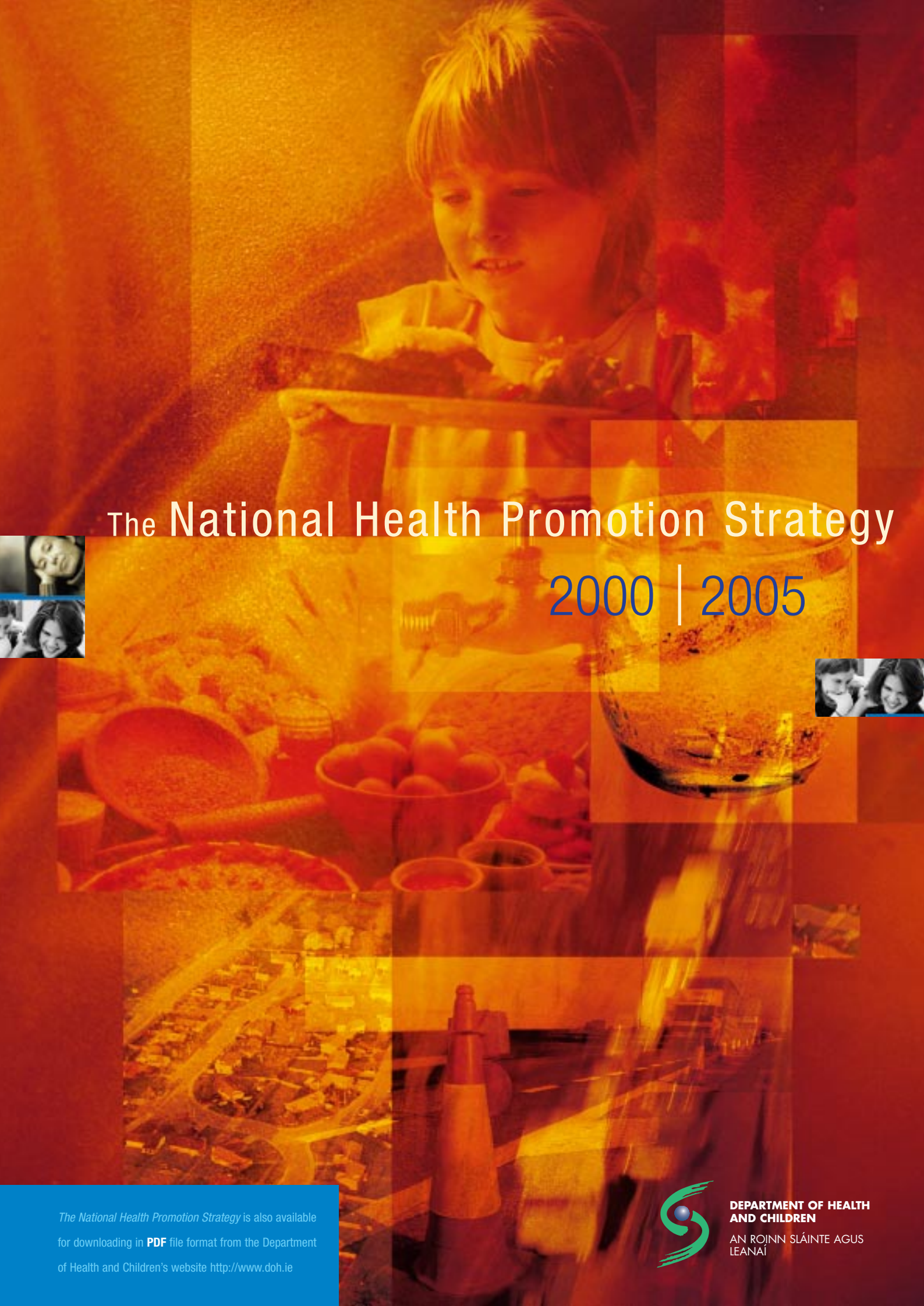


The National Health Promotion Strategy

2000 | 2005

The National Health Promotion Strategy is also available for downloading in **PDF** file format from the Department of Health and Children's website http://www.doh.ie

DEPARTMENT OF HEALTH AND CHILDREN

AN ROINN SLÁINTE AGUS LEANAÍ

FOREWORD FROM THE MINISTER

As Minister for Health and Children I am delighted to publish the second National Health Promotion Strategy. This strategy will cover the years 2000 to 2005 and is intended as a resource and guide for all relevant stakeholders and interested parties concerned with promoting health in the new millennium. It also fulfils the important commitment to health promotion development set out in the *Programme for Prosperity and Fairness*, and addresses Ireland's obligations set out in the *Mexico Ministerial Statement for the Promotion of Health* endorsed by Ministers for Health at the 5th Global conference on Health Promotion held in Mexico in June 2000.

The first national health promotion strategy *...making the healthier choice the easier choice...*was published in 1995 and established the role of health promotion in pursuing health and social gain. It is intended that this document will build on that work.

Over the past five years there have been many significant health promotion developments and achievements at a national and regional level. These include the establishment of Health Promotion Departments within all health boards with dedicated resources, the publication of allied strategies and the availability of the first nationally representative surveys on lifestyle practices, the *Survey of Lifestyle, Attitudes and Nutrition* (SLÁN) and *Health Behaviour in School-Aged Children* (HBSC).

The publication of *Building Healthier Hearts* in 1999 represented a significant development for health promotion with over half the recommendations aimed at preventing heart disease and promoting heart health. These recommendations are supported and complemented in this new health promotion strategy.

This document identifies strategic aims and objectives, which will contribute to the overall health improvement of the Irish population. It must be stressed however that many of the strategic aims and objectives can not be achieved solely by the healthcare sector, but will require an inter-sectoral and multi-disciplinary approach to put health promotion on everyone's agenda. Research, monitoring and evaluation will also play an important role in the ongoing assessment of this strategy and its impact on the nation's health.

I would encourage all statutory and non-statutory organisations to embrace this new strategy so that individuals, communities and population groups can have greater opportunities to attain and sustain health in a manner that is compatible with the broadest aspirations for positive health in the 21st Century. Health promotion has a crucial role to play in realising these aspirations. I would like to take this opportunity to thank everyone who contributed to the preperation of this document and I am confident that it will provide the strategic direction necessary to achieve the task.

Micheál Martin

Michaél Martin T.D.

Minister for Health and Children

Contents

Over the years, health promotion has become increasingly important in pursuing national health goals and this is reflected in the Department of Health and Children's ***mission statement...***

in a partnership with the providers of health care, and in co-operation with other government departments, statutory and non-statutory bodies, to protect, ***promote*** *and restore the health and well-being of people by ensuring that health and personal social services are planned, managed and delivered to achieve measurable health and social gain and provide the optimum return on resources invested*[1].

OVERVIEW

The purpose of this new health promotion strategy is to set out a broad policy framework within which action can be carried out at an appropriate level to advance the strategic aims and objectives. This strategy aims to promote a holistic approach to health in Ireland by:

- Focusing on the link between health promotion and the determinants of health;
- Emphasising the role of inter-sectoral and multi-disciplinary approaches in the planning, implementation and evaluation of health promotion initiatives including the involvement of the consumer;
- Outlining the context within which health promotion is currently taking place at an international and national level;
- Providing a rationale for the further development of health promotion to help maintain, improve and protect health;
- Referring to information and data on socio-economic and environmental factors, lifestyle behaviours and health status;
- Proposing strategic aims and objectives for health promotion under the three approaches of population groups, settings and topics;
- Identifying the prerequisites needed at a national and regional level to support and sustain health promotion;
- Providing a general overview of outcomes from the first strategy.

This strategy presents many new challenges for health promotion to explore and expand upon such as:

- The need for a more comprehensive process of "health proofing" to influence positively policies that impact directly or indirectly on health;
- The formation of a National Health Promotion Forum under the chairmanship of the Minister for Health and Children to progress this strategy ;
- The continued support and expansion of research to identify models of best practice in youth health promotion, parenting programmes, men's health and positive mental health;
- The appointment of national co-ordinators in the community and workplace settings and for breast feeding;
- The review of existing policies such as the *National Breastfeeding Policy, A National Alcohol Policy* and the *Plan for Women's Health*;
- The support of recent policy documents and strategies such as *Youth as a Resource: promoting the health of young people at risk*, *Building Healthier Hearts* and the *Report of the Task Force on Suicide*;
- The development of new policies in the area of men's health, positive mental health and healthy weight;
- The introduction of new strategic aims and objectives aimed at young people, men, colleges and the youth sector;
- The development of programmes to meet the needs of other population groups, children and young people at risk in a manner which complements the work of the National Anti-Poverty Strategy;
- The establishment of pilot projects to identify models of good practice that provide a holistic approach to health within disadvantaged areas (similar to the Drugs Task Force Areas approach);
- The incorporation of Social, Personal and Health Education into the second level curriculum.

CHAPTER 1

Setting the scene...

1.1 THE MAJOR DETERMINANTS OF HEALTH

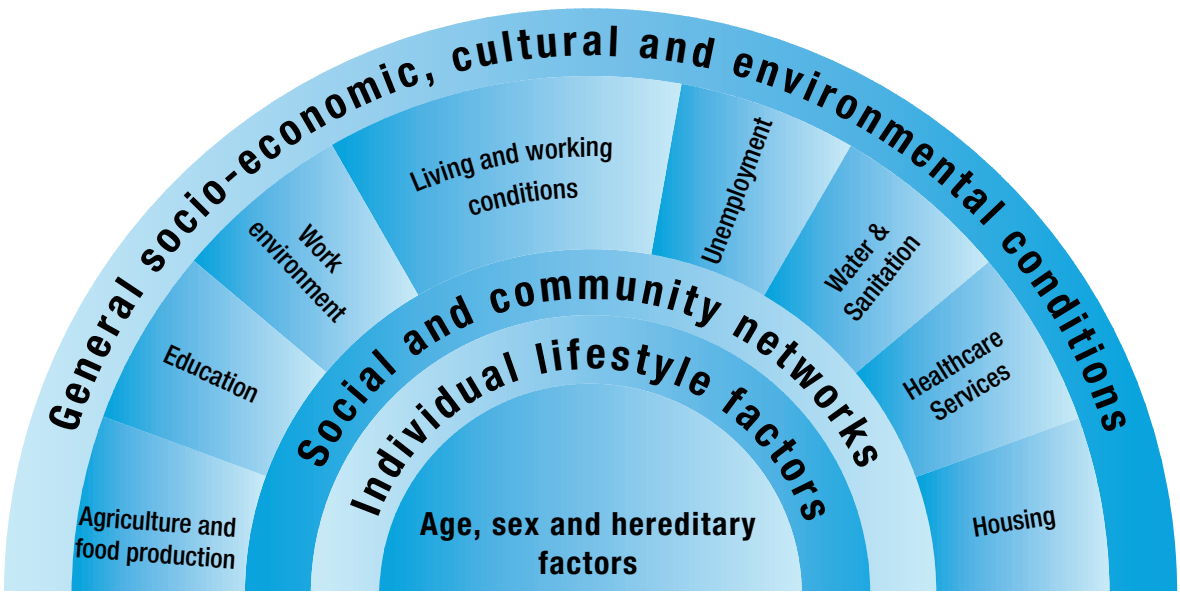
Health has many components although it is frequently referred to in the context of disease and illness. However, health is in fact much more than this. It is a resource for everyday life; it is a positive concept emphasising social and personal resources as well as physical and mental capacities.

The World Health Organisation (WHO) defines health as *...a complete state of physical, mental and social well-being, and not merely the absence of disease or infirmity.* In 1986 this definition was expanded to define health as *...a resource for everyday life, not the objective of living; it is a positive concept emphasising social and physical resources, as well as physical capacity*[2].

Many factors influence and determine health, whether at an individual or population level as seen in diagram 1. Social, economic and environmental factors are the main external or structural determinants of health. At an individual level factors such as age, sex, hereditary factors and lifestyle choices are important.

The reality is that the achievement of physical and mental well-being is not the responsibility of the individual alone. People's ability to pursue good health is limited by varying degrees of skills, information and economic means. The way these determinants of health interact and the linkages between them can be of major importance.

Diagram 1: The major determinants of health[3].



1.2 THE HISTORY OF HEALTH PROMOTION

The Declaration of Alma Ata[4] in 1978 was an important milestone in the promotion of world health which provided the blueprint for Primary Health Care and the Health for All by the year 2000 quest. In 1986 the World Health Organisation held its first International Conference on Health Promotion in Ottawa, Canada and produced the *Ottawa Charter for Health Promotion*[5]. The charter builds on the *Declaration of Alma Ata* and calls for action on five fronts by:

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

Guided by the *Charter,* the practice of health promotion aims to develop innovative, practical approaches to address particular issues by:

- The formulation, implementation and monitoring of **healthy public policy** such as legislation that restricts smoking in public places;

- Working towards a **re-orientation of the health services** to advocate for health and to achieve a greater balance between health promotion and curative services as demonstrated by the international health promoting hospitals movement[6];

- Encouraging **environmental** measures which improve health, such as, better, affordable housing, innovative transport policies, pollution control and recycling opportunities;

- Incorporating **community development** approaches into health promotion interventions so that communities are empowered to take control and improve their health collectively. In this country the emphasis on community consultation and empowerment taken by the Drug Task Forces[7] is an example of this approach;

- Developing **personal skills** by consulting individuals to identify their needs, involving them in the process of planning and evaluation of health promotion programmes to make them relevant and accessible as demonstrated by many of the lifeskills programmes.

In addition to the above, health promotion has a role in well-established preventive health measures such as screening and immunisation.

1.3 INTERNATIONAL DEVELOPMENTS

Since the launch of the *Ottawa Charter* in 1986, other international conferences have resulted in publications and declarations, which have expanded upon various aspects of this Charter.

- **1988** Adelaide, Australia.
  This conference focused on developing healthy public policy as an area of health promotion and identified certain policy priorities including nutrition, alcohol, tobacco, women's health and the environment[8].

- **1991** Sundsvall, Sweden.
  The challenge here was to identify practical ways to create physical, social and economic environments for health, compatible with sustainable development. This conference resulted in the publication of a handbook on action to improve public health and the environment[9].

- **1997** Jakarta, Indonesia.
  The Jakarta conference focused on identifying the range of professional and technical skills required to enable the process to move forward into the 21st Century. It led to the *Jakarta Declaration*[10], which was endorsed by WHO in 1998 and highlights the fact that investment in, and commitment to, an infrastructure for health promotion is of fundamental importance. The declaration identifies five priorities:

  1. Promote **social responsibility** for health.
  2. Increase **investments** for health development.
  3. Expand **partnerships** for health promotion.
  4. Increase **community capacity** and **empower** the individual.
  5. Secure an **infrastructure** for health promotion.

- **2000** Mexico City, Mexico.
  This 5th Global conference focused on bridging the equity gap and progressed the five priorities of the *Jakarta Declaration* for health promotion in the 21st century and led to the signing of the *Mexico Ministerial Statement for the Promotion of Health* endorsed by Ministers for Health from around the world.

- **2000** The Verona Initiative.
  The European office of the World Health Organisation arranged a series of meetings between 1998 and 2000, which was known as *The Verona Initiative*. This initiative looked in depth at the determinants of health as they affected the citizens of the European region and developed an investment for health model, known as *The Verona Benchmark,* which can be used by national and regional authorities in order to develop partnerships with commercial and voluntary organisations, as well as statutory bodies outside the health arenas, with a view to improving population health.

1.4 EUROPEAN DEVELOPMENTS

Over the past five years at a European level there have been significant developments in the field of health promotion:

- **1996**

  The European Union (EU) supported the development of health promotion by its publication of the *Health Promotion Programme*[11] which was adopted by The European Parliament and Council in 1996.

- **1997**

  The European Network for Health Promotion Agencies (ENHPA) was officially established in 1997 by the key agencies for health promotion in the EU Member States. The activities of ENHPA are financed by the European Commission and participating agencies to improve the quality of and to increase the capacity for health promotion in Europe.

- **2000**

  The launch of the European Commission's new public health action programme[12] with one of its three strands devoted to tackling the determinants of health.

1.5 IRISH DEVELOPMENTS

Shaping a Healthier Future[13] the Department of Health and Children's strategy for the health services in the nineties acknowledged the important role of health promotion. The national health strategy paved the way for *A Health Promotion Strategy ...making the healthier choice the easier choice*[14], which identified priority issues, topics, settings and population groups. This first health promotion strategy identified goals and targets that provided a direction for the development of health promotion structures and initiatives at a national and regional level.

