlikely, or the level of risk attributed to the impact is very low compared to other factors);</li> <li>• Associated health outcomes are mild, temporary and reversible;</li> <li>• People affected are not sensitive and can readily avoid or adapt to impact, or impact can be readily mitigated, with no effect on quality of life beyond the short-term.</li> </ul>
Moderate	The Proposed Scheme will have an impact on a determinant of health of a type and degree where there may be a noticeable impact on individual health status but no change to population morbidity or mortality is attributable. Example considerations for assigning this level of significance include whether: <ul style="list-style-type: none"> <li>• There is some scientific evidence of association between the impact and population health outcomes;</li> <li>• The degree of population health impact is consistent with current health trends;</li> <li>• Associated health outcomes are reversible and/or can be managed or mitigated;</li> <li>• No effect on quality of life is anticipated beyond the short-term;</li> <li>• No change in morbidity or mortality can be attributed to the Proposed Scheme.</li> </ul>
Significant	The Proposed Scheme will have an impact on a determinant of health of a type and degree where there may be a significant impact on individual health status (such as change in morbidity or mortality risk) but no measurable change to population morbidity or mortality is likely. Example considerations for assigning this level of significance include whether: <ul style="list-style-type: none"> <li>• There is a strong body of scientific evidence for a clear association between the impact and population health outcomes;</li> <li>• The impact has the potential to have a measurable effect on the health status of some individuals with an associated change in morbidity and/or mortality (i.e. there is a risk of exposure to impact which is likely to be restricted to small numbers of individuals but the health consequences could be affect health status);</li> <li>• The impact may influence health inequalities at a population level.</li> </ul>

Impact Level	Significance Criteria
Very Significant	<p>The Proposed Scheme will have an impact on a determinant of health of a type and degree where there may be a significant impact on the health status (such as change in morbidity or mortality risk) of groups of people within a community.</p> <p>Example considerations for assigning this level of significance include whether:</p> <ul style="list-style-type: none"> <li>• There is a strong body of scientific evidence for a clear association between the impact and population health outcomes;</li> <li>• The impact has the potential to have a measurable effect on the health status of groups of people (for example where exposure to impact is likely to be subject to specific geographic locations, lifestyle choices, social circumstances or health characteristics not widely experienced in a community);</li> <li>• The impact is likely to influence health inequalities within some groups.</li> </ul>
Profound	<p>The Proposed Scheme will have an impact on a determinant of health of a type and degree where there may be a significant impact on the health status (such as change in morbidity or mortality risk) of communities of people.</p> <p>Example considerations for assigning this level of significance include whether:</p> <ul style="list-style-type: none"> <li>• There is a strong body of scientific evidence for a clear association between the impact and population health outcomes;</li> <li>• The exposure to the impact has the potential to be widespread and affect the health status of communities;</li> <li>• The impact is likely to influence health inequalities at a community level.</li> </ul>

An example of how these criteria are applied could be with the health outcome of asthma. An Imperceptible impact would be one with no measurable effect on asthma. A Slight impact might be where a likely temporary increase in symptoms in an individual could be associated, but there would be no change in the severity of the underlying condition or no treatment required. A Moderate impact might be an individual increasing their use of inhalers, which would be attributable to the Proposed Scheme, but there would be no change in underlying condition and no effect on the vast majority of asthmatics. A Significant impact might be an individual becoming asthmatic or an individual's asthma becoming measurably more severe as a result of the impacts of the Proposed Scheme. A Very Significant impact might be a group of individuals becoming asthmatic or their asthma becoming measurably more severe as a result of impacts from the Proposed Scheme. A Profound impact might be a measurable increase in the incidence or severity of asthma in a community as a result of the impacts of the Proposed Scheme.

#### 11.2.4.5 Mitigation

Using evidence from the literature review, as well as professional knowledge and experience, proposals for mitigation have been put forward to help limit pathways to adverse effects and, where feasible, to promote positive health outcomes.

#### 11.2.4.6 Mental Health and Wellbeing

During the planning process stage of an infrastructure project, potential adverse effects on mental health are often mentioned, for example, anxiety and stress experienced by those whose lands are to be compulsorily acquired, or those who might experience a change in the environment in which they live.

The community may also experience annoyance from the temporary impacts of traffic management and other effects during the Construction Phase. Countering this, there is the potential reduction in annoyance amongst bus users in the Operational Phase where journey times will be reduced and journey reliability increased. Annoyance among cyclists and pedestrians will also potentially reduce in the Operational Phase as facilities are improved. Annoyance, however, is not in itself a health effect.

For virtually every proposal, especially for one like the Proposed Scheme, there are concerns about potential adverse effects on a person's overall psychological wellbeing. While one can give detail in predicting, for example noise emissions, one cannot use the same scientific certainty in predicting psychological impacts. It is not possible to use a standards-based approach, for example.

There are various degrees of psychological impact and these can be both positive and negative. There can be a positive impact, whereby people may look forward to better and more reliable public transport or improved cycling experiences. There can also be negative effects of varying degrees. At the lower end of this impact might be annoyance where, for example, somebody is annoyed by outside noise, dust depositing or temporary traffic delays

associated with construction activities. This is not a medically defined health effect. However, if someone develops a psychological illness such as anxiety or depression, this would be a medically defined health effect.

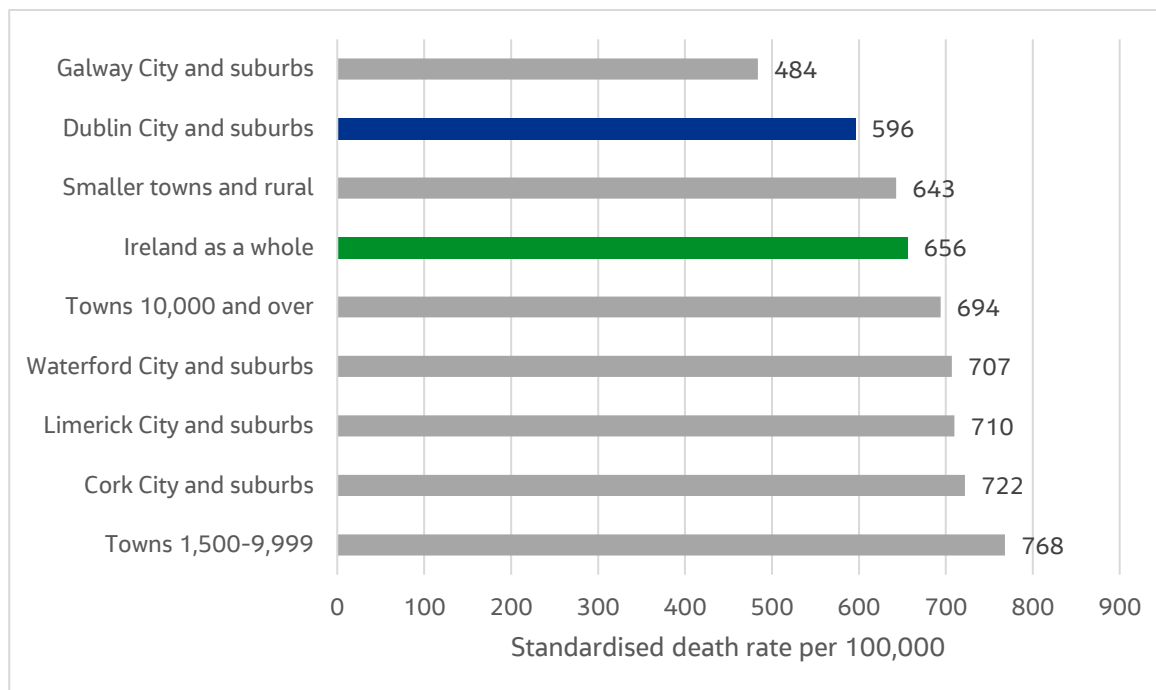
Construction by its very nature is transient but it is expected that construction activities will cause some annoyance such as from road diversions and temporary lane closures. The potential effects will be minimised by use of appropriate traffic management and avoidance of extended night-time closures. There has been a considerable amount of construction, including somewhat similar projects such as Luas projects in Ireland over the last few decades. However, there is no documented evidence from these projects to link adverse outcomes with psychological health in Ireland.

This understanding of potential issues of mental health and wellbeing has helped to inform the judgement of significance of impacts.

## 11.3 Baseline Environment

### 11.3.1 General Health

The population of Dublin City and its suburbs has a lower mortality rate than Ireland as a whole and is notably lower than the other major cities in Ireland with the exception of Galway (Graph 11.1).

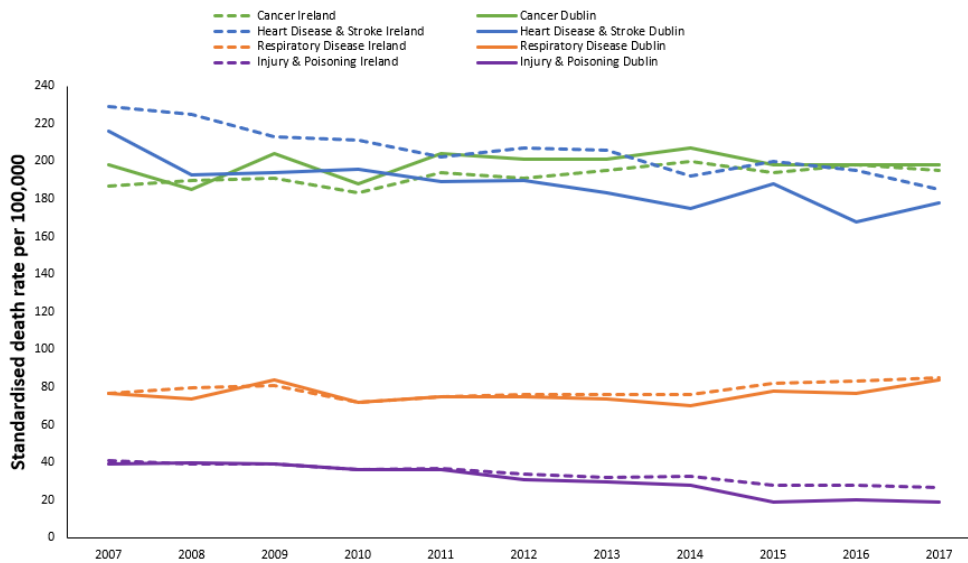


**Graph 11.1: Standardised Death Rate per 100,000 for Dublin, Compared to Other Regions 2016 - 2017 (Data Source (CSO 2019a))**

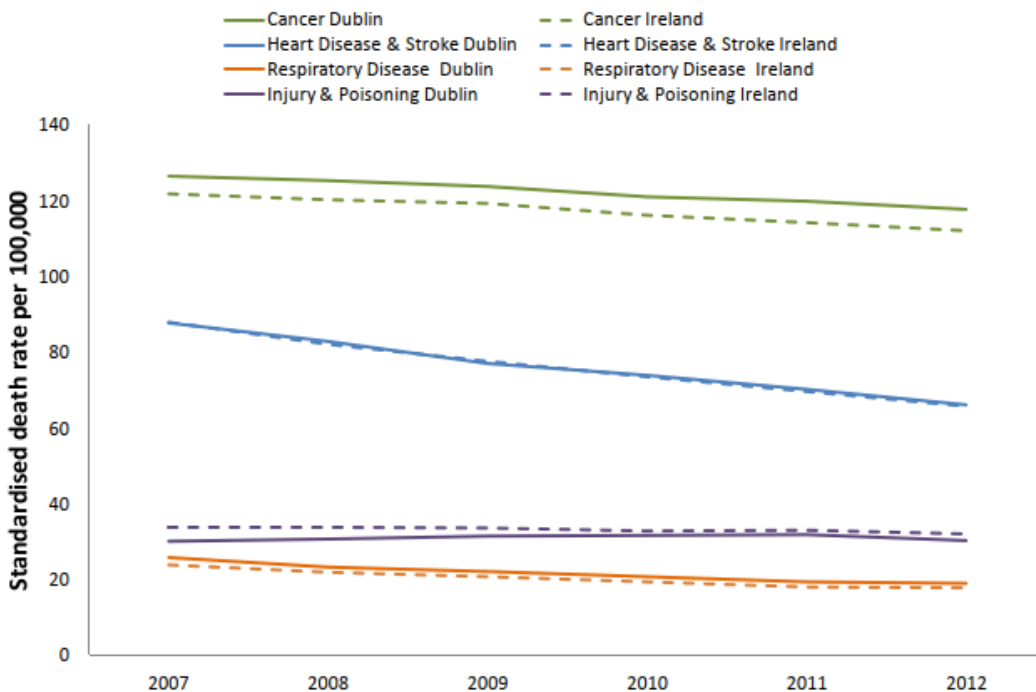
The northern half of the Proposed Scheme will be located within the jurisdiction of Fingal County Council (FCC) while the southern half falls within the jurisdiction of Dublin City Council (DCC). The 2015 health profiles for the DCC (HSE 2015a) and FCC (HSE 2015b) areas, which are the most recent available at the time of writing, have been used to inform the understanding of the Baseline Environment. However, accurate health information on issues such as obesity and chronic disease are only available at city and county level combined.

The four principal causes of death in Dublin and Ireland for all ages are heart disease and stroke (circulatory disease), cancer (all types), respiratory disease, injury, and poisoning. As can be seen on Graph 11.2, there has been a general decline in rates of heart disease and stroke, and injury and poisoning during the 10 year period between 2007 to 2017, while there is no clear trend for cancer or respiratory disease.

