Abstract
This study presents the results of an evaluation of the Health Quality Mark (HQM), a settings-based health promotion intervention in youth organisations currently facilitated by the National Youth Health Programme (NYHP). The study employed qualitative data, and focused on impacts as perceived by stakeholders and on process factors, including the strengths and weaknesses of the process operated by the NYHP in implementing the HQM, perceived benefits and/or disadvantages of participating in the HQM, and the appropriateness of the criteria in the award. The perceptions of health promoters, team members and members of management with regard to the impact of the HQM were very positive, including both individual behaviour changes and organisational level changes. The HQM was perceived to raise awareness of health, validate and extend good practice generally in youth organisations and in health promotion in particular, and to engender a sense of pride in the youth organisation. Positive factors identified by participants include the structure and award-based nature of the initiative, management buy-in, the embedded training element, the process it engenders and support from the NYHP. Implications are discussed in the context of settings-based work and the correspondence between youth work practice and health promotion practice.

Keywords
Health promotion; young people’s health; youth work; settings-based approaches

Introduction: Youth Organisations as Settings for Health Promotion
The World Health Organisation defines a setting for health as a ‘place or social context in which people engage in daily activities in which environmental, organisational and personal factors interact to effect health and well-being’, and where people can create or solve problems relating to health. Settings are further defined as ‘having physical boundaries, a range of people with defined roles, and an organisational structure’ (WHO, 1998a: 19). The impetus for settings-based work in health promotion comes, in part, from the realisation that the health sector alone cannot respond to the health needs of a population, and that health promotion needs to be far reaching and practiced by those involved in a wide range of contexts in order to be successful.
The settings approach goes to the heart of health promotion, focusing on communities and organisations and in particular on how to develop environments that support health. It acknowledges the complexities of systems and requires that not only the integration of the different parts of the whole be explored (the behaviours and the people within the setting and the wider environment) but also the ‘spaces in between’ (Dooris, 2006).

It is important that we capitalise on the variety of settings available to carry out health promotion. Research has been conducted on a range of settings, such as hospitals and primary care settings (Johnson et al., 2006), schools (Lynagh et al., 1997; St. Ledger, 2001) universities (Tsouros et al., 1998) workplaces (Chu et al., 2000; Noblet, 2003) and prisons (Department of Health, 2002; WHO 2003; Møller et al., 2007). Youth organisations clearly qualify as appropriate settings for health promotion, according to the WHO definition, a fact that is recognised in the National Health Promotion Strategy (Department of Health and Children, 2000). The importance of the Strategy for young people and those who work with them was acknowledged in the National Youth Work Development Plan 2003–2007 (Department of Education and Science, 2003: 20), which called for support and investment to be committed to ‘relevant partnerships to promote the health and well-being of young people, volunteers and youth workers’. Health promotion forms a key strand in the work of the National Youth Council of Ireland (NYCI), which is recognised under the Youth Work Act 2001 as the representative body for youth work organisations and which hosts the National Youth Health Programme (see below).

There is a strong complementarity between the principles of youth work and those of health promotion. Youth work provides informal and non-formal educational programmes and activities for young people, helping them to develop their skills and aptitudes; it aims to provide a supportive environment in which young people have a say and are valued and listened to. Youth organisations develop local partnerships with the wider community; they develop internal health related policies, while influencing national policy. They also are well placed to advocate for quality youth health service provision for all young people. Health promotion is defined as the process of enabling people to increase control over, and to improve, their health (WHO, 1986; 1998a: 1) and is underpinned by principles of empowerment, person-centredness, participation, equity and sustainability – all of which are very much in keeping with the vision and principles of youth work (Department of Education and Science, 2003: 13–17). Although often perceived to consist of specific isolated behaviour-change interventions, health promotion is essentially about working in an empowering, participative and culturally sensitive way with individuals, communities and populations to improve both physical and mental health. This complementarity between youth work and health promotion, and its potential benefits for young people, deserves greater recognition.