Since 1995, there have been a number of developments in health promotion in Ireland, both at a national and a regional level in several areas including:

- Multi-sectoral action
- Policy formulation
- Service delivery
- Research
- Professional training
- Cross border co-operation
- Other developments

Multi-sectoral action

In response to the first health promotion strategy a National Consultative Committee on Health Promotion was established in 1995 to foster mult-sectoral action. The Committee is chaired at a Ministerial level in the Department of Health and Children and has representatives from various statutory and major voluntary agencies whose activities impact on the health of the community. This committee has contributed to several policy documents and reports such as *Health Promotion in the Workplace: healthy bodies - healthy work*[15], *Youth as a Resource: promoting the health of young people at risk*[16] and *Building Healthier Hearts*[17].

Policy formulation

A number of key complementary policy documents and reports have been published since 1995. These publications include reference to, and place a reliance on, the practice and principles of health promotion to achieve stated aims and objectives. The most significant of these documents are:

- *Recommendations for a National Food and Nutrition Policy* (1995)[18]
- *A National Alcohol Policy (1996)*[19]
- *A Plan for Women's Health* (1997)[20]
- *Health Promotion in the Workplace: healthy bodies-healthy work* (1998)[15]
- *Adding Years to life & life to years...A health promotion strategy for older people* (1998)[21]
- *Report of the National Task Force on Suicide* (1998)[22]
- *Youth as a Resource: promoting the health of young people at risk* (1999)[16]
- *Building Healthier Hearts* (1999)[17].

Service delivery

Looking back over the past years there have been many developments in health promotion at a health board level. Most notably Health Promotion Departments led by senior managers and with dedicated budgets have been established in all health boards.

Research

The most significant development in this area has been the commissioning by the Department of Health and Children of the nationally representative Survey of Lifestyle, Attitudes and Nutrition (SLÁN)[23] and the WHO collaborative survey on the Health Behaviour of School-aged Children (HBSC)[24].

These two surveys provide baseline data on health and lifestyle behaviours across a range of socio-demographic and economic parameters and will be referred to further in Chapter 3. To complement this national data many health boards also dedicated resources towards regionally based research, some utilising the SLÁN and HBSC survey as protocols.

In addition, the research and planning phase of many new programmes and interventions have incorporated time for analysis of best practice. This process has ensured that new health promotion initiatives are based on evidence based practice. A great deal of this research has been facilitated by the formation of networks both nationally and internationally.

The availability of data on an ongoing basis will contribute significantly to policy formulation and the development of effective health promotion interventions in Ireland.

Professional training

Allied to this research function, there has been a growth in the number of institutions offering professional training in the area of health promotion at certificate, diploma, degree and postgraduate level. With the current interest in ongoing training at many different levels, it is apparent that health promotion has gained recognition and is becoming part of mainstream healthcare delivery.

Cross border co-operation

Over the years there has been an excellent working relationship between the Health Promotion Agency for Northern Ireland, the Health Promotion Unit and the regional Health Promotion Departments from all health boards. As health is one of the areas for co-operation identified by the Good Friday Agreement an opportunity presents itself to develop a strategic approach to health promotion and primary care initiatives on an all island basis.

Several joint initiatives have been identified including: research, the exchange of information on models of best practice, professional training and public information campaigns. Strengthening cross border co-operation will ensure that meaningful and sustainable health promotion initiatives are developed on an all island basis.

Other developments

The evolving role of the Department of Health and Children is reflected in its Strategy Statement *Working for health and well-being*.

This states that *if the Department is to address the key areas which it has outlined as being of strategic importance, it is crucial for it to strike the appropriate balance between its day-to-day operational work and the work required to plan, develop, monitor and review the services and the environment in which they are delivered*[25].

Within this context the remit of the Health Promotion Unit is changing. The Unit's executive function is being further devolved to the health boards allowing its policy function to be strengthened. This devolution of function is complimented by the provision of the Health (Amendment)(no.3) Act 1996 which now confers a statutory obligation on health boards to develop... *health promotion programmes, having regard to the needs of people residing in its functional area and the policies and objectives of the Minister in relation to health promotion generally*.

1.6 SUMMARY

Since the launch of the *Ottawa Charter for Health Promotion* in 1986 there have been considerable developments at an international, national and local level to implement the five principles of the Charter. It is now timely to revisit this process and present a new strategy for the years 2000 to 2005 in light of these developments and to reflect the evolving role of the Department of Health and Children.

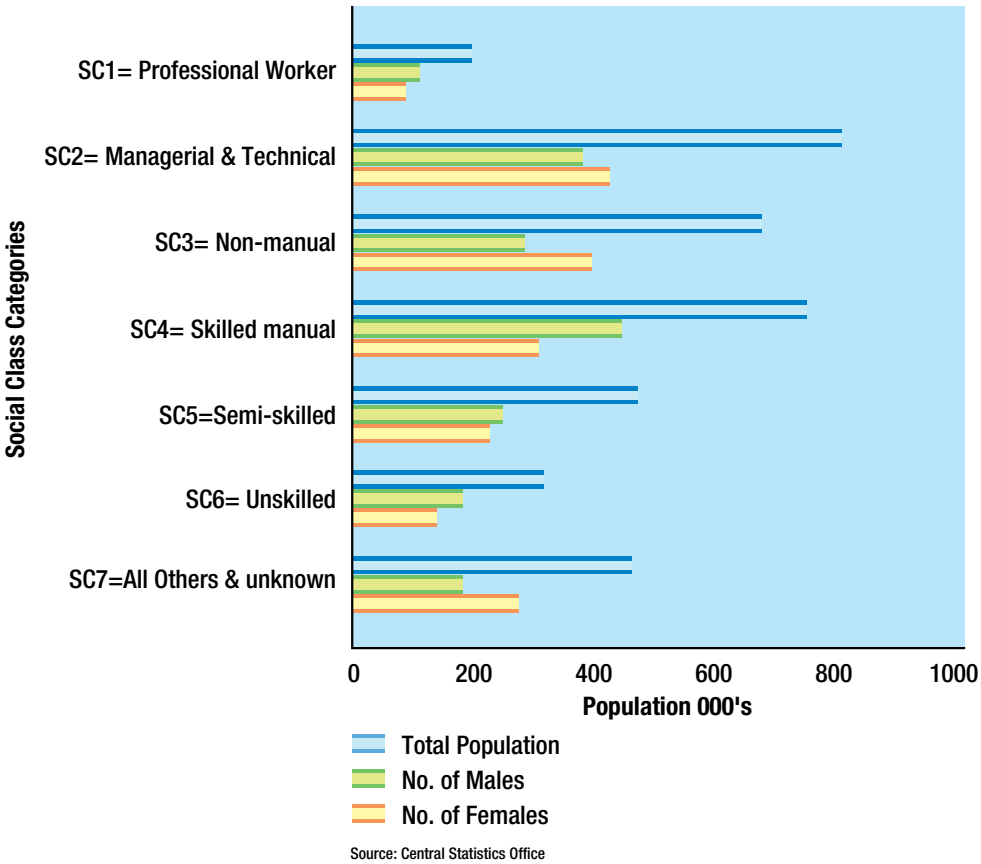
CHAPTER 2

What external and structural factors determine our health?

2.1 SOCIAL, ECONOMIC AND ENVIRONMENTAL FACTORS

In considering the extent to which external and structural factors determine our health it is important to establish a profile of the Irish population. The most recent national census in 1996 enumerated the Irish population at 3,626,087[26]. The number of people in each social class and the corresponding number of males and females are presented in figure 1.

Figure 1: Social Class distribution of the Irish Population for 1996



Source: Central Statistics Office

A range of social, economic[27] and environmental factors[28] together with issues of equity, equality and access impact on the physical, mental and social well-being of the Irish population. By considering the following factors a broader picture of the population's health can be constructed:

- Poverty
- Unemployment and income adequacy
- Education
- Access to health services and
- Environmental factors such as housing and water quality

The following is a presentation of the way these factors impact on health.

2.1.1 POVERTY

The National Anti-Poverty Strategy has defined poverty in the following way:

People are living in poverty if their income and resources (material, cultural and social) are so inadequate as to preclude them from having a standard of living, which is regarded as acceptable by Irish society generally. As a result of inadequate income and resources people may be excluded and marginalised from participating in activities which are considered the norm for other people in society[29].

7% to 10% of the Irish population have been identified as being consistently poor and the National Anti-Poverty Strategy *Sharing in Progress*[29] has been specifically developed to address this issue. *Sharing in Progress* has given particular attention to key areas such as educational disadvantage and income adequacy to help reduce the levels of poverty.

Poverty is widely recognised as having a negative affect on health and people classified as "poor" suffer from greater psychological distress, have lower self-esteem and less confidence compared with those classified as "non-poor"[30]. Findings from the National Health and Lifestyle survey, SLÁN, revealed that individuals from social classes 5 (semi-skilled) and 6 (unskilled) were more likely to participate in behaviours that could adversely affect their health.

Given the important link between poverty and health the Governments "poverty proofing" policy[31] is to be welcomed.

2.1.2 UNEMPLOYMENT AND INCOME ADEQUACY

Due to the current economic growth in Ireland, the standardised unemployment rate has fallen from 10.3% in 1997[32] to 5.1% in the fourth quarter of 1999[33].

International research has demonstrated that those whose levels of economic prosperity is less than that of the wider community in which they live, suffer a disproportionate burden of ill-health and premature death when compared with the community as a whole and, in particular, to those sectors of the community who enjoy greater economic prosperity.[34]

The association between poor health and higher mortality rates amongst individuals who are long-term unemployed and from lower socio-economic groups has not been well researched within an Irish context. In 1998, the Irish Psychiatric services reported that the highest rate of admission for mental illness is amongst the semi-skilled and lowest amongst employers and managers[35]. It is important to interpret the socio-economic data with caution due to the high number of occupations left "unspecified" at 38%.

2.1.3 EDUCATION

Education in its broadest sense has an important role to play if all sectors of the population are to develop skills to deal with the variety of situations they encounter in life. Conversely, education has the potential to widen the gap between the earning power of the already advantaged and those who have little or no qualifications.

Marginalised groups within the population, for example, lower socio-economic groups and the long-term unemployed, experience barriers that affect participation in the formal and informal education system. These barriers have implications for achieving good health.

Young people from lower socio-economic backgrounds are almost five times more likely to leave school with low qualifications[36]. Evidence supports the fact that early school leaving is a common denominator among those who become the long-term unemployed[36] and who participate in lifestyle practices associated with ill health[37,38].

Poor literacy skills are a barrier to many opportunities in our information-based society and this also limits access to health information and health services. It has been estimated that 25% of the general adult population in Ireland have difficulties with reading and writing[39] and this may be as high as 42% amongst the Traveller Community[40].

2.1.4 ACCESS TO HEALTH SERVICES

Whilst availability and access to health services have improved over recent years, there are examples where population groups remain disadvantaged. Rural living and physical isolation are barriers that have been cited for women[41], men[42] and older people[21] accessing health services.

Poor literacy skills, location of health records and varying degrees of discrimination are specific obstacles for other groups within the population accessing health services[43].

2.1.5 ENVIRONMENTAL FACTORS

Environmental factors, whether natural or man-made, can have a significant impact on health. Industrial by-products and changing lifestyle can influence air, water and food quality. The United Nation's document for health in the twenty-first century, Agenda 21, identifies problems and solutions with their roots in basic local issues[44]. These include provision of water supplies, roads and housing. Other environmental factors such as the availability of recreation and transport facilities also have an impact on health.

In Ireland there are several examples of how action has been taken in the past to protect the environment and the health of the nation. One such example was the action taken to maintain air quality. The switch to cleaner fuel and the Government's smoke-control legislation in 1990 eliminated air pollution associated with coal burning[45].

In 1996 regulations were put in place to help protect people from the harmful effects of passive smoking. The Tobacco Health Promotion and Protection Regulations[46] prohibit and restrict smoking in a wide range of public areas and facilities, thus enhancing air quality.

To combat vehicle emission, an EC Directive[47] requires that all EU member states phase out the marketing of leaded petrol by 2000. In Ireland, in 1989, unleaded petrol sales accounted for 7% of all sales but by 1998 this had increased to 85%[48].

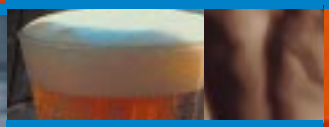
The interdepartmental document *Proposal for a National Environmental Health Action Plan*[49] published in 1999, is the first attempt at preparing an overall national plan specifically to address environmental health in Ireland and is welcomed.

2.2 SUMMARY

There is clearly a need for greater inter-sectoral and multi-disciplinary approaches to address the impact which social, economic and environmental factors have on the physical, mental and social well-being of individuals and communities. A more comprehensive policy of "health proofing" would ensure that the determinants of health, particularly those beyond the remit of the health services, are considered in terms of their direct or indirect impact on health.

CHAPTER 3

How do we as individuals influence our own health?



3.1 LIFESTYLE BEHAVIOUR

The lifestyle choices we make can have a direct impact on our physical and mental well-being. These choices and ultimately behaviours can be influenced or determined by many factors such as age, sex, social class, income, education, peer group pressure, work and living conditions, mental health and access to information.

The SLÁN (adults 18 years plus) and HBSC (school-going children 9-17 years of age) surveys were carried out by the Centre for Health Promotion Studies, National University of Ireland, Galway. The adult sample of 6,539 was obtained randomly from the electoral register and the school-going children sample of 8,497 pupils was randomly selected from primary and post-primary schools[23].

Data from SLÁN and HBSC are presented based on age, gender and social class and only significant findings are reported in this chapter. There are six social classes (SC) referred to in the findings which are analogous to those used in the 1996 Census[26]. SC 1 = Professional workers; SC 2 = Managerial and technical; SC 3 = Non-manual; SC 4 = Skilled manual; SC 5= Semi-skilled and SC 6 = Unskilled.

It is intended that these surveys will be repeated on a regular basis to establish trends in lifestyle behaviour and to help determine the long term effectiveness of interventions. The findings will support a more focussed approach to promoting and encouraging healthy practices.

The main findings reported here from SLÁN and HBSC relate to:

- Smoking
- Food and nutrition
- Alcohol
- Exercise
- Accidents
- Dental care
- Drug use
- Sexual behaviour

3.1.1 SMOKING

Overall 49% of children reported that they had ever smoked a cigarette. By the age of 12-14 years both boys and girls of all social classes are approaching the national target limit of 20% which relates to regular cigarette smoking.

By the age of 15-17 years a third of both boys and girls are current smokers and 40% of girls in social class 5 & 6 are smokers.

Currently one in three adults are smokers and rates among younger women are now comparable with men. There is a strong negative social class gradient in smoking prevalence in all age groups of both men and women. It is only older males in social class 1 & 2 and all older women who appear to be around the target level of 20%. Most smokers want to quit but perceive the lack of willpower as the main problem.

3.1.2 FOOD AND NUTRITION

Nearly half of all girls in the 9-11 and 12-14 year categories reported eating fruit more than once a day whereas only a third of 15-17 year old girls in social class five and six did so. Girls were more likely to be eating fruit more frequently than boys. Approximately 1 out of 5 boys and girls reported eating vegetables once a day or less. Overall 8% of children reported being on a weight reducing diet and an additional 23% reported they needed to lose weight.

The food pyramid (diagram 2) which sets out the recommended number of servings from each shelf was utilised to determine the percentage of adult respondents who were meeting their recommended daily servings.

