Feidhmeannacht na Seirbhíse Sláinte
Health Service Executive

The Health Promotion Strategic Framework

The Health Promotion Strategic Framework

MAIN REPORT

Contents

Executive Summary v

Section 1: Introduction 2
- What is health promotion? 2
- What is the Health Promotion Strategic Framework? 3

Section 2: Health Promotion Strategic Framework Model 5
- Introduction 5
- The process of implementing the Health Promotion Strategic Framework 5
- The Health Promotion Strategic Framework Model 7

Section 3: Determinants of Health and Health Inequalities 8
- Introduction 8
- Determinants of health 8
- Why a 'determinants of health' approach? 9
- Expected outcomes from a 'determinants of health' approach 9
- Health inequalities in Ireland 11

Section 4: Settings for health promotion 12
- Introduction 12
- The settings approach 12
- Health promotion and the settings approach 12
- Priority settings for the Health Promotion Strategic Framework 14
- Health services 14
  - Diseased-based planning 15
  - Health care and health inequalities 15
  - The primary care setting 16
  - The hospital (and other residential care) settings 16
  - Towards a Health Promoting Health Service 16
  - The health of the HSE workforce 17
  - The HPSF priority objectives for the health service setting 17
  - Matrix 1 18
- Community 19
  - The Healthy City initiative 20
  - The HPSF priority objective for the community setting 21
  - Matrix 2 22
- Education 23
  - The HPSF priority objective for the education setting 24
  - Matrix 3 25

Section 5: Implementation of the Health Promotion Strategic Framework **26**
Partnership and capacity building approaches 26
Introduction 26
Partnerships for health 26
Capacity building approaches 27
Training and education 28
Policies and frameworks 29
Social marketing and advocacy 30
Advocacy 30
Research and evaluation 31
Research 31
Evaluation 32
Programme development and implementation 32

Section 6: Outcomes from the Health Promotion Strategic Framework **34**
Introduction 34
Re-orientate health and other public services 34
Create supportive environments for health 35
Reduce health inequalities 36
Improve health 36
Prevent and reduce disease 38
Reduce costs to the health care system 39

Conclusion 42
Abbreviations 43
References 44
Acknowledgements 50

Figures

Figure 1 - The Health Promotion Strategic Framework Model 7
Figure 2 - Determinants of Health Model 10
Figure 3 - Connecting the settings 13
Figure 4 - Settings based approach to health promotion planning 14
Figure 5 - Quality of Life Profile 37

Health Promotion
Primary Care
Health Promoting
Health Service
Training
Hospitals
Policies
MENTAL HEALTH
Integrated Care
Health Inequalities
Obesity

EXECUTIVE SUMMARY

Introduction

Since its emergence at an international level in the 1980s, health promotion in Ireland has developed and grown, with significant achievements in the areas of cardiovascular health, healthy public policies and healthy settings. This Health Promotion Strategic Framework (HPSF) provides the HSE with the means by which it can meet its commitments to protect and promote the health of the population. The framework is informed by the best available international and national evidence of health promotion effectiveness and includes a model to illustrate the main elements of health promotion in the HSE. This model outlines the process by which health promotion will address health inequalities and the determinants of health, as well as the health promotion outcomes it seeks to achieve through the three priority settings of health services, community and education.

Protecting and promoting the health of the population requires intersectoral and interdisciplinary approaches to health promotion. These approaches include key specific roles for the Health Promotion workforce and for the broader health and social care workforce in addition to the Non-Governmental Organisations (NGOs) and statutory and voluntary sectors. These commitments require the re-orientation of health and social care services in Ireland to include the development of organisational structures that support the promotion of health and the development of the skills and capacity of those outside the Health Promotion workforce to adopt a stronger evidence-based health promoting role.

The purpose of the HPSF is to set out the means by which the HSE will:

1. Achieve its strategic objectives of protecting, promoting and improving the health of the population
2. Ensure health promotion practice throughout the health service is in line with international evidence
3. Build the capacity of the organisation to improve health and wellbeing within the population and across the social gradient
4. Integrate health promotion into all aspects of its service (i.e. progress the development of the HSE as a **health promoting health service** based on international best practice)
5. Develop a robust multi-sectoral approach, in all settings, to addressing the social determinants of health and health inequalities
6. Increase the effective and efficient use of resources to promote the health of the population thus reducing the cost burden of chronic disease
7. Ensure value for money (VFM), particularly in the context of a reducing workforce.
8. The HPSF is the first national strategic framework for health promotion in the HSE. The framework sets out clear, consistent, national objectives for the HSE in relation to its health promotion priorities. The settings approach adopted by this framework provides a mechanism for addressing multiple health challenges and issues through a more integrated and cohesive level of intervention.

The Health Promotion Strategic Framework Model

The HPSF introduces a model that illustrates the main structural elements of health promotion for the HSE. The model presents five particular approaches that are adopted through the health services, community and education settings. Figure 1 provides a graphic representation of the model.

Priority objectives of the Health Promotion Strategic Framework

This HPSF focuses on three key settings for promoting health: health services, community and education settings. The framework builds on, and further develops, the extensive work that has already been undertaken in these key settings in Ireland.

Health Service Setting

The HPSF priority objectives for the health service setting are:

To support the implementation of a Health Promoting Health Service (HPHS) model for the HSE, based on existing approaches developed within the Irish Health Promoting Hospital initiative. This will include:

- Supporting the implementation of the HSE Integrated Employee Wellbeing and Welfare Strategy
- Supporting Primary Care Teams to improve capacity in community profiling, needs assessment etc
- Building capacity of HSE staff to integrate health promotion into service delivery
- Stronger links to other settings (such as schools and communities)
- Incorporating other health policy issues (such as patient and public involvement and health inequalities)

In developing the health service as an HPHS recognition is given to the fact that healthcare extends beyond the traditional healthcare settings. The HPSF, therefore, looks at ways that healthcare services can undertake health promotion work with the wider community. Some examples of this include: the provision of cardiac rehabilitation programmes in community settings, the provision of antenatal classes to teen mothers in youth care settings. Through the extension of healthcare services into other key settings, environments are created which are supportive of health and health improvement opportunities.

Community Setting

The HPSF priority objective for the community setting is:

To develop and implement a model for health promoting communities based on existing approaches. This will include:

- Work with key HSE functions to ensure a consistent community development approach to the implementation of the HSE Service User Strategy
- Build capacity within the community and the voluntary sector to identify and address health promotion priorities at community level
- Build on existing health promotion programmes and services to ensure a systematic focus on localities experiencing social and material disadvantage, including RAPID and CLÁR areas
- Design a nationally agreed model for health promoting communities, towns and cities based on available models such as the WHO Healthy City.

Education Setting

The HPSF priority objective for the education setting is:

To implement the nationally agreed health promotion model for the education setting (pre-school, primary, post-primary, third level and out-of-school) based on existing Health Promoting School (HPS) approaches.

Through the development of a HPS programme, schools become healthy settings. The HPS programme offers the staff, pupils and the wider school community increased opportunities to enhance health and wellbeing. Examples of health improvement opportunities include up-skilling teachers through training programmes (for example, summer schools, policy development workshops, Social Personal Health Education support programmes). For parents, programmes are offered to enhance health and wellbeing (for example, Being Well programmes, parenting programmes and mental health promotion programmes). For pupils, opportunities are created for them to become more involved in their school community through participating in the HPS process, thereby enhancing self-esteem and self-confidence.

Outcomes from the Health Promotion Strategic Framework

The HPSF identifies six key outcome areas for health promotion as follows:

1. Re-orientate health and other public services
2. Create supportive environments for health
3. Reduce health inequalities
4. Improve health
5. Prevent and reduce disease
6. Reduce costs to the healthcare system.

Some examples of the outcomes in each of these areas include the following:

Re-orientate health and other public services

- The development and effectiveness of primary care will be strengthened by improved capacities in community profiling, needs assessments, community participation and mobilisation and the provision of socially inclusive services
- The WHO Health Promoting Hospitals/Health Services Initiative will be further developed and expanded to support the integration of evidence-based health promotion within the acute and wider health and social care services
- HSE staff will be supported to engage in meaningful partnerships which encourage the audit of policies and practices in order to reduce health inequalities and ensure maximum health gain.

Create supportive environments for health

- The use of multi-strand approaches to promote and enhance health and include a combination of medical, lifestyle, behavioural and social-environmental approaches
- A planning process that is needs-based and incorporates evaluation and coordination between health care providers
- Full engagement in collaborative partnerships which are adequately resourced and which are regularly reviewed in terms of structure, function and effectiveness.

Reduce health inequalities

- Improved inter-agency cooperation to address the social determinants of health and health inequalities
- Development of partnerships for health which will result in integrated planning in areas such as housing, public spaces, transport, etc.
- Increased involvement and participation of individuals and communities in identifying and addressing health needs and health inequalities.

Improve health

- Increased awareness of the determinants of health and effective approaches used to address the determinants of health
- Increased environments to support healthy choices in the priority settings of health services, communities and education
- Increased capacity of individuals and groups to take action to improve health, for example, through the development of personal skills to address health issues and the determinants of health
- Mechanisms to support improved health behaviour and practices among individual population groups identified through particular settings, for example, children, adults, older people, special interest groups, etc.

Prevent and reduce disease

- Improvements in cardiovascular disease risk factors (for example, smoking, alcohol intake, salt consumption, etc.) and significant improvement in health-related behaviours (i.e. healthier eating, greater participation in physical activity, etc.)
- Modifications in risk-taking behaviours and improving risk factors for cancers
- Reduction in factors that contribute to mental ill-health through creating supportive environments for health, reducing stressful circumstances, developing supportive personal relationships and social networks
- A significant reduction in sexually transmitted infections and negative outcomes in relation to unplanned and unwanted pregnancies
- Contribution to a reduction in unintentional injuries in the home environment, at work and on the road.

Reduce costs to the healthcare system

- For older people, regular physical activity reduces the risk of falls and resulting injuries. As one becomes more active, more often and for longer periods, there is a resultant reduction in the risk of chronic illness.
- The evidence base on smoking cessation is substantial. Cost effectiveness studies indicate that the cost per quality-adjusted life year (QALY) gained by smoking cessation interventions is in the range of £174 to £873. Given that NICE's threshold for cost-effectiveness is between £20,000 and £30,000 per QALY, it is clear that smoking cessation is highly cost-effective.
- Systematic reviews of workplace programmes have found cost benefit ratios from such programmes in the region of 1:41 to 1:61, that is, the savings obtained from improvements in employee health are around four to six times the costs of the programmes. Interventions for the prevention of anxiety and depression among employees have also shown promising results in the reduction of sickness absence.

Implementation of the Health Promotion Strategic Framework

Implementation of the HPSF requires strong support across the HSE at national, regional and area level. This will include the support of management in each of the Directorates, and commitment to change from all staff working in the organisation. Implementation of the framework will be addressed through consultation, action planning and a well-structured process that will bring together key stakeholders who have a role in promoting health and wellbeing. Strong leadership and robust national and area structures will facilitate an integrated approach to health promotion at all levels of the HSE. The primary role of the Health Promotion workforce in achieving the framework objectives is to support organisational, environmental and system change within each setting, as well as building the capacity of these settings to promote health. This will require re-orientation of some elements of existing health promotion activity from a focus on individual health behaviour towards population and organisational approaches. This will also be dependent on strong multi-sectoral partnerships and working arrangements.

THE HEALTH PROMOTION STRATEGIC FRAMEWORK

Section 1: Introduction

What is health promotion?

Health promotion is defined as '*...the process of enabling people to increase control over, and to improve, their health*' (WHO, 1986). It represents a comprehensive approach to bringing about social change in order to improve health and wellbeing. The previous focus and emphasis on individual health behaviour was replaced by a significantly expanded model of health promotion which is reflected by the five elements of the Ottawa Charter as follows:

- Building healthy public policy
- Reorienting the health services
- Creating supportive environments
- Strengthening community action
- Developing personal skills

(Ottawa Charter for Health Promotion WHO, 1986)

The Ottawa Charter remains a source of global guidance and continues to shape the development of health promotion, alongside other important documents including the Jakarta Declaration (WHO, 1997) and the Bangkok Charter (WHO, 2005).

The World Health Organization identified seven key principles of health promotion (cited in Rootman, 2001) as follows:

World Health Organization Principles of Health Promotion

Empowerment	Health promotion initiatives should enable individuals and communities to assume more power over the personal, socio-economic and environmental factors that affect their health.
Participative	Health promotion initiatives should involve those concerned in all stages of planning, implementation and evaluation.
Holistic	Health promotion initiatives should foster physical, mental, social and spiritual health.
Inter-sectoral	Health promotion initiatives should involve the collaboration of agencies from relevant sectors.
Equitable	Health promotion initiatives should be guided by a concern for equity and social justice.
Sustainable	Health promotion initiatives should bring about changes that individuals and communities can maintain once initial funding has ended.
Multi-strategy	Health promotion initiatives should use a variety of approaches in combination with one another, including policy development, organisational change, community development, legislation, advocacy, education and communication.

The overall goal of health promotion is to enhance positive health and prevent ill health. In addition, health promotion has a role in well-established preventive health measures such as screening and immunisation.

What is the Health Promotion Strategic Framework?

The Health Promotion Strategic Framework (HPSF) is the first national strategic framework for health promotion in the HSE. It has been developed to support the HSE's strategic objectives of promoting and improving the health of the population. The framework sets out clear, consistent, national objectives for the HSE in relation to its health promotion priorities. The framework will not only guide the activity of the Health Promotion workforce, but sets out a model for developing a health service that integrates health promotion into all aspects of HSE services in line with international best practice. This framework is guided by the HSE's Corporate Plan (HSE, 2010) and identified National Priorities.

International evidence recommends health promotion approaches that are focused on how and where people live, work, and play; these are known as settings for health promotion. This framework acknowledges the key role that health and social care services have in promoting the health of the population across these key settings, while recognising the greater significance of the social determinants of health and the unequal health status experienced by different population groups.

The framework outlines a model of health promotion that addresses the broad determinants of health and health inequalities, through health services, community and education settings. It describes the approaches that are to be applied in each setting and sets out priority objectives and actions for national processes to support the implementation of the framework and for each of the three priority settings identified. With appropriate investment, the long-term outcomes of these approaches have been demonstrated internationally to improve health and reduce inequalities, disease and costs on the health system.

Health promotion priorities in the health service setting

In the health service setting, the framework outlines an approach that focuses on creating an appropriate balance between the promotion of health and the prevention and treatment of disease. The main objective for the health setting is the development of a Health Promoting Health Service (HPHS).
Through implementation of this objective, the health service itself becomes health promoting, and not just a place in which health promotion activity takes place. This means that the environment, the staff-patient relationship, and the services, are designed to improve and sustain health and wellbeing. The framework will also be used to address health issues such as cardiovascular diseases and cancers using a 'determinants of health' approach. Developing as a HPHS builds on the HSE's existing commitment to the Health Promoting Hospital initiative.