The Health Quality Mark

For over 15 years the National Youth Health Programme (NYHP) a partnership between the National Youth Council of Ireland, the Health Service Executive and the Youth Affairs Section of the Department of Education and Science, has provided health promotion training, services, advice and support to youth work organisations throughout Ireland. This paper focuses on a particular initiative, the ‘Health Quality
Mark’ (HQM) which takes a settings-based approach in youth work, aiming to create health promoting youth organisations. The HQM takes the form of an award conferred on organisations that satisfy agreed quality criteria. The criteria, eighteen in total, have been drawn up nationally and are based on best practice in health promotion: many have been adapted from the World Health Organisation criteria developed for the Health Promoting Schools Initiative1. The HQM, given its flexibility, attracts a variety of organisations to undertake the quality process. Organisations who are predominantly volunteer based, regional youth services and those working with young people no longer in formal education have all undertaken the HQM.

The award is given at three levels; bronze, silver and gold, and youth organisations are re-assessed every three years as a quality control measure. Participation in the award includes setting up a health promotion team which undertakes the following tasks:

- strategically planning which criteria to work on and when;
- conducting an audit of current work to help decide where to begin working on the criteria;
- reviewing of work to meet the standards;
- ongoing linking with young people, management, staff and volunteers in relation to health promotion in the organisation;
- ongoing meetings between the team members to monitor progress of work completed on the criteria.

Each criterion also requires a specific response; for example, the youth health promotion plan requires a needs assessment with young people in the organisation, and from this a strategy is developed to respond to the needs.

Similar health promotion award schemes exist elsewhere, but primarily in workplace settings, for example Scotland’s Health at Work (SHAW) and the Working for Health Award In County Durham (County Durham Primary Care Trust, 2008). An application form and a portfolio providing evidence of fulfilment of the criteria are developed by participating youth organisations and submitted to assessors. The assessment body is comprised of representatives from the NYHP and regional health promotion personnel. An educational programme for personnel in the organisation is embedded into the initiative, as a number of the criteria are met through participation in the programme. One or more individuals in the organisation undertake a ‘Specialist Certificate in Youth Health Promotion’, run by the NYHP in collaboration with the National University of Ireland, Galway.

**Evaluation in settings-based work**

Although settings-based work generally has been described as having evolved and matured (Whitelaw et al., 2001) specific challenges remain, in particular the need for comprehensive evaluations to generate evidence of effectiveness (Dooris, 2006). Dooris argues that there are a number of specific challenges faced in evaluating settings-based work. For example, if, as is intended, health promotion is integrated into the everyday work of the organisations, it becomes difficult to identify and therefore to measure. Traditional positivist approaches to evaluation are not well suited to the evaluation of setting work, as the ‘variables’ cannot be separated out and manipulated as experimental design, for example, demands. Evaluating settings-based work requires
measuring patterns of change, interrelationships, interactions and synergies in the setting ‘system’ (ibid.), which may best be captured using qualitative data.

It is generally agreed that evaluation in health promotion should be comprehensive, including a balance of process, impact, and outcome measures (e.g. Naidoo and Wills, 2000; Dugdill and Springett, 2001; Toronto Health Communication Unit, 2005; WHO, 1998b). Impact evaluation addresses the immediate effects of an intervention while outcome evaluation confines itself to longer-term effects. Process evaluation explores the strengths and weaknesses of the intervention and addresses critical aspects of programme implementation. Of particular interest is an exploration of the processes underlying the relationship between the intervention and its effects (Barry et al., 2006). This paper presents the results of an evaluation of the Health Quality Mark, which, employing qualitative data, focused on impacts as perceived by stakeholders and on process factors, including the strengths and weaknesses of the process operated by the NYHP in implementing the HQM, perceived benefits and/or disadvantages of participating in the HQM, and the appropriateness of the criteria in the award.