In terms of premature death (i.e. deaths of people under 75 years), only data for 2007 to 2012 have been identified specifically covering the Dublin area. Cancer was the leading cause, followed by heart disease and stroke, injury and poisoning (which includes suicide) and respiratory disease (refer to Graph 11.3) (HSE 2015a). The data show a declining trend across these causes between 2007 and 2012, with the exception of injury and poisoning which had a slight upward trend in Dublin from 2007 to 2011. This may reflect the influence of suicide within this category of cause of death and an association with the post-2008 Irish economic downturn. As with all ages, death rates from cancer in Dublin are higher than the national average.



Graph 11.2: Trends in Dublin's Death Rates per 100,000 for the Four Principal Causes of Death (2007 - 2017) for All Ages Compared to Ireland (Data for City and County Area) (CSO 2018)



Graph 11.3: Trends in Dublin's Death Rates per 100,000 for the Four Principal Causes of Death (2007 - 2012) for Under 75 Years (Premature Mortality) Compared to Ireland (Data for City and County Area) (CSO 2018)

Table 11.2 and Table 11.3 outline the key facts according to the HSE health profiles for Dublin City and Fingal County.

**Table 11.2: Dublin City Health Profile Key Facts (HSE 2015a)**

Dublin City Health Profile Key Facts
<p>Dublin City has:</p> <ul style="list-style-type: none"> <li>• Dependency ratio of 38.4% (i.e. those aged 0 to 14 years and 65 years and over as a proportion of those aged 15 to 64 years) which is lower than the national rate of 49.3%;</li> <li>• A high level of households which are local authority rented at 11.5% (national 7.8%);</li> <li>• A diverse population with 21.3% of the population who are not white Irish;</li> <li>• A higher than average number of persons who report their health as being bad or very bad at 2% (national rate at 1.5%) or who have a disability 14.9% (national rate at 13%);</li> <li>• A greater than average birth per 1,000 rate for those aged under 20 at 19% (national rate 12.3%);</li> <li>• Cancer incidence rates above the national rate for male colorectal cancer and female malignant melanoma and male and female lung cancers; and</li> <li>• Mortality rates that are above the national average for heart disease and stroke in those aged under 65 years.</li> </ul>

**Table 11.3: Fingal County Health Profile Key Facts (HSE 2015b)**

Fingal County Health Profile Key Facts
<p>Fingal County has:</p> <ul style="list-style-type: none"> <li>• A low dependency ratio of 46% (i.e. those aged 0 to 14 years and over as a proportion of those aged 15 to 64 years). The national rate is 49.3%;</li> <li>• The most diverse population nationally with 24.5% of its population being of ethnicity other than white Irish;</li> <li>• The lowest percentage nationally of those who report their health as being bad or very bad at 1.1% (national rate 1.5%) or who have a disability 10.2% (national rate at 13%);</li> <li>• The highest birth rate population nationally at 20.2 / 100,000 population and the second highest rate for breast feeding of 53.7% (national 46.6%);</li> <li>• The lowest suicide rate nationally; and</li> <li>• Cancer incidence rates above the national rate for male colorectal cancer and female malignant melanoma and male and female lung cancers.</li> </ul>

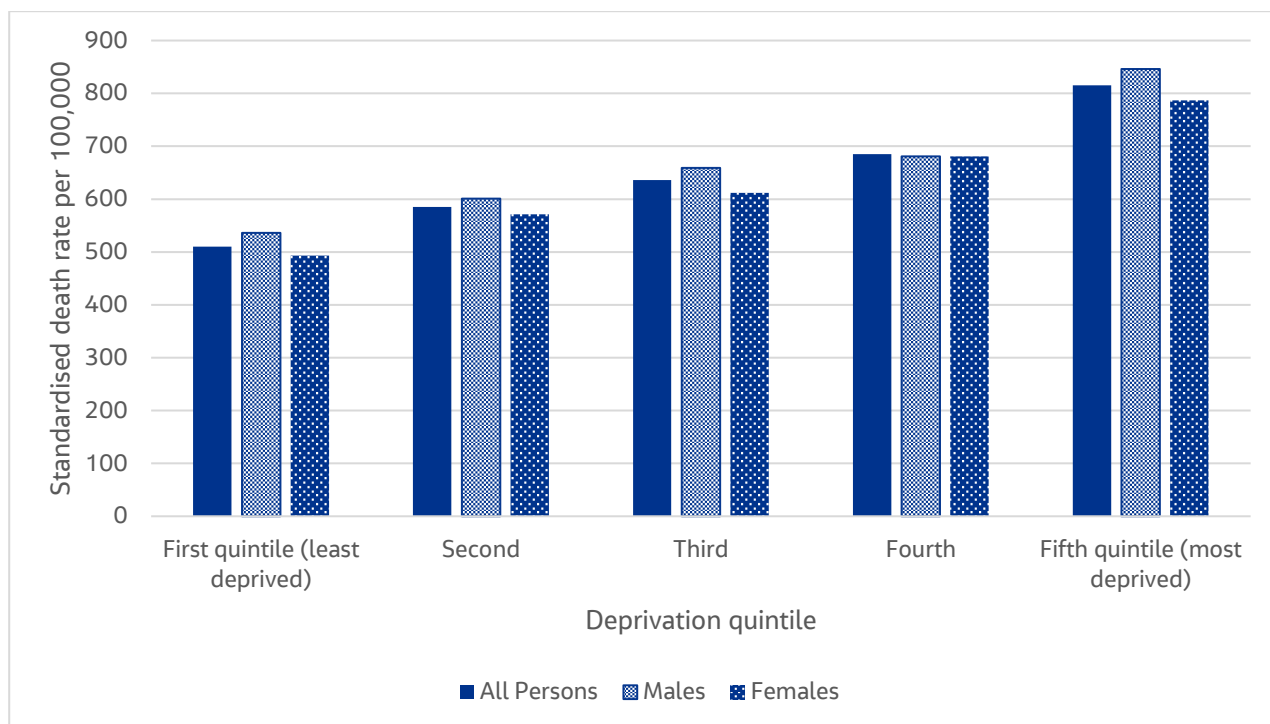
### 11.3.2 Deprivation, Disability and Health Inequalities

As briefly discussed in Section 11.1, wider determinants of health have a greater influence on a person's health outcomes over their life course than access to healthcare services, and there is a recognised social gradient of health. This can be seen for the population of Ireland as a whole between 2016 to 2017, where the death rate per 100,000 increased with every increasing deprivation quintile for both men and women (these data use the Standardised Death Rate (SDR) which is the death rate of a population adjusted to a standard age distribution to allow for comparisons between different areas where the age distribution may vary) (refer to Graph 11.4).

Analysis based on the Census characteristics of persons that died in the 12 month period after Census Day on 24 April 2016 shows the difference in life expectancy between different groups in society. The life expectancy at birth of males living in the most deprived areas of Ireland was five years less than the life expectancy at birth for males living in the most affluent areas (79.4 years compared with 84.4 years). Similarly, for women, the difference in life expectancy at birth was 4.5 years less for those living in the most deprived areas compared to those in the most affluent areas (83.2 years compared to 87.7 years) (CSO 2019a). The differential between male and female life expectancy was greatest in the most deprived areas with women living 3.8 years longer than men (CSO 2019a).

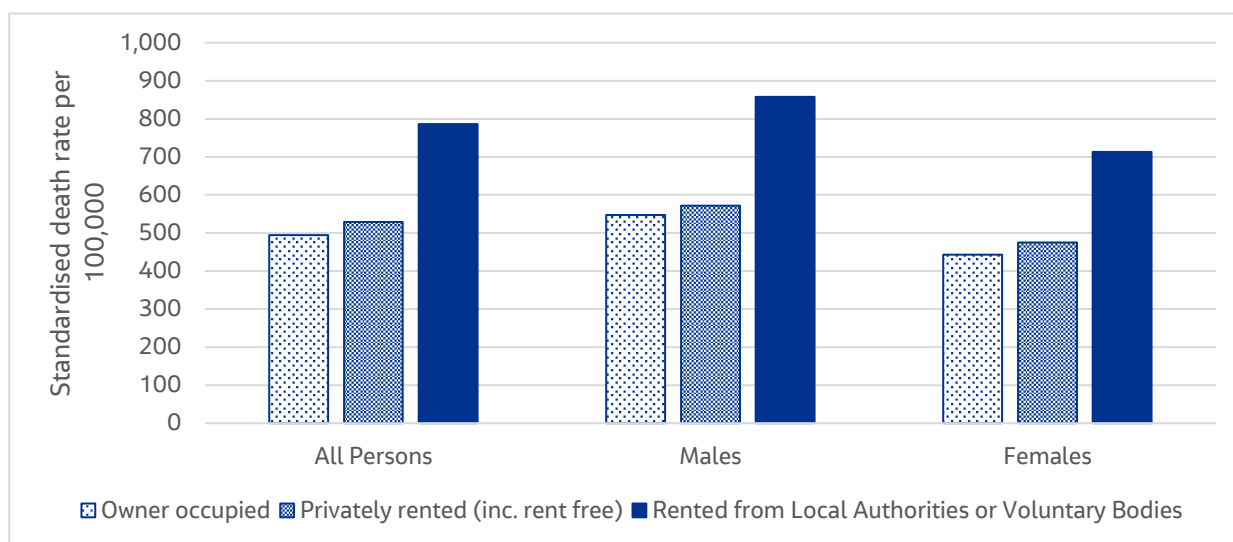
Disability also has a large influence on life expectancy at a population level. In Ireland, during the year 2016 to 2017, a 35-year-old with a disability had a life expectancy of 13.7 years less than a 35-year-old without a disability (CSO 2019a). The SDR for those recorded as disabled in the 2016 Census was approximately four times the rate of those who did not indicate a disability (CSO 2019a).





Graph 11.4: Standardised Death Rate per 100,000 by Deprivation Quintile in Ireland 2016 – 2017 (CSO 2019a)

A further factor associated with a higher mortality rate is whether a person owns or privately rents their home, or whether they rent from the local authority. Analysis of deaths in Ireland during the period 2016 to 2017 indicated that those who rent from a local authority have a mortality that is 1.6 times higher than those who are home owner-occupiers (refer to Graph 11.5). Level of education is also shown to have an association with life expectancy and health. According to the analysis of deaths during the year following the 2016 Census, those with only primary level education had almost twice the mortality rate as those with third level education.



Graph 11.5: Standardised Death Rate per 100,000 by Housing Sector Type in Ireland 2016 - 2017 (CSO 2019a)

The above issues (levels of deprivation, disability, levels of education and housing status) are heavily interlinked and there is likely to be a degree of conflation between the reported death rates associated with each issue (e.g. the death rate associated with education level may be skewed by the influence of deprivation, which is also associated with levels of education). However, the analysis undertaken by the CSO on mortality rate differences supports the concern over the influence of wider determinants of health on health outcomes, and the associated health inequalities that arise. The causes of these differences in health outcomes will relate to many different

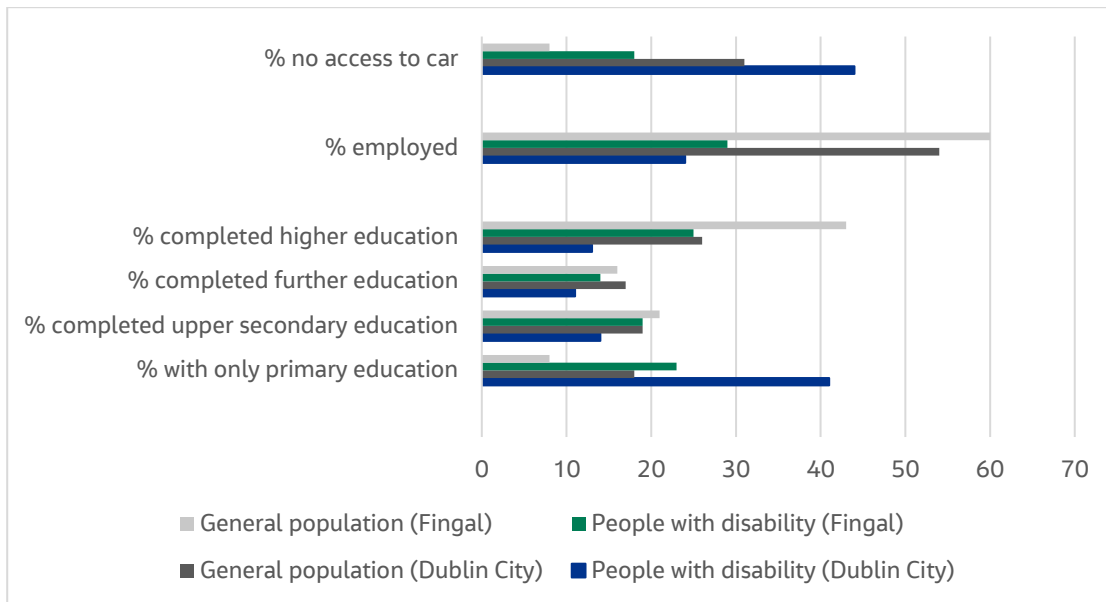
factors such as the prevalence of smoking, differences in dietary choices and alcohol consumption, levels of exercise, quality of social networks, housing conditions and other social and environmental conditions. Further research and analysis would be required to identify and quantify the factors responsible for the differences in mortality between affluent and deprived areas, which is beyond the scope of this assessment.