Health promotion priorities in the community setting

Within the community setting, the priority objective is to develop and implement a model for health promoting communities that will enable and empower communities and individuals to have greater influence over factors that affect their health. A strong focus on inter-sectoral collaboration is essential to achieve this objective.

Health promotion priorities in the education setting

Within the education setting, the priority objective is to implement a nationally agreed model for promoting health in pre-school, primary, post-primary, third level and out-of-school settings based on existing Health Promoting School (HPS) approaches.

Implementation of the HPSF

Implementation of the framework requires strong support across the HSE at national, regional and area level.

In summary, the purpose of the HPSF is to set out the means by which the HSE will:

1. Achieve its strategic objectives of protecting, promoting and improving the health of the population
2. Ensure health promotion practice throughout the health service is in line with international evidence
3. Build the capacity of the organisation to improve health and wellbeing within the population and across the social gradient
4. Integrate health promotion into all aspects of its service (i.e. progress the development of the HSE as a ***health promoting health service*** based on international best practice)
5. Develop a robust multi-sectoral approach in all settings to addressing the social determinants of health and health inequalities
6. Increase the effective and efficient use of resources to promote the health of the population thus reducing the cost burden of chronic disease
7. Ensure value for money (VFM), particularly in the context of a reducing workforce.

This is intentionally a high-level document which sets out a vision for health promotion and puts forward a case for significant organisational change. It lays the foundation for the future development of health promotion capacity across the HSE as an organisation and provides the basis for a plan of action for the integration of health promotion within all HSE activity. As a result, many of the issues it raises will need to be addressed through a subsequent action planning and implementation process. The implementation process will require the support of management in each of the Directorates, and commitment to change from all staff working in the organisation. The development of an action plan will identify and bring together key stakeholders who have a role in promoting health and wellbeing.

Section 2: The Health Promotion Strategic Framework Model

Introduction

The HPSF introduces a model that illustrates the main structural elements of health promotion for the HSE. In developing this model, consideration has been given to both international and national evidence and relevant strategic documents. The model outlines the process by which health promotion will address health inequalities and the determinants of health and deliver health promotion outcomes through health, community and education settings. The model presents five particular approaches that are adopted through these settings. Figure 1 provides a graphic representation of the model.

The process of implementing the Health Promotion Strategic Framework

The process of implementing the HPSF will require action across the HSE at national, regional and local level. At **national level**, the HSE requires a strong infrastructure for health promotion and effective action which includes:

- Strategic leadership and clear governance systems
- Integrated health promotion business planning
- Robust performance management
- Strong links with related functions in the DoHC and counterparts in Northern Ireland, DES and other Government Departments and with key national bodies
- Change management within the HSE, including integrated workforce planning
- Direction, coordination and support for the five main approaches outlined in the HPSF model
- Work across and beyond all settings including:
  - Dissemination of research and evaluation to influence policy and best practice
  - Development of systems to track progress in relation to health promotion policy and strategic objectives for key topics and population groups
  - Establishment of new national health promotion programmes based on emerging evidence and innovation, and accompanied by clear guidance for local delivery
  - Development and maintenance of a partnership approach with academic institutions in relation to professional development
  - Provision of public information to support health-related behaviour
  - Development of robust national planning structures and processes for health promotion
  - Development of national standards for all programmes
  - Development of key result areas
  - Development of key performance indicators
  - Agreed service contracts with the Regional Directors of Operations (RDOs) to ensure implementation throughout the regions
  - Support for local creativity to meet national objectives and help shape new national initiatives

In order for health promotion to be effective, national health promotion policy and strategy will need to be translated through regional and local service area levels to ensure that health promotion services are delivered in a nationally agreed and consistent manner. Delivery of health promotion at **regional and local levels** will be supported at a national level. In order for this synergy to occur, action is required at regional and local levels as follows:

- Coherent and consistent planning, monitoring and evaluation of programmes
- Coordinated development of business plans
- Effective governance processes
- Processes to ensure safe and effective health promotion practice across all health and social care staff groups
- Effective structures that facilitate partnership work across the relevant sectors to improve health, both within and external to the HSE
- Mechanisms to facilitate contributions from local service areas to relevant national plans, policies and procedures
- Support for a wide range of regional and local activities such as community profiling, health impact assessment, community development, addressing health inequalities, enhancing health literacy programmes and building capacity.

Figure 1: The Health Promotion Strategic Framework Model

Section 3: Determinants of Health and Health Inequalities

Introduction

The Commission on Social Determinants of Health (CSDH, 2008) identifies that social inequalities in health arise because of inequalities in the conditions of daily life. The fundamental drivers that give rise to them include inequities in power, money and resources. The Commission highlights the significance of the determinants of health and health inequalities as:

The poor health of the poor, the social gradient in health within countries, and the marked health inequities between countries are caused by the unequal distribution of power, income, goods, and services, globally and nationally, the consequent unfairness in the immediate, visible circumstances of peoples lives – their access to health care, schools, and education, their conditions of work and leisure, their homes, communities, towns, or cities – and their chances of leading a flourishing life...Together, the structural determinants and conditions of daily life constitute the social determinants of health and are responsible for a major part of health inequities between and within countries.

(Commission on Social Determinants of Health, 2008)

Strong international evidence exists to show that the most effective health promotion practices are achieved through approaches that influence the determinants of health and health inequalities. This framework places the emphasis for health promotion activity on addressing the determinants of health and health inequalities. This will primarily be achieved through:

- The adoption of a settings approach to health promotion
- Strong national leadership aimed at putting health on the agenda of all those involved in planning and decision making including advocating for a Health in All Policies approach (HiAP)
- Building and strengthening cross-sectoral and inter-departmental Government partnerships.

Determinants of health

The determinants of health are a range of interacting factors that shape health and wellbeing and are underpinned by social and economic inequalities (Marmot Review, 2010). These determinants include: material circumstances, the social environment, psychosocial factors, behaviours and biological factors. In turn, these factors are influenced by social position, itself shaped by education, occupation, income, gender, early childhood development, ethnicity and race. All these influences are affected by the socio-political, cultural and social contexts in which they sit. In recent years, various determinants of health models have been produced (for example, Dalghren and Whitehead, 1991; Grant and Barton, 2006). Figure 2 outlines the determinants of health model for Ireland. This model clearly describes the factors that influence individual and population health. In this model related factors are shown in concentric circles, but in practice, all factors interact with each other.

Why a 'determinants of health' approach?

As highlighted above, the WHO Globel CSDH (2008) and the subsequent Marmot Review (2010), both identified the importance of addressing the conditions of everyday life that lead to health inequalities.

The HSE recognises that most of the factors that shape our health and wellbeing are, for the most part, outside the direct influence of the health and social care services (HSE, 2005). Therefore, while most of the programmes undertaken by a health and social care system can address the factors that influence the health and wellbeing of the population (Wilkinson and Pickett, 2009), it is only by working in partnership across all sectors that a significant impact can be made on the determinants of health, thereby reducing health inequalities and optimising health gain.

Expected outcomes from a 'determinants of health' approach

In order to be effective, a 'determinants of health' approach requires long-term vision and investment that will result in a reduction in health inequalities by reducing social inequalities. The Marmot Review (2010) identified the health and economic benefits of using this approach which can actively influence and facilitate:

- A focus on health equity in all national policies
- Opportunities for every child to be given the best start in life
- The development of sustainable and healthy communities
- The prevention of ill health and strengthening of mechanisms for early interventions
- Enhanced opportunities for education and training for all in order to maximise their skills and capabilities
- Self fulfilment
- A good quality of life.

Addressing health inequalities has been an important feature of health promotion work in the HSE and is a major priority in this strategic framework. Dahlgren and Whitehead (2006) suggest that health inequalities are:

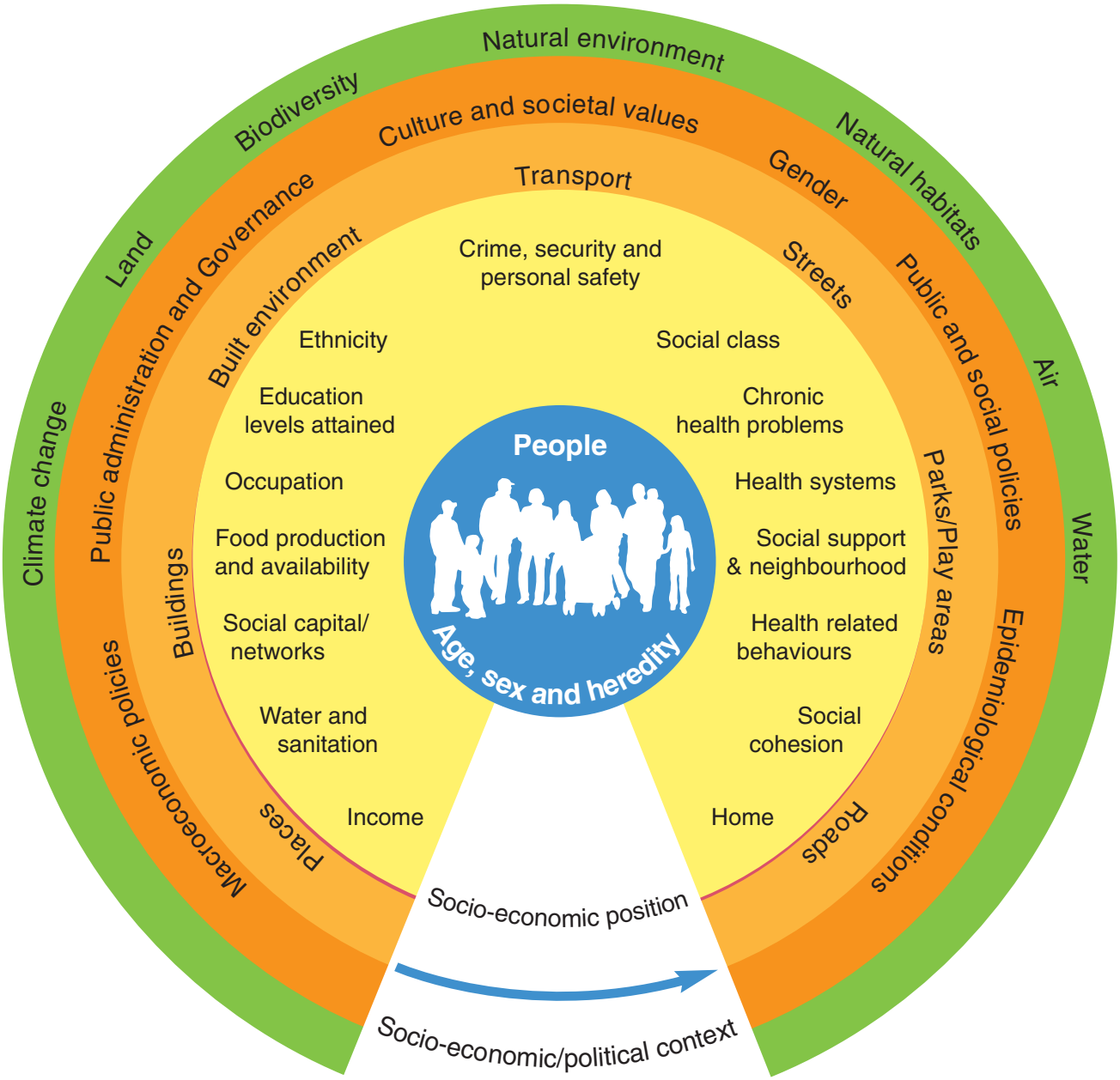
- Systematic - they are not random but follow a consistent pattern
- Socially produced - they can be changed
- Widely perceived to be unfair or inequitable.

As health inequalities are not simply a matter of chance but are strongly influenced by the actions of governments, organizations, communities and individuals, they are not inevitable. Action to reduce health inequalities means tackling those factors which impact unequally on the health of the population in a way which is avoidable and can be dealt with through public policy.

(Commission of the European Communities, 2009)

Figure 2: Determinants of Health

(Adapted from Dalghren and Whitehead, 1991 and Grant and Barton, 2006)



Health inequalities in Ireland

Striking differences in health outcomes exist within the Irish population. People in lower socio-economic groups experience higher rates of chronic illness and live shorter lives compared to those in higher socio-economic groups. This inequality is highlighted in a substantial and growing body of evidence as follows:

- Research carried out among the Organisation for Economic Cooperation and Development (OECD) countries indicates that Ireland is unusual in the degree to which it restricts free access to General Practitioner (GP) and other health services. Furthermore, while those who have a medical card visit their GP twice as often as those who do not, their uptake of prevention screening programmes is lower than people in higher socio-economic groups (Layte et al., 2007).
- Babies born to unemployed parents have approximately twice the risk of having a low birth weight when compared to babies born to parents in the highest professional occupational group (ibid).
- Gender can influence your life expectancy, mental health, risk of chronic disease, experience of abuse and risk of suicide (Institute of Public Health in Ireland, 2008).
- People who are poor are more likely to live in environments that have a negative impact on their health and wellbeing (Layte et al., 2007).

While poverty is the key underlying cause of poor health outcomes, examples of health inequalities also exist independently within specific subgroups in society. For example:

- Life expectancy at birth for male Travellers has remained at the 1987 level of 61.7 which is 15.1 years less than men in the general population, representing a widening of the gap by 5.2 years. This is equivalent to the life expectancy of the general population in the 1940s (DOHC 2010)
- Life expectancy at birth for female Travellers is now 70.1 which is 11.5 years less than women in the general population, and is equivalent to the life expectancy of the general population in the early 1960s. This has improved from 1987 when life expectancy was 65 years (ibid)
- Suicide is **6 times** the rate of general population and accounts for approx 11% of all Traveller deaths (ibid)

Health and wellbeing is affected by the level of health and social care services provided and also by the degree of access to them. For example:

- A health system with a strong focus on primary care is better able to provide person-centred care and to positively address illnesses that affect poorer groups (National Men's Health Policy, DoHC, 2008, Reach Out: National Strategy for Action on Suicide Prevention, HSE, 2005).
- Services that are planned and provided at a local level provide better opportunities to engage with communities about the issues that affect their health, and how to address them (ibid).

While the way in which health services are provided influences health outcomes, it is important to recognise that the root causes of health inequalities are social, economic, cultural and political. Therefore, these determinants must be tackled in order to address the social-class gradient differences in health outcomes effectively (Marmot Review, 2010).

The HSE is fully committed to addressing inequalities. As a result, in 2009 the HSE developed a Health Inequalities (HI) Framework. The HI Framework presents comprehensive and measurable actions designed to provide a clear direction for services, health care management, clinicians and professionals. It also includes evidence-based, high-level actions which will guide planning, monitoring and programme development to address health inequalities. The HI Framework complements the HPSF in this regard.

Section 4: Settings for health promotion

Introduction

This section explores in detail the three key settings around which this framework has been devised: health services, community and education. It also looks at the evidence base for addressing health promotion using the settings approach. It describes how topics, population groups and chronic illness can also be addressed using this approach.

The settings approach

The World Health Organization (1998) defines a setting for health as:

'The place or social context in which people engage in daily activities in which environmental, organizational and personal factors interact to affect health and wellbeing'.