Methods
In order to evaluate the intervention it was deemed necessary to obtain feedback from all stakeholders who were involved. With the assistance of the NYHP2, all youth organisations that had completed the HQM either fully (all three levels) or partially (going forward for consideration for either bronze, silver or gold) were identified. Groups of stakeholders were agreed as follows:

- Young people in attendance at the youth organisation
- The health promoter(s) and members of the team (i.e. persons in the organisation with a designated health promotion role)
- Members of management
- Strategic personnel (senior health promotion personnel within the Health Service Executive at regional and national level) involved in the set up and delivery of the HQ Mark

Young people were interviewed in a focus group setting in one organisation (timing of data collection in the summer made it difficult to reach groups of young people in most youth organisations). Nine young people took part in the focus group. For all other groups semi-structured telephone interviews were conducted, over a three month data collection period. The interview protocol was devised based on programme objectives and piloted prior to data collection.

Sixteen youth organisations had been awarded the HQM on one or more occasions. Eleven of these organisations participated. Nine organisations were in the process of applying for and being assessed for the HQM for the first time (i.e. were being considered for the bronze level award). Eight of these organisations took part. In each participating organisation, researchers requested interviews with all available health promotion staff and a member of management team. Thirty seven individuals were available for interview across all organisations. HSE health promotion managers and individuals who had a strategic input into the HQ Mark and its future development, as recognised by the NYHP, were also targeted for interview. Nine such individuals were identified and eight were available for interview.
All interviews were tape-recorded and transcribed verbatim. The basis of the process of data analysis in this study follows a general template analysis style (Miller and Crabtree, 1992), involving the generation of themes, patterns and interrelationships in an interpretive process.

**Results**

The first level of analysis arranged and described the data based on interview headings. Second level analysis sought to identify general themes within the data and as such was driven by the data itself rather than the interview framework. A range of interacting impacts emerged in the analysis. Regarding process, factors critical to the success of the HQM in youth organisations were discussed, and specific difficulties inherent in the process were also highlighted.

**Impacts**

The perceptions of health promoters, team members and members of management with regard to impact was overwhelmingly positive. The absence of negative impacts in any of the interviews was striking. Positive impacts included individual behavioural changes and organisational level changes. Those interviewed commented in more depth and to a much greater extent on the way in which the HQM impacted on the whole organisation, and the place of health within it. The HQM was perceived to raise awareness of health, validate and extend good practice generally in youth organisations and in health promotion in particular, and to engender a sense of pride, which was motivating for young people and staff. The HQM also led to recognition and ‘kudos’ in the wider community, with possible positive outcomes for funding.

**The place of health in the youth organisation**

It was evident from the data that the HQM had the effect of increasing a general awareness of health throughout the youth organisation. This was identified in all groups interviewed and seen as broadening the concept of health and allowing staff to embrace a holistic concept of health. Health was seen to have expanded to include mental health and well-being;

> Well the younger people just got a wider programme … it sort of widened the health word … more holistic … like stress for kids and relaxation and all that … which wouldn’t have been there before like, getting kids to talk about their feelings and all that stuff which would be a fairly new thing. (HP6)

> I think that was another area that’s important about the quality mark that it’s a holistic approach its not just about being healthy and encouraging the kids not to play play station five days a week but that it encourages all aspects of their lives particularly around stress and areas that young people often aren’t really spoken to about or helped with I suppose. (gfTM2)

> It will open up their eyes to the whole the bigger scheme of things about health. (gfTM5)
In the focus group, it is interesting to note that young people also mentioned outcomes such as 'meeting new people' and getting to 'go places', implying a broad understanding of health. Further, health was seen to have become more integral to the work of the organisation. One manager described it as 'kind of nearly knitted into the project at this stage, for the young people in the project as well' (M3).

It was widely perceived that the HQM has the effect of validating and documenting health promotion activities already taking place within youth organisations. In this way it gives health and well-being issues a 'home' and a structure, and goes beyond other health promotion initiatives. It can blend various strands of bottom-up and top-down work, binding together work undertaken in response to particular local needs and work undertaken in response to national youth work priorities such as those set out In the Youth Work Act or the National Youth Work Development Plan (Department of Education and Science, 2003).