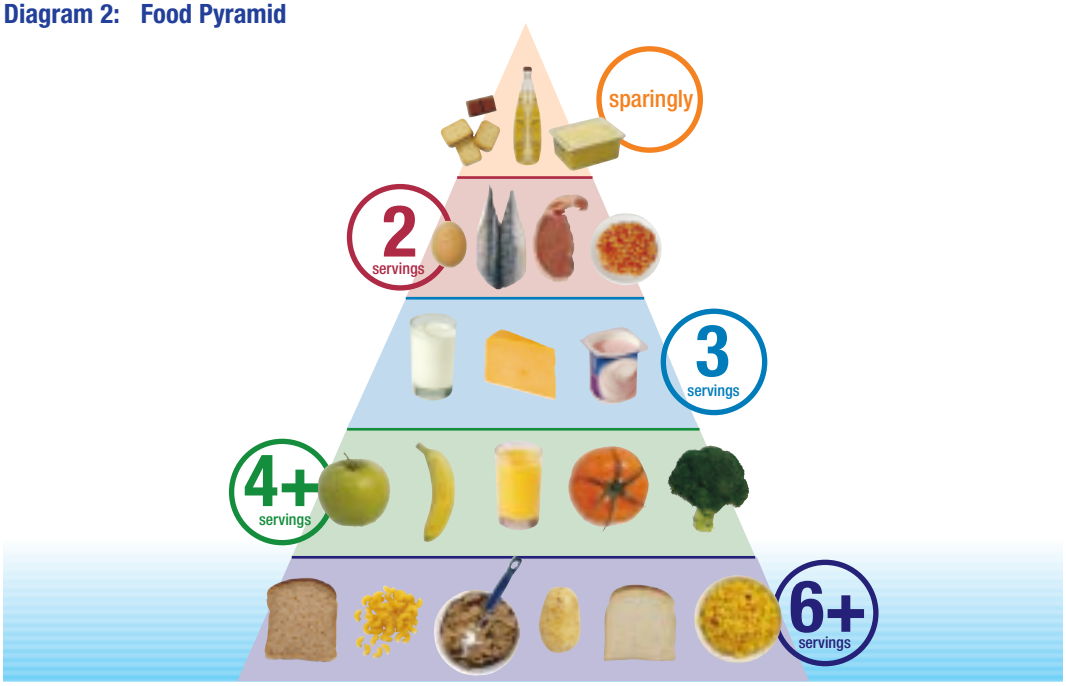
The percentage of adult respondents consuming the recommended number of servings from each shelf of the food pyramid were:

- 41% for cereals, breads and potatoes
- 64% for fruit and vegetables
- 23% for milk, cheese and other dairy products
- 39% for meat, fish and poultry

While some respondents did not achieve the recommended servings from each shelf there were some that consumed more than the recommended servings.

- 16% ate foods from the top of the pyramid sparingly, that is 3 or less servings per day[50].
- 12% of respondents ate fried foods 4 times or more a week and there was a strong relationship with social class in this pattern.

Diagram 2: Food Pyramid



For additional information refer to the Department of Health and Children's National Healthy Eating Guidelines

Thirty two percent of adults reported a Body Mass Index (BMI) classifiable as overweight and 10% as obese. BMI is the ratio of weight to height squared and is used to classify people into the following categories: **normal** (BMI up to 25), **overweight** (BMI 25 to 29) and **obese** (BMI greater than or equal to 30).

3.1.3 ALCOHOL

Overall 29% of children reported having had a drink in the last month. Thirty-five percent of boys compared with 24% of girls reported that they had been drunk on at least one occasion.

There has been a shift in patterns of drinking in that most adults now drink alcohol. Twenty-seven percent of adult males and 21% of adult females consume more than the recommended weekly limits of sensible alcohol consumption. Twenty-two percent indicated that they had driven after having consumed two or more alcoholic drinks.

3.1.4 EXERCISE

While two-thirds of younger boys reported participating in vigorous exercise 4 or more times per week this had declined to just over half of all boys in all social classes in the 15-17 year old age group. A similar pattern was observed with girls, but in the 15-17 year age group only one in four reported this level of activity.

Overall 42% of adult respondents engaged in some form of regular physical exercise. Rates declined markedly with age. Nearly one third of those over 55 years took no exercise at all in a typical week. A social class gradient existed in most age groups for both males and females.

3.1.5 ACCIDENTS

When school-going children were asked about any injuries they had in the previous 12 months, 58% of boys and 39% of girls reported an injury. Boys reported sports injuries more frequently, which related to greater participation in exercise out of school. 35% of boys and 46% of girls reported that they always wore a seat belt when travelling by car.

There was a clear negative age gradient in relation to cycle helmet usage for all social classes with only 3% of 15-17 year olds reporting that they did so.

For adults, sites of injury varied according to gender and age. Young males were most likely to report a sports-related injury (41%). Those in the 35-54 years age group were most likely to report a work related injury (37%) and the oldest age group, 55 years or over, reported home or garden based injuries (48%).

3.1.6 DENTAL CARE

Oral hygiene practices amongst some children are considered to be inadequate to promote and protect oral health. For example less than 50% of boys reported brushing their teeth more than once a day[24].

In relation to dental procedures, the adult survey revealed a marked social class difference, in that social class 1 & 2 have a greater percentage of their own teeth compared with social class 5 & 6[51].

3.1.7 DRUG USE

When school-going children were asked on how many occasions if any, they had used marijuana or cannabis, 84% of boys and 91% of girls replied never[51].

When the Irish adult population were asked about the use of cannabis and other illegal substances over the course of their lifetime, 93% reported never having used any type of illegal substance in their lifetime. Males, under the age of 35 years, social class 3 & 4 and living in urban locations were most likely to have ever used drugs of any type[51].

3.1.8 SEXUAL BEHAVIOUR

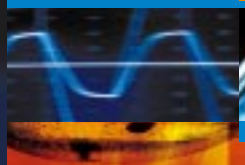
SLÁN data on sexual activity revealed that in the 18-34 year age group, 29% sometimes used contraception and of those adults who are sexually active, condom use accounts for 40% of contraceptive use[51].

3.2 SUMMARY

Prior to 1999, there was a lack of nationally representative data on health and lifestyle behaviour in Ireland. However, with the publication of the SLÁN and HBSC surveys baseline data became available which could be broken down by age, gender and social class. This data highlighted social variations in health and lifestyle behaviours between the lower and higher socio-economic groups. The challenge for health promotion is to narrow this gap. It is apparent from these surveys that participating in healthier choices and healthier lifestyle behaviours may not be an easier choice for those in lower socio-economic groups.

CHAPTER 4

How healthy or unhealthy are we?



Although health has already been defined in Chapter 1 of this document in its widest sense, traditionally the measurement of population health has relied on the use of health indicators such as morbidity (illness) and mortality (death) data. While accepting that this provides a more narrow indication of ill-health (morbidity), for this Chapter it is proposed to present current morbidity and mortality data only in an attempt to reflect the health status of the population.

4.1 MORBIDITY

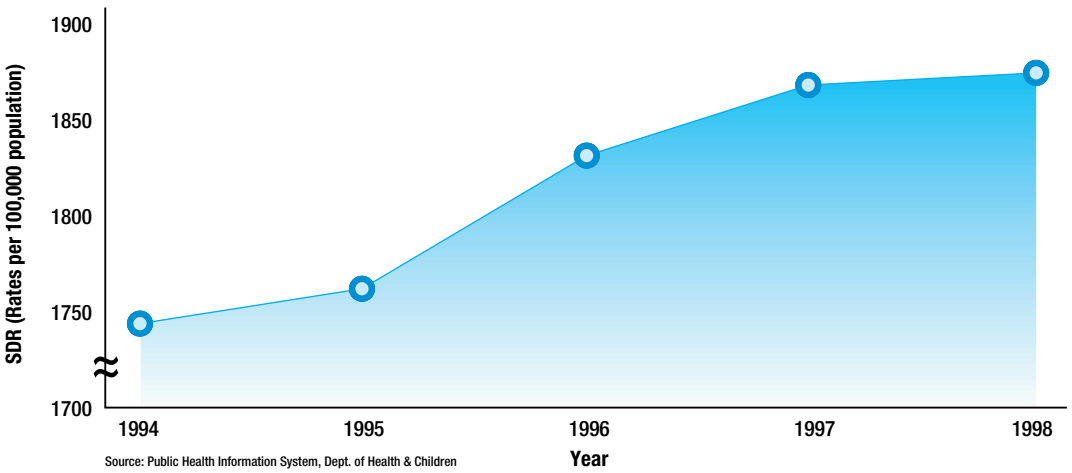
Self-perceived general health is a good predictor of population morbidity[52] and nearly 1 in 2 Irish adults surveyed reported excellent or very good health and this was higher for non-smokers[23]. As for Irish children, the vast majority reported that they were either very healthy or quite healthy. More boys than girls considered themselves as healthy[23].

Examples of morbidity, which reflect the principal causes of death include cardiovascular disease (which includes heart disease, strokes and circulatory diseases), cancers and accidents.

4.1.1 CARDIOVASCULAR DISEASES

Standardised discharge rates for heart disease, strokes and circulatory diseases are only available from 1994 and too early to establish trends (figure 2).

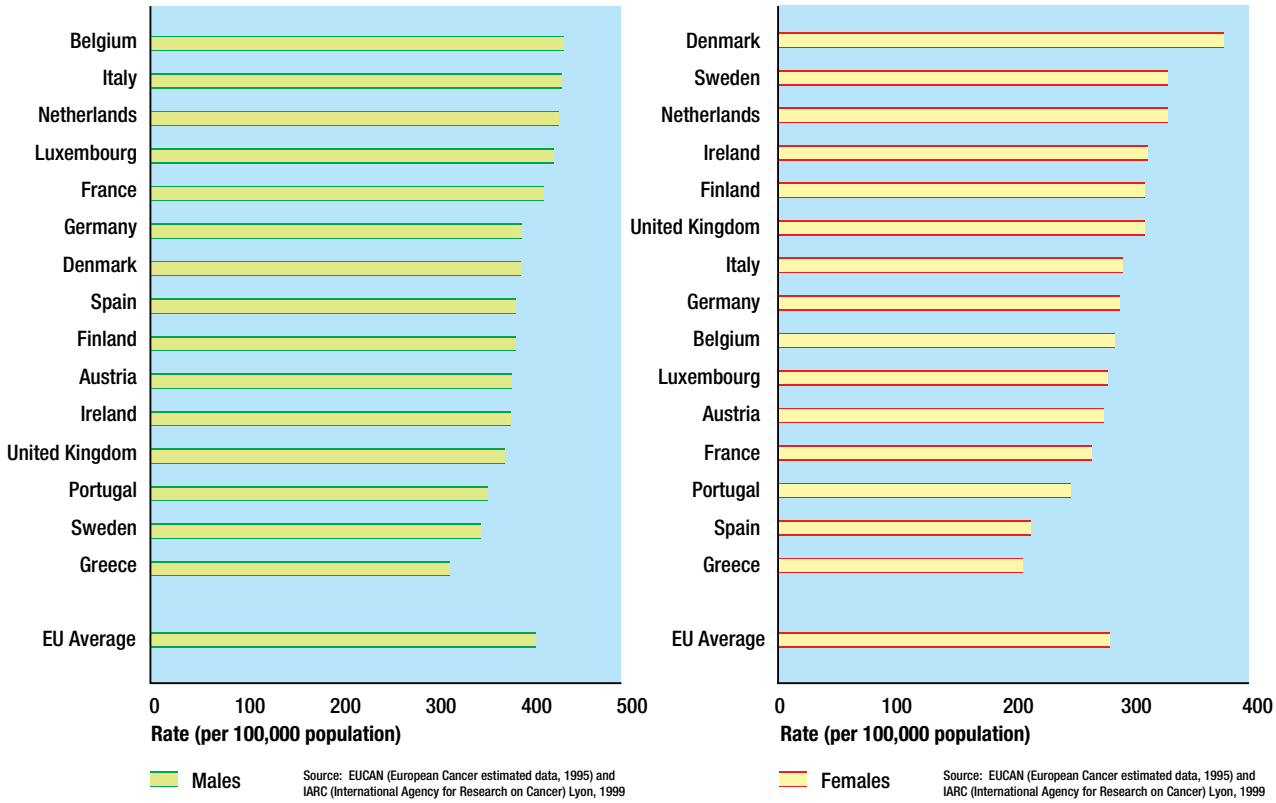
Figure 2: Age-standardised discharge rates for cardiovascular diseases (ICD 390-459) for 1994 to 1998



4.1.2 CANCERS

Age-Standardised Incidence Rates for all cancers (excluding non-melanoma skin cancer) are presented in figure 3 for Ireland and selected EU countries. Irish women have the fourth highest rate and Irish men the eleventh highest rate when compared to their EU counterparts.

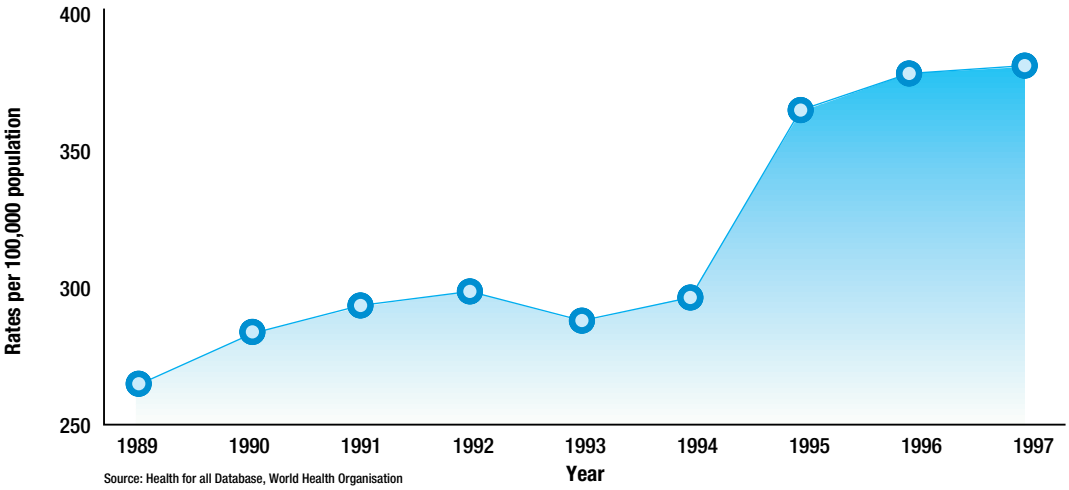
Figure 3: Age-Standardised incidence rates for all cancers excluding non-melanoma skin cancer, EU countries, 1995



4.1.3 ROAD TRAFFIC ACCIDENTS

Since 1989 the rate of persons injured in road traffic accidents has steadily increased (figure 4). It is important to note that the level of injury accidents increased markedly from 1995 due to a significant change in the reporting procedure.

Figure 4: Persons injured in road traffic accidents (rates from 1989 to 1997)

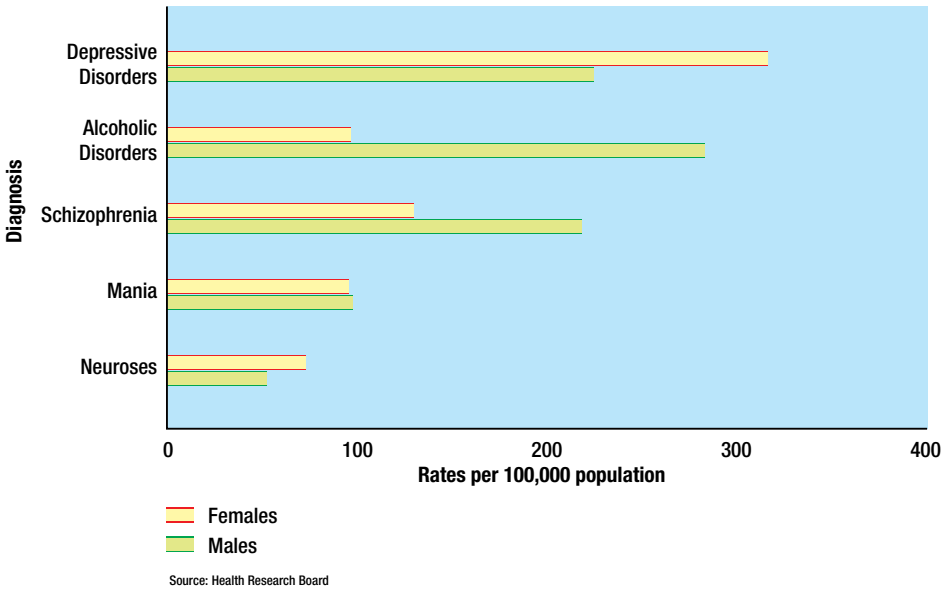


4.1.4 MENTAL HEALTH

There are several mental health conditions that are managed in the community but the magnitude and profile of this is difficult to determine. Data reveals that depressive disorders are the most common cause for females being admitted to psychiatric hospitals whereas in contrast alcoholic disorders are the most common cause for male admissions (figure 5).

In terms of lifestyle practices SLÁN provides data related to perceived requirements for better health. The majority of respondents from both genders ranked “less stress” as the top requirement for better health.

Figure 5: Rate of admissions to psychiatric hospitals by main diagnosis for males and females, 1998



Source: Health Research Board

4.1.5 SEXUALLY TRANSMITTED DISEASES

The number of notified cases of sexually transmitted diseases (STD) has continued to increase in the last number of years and has risen from 2,581 in 1989 to 7,436 in 1998[53].