The settings approach adopts an ecological approach to health that sees health as the dynamic product of interactions between individuals and their environments (Dooris, 2004). It recognises the links and connections that exist between different settings and recognises that people do not live or interact in just one setting, their lives straddle a range of different settings. Figure 3 presents these connections in a conceptual diagram. The settings approach reinforces the need for a 'joined up' approach between the various settings at every level to enable effective health promotion action to happen.

Health promotion and the settings approach

The settings approach is an important development in health promotion theory and practice. The approach has its roots in the Ottawa Charter (WHO, 1986), which introduced the concept of 'supportive environments for health'. This was further developed in the Sundsvall Statement on Supportive Environments for Health (WHO, 1991) which reiterated that: '*Health is created and lived by people within the settings of their everyday life; where they learn, work, play and love (WHO, 1986).*

The settings approach facilitates health promotion interventions to focus more on the broader determinants of health rather than simply addressing individual and/or population behavioural risk factors. Settings are *'major social structures that provide channels and mechanisms of influence for reaching defined population groups'* (Mullen et al., 1995). The approach is underpinned by key health promotion values such as empowerment, public participation, equity and partnership. Key features of a settings approach include:

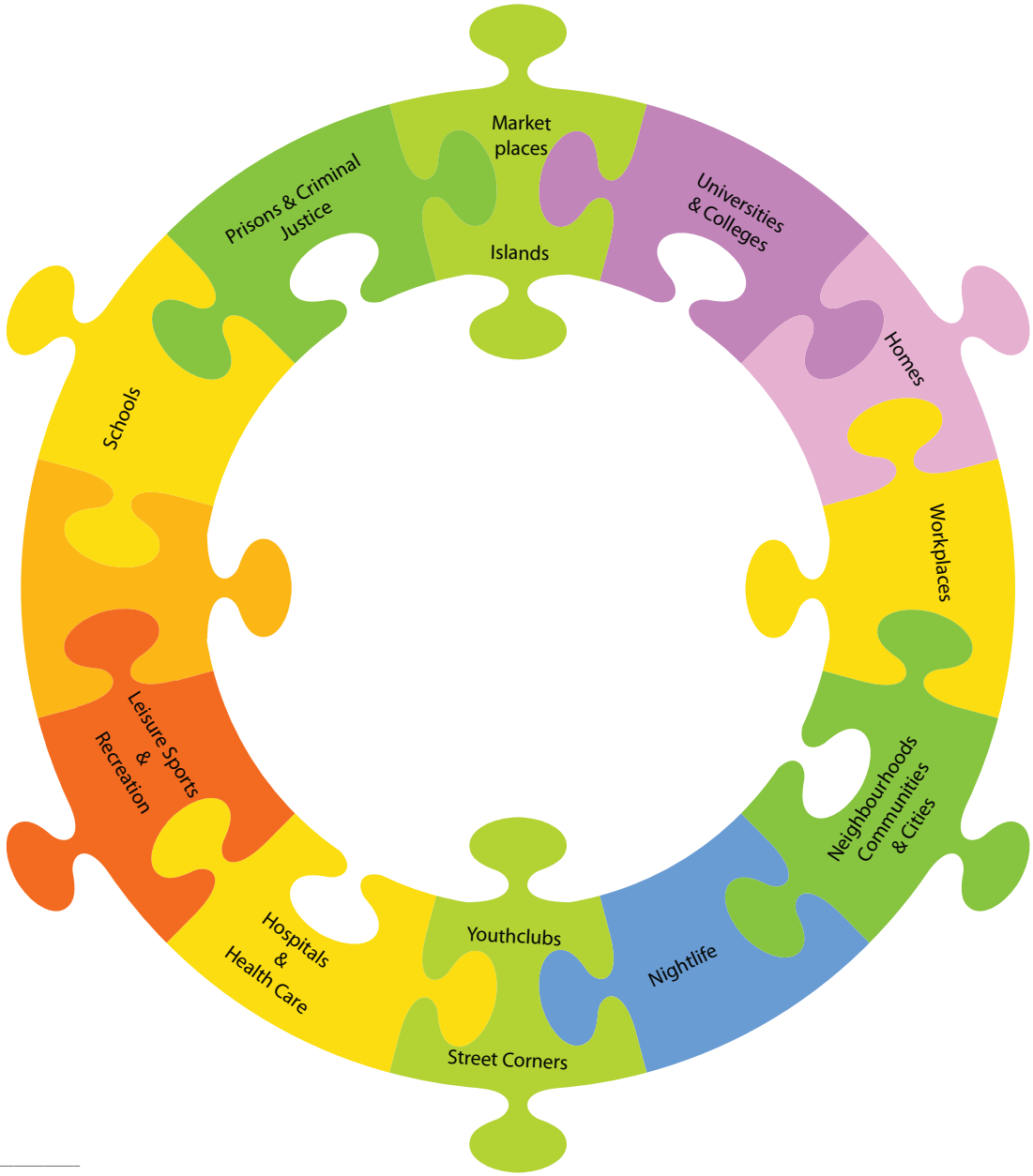
- Developing personal competencies
- Implementing policies effectively
- Re-shaping environments
- Building partnerships for sustainable change
- Facilitating ownership of change throughout the setting (Whitelaw et al., 2001).

There are definite links between the factors that influence health issues such as diabetes, obesity and cardiovascular disease, and health behaviors such as physical activity, smoking and healthy eating. Developing programmes that only address health issues at an individual patient level are limited in their effectiveness. Such programmes require intensive support, fail to interface with the broader public health agenda which has a significant role to play in addressing many of the underlying causes of illness and

disease. A significant advantage of working through a settings approach is that it provides a more integrated and cohesive mechanism for addressing multiple health issues and their determinants. The settings approach enables 'whole-system planning' for health across the relevant sectors.
Figure 4 outlines in detail how the settings approach maps and connects the topics, settings and programmes to enable effective health promotion planning.

The settings approach moves interventions *upstream*[1] from defining goals and targets in terms of populations and people only, towards identifying goals that focus on changes in organisations, systems and the environment. In this context, all of the opportunities for influencing health within a setting can be considered priorities for change, which can be clearly identified, and plans can be developed that lead to maximised health gain.

Figure 3: Connecting the Settings
(Adapted from Dooris, 2004)



[1] Upstream is defined as interventions that focus on the broad determinants of health-related behaviours at a population level.

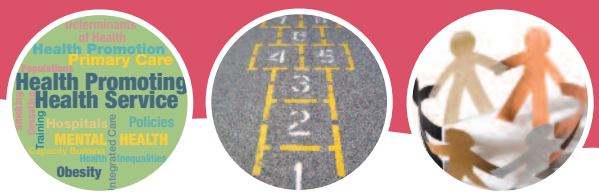
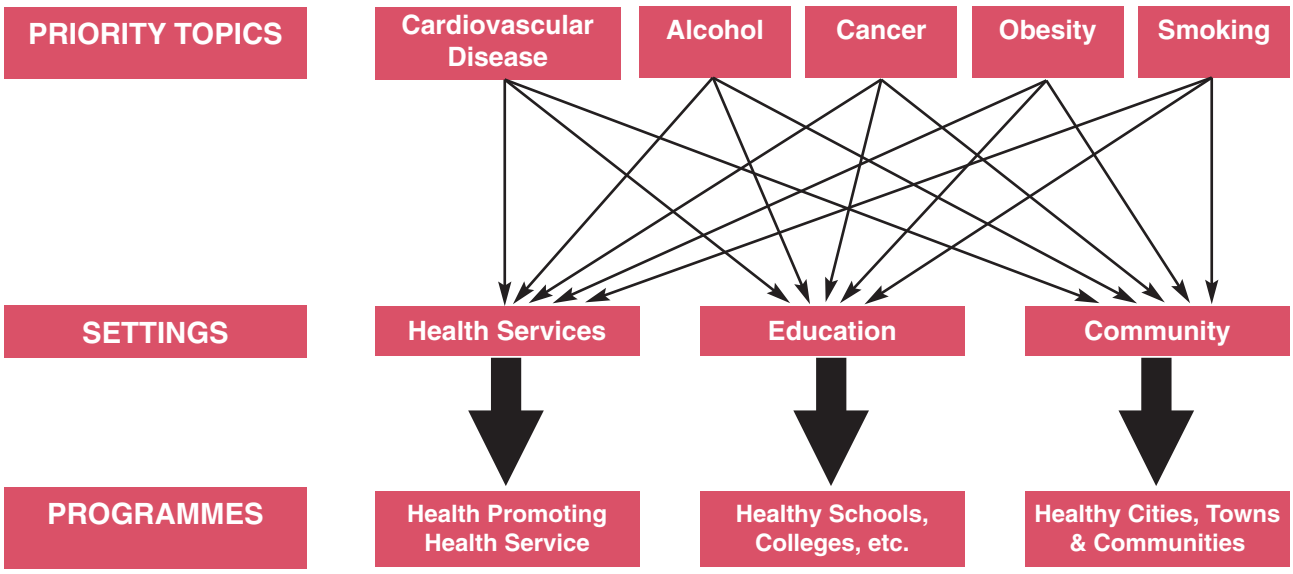


Figure 4: Settings-based approach to health promotion planning (Adapted from Downie, Tannahill and Tannahill, 1996)



Priority settings for the Health Promotion Strategic Framework

This HPSF focuses on three key settings for promoting health: health services, community and education settings. The framework builds on, and further develops, the extensive work that has already been undertaken in these key settings in Ireland. Each of these settings is now discussed in greater detail.

Health services

Over the past 20 years key health-related strategy documents in Ireland have presented a vision whereby health education and health promotion responsibilities would become integrated into health service delivery. Launching 'Quality and Fairness' (DoHC, 2001), Minister Micheál Martin reflected on the earlier 1994 strategy (Shaping a Healthier Future):

'The 1994 strategy [Shaping a Healthier Future] set about reshaping our health services in order to ensure that improving people's health and quality of life became the primary focus of the work of health policy makers and providers.... (However) there is a need to give this issue greater prominence and a new momentum in terms of its key role in tackling a persistent health status problem including inequalities between population sub-groups in Ireland'.

'Quality and Fairness' (DoHC, 2001) further reinforced this vision. Both of these documents built on the Ottawa Charter (1986) which called for a re-orientation of health services towards health promotion and presented a way to enlarge the scope of health care interventions.

Disease-based planning

National policy statements and related clinical programmes generally focus on a single disease or disease group, for example, a coronary heart disease programme, a stroke programme, a cancer programme. Many issue-specific approaches to disease prevention can be limited in effectiveness. This is particularly the case when patients often live with more than one long-term condition. Many diseases have risk factors in common and these risk factors are caused by underlying determinants of health.To understand the causes of any one disease requires a coherent analysis of the determinants of health (Downie et al., 1996).

Treatment of disease and health promotion are generally seen as two specialist functions, however both are intrinsically interlinked. Effective treatment of diseases requires a holistic, whole-system approach, in which the underlying causes of disease, at both an individual and population level, are as much a focus of concern as diagnosis and treatment. An example of this is the management of long-term conditions which require a major re-orientation away from cure, towards information, self-help, shared care and community support.

Health care is a determinant of health, therefore there is significant scope for health systems to be re-configured to take on additional responsibilities in relation to health promotion. One of the first responsibilities for clinicians is to identify what they can do to reduce the increasing burden of chronic disease.[1] Although most clinical work is likely to remain focused on individual patients rather than populations, it makes sense to integrate activities across and beyond single-disease programme lines. To this end health promotion seeks to works across the whole of the health care continuum.

Health care and health inequalities

With regard to health care, it is generally accepted that people with greater need should receive more help than those with less need. Assessment of need, therefore, must extend beyond clinical issues, to a greater range of support needs. Central to this assessment of need and subsequent health care provision is the concept of empowerment:
...it is entirely unrealistic to expect individuals on their own, in deprived areas or circumstances, to take full responsibility for their own health and wellbeing. Assistance, advice and leadership are required, and....it is from this purely professional concern that the distinctive health promotion concept of 'empowerment' derives. (Downie et al.,1996).

When health care services fail to take an empowering approach, this can actually increase the gap in health outcomes between population groups (HSE, 2009). For example, an Irish study of treatment following heart attacks found that men were more likely to receive a range of therapies than women, and younger patients more than older. Women are less often referred to cardiac rehabilitation programmes and mixed-sex groups may limit the benefits for women (Women's Health Council, 2003).

[1] Chronic diseases - including heart disease, cancer, stroke, diabetes, and respiratory diseases - share major risk factors. Because of the shared impact of these risk factors, a concerted effort to modify health behaviours inevitably has positive repercussions on the disease burden for CVD (heart disease and stroke), cancer, diabetes, respiratory diseases, and many other conditions. There are evidence-based interventions that are effective in modifying these risks and subsequently preventing disease. For example, adoption and dissemination of comprehensive, evidence-based clinical practice guidelines on treating tobacco dependence to medical professionals are effective in promoting cessation of tobacco use and providing adequate treatment. This (enhanced role) includes extending and advancing training in the field of chronic disease prevention, as well as making this a top research priority. Health professionals and advocacy groups must (also) learn to act as committed partners, guiding program development, advising the public, and working to validate or discard initiatives based on the outcomes observed.

Source: Halpin, HH, Morales-Suárez-Varela MM, Martin-Moreno JM.(2010).
Chronic Disease Prevention and the New Public Health. Public Health Reviews, 32(1), 120-154.
http://www.publichealthreviews.eu/upload/pdf_files/7/08_Chronic.pdf

The primary care setting

The Primary Care Strategy (DoHC, 2001) sets out an expansion of primary care so that it becomes *'the main setting for delivery of health and personal social services and a key component of health education, early intervention and disease prevention'.* The strategy makes commitments beyond the delivery of individual patient education: *Primary care teams (PCTs) will be facilitated and funded to develop ...activities which can promote and protect the health of people and families ...through, for example, school and community-based health education...[and] links to local area action plans to provide integrated information and services, as well as links to community development projects.* (DoHC, 2001).

To do this, regional and local service area management will be required to assign staff and allocate additional resources to support interventions and collaborative partnerships which recognise and act upon the socio-environmental conditions that shape our health: *Commitment to change at many levels will be required to meet the challenges and build the appropriate capacity into the future.* (DoHC, 2001). Currently, health promotion staff work at national and regional level with primary care managers and practitioners.

The hospital (and other residential care) settings

As highlighted earlier, health care is a determinant of health. Institutional health care offers a particular and unique opportunity to promote health and the hospital and other residential care settings are critical for further development in relation to health promotion.

A Health Promoting Hospital (HPH) is defined as one that *'incorporates the concepts of health promotion into its organizational structure and culture by means of organizational development'* (WHO, 2005). The Irish Health Promoting Hospitals Network (IHPHN) was established in 1997 to help to bring about the improved health of staff, patients and the community in which hospitals and health care settings are situated. The strategic objectives of the IHPHN focus on the integration of health promotion into the hospital setting as follows:

- To support the integration of health promotion into the planning and management of services through the use of service plans and performance management (for example, agreement on cross-sectoral objectives, setting of standards (WHO, 2004), monitoring of progress and related accreditation procedures)
- To facilitate the integration of health promotion across clinical care (primary/acute hospitals) through integrated health assessment processes, care pathways and care planning
- To facilitate the sharing and transfer of knowledge, experiences and good practice through a process of active networking at local, area, national and international levels.