The facilitation of good practice

The HQM was seen to provide a framework for improvement in youth work practice and giving youth organisations an opportunity to upgrade their standards. As this team member commented:

"It was important for the organisation to be providing the best quality service to young people and to the families that we work with, just from looking at specific criteria for the Q mark it was definitely a way of structuring that, ensuring that we had something to work off." (gfTM4)

Improvement of practice included involving staff in policy development, increased opportunities for staff training, better team working, and improving working relationships between management and staff:

"The HQ mark actually gave us an opportunity for people to come together and work together on something common." (M1)

Improved team working was not only seen as an impact of the intervention but as part of the process:

"There’s also team building and the kind of broader development of a team approach and cohesion. So it brings people together in a way that they might not if they didn’t have the opportunity of working through the Health Quality Mark … The Health Quality Mark builds the team but the team builds the Health Quality Mark." (SP7)

The HQM gave organisations the opportunity not only to validate ongoing work but to identify was missing and act on this. All of this contributed to the raising of standards, and provided evidence to management of the quality of work undertaken. Organisations referred to their centre being healthier and better places to work in.

"I thought it was a very good idea, I mean it upgraded the centre definitely … we got to look at areas we would never have looked at before." (HP1)

"Keeping the standards up, getting the staff involved and also maintaining a good service, providing a good service to the young people and you know also a way of making management aware of what we do here as well." (TM3)
Participation and communication

Health promoters, team members and strategic personnel each identified increased participation with young people following involvement in the HQM. Young people were described as being more involved in planning and more included. The initiative helped create a young people’s forum, for example, to give young people a voice and a greater sense of ownership of health issues.

*We had increased consultation with trainees around different things even to do with strategic planning and programme development in the centre, there was a lot more consultation with trainees …* (HP5)

The HQM also was seen to be more inclusive of staff, involving them in decision making and organisational changes. It was seen to encourage youth organisations to go beyond the needs of service users and include staff needs, for example for training and support, as part of good practice.

*The best part of that it involved all the staff team there was no one person responsible for achieving the quality mark it was a team effort and the consultation process and everything I think that was what brought everybody into it.* (HP3)

The HQM had a positive effect on communication. Interviewees referred to increased opportunities for networking within the youth sector and to increased interaction with the NYHP.

Pride and external recognition

Finally, in relation to impacts, all stakeholders considered the achievement of the award to lead to a number of benefits both internally and in the wider community and the youth sector. Securing the award brings pride to the organisation and a sense of achievement, felt by both young people and staff. It led to a renewed focus on health promotion and acted as a morale-booster.

*Getting the awards was something to be proud of and the trainees were proud of, that were involved at the time so overall it was excellent.* (TM4)

It was thought to raise awareness of the organisation and the work it does within the community; ‘it betters it as a place, like’, something which is sometimes particularly valuable when working with marginalized groups.

*Sometimes there would be plenty of negative things associated with being a training centre … where as the fact that this was an achievement to be proud of and positive publicity for us was good.* (HP5)

*And the other thing too was the promotional value was excellent in terms of when you get the gold award, we were presented with it by two ministers then it was nice for the centre to be awarded that you know.* (M4)

One specific perceived advantage of external recognition is the possibility of increasing opportunities for securing funding, vitally important for voluntary organisations.

Cutting across these impacts were perceived positives in respect of young people. The HQM was seen to be of benefit to young people in a number of ways, ranging from
specific behaviour changes, to less tangible but no less important impacts such as increased ownership and inclusion.

*We’ve to do PE every Wednesday.*

*Use the gym across the road.*

*We do health related fitness class.* *(FG)*

*In the short period that I’m doing it it’s benefiting them … they’re eating healthier and they are you know being more aware of their health and what they put into their bodies and that and about the surroundings of like their own health at home as well as in here so like for us to for what we have achieved at the moment with this its really good and for them to bring it outside and I think it will it will benefit their lives in the future definitely.* *(gfHP5)*

*… for them as well a sense of achievement … when we got the award we would have brought a group with us and … it was something for them to be proud of for young people who may not get the opportunity to succeed in other things like mainstream education … I think its good for even promoting their own self-esteem and their sense that this is a valued valued value centered organisation that they’re part of here would be very positive as well.* *(HP5)*

*We will also hopefully have raised their awareness and increased their knowledge sort of around health issues you know and I hope the changes that we make in terms of the staff, the management, the building, you know policy all like that that make them take more ownership and feel more secure and more valued and more you know as well more that we’d be becoming a more young peoples service centered service.* *(M1)*

**Critical Success Factors**

In relation to process aspects of the evaluation, interview data also revealed a number of factors which seemed to contribute to the success of the HQM as a health promotion initiative. These included the structure and award-based nature of the initiative, management buy-in, the embedded training element, the process it engenders and support from the NYHP.