4.1.6 DRUG MISUSE

In 1998, 58% of cases (3,504) in drug treatment centres were under 25 years of age[54]. The mean age of clients admitted to treatment (24.3 years) is the lowest in the EU[55].

4.1.7 HIV/AIDS

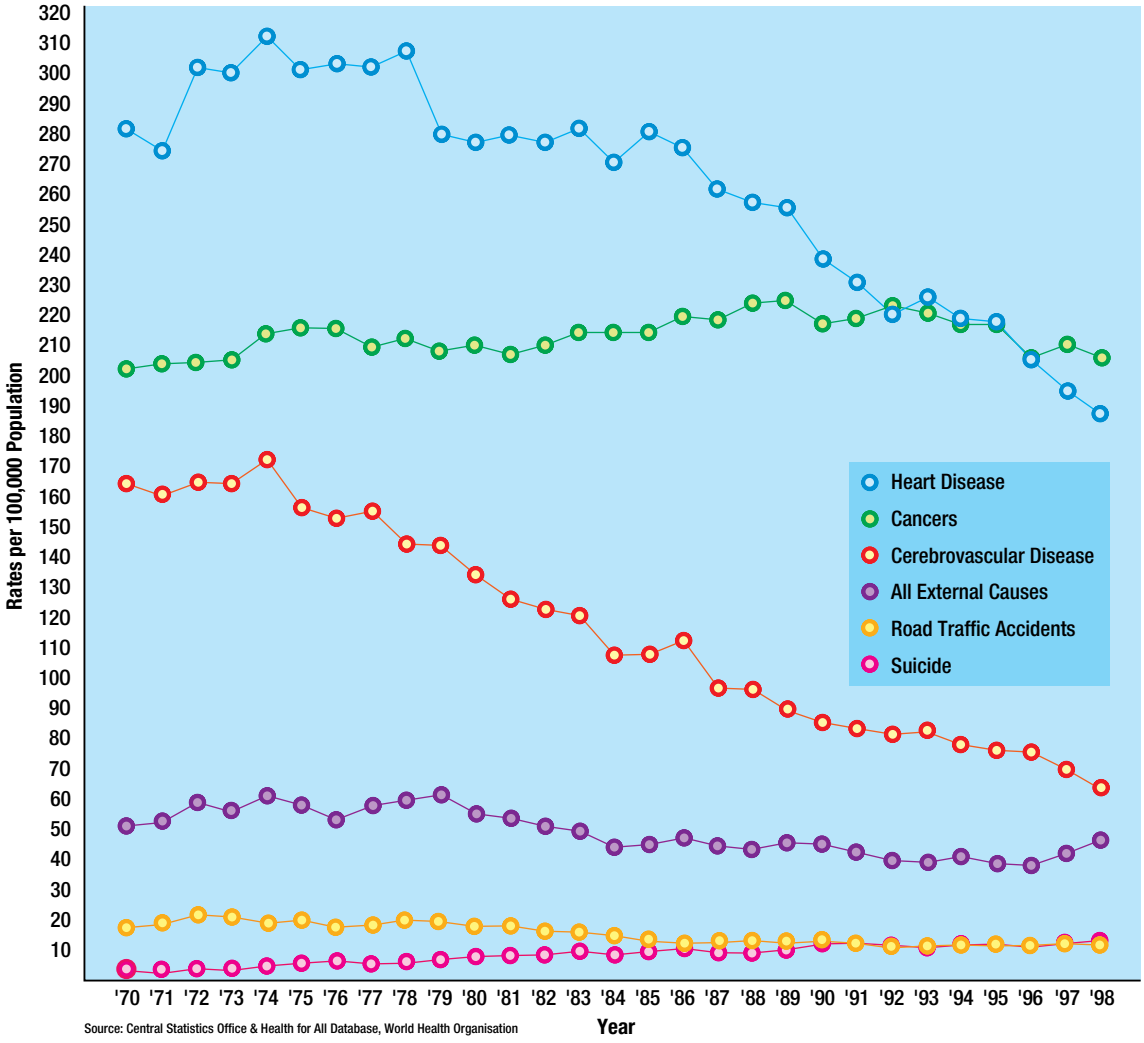
In 1999 the highest number of new HIV cases were reported since data collection began in 1985. The cases of AIDS have gradually increased since 1982, peaked in 1996 and have levelled out in recent years. When compared with the EU, Ireland has one of the lowest rates for AIDS[53].

4.2 MORTALITY

Consistent with morbidity data, the principal causes of death in Ireland continue to be cardiovascular disease, cancers and accidents.

Age-standardised mortality rates (SMR) are presented as a rate per 100,000 per year and take into account varying age distribution between populations. SMR for the principal causes of death are presented in figure 6A for all ages.

Figure 6A: Age-Standardised mortality rates for principal causes of death (all ages)



Source: Central Statistics Office & Health for All Database, World Health Organisation

4.2.1 CARDIOVASCULAR DISEASE

There has been a long term significant decline in the rates of mortality from heart disease, strokes and other circulatory diseases (figure 6A).

4.2.2 CANCERS

Mortality from cancers has remained relatively stable since the early 70's (figure 6A). There is however, evidence of a gradual reduction since 1990.

4.2.3 ALL EXTERNAL CAUSES

Standardised mortality rates for accidents excluding road traffic accidents (e.g. poisoning, violence and suicide) show a gradual decline in trend since 1979 (figure 6B).

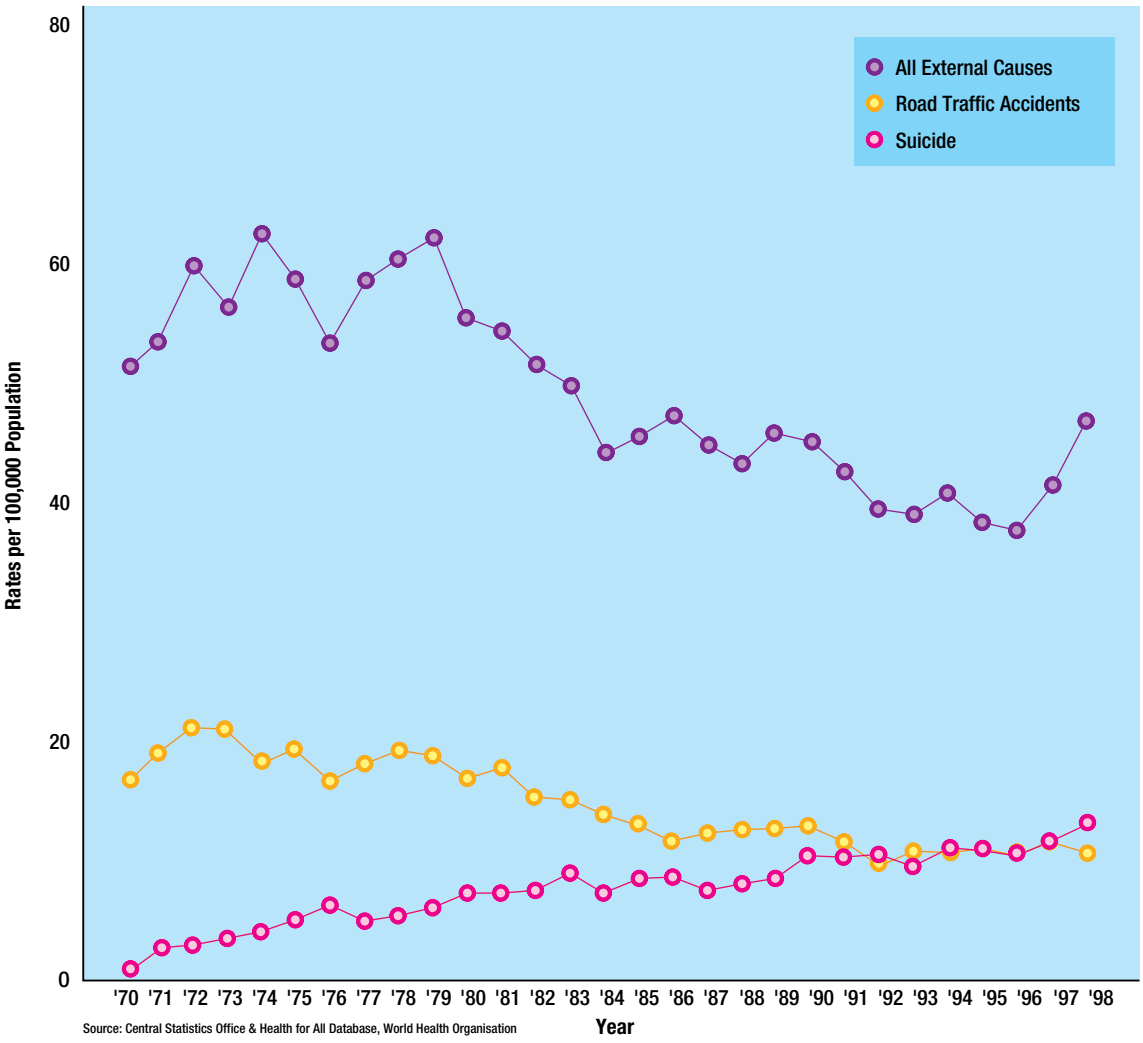
4.2.4 ROAD TRAFFIC ACCIDENTS

Standardised mortality rates for road traffic accidents show a decline from 1972 to 1992 but then plateau from 1992 to 1998 (figure 6B).

4.2.5 SUICIDE RATES

Suicide rates in contrast to road traffic accidents show a significant increase since the 1970's (figure 6B)

Figure 6B: Age-Standardised mortality rates for all external causes, suicides and road traffic accidents (all ages)



Source: Central Statistics Office & Health for All Database, World Health Organisation

4.2.6 AIDS

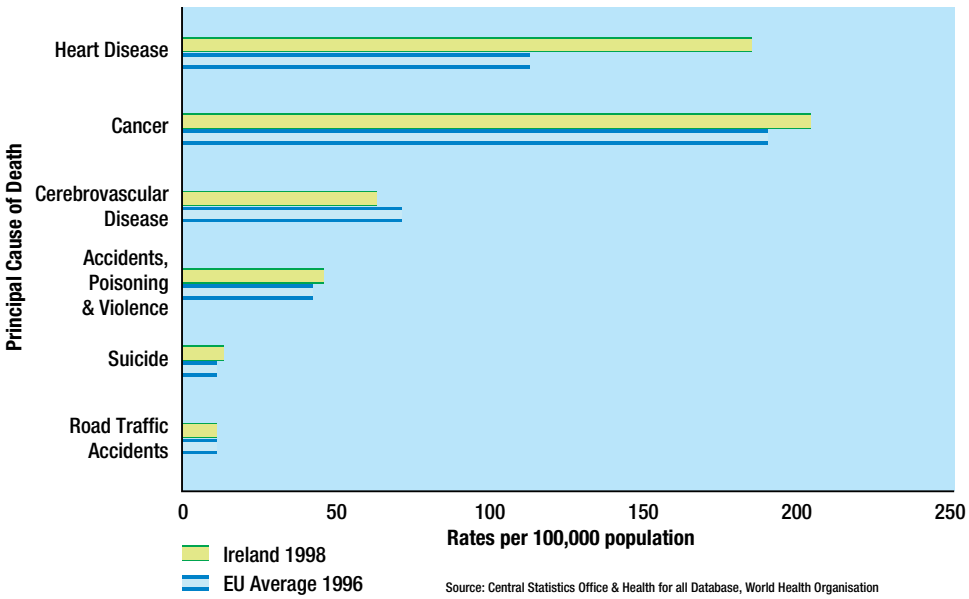
Standardised mortality rates for AIDS are not available but statistics collated by the Department of Health and Children provide cumulative data. Since 1982, 349 deaths have been registered. The highest number of deaths from AIDS was 46 in 1995 and appears to be declining with 7, 21 and 17 in 1997, 1998 and 1999 respectively[53].

4.2.7 EU COMPARISON

Ireland's all-age standardised mortality rates for heart disease and cancers are higher than the EU average (figure 7).

Ireland has a high rate of premature mortality (deaths before the age of 65 years) for cardiovascular disease, cancers and accidents[56]. When compared with the EU Ireland has a greater premature mortality rate for cardiovascular disease[56].

Figure 7: Age-Standardised mortality rates by principal causes for EU countries (All ages)



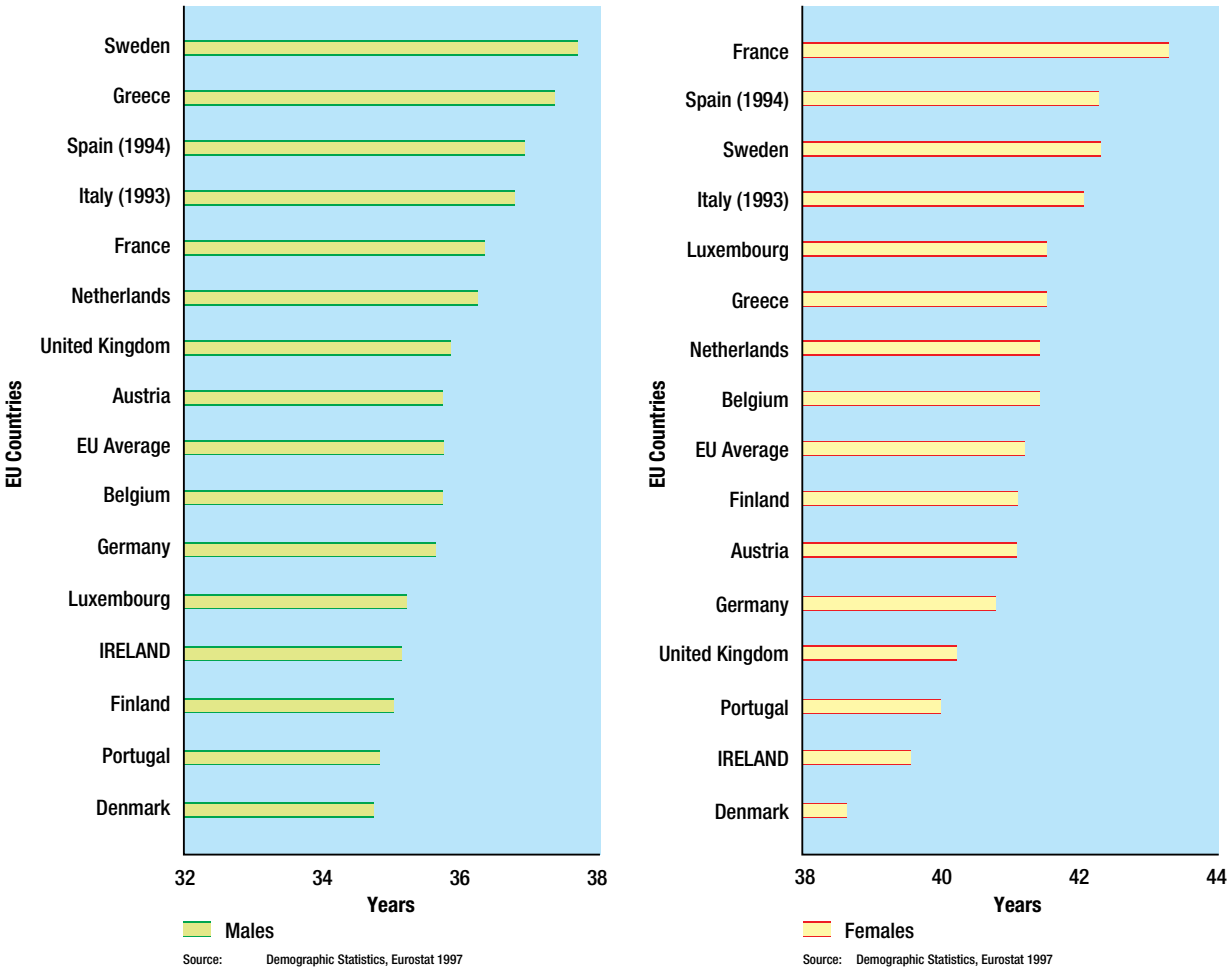
Source: Central Statistics Office & Health for all Database, World Health Organisation

4.3 LIFE EXPECTANCY

In the last 50 years life expectancy has increased by 8.5 years for Irish men and 11.5 years for Irish women. Currently life expectancy for males at birth is 73.0 years and for females 78.6 years[56].

When compared with other EU countries, life expectancy at age 40 is fourth lowest for Irish males and second lowest for females (figure 8). In 1995, Ireland had the lowest life expectancy of all 15 EU countries at age 65 years for both men and women[56].