Within the study area, there are small pockets of disadvantage (refer to Figure 11.1 in Volume 3 of this EIAR) close to the city centre around Gardiner Street Lower, Gloucester Place Upper and Summerhill Place, and around Henrietta Lane and Dominick Street Lower. There is a likelihood that these communities have a disproportionate number of health problems compared to the average population. However, it should be noted that there will be sensitive individuals in all communities whose health may be disproportionately affected by changes in the environment and social conditions that may arise as a result of the Proposed Scheme.

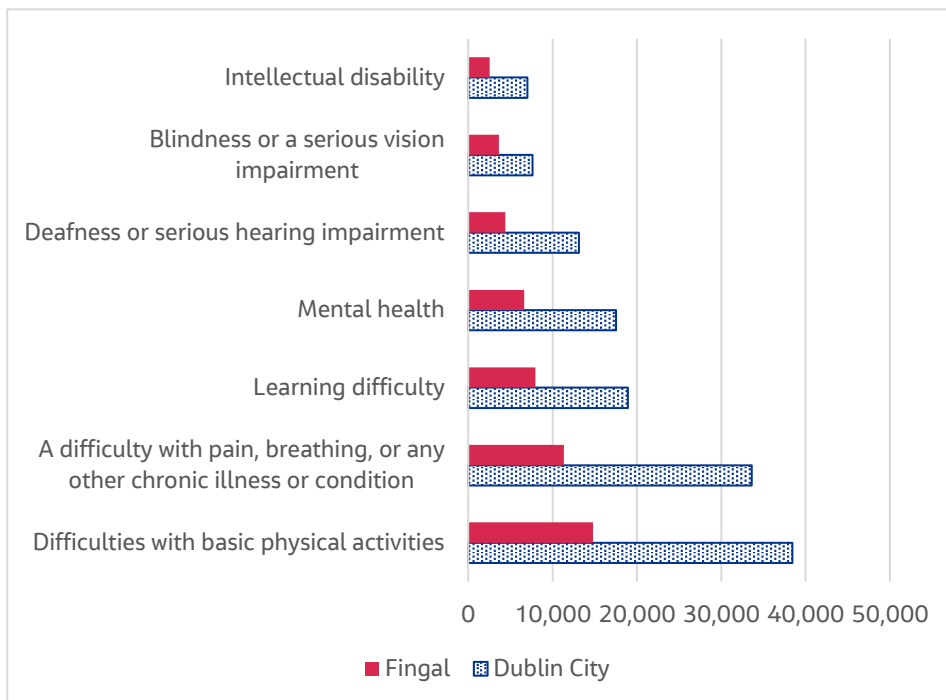
**Table 11.4: Population, Disability and Relative Deprivation within Study Area (See Notes)**

	Proposed Scheme Study Area
No. Small Areas in Study Area	288
Population in Study Area	81,078
Number and proportion with a disability	2,085 (2.6%)
% Small Areas in Deprivation/Affluence Category	
Extremely affluent	0%
Very affluent	2.4%
Affluent	20.1%
Marginally above average	41.7%
Marginally below average	23.3%
Disadvantaged	8.0%
Very disadvantaged	4.5%
Extremely disadvantaged	0.0%
% in Local authority rented accommodation	11.3% (average across Study Area)
<p><i>Notes: The population size has been derived by aggregating the populations of each Small Area which touches or coincides with the 500m buffer around the Proposed Scheme footprint. This will mean that some Small Areas extend beyond 500m and therefore provides only an approximation of the population within most influence of the Proposed Scheme. Deprivation and affluence data are mapped using Small Areas due to their relative uniformity in population size (mean household number is 100 households per Small Area).</i></p> <p><i>Source of data: Pobal HP Deprivation Index 2016</i></p>	

The data in Table 11.4 show that approximately 2.6% of people within the study area have at least one disability. This is a lower proportion of the population than average for Dublin (14.9%), but nevertheless equates to 2,085 people. An analysis of 2016 Census data by Disability Federation Ireland (DFI) identified that 44% of people in Dublin City and 18% of people in Fingal who have a disability do not have access to a car, compared to 31% of the general population. The analysis also shows lower educational attainment and lower rates of employment among people with disabilities compared to the general population (Graph 11.6).



**Graph 11.6: Comparison of Education, Transport and Employment Data Between People with Disabilities and General Population in Dublin City (DFI 2018)**



**Graph 11.7: Disability Types in Dublin City and Fingal County (DFI 2018)**

Graph 11.7 sets out the types of disability reported by people in Dublin City and Fingal County during the 2016 Census (CSO 2016). This shows that the most common form of disability reported was difficulties with basic physical activities, followed by a difficulty with pain, breathing, or any other chronic illness or condition. While these are broad categories which cover several different conditions, it indicates the importance of accessibility and access to services as determinants of health. In 2005, the DFI prepared the Disability and Population Health Discussion Paper (DFI 2005). The Disability and Population Health Discussion Paper highlighted health inequalities associated with disability, including the importance of socio-economic status as a key determinant of health for people with disabilities, *'given the well established fact that poverty and disability are inextricably linked'*. The Disability and Population Health Discussion Paper emphasised that people with disabilities are more likely to have lower levels of education and income and that they face extra costs in daily living associated with travel, heating, diet and medication. It also sets out that *'people with disabilities and their families are more likely than*

*the rest of the population to live in poverty, and that this is a two-way relationship – disability adds to the risk of poverty, and conditions of poverty increase the risk of disability* (Elwan 1999 in DFI 2005). The paper goes on to discuss the physical environment as a determinant of health for people with disabilities. It states that *'Physical access remains a major obstacle to the ability of people with physical and sensory disabilities to live in, and contribute, to their own communities. Lack of accessible public transport continues to be a major impediment to both the social and economic advancement, and subsequently the health of people with disabilities'*. The Disability and Population Health Discussion Paper also discusses the role of traffic accidents as a cause of disability (notably brain and spinal injuries), particularly in those under 25 years of age, since accidents and unintentional injuries were the most common cause of death and illness in that group (Kiely 2004 in DFI 2005). Road traffic accidents are covered in further detail in Section 11.3.4.

Some disabilities are not visible, such as autism spectrum disorder (ASD). It is estimated that approximately 1% to 1.5% of the population in Ireland has ASD (R&D and Health Analytics Division 2018). The autism spectrum covers a broad set of difficulties and people are affected in a variety of ways to differing degrees. The challenges that people with ASD face typically fall within the categories of communication and social skills, forming and keeping relationships with other people, physical coordination and sensory processing.

The Autism Spectrum Information Advice and Meeting Point (AsIAM) has published information on how people with ASD may struggle with using public transport, such as issues with lighting, noise, crowds, format of information, communication and reactions from other members of the public to how people with ASD behave and cope with anxiety and stressful situations (AsIAM 2021; AsIAM 2015; Joint Committee on Transport, Tourism and Sport 2018).

### **11.3.3 Air Quality, Noise and Other Pollutants**

#### **11.3.3.1 Air Quality**

The links between air pollution and health effects are well established. The main pollutants from vehicle emissions are particulate matter (PM) and nitrogen oxides (NO<sub>x</sub>). People are also exposed to ozone (O<sub>3</sub>) which is produced by chemical reactions in the atmosphere. Both short-term and long-term exposure to air pollution is a significant cause of ill health and premature death. Air pollution causes short-term health effects on the respiratory system and more serious impacts due to long-term exposure including permanent reductions in lung function. Air pollution is linked to asthma, chronic bronchitis, cardiovascular disease and cancer (Vardoulakis and Osborne 2018; Krzyzanowski *et al.* 2005; Holgate *et al.* 1999; Rajagopalan *et al.* 2018; Franklin *et al.* 2015) and impaired foetal development (Lamichhane *et al.* 2015). While exposure to air pollution can affect everyone, it can be particularly harmful for the elderly and the very young. For example, air pollution has been linked to decreased cognitive performance among the elderly, whilst exposure to air pollution for young children can have adverse effects such as hindering lung growth, inhibiting brain development and increasing the risk of conditions such as asthma (UN Environment Programme 2018).

PM<sub>2.5</sub> is particularly hazardous to human health as it is small enough to bypass the body's defence system and penetrate deep into the respiratory and circulatory system. Often PM contains harmful substances, such as heavy metals, sulphurs, carbon compounds and carcinogens, which can have adverse health effects on the heart, lung and brain (WHO 2005; WHO 2021). PM<sub>2.5</sub> is the greatest environmental risk factor contributing to cardiovascular deaths and illness (Rajagopalan *et al.* 2018). There is emerging evidence that PM is also associated with lower birth weights (Pedersen *et al.* 2013; Slama *et al.* 2007), premature births (Ritz *et al.* 2007; Rudra *et al.* 2011), and foetal growth restriction (Liu *et al.* 2007; Winckelmans *et al.* 2015).

Air quality standards are set to protect human health. It is notable that the WHO Air Quality Guidelines 2005 (WHO 2005) applied stricter guideline values for PM<sub>10</sub> and PM<sub>2.5</sub> than the EU statutory limit values set out in the CAFE Directive. The WHO annual guideline levels have been reduced further in the recently published revised WHO Air Quality Guidelines 2021 (WHO 2021) following systematic review and synthesis by Chen and Hoek (2020) of more recent evidence of health outcomes associated with air pollution. The WHO's recommended annual air quality guideline (AQG) for PM<sub>2.5</sub> is set at 5µg/m<sup>3</sup> (micrograms per metre cubed) as opposed to the EU limit value of 25µg/m<sup>3</sup> (WHO 2005). This stricter value applied by WHO is considered preferable for health. It has been estimated that if PM<sub>2.5</sub> concentrations were reduced to 10µg/m<sup>3</sup> the number of premature deaths from all causes would be seven times lower than if PM<sub>2.5</sub> concentrations averaged 25µg/m<sup>3</sup> (Ballester *et al.* 2008). The WHO has provided four recommended interim targets of 35µg/m<sup>3</sup>, 25µg/m<sup>3</sup>, 15µg/m<sup>3</sup> and 10µg/m<sup>3</sup> (WHO 2021).

In May 2020, as part of the joint WHO / United Nations Environment Program (UNEP) / World Bank *BreatheLife* campaign, the four Dublin local authorities signed a commitment to achieve the WHO Air Quality Guidelines standards by a target date of 2030.

The baseline environment in Chapter 7 (Air Quality) provides information on the baseline air quality relevant to the Proposed Scheme. Continuous PM<sub>2.5</sub> monitoring carried out at the Zone A locations of Ballyfermot, Phoenix Park, Finglas, Rathmines, St Anne's Park and Marino showed levels ranging between 8µg/m<sup>3</sup> - 10µg/m<sup>3</sup> in 2019. This is within the EU Limit value but exceeds the latest WHO Air Quality Guideline value of 5µg/m<sup>3</sup> for PM<sub>2.5</sub> and therefore across a large population, the effect of air pollution in the baseline would be detectable (as is the case for most cities). Average PM<sub>10</sub> levels at the urban traffic monitoring location of Winetavern Street, which is in proximity to the south of the Proposed Scheme, were reviewed. The annual average level in 2019 was 15µg/m<sup>3</sup>, with nine exceedances of the 24-hour limit value of 50µg/m<sup>3</sup>. The City Centre monitoring location of Winetavern Street has a long-term average (2015 to 2019) of 14µg/m<sup>3</sup> with an annual average in 2019 of 15µg/m<sup>3</sup>. The annual averages are below the national limit value of 40 µg/m<sup>3</sup> and are in line with the latest WHO guideline value recommendation of 15 µg/m<sup>3</sup> (WHO 2021).

Site-specific monitoring of NO<sub>2</sub> in proximity to the Proposed Scheme, and roads that have the potential to be impacted by it, was carried out using passive diffusion tubes. The highest four-month average concentration was recorded at a roadside location in proximity to the junction of Wellpark Avenue on the Upper Drumcondra Road (tube no. 2.5). Concentrations at this location were 43.0µg/m<sup>3</sup> or 108% of the annual mean limit value with the bias adjustment and annualisation factor applied. This was the only location to show an exceedance of the annual mean limit value for NO<sub>2</sub>. The second highest concentration, at 287 Swords Road, Santry South (tube no. 2.4), recorded a concentration of 37.8µg/m<sup>3</sup> or 94% of the annual mean limit value. The lowest concentration was recorded at the colocation site with the EPA monitoring station in Swords (tube no. 2.1) (19.2µg/m<sup>3</sup>). The average concentration across all sites was 33.2µg/m<sup>3</sup> or 83% of the annual mean limit value of 40µg/m<sup>3</sup>. Reference should be made to Chapter 7 (Air Quality) for further detail and interpretation of the baseline air quality monitoring.

There is no 'safe' level of air pollution, and while concentrations may be below levels which are clinically significant on the health of individuals, low levels of air pollution can still have a measurable impact on health at a population level. Table 11.5 sets out the number of premature deaths attributable to various air pollutants for Ireland as a whole.

