



Waterford Institute of Technology

**An Evaluation of the GAA Healthy Club Project**

**By**

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## Honesty Statement

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I declare that the work submitted is my own work. Any of the data presented was collected and analysed by myself and is accurate. Appropriate credit has been given where reference has been made to the work of others.

Signature: \_\_\_\_\_

Alex Donohoe

Date: \_\_\_\_\_

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# Abstract

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## **Introduction**

The sports club has recently been identified as a new setting for health promotion. In Ireland, a Gaelic Athletics Association (GAA) sports club exists in almost every community with a remit that extends beyond promoting Gaelic games. The Healthy Club Project (HCP) was devised by the GAA and HSE in an attempt to both harness current and encourage future health promotion efforts within a GAA club setting. The purpose of this study was to carry out a process and impact evaluation of the HCP.

## **Methods**

Eighteen GAA clubs self-selected to take part in phase one of the HCP. Data were collected using pre and post questionnaires containing a healthy club index, adapted from a tool developed by Kokko, Kannas et al. (2009). Club representatives and stakeholders involved in the HCP also took part in focus groups to describe the process, and outcomes of engaging in health promotion through sport. Quantitative analysis was carried out using SPSS and qualitative data was processed using thematic content analysis.

## **Results**

Twelve clubs completed the baseline and follow up questionnaires, a retention rate of 75%. Analysis revealed that clubs progressed from being on average moderately health promoting at baseline to high health promoting at follow up, scoring lowest for policies and highest for ideologies. In total, clubs delivered 72 health initiatives, with physical activity, emotional wellbeing and health awareness/first aid proving to be the most popular topics covered. Results also showed that clubs viewed health promotion as a natural progression of work already underway in their club, and could see positive implications resulting for engaging in this type of work.

## **Conclusion**

The analysis endorses GAA sport clubs as a viable setting for health promotion in an Irish context. Clubs are actively engaging in some health related activities and are eager to engage further. Clubs however, require support to ensure health is included on the agenda of the club, and embedded into all club operations.

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**Silent gratitude isn't much use to anyone.**

**G.B Stern**

...so thanks again to all

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# Chapter 1 Introduction

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## 1.0 Background

The Department of Health recently devised a framework for improved health and wellbeing from 2013-2025 titled 'Healthy Ireland'. The framework establishes sport as a partner and an important avenue in promoting public health. Sports clubs are prevalent leisure-time settings for youths and adults in all corners of the globe. In Ireland, 1.7 million adults and 800,000 youths aged 16 and under participate in sport every year (Federation of Irish Sport, 2014). As a country with a population of 4.7 million, figures show sports participation is at an encouraging rate with over half the population involved in sports activities. Owing to their societal position and accessibility, the 12,000 sports clubs in Ireland are in high demand (Kokko, 2010, Federation of Irish Sport, 2014). In addition, sport, especially that related to children and adolescents is the single largest source of volunteering with over 500,000 people volunteering in sport each week (Federation of Irish Sport, 2014).

Most sporting organisations exist primarily as a competition orientated entity but many expectations beyond sport exist (Kokko, 2010). Participation in regular and moderate levels of physical activity has numerous health benefits and with an increasing number of young people joining sports clubs they are a key demographic for societal interventions on physical activity but also on the broader subject of health (Geidne et al., 2013). It has been suggested that sports clubs have two types of agendas; the official agenda which has sport related objectives and then the unofficial agenda which can have health related activities (McPhail et al., 2003). For example, in Finland 79% of youth sports clubs emphasise healthy lifestyles in their objectives although only some health promotion activities get translated into practice (Kokko and Kannas, 2004, Heikkala and Koski, 1999)

The concept of a health promoting sports club has only recently garnered attention (Kokko et al., 2004). This concept is centred upon the settings-based health promotion approach which encapsulates the five key strategic areas of the Ottawa Charter (building health

public policy, creating supportive environments, strengthening community actions, developing personal skills and reorienting health services). A settings approach recognises that people's health and health behaviours can be influenced more effectively by targeting settings, rather than individuals (Whitelaw et al., 2001). Dooris (2004) outlines the main three components of this approach: creating healthy and supportive environments, integrating health promotion into daily activities of the setting and finally understanding that people do not operate in one setting; so links need to be made with the wider community. Individuals' health is the eventual goal, but the approach predominantly works to create social and environmental systems which support and reinforce health promotion messages (Lloyd et al., 2007). Literature shows that the settings based approach to health promotion has been applied to workplaces, schools, universities, cities, hospitals and prisons. However, the relationship between sports clubs and health has been investigated far less. Sports clubs form an integral part of Irish society reaching deep into communities and transcending competition in many cases as an opportunity for people of all ages to become part of something bigger than themselves. This demonstrates that as well as the physical environment, the social, cultural and organisational environments of the setting are equally important. A club is therefore more than just an enabler for exercise but can potentially support healthy attitudes, values and behaviours.

Through opening up a club to the wider community and showcasing a welcoming and family friendly image, clubs themselves may potentially benefit by generating and retaining more active membership, enticing more spectators and sponsors and recruiting more volunteers from their growing social network (VicHealth, 2014). Sports clubs have the potential to promote and facilitate healthy behaviours and attitudes within the club while simultaneously boarding their membership base. Sports clubs are a newly emerging setting for health promotion, therefore the concept of sports clubs as a setting for health promotion holds much potential but has been relatively unexplored, with little published literature on how health promotion through sport can be achieved (Casey et al., 2011).

In relation to the current international status of research and practice on healthy sports clubs, work has been carried out in Australia on generating guidelines for what constitutes a healthy club, and on the role of sponsorship and policy in facilitating more healthy

behaviours. Policies and procedures to guide the development and understanding of healthy sports clubs have been developed in Europe, while there have been efforts also to develop and evaluate healthy clubs and health promotion initiatives in a variety of individual sports organisations.

In 2010, the Healthy Sporting Environments Demonstration Project (HSEDP) was implemented in 100 sports clubs in Australia to guide healthy practice for sports clubs in the areas of healthy eating, reduced tobacco use, responsible alcohol use, UV protection, injury protection and inclusion/safety/support. The HSEDP is based on the understanding that community sports clubs play a pivotal role in health promotion providing meeting places, social networks and community involvement opportunities especially in rural communities (Nicholson et al., 2013). Evaluation indicated that while clubs took some positive steps in relation to institutional change there was little impact on health behaviours over a two-year period but this may take some time to manifest (Nicholson et al., 2013). In Europe, Sports Club for Health Guidelines have been developed to help clubs engage in health promotion but have not yet been evaluated (Kokko et al., 2011). There have also been some examples of effective 'sports for health' interventions. The Good Sports programme, launched in 2001, aimed to assess the prevalence of alcohol policies and practices of sports clubs in Australia. An evaluation of the Good Sports alcohol programme showed more positive drinking patterns, lower reliance on alcohol sponsorship for income and greater membership at follow up (Crundall, 2012). While in Scotland, the Football Fans in Training (FFIT) programme, delivered through professional soccer clubs, has reported significant reductions in weight, self-reported physical activity, alcohol intake and measures of physical and psychological wellbeing (Hunt et al., 2013).

The GAA Healthy Club Project (HCP) represents a relatively unique attempt by a national governing body to formally integrate health promotion into the activities and ethos of sports clubs. This initiative led by the GAA and HSE aims to both harness current and encourage future health promotion activity within a GAA club setting. This venture is aligned with the Healthy Ireland Framework, which emphasises the need for community and cross-sectoral action to achieve better health and wellbeing in Ireland. Based on a

settings approach, the aim of the HCP is to explore the potential of the GAA club as a setting in which to promote the health and wellbeing of club members and the wider community. As noted earlier, sports clubs exist primarily to promote sport and thus are involved in promoting physical activity but not always in a health enhancing way. There exists an opportunity to work with sports clubs to promote physical activity, by ensuring greater and more sustained participation in their clubs but there is also potential for clubs to promote health more broadly, not only in the club but in the wider community in which the club exists. Anecdotally at least, the club can benefit from such activities by developing a stronger and more diverse membership and potentially higher levels of performance, as well as greater community support.

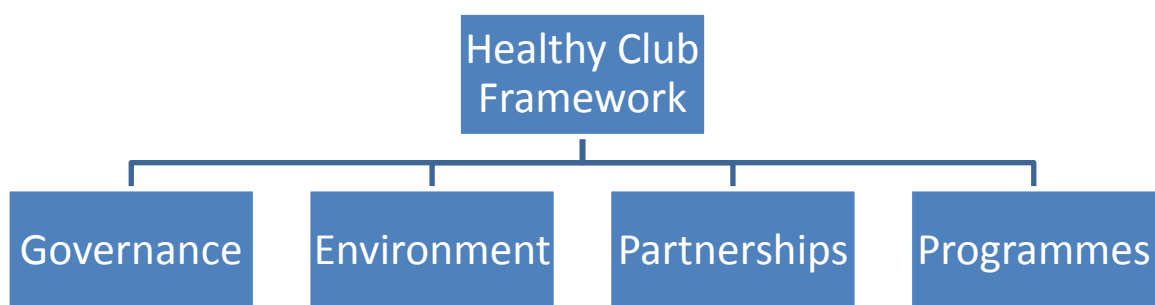
Gaelic Games is the umbrella term given to the sports of gaelic football, hurling, camogie, ladies football, handball and rounders, all of which are organised by the Gaelic Athletic Association or GAA. Ladies football and camogie have their own distinct organisations at national level but none the less are still part of the GAA family and share club facilities and playing pitches at a local level (Delaney and Fahey, 2005). The GAA is a volunteer community based organisation operating throughout the 32 counties of Ireland and across the world. The organisation has the largest membership of any sporting National Governing Body (NGB) in Ireland with over 500,000 members registered in 2014 (Gaelic Athletic Association, no date). There are approximately 2000 GAA clubs throughout Ireland, and thus the reach of the organisation extends into almost all communities nationwide. Additionally, the GAA also have 392 affiliated clubs based internationally (Gaelic Athletic Association, 2015). Spectators and supporters continually show their unwavering devotion to the game with over one and half million turning out to enjoy inter county hurling and football championship games in 2014. During the Summer months GAA camps (Cul Camps) cater for nearly 90,000 aspiring young male and female hurlers and footballers (Gaelic Athletic Association 2015). A unique feature that sets the GAA apart from other sports organisations is that general club members make up a significant proportion of the membership, being even more numerous than players. A feature that can be attributed to the association's incomparable network of local clubs, with membership also spread evenly across factors such as social class, age and gender (Delaney and Fahey, 2005). The common theme with volunteering in sport is that non-players or former players constitute the

majority, while other volunteers are also players (Delaney and Fahey, 2005). As the largest sporting organisation on the island of Ireland, the GAA is unrivalled in terms of the number of volunteers that give their time to running the association's expansive network of local GAA clubs. Delaney and Fahey (2005) suggest the GAA (football, hurling, camogie and ladies football) accounts for over 40% of all sports volunteering, which is an impressive statistic when you compare it to the soccer, the second largest sport in Ireland, which accounts for just 17% of volunteering in sport. It is clear to see, that volunteers are the lifeblood of every club, without which the clubs very existence could not be sustained (Gaelic Athletic Association, 2013). The amateur status of the GAA is highly valued by the association and reflected in the association's mission statement 'The GAA is a community based volunteer organisation promoting Gaelic games, culture and lifelong participation' (Gaelic Athletic Association, 2009). The GAA's strategic vision and action plan 2009-2015 acknowledges the key role played by volunteers and highlights key projects such as an Annual Volunteer's Forum with the aim of continuing to 'value and encourage our volunteers' (Gaelic Athletic Association, 2009). Encouragingly, in the recently published GAA strategic plan 2015-2017 a commitment was also given to focusing efforts in the area of health and wellbeing for players, club members, coaches, and administrators through policy development and an educational campaign (Gaelic Athletic Association, 2015).

Being the largest community-based sporting organisation in Ireland, the GAA is thought to deliver numerous health benefits beyond the promotion of Gaelic games including physical activity, social interaction, and developing a civic responsibility to members and communities through its club system. These benefits, combined with the GAAs philosophy of fostering a community identify, supporting inclusion for all members of society, and operating on an amateur basis, and thus relying on volunteers to operate and function, reinforces the suitability of the GAA club as an entity that can engage in health promotion activities. Of late, the organisation has also recognised the diverse and changing health needs of their members with a demand for assistance in areas such as: healthy eating and diet, drug and alcohol awareness, mental well-being and resilience development, suicide prevention and response, and the promotion of health and well-being through physical activity. The GAA embarked on an initiative in 2006 where health promotion activities were delivered through its Alcohol and Substance Abuse Prevention (ASAP) Programme. In

partnership with the HSE, a national co-ordinator was employed through a Service Level Agreement (resources developed include a Club Drug & Alcohol policy template, a manual, an educational DVD, promotional materials, and a presence on the GAA's national website). By 2012 both the GAA and the HSE recognised that focusing on a singular health topic did not adequately respond to the broad and varied health needs of the Association's membership base, or reflect the degree of health promoting work many GAA clubs were already engaging in. It was subsequently agreed that both entities would explore the potential of the GAA club as a setting in which to promote the health and wellbeing of club members and the wider community. In particular, men and disadvantaged groups within society tend to engage less with traditional health services and suffer a greater burden of ill-health. As previously mentioned, the GAA's membership is spread evenly across social class and gender and therefore, presents an additional opportunity to engage these risk groups in health promotion activities they may otherwise not experience.

In order to reflect and respond to the health and wellbeing needs of a modern GAA club membership a Healthy Club Framework was developed. The approach focuses on a four pillar method of implementation with the aim of creating a sustainable model for all clubs. The four pillars which support the Healthy Club framework include: Governance, Environment, Partnerships and Programmes (*figure 4*).



**Figure 1 GAA Healthy Club Framework**



The model of implementation chosen offers 'clubs a structure that highlights existing areas of competencies whilst also identifying new areas to target' (Gaelic Athletic Association 2013).

- The governance aspect of the Healthy Club framework relates to the setting up of a Healthy Club Committee and having Healthy Club ideals written into the club's constitution and regulations. A key feature in the annals of public health triumphs is the role played by policy interventions. The governance aspect focuses on policy and executive support for health promotion in the club given a policy approach to health promotion is one of the most effective ways of achieving reform (Health Service Executive, 2012). It is essential that health promotion be embedded into the philosophy and working agenda of clubs. This will be assisted by the development of club and regional health and wellbeing committees that will be guided and mentored by a national steering committee. It remains important though that health promotion is packaged for clubs as an activity that can benefit the club in its day-to-day remit of playing, coaching, and administration, as well as increased community engagement.
- For this project the GAA defined environment to mean the physical and/or sociocultural culture and ethos of the club where healthy lifestyles are facilitated through all policies, programmes, facilities, and activities of the club. The environment aspect of the framework therefore highlights generating a physical, social, coaching, playing, and cultural environment that is conducive to health and well-being. Creating this type of health promoting infrastructure was emphasised in the Jakarta Charter (World Health Organisation, 1997). For example, the proficiency and support of the coaches and leaders affects the quality of the youth sport experience, and so the training of coaches therefore needs to be a priority if health promotion is to be sustainable and embedded into the culture of a club from the grassroots up (Duda et al., 2013).
- In relation to the partnerships feature of the framework, the emphasis is on clubs extending their reach and capacity by engaging with relevant local stakeholders and statutory and non-statutory organisations. A partnership is defined as 'a voluntary

agreement between two or more organizations to work cooperatively toward a set of shared outcomes' (Gillies, 1998). The importance of partnership working to promote health, particularly in a health promotion setting, has been outlined as far back as the 'Health for All' movement endorsed by the WHO in 1978, and reemphasised in the Jakarta Declaration 1997 and the Bangkok Charter 2005 (Health Service Executive, 2012). 'Partners contribute their expertise to enhance understanding of a given phenomenon and to integrate the knowledge gained with action to benefit the community involved' (Israel et al., 1998). These partners may be individuals or organisational resources from within a club and community but accessing skills and resources available from outside of the immediate community may also prove beneficial (Israel et al., 1998). With this in mind partnerships can contain up to one hundred people or just two people working together on a health promotion project (Health Service Executive, 2012) and can be formal or informal.

- Programmes are also to be offered in the areas of key health concern. The programmes element is concerned with developing and providing initiatives designed to tackle health issues specific to the needs of the community based upon the principles set out by the GAA and HSE. Programme development is an integral part of any health promotion strategy and involves 'identifying and prioritising health issues and needs, agreeing appropriate interventions to address these health issues and needs, and finally committing support and resources for health promotion strategies' (Health Service Executive, 2012).

Participating clubs were required to appoint a Healthy Club coordinator/officer and a committee. The priority of the Healthy Club Committee initially was to consult with the local community on areas of main concern in relation to health and well-being. Therefore, a needs assessment questionnaire was developed and made available to club and community members, allowing action plans to be developed and implemented addressing the prevalent health concerns highlighted. The Healthy Club steering committee at GAA headquarters also established ten Healthy Club principles and criteria/indicators that participating clubs must adhere to as part of the Healthy Club process:

- ❖ Health promotion is a core value of the club (*Priority Status*)
- ❖ The club offers activities and programmes in key areas of public health concern (*Breadth*)
- ❖ The club takes a holistic approach in all its health related activities (*Holistic Approach*)

- ❖ The club builds capacity and positively influences health through the development of partnerships and alliances with the wider community (*Partnerships*)
- ❖ The club promotes and supports the health and well-being, not just of active members, but parents, retired players, and members of the wider community (*Reach*)
- ❖ The club strives to positively influence the personal development of all members, particularly young players through leadership, example, and provision of formal programmes or opportunities (*Personal Development*)
- ❖ The club encourages members with relevant qualifications to become actively involved in developing/co-ordinating healthy club activities (*Skills Utilisation*)
- ❖ The club endorses sponsorship which promotes healthy behaviours (*Responsible Sponsorship*)
- ❖ The club's health-related activities are sustainable (*Sustainability*)
- ❖ The club promotes the principles of 'fair play' and 'everybody plays' (*Equity*)

(Gaelic Athletic Association, 2013)

Over the two year period which signified phase one of the HCP, 18 community based GAA clubs from across Ireland put in place action plans to promote good health to their membership. They were supported in addressing the health needs most relevant to their individual communities which covered topics such as physical activity, nutrition, emotional wellbeing, social inclusion, anti-bullying, substance misuse and health awareness. The evaluation presented in this thesis relates to the initial stages of the Healthy Club process, as clubs considered, planned and integrated health promotion into club activities in accordance to the structure and specifications of the GAA Healthy Club Framework (Governance, Environment, Partnerships and Programmes).

## **1.1 Purpose of the study**

The purpose of this research is to assess the impact of the HCP on key outcome markers including club policy, practice, ideology and environment, as well as examining the process of becoming a Healthy Club from the perspective of all stakeholders involved. The outcomes resulting from the implementation of key programmes within the project will also be investigated.

## **1.2 Study Aim**

The aim of this study is evaluate the potential of an Irish GAA sports club as a setting for health promotion.

## **1.3 Study Objectives**

- ∇ What is the effect of the HCP in relation to policy, ideology, practice, environment, and juvenile (u18) coaching environment?
  
- ∇ What is the process of the development of a Healthy Club over the duration of the initiative?
  
  
- ∇ What is the process and outcome of specific initiatives delivered by clubs?

## **1.4 Overview of Thesis**

This thesis consists of six chapters. As can be seen, chapter 1 sets the scene and introduces the research and its context.

Chapter 2, the literature review, explores the relevant literature pertaining to i) the concept of health promotion and using a setting based approach to promote health; ii) the value of sport to health; iii) previous health promotion interventions in a sports club setting and iv) the potential of sports club to promote health. Chapter 2 will conclude with an overview of the GAA's Healthy Club Project.

Chapter 3 introduces the methodological approach to data collection and analysis. A mixed methods approach underpinned this research.

Chapter 4 presents the findings from the evaluation of the GAA's Healthy Club Project.

Chapter 5 will critically examine the findings from chapter 4 in light of the previous literature outlined in chapter 2.

Chapter 6 provides an overall conclusion to the thesis.

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## Chapter 2 Literature Review

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In this chapter the theory behind health promotion, its determinants, and how the concept of health promotion could be applied to a sports club setting will be examined. From previously published literature examples of settings based health promotion initiatives, including those in communities, workplaces, and schools, will be presented and critically reviewed. The value of sport to health and the rationale for using a sport club as a health promoting setting will be analysed and from the available literature the potential of a sports club as a healthy setting will be reviewed and summarised. Finally, an overview of the GAA and the framework for the GAA's Healthy Club Project (HCP) will be presented.

### 2.0 Health

The World Health Organisation (WHO) (1986) defined health as 'a complete state of physical, mental and social well-being, and not merely the absence of disease or infirmity'. This definition showcases the complete nature of health encompassing 'social and personal resources and physical capacity' (World Health Organization, 1986). Well-being is also acknowledged an important element of health for both communities and individuals alike as it reflects 'the quality of life and the various factors which can influence it over the course of a person's life' (Healthy Ireland, 2013 ).

### 2.1 Health Promotion

Health promotion is defined as the 'process of enabling people to increase control over and to improve their health' (World Health Organisation, 1986). The origins of health promotion as a defined field of health policy and practice can be tracked back to the Canadian Minister for Health and Welfare Marc Lalonde (Poland et al., 2000). In 1974, he released 'A New Perspective on the Health of Canadians', a national government policy document which acknowledged health promotion as a key method of tackling the health of a population through the improvement of social and environmental conditions (Poland et al., 2000, Bracht and 1999). The interest generated by this report was supported at the first International Conference on Health Promotion 1986 culminating in the issuing of the Ottawa Charter for Health Promotion (World Health Organisation, 1986). The Charter defined the parameters through which health promotion could be implemented and

sustained. These included providing definitions relating to the theoretical basis and mechanisms for supporting the adoption and introduction of health promotion, signifying a move from the traditional illness centred perspective towards a recognition of the physical, social, and environmental determinants of health (Barnekow et al., 2006, Kokko et al., 2013). The Ottawa Charter stated that ‘health is created and lived by people within the settings of their everyday life, where they learn, work, play and love’ highlighting the importance of settings in the delivery of health promotion. The Charter also presents three basic strategies for health promotion (Advocate, Enable and Mediate) presented in Table 1 below.

Table 1 Strategies for Health Promotion

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<b>Advocate</b>	The political, economic, social, cultural, environmental, behavioural and biological climate can all impact on health in a positive or negative manner. Advocating for health is one action that can help create favourable conditions to improve health.
<b>Enable</b>	In order to help people unlock their health potential, inequalities in health must be reduced to allow equal opportunities and resources to enable people to reach their maximum health potential.
<b>Mediate</b>	Effective health promotion needs all section of society from governments and local governments to voluntary organisation and individuals to work together in a coordinated fashion. Health professional have the major task of mediating between all these differing needs across society.

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(World Health Organisation, 1986)

The Charter additionally laid out five key focus areas for health promotion: building healthy public policy, creating supportive environments, strengthening community action, developing personal skills and reorienting health services (Table 2). This reflects the socio-ecological model of health, which advocates a more holistic approach to health highlighting the variety of factors, beyond those related to the individual that influence health.

Table 2 Health Promotion Action Areas

<b>Building Healthy Public Policy.</b>	Legislation, policy and organisational structuring need to facilitate health to become an easier choice.
<b>Creating Supportive Environments.</b>	To generate living and working conditions that are safe, stimulating, satisfying and enjoyable.
<b>Strengthen Community Action.</b>	Utilising existing human and material resources in the community to boost social support, strengthen public participation and influence matters of health.
<b>Develop Personal Skills.</b>	Providing education, skills training and supportive information to develop personal and social skills.
<b>Reorient Health Services.</b>	Ensuring the health care system moves towards health development and cultural needs of the population.