Figure 8: Life expectancy at age 40 (1995)



Source: Demographic Statistics, Eurostat 1997

Source: Demographic Statistics, Eurostat 1997

4.4 SUMMARY

Life expectancy for both Irish males and females has improved in recent years partly due to better health and social provision for infants and children. However many health indicators still compare poorly with other EU countries. Principal causes of death have also changed as in many other European countries from infection and senility to heart disease and cancers.

CHAPTER 5

Strategic direction

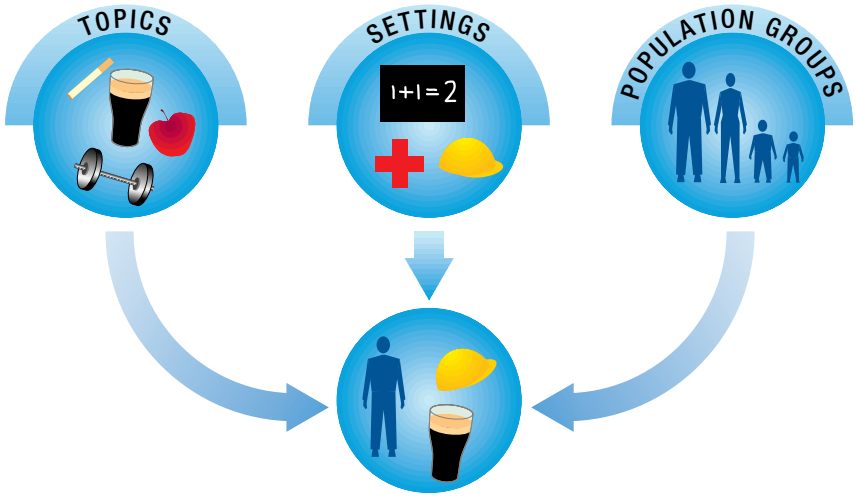
5.1 STRATEGIC AIMS AND OBJECTIVES

In recent years health education as a strategy for achieving health has been integrated into the broader concept of health promotion. Health education is about generating informed choices whereas health promotion is about making the healthier choice the easier choice or the *process of enabling people to increase control over and to improve their health*[2].

Health promotion initiatives may and usually do include health information and education, but also include addressing policy, facilities and environments in which health-related choices are made.

Health promotion is generally carried out within the strategic framework of three approaches: **population groups, topics** and **settings** which are inter-linked and should be considered as a whole entity, each being of equal importance as presented in diagram 3. Health promotion in Ireland will continue to concentrate on utilising all three approaches.

Diagram 3: An example of how the three approaches are inter-linked



Within this framework there are many different ways of planning, implementing and evaluating health promotion initiatives. Choosing the right approach, is influenced by the issue, its determinants, opportunities for action, availability of evidence based-best practice and resources.

The strategic aims and objectives for this health promotion strategy have been guided by the five principles set out in the *Ottawa Charter* and support the comprehensive range of existing policies and reports. While every effort has been made to ensure that the objectives are **specific, measurable, achievable, realistic** and **timebound (SMART)** the implementation of the strategy will depend upon a multiplicity of factors such as resource allocation, policy priorities and changes in the patterns of ill-health in the population.

Over the strategy's five-year implementation period there needs to be a process of accountability, monitoring, research and evaluation both at a national and regional level. Each of these aspects must be built in to all health promotion initiatives from their inception.

5.2 POPULATION GROUPS

A population group approach may be adopted for planning health promotion initiatives due to specific health issues or problems relevant to certain groups. The population approach means combining the principle of developing personal skills within a supportive environment and quite often involves strengthening community action. The following population groups will be addressed:

- Children
- Young people
- Women
- Men
- Older people
- Other groups within the population.

5.2.1 CHILDREN

From a young age, habits of a lifetime are established and insofar as health in later life is concerned children are an important group to target with health promoting messages. Over the past five years health promotion has played an important role in promoting better health for children through collaboration with schools, parents and the health services.

Health behaviour data for Irish children reveals the need to focus attention on lower socio-economic groups, while also highlighting the need for more concentrated efforts to improve the dietary habits of many children[23]. Levels of smoking and other forms of lifestyle behaviours indicate the need for a comprehensive focused approach to health education and health promotion at the earliest possible stage of a child's development.

Strategic aim: to support the development of partnerships with families and relevant bodies to promote a holistic approach to the physical and mental well-being of children.

Objectives:

- To **facilitate** the development and implementation of health education and health promotion programmes with particular emphasis on school-based programmes.
- To **develop** programmes which address the needs of children at risk.
- To **work in partnership** to develop guidelines for models of best practice in parenting programmes which address health in a holistic way.
- To **support** the implementation of the recommendations in *Best Health for Children*[57], *Building Healthier Hearts*[17] and the forthcoming National Children's Strategy[58].

5.2.2 YOUNG PEOPLE

As Ireland enters the new millennium it boasts one of the highest proportion of young people per capita in Europe. Young people as defined by WHO[16] are those between the ages of 10 to 24 years. The largest proportion of our population is in the 15-19 year old age group and approximately half of the population is under 30 years of age[26].

Generally this group enjoys good health and this is likely to continue into the future[59]. However, there are a number of health behaviours and lifestyle patterns emerging that are a potential threat to the health of this group. The data from HBSC revealed a high prevalence of smoking and low levels of physical activity amongst young girls. The increase in young male suicide is also a major cause for concern[60].

Health promotion for young people must be carried out in the context of wider influences and the role of the media, technology and global communication need to be taken into account when planning interventions.

Strategic aim: to maintain health and support the development of healthy lifestyle choices for young people.

Objectives:

- To **strengthen** regional structures that address the health promotion needs of young people.
- To **consult** young people in the planning, implementation and evaluation of interventions focussed at young people.
- To **work in partnership** to implement the recommendations in *Youth as a Resource - Promoting the health of young people at risk*[16].
- To **initiate** research into models of good practice in youth health promotion, including the role of parenting programmes in supporting youth specific interventions.
- To **develop** national health promotion initiatives specifically focussed at young people.
- To **support** the implementation of the recommendations in *Building Healthier Hearts*[17], the *Report of the National Task Force on Suicide*[22] and other relevant reports aimed at promoting the health of young people.

5.2.3 WOMEN

Even though women generally live longer than men do, they suffer more illnesses and when compared to their EU counterparts, their life expectancy is amongst the lowest[56]. To address women's health in Ireland, several policies and reports have been developed and implemented by statutory and non-statutory organisations.

Heart health and related interventions have traditionally focused on men, but it is now apparent that women are also at risk[23]. Of particular concern is the high prevalence of smoking (40%) amongst young women aged 18 to 34 years and the decline in levels of physical activity as women get older.

Other areas of concern for women are related to maternal health and infant feeding. In relation to the prevention of neural tube defects, currently only 23% of women have ever been advised to take folic acid supplements. This reported value is low and reveals a social gradient. The percentage of mothers who reported to have breast fed their last child was only 29%[51].

In terms of mental health, depressive disorders accounted for 38% of female admissions to psychiatric hospitals[35].

Strategic aim: to promote women's physical and mental well-being through the continued development and implementation of relevant policies.

Objectives:

- To **appoint** a National Breastfeeding Co-ordinator to review the *National Breast-feeding Policy*[61].
- To **support** the Baby Friendly Hospital Initiative within the Health Promoting Hospitals Network.
- To **facilitate** the implementation of the *Recommendations for a national infant feeding policy*[62].
- To **promote** the role of folic acid supplementation and food fortification in the prevention of neural tube defects[63].
- To **work in partnership** with the Women's Health Council in reviewing the implementation of the *Plan for Women's Health*[20].
- To **initiate** research in the area of women's health.
- To **promote** positive mental health especially at vulnerable times in women's lives.
- To **develop** women friendly approaches in partnership with community and voluntary organisations designed to enable more active participation of women in their health.
- To **support** the implementation of the recommendations in *Building Healthier Hearts*[17] and the policy *Towards a Tobacco Free Society*[46] that relate to women.

5.2.4 MEN

The first dedicated conference on Men's Health in Ireland was held in 1998 in the north west and reflected the change in men's attitude towards their health. The conference report highlighted possible actions and revealed that men's health is also an area of growing awareness, interest and concern for health professionals[64]. Two years later the first regional men's health strategy *Us Men Our Health*[65] was published and focuses on eight recommendations to improve the physical and mental well-being of men living in the west of Ireland.

There are several lifestyle behaviours that are of concern to the overall well-being of men. Men experience greater non-fatal, but limiting accidents during sporting activities and in the workplace; wearing seatbelts is not a top priority; more males drink than females and being overweight and obese are serious health problems for males particularly in the 35-54 year age group[23].

In relation to mental health and male admissions to psychiatric hospitals, depressive disorders accounted for 22% and alcoholic disorders accounted for 27% of all admissions[35]. The most disturbing trend has been the increase in the number of young males committing suicide[60]. There has also been an increase in the number of young males involved with drug offences[66].

There is a need for two strands of work in the area on men's health. Firstly the development of a national plan for men's health and secondly to raise awareness, develop skills and experience in all the mainstream areas of health promotion work.

Strategic aim: to develop a plan for men's health.

Objectives:

- To **initiate** research in the area of men's health.
- To **work in partnership** to inform the development of a plan for men's health.
- To **facilitate** the development and implementation of current health promotion initiatives aimed at men.
- To **identify** and develop models of working with men to promote their physical and mental well-being.
- To **support** the implementation of the recommendations in the *Report of the National Task Force on Suicide*[22], *Building Healthier Hearts*[17] and the policy *Towards a Tobacco Free Society*[46] that relate to men.

5.2.5 OLDER PEOPLE

With the onset of middle age, Irish life expectancy figures begin to slip down the EU rankings and by the age of 65 years, life expectancy for both men and women is the lowest in the EU[56]. Generally though we are living longer and it is projected that there will be a notable increase in the number of people over the age of 65 years by the year 2011[21]. This is expected to pose a significant challenge to our health and social services[34].

SLÁN data for respondents aged 65 years and over revealed that 38% perceived their general health to be fair or poor. In relation to extreme/moderate problems experienced by older people, pain/discomfort and anxiety/depression rated highly[51]. A cause for concern is that 36% of older people surveyed reported taking no exercise and for those 75 years plus this rose to 51%.

Twenty one percent of the 65 to 75 year age group were current smokers with only 14% in the over 75s.

The challenge for health promotion is to improve longevity so that we live as long as our European counterparts. This can be achieved by promoting lifestyle changes, creating supportive environments and providing appropriate services for older people.

Strategic aim: to enhance the quality of life and improve longevity for older people.

Objectives:

- To **consult** older people in the planning and implementation of health promotion programmes which promote positive mental health.
- To **work in partnership** to implement community-based programmes such as *Being Well*[67] and *Go for Life*[68].
- To **support** the implementation of the *Recommendations for a food and nutrition policy for older people*[69] and the recommendations in *Building Healthier Hearts*[17].
- To **complete** the implementation of the health promotion strategy for older people *Adding life to years and years to life*[21].

5.2.6 OTHER GROUPS WITHIN THE POPULATION

It is recognised that within society there exist many other population groups with different requirements, which need to be identified and accommodated when planning and implementing health promotion interventions.

The Traveller Community still remains the largest indigenous ethnic minority group in Ireland. When compared to the settled community the Travellers have a lower life expectancy and poorer health status[70]. In relation to mental health 46% of Traveller women reported high levels of psychological distress, Also 51% of the women reported being smokers[71]. These findings were related to substandard living conditions, low levels of social support and not engaging in "good" health behaviours.

People with an intellectual, physical or sensory disability also need to maintain a healthy lifestyle within a supportive environment. Consultation with appropriate organisations, individuals, carers and service providers is necessary to adapt current health promotion programmes to meet their needs.

Considerable progress has been made in the area of health promotion interventions with the emphasis on the creation of supportive environments and the strengthening of community action with a focus on the gay and lesbian community. These partnerships must be maintained and consolidated to achieve a holistic approach to health that addresses lifeskills, self-esteem and positive mental health.

A cause for concern is the increasing number of people who are becoming homeless in Ireland[72]. The homeless population are primarily from disadvantaged lower socio-economic groups and there are increasing numbers of younger people, women and children[73]. Additionally, the number of refugees and asylum seekers entering Ireland is also increasing and this poses a challenge in terms of providing health promotion programmes that are culturally suitable and appropriate to the potential differences in patterns of poor health.

Strategic aim: to promote the physical, mental and social well-being of individuals from other groups within the population.

Objectives:

- To **initiate** research into the health and lifestyle behaviour of other groups within the population to prioritise health promotion programmes.
- To **work in partnership** with other groups within the population to develop and adapt health promotion programmes to meet their individual needs.
- To **support** the implementation of the recommendations in the forthcoming Policy on Traveller Health[74], *Needs and Abilities: A Policy for the Intellectually Disabled*[75], *Towards an Independent Future*[76] and the *HIV Prevention Strategies and the Gay Community*[77].

5.3 SETTINGS

In the settings approach efforts are concentrated on working to make the setting itself a healthier place for people to live, work and play. Schools, hospitals and workplaces are examples where many actions have been initiated, but others include colleges, villages and cities, housing estates and shopping centres.

The settings approach means combining healthy policies, in a healthy environment with complementary education programmes and initiatives. For example, a settings approach to health promotion on a housing estate could mean consulting residents regarding their needs, building children's play areas, having access to public transport, providing comfortable places to meet friends and the availability of parenting programmes.

The following settings have been identified:

- Schools and colleges
- Youth Sector
- Community
- Workplace
- Health Services.

5.3.1 SCHOOLS AND COLLEGES

A health promoting school can be characterised as a school constantly strengthening its capacity as a healthy setting for living, learning and working[78].

Within the Irish schools setting, health education has been a feature for many years. Through the medium of Life Skills and Social, Personal and Health Education (SPHE) many health boards have supported the provision of programmes in schools through teacher training and programme development.

Evaluation of several of these programmes to date has shown that effective knowledge gains can be achieved, that skills can be developed and curriculum development can be supported[79,80,81].

More recently the provision of the Substance Abuse Prevention Programme (SAPP) in partnership with the Department of Education and Science has extended the availability of health education and created a more uniform provision nation-wide. Developments in the field of health education have been complemented by the work of the Irish Network of Health Promoting Schools.

Given that Ireland has one of the largest numbers of young people attending third level education in the European Union, the college is an important setting for health promotion. From the SLÁN data those in the 18-34 year old age group, perceived their health as good, very good or excellent. Specific findings related to lifestyle practices provide some positive outcomes but there are practices that are a cause for concern such as drinking behaviour.

Strategic aim: to facilitate the implementation of Health Education and Health Promotion Programmes within the school and college setting.

Objectives:

- To **work in partnership** with the Department of Education and Science to support the implementation of SPHE in all schools consistent with the Health Promoting School concept.
- To **work in partnership** with relevant bodies to implement the recommendations in *Youth as a Resource: promoting the health of young people at risk*[16] aimed at reducing the number of young people who leave school early.
- To **review** the implementation of the *National Schools Lunch Policy*[82] and *Nutrition Education at Primary Schools*[83].
- To **participate** in the a review of the school meals scheme.
- To **facilitate** the development and implementation of a Health Promoting College Network.

5.3.2 YOUTH SECTOR

Within the youth sector, health education has been an important feature for several years. Many programmes have been developed which focus on alcohol and drug education and the development of personal skills. The youth sector represents a forum through which young people, especially those, who leave school early, can be offered a range of opportunities to develop their personal skills and enhance their confidence.

Over the past five years, the role of health promotion within the youth sector has expanded and developed. This has happened most noticeably through the National Youth Health Programme in partnership with the Department's Health Promotion Unit, The Department of Education and Science (Youth Affairs Section) and the National Youth Council of Ireland (the representing body for the majority of youth groups and organisations in this country). The programme has taken responsibility for the provision of Health Promotion training for groups and youth workers on an outreach basis nation-wide using both a settings and topic approach.

Strategic aim: to continue to develop and promote the role of health promotion within the youth sector.

Objectives:

- To **initiate** research into the role of peer education as a health education/health promotion methodology within the youth sector.
- To **work in partnership** to support the ongoing development and implementation of health promotion training programmes.
- To **facilitate** youth organisations and relevant bodies to address the health needs of young people identified as being "at risk".

5.3.3 COMMUNITY

The WHO initiative *Healthy Cities*[5] aims to enhance the health of a city (community, town or village), its environment and its people by a partnership of local government, statutory and voluntary sectors with the active involvement of citizens in decisions affecting their health. Additionally, the community as a setting has the potential to reach individuals or population groups that are not associated with the other settings such as older people and the Traveller Community. To facilitate interventions based in the community it is important to have a profile and understanding of the community, its history, environment, residents and various organisations.