Health promoters, managers and strategic personnel, all recognised that the formal recognition inherent in receiving the award acted as an important incentive for organisations, providing a challenge, a goal that could be reached, and vehicle for motivating staff. Having a challenge to rise to is important, as one interviewee commented

*A challenge for the centre rather than something that’s easily attainable. I think it devalues it if … anybody can get it willy nilly.* *(HP5)*

The criteria create a structure which was seen to be motivating, as fulfilling each criterion and reaching each level of the award provides a boost to move on up to higher levels, although it was noted that that the health promotion team are still part of that structure, and need to be there to drive it along. This interaction between the
actual structure of the HQM and the leadership qualities of the health promotion worker was critical:

*I think the leadership that they’re able to get everybody onboard to support them. …..
Although the criteria is great for kind of forcing them to achieve the criteria as well in order to get some award from it. So it’s a two way track.* (SP8)

All four stakeholder groups identified management buy-in as critical to the success of the initiative. Management buy-in included management having a strong link with the health promotion team or person, and being ‘fully committed’. It has to go beyond ‘signing a piece of paper’ or generally approving of the goal of helping young people to be healthier. It requires support also for staff health initiatives, and an appreciation that all have to be included to create a health promoting youth organisation.

*… there would have been great buy in for looking after trainees and promoting their health but as I said that my issue is around staff and the support or lack of that I got around promoting staff health … I just don’t think feel that management understood that that was part of the deal in order to get the quality mark that you equally have to be looking out for staff welfare and staff health.* (HP5)

The process can turn management around but this was acknowledged to be difficult and less than ideal.

*… now I have seen it where it has been driven from the bottom up that’s a much more difficult process and it shouldn’t have to happen like that. But I have actually seen where people have gone back and after a period of time they’ve actually converted management but it is much easier if top management are fully behind it and fully committed.* (SP5)

The training that is built into the initiative in particular the Specialist Certificate in Youth Health Promotion (SCYHP) facilitated the success of the initiative, by facilitating networking with others in the process. The SCYHP was described as ‘absolutely vital’ to the securing of the HQM, playing a ‘key role’ and bring focus and structure to the initiative.

*… sometimes you go to training and its so lack lustre and repetitive, you don’t feel challenged and its not very rewarding to have achieved it … whereas I found this … challenging enough to feel like a real piece of training and the certificate didn’t feel like a token thing … felt like something that I had earned.* (gfHP3)

The supportive role of the NYHP in general and in facilitating the training was also noted, as was the way in which the NYHP support included assisting with resources and difficulties: ‘… when I was stuck on certain criteria or I was kind of thinking am I going down the wrong road here or am I on key, they were very helpful’ (HP1).

The nature of the initiative – which requires regular team meetings, reviews of progress, and staff support to meet the different criteria – was seen to be a process in and of itself that was critical to the success of the HQM.

*An award is, it’s nice to have stuff acknowledged but really it’s the process is the valuable thing.* (M2)
**Difficulties encountered**

Despite the obvious success of the programme, interviewees did acknowledge some difficulties in the initiative, and two in particular. The first of these related to operational aspects of the initiative and the second to the underpinning principles. In relation to the operation of the HQM, all stakeholders referred to the amount of time required to complete paperwork for a portfolio of evidence for each of 18 criteria. This posed difficulties in the context of juggling commitments to face-to-face youth work and the work of the HQM. Some queried the need for the process to be so time consuming, while other acknowledged its necessity in the light of the achievement.