(World Health Organisation 1986)

## 2.2 Determinants of health

Various factors operate independently and in combination to impact on the health of individuals and communities. The Healthy Ireland (2013) framework comments on how health is not evenly distributed in society, with the occurrence of chronic diseases and associated lifestyle behaviours being heavily linked to variances in socio-economic status, levels of education, employment and living conditions. The persistent inequalities in health are also associated with inequalities in wealth and earnings (Wilkinson, 1996). This is most starkly illustrated by the overall increase in life expectancy which has not extended evenly across all fractions of society (Naidoo and Wills, 2000). Therefore, a person's health can be governed by their circumstances and environment, including factors such as where one lives, genetics, income and education level, and relationships with friends and family. The determinants of health are thus seen as the influencers of health and well-being, and are directed by social and financial disparities (Marmot Review Team, 2010). Health promotion works to address the determinants of health and health inequalities. There is a need for an 'inter-sectorial or partnership approach' since 80% of what constitutes health lies outside the responsibility of the health sector (Kickbush and Quick, 1998). Similarly, Notara and Sakellari (2013) remark how as little as 10-20% of individual's or populations health actually

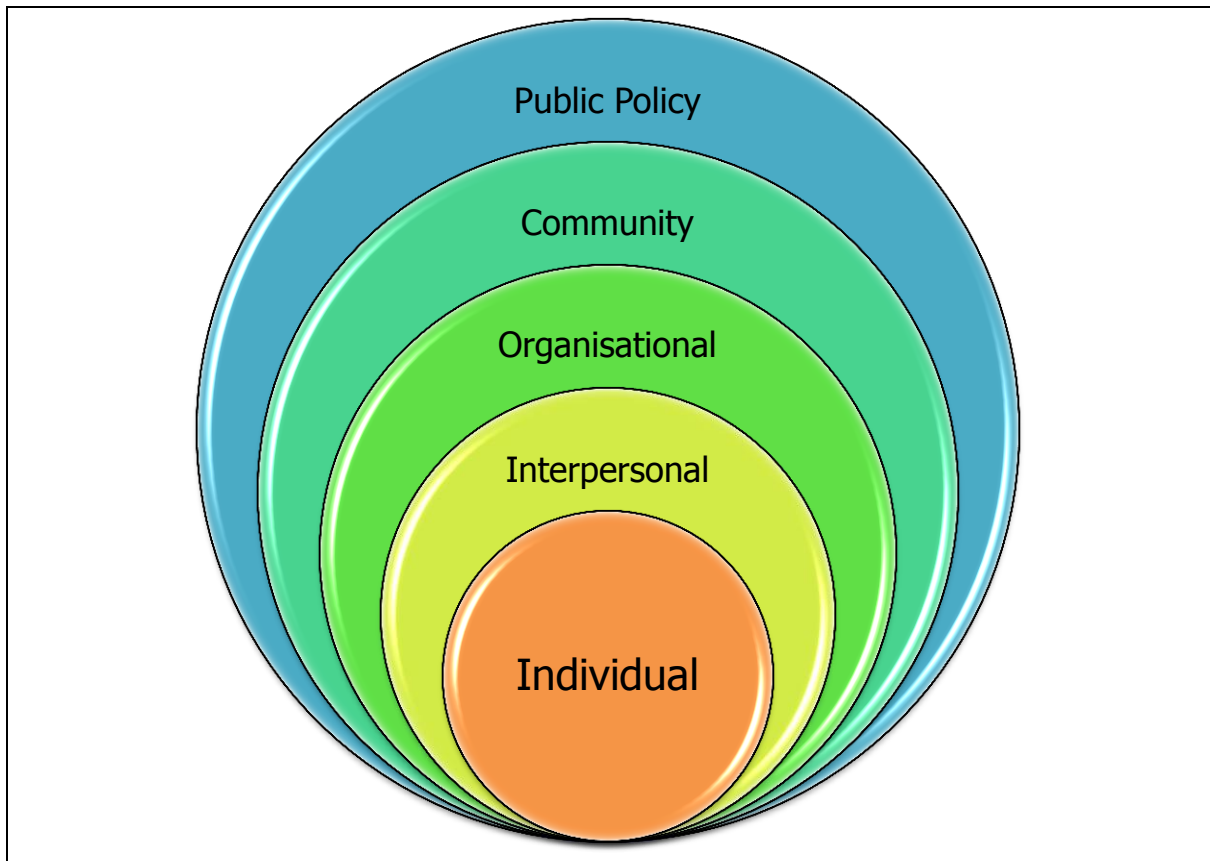


hinges on the delivery of health care services compared with other factors, made up of namely biological, environmental, and personal behaviour factors. Moving to lessen health inequalities therefore requires action across society as a whole as opposed to focusing on the health sector in isolation (Marmot Review Team, 2010). Building a health care system without consideration for the wider biopsychosocial factors of health and well-being would be injudicious in terms of health development (Notara and Sakellari, 2013).

### **2.2.1 The Socio-ecological Model**

The socio-ecological model considers that 'health is a multifaceted relationship of determinants of health with attention paid to health equity' (Keleher and Murphy, 2004).

Devised by Urie Bronfenbrenner 1979, the then called social ecology model, centres the individual and illustrates all the determining influences that impact upon that individual's development and thus their health status (Keleher and Murphy 2004). Ecology itself refers to the interrelationships seen between organisms and their environment (Stokols et al., 2013). Updated and modified, the now called socio-ecological model, as seen in *figure 1*, takes Bronfenbrenner's original model and combines it with the environments in which individuals interact. The model is therefore able to identify the interlinked relationships that exist between an individual and their environment, while also emphasising the dynamic interaction between situational and personal factors.



*Figure 2 Socio-ecological Model*

Understanding that most public health challenges are too intricate to be adequately understood and addressed from a single level analysis, a comprehensive, multi-level approach is needed (Robinson, 2008). The inherent characteristics of an individual are not enough to determine whether that individual will take part in and sustain health enhancing behaviours throughout their lifetime, that responsibility falls much wider than on the individual alone (Department of Health and Children, 2000). Social, organisational, community, and public policy aspects are all powers of persuasion when it comes to individual participation and adherence to healthy behaviours. Therefore, the interaction of all aspects of health are required to formulate a change in behaviour (Nutbeam, 1998).

The individual is at the heart of the socio-ecological model. This level includes knowledge, attitudes, behaviours, beliefs, age, sex, gender, socio-economic status, and other such factors that increase or decrease the likelihood of the individual being healthy. Surrounding the individual is the interpersonal level, which includes family, friends, and social networks all of whom have the ability to strongly influencing an individual's attitude towards health.

Next, the organisational layer refers to institutions such as schools where both environment and ethos are determining factors of health behaviour. The community level of the socio-ecological model looks at the interactions among organisations considering both the built and natural environment. Finally, policy can range from national government to local government to informal local policies in settings such as schools and clubs. The potential for a variety of public policies to promote health gained increasing attention in the 1980's as it was realised that health and illness were rooted in households, workplaces, schools, communities and other environments in which people live and socialise, supporting the socio ecological view in advocating health through favourable public policy (Badura and Kickbush, 1991). Behaviours are significantly influenced through each level, with each level in turn impacting on the next.

It is apparent that health promotion is at its most effective when it tackles multiple levels with the appropriate strategies, recognising the influence of external factors on individual's health behaviour (Kothari and Birch, 2004). In truth, if an individual is to achieve health and well-being, that responsibility should not rest with the person alone (Department of Health and Children 2000). In order to encourage healthy lifestyle behaviours, we must look beyond the individual and into the wider settings in which they conduct their daily lives.

### **2.2.2. Partnerships**

In order for the socio-ecological model to be integrative in practice it requires organisations to work together towards a common goal of promoting health. The focus must not be on individuals, but rather on existing groups of individuals who represent all fractions of a society working in coalition. Partnership can be a difficult concept to define as 'working together' can take on various different meanings on a continuum from informal contact marginal to the goals of organisations involved, to formal structured contact central to the organisations activities (Boydell, 2007). The Health Education Board for Scotland define a partnership as being when 'two or more organisations make a commitment to work together on something that concerns both, to develop a shared sense of purpose and agenda, and to generate joint action towards agreed targets' (Health Education Board for Scotland, 2001). The partnership must also contain a strong level of commitment, trust and ownership if the common goal is to be achieved (Stern and Green, 2005). Both the WHO

Jakarta Declaration (1997) and the Bangkok Charter for Health Promotion (2005) affirmed the importance of partnerships for health by recommending that empowering communities to improve their health and reduce health inequalities can be achieved through partnerships (Lloyd et al., 2007, World Health Organisation, 1997, World Health Organisation, 2005). Similarly, the Irish government have acknowledged the importance of partnerships, appreciating that health needs must be tackled on a much broader scale than by the health sector in isolation. The recently launched 'Healthy Ireland' framework identifies a comprehensive list of partners to improve Ireland's health and wellbeing, see *figure 2* below. A review of the literature by Carlyn and Bracht (1995) found the elements that make up effective partnerships or coalitions included skills such as leadership, management, communication, conflict resolution, perception of fairness, shared decision making, and believing the time given has been beneficial (Carlyn and Bracht, 1995).



**Figure 3** Health Ireland Working in Partnership

## 2.3 Approaches to Health Promotion

### 2.3.1 Setting's based approach

The concept of 'setting' is fundamental to health promotion (Kokko et al., 2013). The socio-ecological perspective has been a significant factor in the amplifying interest in a settings based approach to health promotion. 'A setting is a place comprising a location and its social context in which people interact daily' (World Health Organisation Regional Office for the Western Pacific, 2000). The World Health Organisation defines the settings based approach to health as 'the place or social context in which people engage in daily activities in which environmental, organisational and personal factors interact to affect well-being' (World Health Organisation, 1998). The settings approach therefore acknowledges the role environments play in influencing health and health behaviour (Kelleher, 1998). This supports the above discussion on the determinants of health whereby, we understand the responsibility of promoting health extends beyond the health sector alone and requires a collaborative effort with other settings and institutions to achieve a wide-ranging approach to promoting health and well-being. To utilise this fact, the settings approach to health promotion is based on understanding, appreciating, and working with the settings where people are educated, work and live in to positively impact health behaviours. Dooris (2004) described how a settings approach reflects an ecological approach viewing health as the resultant creation when individuals and their environment interact. Indeed, Whitelaw, Blaxendale et al. (2001) explained how changing people's health and health behaviours are easier to accomplish when the setting is focused on, as opposed to the individual. In defining the setting approach, Dooris (2004) conceptualises the approach into 3 key areas including environmental support, incorporating health into everyday activities, and settings impact upon one another as people operate in more than just one setting.

The focus therefore, needs to be placed on the social, environmental, economic, and policy determinants of health rather than the individual, again reflecting the socio-ecological approach to improving health. Following on from the Ottawa Charter, at the fourth International Conference on Health Promotion, the Jakarta Charter 1997, recognised health promotion as an investment not just in human health but also in terms of social and economic development (Dooris, 2004). Robust inter-sectoral collaborations are therefore

crucial in underpinning the effective implementation of a health promoting model into communities allowing both those individuals and communities to exercise greater control over factors influencing their health (Health Service Executive, 2012).

### **2.3.2 Common Settings for Health Promotion**

Health promotion has been common place in a variety of settings. The health promotion settings approach is directed towards altering environmental conditions and organisational norms, together with developing personal and social skills through education, to facilitate health-related skills to be acquired throughout life (Geidne et al., 2013). Examples of where a settings based approach to health promotion has been utilised in the 21<sup>st</sup> Century, such as communities, cities, schools, and workplaces, will be presented in this section.

#### **2.3.2.1 Community**

In 1979, the Surgeon General's report on health promotion and disease prevention was concerned with individual's health habits and lifestyle practices (Stokols, 1995). Current trends however, show there has been a shift in emphasis away from individually centred explanations towards strategies that incorporate environmental and behavioural elements within the wider community that are conducive to both collective and individual health (Stokols, 1995). Goodman et al. (1996) makes the point that while decreases in risky behaviours are desirable outcomes from community interventions these changes often depend on larger scale social changes or alterations in social ecology. The reasoning for community based health promotion originates from a perspective that realises changing individual risk behaviours must be considered within the social and cultural context in which it occurs. Health promotion programmes therefore need to target social influences such as community norms and the structure of community services, along with personal factors (Goodman et al., 1996, Merzel and D'Afflitti, 2003).

As illustrated in *Figure 1*, community is the fourth level of the social-ecological model and looks at the interactions among organisations, and both the built and natural environments. A community based settings approach includes a variety of populations ranging from men, women, children, families and friends to neighbour hoods, villages, towns and voluntary organisations. In addition to population groups a community also includes the physical environment in which human interactions take place (Health Service

Executive, 2012). This can be a challenge for community based interventions where the community setting doesn't possess a fixed boundary (Poland et al., 2000). While a community may lack a precise boundary, the many settings of which a community is made up of including schools and workplaces provides a unique opportunity to offer health promotion to its inhabitants from all backgrounds. In this regard, community may be less about the physical space and more about the relationships and interactions of people. The Ottawa Charter, outlined at the beginning of this chapter, acknowledges the need for active communities rather than passive communities when it comes to matters that affect health (World Health Organisation, 1986, Health Service Executive, 2012). Three of the five action areas stated in the Charter are applicable to community settings: building healthy public policy, creating supportive environments and strengthening community action. Community based approaches generally encourage capacity building meaning training and skill development to strengthen communities and enable individuals to take control of their health (de Silva-Sanigorski et al., 2010). Fostering ownership and community participation are also important in facilitating long-term changes in the social and built environment that support positive health related behaviours (Kegler et al., 2003).

While we know that evaluation is crucial to sustaining and growing health promotion projects, there is a paucity of evidence in existence regarding the effectiveness of community based health promotion programmes (Cullen et al., 2006). Despite several attempts to evaluate community based health promotion activities, factors such as trying to measure long-term behaviour change from short term projects, projects being based around broad and multiple goals, and the challenge of tailoring programmes to diverse community needs makes the process fraught with difficulty (Cullen et al., 2006).

#### **2.3.2.1.1 Community Health Promotion Initiatives**

The North Karelia Project, Finland, was a pioneering effort in incorporating the above theory into a communitywide setting (Puska et al., 1985). The project's design, as well as its approach to community, intervention, and measurement is now used as a yardstick to measure the adequacy of subsequent community based prevention programmes (Bracht, 1999). The project was developed by the Finnish government in 1971, in response to

growing morbidity and mortality rates due to cardiovascular disease (Poland, Green et al. 2000). At that time, Finland's coronary heart disease (CHD) mortality rates were amongst the highest in the world (Bracht 1999). Using a community based programme design, the project aimed to treat and prevent heart disease by reducing risk factors through the implementation of strategies such as education, behavior change programmes, environmental support, skills training, and community organization which consisted of training programmes for local informal leaders (McAlister et al., 1982). Puska et al.'s (1985) 10 year evaluation study showed considerable reductions in the key biological risk factors for cardiovascular disease for both men and women. Over the next 20 years, Finland saw a 50% decrease in CHD death rates (Puska, et al., 1985).

Another successful example of a community as a setting for health promotion is the 'Healthy Cities' initiative. A healthy city is defined as 'one that is continually creating and improving those physical and social environments and expanding those community resources which enable people to mutually support each other in performing all the functions of life and in developing to their maximum potential' (Baum, 1993). In addition, the HSE (2012) definition includes the need to promote policies and action for health and sustainable development. Over 1,200 cities, including Dublin and Galway, and towns in more than 30 countries in the WHO European Region are now healthy cities (Health Service Executive, 2012).

The healthy cities initiative was developed in response to rapid urbanization and the realization that urban health problems were often outside the remit and capacity of just the health sector. This instigated the development of an integrated and intersectoral approach to health with community participation being a core value (World Health Organisation, 2000). It was essentially a means of putting all the elements of the Ottawa Charter into practice (Bracht, 1999). The healthy cities model followed three key phases. Phase one involves raising awareness, establishing an intersectoral task force and gaining support from local government; phase two looks to develop organisational structure, working mechanisms, and a plan of action for the project; phase three works to implement the proposed plan of action and continue to create sustainable mechanisms to safeguard health promotion practices within the city (World Health Organisation, 2000). A key recommendation of the healthy cities project is that in order for the project to be both



fruitful and sustainable 'people and the local government must make a commitment to the improvement of their health and quality of life and mobilize their own resources and apply their innovative ideas to develop and implement the project' (World Health Organisation, 2000). The degree of political commitment is therefore a determinant of project activity level (Bracht, 1999). Secondly, creating a greater sense of community generates well-being and in doing so helps to retain programme participants, which is vital information for policymakers in any setting (Berg et al., 2014).

Topic specific interventions have also been widely used in community settings, covering areas such as diet, physical activity, smoking etc. One such example is ASSIST the American Stop Smoking Intervention Study for Cancer prevention. Launched in 1991, it was one of the largest government sponsored health promotion initiatives ever undertaken. The project aimed to tackle tobacco prevention and control through policy based interventions, programme implementation, mass media and capacity building distributed at state and community level (Stillman and Schmitt, 2003). Based on the social ecological model, ASSIST aimed to alter the social, cultural, economic and environmental factors that influence smoking behaviour at state level (Stillman et al., 2003). Interestingly, the evaluation revealed that states with a greater capacity for change, in accordance with the multi-element Strength of Tobacco Control (SOTC) index, were most successful and recorded lower smoking rates per capita (Stillman et al., 2003).

#### **2.3.2.1.2 Success Factors in Community Health Promotion**

Kegler et al., (1998) specifically zoned in on the coalition or partnership aspect of ten local level ASSIST projects within North Carolina, stating that community health promotion relies heavily on such factors to address public health matters. Kegler et al. (1998) determined that the amount of time staff gave to working within a coalition is connected to success in implementation. It was also agreed that a coalition benefited from local knowledge rather than depending on staff higher up the chain. Instances where higher level state staff were most involved in the planning process had the least success during the implementation phase, indicating that some local level coalitions were fundamentally weak and therefore, struggled once the support from state level staff diminished. Developing local peer support may provide a much healthier and more sustainable alternative to state support. Peer

support offers a chance to share local knowledge and experiences that may be absent from national organisations, particularly when it comes to aspects like practicality and social and emotional assistance (Boothroyd and Fisher, 2010). As well as this, coalitions at a local community based level need to provide their own vision, have appropriately skilled staff that can give time to the project, communicate efficiently, create a sense of belonging, and have a strong organisational structure, if projects are to be successfully implemented (Kegler et al., 1998). In the North Karelia project, the success of the project was linked to community organization whereby trained local leaders were seen to be a credible source of education and persuasion (Puska et al., 1985). While support at all levels is vital, it is also essential that the idea is an organic one and addresses the unique needs of a particular setting using local resources where possible. Representing the interests of all stakeholders including the community was one element successful projects had in common (Bracht, 1999).

### **2.3.2.2 Workplace**

The workplace is an example of where a settings approach to health promotion has been used to reach a specific population group. Workplace health promotion was defined as the application of the concepts, principles and strategies enshrined in the Ottawa Charter to both the community of employees and managers, and to the organisational and environmental aspects of the workplace itself (Comer, 1996). If health promotion is implemented in the workplace, the health status of staff is likely to improve and in doing so may reduce sick days and increasing overall well-being, which is in the interest of both the individual and the company (National Institute for Health and Care Excellent, 2008). The rationale behind workplace health promotion is that given adults spend as much as 60% of their time in work, the workplace setting is ideally placed to facilitate health promotion activities and the implementation of workplace policies and programmes (McMahon et al., 2001, LeCheminant and Merrill, 2008). In Ireland 60% of those aged 15-64 have a paid job, with men accounting for 65% and women 56% of the total (OECD, 2013). Workplace behaviours can affect many aspects of an employee's health, including physical, mental, economic, and social well-being, and consequently impact the health of their families,

social contacts, and thus the wider the community (Chu et al., 2000, McMahon et al., 2001). The workplace also has an important social function, where peer groups have the potential to positively encourage healthy behaviour patterns (McMahon et al., 2002). This point is important as we know that social support is a foremost factor in terms of how social networks impact upon physical and mental well-being (Berkman and Glass, 2000).

A study by Merrill et al. (2013) on over 20,000 employees suggests health behaviours play an important role in improving productivity and lowering absenteeism, and that achieving healthy behaviours needs an integrated and holistic approach to employee health and wellbeing. In terms of health promotion interventions, the workplace presents a target audience who can be otherwise difficult to reach (Naidoo and Wills 2000). As LeCheminant and Merrill (2012) summarise the workplace is a practical setting for health promotion given it offers a quantity of people with a common culture and established channels of communication. The one caveat that is generally, females represent the vast majority of employees who take part in workplace health promotion initiatives (Robroek et al., 2009). Over the years, workplace health promotion initiatives have included interventions such as health screening, stress management courses, healthy options in canteens, exercise and posture programmes, and health education (Chu et al., 2000). However, as mentioned previously it is important to look beyond individual behaviour modification, and look to create supportive social, environmental and organisational structures to positively influence workers' health. Adopting a more interdisciplinary approach has led to workplace health promotion initiatives becoming more holistic in nature, where both employees and management jointly strive to achieve a culture of health promotion in the workplace setting. Workplace health promotion programmes should stimulate action at an individual level, at an organisational level, and at a community level and should, according to the WHO (1999) guidelines for developing workplace health promotion, centre on the principles of being comprehensive, participatory and empowering (Harden et al., 1999).

### **2.3.2.2.1 Workplace Health Promotion Initiatives**

An example of healthy behavioural change in the workplace is provided by LeCheminant and Merrill (2012) who looked at a workplace wellness programme and behaviour change over two years. Conducted between 2009 and 2011, 267 individuals were employed in the company used in this study. To participate in the study each participant had to complete a personal health assessment at baseline, 12 months and 24 months and take part in any one of six WellSteps behaviour change campaigns each year. The campaigns were three to eight weeks in duration, and were tailored to the needs of the worksite with a small reward given for campaign completion. Based on building behavioural capability and self-efficacy the WellSteps employee health improvement programme uses a framework of 'awareness and education, motivation, skills and strategies, and supportive policies, environments and peers' (LeCheminant and Merrill 2012). The results reveal that 229 employees completed the personal health assessment at baseline, 170 employees at 12 months and 174 employees at 24 months. In total 116 employees completed the personal health assessment at all 3 time points with 80% of completers also participating in at least one WellSteps health campaign during year 1 and 2 (LeCheminant and Merrill 2012). Overall, the study found significant improvements in dietary (increased fruit and vegetable servings per day) and exercise (increase in number of day and minutes exercised at) behaviours which were sustained through 24 months. LeCheminant and Merrill (2012) attribute the sustained behaviour change to four key points including, that the WellSteps health campaigns and the personal health assessment were administered at numerous times, company culture change was stressed, small rewards and recognition were available to reinforce behaviour change, and finally, programme activities were comprehensive. It should be noted however, that the lack of a comparison group is a limitation within this study.

One large scale example, involved over 21,000 workers across four workplaces, lasting eight years. The Shanghai Municipal Health Bureau and the Shanghai Health Education Institute conducted a pilot workplace health-promotion project where, guided by health experts, the workplaces developed, implemented and evaluated workplace health promotion projects (Chu et al., 2000). The project aimed to identify and address the organisational, behavioural and environmental issues that were negatively impacting upon

the health of workers using an integrative health promotion model. The initiatives embarked on ranged from the formation of health-promotion committees and designing and implementing workplaces standards, to canteens supplying health foods, health screening, and creating green spaces and providing alcohol and cigarette cessation programmes. All stakeholders were involved in planning and implementation of the project through regular consultations with workers, management and health experts. Surveys were carried out at three stages; to establish baseline data, to assess mid-term progress and finally to evaluate project outcomes (World Health Organisation, 1999). Data obtained from the baseline survey along with insights from focus group discussions directed the action planning process. The evaluation of the project revealed substantial improvement in outcome measures including increased health and safety knowledge and practice, a reduction in risk behaviours, a decrease in health related injuries (10-20%), and reduced absenteeism and related health care costs (Chu et al., 2000). It is also worth noting that management practices and company image improved.

#### **2.3.2.2 Success Factors in Workplace Health Promotion**

The National Institute for Occupational Health and Safety (NIOSH) produced a resource document to help in the establishment of effective workplace interventions in order to sustain and improve employee health (National Institute for Occupational Safety and Health, 2008). The document emphasises the need for comprehensive programmes, policies, and practices to be embedded into the worksite environment. Intended as a framework, the document highlights four key areas as being essential elements of successful workplace interventions including, organisation culture and leadership, programme design, programme implementation and resources, and finally, programme evaluation. Chu et al. (2000) cites the support of senior management to be an essential factor in the success of workplace health promotion on both a pragmatic and a symbolic front (Jorgensen et al., 2013). In order to achieve the backing of senior management and ultimately lead to greater institutionalisation of health promotion, the organisations interests need to align with the goals of the health promotion programme (Casey et al., 2008, Weisbrod et al., 1992). Chu et al. (1997) equally considers partnerships to be

'paramount' and similarly Harden et al. (1999) labels partnerships as a 'key principle' of workplace health promotion if knowledge and resources are to be combined to produce effective health promoting actions. With this in mind, Harden et al. (1999) goes on to describe that employees should be involved during all phases of intervention planning, implementation, and evaluation, and that support should filter from top management down. McMahon et al. (2001) undertook an evaluation of the Irish Heart Foundations Happy Heart at Work Programme and found that support from management and ownership by participants was essential to the success of the programme. Another promising finding from the McMahon (2001) report was that 44.4% of companies in the Happy Heart at Work Programme had a health promotion policy and it was agreed that workplace morale and productivity were improved, along with company image and employee lifestyle habits. Focusing on a specific risk factor with interventions tailored to suit the needs of the employees are also important elements in the attainment of workplace health promotion.

#### **2.3.2.3 School**

Schools offer effective sites for health promotion interventions that are wide-ranging, multi-level, and address the social determinants of health (European Commission et al., 1995). Schools were viewed as a popular locale for health promotion and health education since the 1950s (World Health Organisation, 1950). However, health promoting schools are a relatively recent development surfacing during the 1980s, with the European Network of Health Promoting Schools (ENHPS) being established in 1992 and subsequently becoming the Schools for Health in Europe Network (SHE). In Ireland, the Education Act 1998 states that school are required to promote the moral, spiritual, social and personal development of students and provide health education for them' (Irish Statute Book, 1998). Irish children spend a significant proportion of time in schools, with schools in operation 183 days a year. Of those 183 days, children spend 5 hours per day in school (Department of Education and Skills, 2012). Poland et al. (2000) explain how appropriate settings for youth health promotion reflect both the places youth spend a significant proportion of their time, and the people who can influence them. With such a captive audience on a daily and weekly

basis the school setting allows a great opportunity to access children and adolescents. Additionally the school setting presents a controlled environment in which children learn and play, and healthy behaviours can be reinforced (Poland et al., 2000). The Department of Education and Skills (DES) recommend that every post-primary pupil should receive two hours of physical education (PE) per week, and one hour per week for primary pupils (Department of Education and Skills, 2012). Schools therefore play a central role in the provision of health promotion along PE, physical activity, and nutrition.

A health promoting school is defined as a school that continuously builds up its capacity as a setting for healthy living, learning and working (World Health Organisation Expert Committee on Comprehensive School Education and Promotion, 1997). According to the WHO (1996) a health promoting school uses its full organisational capability to promote health through six key messages: 1) engaging its students, staff, families and community members and health/education professionals to promote health; 2) providing a safe and healthy environment for all; 3) health education is delivered through skill based learning; 4) access to health services is offered; 5) health promoting policies and practices are applied; and 6) there is a focus on community health needs (World Health Organization, 1996). The SHE developed an auxiliary definition of a health promoting schools outlining it as a school that applies a structured and systematic plan for the health and well-being of all pupils and all staff members, characterized by its whole school approach. The Schools for Health in Europe (SHE) (2013) factsheet 1 identified 34,000 schools across its European network as being health promoting schools in the school year 2012-2013. Up to 100% of primary and secondary schools in countries such as Portugal and Wales are recognized as being health promoting while this figure drops to as few as 2% in other European countries (Schools for Health in Europe (SHE), 2013).