The community development model or the process of empowering and "strengthening community action" is important so that people can gain greater control over their lives, have greater access to information, develop supportive relationships and skills in decision making and the ability to access resources. The challenge for health promotion is to work with communities and not for communities.

Strategic aim: to support the development and implementation of community-based approaches.

Objectives:

- To **appoint** a National Community Co-ordinator to support the development and implementation of community-based health promotion initiatives.
- To **work in partnership** with relevant bodies to develop a healthy village/town model.
- To **adapt** and **develop** community-based programmes to meet the needs of groups within the population.
- To **evaluate** community-based programmes to determine their effectiveness.
- To **identify** and **report** on evidence based community approaches including partnership models.
- To **establish** pilot projects with a view to identifying models of good practice that provide a holistic approach to health within disadvantaged areas (similar to the Drugs Task Force Areas[7] approach).

5.3.4 WORKPLACE

Shaping a Healthier Future[13] and *...making the healthier choice the easier choice*[14] both called for a re-orientation of services and recognised the need to develop a strategy for workplace health promotion. A sub-committee of the National Consultative Committee for Health Promotion was established to examine health promotion issues within the workplace setting. This resulted in the policy, *healthy bodies-healthy work*[15] in 1998, and confirmed that the level of health promotion activities amongst medium to large companies was low and that further research with small to medium sized enterprises was needed.

Healthy bodies-healthy work identified the Department of Health and Children as having a prominent role in formulating policy, liaising with health boards and facilitating the dissemination of information on workplace health promotion. Other key partners identified were the health boards, the Health and Safety Authority, trade unions and employer organisations, occupational health specialists and voluntary organisations.

It is recognised that many employers have successfully implemented health promotion policies and programmes and continue to do so. One of the most significant developments in this area is the implementation of smoking control arrangements within the workplace environment.

An area of concern within the workplace is the risk of accidents and injuries which are largely preventable. This is most notable amongst middle-aged men (35-55 years) where according to SLÁN the workplace is the main site for non-fatal but limiting injuries.

Strategic aim: to work in partnership with relevant bodies to develop health promotion workplace programmes.

Objectives:

- To **appoint** a National Workplace Health Co-ordinator to support the implementation of the Workplace Health Promotion policy *healthy bodies-healthy work.*
- To **work in partnership** to support the implementation and evaluation of current workplace health promotion programmes.
- To **identify** the specific needs of small to medium sized enterprises in relation to workplace health promotion policy.
- To **support** the implementation of the recommendations in *Building Healthier Hearts.*[17]

5.3.5 HEALTH SERVICE

As one of the largest employers with over 60,000 staff the health service is ideally placed to promote health in partnership with other sectors of the community. The challenge in this setting is to find a balance between health promotion, disease prevention and illness treatment. The Health Promoting Hospitals concept and network is striving to find this balance and is a model that can be adapted for other areas of the health service[6].

An area of the health service that is receiving greater attention is the primary health care sector. This is because generally the first point of contact for the public is with pharmacists, general practitioners, public health nurses and allied health professionals. Collectively, these health professionals are ideally placed to provide a supportive environment that promotes health and to undertake brief interventions with clients. A primary health care philosophy that involves the consumer should permeate the entire health service starting with primary medical care.

Strategic aim: to encourage the health service to become a health-promoting environment.

Objectives:

- To **increase** the number of health service employees who are trained in health promotion skills.
- To **work in partnership** to strengthen and expand the Health Promoting Hospitals Network.
- To **facilitate** the involvement of the consumer in the provision of health promotion initiatives within the health service.
- To **support** the implementation of the recommendations in the workplace health promotion policy *healthy bodies-healthy work*[15] *and Building Healthier Hearts*[17].

5.4 TOPICS

A topic approach is one where health promotion activities are centred on a particular issue, such as drugs, mental health, nutrition or smoking. This approach may suit certain organisations whose main remit is a particular topic or it can provide a focus that can be easily identified and understood.

The topic approach can be guided by all the principles of the *Ottawa Charter* and while there are many topics that health promotion could address the following have been identified:

- Positive mental health
- Being smoke free
- Eating well
- Good oral health
- Sensible drinking
- Avoiding drug misuse
- Being more active
- Safety and injury prevention
- Sexual health

5.4.1 POSITIVE MENTAL HEALTH

Mental health is equally important as physical health to the overall well-being of a person. Poor mental health has a significant impact on a person's quality of life and their contribution to society.

In terms of lifestyle practices SLÁN provides data related to perceived requirements for better health. The majority of respondents from both genders ranked "less stress" as the top requirement for better health, followed by more will power, a change in weight, more money and less time in smoky places.

The magnitude of depression, one of the most common mental illnesses, is becoming more evident with research. The commonly accepted figure for the prevalence of depression amongst the general population was 1 in 20 people but recent data revealed it to be as high as 1 in 14 amongst those in the workforce[84].

Since 1986 there has been a 30% increase in the number of psychiatric outpatient attendance[56]. In 1998, depressive disorders accounted for 38% of female admissions and 22% of male admissions to psychiatric hospitals[35].

A cause for concern is the dramatic increase in the suicide rate especially amongst young men[60].

Strategic aim: to promote positive mental health and to contribute to a reduction in the percentage of the population experiencing poor mental health.

Objectives:

- To **initiate** research into models of best practice in mental health promotion.
- To **initiate** research into the development of a national positive mental health strategy.
- To **work in partnership** to support the implementation of the recommendations of the *Report of the National Task Force on Suicide*[22].

5.4.2 BEING SMOKE FREE

Smoking is a known risk factor for heart disease, stroke and cancer. In Ireland, it has been estimated that death from smoking (as a percentage of total deaths) is 21% in comparison to only 8% in Sweden[85].

Twenty one percent (21%) of the 9-17 age group are current smokers. Fifty one percent (51%) of boys and 48% of girls had ever smoked a cigarette. It is apparent that boys start smoking earlier than girls but by the age of 15-17 years, there are more girls smoking than boys. Girls aged 15-17 years from social classes 5 & 6 have a current smoking prevalence rate of 40%[23].

Just over 3 in 10 adults are regular or occasional cigarette smokers with slightly more males than females smoking. However, prevalence of smoking is highest (40%) among females aged 18-34 years. Both genders in social classes 5 & 6 have more smokers per age group[23].

Males and females 55 years and over are near the national smoking target of 20% prevalence.

Strategic aim: to increase the percentage of the population who remain non-smokers with a particular emphasis on narrowing the gap across social classes and to protect non-smokers from passive smoke.

Objectives:

- To **increase** the percentage of children and young people who remain non-smokers (especially young girls).
- To **work in partnership** to develop, implement and evaluate models of best practice in smoking cessation for lower socio-economic groups.
- To **support** the implementation of the recommendations in *Towards a Tobacco Free Society*[46], *Building Healthier Hearts*[17] and *Cancer Services in Ireland: A National Strategy*[86].

5.4.3 EATING WELL

Nutrition from preconception to older age plays a vital role in growth, repair and maintenance of healthy bodies and in achieving and maintaining good oral health. The quality and quantity of food intake is a contributory factor in the two main causes of morbidity and mortality namely, cardiovascular disease and cancer.

Nutrition health promotion interventions have been ongoing since 1991[87] and a key component of this has been the establishment of Community Nutrition Services at a regional level. The National Nutrition Surveillance Centre reviewed the framework for action in nutrition health promotion in 1997[88] and since then action has been focussed more on the needs of socially disadvantaged groups.

When considering the eating habits of Irish children, they consume one of the highest levels of fruit and vegetables in comparison to their EU counterparts, but they have one of the highest consumption rates for confectionery and soft drinks[23].

Approximately 41% of adults surveyed reported eating the recommended number of servings from the bread, cereal and potato shelf of the food pyramid. In relation to other shelves, 64% were consuming the recommended servings for fruit and vegetables, 23% dairy foods and 39% meat, fish and poultry foods. For these food groups there were also reported over and under-consumption of servings. A strong social gradient was observed in the number of foods consumed from the top shelf of the food pyramid, which are higher in fat, sugar and salt[50].

In relation to body weight, self reported heights and weights classified 32% of the adult respondents as overweight and 10% as obese. The issue of body image is important even with school-going children. As children grow older, there is a greater percentage on weight reducing diets[23].

Strategic aim: to increase the percentage of the population who consume the recommended daily servings of food and maintain a healthy weight.

Objectives:

- To **promote** healthy eating habits and healthy body image amongst school-going children and young people.
- To **facilitate** the development and implementation of a national healthy weight strategy.
- To **work in partnership** with lower socio-economic groups to develop and adapt eating well programmes.
- To **support** the implementation of the *Recommendations for a National Food and Nutrition Policy*[18], the *Recommendations for a National Food and Nutrition Policy for Older People*[69], the recommendations that focus on nutrition and eating well in *Building Healthier Hearts*[17] and *Cancer Services in Ireland: A National Strategy*[86].

5.4.4 GOOD ORAL HEALTH

Oral health is achieved when the teeth and the oral environment are not only healthy but also comfortable and functional and there is an absence of sources of infection which may affect general health. This state of oral health should persist for life, which given a healthy lifestyle, is achievable for the majority of the population.

The two main oral diseases are dental caries or dental decay and periodontal or gum disease. However, other significant conditions affecting the oral tissues are oral cancer and dentofacial trauma.

There are a number of risk factors, which are associated with both general health and oral health. Tobacco, diet and alcohol are risk factors that are common to oral diseases as well as cardiovascular disease and cancers including oral cancer. Accidents, injuries and stress also affect oral health as well as general health.

The oral health of Irish people has improved over the last 40 years. The main reasons for this improvement are water fluoridation and the widespread availability of fluoride toothpaste. Medical card-holders have the greatest need for dental treatment and are more likely to have no natural teeth[89].

The results of the HBSC survey shows that the level of risk for dental decay is still high[24]. Ireland amongst 28 countries internationally, has a very high reported consumption of sweets, confectionery and soft drinks while at the same time having less than adequate oral hygiene practices.

Strategic aim: to improve the level of oral health in the general population with a particular emphasis on people with special needs.

Objectives:

- To **promote** the use of fluoride toothpaste amongst lower socio-economic groups and people living in non-fluoridated areas.
- To **educate** parents and carers of the need to supervise oral hygiene practices of children under seven years and to ensure the appropriate use of only a small pea size amount of fluoride toothpaste.
- To **prioritise** oral health promotion initiatives for special needs groups, for example, people with disabilities, socially deprived groups, the Traveller Community and refugees.
- To **work in partnership** to develop and implement health promotion programmes that promote oral health.
- To **support** the implementations of the recommendations in the report *Oral Health in Ireland*[90], *Building Healthier Hearts*[17], *Towards a Tobacco Free Society*[46], the *Cancer Services in Ireland: A National Strategy*[86], the *National Alcohol Policy*[19] and the *Government Strategy for Road Safety 1998-2002*[91] that promote and protect oral health.

5.4.5 SENSIBLE DRINKING

Alcohol by its nature is an important public health issue. Although alcohol is used and enjoyed by many people, it is also a psychoactive drug and for some it is an addictive substance. Inappropriate drinking can result in immense suffering, which impacts on the health and welfare of the whole community. High risk drinking, that is excessive drinking on any one occasion, is strongly associated with acute alcohol-related problems such as accidents, violence, injuries and deaths.

In many cases, these acute alcohol-related problems occur among moderate drinkers who drink immoderate quantities on some occasions. Regular heavy drinking is also strongly linked to a variety of alcohol-related problems such as accidents, violence, family problems, risk of liver cirrhosis, cancers and other health problems. Overall, according to SLÁN on a typical drinking occasion, approximately one third of adults drink to excess. In the 18-34 age group, for both males and females, over half drink to excess[23].

HBSC data revealed that 29% of the children surveyed had a drink in the last month but this ranged from 15% for boys aged 9-11 years to 61% for boys aged 15-17 years and from 2% for girls aged 9-11 years to 52% for girls aged 15-17 years. Generally girls are more likely to abstain from consuming alcohol. Older girls (15-17 years) from social classes 5 & 6 are more likely to have had a drink than girls from social classes 1 & 2. Twenty nine percent (29%) of children report having been drunk ever and 20% of 15-17 year olds reported having been drunk more than ten times[51].

It is conservatively estimated that alcohol is associated with at least 25% of road accidents and 33% of all fatal accidents[66]. In relation to mental health, alcoholic disorders accounted for 11% of female admissions and 29% of male admissions to psychiatric services[35].

Strategic aim: to promote moderation in alcohol consumption for those who wish to drink and to reduce the level of alcohol-related problems.

Objectives:

- To **promote** moderation in alcohol consumption with the message that less is better.
- To **delay** the onset of alcohol consumption among children and adolescents, especially those in the under 15 year age group.
- To **contribute** to a decrease in the number of young people and adults who drink to excess on any one occasion.
- To **continue** to support the National Alcohol Surveillance Project in monitoring alcohol-related problems.
- To **continue** to support research into the impact of alcohol promotion on young people and to investigate the economic cost of alcohol related harm.
- To **work in partnership** with health boards and local communities to bring about positive change in attitudes and to provide a supportive environment.
- To **support** the National Alcohol Co-ordinator in the review of the *National Alcohol Policy*[19].
- To **support** the implementation of the recommendations in *Building Healthier Hearts*[17] that relate to alcohol.

5.4.6 AVOIDING DRUG MISUSE

Drug misuse whether it is of legal or illegal substances has the capacity to cause harm, at a physical and psychological level, not only for the individual but also for their family and broader community.

Research reveals a worrying trend of an increasing number of young people using both legal and illegal substances at an ever-decreasing age[54]. The magnitude of the problem is also revealed by ever increasing numbers of drug seizures being reported by the criminal justice system[66].

In 1998, 58% of cases in drug treatment centres were under 25 years of age[54]. The mean age of clients admitted to treatment (24.3 years) is the lowest in the EU[55]. Intravenous drug users account for the largest number of cases of AIDS (40.5%)[53].

When the Irish adult population were asked about the use of cannabis and other illegal substances over the course of their lifetime, 93% reported never having used any type of illegal substance in their lifetime[51]. Males, under the age of 35 years, social class 3 & 4 and living in urban locations were most likely to have ever used drugs.

Strategic aim: to support models of best practice which promote the non-use of drugs and minimise the harm caused by them.

Objectives:

- To **ensure** that each health board has in place a comprehensive drugs education and prevention strategy.
- To **continue** to support the implementation and evaluation of existing drug related health promotion programmes such as *Drugs Questions - Local Answers* (DQLA), *Substance Abuse Prevention Programme* (SAPP) and *Family Communication and Self Esteem* (FCSE).
- To **work in partnership** with relevant bodies to co-ordinate approaches to drug prevention and education with a particular emphasis on the development and implementation of focussed interventions in areas where drug misuse is most prevalent.
- To **work in partnership** with the Department of Education and Science and relevant bodies to develop and implement drug education and prevention programmes for schools and the youth sector.
- To **support** the implementation of the recommendations in *Youth as a Resource: promoting the health of young people at risk*[16] and the *AIDS Strategy 2000 Report of the National AIDS Strategy Committee.*[92]
- To **support** the review of the *Report of the 2nd Ministerial Task Force on Measures to Reduce the Demand for Drugs*[7].

5.4.7 BEING MORE ACTIVE

The benefits of regular, moderate physical activity are numerous and include cardiovascular fitness, social interaction, stress-reduction, weight management and increased bone density.

It is encouraging that in HBSC the vast majority of children are involved in some exercise outside school, but it is evident that boys are engaged in exercise more than girls. Exercise participation decreases with increasing age and this is a trend most apparent amongst girls[23].

SLÁN data revealed that almost 1 in 5 adults are not exercising at all and this is more pronounced for older males and females from social classes 5 & 6. Overall 4 in 10 adults engage in some form of regular physical exercise on a weekly basis[23].

Strategic aim: to increase participation in regular, moderate physical activity.