**Table 11.5: Premature Deaths in Ireland Attributable to PM<sub>2.5</sub>, NO<sub>2</sub> and O<sub>3</sub> Exposure in 2016**

Country	Population	PM <sub>2.5</sub>		NO <sub>2</sub>		O <sub>3</sub>	
		Annual Mean (a)	Premature Deaths (b)	Annual Mean (a)	Premature Deaths (b)	SOMO35 (a)	Premature Deaths (b)
Ireland	4,726,000	6.8	1,100	11.2	50	1,323	30

Notes:  
 (a) The annual mean (in µg/m<sup>3</sup>) and the SOMO35 (in µg/m<sup>3</sup>.days), expressed as population-weighted concentration, is obtained according to the methodology described by ETC/ACM (2019) and references therein and not only from monitoring stations.  
 (b) The total deaths are rounded to the nearest hundred or ten.  
 Data Source (European Environment Agency 2019)

### 11.3.3.2 Noise

Transport is the main source of noise pollution in Europe and, except for people living in close proximity to railway lines or airports, road traffic is the major cause of human exposure to environmental noise. Traffic noise causes impaired communication (difficulty in making oneself heard), sleep disturbance, annoyance and increased aggression. There is also increasing evidence of a link to heart disease and hypertension which could be significant given the large proportion of the population across Europe who are exposed to noise (Babisch 2006; van Kempen *et al.* 2002; Sobotova *et al.* 2009; Bluhm *et al.* 2007; WHO 2011). Research points to the strongest association with cardiovascular risk, being among those who are exposed to excessive noise (more than 65dB(A) ('A-weighted' decibels) in the day or 55dB(A) at night) in the long-term (i.e. living in the same house for 15 or more years) (Babisch 2006) and who live in older houses without triple glazing and who have bedrooms facing the street (Bluhm *et al.* 2007). It is therefore worth noting that the level of risk of more severe health outcomes such as cardiovascular events is very small for environmental noise compared to other risk factors. The most common associated health impacts are annoyance and sleep disturbance.

There has been concern about the potential impact of traffic noise on cognitive development in children. A systematic review of previous studies on this topic (Clark and Paunovic 2018) identified 13 studies of noise effects on cognitive impairment, from which four were cross-sectional studies of road traffic noise exposure, all of which were assessed through standardised assessments (SATs). Overall, the review indicated a variable level in the quality of the existing evidence, ranging from being of moderate quality for effects on outcomes such as reading comprehension or long-term memory, but being indicative of no substantial effect for other outcomes such as attention and executive function. The review also indicated the limited number of studies for some outcomes, and in particular for some environmental noise exposures such as road traffic noise and railway noise. Nevertheless, the low number of studies and the quality of the evidence across them does not necessarily mean that there are no noise effects in some cognitive domains but rather, that more robust studies and a greater number of studies are required to support evidence based assessments.

Taking into account the broad range of health outcomes associated with noise, WHO Europe has prepared the WHO Noise Guidelines (WHO 2018). These guidelines include a strong recommendation that average daytime road traffic noise should be reduced to below 53dB  $L_{den}$  and that night-time traffic noise should be below 45dB  $L_{night}$ .

Section 9.3 (Baseline Environment) of Chapter 9 (Noise & Vibration) presents the existing ambient noise for locations relevant to the Proposed Scheme study area. As can be seen in Chapter 9 (Noise & Vibration) and its accompanying figures (Figure 9.1.1 and Figure 9.1.2 in Volume 3 of this EIAR) daytime noise levels are particularly high (exceeding 65dB(A)) along all sections of the Proposed Scheme, with levels exceeding 70dB(A) on the section of the R132 Swords between Airside Junction and Northwood Avenue (Section 2). Night-time noise levels exceed 55dB(A) in all sections, with the exception of the Shantalla Road to Botanic Avenue section. The night-time noise levels recorded along all sections of the Proposed Scheme route exceed the WHO recommended noise level of 45dB or less (please refer to Section 9.3 (Baseline Environment) of Chapter 9 (Noise & Vibration) for further detail). Noise annoyance is subjective and the degree to which individuals would be sensitive to noise exposure will be variable. However, the noise levels indicated by the noise contour mapping show that many properties are already within areas where traffic noise levels are significant enough to be associated with adverse health responses. Residents of properties with direct frontage onto those roads recording high noise levels have the most potential of experiencing noise annoyance.

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### 11.3.3.3 Other Pollutants and Environmental Hazards

Between 1% and 10% of homes in Dublin City have radon levels above the national reference level for radon of 200 becquerel per cubic metre (Bq/m<sup>3</sup>) (EPA 2020). Radon is a naturally occurring radioactive gas that is released by uranium, a natural substance found in soil and rock. It is captured in indoor air by moving through the ground to the air above. It is associated with damage to lung cells and risk of lung cancer (Lavin *et al.* 2006). Radon is the most significant cause of lung cancer after smoking and is estimated to cause between 3% to 14% of all lung cancers in a country, depending on the national average radon level and smoking prevalence (WHO 2016). There is a linear dose-response relationship between the risk of lung cancer and exposure to radon. The risk of lung cancer increases by 16% per 100Bq/m<sup>3</sup> increase in long-term average radon concentration (WHO 2016). Although smoking is by far a greater contributor to the risk of lung cancer (approximately 90% of all cases of lung cancer in Ireland are attributable to smoking (National Cancer Registry Ireland (NCRI 2011; NCRI 2017)), there is evidence of a synergistic effect on risk of lung cancer from radon among those who smoke. Smokers are estimated to be 25 times more at risk from radon than non-smokers. To date, no other cancer risks have been established (WHO 2016). While the 2015 Health Profile for DCC (HSE 2015a) show incidences of lung cancer among men and women significantly above the average for Ireland as a whole, a study by Dempsey *et al.* (2017) only found statistically significant evidence of effect on risk of lung cancer from radon, where 10% to 20% of households were above the national reference level for the gas (Dempsey *et al.* 2017). Since exposure to radon is an indoor air pollution risk, there is no direct pathway between transport proposals and radon risk. However, there is a theoretical risk that large scale construction activities and changes to areas of hardstanding could lead

to an indirect risk pathway, should it divert gas pathways into neighbouring properties. This risk is considered very low and is therefore scoped out of further consideration in the assessment.

#### **11.3.4 Traffic, Travel Behaviour and Health**

The health benefits of regular physical activity are well researched and widely accepted. For most people, the easiest forms of physical activity are those that can be built into daily life, for example, by using walking or cycling as an alternative to motorised transport for everyday journeys such as commuting to work or school. Active forms of travel, such as walking and cycling, are associated with a range of health benefits. These include improved mental health, reduced risk of premature death and prevention of chronic diseases such as coronary heart disease, stroke, type 2 diabetes, osteoporosis, depression, dementia and cancer (British Medical Association 2012). Research also suggests that countries with the highest levels of active travel generally have amongst the lowest obesity rates (Bassett *et al.* 2008).

There has been growing concern over increasing levels of obesity in Ireland, with the percentage of people in Ireland who are overweight or obese has risen from 31% in 1998 (Kavanagh *et al.* 2005) to 62% in 2017 (CSO 2019b). Physical inactivity is a key risk factor for obesity and switching from active modes of travel (walking and cycling) to car use has helped to fuel physical inactivity. Car ownership has increased in Ireland, with just under 60% of urban households owning a car in 1986 compared with just under 80% of households owning a car in 2016 (CSO 2019c). Since 2011, there has been a very slight decline in car ownership among urban households, and car ownership in cities in 2016 was substantially lower than rural areas (76.6% compared to 91%) (CSO 2019c).

Section 10.3 (Baseline Environment) in Chapter 10 (Population) identifies the method of travel to work for bus, train, car and foot / bike for the population in the 13 community areas that make up the study area for that topic. 9% of residents in River Valley (Swords), 11% in Swords and 15% in Larkhill – Whitehall - Santry cycled or walked to work, which is slightly below the average proportion for Dublin as a whole. The proportion of residents who cycled or walked to work in the remaining communities (all closer to the City Centre) was substantially higher than average for Dublin as a whole (see Section 10.3 (Baseline Environment) in Chapter 10 (Population)).

The data show that the parishes of River Valley (Swords) and Swords each had a higher proportion of residents commuting to work by car or van than average for County Dublin. These parishes are within 10km to 12km distance from the City Centre. These are distances which can typically be undertaken by bicycle within approximately 43 to 51 minutes based on an average cycling speed of 14kph (CSO 2019d). Given that 10% of work commutes in FCC and 45% in DCC took 30 minutes or less there is potential to encourage modal shift from car use to cycling if the right conditions are provided and this would likely bring health benefits (CSO 2019c). Section 6.3 (Baseline Environment) of Chapter 6 (Traffic & Transport) describes the quality of pedestrian and cycle infrastructure provision in the study area. It identifies that for much of the Proposed Scheme, the quality of cycle provision ranges from B to D against the Quality of Service guidelines in the National Transport Authority's (NTA's) National Cycle Manual, indicating that quality could be improved (NTA 2011).

The data in Section 10.3 (Baseline Environment) in Chapter 10 (Population) also show that travel by bus for all community areas is above the Dublin average and that this mode of travel increases with distance from the City Centre, with Larkhill-Whitehall-Santry, Glasnevin, Gardiner Street and Drumcondra having the greatest proportions of residents who travel by this mode (between 20 – 24%). A study into the influence of public transport use on exercise levels suggests that those who walk to and from public transport stops achieve a notable amount of daily travel-related physical activity (median of 19 minutes) and that 29% of public transport walkers get 30 minutes of daily physical activity solely by walking to and from transport stops (Besser and Dannenberg 2005).

Dublin is the sixth most congested city in Western Europe (TomTom 2019). High traffic volumes and speeds can reduce opportunities for positive contacts with other residents in a neighbourhood, contributing towards increased social isolation and reduced community cohesion (Appleyard 1981; Hart and Parkhurst 2011). Individuals who are socially isolated are more likely to make use of public services due to lack of support networks and have an increased likelihood of developing certain health conditions such as depression and dementia (Social Finance 2015). They are also more likely to be physically inactive (Appleyard 1981), which is again linked to increased likelihood of developing certain diseases, as discussed above. People experiencing high levels of social isolation have significantly higher mortality levels than those with low or average levels of isolation (Steptoe *et al.* 2013).

The SDR from transport accidents has declined in Ireland from 7.6 per 100,000 in 2006 to 3.7 per 100,000 in 2014 (CSO 2019a). An Garda Síochána provides traffic collision data that involves an injury, to the Road Safety Authority (RSA). The RSA collision data for the period 2005 to 2016 indicate locations for 40 traffic collisions along the route of the Proposed Scheme that resulted in serious injury or a fatality. Of these, 16 (40%) involved pedestrians, while nine (23%) involved a cyclist. A cluster of serious collisions involving pedestrians and a cyclist (four incidents in total) has been identified at and within approximately 100m of the crossroads with R101 North Circular and R108 Phibsborough Road.

Risk of death from traffic accidents in Ireland is not evenly distributed across the population and has been shown to be higher among deprived communities, males and persons in late adolescence / early adulthood (Kavanagh *et al.* 2005). In addition to deaths and physical injuries, wider effects on society are also an issue. A follow up study of 1,148 people aged 19 to 69 years who attended Accident and Emergency (A&E) following a road accident identified that 32% suffered notable psychiatric outcomes (post-traumatic stress disorder, phobic travel anxiety, general anxiety or depression) at one year following the accident (Mayou 2001; Kavanagh *et al.* 2005).

There may be concern that the promotion of active travel modes would lead to greater increases in casualties among pedestrians and cyclists. However, evidence suggests that there is 'safety in numbers' for walkers and cyclists. One key study into this concept was reported by Jacobsen (Jacobsen 2003). Jacobsen provided evidence based on analysis of national data from 14 European countries on walking and cycling, as well as data for 47 towns in Denmark, and 68 towns in California. The author concluded that:

- *'there is a relationship between motor vehicle collisions with pedestrians and or cyclists and numbers of pedestrians and or cyclists. For example, in a community where walking doubles it can be expected that there will be a 32% increase in pedestrian injuries, where cycling doubles it can be expected that there will be a 34% increase in cyclist injuries'*;
- *'motorists appear to adjust their behaviour in the presence of people walking and cycling which largely controls the likelihood of collisions; as a result'*; and
- *'the relationship between pedestrians or cyclists' exposure and casualties is not linear, that is, there is safety in numbers for these mode users'*.

A number of other studies have provided further evidence to support the safety in numbers principle (Robinson 2005; Bonham *et al.* 2007; Pucher and Dijkstra 2003).

### **11.3.5 Access to Healthcare, Employment and Education**

Transport is required for access to a variety of resources important to health and social inclusion, including traveling to work or school, visiting family and friends, accessing health services, and shopping and leisure. Poor access to transport results in barriers to these important health resources and can contribute to health inequalities and social exclusion. Key issues for transport are affordability, availability and accessibility.

Section 10.3 in Chapter 10 (Population) presents baseline accessibility in relation to access to work, healthcare and other community facilities. It identifies the following facilities which serve a large number of people:

- Mater Private Hospital and Highfield Healthcare Centre, Eccles Street, Dublin 7;
- Dublin City University (DCU) St. Patrick's Campus, Drumcondra;
- DCU All Hallows Campus, Grace Park Road, Drumcondra, Dublin 9;
- Mater Misericordiae University Hospital, Eccles Street, Dublin 7; and
- Rotunda Hospital, Parnell Square, Dublin 1.

It also sets out the key areas of employment such as Furry Park Industrial Estate and Airways Industrial Estate in Larkhill-Whitehall-Santry, and Airside Retail Park and the Pavilions Shopping Centre in Swords, as well as tourist attractions within Dublin City Centre.

The Mater Misericordiae University Hospital provides a range of specialist clinical services and also provides emergency and intensive care medicine. The Rotunda Hospital provides specialist maternity services. The Mater Private Hospital also has an emergency department and is located on the corner of Eccles Street and Dorset Street. The Children's Health Ireland (CHI) hospital on Temple Street provides emergency care for babies, toddlers and children, as well as other specialist children's health services. Once the new children's hospital on



St James' Street is operational, the Temple Street hospital will close. However, the timescales for this are not currently certain.