#### **2.3.2.3.1 School Based Health Promotion Initiatives**

There is a strong tie between children's health and education, as health impacts on a child's ability to learn and in the same way school attendance is important for improving health (World Health Organisation, 1995). School-based education programmes are an economical, resourceful, and effective method of increasing children's health knowledge and positively influencing their attitudes and behaviours towards health, and are thought

to be particularly advantageous in reaching large quantities of the target audience (World Health Organisation, 1999, USAID, 2011). Additionally, school based health education programmes benefit whole communities as the school setting is a gateway to accessing parents, families and friends (World Health Organisation, 1999). Young et al. (2013) emphasises the fact that health promotion in a school setting is a broad concept, acknowledging that in order to advance and/or safeguard the health and well-being of those attached to the school, health promoting school policies, the curriculum, the physical and social environment of the school, family and community networks, and the health services must all be included.

Based on the WHO's model for health promoting schools, the Childhood Development Initiative's Healthy Schools Programme seeks to improve children's health and well-being through addressing processes (policy, procedures and practice) that will facilitate change, leading a more health-promoting school environment (Comiskey et al., 2012). The evaluation of the Healthy Schools Programme was a longitudinal observational study that followed children and key stakeholders in five Irish intervention primary schools and two comparison primary schools throughout the implementation of the programme. The process evaluation component looked at how the programme worked, its potential to work long term, and areas in the programmes implementation which could be improved upon. The study found that not all stakeholders had a consistent understanding of the Healthy Schools Programme and this impacted on how individual schools engaged with the programme on a daily basis (Comiskey et al., 2012). Another key finding from the study was that the manual contained predetermined health and wellbeing outcomes but schools were most likely to participate in intervention activities that were of direct relevance to that school or address issues the school themselves had identified as being a priority. Schools also found it challenging to make a link with health services.

Studies have shown that health promoting schools can impact on health related behaviours (Barnekow et al., 2006). The APPLE (Alberta Project Promoting Active Living and Healthy Eating) schools project 2008-2010, was a three year intervention study to support healthy eating and active living initiatives among students in Canada. The project operated in ten schools (average school size of 350 students) selected from five school jurisdictions in Alberta, seven urban and three rural (Fung et al., 2012). A unique feature of the APPLE



schools model was that it placed a full time school health facilitator in each school. These school health facilitators were responsible for implementing healthy eating and active living strategies that were tailored to the needs of that individual school. School health facilitators were also tasked with engaging all relevant stakeholders, facilitating professional development days for teachers and school staff, organising parent information nights, initiating healthy programmes such as cooking clubs and after school physical activity, contributing to events and celebrations, and circulating newsletters (Fung et al., 2012). As well as that, the principals in each of the ten schools agreed to fully support the project by dedicating time to the project, commit to a three and a half year involvement, support the school health facilitator, create health promotion policies, and participate in meetings with APPLE school leaders. The effectiveness of APPLE schools project was assessed using yearly surveys measuring diet, physical activity, and health among grade five students. The student participation rate was 85% (n=293) in 2008 and 84% in 2009 and 2010. The results showed that APPLE schools had higher intakes of fruits and vegetables, had lower energy intakes, were more physically active, and were less likely to be obese compared to controls (Fung et al., 2012). Changes in APPLE schools were also assessed relative to changes across Alberta and changes were found to be due to the intervention effect. Between 2008 and 2010, a nutrition policy was adopted by eight of the ten APPLE schools, while all ten APPLE schools adopted physical activity policies which ensured students received a minimum of 30 minutes of physical activity per school day. Further initiatives such as community gardens, walk to school days, breakfast and lunch programs, and parent led extracurricular programs were undertaken (Fung et al., 2012). The APPLE schools evaluation demonstrates the effectiveness of a school-based health promotion project in encouraging healthy behaviours over a two-year period through creating a supportive school environment tailored and developed to the needs of individual schools.

#### **2.3.2.3.2 Success Factors in School Based Health promotion**

Young et al. (2013) suggests that teachers need to embody a strong sense of ownership in order to introduce change and sustain reform, something which must be echoed at school level and supported at national level. Ownership and empowerment was similarly one of the 4 key themes highlighted in order to facilitate the translation of health promoting

school principles into practice (Inchley et al., 2006). In the above example, Comiskey et al., (2012) found schools engaged best with interventions that addressed issues of direct relevance to the school, and so school ownership of the change process is needed for success. It is worth noting however, that what parents do with their children at home is a greater influence than any other factor open to educational influence (Deforges and Abouchaar, 2003). Evidence supports the involvement of family and community in school-based interventions for this reason (van Sluijs et al., 2007). A review of health promotion approaches in the school setting conducted by Stewart-Brown (2006) identified those of lengthy duration and high intensity, and those involving the entire school to be among the most effective. The review also pointed out that multifactorial approaches, principally those involving changes to the school environment, were most effective (Stewart-Brown, 2006). Young et al. (2013) indicate that success in the formation of health promoting schools takes time and involves creating and upholding policies and practices. Inchley et al. (2006) view the integration of initiatives into on-going school life as crucial in the sustainability of any school health promoting programme. The HSE's Health Promoting School Framework reflects this, focusing on four key pillars central to the process of becoming a Health promoting School: environment, curriculum and learning, policy, and planning and partnerships. The future success of health promotion programmes in the school setting is therefore dependant on factors such as political backing, partnership working, mutual understanding between the education and health sectors, leadership from school management, and the training of teachers (Young et al., 2013).

The Ottawa Charter highlights the value of settings in promoting health whereby 'health is created and lived by people within the settings of their everyday life' (World Health Organisation, 1986). An important objective of this approach is to stimulate the development of supportive environments and create a positive shift in organisational culture (Kokko et al., 2006). The examples discussed above provide key insights into the factors needed to introduce and sustain health promoting changes. A common theme that emerged was the need for ownership. Ownership and support from management is important in activating a change in ethos. Further to this type of political backing is the need for policies to be developed and upheld, and an environment must be created which allows for policies and practices to become embedded into daily activities. Finally, the

involvement of all stakeholders in the planning and implementation of a health promotion project is a critical success factor in any setting. Working in partnership and the idea of staff involvement is important both in terms of creating a sense of empowerment and importance, and also in gaining the knowledge and skills to be able to understand the needs of a specific population and then tailor initiatives to suit those individual needs.

With the success of health promotion across a number of established settings the Ottawa Charter also champions the idea of finding new settings in which to promote health as health cannot be confined solely within the remit of the health sector. With growing health concerns, for instance physical inactivity and obesity, there is a need to expand health promotion to include settings with the potential to influence more people, and in particular children and adolescents (Kokko et al., 2013). In recent years, the potential of a sport club setting as a vehicle to promote health has become increasingly recognised. As individuals interact within various settings daily e.g. school, work and sports clubs, surely it would be advantageous if health promotion was mutually reinforced and continued across these settings. In comparison to the setting discussed above the concept of health promoting sports clubs has been studied far less.

## **2.4 The Value of Sport to Health**

Sport is defined by the Council of Europe (2001) as 'all forms of physical activity which, through casual and organised participation, aim at expressing or improving physical fitness and mental well-being, forming social relationships or obtaining results in competition at all levels' (Council of Europe, 2001).

The terms physical activity, sport, and exercise are often used interchangeably, although they are not necessarily similar. Sport is a subsection of exercise and while sport and exercise may be a component of physical activity, physical activity also accounts for occupational and lifestyle factors (Henchoz et al., 2014). Physical activity is defined by the WHO (2012) as 'any bodily movements produced by the skeletal muscles that require energy expenditure' (World Health Organisation, 2012). Sport is distinct from leisure time activities such as walking, hiking, or dancing, in that it follows a regular, methodical, and structured pattern, and the group scenario is valued (Koski, 2005).

The National Guidelines for physical activity in Ireland state that:

- Adults (18-64yrs) need at least 30 minutes a day of moderate activity on five days a week or 150 minutes a week
- Children and young people (2-18 yrs) should be active at a moderate to vigorous level for at least 60 minutes every day including muscle strengthening, flexibility and bone strengthening exercises three times a week (Department of Health and Children and Health Service Executive, 2009).

Moderate intensity activity is when the heart beats faster than normal and breathing becomes harder than usual (Department Of Health and Children and Health Service Executive, 2009). It is also necessary to define the parameters of a sporting organisation i.e. any organisation that regulates, organises, and sanctions sports or sporting events which may involve providing training, finance, and teams, and comprises professional and amateur sporting bodies (Priest et al., 2008).

Discussed below are the physical health, emotional wellbeing, and social capital benefits associated with sports participation.

#### **2.4.1 Physical Activity and Health**

In Ireland, chronic conditions are accountable for a substantial number of premature deaths (Healthy Ireland, 2013). By 2020, the Healthy Ireland framework proposes that the proportion of adults with chronic diseases will rise by up to 40%, while currently in Ireland over 60% of the adult population and a quarter of three year olds are overweight or obese. Both in Ireland and internationally, many children and adults still fail to reach the recommended level of physical activity (Herbert et al., 2015, Morgan et al., 2008, Woods et al., 2010). Given that physical inactivity is the fourth leading risk factor for mortality and that low fitness contributes to 3.2 million deaths annually, it is a perturbing fact that only 41% of Irish adults do moderate or vigorous physical activity for at least 20 minutes three or more times a week, while one in five people in Ireland are physically inactive (Morgan et al., 2008, Kahn et al., 2012, World Health Organisation, 2011). Woods et al. (2010) learned

that less than 20% of Irish 10-18 year olds meet the physical activity guidelines, a figure which has not increased since 2004. In addition, this figure was found to drop as low as 6% for 16-18 year olds. People who are not sufficiently active have 20-30% increased risk of all-cause mortality compared to those individuals that engage in at least 30 minutes of moderate intensity physical activity most days of the week (World Health Organisation, 2004).

Physical activity plays a vital part in the prevention and control of reducing risk factors for Non-Communicable Diseases, especially given that the benefits have been shown to be effective across the lifespan (C3 Collaboration for Health, 2011, Mang'eni Ojiambo, 2013). Warburton et al. (2006) suggests the evidence is irrefutable and 'physical activity contributes to the primary and secondary prevention of several chronic diseases and is associated with a reduced risk of premature death', identifying an energy expenditure of 1600kcal per week is necessary to halt the progression of coronary artery disease and an energy expenditure of 2200kcal a week is associated with plaque reduction (Warburton et al., 2006). The WHO Global status report (2011) also highlighted that participation of 150 minutes of PA per week (or 30 minutes of physical activity 5 days a week) is estimated to reduce the risk of heart disease by 30%, diabetes by 27%, and breast and colon cancer by 21-25% (World Health Organisation, 2011). Diagnostics and treatment services for disease and injury in Ireland cost an estimated 15.5 billion annually (Healthy Ireland, 2013). The largest drivers of these healthcare costs are chronic preventable diseases, such as those associated with obesity, alcohol, and smoking, which present a real clinical, social, and financial challenge. Looking at it from a budgetary point of view, when you consider that health represents the second largest component of public expenditure in Ireland, it presents a strong epidemiological case for capitalising on physical activity as an economic strategy moving forward (Healthy Ireland, 2013).

#### **2.4.1.1 Physical Health Benefits of Sport**

The Irish Sports Monitor (2011, 2013) found that sports participation in Ireland is estimated to have risen to 47.2% in 2013 from 34% in 2009, equivalent to almost 1.7 million Irish adults (16+) participating in sport (Irish Sports Council, 2011). The proportion of women participating in sport was revealed to be 42.7%. Organised sport accounts for 31.2% of

participation rates with team based activities accounting for 10.9% (Irish Sports Council, 2013). Participation in organised sport is more common among younger age groups than older age groups who participate in sport in a more informal manner, while taking part in more than one type of sporting activity is the norm for nearly 40% of those who play sport. Overall, it was found 36.3% of adults identified as being a member of a sports club. Approximately, 94,000 20-24 year olds are members of a sports club. The Irish Sports Council (2013) stated that 75% of 16-19 year olds participate in sport. Focusing on younger age groups, Woods et al. (2010) indicate that 83% of 10-12 year olds and 64% of 12-18 year olds are involved in sport outside of school.

Organised sports are therefore a relatively popular form of physical activity in youth, and have been presented as a viable opportunity for increasing the likelihood of youth meeting the physical activity guidelines and availing of the subsequent health benefits (Marques et al., 2015, Herbert et al., 2015, Eime et al., 2015). On the whole, competitive or organised sports can encourage greater participation in physical activity, as well as healthy eating, weight management, and a reduction in risky behaviours among youth (World Health Organisation, no date). Given that health outcomes related to physical activity potentially tracks from childhood into later life it is important that during childhood ample involvement in physical activity such as sports participation is encouraged to reduce the risk of chronic diseases such as obesity (Mang'eni Ojiambo, 2013). When Alfano et al. (2002) investigated whether involvement in sports activity in youth was related to obesity in later adult life, it was found that a history of sports participation was associated with lower BMI values and higher total physical activity levels in women. Promoting involvement in sport for girls in particular is one strategy for tackling the obesity epidemic, and is particularly relevant since girls tend to experience greater dropout rates in sports participation during adolescence than boys (Alfano et al., 2002). As youth participation in sports can be linked to a greater likelihood of physical activity in adulthood, and it was been found that the majority of youth (80%) had joined a sports club by the age of 7, it is both in the interest of sports clubs and public health to encourage more youth to become involved in sport (Eime et al., 2008, Woods et al., 2010). The Standing Committee on Recreation and Sport (2011) reported that 48% of Australian adults played sport at least three times a week. It should be highlighted however, that organised sport made up only

one fifth of the total sport representation stressing the need for clear definitions of sport and highlighting the popularity of non-organised sports like walking and cycling (Kahn et al., 2012, Standing Committee on Recreation and Sport, 2011). Further studies, the HBSC report (2009/2010) on the social determinants of health and well-being among young people, asked whether or not the respondent was a member of a sports club. Membership and active participation can be two very different concepts so it is important therefore to be vigilant of how questions are phrased when interpreting results (Currie et al., 2012).

There are numerous physical health benefits associated with routine participation in sport. While physical activity, a fundamental component of sport, contributes to health benefits, there is evidence to suggest specific health benefits arising from participation in sport (Andersen et al., 2000). Andersen et al. (2000) linked those who participated in sport to have half the mortality rates of non-participants after a prospective 14.5 year follow up study. As Kokko et al. (2011) describes, exercise or any physical activity can produce positive mechanical or metabolic changes depending on how the body system is worked. Duration, type and intensity all play a part in determining these changes. It is with repetition and progression of training intensity that adaptations are seen in physical structures or physiological functioning of the body.

Requirements such as endurance capacity, strength, power, and skill levels all vary across different types of sports. The health profile of specific sports therefore varies depending on the training elements necessary. Sports, such as running and cycling, demand aerobic fitness which benefits cardiovascular health through improving heart function and stimulates lipid and glucose metabolism, which is important in preventing metabolic disease (Kokko et al., 2011). Sprinting and jumping sports require muscular strength, benefiting musculoskeletal health by improving muscle mass and bone mineral density and a possible reduction in the risk of osteoporosis (Kokko et al., 2011). Team sports, particularly team ball sports, may require a combination of these physiological elements in addition to elements of skill, coordination, and balance.

Oja et al. (2015) conducted a meta-analysis to look at the health benefits of 26 different sport disciplines. Running, football, gymnastics, recreational cycling, and swimming were found to be the most commonly studied sports. Running ( $\geq 1$  hour each week) and

football/soccer (twice weekly sessions) were found to yield the improvements in aerobic fitness, cardiovascular function, and adiposity for both men and women, and gains in these areas help in reducing mortality and morbidity rates (Oja et al., 2015). The example of soccer is presented below.

With an estimated 400 million players worldwide, soccer is a popular team sport. Krstrup et al. (2009) examined whether soccer practice impacted on the health profile of previously untrained men over a 12 week period. The training focused on small sided matches which involved intermittent type exercise containing phases of near maximal heart rate effort. The age range was 20-43 years, and the 36 participants were randomised into soccer, running, or control groups. Participants trained two or three times per week for a period of one hour. The results displayed that soccer practice had a protective effect on the cardiovascular system by lowering heart rate, resting blood pressure, fat mass, and LDL cholesterol. The significant reduction in blood pressure and LDL cholesterol is particularly important in preventing coronary artery disease. As well as cardiovascular adaptations, the 12 week soccer training programme showed advantageous musculoskeletal gains, including raised lean body mass and leg bone mass, with the running group having no change in LDL cholesterol or increase in lean body mass or leg bone mass (Krstrup et al., 2009). The cardiovascular and musculoskeletal benefits arising from soccer, combined with its popularity, suggest it may have a role to play in health promotion, particularly in inactive persons.

Perceived levels of competency and skills can be major barriers to participation in sport particularly for overweight children (Weintraub et al., 2007). The SPORT or Stanford Sports to Prevent Obesity Randomised Trial aimed to make team sports a more attractive prospect for overweight children by creating a supportive environment by including only other overweight children. The six month study compared an after school soccer programme to traditional health education. Soccer was chosen as it was a popular team sport in the locale, and because it can be easily taught to children with varying skill levels. Having the programme after school was an effort to help overcome potential barriers and alleviate any safety concerns such as being out after dark. BMI and accelerometer assessments at baseline, three and six months found sizeable beneficial effects of BMI and total daily physical activity (Weintraub et al., 2007). This supports the previously cited claim



that organised team sports are an effective method of weight management in adolescence (World Health Organisation, no date).

Sports such as soccer, which exert large muscle and ground reaction forces on the skeleton, contribute to greater bone mass gains in athletes (Helge et al., 2010). The benefits arising from participation in a sport such as soccer are in no way limited to males. Soderman et al. (2000) identified elevated bone mineral density in female youth soccer players compared to corresponding untrained controls. Given the fact that osteoporosis is a major public health concern guidelines should be developed to encourage participation in sports such as soccer which have been highlighted as a method of increasing bone mineral density, and therefore may help in offsetting osteoporosis if a higher peak bone mass is established earlier in life (Soderman et al., 2000, Helge et al., 2010).

Referring to the above physical activity guidelines the most beneficial type of activity to undertake in relation to health outcomes is moderate to vigorous type activity which uses the major muscle groups. It makes sense therefore, to encourage leisure time activities such as sport as a strategy to meet the recommended levels of physical activity and reap the health rewards. Sport and physical activity are now being used as a strategy to aid in the resolution of public health epidemics such as obesity. For example, the Dutch government pledged nearly €75 million into sport over a five year period to encourage a greater number of people to take part in sport for health benefits (Casey et al., 2008).

#### **2.4.1.2 Sport and Healthy Behaviours**

Research suggests that settings such as clubs or schools that support sport programmes demonstrate positive effects on health (World Health Organisation, no date). In terms of sport and risk behaviours, Lorente et al. (2004) found serious athletes, those training at least six times per week, consumed alcohol least frequently. Sports participants also exhibited lower overall alcohol and tobacco consumption with regular sports participation linked to later alcohol debut (Australian Institute of Criminology, 2000, Wichstrom and Wichstrom, 2009, Hellandsjo Bu et al., 2002). Sport and exercise were also deemed to have a negative association in relation to other risk behaviours such as cigarette and cannabis

misuse (Henchoz et al., 2014). Fahey et al. (2004) examined the relationship between sports participation and the health of Irish adults, and concluded that those regularly participating in sport are less likely to partake in cigarette smoking. The effect was strongest when participation and levels of effort increased. Koski (2005) reported that girls who actively participated in sports club events considered a sober lifestyle and engaging in healthy lifestyle habits to be of importance to them, equally the finding that boys who never or no longer participated in sports clubs activities to be less likely to engage in preventative health measures. Active participation in sports clubs and health literacy are therefore in part connected (Koski, 2005).

#### **2.4.2 Sport and Emotional Well Being**

The benefits of engaging in sporting pursuits extend beyond those associated with physical health. We know that the WHO (1986) definition of health includes references to physical, mental and social well-being. Therefore, there is no health without mental health, and in terms of overall well-being mental welfare is just as important as its physical counterpart (Department of Health and Children, 2000). A stigma still surrounds mental health however, as lay people felt more comfortable using the term emotional wellbeing wary that mental health would be associated with mental illness (Pavis et al., 1996). Cannon et al. (2013) suggests one in six young people and one in five adults in Ireland struggle with their mental health (Cannon et al., 2013). Mental health is defined as a state of wellbeing in which every individual realises his or her own potential, can cope with the normal stresses of life, can work productively, and is able to make a contribution to his or her community (World Health Organization, 2007).

Priority has traditionally been given to promoting the physical aspects of health. There is growing indications that promoting physical activity can not only be a credible disease prevention strategy, but can also achieve gains in social inclusion and enhancing wellbeing (Smith et al., 2011). Sport Scotland (2003) appreciate that sport has the capacity to improve the quality of life for individuals and communities through its ability to promote social inclusion, healthy lifestyle behaviours, self-esteem and confidence, and depress anti-social behaviours (SportScotland, 2003). Benefits such as a sense of purpose, reduced

stress and anxiety, improved sleep, improved mental health, relieve depression, boost mood and mental alertness and a better quality of life are all associated with regular physical activity (Penedo and Dahn, 2005). The importance of emotional wellbeing to health is emerging, given the suggestion that interventions which aim to promote physical health while excluding emotional wellbeing are destined to be unsuccessful given that emotional turmoil can cause physical illness (Stewart-Brown, 1998).

#### **2.4.2.1 Emotional Health in a Sport Club Setting**

Regular exercisers exhibit lower rates of depression and increased positive wellbeing compared to inactive populations (Steptoe and Butler, 1996). Not alone does regular exercise improve mental health but it may be considered a viable treatment for depression and anxiety (Fox, 1999). Physical activity has been identified as a means of building social relationships, bringing people from diverse backgrounds together, building community identity and trust, and facilitating social interaction (Collins, 2003). Eime et al. (2010) suggested these benefits are more likely to prevail in a sport clubs context. Hypothesising, that compared to undertaking leisure time activities or other types of physical activity, participation in sport stimulates and enhances better mental health due to the positive exchanges and dealings with peers and adults that takes place in sport club settings (Eime et al., 2010). A sports setting can provide socialisation opportunities akin to other pillar community institutions, with organised sport being a valuable avenue in developing important concepts such as teamwork, sharing, perseverance, stress management, appropriate risk taking and positive attitudes towards achievement in youth (Smith and Smoll, 1991). In addition, the engagement opportunities provided by community sports clubs can help to increase confidence and a sense of belonging and lessen aggressive behaviour (Eime and Payne, 2007).

Steptoe and Butler (1996) found a positive association between sports participation and emotional wellbeing independent of sex, social class, and health status. Data was collected using a general health questionnaire and the Malaise Inventory, a 25 item list of psychological and somatic subscales, from 2223 boys and 2838 girls in Britain, with a mean age of  $16.3 \pm 0.38$ . Girls favoured significantly more individual sports or vigorous recreational activities as opposed to boys, who reported higher team sport participation.

Fewer psychological symptoms were recorded by the adolescents who took part in more sport and vigorous activity linking exercise with emotional wellbeing (Steptoe and Butler, 1996). Similarly, Donaldson and Ronan (2006) examined the relationship between sports participation in 203 children and their emotional wellbeing. Data was collected using a sports participation and perception questionnaire and emotional wellbeing self-report questionnaires, the Youth Self Report and the Self-Perception Profile for Children. It was found that children with increased levels of sports participation had a positive relationship with emotional wellbeing. Sports participation was also found to be positively linked to self-concept, with higher self-reported sporting competencies related to fewer emotional or behavioural difficulties (Donaldson and Ronan, 2006). More recently, it has been suggested that practicing sport has a causal effect on self-reported happiness (Ruseski et al., 2014). Team sports and individual sports were both found to be significantly positively associated with life satisfaction, engagement in the former having the greatest effect (Fujiwara et al., 2014). The impact value of sport, given its important link to wellbeing, was suggested to be £1,127 per person per year (Fujiwara et al., 2014). The figure indicates the increase in income that would be needed to achieve the life satisfaction same result.

### **2.4.3 Sport and Social Capital**

In terms of health, sport is not just a means of solely facilitating physical activity, but appears to offer its own health benefits in the form of social capital. As Townsend et al. (2002) describe, community organisations such as sports clubs are instrumental in forming and retaining social capital in communities. The OECD defines social capital as ‘networks together with shared norms, values and understandings that facilitate co-operation within or among groups’ (OECD, 2013). Through events large or small, sport has the ability to bring all sections of society together and create a positive atmosphere where experiences are shared. In doing so, sport contributes constructively to our lives, often in ways we don’t fully comprehend (Office for Recreation and Sport (ORS), 2008).

The facilitation of social capital through sport and recreation is something that has been documented internationally. Cox (1995) understands social capital to be the glue that holds

members of a specific location together, with Putnam (2000) considering sports clubs and community organisations to be important vehicles in fostering social capital (Cox, 1995, Putnam, 2000). A 17 year study of rural Australia reinforced Putnam's belief by suggesting sport, and therefore sports clubs, enabled entire communities to be linked by a common bond, going on to note that physiological and social developments adopted through sport can teach valuable life skills (Dempsey, 1999). Townsend et al. (2002) looked into the health and well-being benefits of sport in two rural towns in Australia. Qualitative interviews were carried out with 23 people representing community leaders, sporting and physical activity organisations, and participants of sporting organisations. Respondents viewed sporting activities as a way of creating unity and trust and as a source of community interaction. Sport and sporting events were also seen to have a link with fundraising and instilling a sense of pride in the community. Finally, respondents saw that sports clubs also functioned as a mentoring system for youth and adolescents (Townsend et al., 2002). The findings support the claim of sports clubs as a means of generating social capital and social cohesion.