Towards a Health Promoting Health Service

The vision for an HPHS extends beyond the health care setting itself to look at the ways in which health care services can undertake health promotion work within the wider community. It begins by recognising that every health care contact is a health improvement opportunity and that all health care staff have a role to play. This, in turn, provides a basis for closer integration with other health promotion programmes. In due course, the organisation itself becomes health promoting, and not just a place in which health promotion activities take place. As a result, the environment, the staff-patient relationships and the services are designed to improve and sustain health and wellbeing.

A number of HPHS models have been developed in Scotland, Sweden and Canada. These models closely mirror the HPH work in Ireland. The Scottish HPHS package (Health Scotland, 2005) provides a model for developing health promoting health services and

useful tools such as an HPHS Action Plan template. Health Scotland also provides access to specialist health promotion advice and expertise provided by a facilitator from the local health promotion department and access to training opportunities, including a six-day promoting health course. Monitoring and evaluation advice and support is also provided, based on the 'LEAP for Health' (Learning, Evaluation and Planning) guidance (Health Scotland, 2003). The 'LEAP for Health' package offers a structure for evaluating the effectiveness of projects and programmes. Evaluation studies, cited in 'LEAP for Health', demonstrate that participation in the HPHS initiative has had a significant impact on staff's ability to apply health promotion concepts in their work as well as examples of how staff have addressed health inequalities across the pilot sites. The HPHS was also judged by participants to have had an impact at organisational level, including changes such as the development of supportive health policies and changes in the way people work (Health Scotland, 2003).

The health of the HSE workforce

In 2009, the HSE launched *the Integrated Employee Wellbeing and Welfare Strategy 2009-2014* as part of a long-term strategic approach to developing the HSE as a healthy workplace (HSE, 2009). The strategy aims to identify and prioritise initiatives to promote the health and wellbeing of HSE staff. It provides the opportunity to integrate Occupational Health, Employee Assistance, Health Promotion and Health and Safety Services throughout the HSE and seeks to embed workplace health promotion into the management processes of the organisation. The HPSF will further support the implementation of this strategy through the development of a Health Promoting Health Service.

The HPSF priority objectives for the health service setting is:

To support the implementation of a Health Promoting Health Service Model for the HSE, based on existing approaches developed within the Irish Health Promoting Hospital initiative. This will include:

- Supporting the implementation of the HSE Integrated Employee Wellbeing and Welfare Strategy
- Supporting Primary Care Teams to improve capacity in community profiling, needs assessment, etc.
- Building capacity of HSE staff to integrate health promotion into service delivery
- Stronger links to other settings (such as schools and communities)
- Incorporating other health policy issues (such as patient and public involvement and health inequalities)

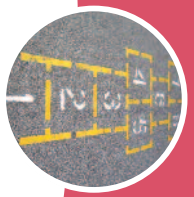
Actions to achieve these objectives:

a. Agree an organisational development plan and develop resources to deliver the HPHS
b. Support implementation of the HSE's Health Inequalities Framework
c. Support regional and local service areas to develop health needs assessment, health impact assessment and community participation
d. Support the implementation of the Tobacco Framework and the Obesity, Breastfeeding and Alcohol Actions Plans
e. Support an integrated approach to address key health issues aimed at reducing disease / morbidity
f. Work with HSE services to further develop partnerships at statutory, community and voluntary level to address health inequalities and the determinants of health, for example, community and voluntary sector, Inter-sectoral Group on Obesity, CAWT, etc.

Matrix 1 presents a picture of how the HPSF Model works in practice. It includes some of the actions identified above and other examples of how health promotion approaches can be applied to meet the priority objectives set out in the HPSF for the health service setting.

Matrix 1: A practical example of how the HPSF Model can be applied to address the priority objectives for the health service setting

	Priority objectives for the health service setting	Partnership and capacity building approaches					
		Training and Education	Policies and Frameworks	Programme Development and Implementation	Research and Evaluation	Social Marketing and Advocacy	
ADDRESSING HEALTH SERVICE SETTING	To support the implementation of a Health Promoting Health Service Model for the HSE, based on existing approaches developed within the Irish Health Promoting Hospital initiative. This will include: • Stronger links to other settings (such as schools and communities) • Incorporating other health policy issues (such as patient and public involvement and health inequalities) • Supporting the implementation of the Integrated Employee Wellbeing and Welfare Strategy	Build capacity of HSE staff to integrate health promotion into service delivery. E-learning package. Support HSE Services to develop health needs assessment, health impact assessment and community participation.	Ensure health promotion is included in all service and business planning. Agree quality standards to support the HSE's capacity to promote health. Support implementation of the HSE's Inequalities Framework. Support implementation of tobacco framework, obesity, breastfeeding, alcohol action plans. Support an integrated approach to address key health issues aimed at reducing disease / morbidity.	Promote staff health through Employee Health and Wellbeing Framework. Work with HSE Services and other parts of the HSE to further develop partnerships at statutory, community and voluntary level to address health inequalities and the determinants of health. For example, Inter-sectoral Group on Obesity, CAWT, etc.	Include an Evaluation Framework within the HPHS to build evidence base for health promotion in health and social care settings. Develop key performance indicators and monitoring arrangements.	Maintain and develop partnerships with key external agencies, for example, Irish Heart Foundation, Irish Cancer Society, to address chronic disease prevention by influencing health determinants.	IN ORDER TO RE-ORIENTATE HEALTH AND PUBLIC SERVICES



Community

The community as a setting for health promotion includes a broad range of population groups such as women, men, children, families, friendship networks and particular interest groups, as well as neighbourhoods, villages, towns, cities, and community and voluntary organisations. Community includes physical spaces and the nature of human relationships within those spaces. The health of people living in disadvantaged communities is determined by structural and environmental conditions such as poverty, poor housing, social discrimination and powerlessness. The Ottawa Charter (WHO, 1986) highlighted the need for active community involvement in matters that affect health, rather than communities merely being passive recipients of professional interventions. At the heart of this participatory approach to health is the empowerment of communities, strengthening their capacity to take collaborative action. Three of the Ottawa Charter strategies are particularly relevant to the community setting, healthy public policy, supportive environments and strengthening community action. The need for active communities is also reflected in the HSE National Strategy for Service Users 2008.

Two distinct community health promotion practices now exist known as **community-based** and **community development** approaches. In the former, community is a venue for health behaviour and lifestyle programmes. In the latter, community is a place for organising and mobilising people to address the challenges that affect their health. Irrespective of the approach used, successful community interventions depend on an understanding and a sharing of power between the community and external agencies. While both approaches can and do co-exist, they differ in a number of important respects as indicated below (Poland et al., 2000).

The community-based approach

- **Individual responsibility for own health**
- **There is a problem or deficit in the community**
- **Problem is defined by agencies or government**
- **Social marketing is the main approach used**
- **Professionals are key to solving the problem**

The community development approach

- **Empowerment of individuals and communities**
- **There are strengths and competencies in the community**
- **Problem is defined by the community**
- **Social justice is the main approach used**
- **Professionals are a resource to the community**

In 2004, this distinction between community-based and community development approaches was incorporated into the national dataset of performance indicators (PIs) in order to monitor a shift towards more community development work. Different levels of understanding of power relations, for example between the professional and the client or the organisation (HSE) and the community group, are inherent within these two *ideal-types* (Poland et al., 2000). The Ottawa Charter reinforces the concept of empowering communities and this can be best achieved by the community development approach. This framework also highlights the community development approach and recognises the HSE Community Development Resource Pack (2007) as a key resource to support the community development approach to health promotion.

The Healthy City initiative

An example of a community as a setting for health promotion is the Healthy City initiative. A healthy city seeks to promote policies and action for health and sustainable development, with an emphasis on the determinants of health, on people living in poverty and the needs of vulnerable groups. Above the level of community or neighbourhood, the town or city offers many structural and cultural opportunities for health-related development. Many cities have pioneered their own healthy city vision and others have participated in the WHO Healthy City initiative, for example, Dublin and Galway.

For many years the WHO has supported the creation and enlargement of a Healthy Cities Network across Europe and in others regions of the world. The Healthy Cities initiative strives to put into practice the ideals of the 'Health for All' movement of the 1970s (WHO, 1978). Over 1,200 cities and towns in more than 30 countries in the WHO European Region are now healthy cities.

The healthy city provides communities with a framework for multi-sectoral planning for health. The current phase (Phase V) of the WHO European Healthy City Network places an emphasis on health, and health equity, in all policies. The WHO (2009) briefing document for Phase V states:

Health in all policies is based on a recognition that population health is not merely a product of health sector activities but largely determined by policies and actions beyond the health sector. Health and well-being are increasingly becoming shared values across societal sectors. Solid evidence shows that the actions of other sectors beyond the boundaries of the health sector significantly influence the risk factors of major diseases and the determinants of health. Health in all policies addresses all policies such as those influencing transport, housing and urban development, the environment, education, agriculture, fiscal policies, tax policies and economic policies.

In essence, the healthy city is not just a place in which health promoting activities take place but one in which all sectors of society place a priority on improving health and plan together, in a coordinated way, to meet community and population health needs. There is a rebalancing of the responsibility for health away from just the health services and people as individuals, to a collective, inter-sectoral response that addresses the broader determinants of health and health inequalities. Galway has been designated as a WHO Healthy City, while currently Limerick, Waterford and Cork are all working towards that status. An Irish Network of Healthy Cities is proposed to support these and other towns and cities to work towards the WHO goals.

At a local level, the development of a health promoting community is typified by the undertaking of a community health needs assessment and building community participation in all levels of service planning and delivery. Participatory appraisal methodologies are commonly used in this regard[2]. A concrete example of this approach in action is a project developed in the Moyross area of Limerick, funded through Combat Poverty's Community Participation in Primary Care initiative. Project partners PAUL Partnership, HSE, RAPID and community representatives designed and delivered a training resource to build capacity for identifying community health needs and engaging communities in decision-making processes. The training was delivered jointly to primary care staff and community representatives. A local health forum is now being developed with representatives from the local community and the PCT. The health forum will ensure that there is ongoing and sustainable community participation in the planning and delivery of primary care services and will also provide a mechanism for ongoing assessment of community health needs.

[2] See http://www.peopleandparticipation.net/display/Methods/Participatory+Appraisal for more information on participatory appraisal.

Increased community involvement, use of community health profiling, community needs assessment and health impact assessment, all provide effective mechanisms for planning for health in the community setting. The principles of the WHO Healthy Cities initiative can be replicated at town and community level.

Additionally, at community level, it is anticipated that opportunities will arise in building healthy communities to identify and develop the workplace as a setting for health promotion. Community needs assessment will include consideration of local workplaces and the role they have to play in promoting health at community level. This will encourage and facilitate a shift in how workplace health promotion is led with local communities, employers and employees leading out on workplace health promotion.

The HPSF priority objective for the community setting is:

To develop and implement a model for health promoting communities based on existing approaches.

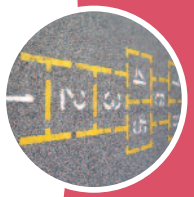
Actions to achieve this objective:

a. Design a nationally agreed model for health promoting communities, towns and cities based on available models such as the WHO Healthy City initiative
b. Work with key HSE functions to ensure a consistent community development approach to the implementation of the HSE Service User Strategy
c. Build capacity within the community and the voluntary sector to identify and address health promotion priorities at community level
d. Build on existing health promotion programmes and services to ensure a systematic focus on localities experiencing social and material disadvantage, including RAPID and CLÁR areas
e. Maintain and develop partnerships with key voluntary, community and statutory agencies, for example, the Department of Health and Children, other relevant Government departments, Irish Heart Foundation, Irish Cancer Society, Irish Sports Council, Institute of Public Health, etc. to promote health, address key health issues and prevent chronic disease by influencing the determinants of health
f. Evaluate and review the operation and successes of the programme as guided by the Health Promotion Evaluation Framework
g. Collate, analyse and disseminate evidence of effectiveness of community development and community participation interventions.

Matrix 2 presents a picture of how the HPSF Model works in practice. It includes some of the actions identified above and other examples of how health promotion approaches can be applied to meet the priority objective set out in the HPSF for the community setting.

Matrix 2: A practical example of how the HPSF Model can be applied to address the priority objective for the community setting

		Partnership and capacity building approaches					
	Priority objectives for the community setting	**Training and Education**	**Policies and Frameworks**	**Programme Development and Implementation**	**Research and Evaluation**	**Social Marketing and Advocacy**	
ADDRESSING HEALTH SERVICE SETTING	To develop and implement a model for health promoting communities based on existing approaches	Training in community development approaches for all sectors. Strengthen capacity within the community and voluntary sector to identify and address health promotion priorities at community level.	Partnership working with outside agencies to ensure supportive environments. Work with key HSE functions to ensure a consistent community development approach to the implementation of the HSE Service User Strategy. Build on existing health promotion programmes and services to ensure a systematic focus on localities experiencing social and material disadvantage, including RAPID and CLÁR areas using a community development approach. Institute arrangements for health proofing, particularly through use of health impact assessment.	Support selected additional Irish cities to meet standards for WHO European Network of Healthy Cities and establish an all-Ireland Network of Healthy Cities. Design a nationally agreed model for health promoting communities, villages, towns and cities based on available models such as the WHO Healthy City initiative.	Build HIA evidence base. Community health profiling. Needs assessments.	Maintain and develop partnerships with key voluntary, community and statutory agencies and ensure that those grant aided by the HSE adapt a community development approach. Advocate and campaign for health promoting communities. Publish information on the determinants of health and the role of the public sector in promoting and maintaining health.	**IN ORDER TO RE-ORIENTATE HEALTH AND PUBLIC SERVICES**



Education

The education setting refers to pre-school, primary school, post-primary school and third level. It also includes formal and informal youth education settings. The links between health and education are well documented in the literature (Taras, 2005[a]; Taras, 2005[b]; Taras & Potts-Datema, 2005[a]; Taras & Potts-Datema, 2005[b]). Children's health status impacts on their learning outcomes and, significantly, societies with high levels of educational participation are healthier (World Bank, 1993; Wilkinson and Marmot, 1998) In addition, research demonstrates that leaving school early can be a determinant of health and contribute to health inequalities (Her Majesty's Treasury/Department of Health, London, 2002). Education is one of the most important predictors of individual levels of health and reported health behaviour (St. Leger, 2001; Kelleher et al., 2003). From a health perspective, it can be argued that good health is a prerequisite for educational achievement and that the school setting, because of the focus on education, is an ideal setting for young people to learn about the influences on personal and social health. Furthermore, from an educational perspective, the role of health education and health promotion contributes to the preparation of young people for participation in society.