A lot of work, pressure and stress. And what I would call unnecessary extra work because its work that we done anyway so it was having to prove that we’d done the work and I would query if the process needs to be so time consuming. (M5)

... you need to put in the time for planning ... and to develop the areas of health related work ... just have to say look something’s got to give if we’re to put all our energies into this and maybe it is a matter of kind of cutting back on the youth work despite the directive do you know what I mean and I think it is justifiable. (gfHP2)

The issue of tension between the ideological underpinnings of health promotion – its commitment to principles such as empowerment, participation and inclusion – and the highly structured nature of the HQM initiative was a second difficulty emerging in the course of the interviews. For example there was a concern within the strategic personnel group that the real ethos of a health promoting organisation was compromised by the enforced structure of the criteria. It was pointed out that the criteria were expert-led, rather than emerging from the service-users and the staff in a way that was responsive to their own situation.

That they get so ingrained in ticking those six boxes to get their bronze that they don’t really see the full picture ... You can’t pigeon-hole health promotion I suppose and that’s what this tries to do. (SP1)

In a similar vein, one manager made it clear that his primary concern was with the young people and their behaviour rather than the rather prescriptive structure of the HQM initiative:

... achieving it became kind of secondary to ... I’d turn around and say that I’ve got some kid In the centre who doesn’t smoke rather than getting another mark you know. (M4)

**Discussion**

The settings approach involves more than just delivering health education in a convenient setting. Health promotion interventions in organisations not only have to address change in individuals but aim to include re-shaping environments and bringing about sustainable change. The results of this evaluative study of a settings-based intervention confirm the importance of the youth organisation as a setting for health promotion work, and the success of the Health Quality Mark (HQM) as a settings-based intervention.
The HQM was received very positively by all stakeholders and perceived to lead to a range of beneficial impacts. The HQM was believed to raise awareness of health, validate and extend good practice, and to engender a sense of pride and achievement, which was motivating for young people and staff. The HQM also led to recognition in the wider community, with possible positive outcomes for funding. Aspects of the intervention which were perceived to contribute to its success included the structure and award-based nature of the initiative, management buy-in, the embedded training element, the actual process the initiative engenders and support from the National Youth Council of Ireland/National Youth Health Programme. Some difficulties with implementation were encountered, principally around the time consuming nature of the portfolio requirement.

Settings-based work provides a challenge to evaluators (Green et al., 2001; Dooris, 2006). In its true form, a settings approach aims to ‘stay with the big picture’ (St Leger, 1997: 101) creating conditions and supportive environments for health gain by improving policies and practices. It is expected to have an ‘added-value’ to specific project-based work, to be integrative, and to focus not only on the different parts of the whole, but on the ‘spaces in-between’ (Dooris, 2006, citing Baric and Baric, 1995). However, this can paradoxically make evaluation difficult, and explains why setting work is ‘legitimized’ more through an act of faith than through rigorous research and evaluation studies’ (St Leger, 1997: 101).

While traditional experimental methods with control or comparison groups are clearly inappropriate to capture this bigger picture, even the use of survey methodologies tends to force evaluators into measuring settings-based work in terms of tangible, countable outputs, such as check lists of topics addressed, or changes in usage of posters and other communication methods as seen, for example, in the evaluation of SHAW (Graveling et al. 2002). The results here however reveal that the initiative was a success in terms of the whole organisation and the way in which health promotion became embedded in the organisation. Health was described as being ‘kind of knitted in’, and ‘absorbed’ into the work of the staff. The HQM ‘focused us on the whole organisation, not just those in receipt of the service’, thereby providing evidence of the ‘spaces in-between aspect of the settings approach.

Dooris argues that settings-based approaches ‘allow the language of “health” to recede … : “health promotion” as an entity becomes more remote’ (Dooris, 2006: 61). However, this study suggests the opposite. The HQM initiative made health more visible and acted as a vehicle or framework for good practice. In this way health promotion took centre stage, facilitating a wider, more holistic interpretation of health and providing a ‘renewed focus’ for the work of the youth organisation. Whether this is unique to this particular initiative, or to the youth organisation setting, requires further exploration.