Surf Life Saving Australia (SLSA) is a voluntary sport organisations well regarded within Australian communities. The SLSA is a national governing body operating professionally through national and state level branches with affiliated individual surf clubs. These individual SLSA sports clubs are predominately run by volunteers for the purpose of competition and beach safety. Eight SLSA clubs from both urban and rural locations were selected to participate in focus groups exploring social capital development in sporting organisations (Darcy et al., 2014). Key SLSA staff, board members and volunteers from the clubs participated in the focus groups. The findings from Darcy et al. (2014) illustrated that club level relationships promoted social capital development. Of the key themes that materialized from the transcription data, the strongest was that of belonging, where individuals felt valued, connected, and had a common goal as a result of being involved in club activities. Another emergent theme related to sharing social values and social responsibility, something which is embedded into the standards and ethos of SLSA clubs and nurtures personal development. This element of social responsibility is something which may be forgotten in other elite sporting organisation where competition comes before service. The combination of sporting and civic programmes engages all generations

of a community extending the social benefit and setting the SLSA apart from other sporting organisations (Darcy et al. 2014).

The National Economic and Social Forum noted that while the concept of social capital in Ireland is somewhat underdeveloped its inherent characteristics have been evident in numerous features of Irish life for decades (National Economic and Social Forum, 2003). Take for example the GAA, the largest sporting body in the country, whose success is based on two main principles, that of volunteerism and community activation (Hassan et al., 2001). A community based sports model such as the GAA allows for a much more prolonged engagement with sport by an aging population, a benefit not typically afforded to other sports models (National Economic and Social Forum 2003). Membership of a sports club for the population over 16 is estimated to be 36% (Irish Sports Council, 2013). When you consider 28% of the population over 65 are members of a sports club in Ireland it is obvious that sport plays a key part in maintaining community engagement as people age (Irish Sports Council, 2011, Hassan et al., 2011). Just as four people play sports for competition or for the purpose of health, three others use it for networking or social capital (Delaney and Fahey, 2005).

#### **2.4.3.1 Volunteering**

Research has previously noted that sport is adept at generating social capital through volunteering. In Irish society, sport well exceeds social services, religion, or church activities when it comes to time spent volunteering (Delaney and Fahey, 2005). In Ireland, Delaney and Fahey (2005) estimate that those who volunteer for sport in some way, shape or form throughout the sporting year equates to 400,000 adults or 15% of the adult population. The activity of volunteering has been defined by Volunteering Australia (2006) as 'not an end to one's self, rather it is an activity that has some positive outcome for the community'. The traditional view of volunteering assumes volunteering is motivated by pure altruism. The more contemporary view is that people engage in volunteer work to achieve a positive result for both the community and themselves (Volunteering Australia, 2006). The very nature of volunteering means it is often an unstructured and sporadic activity making it hard to quantify. The age groups 34-44 years and 45-54 year have the

highest rates of volunteering in sport in Ireland, 23% and 18% respectively, reflecting the high proportion of volunteers who are non-players or former players, with men more likely than women to volunteer (Irish Sports Monitor, 2013). The sheer volume of volunteers involved in sport delivery indicates that 'the role of sport in generating the kind of social capital represented by volunteering is not that short of its role in generating worthwhile physical exercise' (Delaney and Fahey, 2005). The two most commonly carried out voluntary activities include the provision of transport and coaching. The main motivation for male sport volunteers is a desire to give something back to the sport, and for females, it is related to their children's involvement in sport and physical activity programmes (Delaney and Fahey, 2005).

Volunteering in Irish sports clubs is not without its share of difficulties however. Volunteers feel as if too much is expected from them considering they are often not backed up by training or educational resources (Woods et al. 2010). Volunteers give freely of their time but the overall lack of volunteers leads to feelings of being spread too thin, exacerbated by the fact responsibilities often include management, operation, and coaching positions with volunteers having limited exposure to education and training within these roles. This means that without adequate support structures and recognition, tensions within organisations may surface, volunteers may become dissatisfied and could potentially withdraw their services. Without them, there would undoubtedly be fewer sports activities and those activities would be expensive to produce. Thus, they play a major role in sustaining the high level of sporting activity in Ireland (Irish sports Council, 2013). Without 'people and money' the future and sustainability of sport and recreation clubs is under threat and the subsequent power of these clubs to generate social capital may be undermined (Coalter, 2011). It is clear that without the support of volunteers, the considerable physical and organisational infrastructure of sports clubs which exists today would not have been developed. In return for their efforts, both men and women considered that forming new friendships and connections was one of the central benefits they gained from sport. Hassan et al. (2011) remarked on the high numbers of volunteers involved in Irish sport, but yet no coordinated training programme exists. In order to realise economies of scale, best practice should be shared and recruitment and training strategies need to be put in place (Delaney and Fahey, 2005).

Sport plays an important part in promoting relationships and network formation, social bonding, and community involvement, all of which are crucial steps in building social capital. An ESRI report (Delaney and Fahey, 2005) into the Social and Economic Value of Sport in Ireland established that little attention had been paid to the social value of sport as policies focused predominantly on physical activity. The ESRI report also goes on to recommend that the social benefits attributed with sport should be recognised in Irish sporting policy, especially given the importance of sport in generating social capital, since no other form of activity is as effective at mobilising volunteerism, club membership, or harnessing feeling of collective identity.

The cases discussed above suggest that sport has numerous health benefits for individuals and communities, and therefore warrants the inclusion of sport in health promotion campaigns. One example of this is FIFA 11 for Health. FIFA realised that sporting celebrities, particularly footballers, act as role models for younger audiences. FIFA 11 for health is a health education programme targeted at schoolchildren, where 11 key health messages are associated with famous footballers (Kahn et al., 2012). For example, Cameroonian striker Samuel Eto'o presents a video clip on using treated bed nets to protect against malaria. Looking at knowledge, schools that ran the programme experienced an 18% improvement in health knowledge (Fuller et al., 2011). Both the US and the Global Advocacy for Physical Activity dedicate one whole section to sport in their program for the seven best physical activity investments to impact the health of countries (Khan et al., 2012). Health promotion through sport could therefore be one measure in the overall strategy to improve physical and mental wellbeing, and encourage healthy lifestyle behaviours (Ferron et al., 1999, Delaney and Fahey, 2005). Therefore, as well as using sports clubs to promote physical activity, by ensuring active membership there is the potential to promote health more broadly in the club by targeting behaviour change through club policy and environmental level interventions (Kokko et al., 2006, Eime et al., 2008). This will be addressed in more detail later.



## **2.5 Sport and Unhealthy Behaviours**

We have seen that sport provides numerous physical, mental and social benefits to both its participants and the wider community, and is a setting which can be harnessed to promote health (Kokko et al., 2006). However, sports clubs are often not supportive for health. Worryingly, data from Healthway, the Western Australian Health Promotion Foundation, found that involvement in sport amplified risk behaviours in nearly all areas with the exception of physical activity participation itself (Jackson et al., 2005).

### **2.5.1 Sport and Injury**

Sport does present a potential risk of injury to participants; this is mainly in the form of musculoskeletal injuries and is generally associated with those performing to the highest levels and more so in competitive sports (Kahn et al., 2012). Leisure-time activity allows partakers to freely adjust the volume or intensity of their practice, a luxury not typically afforded to those involved in organised sports or striving for international level performance (Theisen et al., 2012). Team sports had a greater injury risk compared to individual sports and racket sports (Theisen et al., 2012, Malisoux et al., 2013). Malisoux et al. (2013) demonstrated athletes from team sports have twice the risk of sustaining traumatic or overuse injuries. Overuse injuries were also found to be significantly related to increased practice sessions (Theisen et al., 2012). It is interesting to note that although team sports had the lowest working load, they had the greatest number of competitions which contributed to injury risk. Although not commonly reported, it is thought that the costs from sports injuries are substantial, generating millions annually (Kahn et al., 2012). Berg et al. (2014) simply comments that injuries will be an inevitable part of sport.

### **2.5.2 Unhealthy Sports Sponsorship**

Lindsay et al. (2013) describes how the sponsorship of sports teams and sporting eventing creates lucrative relationships between companies and the sports that they sponsor. Not only does it increase brand awareness, it allows for a company's image to be considerably improved by aligning their products with an activity heralded as healthy (Lindsay et al., 2013). Kelly et al. (2011) examined the food and drink sponsorship of sporting

organisations in Australia. Four hundred and forty three sponsors were identified in total. Of those 443, food industries made up 9% of sponsors and 3% were alcohol companies. All of the alcohol companies and nearly two thirds of the food industries identified as sponsoring sporting organisations were deemed unhealthy, not meeting the criteria to be classified as healthy sponsors (Kelly et al., 2011). This is an unsettling finding given that sports sponsorship is effective in targeting children. Pettigrew et al. (2013) established that over half of Australian children (n=164) aged 5-12 correctly matched the most popular Australian football league team with its main sponsor, a fast food chain. Kelly et al. (2011) likewise found that half of children correctly selected the sponsor of their favourite professional sports team. Worryingly, it was found that in Australia 15% of all alcohol commercials and 20% of beer commercials on television aligned sport with alcohol (Pettigrew et al., 2013).

In Ireland, there is no ban on the alcohol sponsorship of sports events relying only on industry self-regulation standards. The alcohol sponsorship of sports has become a key marketing activity for companies such as Diageo, who sponsor Irish rugby and GAA, directly linking their sports sponsorship activity with increased sales (Diageo, 2013). In recent years however, the GAA have ended their long standing sponsorship agreement with alcohol company Guinness. While this shows leadership at national level it is still up to individual clubs to develop their own policy relating to sponsorship or alcohol advertising as there is no overarching policy or regulations enforced from GAA headquarters. Alcohol Action Ireland report that almost half of the members of the Vintners Federation of Ireland (VFI) sponsor local sports teams (Alcohol Action Ireland, 2014). Alcohol advertising influences youth alcohol consumption rates and emboldens an overall culture of overconsumption of alcohol. This is especially true with alcohol sponsorship of sporting events which have been seen to foster alcohol consumption (Royal College of Physicians of Ireland (RCPI), 2014). A study by Houghton et al. (2014) examined Irish children's (7-13 years of age) awareness of sport sponsorship, in particular Munster rugby following their 2008 European Rugby Cup win. It was found that 69.9 % of children within the province of Munster correctly identified Heineken as the sponsor compared to 21.5% of children outside Munster (Houghton et al., 2014). In addition to identifying the sponsor, children were also able to name the product produced by that company as alcohol, which demonstrates the influence

of alcohol advertising in sport. Along with the brewing industry there are numerous example of Irish sports being sponsored by unhealthy food companies e.g. Irish basketball's new partner for 2015/2016 Hula Hoops (crisps) and McDonald's (fast-food) sponsorships of the Football Association of Irelands Future Football programme. Focusing on the GAA, again there is a need for policy and direction from national level concerning Gaelic games its sponsorship by unhealthy food companies. Numerous inter-county teams are synonymous with companies such as fast food companies (Supermacs) and crisp brand (Hunky Dorys) with no regulation at club level.

### **2.5.3 Sport and Substance Abuse**

During youth, involvement in health-risk behaviours, not disease, is the greatest concern for morbidity and mortality (Johnson et al., 2014). Since time immemorial a culture has existed where both watching and playing sport is associated with alcohol, be it through the sponsorship of teams or sport events by alcohol companies, the masculine stereotype of drinking alcohol while watching sports or after playing sport, or the ever available option of alcohol served during live sporting events (Collins and Vamplew, 2002). A report from the ESRI on the social value of sport, revealed how the social side of sport was routinely allied with alcohol consumption and possible excessive drinking (Delaney and Fahey, 2005). Worldwide, along with being a causative factor in injury and chronic disease, over 3% of deaths and 4% of disability-adjusted life years (DALYs) are related to alcohol consumption (Rehm et al., 2009, World Health Organization, 2007). In Ireland, an estimated 10.7 litres of alcohol were consumed per adult in 2013, a figure in excess of the Healthy Ireland (2013) maximum of 9.2 litres and a comparatively high level when paralleled to other European Countries (Foley, 2014). Excessive alcohol consumption negatively influences health, as well as social and economic factors, with 88 deaths a month in Ireland directly connected to alcohol (Royal College of Physicians of Ireland (RCPI), 2014).

It has been suggested that sports involvement moves from being a protective mechanism during childhood to becoming a risk factor for alcohol and cigarette use in older athletes (Kulesza et al., 2014). Fahey et al. (2004) put forward the case that sports participation, while associated with lower levels of cigarette smoking, is linked with higher levels of alcohol consumption. Studies looking into the relationship between alcohol and college and

intercollegiate athletes revealed that binge drinking was more prevalent among athletes than non-athletes (Nelson and Wechsler, 2001, Martens et al., 2008). Ferron et al., (1999) also found high school students belonging to a sports club drink comparatively more beer when compared to non-athletic populations. Wichstrom and Wichstrom (2009) followed a sample of Norwegian students from high school to college and found the rate of sports training in high school was positively related with consumption of alcohol in college. A French study went so far as to say sport participation was an indicator of alcohol usage (Lorente et al., 2004). Rates of binge drinking may vary however by type of sport. In one study, it was determined that athletes from team sports were more likely to binge drink than athletes from individual sports (Ford, 2007). Wichstrom and Wichstrom (2009) added that those who played team sports over endurance type sports were more likely to drink alcohol. It is suggested that because of the intrinsically competitive nature of athletes, their perception of other player's social norms and the stress associated with sport, sportsmen, in particular team sport participants, consume vast quantities of alcohol owing to peer pressure (Henchoz et al., 2014, Kulesza et al., 2014). Furthermore, Kulesza et al. (2014) in a study of high school athletes signalled that participants involved in team and individual sport activities were at a greater risk of using tobacco than athletes involved in one type of sport (team or individual) only. In an Irish context, it has been shown how adults involved in sports are more likely to drink higher units of alcohol per week when compared to the general population (Fahey et al., 2004). This effect is particularly evident among women, especially women involved in team sports, and for both men and women in the 25 and under age category.

In a review of 34 peer-reviewed studies on high school and college sports involvement, it was found that while sport is related to higher levels of alcohol consumption, it is also associated with lower levels of illegal drug use (Lisha and Sussman, 2010). However, the use of performance enhancing drugs or 'doping' may be more of a concern for athletic populations. Athletic performance intensifies each year as athletes strive to achieve higher and higher levels of success. There is a fixation on winning and a win at all cost mentality has ensued among all categories of athletes, meaning no longer is the use of performance enhancing drugs limited to elite athletes (Dawson, 2001). The greatest areas of concern surrounding the use of substances relates to the athletes physical health and also the

ethical dilemma that derives from obtaining an unfair advantage through the use of products rather than training (Laure and Binsinger, 2005). Among 12 to 17 year olds, anabolic steroids were the second most commonly known substance for athletic performance (Blue Cross and Blue Shield Association). Studies have found that 4-12% of US high school boys and 1-2% of adolescent girls have used anabolic steroids at some point in their life (Kutscher et al., 2002). It was even found that doping exists among preadolescent athletes who train daily with 3% having taken a doping substance and that of the adolescents who use anabolic steroids 65-84% were participants in organised sports (Laure and Binsinger, 2007, Sullivan et al., 1998).

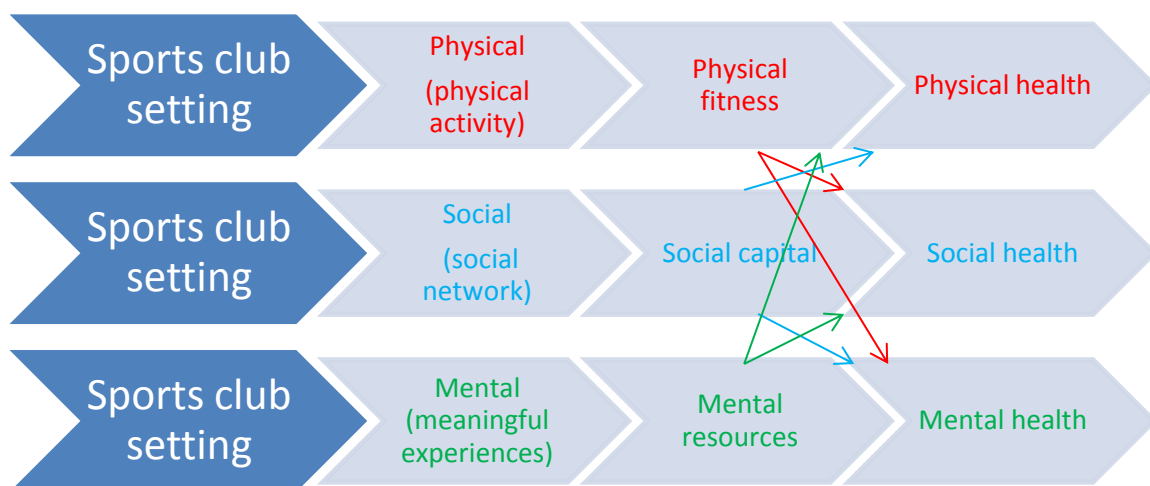
The above evidence highlights the need and opportunity for sports clubs to become involved in risk behaviour preventions programmes, particularly primary prevention approaches in relation to substance abuse (Hellandsjo Bu et al., 2002, Henchoz et al., 2014). Healthy People 2020, recommends adolescents increase their engagement in extracurricular activities because of the protective health benefits associated with such activities (Johnson et al., 2014). Jackson et al. (2005) reinforces this point adding that sports clubs, as a health promotion setting, may be especially effective in targeting risk behaviours through the use of policies, healthy education and information and creating an environment supportive to healthy behaviours.

## **2.6 Health Promotion Potential of a Sports Club**

The evidence presented thus far points out that health promoting setting such as schools, workplaces, and communities have been advocated by the WHO for decades. Yet, there is no mention of sports clubs and the application of health promotion in a sports clubs context is negligible (Meganck et al., 2014).

Organised sport, is by tradition, associated with health, with athletes seen as role models who are expected to epitomise and endorse positive health related behaviours (Koski, 2008). A chief socialisation domain, along with family and school, sports clubs can be an important developmental environment for youth (Rutten et al., 2007, Hellandsjo Bu et al., 2002). Sports clubs are also an attractive setting when you consider that, as previously mentioned, a significant proportion of children are involved in organised sports. In Finland

for instance, it is estimated that 70 - 80% of young people are involved directly and indirectly in sports clubs activities. In their research, the Irish Sport Council (2008) also predicts that one in every five men over the age of 65 is a member of a sports club meaning that social involvement in sport can be prolonged beyond ones playing career (Irish Sports Council, 2008). Clubs provide a setting in which youth actively participate in sport and older adults contribute through their actions e.g. coaching (Kokko et al., 2009). *Figure 3* illustrates that there are various dimensions of health within a sports clubs setting, suggesting that physical activity is not the only element of sports club activities that impacts health. Social activity, meaningful interactions, and experiences of joy within a sports club can all contribute to social and emotional health regardless of physical activity (Kokko et al., 2011). Sports clubs therefore offer great appeal, benefiting physical, social, and emotional health and providing a wide reach into the community (Kelly et al., 2014, Jackson et al., 2005). The ability of a sports club setting to target large and/or hard to reach population groups and promote health enhancing behaviours is invaluable from a public health perspective (Casey et al., 2009a).



**Figure 4 Dimensions of health within a sports club setting**

Kokko et al. (2006) recently advocated the use of sports clubs as another setting to promote health. Sports clubs as a setting for health promotion have been relatively

unexplored, with little published literature on how health promotion through sport can be achieved (Casey et al., 2011). Typically, sports clubs are settings in which youth/adolescents and adults can actively participate in sport and/or contribute to participation through their actions (Kokko et al. 2009). Competitive sport may typically be perceived as the focus of many sports clubs, however, there appears to be an increasing number of people interested in other ways of engaging in physical activity aside from competitive sport (Casey et al., 2009). Organisations need to consider these findings and incorporate them into the way sport and recreational programmes are delivered. Participation in regular and moderate levels of physical activity has numerous health benefits, but with an increasing number of people joining sports clubs, there is potential for societal interventions on the broader concept of health (Geidne et al., 2013). The socio-ecological model detailed at the beginning of this chapter provides a framework to help understand the factors which can either enable or prevent physical activity participation. Interventions incorporating physical activity thus have the greatest potential to be successful if they target multiple levels of the model. Delivery of this information can enable the design of more effective interventions including policies and strategies designed to encourage sport participation. Kokko et al. (2013) presented a conceptual framework for health promoting sports clubs, identifying layers of activity at the macro, meso and micro level; from the policy and orientation of a club to, support for, and action around health promotion in the daily running of club activities (Kokko et al., 2013).

### **2.6.1 A Practical Setting to Facilitate Health**

Sports clubs have the potential to promote and facilitate healthy behaviours and attitudes within the club, but also could potentially extend their reach into local communities. A recent White Paper in Sport emphasises the impact sport can have in creating health-promoting environments, however, the White Paper also accepts the health promotion aspect of sport is redundant and needs to be developed (Commission of the European Communities, 2007). This led to the creation of the Promoting Adolescent Physical Activity (PAPA) project, a project aiming to improve adolescent health through a quality intervention focused on promoting mental, emotional, and physical activity engagement (Duda et al., 2013). A similar development from the Centre for Disease Control in the USA underlines that youth sport is a key method through which communities can increase the

physical activity levels of children and adolescents and encourage lifelong participation in sport (Duda et al., 2013).

The supplementary health potential of sports clubs is vast, with the addition of environmental and policy change, health promotion campaigns can support in making the 'healthy choice the easy choice' (Jackson et al., 2005). Kokko et al. (2011) defined a health oriented sports club as 'a sports club that recognises health in its orientation to activities. Health is not the main orientation, but has been recognised as one of the main operating principles'. In this way, health promotion should not be a separate policy but should be incorporated into the constitution of a club, thereby infiltrating into the day to day running and activities of a sports club, and generating a culture where health promotion is embedded into the fabric of a club. One previous study found that in Australian sports clubs, some health promotion policies were already in place but the degree to which there were recognised varies between clubs, possibly due the voluntary context (Dobbinson et al., 2006). Given that health promotion may be a new diversion from the traditional route of providing competition there has been conversation about the need to alter 'from a narrow focus on sport to one encompassing health promotion' where environments are developed to support behaviour change (Casey et al., 2009a). To ensure policies and actions are given the best chance of success in any health promoting setting they need to assist the organisations core values (Dooris, 2004). Regarding sports clubs this would include achieving top-class training, peak performances and the efficient operation of the club (Meganck et al., 2014) but could also include, as noted earlier, extending beyond sporting activity and into the local community.

Kokko et al. (2009) outline the 3 main opportunities sports club have when it comes to health promotion. Sports clubs not only involve large volumes of children and adolescents but also have access to their families, enabling sport clubs to promote health to adults alongside youth. The informal educational nature of sports clubs is also seen as an opportunity as participants take part in activities voluntarily. The final opportunity resides in the fact coaches are an essential element of sports clubs, and act as important authority figures and role models for young people, with the ability to greatly impact on young people's lifestyle choices. The importance of coaches in contributing to the creation of a healthy environment has been recognised by organisations such as Sport Scotland and the



European PAPA (Promoting Adolescent Physical Activity) project, which have both invested in the training of coaches to facilitate an empowering climate leading to improved health and wellbeing (Sport Scotland, 2015, PAPA, 2015).

The recent study by Meganck et al. (2014) aimed to ascertain the current position of youth sports clubs in Flanders in relation to health promotion, and also intended to investigate the barriers and motives associated with integrating health promotion into youth sports clubs using the health-promoting sports club index (HPSC-I) as identified by Kokko et al. (2009). The HPSC-I was developed from the Delphi Model and uses 22 standards to assess the health promotion status of youth sports clubs in Finland in relation to policy, ideology, practice, and the club environment. Kokko et al. (2009) examined 97 youth sports clubs in Finland, where 273 sports officials and 240 coaches answered the questionnaire. Scores on the HPSC-I could range between 0 and 22, as with 22 standards in total each standard scored either zero if the answer was 'The standard in question describes our club to some extent at most', or one if the answer was 'The standard in question describes our club well or very well'. Clubs needed to reach 15.00 or greater to be considered high health promoting, 11.00-14.99 was considered moderately health promoting, and less than 11.00 was a low health promotion status. The average HPSC-I score for clubs was  $12.25 \pm 4.04$  translating to mean clubs, on average, were moderately health promoting. Twenty three percent (23%) were found to be high health promoting. The lowest HPSC-I score was found to be 2.75 and highest 18.75 demonstrating a large degree of variation. Of the four sub-indices (policy, ideology, practice, and environment), clubs recognised ideologies best with 72% of clubs reaching the higher health promoting level. The environment section also score relatively high compared to policy and practice which scored lowest. Not even one fifth of clubs were deemed to be high health promoting when it comes to policy and almost half of clubs scored low in relation to practice. Size, discipline or location of the club did not have an influence of the prevalence of health promotion activity. While on average youth sports clubs in Finland can be considered moderately health promoting, there is room for much development when it comes to comprehensively integrating health promoting into the daily activities of a youth sports club (Kokko et al., 2009). It was noticeable that club size had no bearing on a clubs health promoting status with small clubs reaching the highest level of health promotion. Therefore, a clubs background may not hinder the

capability of a club when it comes to health promotion but it is the drive and determination of volunteers that ultimately decide a club's capacity for promoting health (Kokko, 2010).

Transferred from Finland to Flanders, Meganck et al. (2014) found that youth sports clubs did not score well on the HPSC-I, with three in five clubs categorised as low health promoting. Similarly to Kokko et al. (2009) ideology received the highest mean score followed by environment. Significant predictors of higher scores included 'clubs that had been founded more recently' and 'clubs that focused on both recreation and competition' (Meganck et al., 2014). With respect to policy and practice, the youth sports club's average scores were below the midpoint of the scale. Concerning motives and barriers, youth sports clubs recognised the benefits of introducing health promoting policies and practices and felt none of the potential barriers were substantial enough to deter them from including health promoting policies and action in their club. Worryingly however, 33% of respondents cited health promotion not being a priority in their club as the largest barrier. It is clear that youth sports clubs in Flanders have a long way to go in realising their potential as health promoting settings with less than one in five youth sports clubs classed as high health promoting (Meganck et al., 2014). Overall, the presence of any health promotion orientation in these clubs suggests that a sports club does present a practical opportunity for the implementation of policies and practices to support healthy behaviour change. There have been some initial attempts to implement and evaluate health promotion through sport.