The main hospitals in the study area have limited parking facilities however are served by public transport services such as Dublin Bus, the Luas (Dublin trams) and Dublin Bikes. The impact of the Proposed Scheme on baseline access to services will be an important consideration in terms of links to health and wellbeing.

### **11.3.6 Communicable Diseases**

While the dominant causes of ill health and premature death in Ireland are non-communicable diseases, typically associated with lifestyle factors such as diet, alcohol consumption and physical activity levels, the COVID-19 pandemic that affected Ireland in 2020 and 2021 has brought the risk of communicable diseases into sharp focus.

COVID-19 is a viral illness caused by the coronavirus SARS Co-V 2. It was first described in China in late 2019 and has gone on to cause a global pandemic. In Ireland, it led to a number of 'Level 5' restrictions with closures of hospitality, entertainment and non-essential work. It has also led to restrictions on the numbers who could use public transport at any time. Nevertheless, at all times during the pandemic, public transport has continued to operate. This is because it is an essential service, transporting essential workers to and from their workplaces.

Early in the pandemic, it was feared that public transport could be a major vector of transmission of COVID-19. However, evidence has suggested otherwise. A useful review of evidence was published by the International Association of Public Transport (UITP 2020). The review considered studies from Germany, France, the UK and Japan. The studies showed very low levels of COVID-19 cases traceable to public transport. The UITP concluded that public transport is safe in an era of COVID-19, providing that precautions such as the use of face masks and sanitiser are employed.

COVID-19 is often transmitted from an infected person through droplets generated when they talk, cough, sneeze or exhale. Some of these convert into aerosol particles, which are lighter than droplets and can be spread further and remain in the air for longer, and anyone who inhales them can become infected. Several studies have concluded that the transmission of droplets and aerosols can be prevented, or at least limited, by using a face covering, even in more confined spaces such as public transport. The importance of face coverings in reducing transmission of COVID-19 became increasingly evident as the pandemic progressed.

The WHO has suggested that air pollution is most likely a contributing factor to the health burden caused by COVID-19, as polluted air is already known to inflame the lungs and cause respiratory and heart disease that make people more vulnerable (WHO 2020 in UITP 2020). The use of public transport, walking and cycling may therefore help to reduce the health burden of respiratory diseases such as COVID-19 by associated reductions in air pollution.

The vaccination programme has been effectively rolled out in Ireland. There are a number of vaccines which appear highly effective, although there is the risk of the emergence of new coronavirus variants which could be resistant to existing vaccines. However, it is likely that further vaccines would be developed to address this development.

While the COVID-19 situation appears increasingly hopeful, the experience has demonstrated the reality of the risk of other infections and pandemics in the future. The recent experience has shown that public transport will continue to be required even in the events of such pandemics.

### **11.3.7 Summary of Key Baseline Health Issues**

Overall, Dublin has a better health profile with lower mortality rates than average for Ireland. The leading causes of death relate to non-communicable health conditions (heart disease and stroke; cancer; respiratory disease, and injury and poisoning). Dublin has higher cancer rates than the national average.

Based on available monitoring data, levels of air pollution are almost entirely within the EU limit values for NO<sub>2</sub> and PM. However, there is a relatively high prevalence of exposure to excessive traffic noise, particularly at night-time for properties close to the Proposed Scheme corridor.

Exposure to traffic noise causes annoyance and is linked to several other adverse health outcomes. There is widespread exposure in the study area to noise levels which exceed the levels set out in the WHO Noise Guidelines (WHO 2018), which are recommended to prevent adverse health outcomes.

Rates of walking and cycling are relatively high for communities in the study area within km of the City Centre, but car dependency increases beyond 3km. Switching from sedentary modes of travel (i.e. car use) to more active modes (walking and cycling) reduces risk of a number of causes of premature death.

Evidence from many different countries and contexts, including Ireland as a whole, shows that there is a social gradient of health whereby people in deprived areas suffer worse health outcomes than those in affluent areas. Assuming this holds true for Dublin, the areas with higher levels of deprivation in the study area are likely to carry a greater burden of disease and may be disproportionately affected (either adversely or beneficially) by impacts from the Proposed Scheme.

A greater proportion of people in Dublin who have a disability do not have access to a car, compared to the general population.

## 11.4 Potential Impacts

This section presents potential impacts that may occur due to the Proposed Scheme in the absence of mitigation. This informs the need for mitigation or monitoring to be proposed (refer to Section 0). Potential 'residual' impacts, taking into account any proposed mitigation, are presented in Section 11.6.

### 11.4.1 Characteristics of the Proposed Scheme

The Proposed Scheme is described in detail in Chapter 4 (Proposed Scheme Description). In summary, the Proposed Scheme has an overall length of approximately 12km and commences south of Swords at Pinnock Hill Junction and travels in a southerly direction along the R132 Swords Road past Airside Retail Park, Dublin Airport and Santry Park. The route continues on the R132 past Santry Demesne, where the Swords Road joins the R104 at Coolock Lane. The route continues on the R132 in a southerly direction through Santry village. It continues along the Swords Road past Whitehall to Griffith Avenue. The route follows Drumcondra Road Upper past the DCU St Patrick's Campus to the River Tolka. It continues through Drumcondra, on Drumcondra Road Lower to Binns Bridge on the Royal Canal. From there it continues on Dorset Street Lower as far as Eccles Street, from where it continues on Dorset Street Upper to North Frederick Street and Granby Row.

The Proposed Scheme includes an upgrade of the existing bus priority and cycle facilities. The scheme includes a substantial increase in the level of bus priority provided along the corridor, including the provision of additional lengths of bus lane resulting in improved journey time reliability. Throughout the Proposed Scheme, bus stops will be enhanced to improve the overall journey experience for bus passengers and cycle facilities will be substantially improved with segregated cycle tracks provided along the links and protected junctions with enhanced signalling for cyclists provided at junctions.

Moreover, pedestrian facilities will be upgraded, and additional signalised crossings be provided. In addition, urban realm works will be undertaken at key locations with higher quality materials, planting and street furniture provided to enhance the pedestrians experience, an example of this can be seen at the Frank Flood Bridge in Drumcondra where a new pedestrian and cycle bridge is being provided to support walking and cycling across the River Tolka.

Chapter 5 (Construction) of this EIAR describes the construction of the Proposed Scheme on a section-by-section basis. Reference should be made to Chapter 5 (Construction) for a description of the construction activities and programme of works for each section. The key characteristics and impacts of the Proposed Scheme of relevance to human health during the Construction Phase are:

- Traffic management required, such as temporary traffic diversions or lane restrictions, to allow completion of particular elements of the Proposed Scheme whilst maintaining traffic flows as far as reasonably practicable (refer to Chapter 5 (Construction)). Temporary night closures may be required for Sections 1, 3a, 3b and 4b of the Proposed Scheme.
- Noise and vibration from the construction activities, construction plant and vehicles (refer to Chapter 9 (Noise & Vibration));
- Dust and potential air pollution from construction activities and plant (refer to Chapter 7 (Air Quality));
- General disruption of footways, cycleways and other areas due to construction works, including utility diversions. For example phased closures of footways are expected throughout the Proposed Scheme (refer to Chapter 5 (Construction)); and
- Occasional interruption of services such as water and power to allow some elements of construction activities to take place (refer to Chapter 19 (Material Assets)).

The key characteristics of the Proposed Scheme of relevance to human health are:

- Bus priority so that buses are not delayed by general traffic congestion, improving journey times and journey reliability for bus users;
- Increase in cycle facilities along route from 14km to 21.4km, of which 89% will comprise segregated cycle tracks while there is also a section of Quiet Street Treatment (Lorcan Road and Shanrath Road, and Swords Road between Larkhill Road and Collins Avenue);
- Removal of approximately 88 on-street parking spaces (no disabled parking spaces would be removed);

- Enhanced pedestrian and cyclist crossing facilities at eight major junctions, and nine moderate junctions (an overall increase from 86 signalised pedestrian crossings to 125 signalised pedestrian crossings);
- Urban realm improvements, for example at Pinnock Hill Junction, Lorcan Road north-eastern corner, shopping parade near Iveragh Road, Drumcondra Rail Station and Parnell Square. Examples of urban realm enhancements include tree and wildflower planting, decluttering of footways, use of high quality paving and new street furniture (refer to Chapter 4 (Proposed Scheme Description)); and
- Land acquisition impacts on approximately 60 residential properties to accommodate upgraded road and transport infrastructure (see Chapter 10 (Population)).

#### **11.4.2 Do Nothing Scenario**

In the 'Do Nothing' scenario, the Proposed Scheme would not be implemented and there would be no changes to existing highway infrastructure, so infrastructure provision for buses, pedestrians and cyclists would remain the same. The streetscape would continue to be based around the movement and parking requirements of private cars. High levels of traffic are associated with discouraging pedestrian and cyclist activity, and so the pattern of increasingly sedentary lifestyles, and the associated adverse health effects would continue, and potentially worsen as traffic congestion is predicted to increase (see Section 11.3.4). The baseline situation of high levels of traffic congestion and consequent delays to public transport would also continue, and potentially become exacerbated over time as traffic congestion is predicted to increase.

The current trends in the health baseline are likely to continue in the 'Do Nothing' scenario, although there is still considerable uncertainty at the time of assessment as to the impact of the COVID-19 coronavirus pandemic on travel behaviour (for example, choosing between home working, public transport, active travel or private transport), healthcare services, the economy and people's lifestyles, all of which would have direct and indirect effects on population health. It should be noted that travel demand and patterns of travel are anticipated to grow in line with population growth.

#### **11.4.3 Construction Phase**

The implications of temporary traffic management on issues relating to human health have been assessed. Specifically, the assessment considers the potential impacts on access to health services and health impacts associated with traffic congestion and diversions. The potential impacts on human health of other aspects of construction such as dust and noise have also been assessed. Chapter 10 (Population) provides a general assessment of accessibility, considering a wider range of community services and facilities, as well as impacts from land acquisition. Impacts of land take are also assessed in Chapter 10 (Population). No impact on population health is anticipated from this localised land take, and therefore this issue is scoped out of the human health assessment. Chapter 19 (Material Assets) provides an assessment of impacts on utilities such as water supply and power. It is not considered that any interruption of these services would be of a scale that could have any likely significant impacts on human health, and therefore this issue is scoped out of the assessment.

##### **11.4.3.1 Temporary Impacts on Access to Health Services and Education**

The Mater Misericordiae Hospital, Mater Private Hospital and CHI hospital on Temple Street (refer to Figure 11.1 in Volume 3 of this EIAR) are both accessed from Section 5a of the Proposed Scheme where construction works are anticipated to last approximately eight months. The Rotunda Hospital is accessed from Section 5b of the Proposed Scheme where construction activities are anticipated to last approximately six months. No road closures are anticipated in these sections and at least one lane will be open for traffic but there may be short 'stop-go' sections outside of morning and afternoon peaks which have the potential to cause some transient delays to general traffic. Survival rates from out-of-hospital cardiac arrests (Lyon *et al.* 2004) and stroke (Simonsen *et al.* 2014) are strongly influenced by emergency response times. Therefore, any delay to emergency admissions caused by traffic disruption could have a significant impact on health outcomes for some individuals who need emergency care. Access will be maintained along the Proposed Scheme for emergency vehicles at all times, throughout the Construction Phase. Therefore, the potential impact on emergency access to healthcare would be in line with baseline trends and will be Negative, Moderate and Short-Term.

For non-emergency appointments, it is likely that journeys can be planned to take account of the construction activities. It is likely that impacts would be limited to slight delays or additional journey times where diversions need to be taken. The risk of missing appointments to health services for the general population will be low, and health outcomes associated with these impacts are more likely to be frustration, annoyance and temporary stress as a consequence of inconvenience. The potential impact on general healthcare will be Negative, Slight and Short-Term.

The educational facilities closest to the Proposed Scheme are in Section 5a. These include Plunket College of Further Education, Whitehall Secondary School, Saint Patrick's Teacher Training College and Saint Patrick's Senior School, Dominican College, DCU All Hallows Campus and Drumcondra National School. Works in Section 5a are anticipated to last approximately 8 months. No road closures are anticipated and at least one lane of traffic in both directions will be maintained. However there are likely to be some phased footway closures which will necessitate either the use of a footway diversion or to cross the road via a pedestrian crossing point to continue journeys on foot. The nature and duration of construction work has the potential to cause some transient inconvenience to access to educational services but it is likely that journeys can be planned to minimise the risk of missing lessons. Health outcomes associated with these impacts are more likely to be frustration, annoyance and temporary stress as a consequence of inconvenience rather than any long-term loss of education opportunity or achievement. The potential impact will therefore be Negative, Slight and Short-Term.

#### **11.4.3.2 Health Impacts from Temporary Traffic Diversions**

Temporary diversions of pedestrians and cyclists may increase the likelihood of collisions with traffic if not appropriately managed. The traffic management arrangements, as described in Chapter 5 (Construction), will set out alternative routes and crossing arrangements for pedestrians. Where feasible, temporary cyclist provision will be made to assist cyclists where cycle paths or cycle lanes are temporarily closed for construction activities. In some instances, cyclists may be required to share space with vehicular traffic which could expose cyclists to risk of collisions with vehicles, particularly if there is route uncertainty or lanes are narrow. However, there is a requirement to adhere to the Traffic Signs Manual, Chapter 8 Temporary Traffic Measures and Signs for Roadworks (Department of Transport Tourism and Sport 2019), which provides guidance for the protection of vulnerable road users, including cyclists, when undertaking roadworks. This includes ensuring there is sufficient space for cyclists in the event it is necessary for cyclists to share space with vehicular traffic. The required provision for cyclists will be determined by the street characteristics and the guidance notes that '*the overall risk to cyclists should be considered on a case-by-case basis*'. The provision will be determined as the detailed Construction Traffic Management Plan (CTMP) is subsequently prepared by the appointed contractor prior to construction, including Temporary Traffic Management arrangements prepared in accordance with the Traffic Signs Manual, Chapter 8 Temporary Traffic Measures and Signs for Roadworks (Department of Transport Tourism and Sport 2019). However, it is assumed that the provision will ensure risk to both cyclists and pedestrians is mitigated. On this basis, the potential impact to human health from traffic collision related injuries will be Negative, Slight and Short-Term, as it is expected that exposure to risk during construction would be in line with current trends in the street environment.