The concerns regarding the structured nature of the initiative being at odds with the ethos of health promotion are of interest since they were raised principally by those people who are external to work on the ground in youth organisations. It is the case that health promotion advocates that health should not be imposed on people by ‘experts’, yet the health promoters and team members spoke repeatedly of how the initiative led to greater participation with young people, and increased teamwork within the organisation. Participation is widely agreed to be an underpinning principle
of health promotion (WHO, 1998), and is critical to empowerment, which is a primary criterion for determining whether a particular initiative should be considered health promoting (Rootman et al., 2001). The WHO definition of health promotion refers most particularly to process, identified in this study as critical to the success of the initiative. Another underpinning principle, holism in health, was also reported as impact of the HQM, leading us to conclude that despite reservations, the initiative did in fact reflect the ethos of health promotion well.

Whether the structure of the HQM would transfer easily into other settings is unclear, given the paucity of research both in Ireland and at an international level evaluating settings-based health promotion initiatives. However it is argued here that the success of the initiative may be due to the ideological consistency between the principles of youth work and health promotion. In both disciplines, the principles of empowerment, active partnership between all parties and stakeholders are paramount. Youth work is expected to involve young people on a voluntary basis and to engage them through issues and themes of interest and concern to them (Department of Education and Science, 2003; Spence and Devanney, 2007; Young, 2006); while health promotion approaches its work from the point of view that health cannot be imposed on people but has to be won in partnership with them (Abel-Smith, 1994). Both health promotion and youth work advocate active learning and collaborative decision-making, planning, organising and evaluation, as well as the importance of building on existing opportunities – ‘starting where people are at’. The flexibility of the HQM initiative may contribute to its success. It is recognised that different youth groups and organisations in Ireland are in different circumstances or at different stages of development and the availability of the award at three levels provides a staged approach to developing health promotion structures.

However, it must be acknowledged that despite the consistency in approach between youth work and health promotion, it was unfortunate that the voices of young people themselves were not heard with more force within this evaluation. As already noted, the timing of data collection (summer) made it difficult to access many of the groups that had participated in the initiative. Further research should explore in greater depth the experiences and perceptions of young people in respect of the HQM and their engagement with it.

Finally, the findings of the study may provide reassurance for Irish youth work practitioners regarding the advent of the ‘Quality Standards Framework’ (QSF) for youth work. A quality-based structure can be integrated into youth work and provide real opportunities for the enhancement of good practice, and a motivating impetus for staff. In the words of one health promoter in the evaluation of the HQM: ‘Once we have it, we’re keeping it!’.
Notes

1. WHO’s Global School Health Initiative aims to mobilise and strengthen health promotion and education activities at the local, national, regional and global levels, in order to improve the health of students, school personnel, families and other members of the community through schools.

2. One of the authors (Margaret Hodgins) conducted the independent evaluation on which this paper is based; the other (Lynn Swinburne), as a staff member of the NYHP, supported and facilitated the evaluation but was not directly involved in conducting it. See the biographical notes.

3. Key to attributions: FG = focus group; HP = Health Promoter; M = Manager; TM = Team member; SP = strategic personnel; prefix gf = organisation going forward for award.

4. ‘Health promotion is the process of enabling people to increase control over, and to improve, their health’ (WHO, 1998a).

References


Toronto Health Communication Unit (2005) Evaluating Comprehensive Workplace Health Promotion version 1.0. Toronto:Centre for Health Promotion, University of Toronto.


Biographical Note
Margaret Hodgins MA, PhD, Reg. Psychology, is a Lecturer at the Department of Health Promotion at the National University of Ireland, Galway and is a Project Leader in the Health Promotion Research Centre. She was the independent evaluator of the Health Quality Mark initiative.

Lynn Swinburne MA is Screening Promotion Officer with the National Cancer Screening Service. She was formerly Health Promotion Coordinator of the National Youth Health Programme, National Youth Council of Ireland, in which capacity she played a strategic role in developing the NYHP’s Health Quality Mark from 2003–2008.

Address
Dr Margaret Hodgins,
Department of Health Promotion,
Clinical Science Institute,
National University of Ireland, Galway,
University Road, Galway, Ireland.
Tel: +353 – 91- 493092 / 493644
Email: margaret.hodgins@nuigalway.ie