### **2.6.2 The Healthy Sporting Environments Demonstration Project (HSEDP)**

Australia is an example of a country which has taken a holistic look at community sports clubs in order to promote health (VicHealth, 2013). Kelly et al. (2011) determined that when it comes to the areas of fair play and anti-discrimination, organised sports clubs in Australia have written documents and supporting practices well engrained in their ethos. However, in the areas of inclusion, healthy eating, and sun protection clubs were less likely to have written documents and supporting club practices. HSEDP is an example of a programme in which VicHealth have invested in, in order to develop sports clubs into healthier, welcoming and more inclusive environments from the grassroots up, with the goal of increasing participation in sport and improving the health and well-being status of

whole communities (VicHealth 2013). The premise of the HSEDP is that if you create a healthier club experience for people it will result in greater levels of membership (VicHealth 2013). It is equally as important to advertise the health enhancing policies and practices already contained within some clubs, as it was discovered that in Australian sports clubs a large number of respondents were unsure whether their clubs engaged in any form of health promotion practice or were unaware if their club provided any practices like training for coaches (Hemphill et al., 2002).

The programme was introduced in 2010 and guides healthy practice for sports clubs through policy, environmental, and cultural efforts specific to 6 standards: injury prevention, inclusion, sun protection, smoking, alcohol, and healthy eating, and to challenge the opportunistic marketing that often occurs in a sports club environment (VicHealth, 2010). The program is based on the understanding that community sports clubs play a pivotal role in health promotion, providing meeting places, social networks, and community involvement opportunities, especially in rural communities (VicHealth 2013).

#### **2.6.2.1 HSEDP Outcomes**

Evaluation of the HSEDP indicated positive changes in the areas of healthy eating, sun protection, inclusion, and injury prevention, but little impact on health behaviours over a two-year period (Nicholson et al., 2013). It is likely that such an institutional change will take some time to manifest as improved health outcomes. When evaluating the overall capability of HSEDP sports clubs to create healthy sporting environments, numerous factors emerged. Firstly, there is a substantial dependence on volunteer members who are committed to creating a healthy and welcoming environment for members. There is also a reliance on a strong governance structure and a well organised management committee in the club focused on implementing practices and policies to support a healthy environment. Finally, it was advantageous for clubs to view the HSEDP as a 'whole club commitment' from its inception rather than a specialist task for a small subset of members (Nicholson et al. 2013). Having such a system in place would allow greater support when executing changes. One of the challenges faced by the HSEDP clubs was that it was not seen as a core activity of the club by all, something which establishing whole club support at the beginning of the project may be helped to alleviate. Along with this, the HSEDP may be

seen to place an extra workload on volunteers, stressing the need to have more than one or two members charged with running the project, adopting a team based approach instead. Of the 6 standards, decreasing tobacco use was the most difficult given it is hard to police, especially with visiting clubs who didn't know the policy and some committed smokers do not want to change their behaviours.

Initially attracted to the project by a monetary incentive, 74% of participating clubs indicated that financial incentives were a key factor in joining the project, motivations changed to more substantive benefits by the end of the project with one club representative quoted as saying 'taking part in the project could only be good...mainly through knowledge and sharing experiences with other clubs and course people' (Nicholson et al. 2013). For some, the project was seen as a natural progression of the work already being undertaken in the club. End of season surveys were used to establish overall satisfaction and outcomes of the HSEDP. Findings showed that 86% of club representatives would take part in the project again, with 93% stating their club is a better place having taken part in the project. The culture within clubs was also viewed to have improved as a result of the project, with only three of the 42 clubs disagreeing with this. The project was further endorsed with 95% of club representatives agreeing the project has allowed them to tackle health issues they otherwise would not have done. When club representatives were surveyed they were asked what word they would most associate with their experience of the project. The two words that came out on top were 'positive' and 'support' indicating that the HSEDP was either a positive experience for the committee or had positive outcomes on the membership and that the project provided support to improve the club environment (Nicholson et al. 2013).

Otway Districts Football Netball Club is an example of one of the clubs that took part in the HSEDP. Taken as an opportunity to review and revise club culture, one year on the club has raised its profile in the community and built a reputation for being extremely family friendly and valuing safety, inclusion, and diversity. Along with enhancing the clubs reputation, the club has received more grants and in kind support along with being able to raise more cash (VicHealth, 2013). On the lasting impact of the project the former club

president is quoted as saying 'It's not just about the senior men's football team anymore, it's about everybody' (VicHealth, 2013).

### 2.6.3 Sport for Health initiatives

In Europe, Sports Club for Health (SCforH) guidelines have been developed to help clubs engage in health promotion, however these have not yet been evaluated (Kokko et al., 2011). SCforH aims to encourage sports clubs to invest in and adopt health-related sports activities into their sport activity and agenda. Casey et al. (2009b) reported increased organisational capacity among national sporting bodies, and good evidence for policy and practice at national level, but this was not always translated to club activity. The SCforH guidelines focus on how local level voluntary sports clubs can recognise the health potential of their work, develop structured health promotion programmes and eventually incorporate health into the culture and running of the club. As highlighted in table 3 below the guidelines consists of ten actions across three stages: planning, implementing, and documenting and communicating.

Table 3 SCforH guidelines

<b>Stage</b>	<b>Guidelines</b>
<b>Planning</b>	1. Ascertain the possibilities and support for a health promoting programme within the sports club
	2. Establish the health potential of the sports clubs activities
	3. Identify the skills and resources available outside the club
	4. Keep the quality of the SCforH a priority
	5. Set out aims of the programme and formalise the operating procedures
<b>Implementing</b>	6. Notify of planned action internally and externally
	7. Involve and support qualified instructors
	8. Monitor planned activities in order to evaluate
<b>Documenting and Communicating</b>	9. Detail all SCforH activities
	10. Communicate success both within and beyond the club

There have been some examples of effective sports for health programmes. Alcohol consumption is viewed as a negative aspect of involvement in sport, and yet it has become a normal part of community sport club culture in Australia (Crundall, 2012). In response to this, sports clubs are now being recognised as locations in which to develop better alcohol management practices. The 'Good Sports Programme' is an example of one such case where the sports club setting is used to challenge reckless alcohol consumption and associated anti-social behaviours, helping clubs to improve alcohol management practices and reduce irresponsible drinking patterns through a planned and comprehensive accreditation process setting out minimum standards for regulatory compliance, club practices, and policies (Crundall, 2012).

Investigating if better alcohol management practices could actually benefit clubs through increasing membership, financial sustainability, and an expanded spectator and competition base, Crundall (2012) collected data from 657 Australian sports clubs already enrolled in the Good Sports programme using pre- and post- surveys. It was thought that by lessening the emphasis on alcohol clubs may create an environment which feels safer and relaxing leading to an increased uptake in club activities by women and juniors. A survey of community sport clubs in Victoria supports this by stating 72% of respondents would find clubs more family friendly environments if alcohol consumption was reduced, meaning the opportunities for growing membership and fundraising are enhanced (Crundall, 2012, Kingsland et al., 2015, VicHealth, 2010). Crundall (2012) revealed that the Good Sports alcohol programme showed more positive drinking patterns, lower reliance on alcohol sponsorship for income, and greater membership at follow up. Increased membership was most prevalent among non-players, females, and youths; no change was seen in playing membership. Responses to a web based survey also revealed that the majority of respondents agreed that establishing healthy and welcoming environments that included alcohol management practices would grow involvement and membership in their sports club. The author did note however that qualitative research would further explain the processes and dynamics involved in achieving change. Rowland et al. (2014) also suggests that effective alcohol management programmes contribute to how safe people feel in a sports club setting and subsequently the extent to which they participate in club activities (Rowland et al., 2014).

The Football Fans in Training (FFIT) programme is a weight management intervention designed to attract males at risk of ill-health. The programme is delivered through professional football clubs in the Scottish Premier League (SPL). The choice of setting, professional football clubs, proved extremely influential as it allowed participants to feel 'right', rather than threatened, showcasing that health promotion activities can be consistent with, instead of challenging towards, the common ideals of masculinity (Hunt et al., 2013). The chance of experiencing an SPL club itself encouraged participants to attend the programme in the first place, and once there, the participants shared a common interest in football along with recognising themselves in the appearance and fitness ability of the other men (Hunt et al., 2014). Hunt et al. (2014) reasons that 'the professional football club setting gave these men a physical and social opportunity which corresponds well with their own identities and male values, adding a sense of masculinity to the idea of weight loss as well as providing an influential social and psychological connection that being a football fan stimulates (Gray et al., 2013). The FFIT intervention consisted of 12 weekly group sessions at SPL football stadia conducted by trained community coaches. The intervention provided advice on healthy lifestyle choices and maintainable behaviour change approaches (Hunt et al., 2013). FFIT also incorporated a physical activity element consisting of a walking programme (Hunt et al., 2013). Walking was thought to be an appropriate choice for sedentary adults as it can produce many physiological benefits as well as being a relatively safe and cheap method of physical activity (Hunt et al., 2013). The FFIT programme reported significant reductions in weight in the intervention group compared to the control group. Along with a reduction in weight participants fostered healthy living behaviours and regained physical capacities (Hunt et al., 2013). The FFIT programme is an example of an innovative use of a setting to engage with population groups that could otherwise be hard to access. The programme demonstrates that using a setting which is 'highly valued and unthreatening' proved to be the necessary catch to involve the target population and could be transferred to alternative settings such as rugby clubs or social clubs (Hunt et al., 2013). As experienced by the FFIT programme, a sports club setting may also help to reduce cultural stigmas around attending health interventions, in this case weight management support, and provide an opportunity for people with a common interest in sport to meet (Wyke et al., 2015).

Eime et al. (2008) investigated the potential of creating a healthy and welcoming environment sports club environment as an indirect strategy to increase participation. The majority (97.2%) of Executive Officers for Australian State Sporting Assemblies felt the creation of a supportive environment would facilitate increased membership alongside the traditional lure of sports competition. The Executive Officers appeared to be linking the concept of club development with the provision of a healthy and inviting club environment, but it is the conversion from awareness to actual club based behaviour change where local level clubs struggle and need to guidance (Eime et al., 2008).

A recent review of literature looking health promotion in sports clubs and behaviour change fail to identify any studies which actually guide the use of policy interventions used in sporting settings (Priest et al., 2008). It is unsurprising then, that Kingsland et al. (2015) reports sports clubs continually fail to comprehensively or consistently implement evidence based practices, or that Finch et al. (2012) found scientific based injury prevention is not translated into real world coaching sessions, although coaches seem aware of the benefits (Finch et al., 2012).

#### **2.6.4 Support Structures**

In order to successfully redirect the motivations of any organisation, sporting or otherwise, a common set of features must be in place. Amis et al. (2004) studied the process of organisational change in Canada whereby Canadian National Sporting Organisations were financially backed to convert from amateur volunteer organisation to professionally organised associations. Success was found to be highly reliant on the leader's interests, motivations, and their ability to prompt and facilitate change. In cases where the leaders resist change, only superficial changes are made (Amis et al., 2004). When evaluating the capacity of sports clubs to become healthy sporting environments guided by the HSEDP, Nicholson et al. (2013) made reference to volunteers and committee members needing to be fully committed to the task of creating a healthy sporting environment in their club, supported by a good governance structure leading the way in terms of policy, procedures and practices, and a whole club approach. Policy efforts are an important foundation, as



though they take time, they possess the ability to bring about widespread changes in social norms, reduce risk behaviours, and generally improve public health.

When considering support structures, a similarly important construct is the formation of partnerships. Partnerships amid the health sector and community organisations are a recognised method of developing sport and recreation programmes to address public health needs (Casey et al., 2009). Smith et al. (2011) acknowledges hardly any community organisations equal sport and recreation organisations when it comes to reaching the population. VicHealth recognised the need to collaborate and build associations with other pivotal sport and recreation bodies, as well as, community organisation and local and state governments (Casey et al., 2009). It was envisaged that Australian sport assemblies could achieve this link, with VicHealth funding the promotion of participation in physical activity through the Participation in Community Sport and Active Recreation (PISCAR) scheme (Casey et al., 2009). The PISCAR program, conducted by VicHealth, recognised the valuable role that sport and recreation schemes play in increasing rates of physical activity and diminishing health inequalities (Smith et al., 2011). The program set about targeting disadvantaged groups through the funding of 61 projects through 10 State Sport Assemblies, 4 Regional Sport Assemblies, 3 Peak organisations, and 5 rural or regional organisations. A key focus of the implementation strategy, as set out by VicHealth, was a partnership approach realising that this was essential for the success of the project implementation. Partners included organisations involved in 'sport, health, social welfare, local government, education and community' (Smith et al., 2011).

Evaluated over three years, PISCAR partnerships were identified as playing a vital part in enabling sport and recreation organisations to access disadvantaged groups, supplying knowledge and skills to enable these groups to participate, and resourcing the delivery of programs. Successful partnerships in the PISCAR project were deemed to have good relationships, a clear purpose, be mutually beneficial, share resources and knowledge, communicate effectively, and be consistent in their work together (Smith et al., 2011). Some of the benefits which applied to sport and recreation organisations and their partners were a better reach and understanding of target groups, shared skills and learnings, increases available resources, raising the profile of all involved organisations, lending itself to better sustainability of the PISCAR project (Smith et al., 2011).

It is no secret however, that financial support and workforce development helped in enabling this transformation, so the removal of such supports may be a cause for concern in the sustainability of the scheme (Casey et al., 2009). The PISCAR evaluation points towards an underestimation of human and financial resources as characteristics often linked to projects that have the greatest difficulty engaging their community (Smith et al., 2011). Casey et al. (2009) also suggests that the more formalised the partnership, the higher the rate of successfully implementing and sustaining initiatives. In order for a programme to be sustainable within a sport or recreational organisation it needs to consider stakeholders right from the developmental stage, link with existing structures, and provide training opportunities (Casey et al., 2009).

In conclusion, although some detrimental effects of sport have been identified, the positive value of sport, especially club participation, is still substantial in relation to physical, mental, and social benefits, highlighting the potential for sport clubs to tackle a range of health issues (Geidne et al., 2013). It is important to consider the wider community in this work, as Casey et al. (2009a) drew attention to the growing number of people searching for alternative ways of getting involved in physical activity rather than through competitive organised sport. Sports clubs can respond to this need through the delivery of various recreation or health programmes helping to open up the club to a wider membership base. The main role of sports clubs may be to provide opportunities for competition, but there is a growing trend in recognising the value sports clubs can add to the social, physical, and emotional health of all those involved. Sports club settings also offer a less formal environment where it has been argued youth may be more open to receiving health information (Maro et al., 2009). Through activating health promotion initiatives a sports club can deliver innovative services to its membership, as well as sensitively addressing the needs of the community (Kokko et al., 2011). To realise the potential of sport clubs as a setting for health promotion investment is needed to ensure the delivery of appropriate programmes (Donaldson and Finch, 2012).

## 2.7 Summary

'Public health goes far beyond the confines of healthcare' and there is an increasing emphasis on the merits of community based health promotion (Lloyd et al., 2007). The benefit of utilising sports clubs to promote public health is based on their influential and undeniable position within communities. A sports club presents an opportunity whereby health promotion activities are not solely limited to players, but can be experienced by a much broader cohort of people. One cannot deny that sports clubs are settings in which youth/adolescents and adults can actively participate in sport, but access is also provided to family, friends and spectators. For this reason, sport can be considered to be one avenue that warrants a place on the public health agenda, stressing that public health programmes often focus on healthy behaviour change only among youth, and may inadvertently leave other groups in society feeling side-lined by programmes that should serve the public interest (Berg et al., 2014). Organisational support and leadership are key pillars in ensuring a healthier culture and safer environment. To do this and encourage community participation the community needs should be taken into consideration, meaning all stakeholders need to be involved in the planning, development, and implementation of community based health promotion projects. The evidence presented in the review of literature demonstrates that sports clubs have the potential to be viable settings for health promotion.

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## Chapter 3 Methodology

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This chapter details the research methodology used in the evaluation of the GAA's Healthy Club Project (HCP). Introductory sections of this chapter describe the participant sample and include justification for the methodological framework employed. Concluding sections of this chapter outline the data analysis approach and ethical approval.

### 3.0 Research Approach

An applied research approach was used to evaluate the GAA's HCP. While basic research deals with gaining knowledge and promoting the scientific understanding of the world, applied research 'addresses real life situations that require immediate attention' (Sarantakos, 2012). Given the purpose of this research was to assess the impact of the HCP on clubs, as well as examining the 'how' of the Healthy Club process, the type of applied research deemed most suitable was evaluation research. The key features of this approach is that it aims to 'assess the merit of programmes, policies, services or interventions' and 'provide information about various aspects of programmes, such as whether proposed programmes, policies, services or interventions are worth pursuing, supporting or continuing' where the provision of practical knowledge aids the decision making process (Sarantakos, 2012).

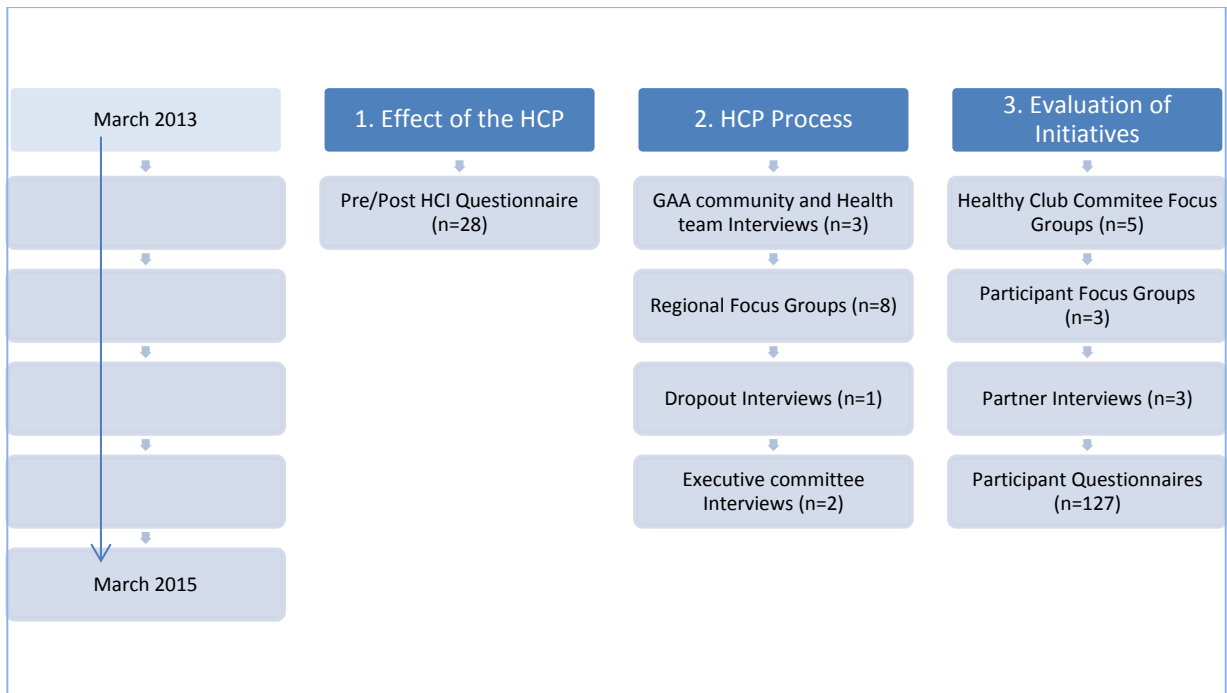
### 3.1 Study Design Overview

The GAA's HCP was a pilot settings based health promotion project which involved 18 affiliated GAA clubs across the four provinces of Ireland (Leinster, Munster, Connacht, Ulster). This evaluation focuses on phase one of the HCP which ran over a two year period from March 2013 to March 2015. A mixed methods approach consisting primarily of qualitative research methods was incorporated into this evaluation. Mixed methods research allows the combination of 'elements of qualitative and quantitative research approaches for the broad purposes of breadth and depth of understanding and

corroboration' (Johnson et al., 2007). Using mixed methods allowed for different types of evaluation to take place i.e. process and outcome evaluation. Outcome evaluation measures the impact of the project and whether its goals were achieved looking at policy change, adoption of health promotion initiatives, a changed perception of health in the club, and potentially improvements in health and well-being (Round et al., 2005, Chu et al., 2000). Process evaluation is particularly useful when evaluating implementation strategies. It monitors and records programme implementation and helps in building an understanding of the relationship between certain programme elements and programme outcomes (Saunders et al., 2005). Process evaluation looked at aspects like how the HCP and specific initiatives were received, who the initiatives were targeted at, if participants were satisfied, and the quality of delivery etc. (Chu et al., 2000). As the HCP took place in the 'real world' and a large proportion of the research focused on determining what worked or didn't work, when, where and how with a view to the findings being meaningful and quickly and easily transferable within a real world sport club setting no control group was used.

The predominant use of qualitative methods through focus groups and one-on-one interviews with all key stakeholders was deemed most appropriate for the majority of data collection as the researcher sought to elicit the perceptions, feelings, attitudes and experiences of participants. The quantitative element, questionnaires, helped to establish if there were changes in the health promotion activities of clubs and subsequent changes in the attitudes and behaviours of participants involved in initiatives delivered by the clubs as a result of participation in the HCP. The use of both qualitative and quantitative approaches, in combination, provide a better understanding of the process of becoming and running a Healthy Club than either approach alone (Denzin and Lincoln, 2013). For this reason a mixed methods data collection strategy was implemented.

A framework for research, to address each research question, is shown in *figure 5*



**Figure 5 Framework for research**

### **3.1.1 Effect of HCP**

As mentioned on page 5 the purpose of this research was to examine the impact of the HCP on participating clubs in relation to club policies, practice, ideologies and environment. Outcome evaluation was used to assess impact of the overall HCP over a 2 year period using quantitative methods including pre- and post- self-completed Healthy Club Questionnaires (HCQ). Outcome evaluations provided some indication of the impact of the initiative but also its suitability for replication or adaptation. The HCQ, which incorporated a validated health promotion sports club index developed by Kokko et al. (2009) was used to assess the baseline and follow up health promotion characteristics of participating clubs, general workings and composition of each club and to generate a standardised, comparable set of data for all clubs participating in the HCP (n=18).

### **3.1.2 HCP Process**

In order to explore the process of the development of a Healthy Club, qualitative data was collected through focus groups and interviews were held with Healthy Club Committee members over the course of the project. This allowed for the inclusion of experiences and

reflections on becoming a Healthy Club and a comprehensive overview of Healthy Club activities undertaken. Focus groups are particularly suitable in this instance as the development of a Healthy Club is very much a collaborative and combined effort between a variety of individuals. Focus groups are also an appropriate method of data collection, given the nature of GAA clubs and the interaction between all individual entities within the club, ensuring the interaction between these individuals was accurately captured. One-on-one semi structured interviews were also carried out with a sample of club Executive Committee representatives from the 18 clubs taking part in the project. These interviews provided an insight into the positioning of the Healthy Club Committee in the overall club structure, how much support the executive committee provides towards the projects and the benefits of having a club involved in the Healthy Club project. One of the two clubs who dropped out prior to the study end, represented by a member of their former Healthy Club Committee, completed an exit interview with the researcher to gauge their perception of the HCP and the reasons behind their exit from the project.

### **3.1.3 Evaluation of Initiatives**

Finally, to evaluate the process and outcomes of specific initiatives delivered by clubs, both process and outcome evaluation was carried out using a combination of qualitative and quantitative methodologies.

Process Evaluation: this included an assessment of resources required to design and deliver the programme, the nature and amount of programme content, collaborative delivery, attendance and participation in the programme. Process evaluation is important in this instance for two reasons. Firstly, it will provide key guidance for other clubs interested in delivering similar programmes, thus improving the generalizability of the initiative. Secondly, programme outcomes can be linked to programme delivery, which can indicate success, or lack thereof, of certain components and effectiveness can be quantified by successful implementation and engagement as well as successful outcomes. Process evaluation was mainly be carried out using quantitative methods involving participant questionnaires.

Outcome Evaluation: effectiveness of programmes was assessed in relation to feedback from participants, changes in behaviour, awareness, level of education or skill, and changes in attitude. Outcome assessments were carried out using quantitative (participant questionnaires) and qualitative methods (in-depth interviews with key committee members and partners involved in facilitating the initiative and participant focus groups). The exploration of people's experiences and perspectives offered by the in-depth interviews and focus groups are ideal in gaining understanding of how selected initiatives operated. Also, as noted earlier, it was difficult to capture all of the work carried out in the club using the HCQ so in depth-interviews and focus group discussions facilitated a broader understanding of activities that constitute Healthy Club related initiatives. Engagement with partners in delivering and facilitating Healthy Club initiatives is a key component of the Healthy Club Project and was investigated by carrying out in-depth semi structured interviews with a selection of defined internal and external partners involved, based on the amount of access to these partners.

## **3.2 Participants**

### **3.2.1 Clubs**

To recruit clubs for the HCP, an expression of interest was disseminated by the GAA to 2,126 affiliated local community based GAA clubs across the 32 counties of Ireland. Fifty six subsequent submissions were reviewed in a selection process agreed upon by the National HCP Steering Committee. This involved a scoring system across three criteria, which included ratings for current initiatives and community links and the location of each club. In total eighteen clubs (n=18) were selected by the GAA to take part in phase one (March 2013-March 2015) of the HCP. These eighteen clubs represent four clubs from each of the four provinces of Ireland (Leinster, Munster, Connacht and Ulster) along with two additional mentoring clubs in Munster and Ulster. A mentoring club is a club 'deemed to already be at an advanced stage as a 'Healthy Club' and was identified as having strong learning sharing potential for the other participating clubs' (GAA, 2013). Despite this distinction, all clubs were included in the analysis for this report, as they each have experienced the same process over the first year of the project.