#### **11.4.3.3 Health Impacts from Temporary Traffic Congestion**

Traffic management will be required to allow space for working areas during the Construction Phase. While no lengthy road closures are anticipated for this CBC, reductions in numbers of lanes open to traffic and the use of stop-go systems will reduce capacity and may result in temporarily increased traffic congestion along these routes. Momentary traffic congestion may also arise as a consequence of loading and unloading of construction vehicles bringing materials and plant to and from the construction sites.

Psychological stress is associated with traffic congestion (see Section 11.3.4), which is typically self-reported and does not have a precise medical definition. The population most exposed to these impacts would be regular commuters who use Swords Road, Drumcondra Road Upper, Drumcondra Road Lower and Dorset Street Lower, although it is anticipated that these people in the main would be able to adapt their routes to avoid areas of local congestion. The following diversions are available for commuters wishing to avoid the works:

- Between Swords Demesne and Airport Roundabout via Mountgorry Way, the R125 and M1 to avoid works in Section 1;

- Between Pinnock Hill Junction and Airport Roundabout via the R125 and M1 to avoid works in Section 1;
- Along the Old Airport Road, R108 and Santry Avenue to avoid works in Section 2a; and
- Along the N1 via Coolock Lane to avoid works in Sections 3 and 4.

Populations who would be most sensitive would be those disabled people who are dependent on cars, as well as children and parents on the school run. Since the congestion related to the Proposed Scheme in the Construction Phase is expected to be temporary and confined to different sections of the CBC route at certain stages of construction, the impact is anticipated to be relatively local in extent and transient in any given location of the route. Given that traffic congestion is a key existing issue for Dublin (see Section 11.3.4), it is unlikely that congestion associated with the construction of the Proposed Scheme would contrast notably from the baseline situation, as routine highway maintenance, loading/unloading activities and traffic incidents would regularly contribute to temporary increases in congestion with associated effects on driver stress. On this basis, the impact will be Negative, Slight and Temporary for the general commuting population who use the route and Negative, Moderate and Temporary for more sensitive groups.

#### **11.4.3.4 Construction Related Air Pollution and Health**

Chapter 7 (Air Quality) reports air dispersion modelling assessment of the Construction Phase traffic emissions has found that the Proposed Scheme will be Neutral overall in the Study Area. For PM<sub>10</sub> and PM<sub>2.5</sub> the difference between the Do Minimum and Do Something construction scenarios will be negligible for the most impacted receptor locations. The predicted concentrations at these locations will all be below the national limit values, but for PM<sub>2.5</sub> they will exceed the WHO Air Quality Guidelines fourth interim guideline (WHO 2021) value of 10µg/m<sup>3</sup>. This is the case for both the Do Minimum and Do Something Construction Scenarios, so the influence of the Proposed Scheme on any associated health outcomes will be negligible.

In the 2024 DS scenario, annual mean concentrations of NO<sub>2</sub> are above the relevant national air quality limit value objective in some areas; 87 exceedances were modelled at receptors on the N1 Drumcondra Rd Upper/Drumcondra Rd Lower/Dorset St Upper/Dorset St Lower/Bolton St, the R101 North Circular Rd, the R103 Collins Avenue, the R104 Coolock Lane, the R108 Phibsborough Rd, the R802 Gardiner St Upper/Middle/Lower, the R803 Ballybough Rd, the R836 Dublin Rd, Frederick St North, Gardiner Row, Granby Row and Parnell St. This is a decrease from 114 exceedances modelled in the DM scenario. As shown in Table 7.26 in Chapter 7 (Air Quality), the majority of modelled receptors are estimated to experience a negligible impact due to the Proposed Scheme in terms of the annual mean NO<sub>2</sub> concentration. A slight beneficial impact is estimated at 35 receptors, a moderate beneficial impact at 63 receptors and a substantial beneficial impact at 34 receptors. All beneficial impacts are modelled along the Proposed Scheme due to the diversion of traffic off these routes. A slight adverse impact is expected at 55 receptors and a moderate adverse impact at six receptors on the R101 North Circular Rd, the R802 Gardiner St Upper/Middle/Lower, the R803 Ballybough Rd, and Gardiner Row. These localised moderate adverse impacts are considered Negative, Significant and Short-Term as NO<sub>2</sub> concentrations exceed the limit value but only occur during the short-term Construction Phase. However, the degree to which people would be exposed to these changes is uncertain. Furthermore, the Construction Phase is not likely to result in changes in overall health outcomes given the temporary duration of the works and the degree of change expected.

On this basis, no impact on human health is likely to be attributable to the Proposed Scheme. Therefore, the potential impact on human health will be Neutral and Short-Term.

Construction Phase activities may generate nuisance dust. Table 7.23 in Chapter 7 (Air Quality) has assessed the risk of dust impacts as an overall high risk of temporary dust soiling impacts and an overall medium risk of temporary human health impacts, as a result of the proposed earthworks activities (the risk is the same or lower for trackout and construction activities). However, with the dust management measures in place, the impact of dust in terms of air quality will be Neutral and Short-Term. The potential for local residents to become anxious about the potential impacts of dust, and possibly attribute any respiratory symptoms they may have to perceived impacts from construction dust cannot be discounted. It is not considered that there will be a lasting impact, and the impact will be managed by means of an effective Construction Environmental Management Plan (CEMP) (refer to Appendix A5.1 CEMP in Volume 4 of this EIAR) incorporating the mitigation measures outlined in Chapter 7 (Air Quality). The potential health impacts from construction dust will be Negative, Slight and Temporary.

Earthworks, demolition and construction activities can be associated with the release of fungal spores into the atmosphere. Aspergillus is a ubiquitous organism and is present everywhere but is of particular concern when large scale demolition, excavation and earth-moving activity takes place. The vast majority of people are immune to this, but invasive Aspergillosis is a disease which is harmful to people with suppressed immune systems such as hospital inpatients. This issue is therefore considered in this assessment due to the presence of hospitals within the study area and relatively close to the Proposed Scheme (see Section 11.3.5). The National Guidelines for the Prevention of Nosocomial Aspergillosis During Construction / Renovation Activities (Health Protection Surveillance Centre 2018) deals specifically with construction works occurring within or adjacent to hospitals. Fungal spores are dispersed to no measurable concentration at approximately 250m from the source of the release. The National Guidelines for the Prevention of Nosocomial Aspergillosis During Construction / Renovation Activities note that the fundamental requirements in preventing Aspergillus infection arising from construction works are, first, to minimise the dust generated during construction and, second, to prevent dust infiltration into patient care areas. Works in the vicinity of the hospitals will be carried out in accordance with the National Guidelines for the Prevention of Nosocomial Aspergillosis During Construction / Renovation Activities with dust suppression measures in place. Furthermore, susceptible patients are normally placed in specially designed units that have highly filtered air to protect them from outside sources. On this basis, it is assessed that the potential impact of invasive Aspergillosis will be Negative, Not Significant and Short-Term.

#### **11.4.3.5 Construction Noise and Vibration and Health**

Chapter 9 (Noise & Vibration) provides details of the predicted noise levels associated with different aspects of the construction works. It reports that with mitigation in place, during the Construction Phase of the Proposed Scheme, noise levels at properties closest to working areas will be temporarily increased. The Construction Phase working hours will be time restricted and subject to local authority requirements and agreements. Normal construction working hours will be restricted to between 07:00hrs and 23:00hrs on weekdays, and between 08:00hrs and 16:30hrs on Saturdays. Night-time and Sunday working may be required in order to minimise the impact on road traffic movements during the daytime, for example at busy road junctions and in commercial areas and for such works as pavement / road surfacing. Any such working hours outside the normal construction working hours will be agreed with the road authority who control road opening licences. The planning of such works will take consideration of sensitive receptors, in particular any nearby residential areas. The most appropriate noise mitigation measures for each works area will be determined taking account of the various control measures included within Section 9.5 of Chapter 9 (Noise & Vibration), and Appendix A5.1 CEMP in Volume 4 of this EIAR. Noise from evening activities such as some road widening and utility diversions, is predicted to be reduced by 10dB through mitigation. The effect would be to reduce the distance of receptors exposed to Negative, Significant to Very Significant and Temporary noise impacts from those within 40m to those within 10m. Given the linear nature of the works, noise emissions related to construction works will have a temporary impact at any one area as the works progress along the length of the Proposed Scheme, further limiting the number of people exposed to noise.

Reference should be made to Section 9.4 to Section 9.6 in Chapter 9 (Noise & Vibration) for details of specific noise impacts and their mitigation.

The Construction Phase noise impacts may, in some places, be above the guidelines associated with health effects. In terms of effects on health, there is the potential for occasional sleep disturbance at night for some local residents, and during the day for shift workers. Other health outcomes are likely to be annoyance and temporary psychological stress as a reaction to noise. There is no evidence for significant impacts on health outcomes from transient levels of annoyance or occasional sleep disturbance. People likely to be more sensitive to these impacts could include those with ASD (autism spectrum disorder) and those who suffer from anxiety. The potential noise impacts will be temporary, and therefore, unlikely to be attributable to a change in health status for the general resident population, although sensitive individuals are likely to experience a degree of annoyance, which may result in some complaints. On this basis, the potential impact of noise and vibration on human health will be Negative, Moderate and Temporary on the neighbouring population.

#### **11.4.3.6 Other Environmental Hazards**

Chapter 13 (Water) and Chapter 14 (Land, Soils, Geology & Hydrogeology) have not reported any residual impacts of a nature that could be linked to likely significant impacts on human health outcomes. On this basis, the

potential impact of other environmental hazards associated with the Construction Phase of the Proposed Scheme on human health will be Neutral.

#### 11.4.3.7 Summary of Potential Construction Phase Impacts

Table 11.6 provides a summary of the assessment of impacts described in Sections 11.4.3.1 to 11.4.3.6. The pathways to the greater predicted health effects are temporary changes in noise and traffic conditions but these are not expected to result in any significant impacts on population health status.

**Table 11.6: Summary of Potential Construction Phase Impacts**

Assessment Topic	Associated Health Outcomes	Potential Impact
Temporary Impacts on Access to Health Services	<ul style="list-style-type: none"> <li>Emergency healthcare outcomes (Mater Misericordiae University Hospital, CHI hospital Temple Street, Mater Private Hospital)</li> </ul>	Negative, Moderate and Short-Term. Access to emergency healthcare will be maintained throughout construction and impacts of traffic disruption on response times are expected to be typical of baseline trends of traffic congestion in Dublin.
	<ul style="list-style-type: none"> <li>Non-emergency general healthcare outcomes associated with access to healthcare (including to Mater Misericordiae University Hospital, CHI hospital Temple Street, Mater Private Hospital, Highfield Hospital)</li> <li>Temporary psychosocial effects such as frustration, annoyance and stress</li> </ul>	Negative, Slight and Short-Term. Access to healthcare is likely to be maintained albeit with some minor inconveniences of access. Effects would be temporary and reversible.
Temporary Impacts on Access to Education Services	<ul style="list-style-type: none"> <li>Health inequalities associated with educational achievement</li> </ul>	Negative, Slight and Short-Term – disruption of access likely to be occasional occurrences which are not noticeable over baseline context
Health Impacts from Temporary Traffic Diversions	<ul style="list-style-type: none"> <li>Risk of injury from road collisions, especially for pedestrians and cyclists</li> </ul>	Negative, Slight and Short-Term on the basis that measures will be implemented to protect diverted cyclists and pedestrians.
Health Impacts from Temporary Traffic Congestion	<ul style="list-style-type: none"> <li>Temporary psychosocial effects such as frustration, annoyance and stress</li> </ul>	Negative, Slight and Temporary for the general commuting population.
		Negative, Moderate and Temporary for more sensitive people (e.g. those who suffer from mental health conditions such as anxiety).
Construction Related Air Pollution – Construction Traffic and Plant Emissions	<ul style="list-style-type: none"> <li>Exacerbation of asthma and other respiratory conditions</li> </ul>	Negative, Slight and Short-Term – the degree of exposure to predicted changes in NO <sub>2</sub> is expected to present a very low risk to population health.
Construction Related Air Pollution - Dust	<ul style="list-style-type: none"> <li>Exacerbation of asthma and other respiratory conditions</li> <li>Temporary psychosocial effects such as frustration, annoyance and stress</li> </ul>	Negative, Slight and Temporary on the basis that there would be potential concern about risk from construction emissions which individuals may associate with their symptoms.
	<ul style="list-style-type: none"> <li>Risk of invasive aspergillosis</li> </ul>	Negative, Not Significant, Short-Term risk for patients in nearby hospitals on account of dust control measures in place.
Construction Related Noise	<ul style="list-style-type: none"> <li>Temporary psychosocial effects such as frustration, annoyance and stress</li> <li>Sleep disturbance (shift workers)</li> </ul>	Negative, Moderate and Temporary on the basis that no change in health status is anticipated from the temporary and occasional construction noise impacts.
Other environmental hazards (water pollution, flood risk, ground contamination)	<ul style="list-style-type: none"> <li>Various health outcomes</li> </ul>	Neutral. No residual impacts from other environmental factors have been identified as likely to affect health.