The HPSF identifies education as one of the key settings for health promotion. It advocates the implementation of the national agreed framework for Health Promoting Schools which is strongly supported by the WHO Health Promoting Schools programme. The HPS offers significant potential in terms of improving the health, and health potential, of individuals associated with the school and its wider community. In developing as a health promoting school, schools become healthy settings. The HPS model offers the staff, students and the wider school community increased opportunities to enhance health and wellbeing. Examples of health improvement opportunities within the HPS model include:

- **Teacher training:** Up-skilling teachers through in-service training programmes, for example, summer schools, policy development workshops, SPHE support.

- **Parent initiatives:** Out-of-school programmes can be provided to parents to enhance general health and wellbeing, for example, Being Well programmes, parenting programmes, mental health promotion programmes.

- **Student involvement and participation:** Opportunities are created for students to become more involved in their school community through participating in the health promoting school process, thereby enhancing self-esteem and self-confidence. It also supports students to take on roles that can enable them to contribute more to their school, their community and to society in general. Through the development of an HPS, school completion is further enhanced.

Ireland has a long history of involvement with health promoting schools and joined the European Network of Health Promoting Schools (ENHPS) in 1993. Since then there have been significant developments:

- The establishment of the Social Personal and Health Education (SPHE) second level support service in partnership with the Department of Health and Children and the Department of Education and Science (now the Department of Education and Skills - DES) which includes:
  - Interdepartmental group with DoHC, DES, HSE
  - Implementation of SPHE Junior Cycle Curriculum (mandatory in all second level schools)
  - Training of teachers and development of resources to support the SPHE programme throughout the country
- The development of a nationally agreed model of health promoting schools at primary and post-primary school level.
- In the out-of-school setting, the HSE and the Office of the Minister for Children and Youth Affairs (OMCYA) jointly fund and manage the National Youth Health Programme. This partnership ensures that health promotion policy, strategy and practice positively influence health promotion work in the out-of-schools setting. It also supports the development of standards and the delivery of health promotion programmes in the out-of-school setting.

The HPSF priority objective for the education setting is:

To implement the nationally agreed health promotion model for the education setting (pre-school, primary, post-primary, third level and out-of-school) based on existing Health Promoting School approaches.

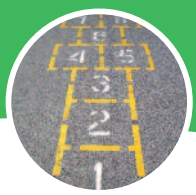
Actions to achieve this objective:

a. Design and agree a plan to implement the HPS model in consultation with key stakeholders
b. Continue to build the capacity of key stakeholders within the school, wider community and local service areas, for example, Primary Care Teams to support the development of the HPS
c. Agree and implement national protocols, standards and monitoring and evaluation processes linked to whole-school planning
d. Incorporate data from school surveys into ongoing development of the HPS
e. Include an evaluation framework within the HPS model to build evidence for health promotion effectiveness and processes in education settings
f. Collate, analyse and disseminate evidence of effectiveness of interventions in education settings.

Matrix 3 presents a picture of how the HPSF Model works in practice. It includes some of the actions identified above and other examples of how health promotion approaches can be applied to meet the priority objective set out in the HPSF for the education setting.

Matrix 3: A practical example of how the HPSF Model can be applied to address the priority objectives for the education setting

		Partnership and capacity building approaches					
	Priority objectives for the education setting	**Training and Education**	**Policies and Frameworks**	**Programme Development and Implementation**	**Research and Evaluation**	**Social Marketing and Advocacy**	
ADDRESSING HEALTH SERVICE SETTING	To implement a nationally agreed health promotion model for the education setting (pre-school, primary, post-primary, third level and out-of-school) based on existing Health Promoting School approaches.	Continue to build capacity of key stakeholders within the school, wider community and PCTs to support the development of HPS models and approaches.	Agree and implement national protocols, standards and monitoring and evaluation processes linked to whole-school planning.	Design and agree a plan to implement the HPS model in consultation with key stakeholders.	Incorporate data from school surveys into ongoing development of HPS. Introduce an evaluation framework to build evidence for Health Promoting Schools effectiveness and processes in education settings	Advocate for a whole-systems approach to include management, staff, parents, students and links to the wider community.	**IN ORDER TO RE-ORIENTATE HEALTH AND PUBLIC SERVICES**



Section 5: Implementation of the Health Promotion Strategic Framework

Partnership and capacity building approaches

> *'Improving the possibility of people or organisations collaborating, characterised by shared goals and clear working relationships.'*

Introduction

Partnership working underpins almost all health promotion practice, for example, from a shared approach to patient education to the joint formulation of national policy. Building the capacity of others, whether in a lead or support role, is also a significant part of health promotion practice and contributes to the transformation of services and social change. The HPSF proposes that a partnership approach will be undertaken through a number of different areas including training and education, policies and frameworks, social marketing and advocacy, research and evaluation, programme development and implementation, and partnerships with other sectors.

Partnerships for health

As previously highlighted, health promotion is focused on influencing the determinants of health and reducing health inequalities. Since 80% of what creates health is beyond the remit of the health sector, it follows that the determinants of health and health inequalities cannot be influenced by the health sector working alone, therefore, an inter-sectoral or partnership approach is essential (Kickbush and Quick, 1998). Partnership working, as an approach for promoting health, is more than 30 years old and goes back to the 'Health for All' movement endorsed by the WHO in 1978. The Jakarta Declaration (WHO, 1997) subsequently placed partnership working to the forefront of health promotion action:

Cooperation is essential; this requires the creation of new partnerships for health … between the different sectors, at all levels of governance in societies.

More recently, the Bangkok Charter (WHO, 2005) reiterated this need for effective partnership working for promoting health. Partnerships for health come in all shapes and sizes and can be formal or informal. At one level, partnerships can have up to 100 members and at the other level, partnership can involve two people working on a health improvement project. Many definitions of partnership exist and a range of words are used to describe ways of working together which include: alliance, network, cooperation, collaboration, coalition, multi-sectoral, inter-sectoral and partnership (Jones, 2008). There is no clear and uncontested definition and these terms are largely interchangeable.

The principal theory that underpins partnerships for health is that the partners can achieve more by working together than each could achieve on their own. This is known as *'synergy'* and is at the heart of all partnership working within the health sector and between different sectors. Child and Faulkner (1998) note that '*the idea of synergy is that the whole is greater than the sum of the parts'*. Synergy is the degree to which the partnership combines the strengths, perspectives, resources and skills of all the partners in the search for better solutions (Gray, 1989). Jones (2008) has developed and validated an eight-item, five-point synergy scale which provides a useful tool for measuring partnership synergy.

It is generally recognised in the academic literature that successful partnerships depend on two things: the capability of the partnership in terms of its **partner assets** and the **quality of the relationships and processes**. Most importantly, the partners and partner organisations involved need to be those who can solve the problems the partnership was set up to address. For example, if a solution is to be found for obesity, then local authorities and the transport sector are the most relevant partners with health, as they control most of the determinants of obesity.

As discussed in previous sections, partnerships with other sectors are critical to the successful implementation of the HPSF. Central to effective and productive working arrangements between partners from different sectors is trust. Trust is one of the most important determinants of *partnership synergy* and Child and Faulkner (1998) highlight that '*no amount of energy from the partners will compensate for its absence'*. Trust is particularly important in health promotion partnerships as these can include partners from a number of different sectors and disciplines who might normally not choose to work together but who need to do so in order to solve health problems and deliver better services (Jones, 2008).

Trust-building mechanisms need to be incorporated into the partnership-forming stage and this trust needs to be sustained throughout the collaborative process. Given the importance of trust in partnership synergy, a 14-item, five-point scale designed to measure trust in health promotion partnerships has been developed and validated by Jones (2008). This trust scale provides the discipline of health promotion with a valuable, evidence-based tool with which to examine and analyse existing and future partnerships for health with other sectors. In turn, the information gained from this analysis can usefully contribute to capacity-building and trust-building measures within these partnerships in order to maximise partnership synergy.

Aids and obstacles to effective partnership functioning (Jones, 2008)

Aids

- Trust
- Structure and governance
- Leadership
- Clear purpose/goal
- Boundary spanners
- Community/public involvement
- Commitment from the partner organisations
- Commitment from the partners

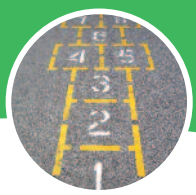
Obstacles

- Power imbalances
- Professional rivalry/turf
- Competing paradigms
- History of mistrust
- Conflict, stereotypes
- Language/communication problems
- Partner turnover
- Low cultural fit

Capacity building approaches

> *'Building the capacity of organisations/groups/communities to address the determinants of health involves interventions in several areas of functioning'*

Capacity building is another important element of effective health promotion practice (Hawe et al., 1997; Hawe et al., 2000; Eade, 1997). It can be developed with individuals, organisations and communities (Ontario, 2002; Hawe et al., 1997, 2000; NSW, 2001). Capacity building occurs within systems and programmes, and is heavily dependent on collaboration and partnership working. It has three distinct dimensions (Hawe et al. 1997) which facilitate the clear statement of aims, objectives and strategies (Eade, 1997). These are:



Capacity building dimensions

Health infrastructure or service development	Capacity to deliver particular programme responses to particular health problems. Usually refers to the establishment of minimum requirements in structures, organisations, skills and resources in the health sector.
Programme maintenance and sustainability	Capacity to continue to deliver a particular programme through a network of agencies, in addition to, or instead of, the agency which initiated the programme.
Problem solving capability of organisations and communities	The capacity of a more generic kind to identify health issues and develop appropriate mechanisms to address them, either building on the experience with a particular programme or as an activity in its own right.

(Hawe et al., 1997)

Within the HSE, capacity building involves the development of sustainable skills, structures and resource commitment in order to promote and improve health and wellbeing and to prevent and reduce the impact of illness. This is achieved by incorporating effective health promotion and training into the routine work of services across the health and social care continuum (prevention, diagnosis, treatment, rehabilitation and palliative care). Examples of training include brief intervention training, smoking cessation training and advocacy training.

Throughout the lifetime of this framework, capacity building to address the determinants of health will be one of the most important roles for health promotion services.

Training and education

'Training and supporting personnel to adopt and implement a 'determinants of health' approach through the development of new techniques and strategies'

A key priority for health promotion is to build the capacity of health care staff and others to promote health. This happens through training and education programmes as well as ongoing development and support.

Training and education are delivered as part of a suite of interventions which address individual, group and population-based approaches for promoting health in addition to focusing on the broader determinants of health. The aim of these interventions is to improve knowledge, attitudes, self-efficacy and individuals' own capacity to change (IUHPE, 2000). Furthermore, the education and training process, in itself, contributes to the personal and professional development of individuals, communities and organisations through their ongoing engagement over a period of days, weeks or months. Maximum impact from training, education and ongoing development is achieved when interventions are relevant, valued, participatory and achievable for all participants (IUHPE, 2000).

Health promotion has a significant role to play in the development and delivery of specific training for health care staff and others in order to facilitate and support the implementation of the HPSF. In the design of this training three important elements need to be addressed:

- The HSE as a workplace taking account of the health promotion needs of staff
- The HSE as a service provider whose employees have a health promoting function
- The education, training and development needs of partners in community, voluntary and other statutory agencies.

Each of these elements will require training needs analysis in order to inform the design of an appropriate training strategy for the HSE.

Policies and frameworks

> *'Require a strong mandate for action at the highest political level to stimulate the implementation of effective and efficient structures and mechanisms to achieve joint policy goals'*

The development of health-related policy happens at a number of different levels:

- National level with the development of Government policies
- Organisational level or within specific settings, for example, within the HSE
- Local level, for example, the development of housing policy within a local authority.

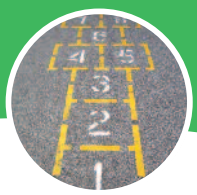
The HSE has responsibility for developing and implementing HSE policies and for contributing to, and influencing, policy development in other sectors. A key role for the national health promotion function is to lead on the inter-sectoral partnerships with key government departments and agencies. This inter-sectoral approach is mirrored in the HSE regions in partnership working with local authorities and other voluntary, community and statutory agencies. One of the valuable outcomes of this inter-sectoral approach is the development of health-related policy which can, in turn, influence the development of strategies, frameworks and programme interventions that make real changes to the determinants of health.

A policy approach to health promotion has been shown to be one of the most effective ways of achieving change. With regard to reducing health inequalities, there is good evidence to suggest that change is best effected by altering the **policies and environments** which have greatest impact on the lives of poor and marginalised people, rather than targeting the people themselves. An example of this type of action is the very effective Irish smoking legislation. Other important examples of a policy approach to health promotion include:

- A 10% increase in the price of cigarettes through taxation policies has been shown to decrease consumption by 4% among adults and up to 14% among young people (World Bank, 1999).
- Improving road safety through legislative policy and enforcement has the potential to save lives and reduce morbidity (Elvik et al., 2009).

The potential of public policy to influence an individual's everyday choices is considerable. Some policies are introduced with the intention of having a health-related impact (for example, workforce smoking ban), whilst others are introduced with a fiscal and health improvement purpose (for example, social welfare policies). Some are introduced with no intended health impact but often do result in a positive health impact (for example, transport policies). Consequently, the WHO has identified the need to plan for 'Health in All' Policies (Ministry of Social Affairs and Health, 2006).

Underpinning all policy development is the need for policy makers to appraise the likely impacts of the policy in question, positive and negative, and to ensure that the policy is compatible with other policy aims in order to avoid any negative impacts (Kemm, 2006). Therefore, there is a critical role for health impact assessment to 'contribute to the goal of joined-up policy-making to which policy makers aspire' (ibid).



Social marketing and advocacy

'Social marketing and advocacy require clear and effective communication tools and strong arguments about the importance of addressing the determinants of health and reducing health inequalities'

Social marketing is a process that applies marketing principles and techniques to create, communicate and deliver value in order to influence target audience behaviors that benefit society (public health, safety, the environment and communities) as well as the target audience. (National Social Marketing Centre, 2010).

Since its introduction in the 1970s, social marketing has developed a strong evidence base and its practice combines approaches used in the public and commercial sectors. Best practice requires planned, targeted campaigns of three to four years duration. The techniques of social marketing, when applied systematically, have been shown to be effective in achieving behaviour change goals with both policy makers and the public (ibid).

Social marketing incorporates approaches used throughout the health and social care system including the Stages of Change Model (Prochaska and DiClemente, 1983), the Health Belief Model (Rosenstock, 1966), Social Cognitive Theory (Bandura, 1986), Social Norms Theory (Perkins and Berkowitz,1986) and the Theory of Exchange (Homans,1958).

Within the HSE, health promotion incorporates a social marketing approach to influence and improve health and wellbeing. Health promotion acknowledges that social marketing is more than an attempt to raise awareness, provide information or change behaviour. Campaigns include measurable objectives which aim to support and encourage specific population groups in their desire to improve their health and quality of life, and to reduce health inequalities. Central to communicating effective campaign messages is access to solid and reliable research which can provide a better understanding of the lifestyles of population groups, the environments in which they live and work, the strategies that will support and motivate them to make positive changes, as well as the costs of these changes for them.