Objectives:

- To **identify** models of good practice which encourage young people (especially young girls) and older people to participate in regular, moderate physical activity.
- To **work in partnetship** with relevant bodies to facilitate access and participation in regular, moderate physical activity.
- To **support** the implementation of the recommendations in *Promoting Physical Activity: A Strategy for Health Boards in Ireland*[93] and *Building Healthier Hearts.*[17]

5.4.8 SAFETY AND INJURY PREVENTION

Accidents are widespread and can have severe consequences for all ages. They range from non-fatal to fatal and the most common are road traffic accidents. Standardised mortality rates for road traffic accidents have declined since the 1970's and levelled off in recent years. In 1998 there were 429 road fatalities on the national roads and for 1999 this figure was reduced to 398[60]. In relation to the use of seat belts, 82% of drivers always or nearly always wore a seat belt, with more females than males in this category[23].

Accidents can arise due to drink driving. Twenty two percent (22%) of adults surveyed had driven after consuming 2 or more alcoholic drinks. More males (31%) than females (13%) reported this behaviour and of the males it was predominantly middle-aged men (35-54 years)[23].

When school-going children were asked about any injuries they had in the previous 12 months, 58% of boys and 39% of girls reported an injury. Boys reported sports injuries more frequently, which relates to greater participation in exercise out of school[23].

Thirty five percent (35%) of boys and 46% of girls reported that they always wore a seat belt when travelling by car. Only 8% of children reported that they always wore a helmet when cycling.

For younger males (18-34 years), sporting locations were the main site for injury and for middle aged males (35-54 years) the workplace was the main site. For females of all age groups the most common site for an injury was at home[23].

Strategic aim: to contribute to a reduction in the percentage of the population affected by fatal and non-fatal injuries.

Objectives:

- To **work in partnership** to promote safety and injury prevention (especially amongst children and older people) with a particular focus on fall prevention, accidents in the home and on the road and farm.
- To **support** the implementation of the recommendations in the *Government Strategy for Road Safety 1998-2002*[91] and *A National Alcohol Policy*[19].

5.4.9 SEXUAL HEALTH

Sexuality is an integral part of being human and healthy sexual relationships can contribute to an overall sense of well-being. However, unsafe sexual practice may lead to sexually transmitted infections (STI) and infection by the human immuno-deficiency virus (HIV).

Since 1989 the number of notified cases of STIs has increased threefold to over 7,436 cases in 1998[53]. The number of people who have tested positive for HIV has fluctuated since 1986 but the highest number was reported in 1999[53].

The cases of acquired immuno-deficiency syndrome (AIDS) have gradually increased from 2 in 1982 to 79 in 1996 but have levelled out in recent years[53]. When compared with the EU, Ireland has one of the lowest rates for AIDS[56]. There have been a total of 349 deaths from AIDS since 1982[53].

SLÁN data on sexual activity revealed that in the 18-34 year age group, 29% sometimes used contraception and of those adults who are sexually active, condom use accounts for 40% of contraceptive use. In relation to pregnancy and young mothers, in 1998 9% of registered births were from mothers 20 years of age and younger[60].

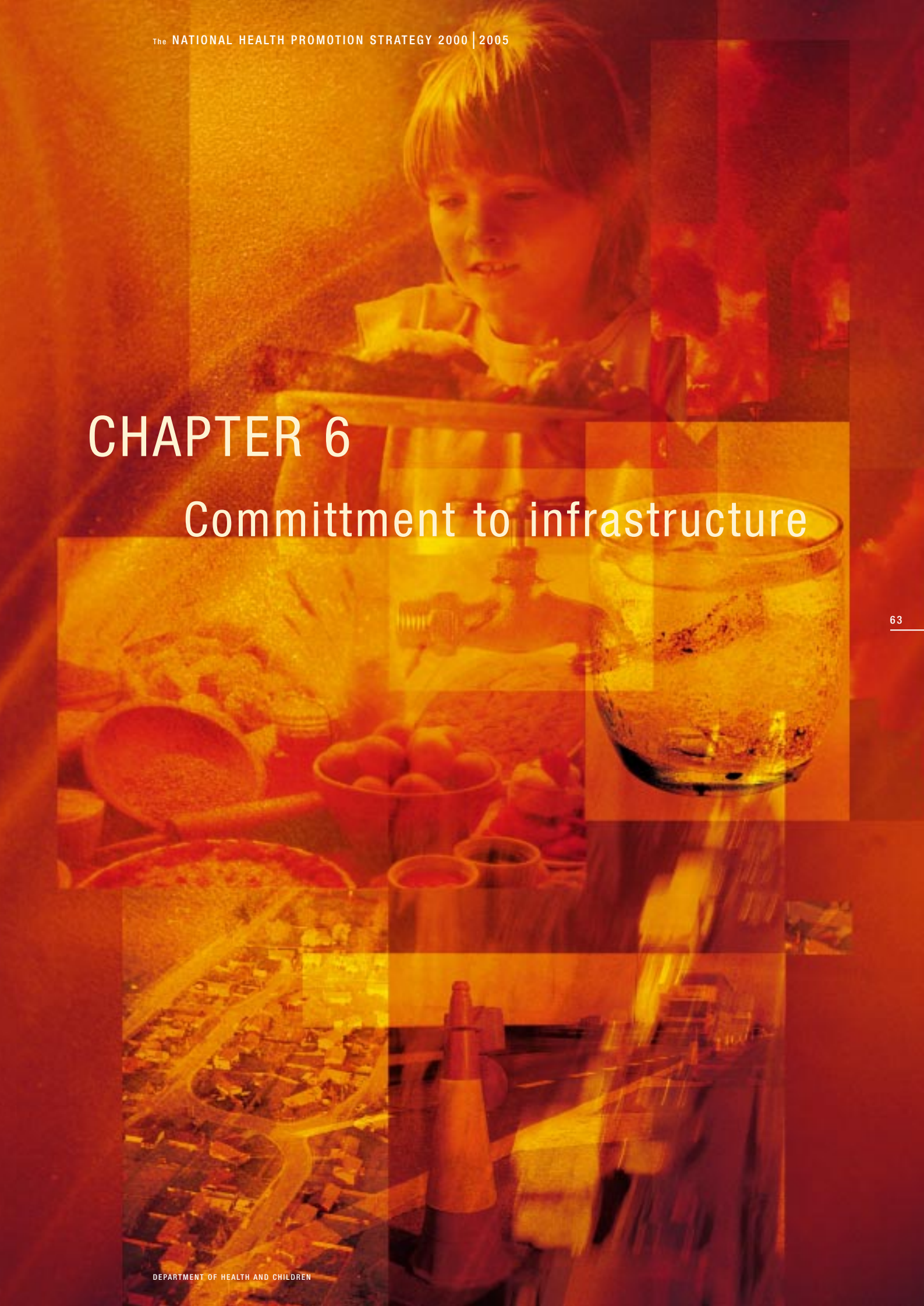
Strategic aim: to promote sexual health and safer sexual practices amongst the population.

Objectives:

- To **support** school based programmes designed to develop personal skills such as Relationships and Sexuality Education (RSE) and Social, Personal and Health Education (SPHE).
- To **work in partnership** to develop and implement health promotion initiatives which address the issues in relation to teenage pregnancies.
- To **contribute** to a reduction in the number of crisis pregnancies.
- To **work in partnership** to develop and implement strategies aimed at reducing the incidence of STIs.
- To **initiate** research into the need for a national sexual health strategy that would encompass the prevention of STIs and crisis pregnancies.
- To **support** the implementation of the recommendations from the Aids Strategy 2000 Report of the *National AIDS Strategy Committee*[92].

5.5 SUMMARY

Chapter 5 sets out the strategic direction and appropriate level within which action can be carried out to advance the aims and objectives. All three approaches to health promotion (population groups, settings and topics) have been considered as inter-linked and being of equal importance. There is an emphasis on working in partnership to support the implementation of the strategic aims and objectives and on the role that research and evaluation play in determining the effectiveness of health promotion initiatives. The challenge for health promotion is to bring about health and social gain in a comprehensive and equitable manner by responding to the evidence presented from social, economic and environmental factors, lifestyle behaviour and illness patterns. This can only be achieved via an inter-sectoral and multi-disciplinary approach.



CHAPTER 6

Committment to infrastructure

6.1 EFFECTIVE IMPLEMENTATION AND SUSTAINABILITY

The Health Promotion Unit and the Health Promotion Departments of the health boards need the support of other stakeholders to successfully implement this strategy. Given the evolving role of the Health Promotion Unit, many of the operational issues arising out of the implementation of this strategy will fall to the health boards. National developments in policy, research and evaluation will continue to be the Health Promotion Units responsibility.

For this strategy to be successful a number of key prerequisites and challenges have been identified. These include:

- Developing a health proofing policy
- Strengthening partnerships
- Establishing a National Health Promotion Forum
- Reorienting the health services
- Securing resources
- Supporting research, monitoring and evaluation
- Strengthening regional health promotion structures
- Consulting with the consumer.

6.1.1 DEVELOPING A HEALTH PROOFING POLICY

There are many policies, strategies and legislation originating from non-health sectors, which impact directly or indirectly on health. It is essential that relevant policies, strategies and legislation undergo a comprehensive process of **"health proofing"** so that their impact on the physical, mental and social well-being of the population is positive.

6.1.2 STRENGTHENING PARTNERSHIPS

For the strategic aims and objectives of this strategy to be implemented, current inter-departmental links must be strengthened and expanded. At a cross-ministerial level, there must be an acknowledgement and committment to the inter-sectoral and multi-disciplinary approach required for effective health promotion interventions.

The task of maintaining, improving and protecting health can no longer be seen as the responsibility of the health sector alone. Establishing health alliances involves consultation with, and participation of, all partners to address the social, economic and environmental determinants of health. It is important that non-health sectors become aware of their capacity to contribute and that their involvement in health promotion interventions is encouraged and supported.

6.1.3 ESTABLISHING A NATIONAL HEALTH PROMOTION FORUM

To give renewed impetus to this approach the Minister for Health and Children will establish under his chairmanship a National Health Promotion Forum to build on the achievements of the National Consultative Committee on Health Promotion. The National Health Promotion Forum, which will be widely representative, will facilitate an inter-sectoral approach to addressing the major determinants of health.

6.1.4 REORIENTING THE HEALTH SERVICES

Within the health services a balance needs to be struck between the curative services and services which promote and protect health. This broader, more comprehensive approach will in turn help to increase levels of physical and mental well-being, reduce levels of morbidity and improve life expectancy.

6.1.5 SECURING RESOURCES

To ensure the effectiveness of all health promotion interventions, it is essential that adequate funding be earmarked to support and sustain research, planning, implementation and evaluation. Sustainable health promotion initiatives require adequate resources with ongoing financial support for professional training, peer led interventions and the dissemination of information. The Health Promotion Unit has a central role to play in securing these resources.

6.1.6 SUPPORTING RESEARCH, MONITORING AND EVALUATION

To inform the direction of health promotion, it is essential that accurate data is available on the major determinants of health such as the social, economic and environmental factors, mental health and lifestyle behaviour of population groups.

The Health Promotion Department at the National University of Ireland, Galway, the National Nutrition Surveillance Centre and regional Public Health Departments have facilitated this research, monitoring and evaluation function in the area of health promotion. It is essential that this research function be sustained.

Monitoring and evaluation of the strategic aims and objectives established in this document in parallel with revisiting other strategies, fostering debate and supporting the dissemination of information on evidence based best practice[94] will present a major challange for health promotion.

6.1.7 STRENGTHENING REGIONAL HEALTH PROMOTION STRUCTURES

A great deal has been achieved at a regional level in terms of the development of Health Promotion Departments in all health boards. It will be the responsibility of the Health Promotion Departments to plan, implement and evaluate at a regional level the objectives outlined in Chapter 5. For all health boards to successfully implement this strategy existing regional health promotion structures need to be developed and strengthened.

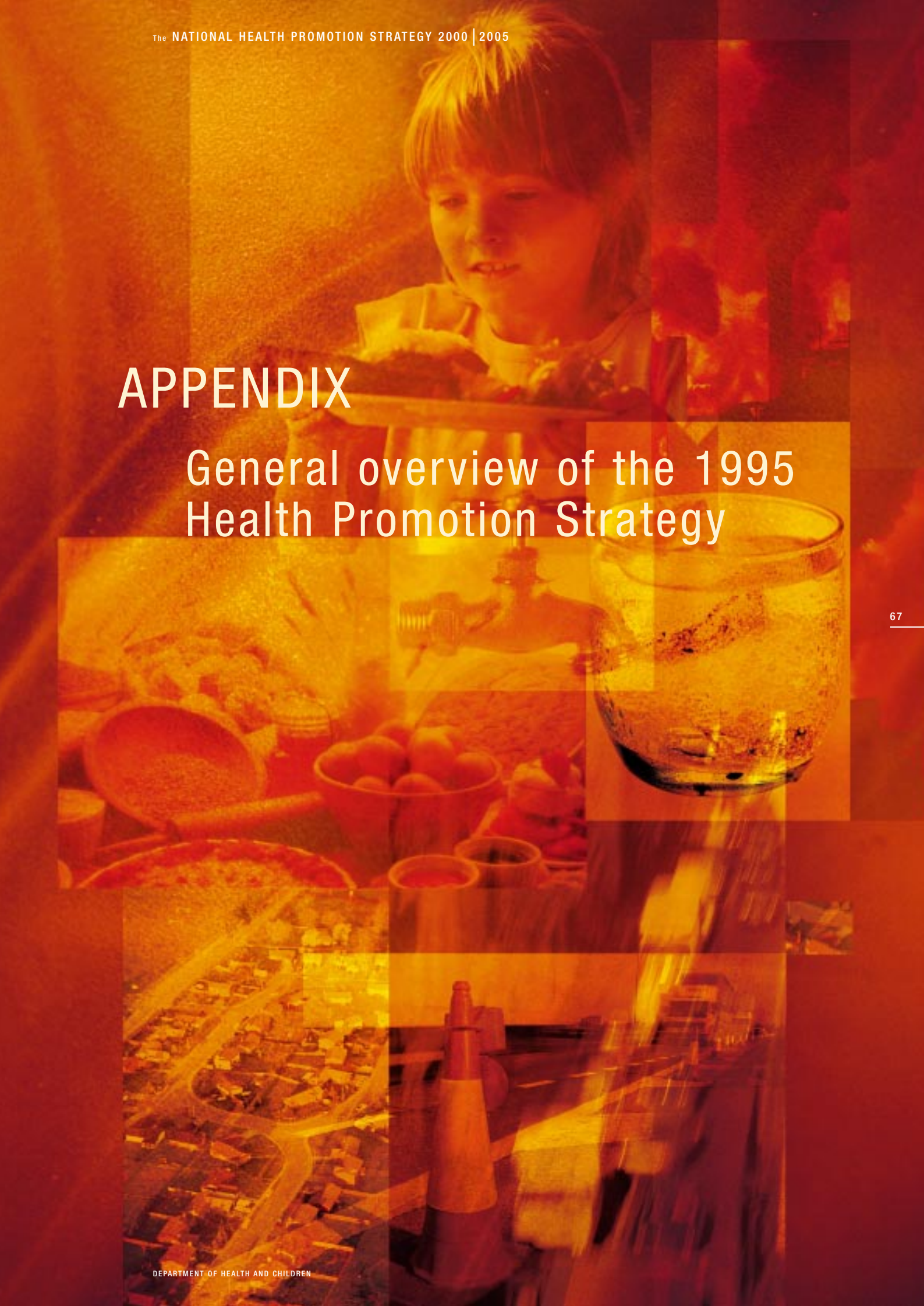
6.1.8 CONSULTING WITH THE CONSUMER

Programme development and implementation is a key area for health promotion as it provides opportunities to develop health skills, to explore attitudes to health and to disseminate information. Health promotion programmes include school and community-based programmes, interagency work, community development, workplace and health service initiatives, professional training and public awareness campaigns. Programmes should be based on needs[94] identified by relevant partners including individuals and communities; based on models of good practice; implemented in a supportive environment and address the issue of ownership to maximise effectiveness and to support sustainability.

6.2 SUMMARY

While a great deal has been achieved in recent years the challenge is to keep health promotion on everyone's agenda for the future. This new strategy will inform the future direction and focus for the Health Promtion Unit and the Health Boards for the next five years. Additionally, it will provide a resource and guide for relevant partners, statutory and non-statutory, concerned with promoting positive health in the new millennium. The National Health Promotion Forum will provide a platform to foster an inter-sectoral approach to addressing the major determinants of health.

Health promotion is now a world-wide movement concerned with improving individual and population health. It is now considered an umbrella term for a wide range of activities that seek to enhance physical, mental and social well-being and prevent ill health. It is increasingly referred to as a mechanism for delivering on a health improvement agenda. This National Health Promotion Strategy for Ireland provides the strategic direction to contribute to this global health improvement agenda.