## 11.4.4 Operational Phase

### 11.4.4.1 Health Impacts of Increased Physical Activity

The Proposed Scheme will introduce improved pedestrian and cycling facilities, as well as improved reliability of journey times for buses. There is a substantial body of evidence to demonstrate that investment in walking and cycling infrastructure can increase rates of physical activity among children and adults (Carlin *et al.* 2015; D'haese *et al.* 2015; Grasser *et al.* 2013; Wanner *et al.* 2012). There is moderate to good evidence that such infrastructure can lead to health gains, for example the implementation of new cycle lanes has been associated with improved cardiovascular health and improved weight management (D'haese *et al.* 2015; Mueller *et al.* 2015, Wanner *et al.* 2012.). Furthermore, studies also suggest that those who walk to and from public transport stops obtain a notable amount of daily transport related physical activity, with one study showing that 29% of public transport walkers achieved 30 minutes of daily physical activity purely by walking to and from transport stops (Besser and Dannenberg 2005). The Cambridgeshire Guided Bus Project in the UK provides evidence that physical activity is likely to increase from new bus and cycle infrastructure. One study (Panter *et al.* 2015) followed 469 adult commuters who lived within 30km of Cambridge and worked in areas that could be reached by bus. The median distance from worker's homes to their places of employment was 8km. The majority of participants had at least one car in their household. The study showed that exposure to the busway was associated with a significantly greater likelihood of an increase in weekly cycle commuting time, and an increase in the overall time spent in active commuting among the least active commuters at the baseline level. Participants living 4km from the busway were 34% more likely to have increased their cycle commuting time than those living 9km away. Among those who reported more cycle commuting after the busway opened compared to before, the mean increase was 86.6 minutes per week, or more than half the recommended weekly activity. The study shows that providing new sustainable transport infrastructure was effective in promoting an increase in active commuting. Some caution should be applied when generalising the results of this study to the Dublin context due to the very high prevalence of cycling in Cambridge. However, like Cambridge, Dublin has above average levels of health and affluence.

It is reasonable to assume, based on the above evidence, that the Proposed Scheme will facilitate increased levels of physical activity among the residential population within the study area. School children may be particular beneficiaries of this new infrastructure due to the presence of schools. The likely level of increase in physical activity to be gained is uncertain but could contribute to approximately 30% to 50% of weekly recommended physical activity on the assumption that the studies can be generalised to this area of Dublin. The health outcomes associated with increased physical activity are:

- Reduced risk of stroke and heart disease;
- Reduced risk of hypertension;
- Reduced risk of type 2 diabetes;
- Reduced risk of eight types of cancer;
- Reduced risk of depression;
- Improved cognitive function;
- Reduced risk of dementia;
- Improved musculoskeletal health;
- Improved weight management; and
- Improved mental wellbeing.

While there is strong scientific evidence of associations between increased physical activity and the above health outcomes; the degree to which levels of physical activity will increase among the population in the study area, together with the uncertainty over how much time being physically active will increase, means that the overall potential impact on health outcomes will be Positive and Significant in the long-term. This is on the basis that some individuals are likely to change their behaviour and accrue the recommended weekly levels of physical activity by building this into their regular commute, but it is not certain that these health benefits will be accrued across the general population in the study area. Positive mental wellbeing and weight management health outcomes are likely to be achievable in the short-term through increased physical activity levels, whereas the other health conditions identified above are likely to be longer-term outcomes.

#### 11.4.4.2 Health Impacts of Changes to Noise and Air Quality

The air quality assessment in Chapter 7 (Air Quality) predicts a mix of beneficial and adverse impacts on annual mean concentrations of NO<sub>2</sub> between the Do Something and Do Minimum scenarios for 2028. The majority of modelled receptors are estimated to experience a negligible impact due to the Proposed Scheme in terms of the annual mean NO<sub>2</sub> concentration. A slightly beneficial impact is estimated at 75 receptors, a moderate beneficial at 52 receptor and a substantial beneficial at 60 receptors due to the diversion of traffic off the Proposed Scheme routes. A slight adverse impact is expected at 61 receptors, and a moderate adverse impact at three receptors on the R101 North Circular Rd and the R108 Phibsborough Rd. These localised moderate adverse impacts are considered Negative, Significant and Short-Term as NO<sub>2</sub> concentrations exceed the limit value but will decrease below the limit by 2043 due to reductions in emissions between 2028 and 2043 from advancements in engine technology and the addition of a higher percentage of electric vehicles to the fleet. The Proposed Scheme is assessed as overall neutral in terms of annual mean PM<sub>10</sub> concentrations and annual mean PM<sub>2.5</sub> concentration with all receptors experiencing a negligible air quality impact. It is considered unlikely that a significant change in population health outcomes related to air quality can be attributed to the Proposed Scheme compared to baseline trends, and so, the potential impact to human health will be Positive to Negative, Slight and Long-Term.

Chapter 9 (Noise & Vibration) identifies the following potential operational noise impacts:

- Direct, Positive, Imperceptible to Slight Impacts along the Proposed Scheme due to a reduction in traffic volumes during both the Opening Year (2028) and the Design Year (2043); and
- Indirect, Neutral, Imperceptible and Short to Medium-Term Impacts to Indirect, Negative, Moderate and Short to Medium-Term impact during the Opening Year (2028) from increased traffic noise levels along a small number of roads adjacent to the Proposed Scheme as a result of traffic re-distribution during daytime periods. This impact would be Short to Medium-Term. During the Design Year (2043) this impact is calculated as Indirect, Positive, Imperceptible and Long-Term to Indirect, Negative, Slight to Moderate and Long-Term.

The parameter used in the noise assessment is the  $L_{Aeq, 16hr}$  which is the most appropriate to capture the traffic related noise effects of the Proposed Scheme. This parameter also aligns with the thresholds for noise management set within the Dublin Agglomeration Environmental Noise Action Plan 2018 – 2023 (DCC 2018). To support this health assessment,  $L_{den}$  outputs have also been provided (see Appendix A9.2 Noise & Vibration Results in Volume 3 of this EIAR). This assessment considers the implications for health outcomes as described in the WHO Environmental Noise Guidelines, (WHO, 2018). As discussed in Section 11.2.2 of this chapter, the WHO acknowledges that the Environmental Noise Guidelines cannot be reasonably achieved at every individual residence and so the assessment of the impact on health presented in this chapter considers the overall impact on the population. Section 9.4.4 of Chapter 9 (Noise & Vibration) should be referred to for information on specific locations which would experience notable noise impacts.

No impact on night-time traffic noise is anticipated from the Proposed Scheme as traffic modelling indicates that there is no significant redistribution of traffic during the night. Therefore, there would be no likely impact on sleep disturbance.

Under normal conditions, a 3dB change is the minimum change, which is perceptible to people, while a 1dB change is the minimum change which is perceptible in controlled (laboratory) conditions. The results of the assessment of noise from traffic redistribution in Appendix A9.2 show the predicted changes in  $L_{den}$  at 1298 modelled roadside locations. The highest level of change predicted along one road where a decrease in noise from 72dB  $L_{den}$  to 68dB  $L_{den}$  is predicted (a reduction of 4.2dB  $L_{den}$ ). The greatest level of increase predicted is 2.9dB  $L_{den}$ , which is predicted for two modelled receptors. At these receptors, the noise would change from 52dB  $L_{den}$  in the Do Minimum to 55dB  $L_{den}$  in the Do Something. None of the modelled receptors would experience an increase of 3dB  $L_{den}$  or above, while 685 out of the 1298 modelled receptors are predicted to change by less than 1dB  $L_{den}$ . This would suggest an imperceptible impact on population health from the Proposed Scheme.

On this basis, the potential health impacts associated with operational noise from the Proposed Scheme will be Neutral and Long-Term.

#### **11.4.4.3 Impacts on Use of Outdoor Spaces, Community Severance and Health**

Some streets will benefit from a reduction in through-traffic, while for others there will be an increase in traffic, as traffic is redistributed away from the Proposed Scheme bus corridor. Chapter 6 (Traffic & Transport) reports that there will be a reduction in general traffic flows along the Proposed Scheme route and assesses this as a Positive, Significant and Long-Term impact. However, it also assesses a Negative, Slight and Long-Term impact due to increases in traffic on some of the surrounding road network. Overall, the Proposed Scheme will improve the pedestrian environment along the main bus corridor, giving people more time to interact. The benefits of this may be counteracted in locations where through-traffic would increase. There is speculative evidence that the transition from reliance on cars to the use of a more reliable public transport service will help to facilitate a degree of social interaction as people would gather at bus stops or have the opportunity to converse on buses (Dugundji *et al.* 2011). Furthermore, the proposals to improve the quality of the street environment, such as tree planting, creation of rest areas, paved areas, and areas of ornamental planting, may support more social interaction. On balance, it is anticipated that there would be a greater level of social interaction facilitated by the Proposed Scheme than inhibited by it.

Studies show that there is an inverse relationship between the average number of social contacts people in a residential street have and the volume of traffic (see Section 11.3.4 of this chapter for supporting evidence). Reduced through-traffic would reduce actual and perceived community severance and support more social interaction. There are limited studies that demonstrate measurable short- or long-term health outcomes from reduced community severance. However, there is substantial evidence of the importance of social contacts to improved health outcomes (Mindell and Karlsen 2012).

On the above basis, the potential impact on human health will be Positive, Slight and Long-Term.

#### **11.4.4.4 Health Impacts of Improved Journey Times**

It is predicted that total bus journey times will reduce on average by 16% in the 2028 AM peak, and by 12% in the 2028 PM peak, and by 14% in the 2043 for both AM and PM peaks. This translates to a time saving of up to around 10 hours combined across all buses when compared to the Do Minimum.

Health benefits of this improvement in journey times include reduced stress for commuters, as they will have a more efficient journey and certainty over journey time, and it is possible that the time saving may allow more time for health promoting activities such as seeing family and friends, exercise, sleeping and healthy food preparation. Furthermore, a shorter period of time travelling would also reduce the length of time passengers are exposed to air pollutants (Gulliver and Briggs 2004). The associated health outcomes are likely to be Positive overall. The impact on human health is judged to be Positive, Moderate in the Medium-Term. This is on the basis that there will overall be time savings and improved reliability which may improve wellbeing for some individuals. However, there is insufficient evidence to ascertain whether these benefits would be sufficiently widespread to significantly influence population health.

#### **11.4.4.5 Impacts on Access to Health Services**

The Proposed Scheme will not change the physical ability to access healthcare services. However, the anticipated improvements in public transport journey times (as described above) and reliability would make public transport a much more convenient choice for travelling to healthcare services and would reduce the likelihood in missing appointments due to traffic congestion delays. The improved walking and cycling facilities would also support safer and more convenient journeys to healthcare facilities by active travel modes. Reduced general traffic and the possibility of using segregated bus lanes for emergency access would improve permeability and journey time reliability for ambulances. This is potential impact will be Positive and Significant in the medium term due to the importance of journey times in influencing emergency health outcomes, and a Positive and Significant impact in the long-term on access to health services generally, due to the more equitable transport experience, including for those without access to a car.

#### **11.4.4.6 Impacts on Health Inequalities**

The Proposed Scheme is unlikely to widen any existing health inequalities. It may help to reduce inequalities by improving access to employment for those dependent on public transport. Groups that would benefit most are the socially disadvantaged and some people with disabilities, noting that there is often an interrelationship between disability and deprivation and that car ownership among disabled people is lower (see Section 11.3.2).

The Proposed Scheme has been designed following the guidelines Building for Everyone – A Universal Design Approach (Centre for Excellence in Universal Design 2020), ensuring it will meet current universal design good practice standards, or at least make it no worse than the current situation. An accessibility audit identified several issues with the existing urban environment and the audit report sets out recommendations for the Proposed Scheme to address these issues. The recommendations include issues such as accessible parking, accessible routes (including use of tactile paving), appropriate changes in levels, appropriate surface materials, use of street furniture and the management of shared spaces. Assuming these design measures are correctly installed, the urban environment will be easier and safer for a wider variety of pedestrians including the visually impaired, wheelchair users and people with mobility difficulties, parents with young children and pushchair users. Details of provision for mobility impaired users are set out in Chapter 4 (Proposed Scheme Description). This would help to reduce health inequalities in terms of access in the urban environment particularly for people with disabilities.

The introduction of a reliable public transport corridor, with improved accessibility for public transport users and pedestrians, would have a likely positive effect in the short to medium term for reducing health inequalities associated with accessibility for disabled people in particular. The potential impact will be Positive and Moderate in the Medium-Term on the basis that the study area has a smaller proportion of disabled residents and lower levels of deprivation than average for Dublin, so the benefits may influence health inequalities for some individuals.

It is possible that adolescents and children may also benefit from the Proposed Scheme, as more reliable bus journeys and an improved pedestrian and cycling environment will support more independent mobility for young people. Concern over road safety can deter parents from allowing their children independent mobility, which limits opportunities for social interaction and exercise. Independent mobility, as well as making an important contribution to overall physical activity, provides additional benefits to children by promoting their social, cognitive and emotional development (Kytta 2004 in Veitch *et al.* 2017). It is uncertain the degree to which the Proposed Scheme could impact on children's independent mobility but there are several schools and colleges in the study area (see Figure 11.1 in Volume 3 of this EIAR) and so the improved conditions are likely to benefit some children. On this basis, the potential impact on reducing health inequalities relating to independent mobility will be Positive, Moderate and Long-Term. The potential benefit may increase in the longer term should social norms concerning cycling and travel change.