The HSE Tobacco Control Framework (HSE, 2010) identifies social marketing as a key approach for addressing the determinants of tobacco use and for reducing health inequalities. In partnership with the Irish Cancer Society, the current HSE tobacco campaign incorporates a mix of radio, TV and outdoor advertising campaigns as well as public relations and cessation supports such as the National Smokers' Quitline and www.giveupsmoking.ie. The campaign evaluation (HSE Health Promotion Social Marketing Function, unpublished, 2009) demonstrates a positive impact and a strong resonance with the target population group. Building on this evidence of success, a key aim of health promotion is to build the capacity of staff across the HSE, and within partner organisations, to embrace and improve the effectiveness of social marketing while ensuring value for money.

Advocacy

'Advocacy - the pursuit of influencing outcomes'

Advocacy is the pursuit of influencing outcomes, including public policy and resource allocation decisions within political, economic, and social systems and institutions - that directly affect people's current lives. (The Advocacy Institute, cited in Public Health Alliance, 2007). Political, economic, social, cultural, environmental, behavioural and biological factors are all determinants of health. Health determinants are, for the most part, created through the decisions and actions taken by Governments, organisations and individuals. It is important, therefore, that practitioners who want to promote health, find ways to influence these decisions across a range of sectors, either directly 'at the table', or indirectly through advocacy. Health promotion action

aims to address these determinants of health through advocating for healthy public policy and supportive environments, as well as developing and facilitating partnerships between different interests in society to benefit health, thus enabling individuals and communities to achieve their full potential. In this regard, many examples of advocacy exist within health promotion. These include:

- Challenging powerful anti-health interests such as the tobacco lobby
- Being a conduit or channel between differing positions to develop a common agenda and mutually achievable goals
- Building capacity and providing support to key stakeholders to improve their own and others' health by becoming effective policy advocates.

Health advocacy is often confused with social marketing, particularly in the area of media advocacy, however, the two approaches are significantly different. While social marketing is generally used to influence individual lifestyle choices and behaviours, media advocacy is a political tool strategically used to promote healthy public policy (Crisp et al., 2000).

Health advocacy can frequently be reactive, unplanned and strategically naïve. Therefore, in order to be effective, health advocacy must be planned, using strategies based on a systematic analysis of the positions of opposing forces. Effective advocacy must be focused *upstream,* be people-centred, focus on building relationships, engage decision-making systems and translate protest into demands for specific change. In this regard, health practitioners must draw on different methods of advocacy which include lobbying, grass roots organising, strategy development, partnership building, development of clear position statements and submissions as well as media advocacy.

Research and evaluation

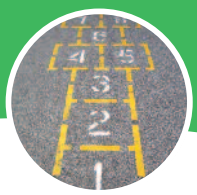
'Taking action on the determinants of health depends on the availability and accessibility of data as well as reviewing the effectiveness of policies and interventions to address these determinants'

Research

Health promotion research is predominantly based on theories of organisational behaviour, sociology, social psychology, anthropology, education, economics and political science (Dean, 1996). In research, evidence is obtained to support, reject or modify theories, to explain patterns of behaviour, and to develop appropriate interventions. The ultimate aim of all health research is to understand and then improve the health of individuals and communities. Research is, therefore, central to the discipline of health promotion and should be designed and undertaken in ways which are, themselves, health promoting, for example, using methods which are inclusive, participative and respectful.

In relation to the successful implementation of the HPSF a number of research related actions are required as follows:

- Effective communication structures will be developed to ensure that published research is considered, disseminated and appraised for practice implications.
- Links will be developed with academic institutions to connect research with pressing service issues and to promote models of participative research between researchers and those population groups being 'researched'.
- New partnerships and collaborations are needed to exchange practitioner and academic perspectives and to include knowledge and intelligence gathered from lay perspectives. The challenge then will be to analyse and synthesise these different sources of intelligence into a form that all stakeholders recognise and accept.
- Training in research skills and methodologies will need to be inclusive and wide-ranging, to allow for the different skill mix of professionals and lay participants involved. Mechanisms will also need to be developed in order to facilitate appropriate knowledge transfer and expedient transfer of learning into practice.



Evaluation

Within the health arena, the ever-increasing demand for evaluation comes from a wide range of stakeholders for a variety of different reasons; managers require accountability, funders require evidence of effectiveness, project managers require feedback on the successes and challenges and evidence to promote their projects. Effective evaluation is underpinned by clear aims and objectives which make explicit the changes expected as a result of an intervention, in order that the level to which the expected change has taken place, or not, can be accurately measured.

Evaluation is often treated as a discrete research-like activity, or as a technical exercise focused on sample design and methodology. While knowledge of appropriate methods is important, it is more important that evaluation is sufficiently well integrated into **the planning stages** of a policy, programme or project, and into the day-to-day management of related activities. Well-established models of planning and evaluation reinforce this critical point consistently (Green and Kreuter, 1991; Ewles and Simnett, 1999; The Health Communication Unit, 2000).

With this in mind, the framework for the future evaluation of health promotion will be situated within the overall planning framework for health promotion practice and services. Central to the implementation of the HPSF will be increasing the capacity of the Health Promotion workforce to plan and undertake effective evaluation.

Programme development and implementation

> *'Addressing the determinants of health and health inequalities requires programmes to be developed and implemented at organisational, local regional and national level.'*

Programme development and implementation has been, and continues to be, an integral part of health promotion strategies and policies at national, area and local level. Programme development provides a means for translating strategy and policy into action through the key settings of health services, communities and education.
Health promotion programmes which have been successfully developed internationally and rolled out nationally in Ireland include: WHO Healthy Cities, European Health Promoting Hospitals and Health Promoting Schools. National programmes rolled out by the HSE include: Social, Personal and Health Education Programme (SPHE) for post-primary schools, National Youth Health Programmes and GP Exercise Referral programmes. These programmes will be further progressed under the key priorities identified in the HPSF as well as through other HSE frameworks including those specifically relating to tobacco and obesity.

Health promotion programmes are delivered by a wide range of health professionals and organisations and are directed towards achieving defined objectives and targets. The development of health promotion programmes involves:

- Identifying and prioritising health issues and needs
- Agreeing appropriate interventions to address these health issues and needs
- Committing support and resources for health promotion action.

Effective health promotion programmes require a strategic direction, an evidence base, clear outcomes for health gain and a focus on health inequalities and partnership working.

The development of the Health Promoting Schools programme is currently progressed in partnership with the Department of Education and Skills and a national framework for its implementation is also being drafted. The establishment of all new programmes will be based directly on the HPSF in line with the national guidelines for programme development. This national approach to programme development and implementation facilitates health promotion to develop national standards, contribute to quality assurance through ongoing monitoring and evaluation, identify key performance indicators and contribute to the HSE's key result areas.

Section 6: Outcomes from the Health Promotion Strategic Framework

Introduction

As a measure of effectiveness health and medical interventions can produce different outcomes. Health promotion seeks to address the determinants of health and health inequalities and the outcomes that can be expected represent those personal, social and structural factors that can be modified in order to change the determinants of health. These outcomes also represent the most immediate impact of planned health promotion activities. For example, health literacy is typically the outcome of health education programmes whereby individuals have acquired skills to gain access to, and to understand and use, information for promoting and maintaining good health. Healthy public policy and organisational practices are the results of efforts (whether related to internal Government policy development or health advocacy) to overcome structural barriers to health, leading to legislative change as in the tobacco control legislation.

This section describes a range of outcomes that can be achieved through the successful implementation of the HPSF. The HPSF identifies six key outcome areas for health promotion:

1. Re-orientate health and other public services
2. Create supportive environments for health
3. Reduce health inequalities
4. Improve health
5. Prevent and reduce disease
6. Reduce costs to the health care system.

Each of these outcome areas is discussed in greater detail.

Re-orientate health and other public services

> *'Health promotion has a significant contribution to make to 'radically change the way we organise our services and the way we deliver these services'*
>
> (HSE Transformation Programme, 2007-2010).

Health promotion has a key role to play in transforming and reorientating the health and social care services in Ireland. A strong evidence base exists for the effectiveness of health promotion and provides a means for the HSE to improve the health status of the entire population, including its ability to respond more effectively to the growing burden of chronic disease (Sindall, 2001). The HSE's Transformation Programme (HSE, 2007) and the Ottawa Charter's concept of re-orientation (WHO, 1986) share a common goal, to bring about a whole system shift which plans and provides for health. The settings approach adopted by this framework sets the context for the reorientation of health and public services. In developing as healthy settings, schools and communities can adopt a more coordinated approach to health which can have a synergistic impact. The settings approach not only seeks to use the setting as a vehicle for reaching specific audiences with lifestyle modification programmes but also the settings themselves as targets of intervention. Implementation of the HPSF across the HSE will help bring about the transformation and reorientation of health and social care services and will result in the following outcomes:

- The capacity of HSE staff and health partners to address health determinants and health inequalities will be increased.

- There will be a shift towards a national health service which focuses on promoting health, preventing ill-health and providing the best quality care for those who require it, in the most appropriate setting.
- The development and effectiveness of primary care will be strengthened by improved capacities in community profiling, needs assessments, community participation and mobilisation and the provision of socially inclusive services.
- An evidence-based model for the prevention and management of chronic illness will be developed which measures performance and improves outcomes and patient satisfaction.
- The WHO Health Promoting Hospitals/Health Services Initiative will be further developed and expanded to support the integration of evidence-based health promotion within the acute and wider health and social care services.
- HSE staff will be supported to engage in meaningful partnerships which encourage the audit of policies and practices in order to reduce health inequalities and ensure maximum health gain.
- Health impact assessment will be utilised to ensure the 'health proofing' of policies, decisions, programmes and services.
- The HSE will develop appropriate health and performance indicators which, in turn, will provide meaningful baseline data and evidence of health and social gain. These indicators will include data on the social determinants of health, health inequalities and community participation.

Create supportive environments for health

The role of supportive environments is essential to achieving health gain. Supportive environments include the built and social aspects of where we live, work and play. Actions to create environments that support health have four main dimensions: physical, social, economic and political. A supportive environment for health includes the following outcomes:

- A planning process that is needs-based and incorporates evaluation and coordination between health care providers
- Full engagement in collaborative partnerships which are adequately resourced and are regularly reviewed in terms of structure, function and effectiveness
- The use of multi-strand approaches to promote and enhance health and include a combination of medical, lifestyle, behavioural and social-environmental approaches
- The development of empowerment/engagement indicators
- The allocation of adequate resources to effectively address the broader determinants of health and social inequities
- The development of evidence-based programmes and interventions, which include robust monitoring and evaluation measures.

As part of implementing the HPSF, a standardised approach to programme development and implementation will be agreed and guidelines drafted for all new national health promotion programmes. All new programmes will begin with an assessment of health determinants at population level. This process will bring together intelligence from key stakeholders representing the settings and services in addition to available health data. The consultation process and partnership working will continue through all subsequent planning stages.

Reduce health inequalities

Addressing health inequalities is critical if improvements in health and wellbeing are to be achieved across society and the gap in health outcomes is to be reduced. The HSE Health Inequalities Framework 2009-2012 (HSE, 2009) demonstrates the organisation's commitment to addressing the existing inequitable social class health gradient in Ireland. The framework contains evidence-based, high-level actions which will guide HSE planning, monitoring and programme development and will also provide a clear direction for services, health care management, clinicians and professionals. Outcomes that can be expected from the implementation of the HSE Health Inequalities Framework include:

- Improved interagency cooperation to address the social determinants of health and health inequalities
- Development of partnerships for health which will result in integrated planning in areas such as housing, public spaces, transport, etc.
- Increased involvement and participation of individuals and communities in identifying and addressing health needs and health inequalities
- The effective use of community development approaches to addressing lifestyle risk factors
- Increased capacity of health and social care agencies to promote health and address health inequalities, and in particular, to support the development of primary care teams
- Increased consideration of national and local health deprivation indicators and equality legislation within HSE service planning and delivery
- Development and utilisation of specific information, data systems, tools and key performance indicators which provide reliable evidence to support more effective decision-making
- Monitoring and dissemination of evidence to support economic investment in health and the reduction of health inequalities
- Actions to ensure that HSE services and health information meet national literacy standards and promote health literacy.

Improve health

One of the most important goals of health services is to improve health. The concept of health improvement is based on the premise that health is something that can be created, and can, therefore, be improved. This concept is best understood through a comparison with disease-based approaches which focus on preventing illness. While disease prevention primarily addresses risk factors that cause people to become ill, health improvement seeks to promote wellbeing or health gain.

For example, a cardiovascular disease prevention initiative may target those who are overweight through encouraging them to become more active, because reducing weight and increasing activity levels are known to reduce the incidence of heart disease. Conversely, health improvement approaches would predominantly focus on a positive sense of wellbeing, improved social interaction, and a greater sense of control over one's health that might result from being active. In this way, health improvement places greater value on what Eriksson and Lindstrom (2008) call quality of life, rather than avoiding illness.

Quality of Life measures are a useful tool in measuring health improvement. The Quality of Life Research Unit, Toronto, has developed a Quality of Life Profile (figure 5). In this model, quality of life is defined as the degree to which a person enjoys the important possibilities of his or her life (Raphael et al., 1999). Raphael et al. describe how this concept can be adapted to understand and measure community quality of life.

Figure 5 - Quality of Life Profile

(The Quality of Life Research Unit, Toronto)

BEING	**Physical Being**	• Being physically able to get around. • My nutrition and the food I eat.
	Psychological Being	• Being free of worry and stress. • The mood I am usually in.
	Spiritual Being	• Having hope for the future. • My own ideas of right and wrong. • Spiritual beliefs.
BELONGING	**Physical Belonging**	• The house or apartment I live in. • The neighbourhood I live in.
	Social Belonging	• Being close to people in my family. • Friendships.
	Community Belonging	• Being able to get professional support services (medical, social, etc.). • Having enough money and resources.
BECOMING	**Practical Becoming**	• Doing things around my house. • Working at a job or going to school.
	Leisure Becoming	• Outdoor activities (walks, cycling, etc.) • Indoor activities (TV, reading, etc.) • Recreational resources.
	Growth Becoming	• Improving my physical health and fitness. • Being able to cope with changes in my life. • Learning new skills.

Implementation of the HPSF will support the HSE to work towards achieving outcomes of improved health in the following areas:

- Increased awareness of the determinants of health and effective approaches used to address the determinants of health
- Increased environments to support healthy choices in the priority settings of health services, communities and education
- Increased capacity of individuals and groups to take action to improve health, for example, through the development of personal skills to address health issues and the determinants of health
- Mechanisms to support improved health behaviour and practices among individual population groups identified through particular settings, for example, children, adults, older people, special interest groups, etc.

Prevent and reduce disease

Health promotion plays a critical role, not only in improving health, but also in maintaining and protecting health. An important element of this role is disease prevention.

Traditionally, disease prevention is classified as:

1. **Primary prevention** where efforts are made to prevent the occurrence of any disease. This ranges from the prevention of an acute illness, for example, by inoculation or vaccination, to the prevention of chronic conditions such as heart disease, cancers, sexual or mental illnesses.
2. **Secondary prevention** where efforts are made to ameliorate and stop progression of the disease. This includes the use of therapies, surgical procedures and an array of other interventions such as smoking cessation, diet and physical activity programmes as well as one-to-one support.
3. **Tertiary prevention** where all efforts are made to minimise the impact of disease on the affected individual and/or rehabilitate them.