### **3.2.2 GAA Community and Health Team**

The HCP is being directed at national level by a three member team (n=3). The team facilitated a number of provincial operational group meetings throughout the course of phase one to assist the projects roll out. The team is also the main point of contact for clubs within the GAA and provide guidance, support and resources to participating clubs. Interviews were carried out with two of the team members who each have responsibility for the roll out of the HCP to participating clubs in Leinster and Munster and Connacht and Ulster respectively.

### **3.2.3 Healthy Club Committee members**

All participating Healthy Clubs (n=18) were required to set up a Healthy Club Committee to guide and lead the initiative. To reflect the community ethos of the project, it was envisaged that this committees would include club members but also would enlist non-members with skill sets suitable to the HCP concept. A sample of n=7 Healthy Club Committees partook in either focus group discussions or one-on-one semi structured interviews with the researcher. The sample contained Leinster clubs (n=2), Munster clubs (n=2), Connacht clubs (n=1), and Ulster clubs (n=2).

### **3.2.4 Executive Committee members of participating clubs**

The GAA dictates that all of its affiliated clubs must elect an Executive Committee. This Executive Committee manages the overall business and affairs of the club and is comprised of a Chairperson, Vice-Chairperson, Treasurer, Secretary, Registrar, Officer for Irish Language and Culture, Public Relations Officer, Children's Officer, one Players' Representative, and at least five other Full members (GAA, no date). Sub-committees are appointed to work in one area of club activities and report back to the Executive Committee. A total of four Executive Committee representatives (n=4) were interviewed around their view of the role health promotion plays within a GAA club setting and the progress of their Healthy Club Committee. The selected clubs represent Leinster (n=1), Munster (n=2) and Ulster (n=1).

### 3.2.5 Initiative Participants

Initiatives run by Healthy Clubs were based on the premise of addressing the needs of the local community. Initiatives covered a range of topics and were delivered to various sections of the community i.e. players/parents/elderly/retired members/community members etc. Participants were selected from six different initiatives to take part in a focus group discussion and/or complete a questionnaire. A total of n=127 participants completed a questionnaire and n=49 participants took part in focus group sessions. The break down by province is shown in the table 4 below.

Table 4 Questionnaire and focus group respondents from initiatives broken down by province

<b>Questionnaire (n=)</b>	<b>Focus Group (n=)</b>	<b>Province</b>
21	0	Connacht
71	30	Leinster
35	19	Ulster
0	0	Munster
127	49	<b>Total</b>

Also highlighted in table 5 below is the number of participants who attended each initiative broken down by initiative type.

Table 5 Number of participants by initiative type

<b>Number of Participants (n=)</b>	<b>Initiative Type</b>
16	Healthy Eating
21	Anti-Bullying
14	Mental Wellbeing
41	Anti-Smoking
21	Physical Activity
14	Youth mental health
127	<b>Total</b> (for all initiatives)

### **3.2.6 Key Partners**

Partners offer expert support and advice across any number of areas including health, sport, transport, education & training, transport and can range from large public funded bodies to small volunteer/community organisations. Partnerships are a key component of the Healthy Club Project as set out in its framework. Through consultation with clubs, a sample of key partners (n=3) was identified and selected to take part in one-on-one semi structured interviews. The partners chosen represented a local sports partnership delivering a healthy food workshop in Leinster, a statutory body providing stress control classes in Munster and a charity foundation offering a wellness programme for young people in Ulster.

## **3.3 Key Concepts**

### **3.3.1 Club Characteristics**

The fundamental club characteristics to capture are membership, size of club, facilities, codes offered, coaches and communication platforms. Gathering this type of quantitative data from the baseline HCQ allowed for a profile of each club to be developed. Analysis of

follow up HCQ determined subsequent changes or lack thereof, for each of these characteristics across all the participating clubs involved during phase one of the HCP.

### **3.3.2 Effect of HCP**

One of the objectives of this research is to assess the impact of the HCP on club health promotion activity which includes policies, ideologies, practice, environment and juvenile (u18) coaching environment. The policies element of health promotion activity refers to the formal adoption of policies addressing specific health needs into a club's regulations and constitution. The Ideologies component is concerned with the promotion of two individual GAA principles: the Go Games initiative and the Respect initiative. Go Games are small sided hurling and football games for players under 11 designed to ensure everybody plays and to encourage fun, friendship and a sense of achievement. The Respect initiative was developed to enable players to reach their full potential by ensuring Gaelic games are promoted in a positive manner. Practice relates to how a club communicates and educates people around health issues. Environment includes both the physical and cultural environment and looks at the provision of a safe sports environment, setting a good example, and an awareness that health promotion goes beyond sports performance and links with the wider community. The juvenile (u18) coaching environment pays particular attention to promotion of the 'everybody plays' and 'fair play' policies and identifying suitable and qualified underage coaches. The pre and post HCQ was used to quantitatively determine this impact and ascertain whether health is on the agenda of the participating Healthy Clubs.

### **3.3.3 Process of the HCP**

Too often, research exclusively focuses on the impact of interventions and fails to investigate the process by which the outcomes were achieved. In order to improve the provision of health promotion activities in GAA clubs in Ireland, and indeed in other sports clubs elsewhere, it is essential that the process of delivering interventions is chronicled and used to educate others. The concept of the 'process' of the HCP relates to elucidating the challenges and opportunities surrounding why clubs decided to get involved in the HCP, the factors that influenced the delivery of the HCP and finally the perceived outcomes of the HCP. The process of delivering the HCP was investigated using qualitative methods.

Interviews were carried out with Healthy Club committee members and Executive committee representatives. It is essential that findings from this research are transferrable and subsequently, disseminated to other clubs.

### **3.3.4 Initiatives**

The running of initiatives by clubs was a means of tackling health issues, specific to the needs of each individual club. The initiatives were developed by clubs themselves or in consultation with local stakeholders and guided by the GAA Community and Healthy Team. It is important to capture the implementation and roll-out of initiatives across the depth and breadth of health topics. Health topics included: physical activity, emotional wellbeing, diet/nutrition, health awareness/first aid, alcohol awareness/anti-smoking, social inclusion, and anti-bullying. The delivery of programmes, content and attendance will be evaluated along with changes in behaviour and changes in club's policy and practices.

### **3.3.5 Partnerships**

A key pillar of the Healthy Club framework was the development of partnerships. Clubs' aimed to develop or strengthen partnerships with relevant statutory bodies that support the HCP concept. Particular emphasis is placed on opportunities that exist locally to support the roll out of the HCP as there is a need for clubs to extend their reach into the wider community. Support such as training, resources (material and human) and combining expertise with local knowledge potentially make partnering mutually beneficially. The emphasis is on clubs capacity building and delivering initiatives through engagement with relevant local stakeholders and was investigated by carrying out semi structured interviews with defined internal and external partners involved in the HCP and discussing their views on the nature, success and outcomes of the Healthy Club concept.

## **3.4 Data Collection**

### **3.4.1 Effect of the HCP**

#### **3.4.1.1 HCQ**

The Healthy Club steering committee have, in consultation with key stakeholders, developed a set of key criteria for Healthy Clubs. These criteria were adapted into a likert

scale type index, based on a similar instrument developed by Kokko et al. (2009) where using the Delphi method, experts in sports clubs, and health promotion came to an agreement on the fundamental characteristics of a health promoting sports club, culminating in 22 standards on the ways a sports club can positively impact the health of club members (Meganck et al., 2014). Translated into the health-promoting sports club index (HPSC-I), the reliability and validity of this instrument was established by Kokko et al. (2009) and permitted a baseline and follow up assessment of club characteristics and the health promotion activities of clubs. The 22 standards were divided across four sub-indices: policy, ideology, practice and environment. As the original HPSC-I was designed for use in Finnish youth sports clubs some amendments were made to the current version (HCQ) used in this study in order to reflect the GAA sports club setting. The revised edition contained 34 standards. For example, in the ideology sub-index the standard changed from 'The sports club promotes the everybody plays ideology' to 'The club promotes the Go Games principles' as this is more relevant and representative of the GAA culture. In the same section 'fair play' was also substituted for the 'Respect initiative' for the same reason. Under the policies sub-index, the terminology of one standard was changed to read 'Health and wellbeing ideals are written in the clubs' constitution and regulations' as opposed to the original which read 'Health and wellbeing viewpoints are observed in the sports club's decision-making process'. One standard was also replaced with 'Training pitches and schedules are distributed fairly across all teams in the club' an issue which is very pertinent in GAA clubs. One standard 'The sports club assures that health education is carried out' was omitted from the practice section. One new sub-index the 'Juvenile (u18) Coaching Environment' was also added and contained 11 standards which related to the way 'everybody plays' policies were implemented and the environment in which they were implemented (see appendix 1).

The HCQ was sent out to all participating Healthy Clubs (n=18) by the Community and Health Team in Croke Park. The HCQ was completed by the Healthy Club Officer and Committee in each of the Healthy Clubs during the timeframe September-December 2013. Participants were informed that the questionnaire was not a test, that there were no right or wrong answers, and that the responses they gave needed to be accurate and honest. Participants were encouraged to ask any questions and they were informed that their

responses would be treated in confidence. The HCQ is a quantitative method chosen to identify fundamental club characteristics and health promotion activity.

The HCQ was broken up into 6 parts. Part 1 of the HCQ focused on Healthy Club membership characteristics, part 2 featured the Healthy Club Index which measured clubs in relation to policies, ideology, practice, environment, and juvenile (U18) coaching environment. Health promotion was defined for reference and the respondent was instructed to tick one box per question. A five point likert scale was used where 1= does not describe the club at all, 2= describes the club very little, 3= describes the club to some extent, 4= describes the club well, 5= describes the club very well. Part 3 of the HCQ contained a facilities audit, part 4 covered a programmes audit, and part 5 firstly presented a definition of partnership before assessing the clubs link with partners. Finally, part 6 was concerned with forms of club communication. A follow up HCQ was administered 18 months later at the end of phase one, to all remaining Healthy Clubs (n=16) and control clubs (n=4) by the GAA Community and Health Team. Some alterations were made to the HCQ follow up questionnaire following a review of clubs' comments and compliance with the initial baseline HCQ. While the 6 sections remained, additional questions were added, given the need to capture the scope of work done throughout phase one of the HCP. The HCQ, baseline and follow-up, can be seen in appendix 2.

### **3.4.2 HCP Process**

#### **3.4.2.1 GAA Community and Health Team Interviews**

One-on-one semi structured interviews were conducted with two members of the GAA's Community and Health Team based in Croke Park on conclusion of phase one of the HCP. The interviews were a qualitative method selected to gather the views and experiences of the Healthy Club project team members from the initial concept of the Healthy Club idea, through its development and roll out in participating clubs and in their interactions with the Healthy Club committees. The interviews were held one after another in GAA headquarters at Croke Park, a convenient and comfortable setting for the Project Team. The research project was explained to the interviewees and they were asked to sign a consent form before proceeding (Appendix 3). The interviewer led the participant through a series of pre-determined questions developed using guidelines by Seidman, (2012) to prompt discussion and also provide an opportunity to explore particular themes further when necessary. The questions covered a number of topic areas including

the roll of the HCP in promoting health in GAA clubs, their expectations of the HCP, challenges, sustainability, and key learning from phase one. Interviews were recorded via a digital audio recorder. The one-on-one semi-structured interview questions are outlined in appendix 4.

#### **3.4.2.2 Regional Focus Groups**

Focus groups took place at two stages during phase one of the Healthy Club project at scheduled regional operational group meetings, one in March 2014 and a second in January/February 2015. The operational group meetings took place at a provincial level every 3 months between the participating healthy clubs in that province and are chaired by a member of the Community and Health Team from GAA headquarters. They are an opportunity for the participating Healthy Clubs to come together and share their experiences, ideas and revised action plans. The operational group meetings also allow communication and dissemination of information between the Healthy Club project team and clubs, providing the support, advice and guidance the Healthy Club pilot clubs need to turn their ideas into feasible actions. The time, date and location for each provincial operational group meeting are agreed upon in advance by the Healthy Clubs in each province and the Healthy club project team representative. Carrying out the focus groups at the operational group meetings meant all the participating Healthy Clubs from each province would be scheduled to be together and in a sharing environment meaning it was a convenient and relaxed setting. Designing the focus groups in this manner meant group dynamics and importantly club interactions could be used to yield additional insights.

A total of eight focus groups were conducted at provincial operational group meetings (OGM), two in Croke Park, Dublin, Leinster; two in Middleton GAC club house, Cork, Munster; two in the Athletic Grounds, Armagh, Ulster and two in the Connacht GAA Centre of Excellence, Mayo, Connacht. Each group was composed as followed:

- March 2014
- Group 1: Conducted 03/03/14 Croke Park, Dublin, Leinster. Participants were (n= 7) representatives from three of the four Leinster clubs involved in phase one of the Healthy Club Project. The group included 5 males and 2 females.



- Group 2: Conducted 05/03/14 Middleton GAC Club House, Cork, Munster. Participants were (n= 12) representatives from all five of the Munster clubs involved in phase one of the Healthy Club project. The group included 6 males and 6 females.
- Group 3: Conducted 12/03/14 Athletic Grounds, Armagh, Ulster. Participants were (n= 7) representatives from four of the five Ulster clubs involved in phase one of the Healthy Club Project. The group included 3 males and 4 females.
- Group 4 Conducted 20/03/14 Connacht GAA Centre of Excellence, Mayo, Connacht. Participants were (n=3) representatives from two of the four Connacht clubs involved in phase one of the Healthy Club Project. The group included 1 male and 2 females.
- January/February 2015
- Group 1: Conducted 27/01/15 Croke Park, Dublin, Leinster. Participants were (n=6) representatives from all four of the Leinster clubs involved in phase one of the Healthy Club Project. The group included 3 males and 3 females.
- Group 2: Conducted 03/02/15 Midleton GAC Club House, Cork, Munster. Participants were (n=9) representatives from four of the five Munster clubs involved in phase one of the Healthy Club Project. The group included 6 males and 3 female.
- Group 3: Conducted 03/02/15 Athletic Grounds, Armagh, Ulster. Participants were (n=7) representatives from all five of the Ulster clubs involved in phase one of the Healthy Club project. The group included 5 males and 2 females.
- Group 4: Conducted 04/02/15 Connacht GAA Centre of Excellence, Mayo, Connacht. Participants were (n=2) representatives from one of the two clubs left (2 clubs having dropped out) in phase one of theHCP. The group included 1 male and 1 female.

The research project was explained and all participants provided written consent before proceeding (Appendix 15). Each Focus Group began with informal introductions. The moderator introduced each session and steered the participants through a topic guide of questions, developed using guidelines from Krueger (2009). Each focus group followed the same set of questions, but participants were given the opportunity to somewhat diverge from particular questions, once it remained within the remit of the topic, to ensure conversations flowed. This also made certain that participants were afforded the opportunity to explore their opinions and ideas. Focus groups were recorded via a digital audio recorder. At the end of the discussion, the participants were asked if they had

anything else they wanted to add, they were thanked for their participation in the focus group and the audio recorder was switched off. The focus group topic guide used in 2014, one year into the HCP, looked to explore how clubs had found the initial set up and delivery of the HCP. The topic areas included how and why clubs became involved in the HCP, the start-up process, support, challenges, and benefits. The 2015 focus groups topic guide steered the discussion around the progress made within their club over the two year period. Topics included policy changes, support structures, benefits, barriers, partnerships, the future, and final thoughts on the HCP. Both focus group topic guides are outlined in appendix 5.

#### **3.4.2.3 Dropout Interviews**

The GAA Community and Health Team identified struggling clubs and once these clubs were deemed to have significantly fallen behind and seen not to be engaging in the process any longer, they were classified by the team as dropouts and were telephoned by the researcher to organise a meeting to complete a one-on-one exit interview. Two clubs from the original 18 Healthy Clubs exited prior to the completion of phase one of the Healthy Club project. However, only one dropout interview was conducted. This was due to difficulties in contacting one of the clubs after their exit from the HCP. The research project was explained and the club representative was asked to sign a consent form before proceeding (Appendix 15). The researcher led the dropout club representative through a series of key questions designed with the primary aim of gauging the reason for dropout, the club's opinion of health promotion and of the Healthy Club project in general. Interviews were recorded via a digital audio recorder. The one-on-one exit interview questions are outlined in appendix 6.

#### **3.4.2.4 Executive Committee Interviews**

To ascertain the views and opinions of the executive committee in relation to the role they see health promotion playing in their club and where and how a Healthy Club Committee fits into the overall club structure, one-on-one semi structured interviews were conducted with an Executive committee representative from two of the participating Healthy Clubs. The Executive committee interviews (n=2) represented Ulster (n=1) and Munster (n=1). The Executive committee members interviewed included two chair persons and two

secretaries. The interviews were carried out at each individual's club grounds. The research project was explained and the interviewee provided written consent before commencing with the interview (Appendix 15). The researcher followed scripted interview questions and prompts. As is the nature of semi-structured interviews, new ideas were also brought up based on what the participant's contribution. Interviews were recorded via a digital audio recorder. Interviews took place between 25/11/2014 and 26/03/15. The one-on-one Executive committee interview questions are outlined in appendix 7.

### **3.5 Initiative Evaluation**

To evaluate the effectiveness of initiatives delivered by a sample of Healthy Clubs, four approaches were applied: selected Healthy Club committee focus groups, participant focus groups, partner interviews, and participant questionnaires. In order to plan the initiative evaluations a list of initiatives planned by clubs (n=16) covering 7 topic areas was compiled using action plans submitted by clubs and information gained during regional operational group meetings. The initiative selection process was determined by the need to ensure a balanced geographical representation of clubs and to encompass the diversity of topic areas being addressed by clubs.

#### **3.5.1 Selected Healthy Club Committee Focus Groups/Interviews**

In order to appraise the effectiveness of selected initiatives being run by the participating Healthy Clubs, focus groups were conducted with Healthy Club Committees (n=7) involved in orchestrating a sample of initiatives. The questions posed to the groups were designed to find out whether the initiatives had achieved the Healthy Club Committee's objectives and to understand the influencing factors that shaped the direction and execution of programmes. Some committees were represented by only one member owing to late apologies and unexpected circumstances, meaning attendance at the focus group was forfeited. These focus groups are denoted therefore as 'interviews'. A total of three focus groups and four interviews were carried out. The initiatives covered by the selected Healthy Club Committees include mental wellbeing (n=3), youth mental health (n=1),

physical activity (n=1), anti-bullying (n=1), and anti-smoking (n=1). Each focus group was carried out in the club's own surrounds and were carried out between May 2014 and March 2015. The research project was explained and all participants provided written consent before proceeding (Appendix 15). The moderator introduced each session and steered the participants through a topic guide of questions, consisting of introductory, transition, key and ending questions developed using guidelines from Krueger (2009). Participants were given the opportunity to somewhat diverge from particular questions, once it remained within the remit of the topic, to ensure conversations flowed. This also made certain that participants were afforded the opportunity to explore their opinions and ideas. Focus groups were recorded via a digital audio recorder. Healthy Club Committee focus group topic guides are outlined in appendix 8.

### **3.5.2 Participant Focus Groups**

Participants (n=49) from four selected initiatives took part in separate focus group discussions. They represented two Healthy Clubs in Leinster and two Healthy Clubs from Ulster. One group had taken part in a six week healthy eating demonstration class, the second group were involved in weekly mindfulness classes, the third group attended a 12 week physical activity programme and the fourth group consisted of an U18 student group who had experienced a youth mental health workshop. Apart from the final grouping here, no other focus group or interview session, involved participants under 18 years of age. Before the final focus group session parents and guardians were informed by a Healthy Club Committee member of the research project and how a focus group scenario operated. It was then up to individual parent or guardian if they wanted their child to participate. A focus group topic guide containing the list of introductory, transition, key and ending questions guided the discussions, yet they were not used to limit the researcher probing or asking follow-up questions. The focus group topic guide differed slightly with each individual initiative and set of participants, however all scripts were centred on the primary research aim. The focus groups were held post initiative, with discussions staged in a convenient and comfortable environment. In all cases the participants were centred around a table with the facilitator. The researcher made the participants aware that the discussion would be recorded, but that no one would hear the recording other than the

researcher, and also they were assured of their confidentiality. It was also highlighted that participants did not have to answer any questions that they did not want to and they could withdraw from the focus group discussion at any time. All participants provided written consent before proceeding (Appendix 15). At the end of the discussion, the participants were asked if they had anything else they wanted to add, they were thanked for their participation in the focus group discussion and the digital audio recorder was switched off. Participant focus group topic guide are outlined in appendix 9.

### **3.5.3 Partner Interviews**

One-on-one semi structured interviews were carried out with a sample of partners involved in facilitating and/or delivering health promotion programmes in union with participating Healthy Clubs. These partner interviews helped in learning and explaining the experiences and perspectives of the facilitators involved in running programmes and practical implications of partnering with Healthy Clubs. Four partner interviews were conducted in total with the actual partner who facilitated or delivered the initiative in locations that were convenient and comfortable for that person. The first partner interview was conducted on the final night, 07/04/14, of the six week course being delivered by the partner. The second partner interview took place on the 12/06/14 in the partner's headquarters after the conclusion of the initiative. The third partner interview was held on 26/03/15 in a local and familiar setting to the partner once again after the initiative had ended. The fourth and final partner interview was conducted over the phone on the 08/06/15 and looked to explore the partner's experience being involved in the HCP more generally. An interview guide, which consisted of a series of questions and prompts, was individually tailored for use with each partner, but always related back to the principle research question. The research project was explained to the each interviewee before they were asked to sign a consent form before beginning (Appendix 15). The interviewee was then led through the series of questions. Interviews were recorder via a digital audio recorder. Partner interview scripts are outlined in appendix 10.

### **3.5.4 Participant questionnaires**

Participant questionnaires provided quantitative feedback from the initiatives. The questionnaires, although slightly modified to suit the needs of each individual Healthy Club initiative, began by establishing participant demographics and progressed through sections on awareness, attitudes, knowledge and behaviours. The questionnaires were developed by the research team at WIT and either sent to clubs to be administered to participants on conclusion of the initiative, or in parallel data gathering, where the questionnaire was distributed to participants by the researcher after the initiative but immediately prior to taking part in the participant focus group. Questionnaires were completed by participants of six separate initiatives in six different clubs across the four provinces. The initiatives covered healthy eating, mental wellbeing, anti-bullying, anti-smoking, physical activity and youth mental health topics. Participants were informed that the questionnaire was not a test, that there were no right or wrong answers, and that the responses they gave needed to be accurate and honest. Participants were encouraged to ask any questions and they were informed that their responses would be treated in confidence. Participant questionnaires are shown in appendix 11.

### **3.5.5 Initiative rating scale**

An impact rating scale of high impact, medium impact and low impact was also developed by the evaluation team in order to assess the initiatives in the context of the Healthy Club Framework. The Healthy Club Framework consists of four elements Governance, Environment, Programmes and Partnerships. Clubs earned a rating of high impact if their initiative encompassed all four elements of the framework in its implementation. A rating a medium impact was given for initiatives, which comprised of at least three elements of the framework. Finally, a low impact rating was given when initiatives included two or less elements of the Healthy Club framework in their implementation. Two was identified as the lowest score because all initiatives were classed as a programme and thus had a minimum score of 1.

### **3.5.6 Community needs assessment questionnaire**

A community needs analysis was undertaken by 17 of the 18 participating clubs at the start of the Healthy Club process. The community needs assessment questionnaire was designed and carried out by the Community and Health Team in Croke Park prior to the start of the research project. Results from the questionnaire were not collected as part of this project. The purpose of clubs carrying out the questionnaire was to identify priority action areas or health needs specific to their locality and to recruit volunteers, particularly those with skill sets, which could contribute to the development of a healthy club. The community needs assessment was an online 'survey monkey' questionnaire. Each club individually promoted the needs assessment in their community highlighting the value of completing the questionnaire and making the online link available through their website and other forms of social media. There were 1426 responses across the 17 clubs who took part in this element of the project. The community needs assessment intentionally took place prior to the beginning of the HCP as it then acted as the basis for the development of action plans for year one and year two of the initiative. The survey instrument was adapted by the GAA Community and Health team from the Health Promoting Schools Framework and data was collated centrally as well as regionally. A follow up community questionnaire was distributed to clubs in May 2015 to assess the attitudes, awareness and engagement of club and community members towards the HCP (n=77).

### **3.6 Ethical Considerations**

All participating Healthy Clubs agreed to take part in the study and all activities involved in the evaluation were approved at national and club level. However, informed consent was required from all focus group and interview participants. Participants were free to withdraw from the study at any stage. Focus groups were audiotaped for accuracy and stored on a password protected computer in WIT. To protect confidentiality of all participants, no individual identifiers were included on questionnaire results or qualitative transcripts; each participant was allocated a code and referred to as such. Questionnaire results and qualitative transcripts were stored securely, and accessed only by the

researchers. The study protocol was approved by the Research Ethics Committee of Waterford Institute of Technology (Appendix 12).

### **3.7 Data Analysis**

#### **3.7.1 Quantitative**

All HCQ data were entered into Statistical Package for Social Sciences (SPSS 21.0). Data from participant questionnaires were also logged into SPSS 21.0. The original likert scale used in the questionnaire was reduced to a two-point scale (0-1) so the overall range of scores on the index was between 0 and 34. Higher scores indicate higher levels of health promotion activity. Specifically, clubs were scored between 0 and 1, on different factors related to the health promotion orientation of the club, using a five-point likert scale ranging from 'does not represent a club at all (0)' to 'it represents the club very well (1).' Likert type responses permit a graded assessment that should capture some variation between clubs and across different criteria. Scores for items in each sub-index (policy, ideology, practice, environment, and juvenile (u18) coaching environment) were summed and mean scores were used to categorise clubs as low, moderate or high health promoting in each of the sub-indices, and overall using a classification system similar to that used by Kokko et al. (2009). Higher scores indicate higher levels of health promotion activity, so to reach an overall high health promoting standard, clubs had to have a score of 23 or more. Scores ranging between 17 and 22.99 were deemed to indicate a moderate level of health promotion while clubs who scored lower than 16.99 were classified as low health promoting. Scores for each of the sub-indices were also categorised into low, moderate and high. For policy, scores higher than six and lower than 3.99 were deemed high and low health promoting respectively, >1.72 and >4.50 were required for a high health promotion score for ideology and practice respectively while cut-off points for high and low health promotion were >5.30 and <3.49 for the environment and >8.25 and <5.49 for the juvenile environment. Paired sample t-tests were used to establish statistical changes for each sub-index and for the overall health promotion category. The health promotion classification matrix can be seen in appendix 13. Index scores were also assessed across clubs of different sizes, which were classified into small (<400 members), average (401-700 members) and large (>701 members) clubs using membership numbers. Descriptive statistics were computed in SPSS to present the average and spread of scoring across



participating clubs. Categorical data was summarised using frequencies and crosstabs. Dependent t-tests were used to assess changes in scores over time.