The Proposed Scheme will likely reduce health inequalities for pedestrians and cyclists. In a car-dominated environment, walking and cycling generally carries a five to 10 times higher risk of injury per kilometre travelled than driving a car (Elvik 2009). There are several studies that show that there is a 'safety in numbers' principle, whereas rates of active travel increase, rates of pedestrian, cyclist and overall road traffic injuries have been observed to decline. There is good evidence that rates of cycling increase where active travel infrastructure is provided. The Proposed Scheme will not only introduce improved active travel infrastructure, but will also reduce traffic along the route, further increasing safety for pedestrians and cyclists. On the basis that this will benefit active travellers for two key routes into Dublin, the potential impact for health inequalities relating to injuries from vehicle collisions involving pedestrians and cyclists will be Positive, Very Significant and Long-Term.

#### **11.4.4.7 Other Environmental Hazards**

Chapter 13 (Water) and Chapter 14 (Land, Soils, Geology & Hydrogeology) have not reported any residual impacts from the Operational Phase that are of a nature that could be linked to likely significant effects on human health outcomes. On this basis, the potential impact of other environmental hazards associated with operation of the Proposed Scheme on population health will be Neutral.

#### 11.4.4.8 Risk of Communicable Diseases

As set out in Section 11.3.6, the experience of the COVID-19 pandemic has shown how health protection measures, such as the use of face coverings can help manage the risk of the transmission of communicable diseases. It is known that the winter of 2020/2021 showed a record low level of influenza and other respiratory viruses other than COVID-19. It is very likely that this is attributable to public health measures taken because of COVID-19. Some of these such as sanitisation and mask wearing may bring benefits even when COVID-19 is no longer an issue.

The Proposed Scheme would facilitate improved public transport journeys, as well as improved opportunities for walking and cycling (which support journeys in a socially distanced environment). However, it would not in itself introduce a perceptible change in risk, since it is providing built infrastructure only, and public transport services, walking and cycling are already present within the Dublin baseline. Better air quality due to the use of public transport, as opposed to private cars, has the potential to benefit respiratory health and could reduce the risk of COVID-19 and other respiratory illnesses. The overall impact of the Proposed Scheme is considered to be Neutral in relation to risk of communicable diseases in the short- to long-term.

#### 11.4.4.9 Summary of Potential Operational Phase Impacts

Table 11.7 provides a summary of the assessment of impacts described in Section 11.4.4. The pathways to the greater predicted health effects are permanent changes in transport provision and access which would bring multiple pathways associated with health improvement such as opportunities for improved physical activity (active travel), reduced air pollution, opportunities for more equitable transport and access to services, and opportunities for more social interaction. Health effects such as reduced burden of disease associated with greater physical activity, access to health services and improved safety for vulnerable road users are expected to be Positive, Significant and Long-Term.

**Table 11.7: Summary of Potential Operational Phase Impacts**

Assessment Topic	Associated Health Outcomes	Potential Impact
Increased physical activity from improvements to walking and cycling conditions	Improved outcomes relating to several non-communicable diseases: <ul style="list-style-type: none"> <li>All-cause mortality</li> <li>Stroke and heart disease</li> <li>Hypertension</li> <li>Type 2 diabetes</li> <li>8 type of cancer</li> <li>Depression</li> <li>Cognitive function</li> <li>Dementia</li> <li>Musculoskeletal health</li> <li>Obesity</li> </ul>	Positive Significant and Long-Term from increased regular physical activity levels. There is good evidence that physical exercise improves health outcomes and that provision of good active travel infrastructure and restricting traffic encourages more walking and cycling. It is likely that some individuals are likely to change their behaviour and accrue the recommended weekly levels of physical activity by building into their regular commute, but it is not certain that these health benefits would be accrued across the general population in the study area.
Air quality impacts	<ul style="list-style-type: none"> <li>Cardiovascular disease</li> <li>Exacerbation of asthma</li> <li>Exacerbation of respiratory conditions (e.g. bronchitis and pneumonia)</li> <li>Dementia (emerging evidence)</li> <li>Low birthweight (emerging evidence)</li> </ul>	Positive to Negative, Slight and Long-Term impacts. Impacts are likely to be in line with baseline health trends relating to air quality.
Noise impacts	<ul style="list-style-type: none"> <li>Cardiovascular disease</li> <li>Annoyance</li> <li>Sleep disturbance</li> <li>Quality of life, wellbeing and mental health</li> </ul>	Neutral and Long-Term. Changes to the noise environment would not be perceptible for the vast majority of the population. Where a perceptible change in noise is predicted, this would be a decrease in noise.
Impacts on social use of space	<ul style="list-style-type: none"> <li>Levels of social interaction (and associated outcomes such as mental health and wellbeing and overall life expectancy)</li> <li>Levels of physical activity (and associated outcomes – see above for physical activity)</li> </ul>	Positive, Slight and Long-Term – on the basis of public realm enhancements that would bring improved opportunities for social interaction.

Assessment Topic	Associated Health Outcomes	Potential Impact
Improved journey times (general)	<ul style="list-style-type: none"> <li>Reduced stress/improved mental wellbeing from reliable journey times/control</li> <li>Outcomes associated with having additional time for health promoting opportunities such as exercising, socializing, sleeping and preparing healthy food (speculative)</li> </ul>	Positive, Moderate and Long-Term – improved reliability and shorter journey times is likely to be to be beneficial to some individuals, but there is insufficient evidence that this may significantly improve population health.
Improved journey times to hospitals and healthcare	<ul style="list-style-type: none"> <li>Improved access by public transport to clinical care from reduced likelihood of delays and missed appointments at city centre hospitals</li> <li>Reduced stress/improved mental wellbeing from reliable journey times/control</li> </ul>	Reduced traffic on arterial route will improve journey reliability for ambulances and public transport which would have a Positive and Significant impact in the Long-Term.
Disability and deprivation	<ul style="list-style-type: none"> <li>Reduced health inequalities relating to accessibility</li> </ul>	Positive, Moderate and Medium-Term due to addressing sub-standard infrastructure and making accessibility improvements throughout, which will particularly benefit people with disabilities. The Proposed Scheme also provides for more equitable transport which will benefit those without access to a car.
Children and adolescents	<ul style="list-style-type: none"> <li>Reduced health inequalities relating to independent mobility</li> </ul>	Positive, Moderate and Long-Term – it is uncertain the degree to which the Proposed Scheme will impact on children’s independent mobility, but there are a number of schools in the study area, and so the improved conditions are likely to benefit some children.
Pedestrians and cyclists	<ul style="list-style-type: none"> <li>Reduced health inequalities relating to road traffic injuries and deaths</li> </ul>	Positive, Very Significant, Long-Term effect through the provision of improved pedestrian and cycling infrastructure coupled with reduced through-traffic, which will reduce risk of collisions and associated injuries for pedestrians and cyclists.
<p>Notes:</p> <p>‘Annoyance’ as a noise associated health outcome is defined as a feeling of displeasure, nuisance, disturbance or irritation caused by a specific sound (Ouis 2001 in WHO 2018). In the current guidelines, ‘annoyance’ refers to long-term noise annoyance (WHO 2018).</p> <p>For associated health outcomes the following terminology is applied where there is not a strong body of scientific evidence reporting good evidence of association between the health determinant and health outcome:</p> <ul style="list-style-type: none"> <li>Emerging – a growing area of scientific research indicating evidence of association between the health determinant and health outcome but as yet not a strong body of evidence from a variety of studies/contexts</li> <li>Speculative – there is currently a lack of good quality scientific research into associations between the health determinant and health outcome</li> </ul>		

## **11.5 Mitigation and Monitoring Measures**

### **11.5.1 Construction Phase**

Mitigation for Construction Phase related traffic impacts are set out in Chapter 6 (Traffic & Transport) and Appendix A5.1 CEMP in Volume 4 of this EIAR. Measures will also be developed by the appointed contractor in the final CTMP to provide safe access for pedestrians and to help protect cyclists against an increased risk of collision with vehicles in areas of works and traffic management. Segregated lanes or diversions down Quiet Streets should be considered. Pedestrians will be protected through various measures such as segregated diversions around areas of works, clear signage, removal of obstacles and the provision of safe crossing points.

Access to the Mater Misericordiae Hospital, Mater Private Hospital, Rotunda Hospital and CHI Temple Street Hospital will be maintained during the Construction phase of the Proposed Scheme. In advance of construction works in the vicinity of the hospitals, the appointed contractor will liaise with the hospitals to inform them of the proposed construction traffic management arrangements. The CTMP (in Appendix A5.1 CEMP in Volume 4 of the EIAR), provides further detail with regard to maintaining access to properties during the Construction Phase.

Mitigation for construction related air quality impacts are set out in Section 7.5 of Chapter 7 (Air Quality).

Mitigation for construction related noise and vibration impacts are set out in Section 9.5 in Chapter 9 (Noise & Vibration). Of relevance is that the appointed contractor will comply with the recommendations of British Standard BS 5228–1 Code of practice for noise and vibration control on construction and open sites (British Standard Institute 2014) and S.I. No. 241/2006 - European Communities Noise Emissions by Equipment for Use Outdoors (Amendment) Regulations 2006.

Mitigation for adverse psychosocial responses to the Construction Phase will include providing the public with sufficient information to enable people to plan their days, journeys and activities around the construction works and take control of their options to some extent. The NTA will manage and take responsibility for community liaison and engagement. This will include timely communication to the local community on the planned works activities, timings and traffic management. A point of contact will be provided by the NTA where residents and other interested parties may have their concerns and queries addressed. This will help allow for any shift workers to make arrangements when works are likely to be close by their premises. These requirements are set out in the CEMP (see Appendix A5.1 CEMP in Volume 4 of this EIAR).

No specific monitoring measures are considered necessary for human health over and above monitoring measures identified elsewhere in this EIAR.

### **11.5.2 Operational Phase**

Mitigation and monitoring measures in Chapter 6 (Traffic & Transport) identify that impacts to general traffic and parking / loading are embedded into the Proposed Scheme, as outlined in Chapter 4 (Proposed Scheme Description). The Proposed Scheme will result in positive impacts for walking, cycling, bus and people movement and so no mitigation and monitoring measures are required for traffic and transport.

As set out in the mitigation and monitoring measures in Chapter 7 (Air Quality), no specific Operational Phase mitigation or monitoring measures for air quality are required as all ambient air pollutants will remain in compliance with the ambient air quality standards and the Proposed Scheme will have a generally neutral impact on air quality.

As set out in the mitigation and monitoring measures in Chapter 9 (Noise & Vibration), the range of noise level changes and overall noise levels calculated for traffic noise do not require any specific noise mitigation measures to be incorporated into the Proposed Scheme. No further noise mitigation measures are proposed for the new bus stops, as the overall noise context associated with the bus corridors is expected to improve with the transition of the bus fleet to electric and hybrid vehicles between the Opening Year (2028) and the Design Year (2043).

No significant negative health effects have been identified as a result of the Operational Phase of the Proposed Scheme, and therefore, no further mitigation measures are required.

No specific monitoring measures are considered necessary for human health over and above monitoring measures identified elsewhere in this EIAR.



## 11.6 Residual Impacts

### 11.6.1 Construction Phase

No significant residual impacts on health are predicted.

### 11.6.2 Operational Phase

Three issues were assessed as likely to be associated with significant residual impacts on human health, all of which were considered positive.

Lack of regular physical activity is a leading cause of chronic disease and premature deaths. The Proposed Scheme will improve opportunities and convenience for walking and cycling, which will support many people in the study area in achieving recommended levels of weekly physical activity, for example as part of an active travel commute to work or education. It will also increase safety and the perception of safety for pedestrians and cyclists, who are more vulnerable to injury and mortality from traffic collisions. Furthermore, by redressing the balance between private car use and other forms of transport, the Proposed Scheme will improve public transport journey times and reliability, as well as introducing greatly improved active travel infrastructure. This will provide for a more equitable transport experience, including for those without access to a car.

The Proposed Scheme is expected to have a significantly positive contribution on health outcomes related to increased physical activity, equitable access to services and improved safety for vulnerable road users.

The significant positive impacts which are expected to arise in the Operational Phase fully align with the relevant objectives of the Proposed Scheme identified in Section 11.1 (see Table 11.8).

**Table 11.8: Summary of Operational Phase Significant Residual Impacts**

Assessment Topic	Significant Residual Impact
Increased physical activity from improvements to walking and cycling conditions	Positive, Significant and Long-Term
Improved journey times to hospitals and healthcare	Positive, Significant in the Long-Term
Impacts of Health Inequalities: Pedestrians and cyclists	Positive, Very Significant and Long-Term

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#### Directives and Legislation

Council Directive 85/337/EEC of 27 June 1985 on the assessment of the effects of certain public and private projects on the environment

Directive 2008/50/EC of the European Parliament and of the Council of 21 May 2008 on ambient air quality and cleaner air for Europe

Directive 2014/52/EU of the European Parliament and of the Council of 16 April 2014 amending Directive 2011/92/EU on the assessment of the effects of certain public and private projects on the environment

S.I. No. 241/2006 - European Communities Noise Emissions by Equipment for Use Outdoors (Amendment) Regulations 2006.