Evidence indicates clearly that primary prevention is the most efficient and effective tool for decreasing the burden of disease on societies and individuals alike. For example, this HPSF document (see next section on reducing costs to the healthcare system) highlights the valuable contribution of health promotion to the significant decline in cardiovascular disease between 1985 and 2000, identified in the 2007 audit on the implementation of Building Healthier Hearts (HSE, 2007).

Through the implementation of the HPSF, and ongoing investment in health promotion, significant progress can be made in the following areas to prevent and reduce disease:

- Improvements in cardiovascular disease risk factors (for example, smoking, alcohol intake, salt consumption, etc.) and significant improvement in health-related behaviours (for example, healthier eating, greater participation in physical activity, etc.)
- Modifications in risk-taking behaviours and addressing risk factors for cancers
- Reduction in factors that contribute to mental ill-health through creating supportive environments for health, reducing stressful circumstances and developing supportive personal relationships and social networks

- A significant reduction in sexually transmitted infections and negative outcomes in relation to unplanned and unwanted pregnancies

- Contribution to a reduction in unintentional injuries in the home environment at work and on the road.

Reduce cost to the healthcare system

It has been well documented that lifestyle and other determinants of health have a significant impact on health, leading to chronic illness and premature death.

- At least 80% of premature heart disease, stroke and Type 2 diabetes can be prevented through healthy diet, regular physical activity and avoidance of tobacco products (HSE, 2008)
- Chronic diseases are the leading cause of mortality in the world, representing 60% of all deaths (HSE, 2008).

In Ireland, unhealthy lifestyles contribute to the five major causes of death. The prevalence of overweight and obesity in both adults and children continues to rise.

- 39% of adults are overweight and 23% are obese (Morgan et al, 2008))
- Overweight and obesity in children increases with age: at age five to twelve years, 11% of boys and 12% of girls are overweight with 9% of boys and 13% of girls obese (Irish Universities Nutrition Alliance, 2008).

In the coming years, increasing levels of overweight and obesity will pose significant challenges for the health and social services in terms of increases in chronic disease.

The most successful strategies for prevention of chronic illness employ both individual-based approaches and population-wide approaches which address the determinants of health. (WHO, 2008). Throughout this framework document, a strong case has been made for the role of health promotion in planning and implementing such strategies. The role of health promotion is further reinforced by strong international evidence to show that health promotion works. The International Union of Health Promotion and Education (IUHPE) Report for the European Commission on the Evidence of Health Promotion Effectiveness (2000) states that in the last 20 years *'evidence has been collected and evaluated which gives strength to the case for increasing resources behind the discipline* (of health promotion) *and for it to become more central in producing a healthy society'*. Furthermore, there is a strong economic case for investing in health promotion.

The role of health promotion in reducing the cost to the health care system

Effective health promotion programmes, properly funded over sustained periods, can produce significant economic and health gains for individuals, the health service, Government and society. In the United Kingdom, estimates show that four out of five deaths of people under 75 years could have been prevented and economic analysis shows that the total annual cost of preventable illness amounts to a minimum £187 billion - this equates to 19% of total GDP. These estimates suggest that for every 1% improvement in health outcomes from health promotion and prevention, public expenditure could be reduced by £190million, saving families £700m and reducing employer costs by £110m as well as reducing the level of premature death and disability (National Social Marketing Centre, 2010).

In Ireland, the 2007 audit of progress on the implementation of Building Healthier Hearts (HSE, 2007) demonstrates the major contribution that health promotion has made in the significant fall in cardiovascular health disease mortality (1985-2000). During this period, there were 3,763 fewer deaths; 51% of these were directly attributable to health promotion, while 43% were attributable to better treatments. Other examples of cost effectiveness in health promotion include the following:

Workplace health promotion programmes

- Systematic reviews of workplace programmes have established cost-benefit ratios from such programmes in the region of 1:41 to 1:61, that is, the savings obtained from improvements in employee health are around four to six times the costs of the programmes. Average reductions in cost are around 25% (Aldana, 2001).
- In Thameside Metropolitan Borough Council, the introduction of a wellbeing programme for employees, including a number of simple and low-cost interventions such as walking schemes and free fruit and water bottles, proved highly successful. The rate of absenteeism fell from 13.2 days per employee in 2001 to 8.9 days in 2007 (Callender, 2007). The value of this reduction has been calculated as £1.5m over three years. There have also been measurable improvements in employees' overall physical and mental health (Anon, 2006).
- A stress reduction programme for staff implemented by London Underground was estimated to have saved £455,000; this equates to approximately eight times the cost of the scheme. Interventions for the prevention of anxiety and depression among employees have also shown promising results in the reduction of sickness absenteeism (Washington, 2008).

Examples of VFM and health gain outcomes from focusing on specific risk factors are set out below:

Smoking cessation:

- A comparison of a range of interventions designed to reduce cardiovascular disease was undertaken in Spain. Smoking cessation was the most cost effective. The cost per life year gained from these programmes ranged from €2,600 to €5,700 in comparison the cost per life year gained from treatment for mild hypertension was up to €86,000 (Mackenbach et al., 2007).
- The evidence base for smoking cessation is substantial. Cost-effectiveness studies (Parrott et al., 1998) indicate that the cost per quality-adjusted life year (QALY) gained by smoking cessation interventions is in the range of £174 to £873. Given that NICE's threshold for cost-effectiveness is between £20,000 and £30,000 per QALY (ibid), it is clear that smoking cessation is highly cost-effective. Interventions in healthcare settings, including brief interventions by GPs, pharmacological therapies and nicotine replacement, are also known to be effective (ibid).

Physical activity and obesity:

- An Australian study estimated that if Australian people became more active for just 30 minutes per day, it could save $1.5 billion (€815m) per year in costs linked to cardiovascular heart disease, stroke, Type 2 Diabetes, breast cancer, colon cancer, depression and falls. This equals 17% of the total health costs linked with the medical conditions included in the study (Medibank, 2007). The level of inactivity in Ireland is known to be even higher than in Australia (Department of Health and Children and HSE, 2009), so the cost benefits of increased activity may be even greater.
- In the USA, an investment of $1 in physical activity (time and equipment) leads to $3.2 in medical cost savings. The cost linked with inactivity and obesity was 9.4% of the national health expenditure in 1995. Workplace physical activity programmes in the USA can reduce short-term sick leave by 6% – 32%, reduce health care costs by 20% – 55% and increase productivity by 2% – 52% (WHO 2003).
- In Canada physical inactivity results in about 6% of total health care costs (WHO, 2003).

Older people:

- In the UK, it is estimated that long-term care for older people costs £11 billion currently, and is forecast to rise to £15 billion by 2040 (Karlsson et al., 2006). Even small improvements in older people's health and functional independence could, therefore, produce very substantial cost savings.
- For older people, regular physical activity reduces the risk of falls and resulting injuries. As one becomes more active, more often and for longer periods, there is a resultant reduction in the risk of chronic illness (Gillespie et al. 2009; Chang et al., 2004).

The figures set out above demonstrate that effective health promotion programmes, properly funded over sustained periods, can produce significant economic and health gains for Government, the health services and society in general.

Conclusion

Since its emergence at an international level in the 1980s, health promotion in Ireland has developed and grown, with significant achievements in the areas of cardiovascular health, healthy public policies and healthy settings. This Health Promotion Strategic Framework provides the HSE with the means by which it can meet its commitments to protect and promote the health of the population. The framework is informed by the best available international and national evidence of health promotion effectiveness and includes a model to illustrate the main elements of health promotion in the HSE. This model outlines the process by which health promotion will address health inequalities and the determinants of health, as well as the health promotion outcomes it seeks to achieve through the three priority settings of health services, community and education.

Protecting and promoting the health of the population requires inter-sectoral and interdisciplinary approaches to health promotion. These approaches include key specific roles for the Health Promotion workforce and for the broader health and social care workforce in addition to the non-Governmental organisations and statutory and voluntary sectors. These commitments require the re-orientation of health and social care services in Ireland to include the development of organisational structures that support the promotion of health, and the development of the skills and capacity of those outside the Health Promotion workforce to adopt a stronger evidence-based health promoting role.

Abbreviations

CAWT	Cooperation and Working Together
CLÁR	Ceantair Laga Árd-Riactanais
DoHC	Department of Health and Children
DES	Department of Education and Skills
ENHPS	European Network of Health Promoting Schools
GDP	Gross Domestic Product
GP	General Practitioner
HIA	Health Impact Assessment
HP	Health Promotion
HPH	Health Promoting Hospitals
HPS	Health Promoting Schools
HPSF	Health Promotion Strategic Framework
HPHS	Health Promoting Health Service
HSE	Health Service Executive
IHPHN	Irish Health Promoting Hospitals Network
IPH	Institute of Public Health in Ireland
IUHPE	International Union of Health Promotion and Education
KRA	Key Result Areas
NICE	National Institute of Clinical Excellence
NGO	Non-governmental organisation
OECD	Organisation for Economic Cooperation and Development
OMCYA	Office of the Minister for Children and Youth Affairs
PAUL	Paul Partnership Limerick
PCT	Primary Care Team
PIs	Performance Indicators
QALY	Quality Adjusted Life Years
RAPID	Revitalising Areas by Planning, Investment and Developement
RDO	Regional Director of Operations
SLÁN	Survey of Lifestyles, Attitudes and Nutrition (in Ireland)
SPHE	Social, Personal and Health Education
VFM	Value for money
WHO	World Health Organization

References

Aldana, S. G. (2001). Financial impact of health promotion programs: a comprehensive review of the literature. *American Journal of Health Promotion*, 15(5), 296-320.

Anon. (2006). Rewriting the script. Personnel Today, 28 March 2006.

Bandura, A. (1986). Social foundations of thought and action. Englewood Cliffs, HJ: Prentice Hall.

Callender, J. (2007). Tameside Metropolitan Borough Council: improvement through good people management. www.idea.gov.uk/idk/core/page.do?pageId=6707594

Chang, J. T., Morton, S. C ., Rubenstein, L. Z, Mojica. W. A., Maglione, M., Roth, E. A. and Shekelle, P. G. (2004). Interventions for the preventions of falls in older adults: systematic review and meta-analysis of randomised controlled trials. *British Medical Journal*, 328, 680.

Child, J. and Faulkner, D. (1998). Strategies of Co-operation: Managing Alliances, Networks and Joint Ventures. Oxford: University Press.

Commission of the European Communities (2009). Communication from the Commission to the European Parliament, the Council, the European Economic and Social Committee and the Committee of the Regions Solidarity in Health: Reducing Health Inequalities in the EU. Brussels: COM (2009) 567 final.
http://ec.europa.eu/health/ph_determinants/socio_economics/documents/com2009_en.pdf

Commission on Social Determinants of Health (2008). Closing the Gap in a Generation. Health equity through action on the social determinants of health. World Health Organization, 2008. http://whqlibdoc.who.int/hq/2008/WHO_IER_CSDH_08.1_eng.pdf

Crisp, B, Swerrissen, H. Duckett, S.J. (2000). Four approaches to capacity building: Consequences for measurement and accountability. *Health Promotion International,* 15 (2), 99–107.

Dahlgren, G. and Whitehead, M. (1991). Policies and Strategies to Promote Social Equity in Health. Stockholm: Institute for Further Studies.

Dahlgren, G. and Whitehead, M. (2006). Levelling Up (Part 2): a discussion paper on European strategies for tacking social inequalities in health. Copenhagen: World Health Organization.

Dean, K., (1996). Using theory to guide policy relevant health promotion research. *Health Promotion International*, 11(1), 19-26.

Department of Health and Children (2010) All Ireland Traveller Health Study.

Department of Health and Children and the Health Service Executive (2009). Get Ireland Active. Promoting Physical Activity in Ireland. The National Guidelines on Physical Activity for Ireland. http://www.getirelandactive.ie/pdfs/GIA_GUIDE.pdf

Department of Health and Children and the Health Service Executive (2008). National Strategy for Service User Involvement in the Irish Health Service. http://www.hse.ie/eng/services/Publications/Your_Service,_Your_Say_Consumer_Affairs/Strategy/Service_User_Involvement.html

Department of Health and Children (2008). National Men's Health Policy 2008-2013: Working with men in Ireland to achieve optimum health and wellbeing. Health Promotion Policy Unit, Department of Health and Children.
http://www.dohc.ie/publications/pdf/en_mens_health_policy.pdf?direct=1

Department of Health. (2008). Health Inequalities: Progress and Next Steps. London: Department of Health.

Department of Health and Children (2002). Traveller Health –A National Strategy 2002-2005. Dublin: Government Publications.
http://www.dohc.ie/publications/pdf/traveller_health.pdf?direct=1

Department of Health and Children (2001). Quality and Fairness: A Health System for You. Dublin: Government Publications.
http://www.dohc.ie/publications/pdf/strategy.pdf

Department of Health and Children (2001). Primary Care A New Direction. Dublin: Government Publications. http://www.dohc.ie/publications/pdf/primcare.pdf

Department of Health and Children (1994). Shaping a Healthier Future. A Strategy for Effective Healthcare in the 1990's. Dublin: Government Publications. http://www.drugsandalcohol.ie/5909/1/DOH_Shaping_a_healthier_future.pdf

Dooris, M. (2004). Joining up settings for health: a valuable investment for strategic partnerships? *Critical Public Health* 14(1), 49-61.

Downie, R.S., Tannahill. C and Tannahill, A. (1996). Health promotion: Models and values. Oxford University Press, Oxford.

Eade, D. (1997). Capacity-Building: An Approach to People-Centred Development, Oxford.

Elvik, R., Vaa, T., Hoye, A., Erke, A. and Sorenson, M. (2009). The Handbook of Road Safety Measures (2nd edition). Emerald Group Publishing.

Eriksson, M and Lindstrom, B. (2008). A salutogenic interpretation of the Ottawa Charter. *Health Promotion International*, 23(2), 190-199

Ewles, L. and Simnett, I. (1999). Promoting Health: A Practical Guide. Bailliere Tindall.

Gillespie, L.D., Robertson, M. C., Gillespie, W.J., Lamb, S.E., Gates, S., Cummings, R. G., and Rowe, B.H. (2009). Interventions for preventing falls in older people living in the community. *Cochrane Database of Systematic Reviews,* Issue 2.

Grant, M. and Barton, H. (2006). A health map for the human habitat. *Journal of the Royal Society for the Promotion of Public Health*, 126(6), 252-261.

Gray, B. (1989). Collaborating Finding Common Ground for Multiparty Problems. San Francisco: Jossey-Bass.

Green, L.W. and Kreuter, M.W. (1991). Health Promotion Planning: An Educational and Environmental Approach (2nd edition). Mayfield Publishing.

Halpin, H.H., Morales-Suárez-Varela, M.M., Martin-Moreno, J.M. (2010). Chronic Disease Prevention and the New Public Health. *Public Health Reviews*, 32(1), 120-154.