APPENDIX

General overview of the 1995 Health Promotion Strategy

Appendix THIS IS A GENERAL OVERVIEW OF OUTCOMES FROM THE FIRST NATIONAL HEALTH PROMOTION STRATEGY, '...MAKING THE HEALTHIER CHOICE, THE EASIER CHOICE.'[14]

1. KEY SETTINGS	2. PRIORITY POPULATION GROUPS	3. RISK FACTORS AND LIFESTYLE
i) The family ii) The community iii) The school iv) The health services v) The workplace	i) Children ii) Sexually active people iii) Women iv) Maternal health v) Disadvantaged vi) Elderly	i) Alcohol abuse and substance abuse ii) Nutrition iii) Breast-feeding iv) Exercise v) Cholesterol and blood pressure vi) Diabetes Mellitus vii) HIV/AIDS viii)Mental Health ix) Oral health x) Safety

1. KEY SETTINGS: GOALS AND OUTCOMES

I) The family	Overview of outcomes:
Goal: Development of health promotion programmes in the family.	• Development and Support for Parenting and Family Support Initiatives and Programmes. e.g. Family Communications and Self-esteem, Community Mothers Scheme.

II) The community	Overview of outcomes:
Goal: Development of health promotion programmes in the community.	• Being Well programme; Food and Health programme; Drugs Questions, Local Answers • Other national and regional initiatives supported and developed in conjunction with voluntary and statutory agencies, for example, The National Youth Health Programme; Dublin Healthy Cities Project.

III) The school/college	Overview of outcomes:
Goal: Development of health promotion programmes in college/school.	• Development and implementation of programmes and initiatives in partnership with the Department of Education and Science, for example, the Health Promoting Schools Project, the Substance Abuse Prevention Programme and Social, Personal and Health Education • General and topic based programmes developed and supported, for example, Nutrition Education at Primary School • Teacher Training and Parenting Programmes • Implementation of the Pilot Health Promoting College Project.

IV) The health services	Overview of outcomes:
Goal: Development of health promotion programmes in the health services.	• Statutory obligation on Health Boards to establish Health Promotion Departments and designate funding for Health Promotion • Establishment of Health Promoting Hospitals Network • Training and development for health professionals.

V) The workplace	Overview of outcomes:
Goal: Development of health promotion programmes in the workplace.	• Publication of 'healthy bodies – healthy work' Policy Document • National Conference on Health Promotion in the Workplace • Pilot projects in Health Boards • Models of Good Practise published through European Network • Pilot project implemented to establish the basic criteria for Work Place Health Promotion in Small to Medium Enterprise • Happy Heart at Work and Happy Heart Eat Out.

2. PRIORITY POPULATION GROUPS: GOALS AND OUTCOMES.

I) Children:	Overview of outcomes:
Goal: Maximise young people's health potential with reference to physical activity, anti-smoking, substance misuse, healthy nutrition and healthy relationships.	• Various school and community based projects and programmes supported, for example, Knowledge is Power and Smoke Busters • Appointment of Youth Health Promotion Project Officer.
Goal: Achieve an uptake of 95% for National Immunisation Schedule.	• Development of new schedule • Awareness campaign.

ii) Sexually active people:	Overview of outcomes:
Goal: Promoting safer sexual practices.	• Support for the implementation of Relationships and Sexuality Education • Participation in the implementation of the Report of the National Aids Strategy Committee • Development of 'Knowledge is Power' – HIV/AIDS Education Pack for exploring the issue with young people • Convenience Advertising Campaign • World AIDS Day Campaign • Production of AIDS Education Video • Development of Information leaflets relating to STI's/D's and contraception.
Goal: Achieving a reduction in the risk of disability by providing a range of information on topics such as the influence of age on pregnancy; family planning; and genetic counselling.	• Development of mass media campaigns, information leaflets, booklets and posters.

iii) Women:	Overview of outcomes:
Goal: Ensure that women's health needs are identified.	• Discussion Document - Developing A Policy For Women's Health • Establishment of Women's Health Council • Publication of a Plan for Womens Health.
Goal: Where appropriate health promotion programmes put in place to address these needs.	• Investment in Women's Health at regional level • Food and Health programme.

iv) Maternal Health:	Overview of outcomes:
Goal: Encourage the avoidance of smoking, alcohol and drug misuse before and during pregnancy.	• Range of information materials produced and supplied to expectant and new mothers • Brief Intervention Training provided at regional level for Health Professionals in contact with pregnant women.
Goal: Promote breast-feeding.	• Baby Friendly Hospital Initiative established • Implementation of the National Breastfeeding Policy • Support for voluntary organisations • Training pack, including video, for health professionals.
Goal: Promote healthy nutrition before and during pregnancy.	• Training pack/video for health professionals produced • Folic Acid Public Awarness Campaign in conjunction with the Irish Country Women's Association.
Goal: Encourage improvements in parenting skills.	• Parenting Programmes developed and supported at national and regional level.
Goal: Increase the numbers who understand the value of immunisation and accident prevention and first aid.	• Immunisation campaign • First Aid Chart produced • Accident Prevention Awareness Campaigns at regional level.

v) Disadvantaged:	Overview of outcomes:
Goal: Reduce inequalities in health status by giving priority in health promotion activities to vulnerable groups, e.g. lower socio-economic.	• At a national and at a regional level, Health Promotion personnel have participated in the development, support and implementation of initiatives targeting disadvantage in partnership with relevant bodies • Contribution to the National Anti Poverty Strategy • Research into the health needs of young people at risk leading to the publication of Youth as a Resource: Promoting the Health of Young People at Risk.

vi) Elderly:	Overview of outcomes:
Goal: Increase the proportion of the elderly who enjoy an active, independent and healthy old age.	• Publication of Policy Document 'Adding Years to Life and Life to Years' • Relevant sections of the Plan for Women's Health implemented • The promotion of physical activity.

3. RISK FACTORS AND LIFESTYLES: GOALS AND OUTCOMES

I) Alcohol and substance misuse:	Overview of outcomes:
Goal: Develop a national policy to promote moderation in alcohol consumption and reduce risks to physical, mental and family health associated with alcohol misuse – such policy to be adopted and aunched during 1995.	• Publication of the National Alcohol Policy, including an Action Plan and identification of key players.
Goal: Ensure that 75% of the population aged 15 years and over knows and understands the recommended sensible limits for alcohol consumption within the next 4 years.	• Various campaigns developed over lifetime of policy document • Support for the development of Substance Abuse Prevention Programme for schools, Drink Awareness for Youth Programme and the Youth Work Support Pack for Dealing with the Drugs Issue within the youth sector • Development of Family, Communication and Self-esteem Parenting Programme; Being Well and Drugs Questions, Local Answers • National and regional initiatives developed and supported such as the production of information booklets, posters, campaigns and programmes.
Goal: Reduce substantially over the next 10 years the proportion of those who exceed the recommended sensible limits of alcohol consumption.	• Programmes and initiatives such as those listed above have aimed to promote sensible attitudes to alcohol • The SLÁN survey provided the first baseline marker to establish the number who drink over the weekly limits (14 and 21 units) and the number who engage in high risk drinking (binge drinking on a single occasion).
Goal: A reduction in the percentage of cigarette smokers in the population by at least 1% per annum so that more than 80% of the population aged 15 years and over are non-smokers by the year 2000.	• Preventative, Educational and Cessation initiatives have been implemented at regional level to reduce the number of young people taking up smoking and provide assistance to those who want to stop • Development of National Smoking Campaigns in partnership with relevant voluntary organisations.
Goal: All pupils leaving school will have received information and education programmes on the dangers of substance misuse in the context of a comprehensive health.	• In partnership with the Department of Education & Science the Substance Abuse Programme has been developed and implemented • Support for National, Regional and local initiatives to prevent substance misuse, for example, campaign development, programme implementation and policy formulation.

ii) Nutrition:	Overview of outcomes:
Goal: Ongoing implementation within the next five years of the Department of Health 'Healthy Eating Guidelines'.	• Implementation and review of the Nutrition Health Promotion Framework for Action • Annual National Healthy Eating Campaigns - supported and evaluated regionally and nationally • Establishment of Community Nutrition Service at regional level • Nutrition and Oral Health Project - piloted, evaluated and implemented • Food and Health community based programme developed and evaluated • Happy Heart Nutrition Initiative in partnership with the Irish Heart Foundation.

iii) Breast feeding:	Overview of outcomes:
Goal: Initiation rate of 35% by 1996 & 50% by the year 2000 and an overall breast feeding rate of 30% at 4 months by the year 2000.	• Implementation of National Breastfeeding Policy.
Goal: Among the lower socio-economic groups breast feeding initiation rate of 20% by 1996 and 30% by the year 2000.	• Interventions developed at a regional level targeting lower socio-economic groups.

iv) Exercise:	Overview of outcomes:
Goal: 30% increase in the proportion of the population ages 15 years and over engaging in an accumulated 30 minutes of light physical exercise most days of the week by the year 2000.	• Publication of Promoting Increased Physical Activity; A Strategy for Health Boards In Ireland.
Goal: 20% increase in the proportion of the population aged 15 years and over who engage in moderate exercise for at least 20 minutes three times per week by the year 2000.	• Campaigns promoting increased physical activity • Building Healthier Hearts Report published.

v) Cholesterol and Blood Pressure:	Overview of outcomes:
Goal: To achieve a situation where 75% of the population in the 35-64 age group will have a blood pressure less than 140-90mm Hg by the year 2005.	• Publication of Building Healthier Hearts Report • Support for initiatives at national and regional level by both voluntary and statutory agencies to promote heart health.
Goal: Reduce mean serum cholesterol in the 35-64 age group from a present level of 5.6mmol/L to 5.2mmol/L by the year 2005.	• Awareness Campaigns.

vi) Diabetes Mellitus:	Overview of outcomes:
Goal: Improve quality and quantity of life expectancy.	• Regional pilot scheme of Combined Care Initiative.
Goal: Improve the prevention and cure of diabetes and it's complications.	• Establishment of the Community Nutrition Service to provide community based assessment and education.

vii) HIV/AIDS:	Overview of outcomes:
Goal: Decrease the percentage of the population engaging in behaviours which risk HIV transmission and the transmission of other sexually transmitted diseases.	• Educational programmes • Convenience advertising • Targeted campaigns • Information leaflets • Training for health professionals. • Support for the implementation of the report of the National Aids Stategy Group • Collaboration with voluntary organisations • Participation in European HIV/AIDS Prevention Networks.

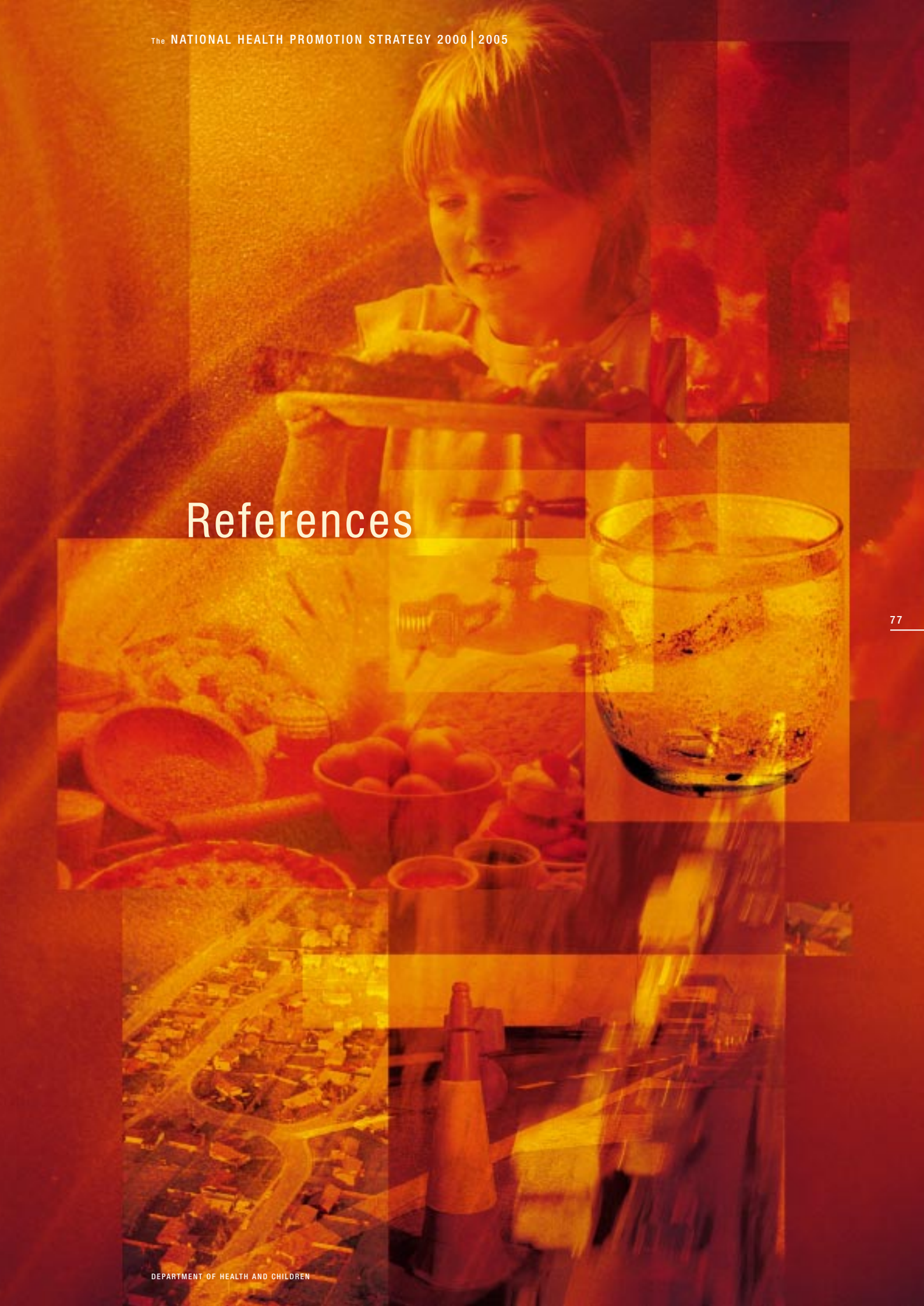
viii) Mental Health:	Overview of outcomes:
Goal: Promote positive mental health in co-operation with the voluntary mental health bodies and the health boards.	• In conjunction with statutory and voluntary organisations a range of initiatives have been supported at a regional and national level to promote positive mental health • Establishment of the Task Force on Suicide and publication of the Report of the National Task Force on Suicide.

Ix) Oral Health:	Overview of outcomes:
Goal: Improve the level of oral health in the population overall.	• Implementation of the 1994 Four Year Dental Health Action Plan • A review of the Dental Treatment Services Scheme • Provision for the appointment of 30 dental auxiliary personnel by the health boards, assigned specifically to oral health promotion and with a particular emphasis on special needs groups • The establishment of an Oral Health Promotion Evaluation within Epidemiology, Oral Health Services Research and Specified Consultancy Services Contract • Development of an Oral Health component within National Research Programmes • Establishment of specialist certificate in Health Promotion (Oral Health) offered through Distance Education by the centre for Health Promotion Studies, NUI Galway and the Dental Health Foundation of Ireland.

x) Safety:	Overview of Outcomes:
Goal: 10% reduction in mortality due to accidents within the next 10 years.	• Support for regional and national initiatives aimed at reducing the number of accidents, particularly road and home accidents.
Goal: Significant reduction in morbidity particularly among children.	• National Accident Prevention Campaign for Children. • Educational and awareness raising measures.

Abbreviations

AIDS:	Acquired immuno-deficiency syndrome
BMI:	Body Mass Index
DQLA:	Drugs Questions, Local Answers
EC:	European Commission
ENHPA:	European Network for Health Promotion Agencies
EU:	European Union
FCSE:	Family Communication and Self Esteem
HIV:	Human immuno-deficiency virus
HBSC:	Health Behaviour in School-Aged Children
ICD:	International Classification of Diseases
NEAPS:	Nutrition Education at Primary Schools
NMS:	Non-melanoma skin cancer
SAPP:	Substance Abuse Prevention Programme
SC:	Social Class
SDR:	Standardised Discharge Rates
SIR:	Standardised Incidence Rates
SMR:	Standardised Mortality Rates
SLÁN:	Survey of Lifestyle, Attitudes and Nutrition
SPHE:	Social, Personal and Health Education
STD:	Sexually Transmitted Disease
STI:	Sexually Transmitted Infection
WHO:	World Health Organisation



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