### **3.7.2 Qualitative**

Data analysis begins as soon as data collection commences with the transcription of recordings. Due to the high number of focus groups/interviews (n=28) and participants (n=112) involved, during phase one, an extensive amount of text was assimilated. In total, 143,953 words were transcribed. The majority of focus groups and interviews were conducted by the researcher (AD), initially under the supervision of Dr. Aoife Lane and Dr. Niamh Murphy (co-supervisors). The focus groups were transcribed verbatim by the researcher. Transcripts were closely reviewed and checked against original audio recordings by the primary researcher to ensure translation accuracy.

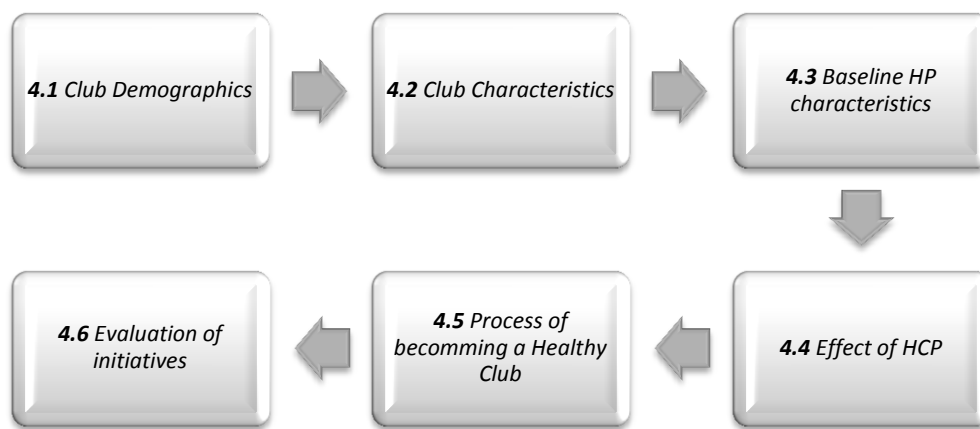
Data collected through focus groups was analysed using thematic content analysis. Each transcript was coded in order to develop an inventory of data that accurately reflected the core themes the participants considered most important. For theme identification, the researcher looked for patterns, themes, concerns or suggestions which were posed repeatedly by the focus-group participants. Data for each theme were then grouped together, read repeatedly, re-analysed and if necessary broken down into more specific subordinate themes to better reflect the insight derived from the data provided by the participants. These themes included sought or expected information insights as well as emergent themes which were unexpected and revealed additional insights. The transcripts and a list of the themes and sub-themes were read over by a supervisor. Following conversation, themes and sub-themes were agreed on, and the most applicable and interesting quotes from participants were used to highlight the main themes that arose from the transcripts.

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## Chapter 4 Results

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This chapter will present the findings of the evaluation study. *Figure 6 below* details the overall structure of this chapter. Firstly, club demographics, club characteristics and the baseline health promotion characteristics of clubs will be outlined. Then in answering the research questions put forward in this study, section 4.4 will examine the effect of the HCP, section 4.5 will focus on the process of becoming a Healthy Club and finally, section 4.6 will evaluate a sample of initiatives undertaken by clubs.



*Figure 6 Results chapter overview*

### 4.0 Club demographics

The baseline HCQ collected data from 16 of the 18 participating HCP GAA clubs across the four provinces of Ireland. Two clubs did not submit their HCQ. Clubs were categorised as either small (0-400 members), medium (401-700 members) or large (701+ members) according to their membership size. Club membership was available in different forms; full membership in all clubs, social membership in approximately 80% of clubs (n=13), and finally juvenile and family membership options in all but one club. Table 6 presents an overview of the membership figures and club size at the beginning of the HCP. Playing members made up the 75% of total membership. There was a large degree of variance in club size with the smallest clubs recording a membership of 189 while the largest club boasted a membership of 1,285. The majority of clubs were classed as medium sized clubs (43.7%).

Table 6: Size and Membership of Participating Clubs at baseline (n=16)

		<b>Average (Min-Max)</b>
<b>Membership</b>	Playing Members	408 (124-
	Non Playing Members	1012)
	Total Membership	146 (45- 322) 544 (189- 1285)
		<b>% (n)</b>
<b>Club Size</b>	Small/0-400 Members	31.3 (5)
	Medium/401-700 Members	43.7 (7) 25 (4)
	Large/701+ Members	

#### 4.1 Club characteristics

Table 7 below gives an overview of club characteristics including facilities, the number of coaches with GAA qualifications, and the most popular forms of disseminating information. Full club membership was offered in all clubs with the option of juvenile and family membership offered in 88% (n=14) and social or associate membership provided in 13 clubs. All clubs had dressing rooms and pitch access, while all-weather pitches and running/walking tracks were available in three clubs, ball walls in six and 12 clubs reported having floodlights. The majority of clubs (82%, n=13) had a clubhouse or community centre at their club facility, which was used for general community purposes including talks and events by all but two clubs (88%, n=14). Overall, 75% (n=12) of clubs rated their facilities as excellent or very good. In relation to disability access, a lower proportion (43%, n=6) rated accessibility to club facilities as excellent/good. All clubs ensured their coaches had certification from the GAA, Camogie or Ladies Gaelic Football coaching education framework. Likewise, 100% of clubs indicated their coaches engaged in continuous professional development (CPD) such as child protection and first aid. Finally, participating clubs do engage in a variety of modes of communication in their clubs (five on average per club) and are active on social media, particularly through Facebook.

Table 7 Club Characteristics (n=16)

		Average (Min-Max)
<b>Facilities</b>	No. of Pitches	2.2 (1-4)
	Dressing Rooms	4.7 (2-12)
<b>Coaches (level of certification)</b>	Foundation	29.3 (10-46)
	Level 1	12.3 (1-25)
	Level 2	2.3 (1-3)
	Level 3	2 (1-3)
		<b>% (n)</b>
<b>Communication Profile</b>	Facebook	100 (16)
	Twitter	80 (12)
	Newsletter	78.6 (11)
	Local Media	100 (16)
	Website	100 (16)
	Texting Service	75 (12)

Figure 7 presents the main types of Gaelic games offered by the participating clubs. Men's football was most commonly available, accessible in all but one club, whereas only three clubs offered handball and one club provided rounders. The majority (76%, n=13) of clubs offered between two and four codes to their community.

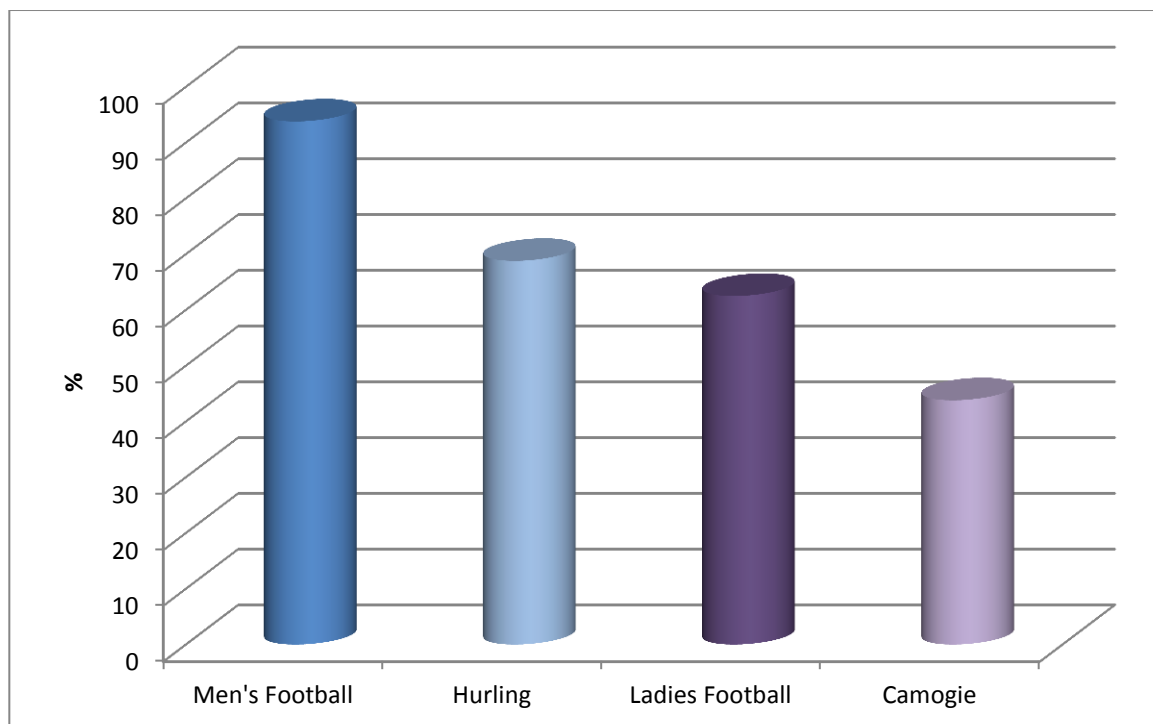
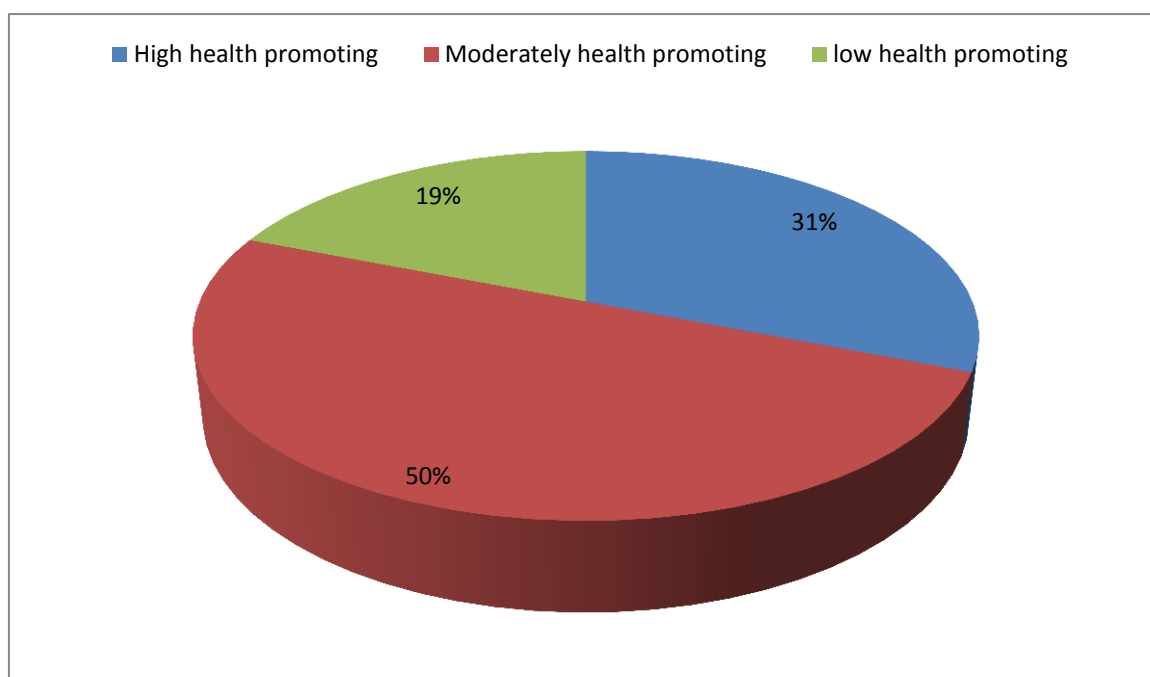


Figure 7 Sports/codes available in participating clubs

## 4.2 Health promotion status of participating clubs at baseline

Analysis of the health promoting index contained within the baseline HCQ established that overall 31% of clubs were considered to be high health promoting, 50% moderately health promoting, and 19% low health promoting (*figure 8*). On average, clubs received a score of 19.88 indicating a moderate health promoting status at baseline. The variation in scores was large with values ranging from the lowest at 13.75 to the highest value of 27.75. Of the five sub-indices that make up the health promoting index, clubs recognised ideology best. Scores were above average in relation practice and the environment, including juvenile environment, but below average for policy. The policy domain represents the weakest element of health promotion in the clubs. Interestingly, data from the community questionnaire showed that awareness of any health/wellbeing policies in the club was low (30%) despite the fact that all clubs have at least some policy context for health promotion through the ASAP programme.



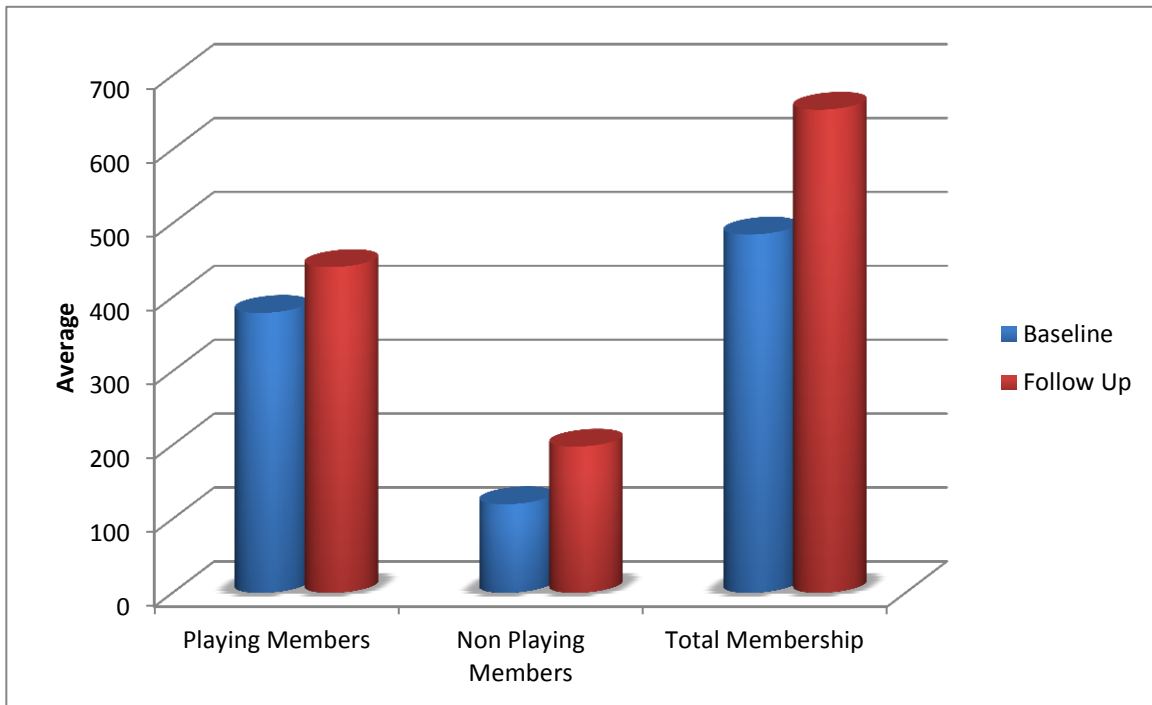
*Figure 8 Health promotion categories of clubs at baseline*

## 4.3 Effect of the HCP

### 4.3.1 Membership at baseline and follow up

The HCQ was administered again at the end of phase one of the HCP, there was a 75% retention rate between baseline and follow up; four clubs did not complete the follow up

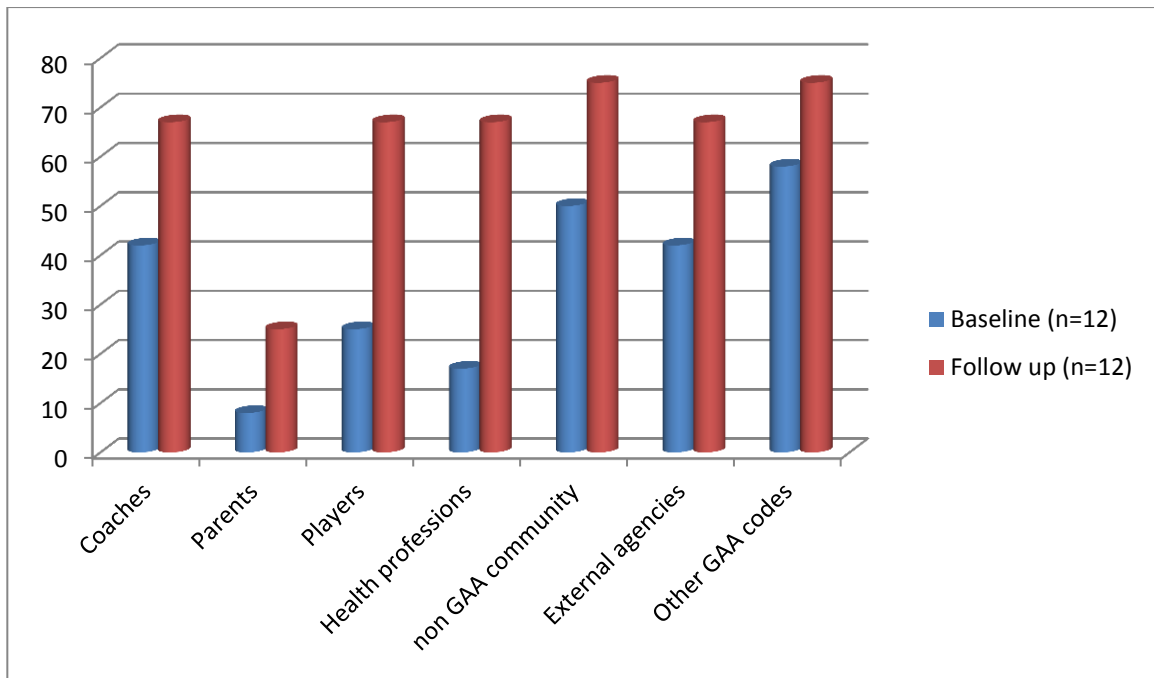
assessment. Clubs (n=12) submitted their membership numbers at both time points and there were increases noted for playing and non-playing members (*Figure 9*). Overall, total membership increased by 14.2%, playing membership rose by 16.4%, while non-playing membership saw the greatest increase of 65%. These increases means that the number of large sized clubs grew from three to five, medium sized clubs decreased from five to three and small clubs remained constant at four.



**Figure 9 Membership at Baseline and Follow Up**

#### **4.3.2 Partnerships at baseline and follow up**

The baseline HCQ analysis revealed the most common partner for clubs to hold discussions with or collaborate with on health matters was other GAA codes (62.5%), followed by coaches (50%), external agencies (50%), and the non GAA community (50%). Just 30% have collaborated with health professionals. A comparison of the baseline and follow up HCQ shows that collaborating with other GAA codes is still a popular form partnership (75%) and is now equalled by partnerships with the non GAA community when it comes to promoting health. However, discussions with parents around club matters remains low at 25%, although this is still an increase from baseline as outlined in *figure 10*. Club collaboration with health professionals saw the greatest increase from baseline.



**Figure 10 Engagement with partners at baseline and follow up**

Local schools remain the most common form of active engagement for clubs, where they provide coaching (67%) and recruits members (75%). Helping to deliver community events (75%) proved to be a popular form of active partnerships where 50% of clubs had collaborated with local community development groups. Working with older/retired adults and minority groups in the community both saw an increase from 19% to 42% and 13% to 33% respectively

Table 8 gives a comparison of the baseline and follow up perceptions of partnerships. Increases were most notable for a ‘need to formalise the partnering process’ and to agree roles and responsibilities. Interestingly there was a decrease in agreement with the statement ‘contact with partners is mostly informal’.

Table 8: Comparison of the Perceptions of Partnership in a GAA Context

	<b>Baseline (n=12) % Agree (n)</b>	<b>Follow up (n=12) % Agree (n)</b>
<b>Partners have always been an important part of the club</b>	75 (9)	75 (9)
<b>Roles, responsibilities and expectations are agreed with partners</b>	33 (4)	41.7 (5)
<b>Regular meetings are held with partners</b>	33.3 (4)	33.3 (4)
<b>Partners sit on committees in the club</b>	8.3 (1)	8.3 (1)
<b>Contact with partners is mostly informal</b>	41.3 (5)	25 (3)
<b>There is no need to formalise the partnership process</b>	16.7 (2)	41.6 (5)
<b>Formalising the partnership process takes too much time</b>	16.7 (2)	25 (3)
<b>Club members actively seek new partners</b>	33.3 (4)	33.3 (4)

#### 4.3.3 Health promotion activity of participating clubs at follow up

The overall HP index score for clubs at follow up was  $23.85 \pm 3.34$ , increasing from 19.88 at baseline, and indicating clubs had on average increased to be high health promoting. The variation between clubs was 11.19 with the club that scored the lowest getting a HP score of 18.50, whereas the club with the highest HP score reached 29.00. None of the clubs reached the maximum value of 34 at baseline or follow up. Table 9 below shows the scores across each sub-index of the health promotion activity index. There were significant increases in the policy and practice domains (paired samples t-test,  $p < 0.05$ ) with improvements also noted for both environmental sections. There was a marginal decrease in the ideology score, which was not meaningful in a statistical context. Overall, clubs health promoting score increased significantly across both time points (paired samples t-test,  $p < 0.05$ ). Clubs moved from low to moderate for the policy index, decreased into the moderate category from high for ideology, and overall increased from medium to high in relation to health promotion characteristics.



Table 9: Health Promotion Characteristics of Participating Clubs (n=12) at Baseline and Follow up

<i>(Higher scores indicate higher levels of health promotion activity)</i>	<b>Baseline Average (Min-Max)</b>	<b>Baseline Health Promotion Category</b>	<b>Follow Up Average (Min-Max)</b>	<b>Follow Up Health Promoting Category</b>
<b>Policy Index (range 0-8.0)</b>	3.65 (0.5-7)	Low	5.38 (3.75-7.75)	Moderate
<b>Ideology Index (range 0-2.0)</b>	1.75 (0.75-2)	High	1.70 (1-2) <i>High</i>	Moderate
<b>Practice Index (range 0-6.0)</b>	3.17 (1.25-5)	Moderate	4.06 (3-5.75)	Moderate
<b>Environment Index (range 0-7.0)</b>	4.31 (2.5-6)	Moderate	5.04 (4-6.25)	Moderate
<b>Juvenile Environment Index (range 0-11.0)</b>	7.00 (4-8.5)	Moderate	7.67 (5.5-9)	Moderate
<b>Overall HP Index Score (range 0-34.0)</b>	19.88 (13.75-27.75)	Moderate	23.85 (18.5-29.95)	High

#### 4.3.3.1 Health promotion activity and club size

Over the course of phase one of the HCP, the average increase in clubs health promoting activity score was  $4.5 \pm 4.3$ , see table 10 below. The greatest increase was seen in medium sized clubs ( $6.4 \pm 7.5$ ). Small sized clubs saw an average increase of  $3.75 \pm 2.6$ , while large clubs recorded an average increase of  $3.5 \pm 1.75$ . There was no correlation found between a change in membership size and a change in health promoting activity score.

Table 10: Change in health promotion activity relative to club size

<b>Club Size (membership)</b>	<b>Number of clubs (n=9*)</b>	<b>Change in health promotion activity score (average)</b>
<b>Small (0- 400)</b>	3	3.75±2.
<b>Medium (401-700)</b>	3	6.4±7.5
<b>Large (701+)</b>	3	3.5±1.75
<b>Total</b>	9	4.5±4.3

*\*Three clubs out of the 12 who did complete the follow up HCQ did not submit follow up membership numbers.*

Between the four provinces, clubs in Connacht (n=2) heralded the greatest change in health promotion activity scores boasting an average increase of 7.9. This was followed by clubs in Leinster (n=4) with an average increase of 4.2, Munster clubs (n=4) which saw an average increase of 3.2 and finally Ulster clubs (n=2) where the average increase was 2.7. There was no significant relationship found between location and health promoting category.

#### **4.3.4 Individual standard analysis at baseline and follow up**

Table 11 illustrates the baseline and follow up scores for each of the individual standards assessed by the health promotion index in the HCQ. Again, all scores range between 0 and 1; 0 indicates that the factor does not describe the club at all and 1 indicates it describes the club very well.

At baseline scores for the policy domain were among the lowest across all indicators of health promotion in the clubs, particularly in relation to written regulations (.27), and acknowledgement of health and wellbeing in clubs constitution (.23). At follow up scores for each item in the policy domain improved markedly, but particularly in relation to

evaluating club health promotion activities, and engagement with other clubs and the health sector. However, the inclusion of health promotion in the regulations and constitution of the club remained the lowest scores at follow up (.41-.42). Highest scores are allocated to the ideology standards of Go Games (.89) and the Respect Initiatives (.83) at both baseline and follow up. The slight decrease in relation to the 'Go Games' initiative is not statistically significant. The fair distribution of pitches, and issues in relation to bullying, respect, fair play, safety, and maintenance of a safe, smoke free environment, and alcohol free environments for juvenile events also scored well.

Increases were apparent across all elements of the practice domain, most notably in relation to engagement with coaches and parents. Dealing with bullying and other conflicts was the highest scoring factor at follow up (.91) while there were increases in relation to the good examples of coaches and behaviours towards referees. Indicators for an emphasis on health promotion beyond performance and providing healthy food options increased but remained among the lowest scores at follow up. Low scores, in this case a positive, were recorded at both time points in the juvenile (U18) coaching environment for success at underage level is measured by winning, or by having only the best players on the pitch at all times, and the 'every child gets a game' philosophy.