Hawe, P., Noort, M., King, L. and Jordens, C. (1997). Multiplying Health Gains: the critical role of capacity building within health promotion programs. *Health Policy*, 39(1), 29-42.

Hawe, P., King, L., Noort, M., Jordens C. and Lloyd B. (2000). Indicators to help with Capacity Building in Health Promotion. Sydney: NSW Health Department.

Her Majesty's Treasury/Department of Health London (2002). Tackling Health Inequalities, Summary of the 2002 Cross-Cutting Review. London.

Health Scotland (2003). LEAP for Health - Learning, Evaluation and Planning. http://www.healthscotland.com/uploads/documents/LEAP_for_health.pdf

Health Scotland (2005). Health Promoting Health Service - an introduction. http://www.thpc.scot.nhs.uk/PDFs/HPHS/HPHS%20an%20introduction.pdf

Health Service Executive (2005). HSE Corporate Plan 2008-2011. http://www.hse.ie/eng/services/Publications/corporate/Corporate_Plan_2008_-_2011.pdf

Health Service Executive (2005). Reach Out: National Strategy for Action on Suicide Prevention 2005-2014. http://www.sirl.ie/other/repository_docs/77.pdf

Health Service Executive (2007). HSE Transformation Programme 2007-2010. http://www.hse.ie/eng/services/Publications/corporate/transformation.pdf

Health Service Executive (2007). Community Development Resource Pack.
http://www.hse.ie/eng/services/ysys/SUI/Library/Guides/Community_Development_Resource_Pack.pdf

Health Service Executive (2007). Ireland Take Heart, An Audit of the Implementation of Building Healthier Hearts.
http://www.hse.ie/eng/staff/FactFile/Health_Status_Reports/Population_Health/Cardiovascular_Care_/Ireland_Take_Heart/

Health Service Executive (2008). Corporate Plan 2008-2011.
http://www.hse.ie/eng/services/Publications/corporate/Corporate_Plan_2008_-_2011.pdf

Health Service Executive (2008). Chronic Illness Framework.
http://www.lenus.ie/hse/bitstream/10147/65295/1/Chronicillness08.pdf

Health Service Executive (2009). Integrated Employee Wellbeing and Welfare Strategy 2009-2014.
http://www.hse.ie/eng/staff/HR/Policies,_Procedures_and_Guidelines/Integrated_Employee_Wellbeing_and_Welfare_Strategy_2009-2014_.pdf

Health Service Executive (2009). Health Inequalities Framework. http://www.publichealth.ie/healthinequalities/policy

Health Service Executive (2010). HSE National Service Plan. http://www.hse.ie/eng/services/Publications/corporate/serviceplan.pdf

Health Service Executive (2010). Tobacco Control Framework.
http://www.lenus.ie/hse/bitstream/10147/97291/1/NewTobaccoControlPlan.pdf

Homans, George C. (1958). Social Behavior as Exchange. *American Journal of Sociology*, 63(6), 597-606
International Union for Health Promotion and Education (2000). The Evidence of Health Promotion Effectiveness: Shaping Public Health in a New Europe. Brussels: European Commission.

Irish Universities Nutrition Alliance (2008). National Teens' Food Survey. www.iuna.net

Institute of Public Health in Ireland (2008). Annual Update on Fuel Poverty and Health. Institute of Public Health in Ireland.
http://www.publichealth.ie/

Jones, J. (2008). Health Promotion Partnerships: An analysis of the factors that contribute to successful partnership functioning. Unpublished PhD thesis, National Univesity of Ireland, Galway.

Karlsson, M., Mayhew, L., Plumb, R., Rickayzen, B. (2006). Future costs for long-term care: Cost projections for long term care for older people in the United Kingdom. *Health Policy,* 75(2) 187-213.

Kelleher, C., Nic Gabhainn, S., Friel, S., Corrigan, H., Nolan, G., Sixsmith, J., et al. (2003). The National Health and Lifestyle Surveys (II) Survey of Lifestyle, Attitudes and Nutrition (SLÁN) and the Irish Health Behaviour in School-Aged Children (HBSC). Dublin: Department of Health and Children.

Kemm, J. *(*2006*).* The limitations of 'evidence-based' public health. Journal of Evaluation in Clinical Practice, 12(3), 319–324.

Kickbush, I.S. and Quick, J. (1998). Partnerships for health in the 21st Century. *World Health Statistics Quarterly*, 51(1), 68-74.

Kotler, P., Lee, N and Rothschild M. (2007). Personal Communications. In Kotler, P. and Lee, N. Social Marketing: Influencing Behaviours for Good (3rd edition). Sage Publications.

Layte, R., Nolan, A., Nolan, B. (2007). Poor Prescriptions: Poverty and Access to Community Health Services. Dublin: Combat Poverty Agency.

Mackenbach, J.P., Meerding, W.J., Kunst, A.E. (2007) Economic implications of socio-economic inequalities in health in the European Union. Luxembourg: European Commission.

Marmot Review Team (2010). Fair Society, Healthy Lives: Strategic Review of Health Inequalities in England post-2010.
http://www.instituteofhealthequity.org/projects/fair-society-healthy-lives-the-marmot-review

Medibank, (2007). The cost of physical inactivity. What is the lack of participation in physical activity costing Australia? Medibank, Australia.

Ministry of Social Affairs and Health (2006). Health in All Policies. Prospects and Potentials. EU Observatory on Health Systems and Policies http://www.euro.who.int/__data/assets/pdf_file/0003/109146/E89260.pdf

Morgan, K., McGee, H., Watson, D., et al. (2008). SLAN 2007: Survey of Lifestyle, Attitudes and Nutrition in Ireland. Main Report. Dublin: Department of Health and Children.

Mullen, P., Evans, D., Forster, J., et al. (1995). Settings as an important dimension in health education/promotion policy, programs and research. *Health Education Quarterly,* 22(2), 329-345.

National Social Marketing Centre (2010). Kottler, Philip., Lee, Nancy. R., (2008). Influencing behaviours for good, SAGE

New South Wales Health Department (2001). A Framework for Building Capacity to Improve Health. Sydney, NSW Health Department. Publication Warehouse.

Ontario Prevention Clearinghouse (2002). Capacity Building for Health Promotion - more than bricks and mortar. *Ontario Health Promotion E-Bulletin*, 2002, (266).

Parrott, S., Godfrey, C., Raw, W., West, R., and MacNeill, A. (1998). Guidance for the commissioners on the cost-effectiveness of smoking cessation interventions. *Thorax*, 53 (Suppl.5) s2-s37.

Perkins, H.W. and Berkowitz, A.D. (1986). Perceiving the community norms of alcohol use among students: Some research implications for campus alcohol education programming. *International Journal of the Addictions,* 21(9-10), 961-976.

Poland, B.D., Green, L.W. and Rootman, I. (eds.), (2000). Settings for Health Promotion Linking Theory and Practice. London: Sage Publications.

Prochaska, J.O. and DiClemente, C.C. (1983). Stages and processes of self-change of smoking: Towards an integrative model of change. *Journal of Consulting and Clinical Psychology*, 51(3), 390-395.

Public Health Alliance (2007). Public Health Advocacy Toolkit. http://advocacy.phaii.org/uploads/docs/toolkit.pdf

Quality of Life Profile Toronto: The Quality of Life Research Unit. http://www.utoronto.ca/qol/profile.htm

Raphael, D., Steinmetz, B., Renwick, R., Rootman, I., Brown, I., Sehdev, H., et al. (1999). The Community Quality of Life Project: a health promotion approach to understanding communities. *Health Promotion International*, 14(3), 197-210.

Rootman, I. (2001). A framework for health promotion evaluation. In I. Rootman, M. Goodstadt, B. Hyndman, D. McQueen, L. Potvin, J. Springett & E. Ziglio (eds.), Evaluation in health promotion (WHO Regional Publications Europen Series, No. 92., pp. 3-6). Geneva: World Health Organisation.

Rosenstock, I.M. (1966). Why people use health services. *Milbank Memorial Fund Quarterly*, 44(3), 94-124.

Sindall, C. (2001). Health Promotion and Chronic Disease: building on the Ottawa Charter, not betraying it. *Health Promotion International*, 16(32): 215-217.

St. Leger, L. (2001). Schools, health literacy and public health: possibilities and challenges. *Health Promotion International*, 16(2), 197-205.

Taras, H., (2005[a]). Nutrition and student performance at school. *Journal of School Health,* 75(6), 199-213.

Taras, H., (2005[b]). Physical activity and student performance at school. *Journal of School Health*, 75(6), 214-218.

Taras, H. and Potts-Datema, W. (2005[a]). Obesity and student performance at school. *Journal of School Health,* 75(8), 291-295.

Taras, H. and Potts-Datema, W. (2005[b]). Sleep and student performance at school. *Journal of School Health,* 75(7), 248-254.

The Health Communication Unit (2000). Introduction to Health Promotion Planning. THCU at the Centre for Health Promotion, University of Toronto, Canada.

Washington, T. (2008). Case Study: Tameside Metropolitan Borough Council fights sickness absence. Employee Benefits.

Weiss, E.S., Miller Anderson, R. and Lasker, R.D. (2002). Making the Most of Collaboration: Exploring the Relationship Between Partnership Synergy and Partnership Functioning. *Health Education and Behaviour*, 29(6), 683-698.

Whitelaw, S., Baxendale, A., Bryce, C., Machardy, L., Young, I. & Witney, E. (2001). Settings based health promotion: a review. *Health Promotion International,* 16(4), 339-353.

Wilkinson, R. and Pickett, K., (2009). The Spirit level: why more equal societies almost always do better. London Allen Lane, Published by the Penguin Group.

Wilkinson, R. and Marmot, M. (1998). Social Determinants of Health: the solid facts. Geneva: World Health Organization.

Women's Health Council (2003). Women and Cardiovascular Health. Dublin: The Women's Health Council. http://www.dohc.ie/publications/pdf/women_cardiovascular.pdf?direct=1

World Bank (1993). World Development Report: Investing in Health. World Development Indicators. Oxford, OUP. http://files.dcp2.org/pdf/WorldDevelopmentReport1993.pdf

World Bank (1999). Curbing the epidemic: Governments and the Economics of Tobacco Control. http://www.usaid.go/policy/ads/200/tobacco.pdf

World Health Organization (2009). Phase V (2009–2013) of the WHO European Healthy Cities Network: goals and requirements. Europe: World Health Organization. http://www.euro.who.int/__data/assets/pdf_file/0009/100989/E92260.pdf

World Health Organization (2008). Closing the gap in a generation: Health equity through action on the social determinants of health. WHO Global Commission on Social Determinants of Health. http://whqlibdoc.who.int/publications/2008/9789241563703_eng.pdf

World Health Organization (2005). Bangkok Charter for Health Promotion in a Globalized World. http://www.who.int/healthpromotion/conferences/6gchp/bangkok_charter/en/

World Health Organization (2005). International Network of Health Promoting Hospital. Copenhagen: WHO Regional Office for Europe. http://www.euro.who.int/en/what-we-do/health-topics/Health-systems/public-health-services/activities/health-promoting-hospitals-network-hph

World Health Organization (2004). Standards for Health Promotion in Hospitals. Copenhagen: WHO Regional Office for Europe. http://www.euro.who.int/__data/assets/pdf_file/0006/99762/e82490.pdf

World Health Organization (2003). Health and Development Through Physical Activity and Sport. Geneva: World Health Organisation. http://whqlibdoc.who.int/hq/2003/WHO_NMH_NPH_PAH_03.2.pdf

World Health Organization (1998). Health Promotion Glossary. Geneva: World Health Organization. http://www.who.int/healthpromotion/about/HPR%20Glossary%201998.pdf

World Health Organization (1997). Jakarta Declaration on Leading Health Promotion into the 21st Century. Geneva: World Health Organization. http://www.who.int/healthpromotion/conferences/previous/jakarta/declaration/en

World Health Organization (1991). Sundsvall Statement on Supportive Environments for Health. Geneva: World Health Organization. http://www.who.int/healthpromotion/conferences/previous/sundsvall/en/

World Health Organization (1986). Ottawa Charter for Health Promotion. First International Conference on Health Promotion Ottawa. Geneva: World Health Organization. http://www.who.int/hpr/NPH/docs/ottawa_charter_hp.pdf

World Health Organization (1978). Declaration of Alma-Ata International Conference on Primary Health Care. http://www.who.int/hpr/NPH/docs/declaration_almaata.pdf

Acknowledgements

The development of the Health Promotion Strategic Framework (HPSF) has been possible because of the assistance and collaboration of individuals and groups with an interest in health promotion. Their commitment to develop a framework that will shape and focus the strategic direction for the future of health promotion here in Ireland is greatly acknowledged and appreciated. This is the first Health Promotion Strategic Framework developed by the HSE and reiterates the HSE's commitment to promote and protect health and wellbeing. Work on the HPSF benefited greatly from the input of the Health Promotion Management Team. It would not have been possible to bring the work to completion without the input from the Health Promotion workforce throughout the health and social care regions. The feedback, comments and suggestions given by the Health Promotion workforce motivated and provided an important stimulus to create an integrated vision for health promotion within the three key settings identified in the framework.

Sincere thanks are offered to the Project Manager, Ms. Joan Ita Murphy, and members of the Health Promotion Management Steering Group who led the development of this framework. The Steering Group included:

- Mr. Andy Walker, Health Promotion Manager, HSE South
- Ms. Biddy O'Neill, Health Promotion Manager, Programmes
- Mr. Bill Ebbitt, Health Promotion Manager, Policy and Strategy
- Mr. Brian Neeson, Health Promotion Manager, Research and Development
- Ms. Catherine Murphy, Assistant National Director of Health Promotion*
- Ms. Geraldine Hanna, Health Promotion Manager, Communication, Social Marketing and Advocacy
- Dr. Jacky Jones, Health Promotion Manager, HSE West
- Ms. Marie Lordan Dunphy, Assistant National Director, Integrated Services Directorate – Performance and Financial Management (Chair and lead on HPSF)**
- Dr. Nazih Eldin, Health Promotion Manager, HSE Dublin North East
- Ms. Sheilagh Reaper Reynolds, General Manager, Office of the National Director, Integrated Services Directorate – Performance and Financial Management***

Project Manager: Ms. Joan Ita Murphy, HSE South

Project Sponsor: Ms. Catherine Murphy, Assistant National Director of Health Promotion

** Ms. Catherine Murphy was replaced by Ms. Biddy O'Neill*

*** Ms. Marie Lordan Dunphy was replaced by Ms. Sheilagh Reaper Reynolds*

**** Ms. Sheilagh Reaper Reynolds was replaced by Mr. Andy Walker*

Health Promotion
Primary Care
Health Promoting
Health Service
Hospitals
Policies
MENTAL HEALTH
Obesity

Notes:

Feidhmeannacht na Seirbhíse Sláinte
Health Service Executive

Published by
HSE National Health Promotion Office

2011

ISBN: 1-874218-87-0978-1-874218-87-6

Design & Printed by Modern Printers: 056 7721739