Table 11: Individual Standard Analysis Baseline and Follow-up (n=12)

<b>34 standards</b>	<b>Baseline Average (0-1)</b>	<b>Follow Up Average (0-1)</b>
<i>Policy index</i>		
The clubs regulations include a written section on well being and / or health promotion / health education / healthy lifestyle	.27	.42
The clubs regulations include a written policy on substance misuse (ASAP policy)	.52	.71
Health and well being ideals are written in the clubs constitution and regulations	.23	.41
The club health promotion activities are evaluated in the Annual Report	.36	.84
The club collaborates with other sports clubs and / or health professionals on health issues	.55	.75
The club assures that its sub committees have agreed regulations and practices	.59	.73
Health promotion is part of the coaching	.61	.75

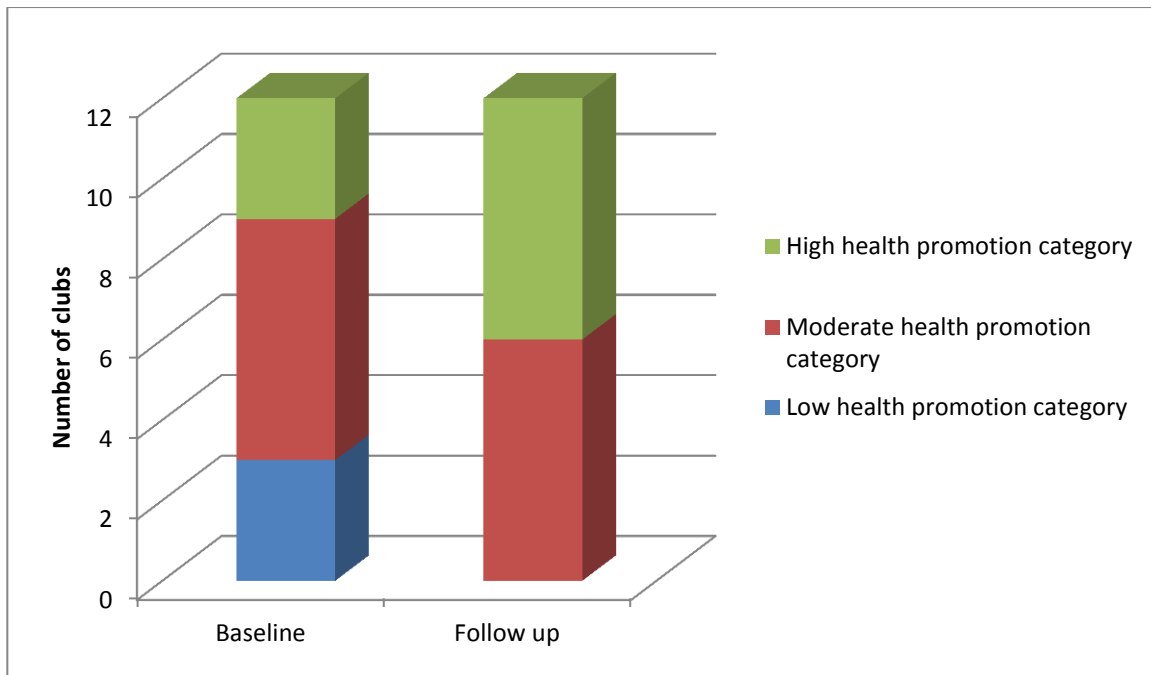
practice		
Training pitches and schedules are distributed fairly across all teams in the club	.83	.82
<b><i>Ideology index</i></b>		
The club promotes the 'Go Games' principles	.89	.85
The club promotes the 'Respect Initiative'	.83	.85
<b><i>Practice index</i></b>		
The clubs Executive Committee discusses its regulations with coaches and parents at regular intervals	.45	.63
The club pays particular attention to coaches/instructors interaction skills	.52	.73
The club provides education on health issues or makes provisions for its members to receive such education	.45	.58
The club promotes individual growth and development	.64	.75
Sports injuries are comprehensively dealt with (including the psychological effect of injury)	.57	.73
The club reviews and communicates treatment policies in the case of a sports injury	.61	.65
<b><i>Environment Index</i></b>		
The club assumes its fair share of responsibility for a safe sports environment (eg: reviews the sports environment yearly)	.77	.77
The club provides a sports environment that is smoke free during juvenile activities	.73	.71
Coaches and other officials give a good example through their own behaviour	.77	.85
Respect for the referee is evident at all levels in the club (players, coaches, administrators)	.69	.77
Possible conflicts (eg bullying) are monitored and dealt with	.73	.91
In coaching, there is a health promoting element beyond sports performance	.50	.58
Healthy food options are made available following sports activities	.39	.52
<b><i>Juvenile (U18) Coaching Environment index</i></b>		
All juvenile events are held in an alcohol free environment	.81	.88
The club promotes maximum participation adopting an 'every child gets a game' policy	.70	.84
The implementation of 'everybody plays' policy is dependant on the importance of the competition	.59	.32
The implementation of 'everybody plays' policy is hindered by parents expectations of success	.36	.30

by winning		
The implementation of 'everybody plays' policy is hindered by other clubs reluctance to adopt a similar approach	.52	.30
The club measurement of success is winning underage tournaments	.30	.32
The club perceives that success can only be achieved by having the best players on the pitch at all times	.28	.31
The club selects and approves coaches who have accredited coaching qualifications	.55	.73
The club specifically identifies suitable and qualified coaches for juvenile coaching positions	.69	.71
The club does not tolerate the use of bad language	.59	.79
The club enforces a fair play policy	.75	.83

Furthermore, 83% of clubs (n=10) appointed a health and wellbeing officer and 50% (n=5) reported a full/partially implemented health and wellbeing policy at follow up. Three quarters, and 55% of clubs had an ASAP policy and Mental Health Charter ready for, or already implemented. With respect to the physical environment 75% (n=9) of clubs had erected signage to support and promote the aims of the HCP, 5 clubs (42%) had developed no smoking areas and 4 clubs (33%) had introduced healthy food options. The lowest scores were received for developing walking tracks (17%) and installing bike racks (8%).

#### 4.3.5 Overall health promotion category at baseline and follow up

Figure 11 below gives a comparison of the health promotion category over the course of phase one of the HCP for clubs (n=12) who completed baseline and follow up HCQs. At follow up no clubs were considered to be low health promoting. Six clubs were moderately health promoting and six clubs were high health promoting.



**Figure 11 Health promotion categories at baseline and follow up**

#### **4.3.6 Perceived effect of HCP on clubs**

In the final section of the follow up HCQ clubs were asked to reflect on the effect their involvement in the HCP had on the club. *Table 12* shows that on most indicators, clubs agreed that they had benefited substantially. Performance was lowest in relation to the statement more people are becoming involved in club activities. The follow up community needs assessment was completed by a small number of participants (n=71). Respondents were asked many of these same questions. Marginally lower proportions agreed that health was more of priority in the club (83%), attitudes to health had changed (81%), all areas of the club were addressed in the project (83%), and that support would be maintained (81%).

Table 12: Overall effect of the HCP

Statement	% Agree (n)
Health has become more of a priority in the club	91 (10)
People’s attitudes to health have changed	91 (10)
Our club is better as a result of being involved in the project	100 (11)
The profile of the club/community has been raised	91 (10)
The project has addressed all sections of the club	91 (10)
Involvement in the project has helped our club focus on health issues in ways we could not have done otherwise	100 (11)
More people are joining/becoming involved in club activities	70 (7)
Knowing what we know now, would we sign up again	82 (9)
The culture of the club has changed for the better	82 (9)
There will be support for this project if it continues	91 (10)

At the last set of focus group sessions, Healthy Club Committee representatives were asked to summarise their experience of the HCP in three words. *Figure 12* captures the impact of the HCP, particularly its community ethos, while also portraying the experience as a challenging yet enjoyable journey for clubs.

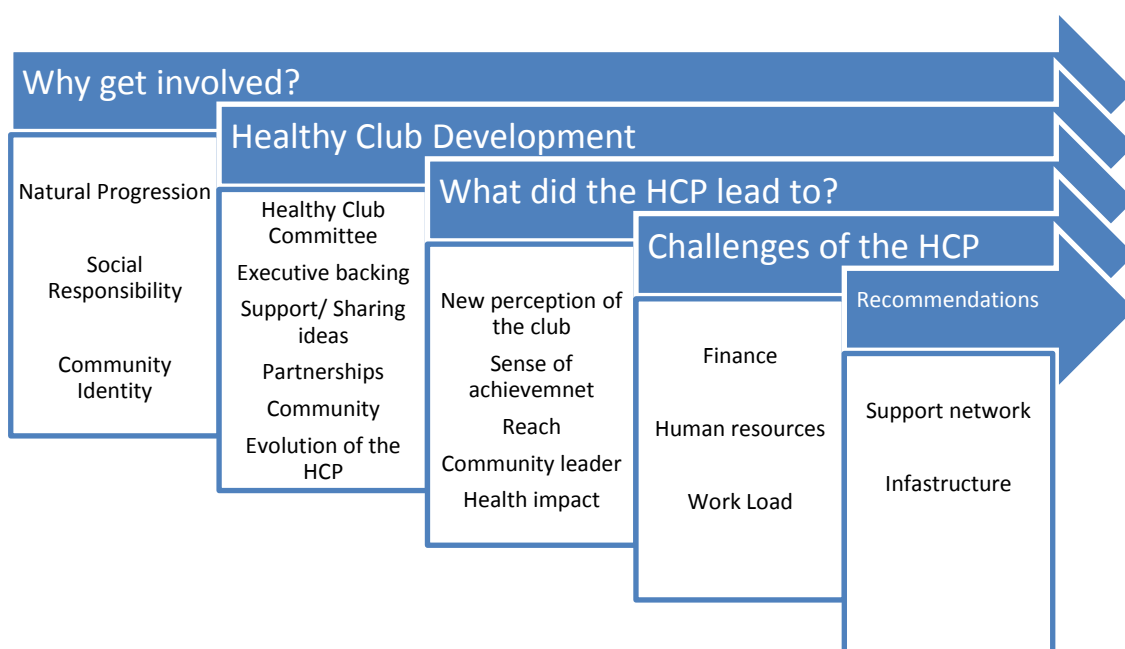


Figure 12: Word cloud of HCP experience

## 4.4 Process of Development of a Healthy Club

### 4.4.1 Introduction

Investigating the process of becoming a Healthy Club revealed five key themes: why clubs initially became involved in the HCP, Healthy Club development, what their HCP involvement led to, the challenges of the creating and sustaining the HCP, and future recommendations. Each of these key themes contained subordinate themes, demonstrated in *figure 13* below. Each subordinate theme will be discussed in turn.



**Figure 13** Key and subordinate themes in the process of becoming a Healthy Club



#### 4.4.2 Why get involved in the HCP?



*Figure 14 Why get involved in the HCP?*

A common sentiment expressed by HCP club representatives across all provinces was that the decision and motivation to become a healthy club was, in some respects, a natural progression of work already undertaken in the club setting. Clubs also felt they had a social responsibility to give back to their members and the community, and address their health and societal concerns. Finally, it was seen as an opportunity by some clubs to rejuvenate their community identity and become more of a focal point in their local area.

##### ∇ *Natural Progression*

GAA clubs already promote health and wellbeing amongst its members and the wider community and the GAA HCP is a welcome framework to further support, harness and capture the full extent of these health promotion efforts in this particular setting. One club remarked that *'it had been something they had been thinking about doing anyway...to use the club to do some sort of health initiative for its members, and the community'* (Connacht, OGM 2014)<sup>9</sup>. This was observed by several clubs:

*'I think we were already doing a lot of the things that a healthy club should be doing. Promoting health and inclusion and that before healthy club was ever mentioned. So when it did come up we thought well sure why not.'*(Ulster, OGM 2014)

*'I just saw it on the website and just decided to apply for it. We already had classes started the previous year and we opened the gym the previous year.'*(Munster, OGM 2014)

*'We were doing lots of different things, trips for the community like and different things like so it was only kind of a progression really then, putting a name on it.'* (Munster, OGM 2014)

It was also suggested by some clubs that the HCP was an ideal extension of the ASAP programme and concept, which has been underway in clubs for some years.

*'I saw the healthy living piece coming up and I said the ASAP need focus you know and I suggested doing something like that.'* (Leinster, OGM 2014)

*'I suppose sometimes with the ASAP you can be like 'there's the anti-drink fella' so he felt this was an opportunity to be more involved in bringing everyone on board because this is something very positive...'* (Munster, OGM 2014)

The clubs almost viewed the ASAP programme as a stepping stone to tackle larger health and wellbeing issues.

*'there's only so far you can go with the ASAP....it's much bigger than that.'* (Leinster, OGM 2014)

#### ∇ Social Responsibility

One of the most poignant statements to come from the focus groups reads *'I always say and I still say it that through the healthy club project if I could save one life in some way then that is enough for me'* (Connacht, OGM 2015).

The GAA themselves state that *'everything we do helps to enrich the communities we serve'* (GAA, no date). This ethos is clearly evident amongst the clubs on the ground as it was noted by clubs that we *'owe it to our players and members as well to be able to help them out in other aspects of their life'* (Ulster, OGM 2014).

*'And I think everyone has become keenly aware of health issues be it mental health or all things that are going on with young people so I think in our club there is a want there to help people and participate and do what we can do'* (Ulster, OGM 2014) suggesting an awareness of the role of the GAA club beyond the playing, coaching, and administrative environment.

Interestingly, one club indicated that *'bar the hurling and camogie there is nothing else really going on at our club'* (Connacht, OGM 2014) suggesting they hadn't previously engaged with other initiatives beyond this but were now eager to extend their remit.

There was also a realisation that, if you are asking players to give it their all on the pitch, it is only fair that the club should be seen to give it their all as well.

*'...if you are expecting high standards from your players then you've got to be doing your bit to the best of your ability as well and so getting involved in the healthy club was a way of demonstrating we're top notch'* (Ulster, OGM 2014)

*'I think that's everybody's aspiration is if you have healthier players, healthier in body and mind...If you have a healthier community you'll want to kick on and do something on the field as well as off the field'* (Ulster, OGM 2014)

#### ∇ Community identity

Community is at the heart of the GAA, but the changing context of the GAA club where once it was *'central to the parish but now the parish is no longer identifiable'* (Munster, OGM 2014) has challenged all clubs to *'extend a bit more'*, and to re-establish *'an identity within the community'* (Leinster, OGM 2014). Despite these challenges, the belief remains that *'the GAA are brilliantly positioned to get into every nook and cranny in Ireland...that's the way it should be and it's great'* (Ulster, OGM 2014). Consequently, the concept of taking responsibility and working towards remaining relevant in the community was alluded to as clubs indicated their rationale for taking part in the HCP.

*'It's about making it relevant in our community...'* (Munster, OGM 2014)

*'Community and being relevant in the community...that's actually what people are looking for.'* (Leinster, OGM 2014)

*'We had to make ourselves relevant to the community that was developing around us.'* (Munster, OGM 2014)

*'It's a big town we have a big soccer club a big rugby club so everyone is vying for the kids...it's about bringing them in to the club and making them hopefully love hurling and football.'* (Munster, OGM 2014)

Overall, clubs want to ‘...make sure that people in our community have a better experience by getting involved in the local GAA club’ (Munster, OGM 2014) and the HCP is giving them a platform and structure to do that.

*‘it’s great because it gave us a focus and its leading us and helping us to improve as a club.’ (Ulster, OGM 2014)*

#### 4.4.3 Healthy Club Development



**Figure 15 Healthy Club development**

#### ▽ Healthy Club Committee

All clubs were required to set up a Healthy Club Committee to guide and lead the initiative. To reflect the community ethos of the project, it was envisaged that this committee would include club members but also would enlist non-members, with skill sets suitable to the HCP concept.

The number of people involved in the Healthy Club Committee varied considerably, from nine in one club to four in another. There was a concerted attempt to recruit community representatives as well as active club members, which was encouraged to reflect the community ethos of the HCP.

*'The group that's come together have actually been a group that you know there's a couple of parents, a player, coaches, we have people who weren't doing very much else in the club which is great.'* (Munster, OGM 2014)

*'I suppose we have two people on the committee that are not members of the club, a local councillor and my wife is a teacher she is on it as well. ...we tried to target a player, a coach, a member of the executive and a person from the community.'* (Munster, OGM 2014)

#### ∇ *Executive committee backing*

Support from the club Executive committee was perceived differently across clubs but universally indicated as central to the roll out of the HCP. Some clubs had an executive member on the HCP team, which meant that the HCP is part of the committee's objectives and that health promotion activity was integrated into the core activity of the club. This was most clearly manifested in the inclusion of the HCP on the agenda at club meetings, which ensures that (club) people *'take note'* and there is always a focus on HCP activity.

*'...it's on the agenda for every meeting and the healthy club gets its own section of the meeting'*. (Ulster, OGM 2014)

*'The club has bought into it, our executive has bought into it, all the sub-committees have bought into it and people are very much aware of what's going on, when it's going on. We have a good committee'*. (Leinster, OGM 2014)

However, as pointed out by a member of the GAA's Community and Health Team *'...sometimes a lot committees are working nearly on their own like doing all this great work but weren't included in the overall committee of the club'*. It appears that the Healthy Club committee and the Executive in these instances perceive support differently. The Executive views support as consent to run and attendance at initiatives, while the HCP team are clear that integrating health promotion activity into the Executive committee agenda is a more effective expression of support.

*'If they have an event coming up they (Healthy Club Committee) have to get permission from the executive, there's never been any questions about that...I'd say we've attended everything they've ever done...and we promoted it'* (Munster, Executive Committee member)

*'We have an executive meeting once a month and there is always a report. X will send in a report, then it will be discussed and I will always make sure it's on the agenda. So it's on the agenda it's just one of those things.'* (Leinster, OGM 2014)

*'...we are very lucky with the people we have involved at executive level and that nothing is a 'no'. If somebody comes with a good enough idea and thinks they can run with it, it will be backed and we'll give it a go.'* (Ulster, Executive Committee Member)

*'I think another thing that helped the status of the committee was the fact that the club chairperson and secretary became part and parcel of the committee so that meant it had a central position.'* (Munster, OGM 2015)

The GAA Community and Health Team understood the value of having the clubs Executive committee on board and made a concerted effort to encourage Executive's to back the Healthy Club Committees in their clubs. In some instances, because *'...it was new to them'* they found the Executive were *'kind of more scared or didn't know what it was about more than anything else'* (GAA Community and Health Team member). It was then a case of *'...showing them the reason behind it and healthier members and it all comes in and engaging in a better community and a better club so again it was for me to educate them and sell it to them really'* (GAA Community and Health Team member).

The Healthy Club Committee felt that having a representative from Croke Park take the time to talk with the executive and pitch the HCP idea *'...reinforces the whole thing'* (Ulster, OGM 2015), and shows *'...it is important this healthy club initiative is really important so they are taking it serious and I think it has a knock on effect'* (Connacht, OGM 2015). In some instances, it was crucial step in order to *'...change the mind-set of maybe two or three people'* (Ulster, OGM 2015) and get the Executive committee's backing.

#### ▽ Support/sharing ideas

Regional operational group meetings appeared to be an important learning experience for participating clubs, both in terms of sharing ideas and negotiating challenges.

*'We learned more in a hour in terms of what other people are actually doing, than you would do on your own very much so it was a very worthwhile exercise.'* (Leinster, OGM 2014)

*'They are going through the same as you are going through and they are having the same barriers so you don't feel like you are on your own.'* (Ulster, OGM 2015)

*'I think we get a good lift from all the ideas... seeing what they're (other clubs) doing' (Leinster, OGM 2014)*

*'...even the barriers that are there you've got assistance in terms of how to get over them' (Ulster, OGM 2015)*

Similarly, support from the GAA Community and Health Team in Croke Park was welcome and impactful. This relationship was characterised as *'approachable' and 'helpful'*, with *'great correspondence' and 'good communication'*. One club expressed *'I definitely couldn't fault the help from that end' (Ulster, OGM 2014)*.

#### ▽ *Partnerships – club perspective*

The idea of partnerships was a concept that clubs struggled with at the beginning of the HCP. At that stage it was felt that partnerships were potentially *'a step away from the doing stuff' (Ulster, OGM 2014)*. It was a new venture for some clubs and there seemed to be no clear direction given around the process of instigating a partnership.

*'As for the HSE I don't even know who to approach'(Ulster, OGM 2014)*

*We're not hearing anything from them you know, nobody has come down and said by the way X is the girl in your district go and talk to her and she will help you out and she'll point you in the right direction there has been none of that'.*(Ulster, OGM 2014)

HSE and LSP representatives attended meetings but it was felt that they were there *'to give their ideas but not to work' (Connacht, OGM 2014)*, which clubs appeared to struggle with.

Over the course of phase one of the HCP, partnerships have progressed, and for many clubs they have become integral to the delivery and sustainability of the HCP.

*'We were very naïve starting and I think we were nearly a year going when we got someone to come out from the sports partnership. They told us everything they were doing and what was there for us and how they would help us.'* (Connacht, OGM 2015)

*'I mean we couldn't have done, we couldn't do even a small amount of the work we've done with just club resources and people'.*(Ulster, OGM 2015)

Clubs appreciated the value and credibility of a *'fresh voice'* to relay important messages and acknowledged partners as a source of innovative ideas that they may have otherwise overlooked. These manifested as actual initiatives in a number of clubs.

*'You couldn't do it (Operation TransFAUGHmation) without the partnerships that we have you know like every week somebody different comes in and holds and class. The venue we used we get that free of charge as well so it is important to have relationships with people.'*(Connacht, OGM 2015)

*'The local butcher came on board and he was doing a pack of healthy meats. And he was saying if you are part of Colmcilles you get 10% discount. Similar in the summertime there was a project run with sunscreen. We got three local pharmacies that if you wore your X jersey in you got 10% discount.'* (Leinster, OGM 2015)

Challenges remained for clubs, particularly in relation to the lack of a template or map to follow. It was also apparent that the HSE and LSP were not clear around their role in the HCP and mentioned a lack of guidance and resource allocation from their management hindered their involvement in the project. The other observation from clubs was the degree of work involved in establishing and actualising partnerships: *'It was very labour intensive....there were lots of obstacles'* (Leinster, OGM 2014). It was noted that greater links locally between the GAA and LSP and HSE would assist the management and development of partnerships at a local level. There is also a need to clearly signpost how clubs should engage with service providers, as well as what services they can provide.

*'Rather than just saying you can contact your LSP...at national level a clear agreement and document communicated as to how to do this'.* (LSP partner)

The Community and Health Team in Croke Park also acknowledge that clubs were somewhat flying blind when it came to sourcing and establishing more formal types of partnerships. They feel that clubs could be better *'...supported and resourced in terms of how they can identify their own local partner and how they can sustain that partnership and make sure they get something out of the partnership and understand that they have to provide something in that partnership'.*

On the whole, the consensus from clubs was that smaller local level partnerships were the most beneficial as *'those higher level partnerships they do add an extra layer of sophistication to the thing but is a lot of work as well'* (Ulster, OGM 2015).

*'So I think the local partnerships are far more important than the higher up. Maybe down the line when this develops or whatever you'll get more from it but at the moment I don't think it is of much benefit to us'* (Ulster, OGM 2014).

#### ∇ Partnerships – Partner perspective



The partners themselves were in agreement that the opportunity to engage with the HCP represented an efficient way of working with Irish society due to the reach and cultural fabric of the GAA. The HSE representative noted that there was an overlap between the goals of the HCP and the HSE, so coming together allowed them to *'deliver into the fabric of a community.'* Similarly, SOAR observed that *'the GAA is unique in the fact that it is such a cultural organisation embedded in the blood of our veins and by using that as a vehicle we can absolutely contribute to real change.'* The partnerships worked well when there was a clear understanding of roles, willingness to pool resources, and regular engagement between all parties. For example, in the running of one initiative the GAA club felt they were responsible for providing venues, promoting the project and other organisational issues, while the HSE provided clinical accountability and the delivery of the programme. This clarity needs to be established at the outset of the partnership, something that was mentioned by the LSP interviewee as well. Funding was a clear benefit for clubs who engaged with partners, as the HSE funded, resourced, and delivered programmes at little, if any cost. Partnership between HCP clubs also proved worthwhile in Cork, allowing for further pooling of resources.

#### ▽ *Community Link/Reach*

The HCP process was very much characterised by the generation and maintenance of a strong community link for both altruistic and pragmatic reasons. Reach into the community provided support for the actual roll out of HCP initiatives and was an important source of ideas.

*'There was always volunteers and if there was someone asked to do something they would do it'*  
(Leinster, OGM 2015)

*'A few people are willing to step up and come up with ideas and push them on themselves'*  
(Munster, OGM 2015)

Extending the link into the community was also a way of opening up the club to potential new members ensuring a club can continue to grow.

*'I mean we always say anything to do with healthy club for us it is all about the community. If you build community the lads they will come to the club I think'* (Munster, OGM 2015)

*'And with the activities that are on...they're not restricted to club members. And without doing that it's going to die because otherwise it becomes a closed shop and you can't actually expand.'*  
(Munster, OGM 2014)

Some clubs *'zoned in on the community aspect of it'* (Munster, OGM 2014) right from *'day one'* (Munster, OGM 2014) where other clubs focusing more so on club members are now widening their reach into the community:

*'I think going forward...the community aspect of the project is where we're concentrating on'*  
(Munster, OGM 2014)

*'But I suppose we have only kind of concentrated on club members so far, it's the easiest to communicate to them. But I am hoping with these walking groups next week that we will hopefully get to the wider community'.(Connacht, OGM 2014)*

When asked about the community needs assessment they were advised to carry out prior to delivering initiatives one club remarked that they were *'sceptical'* (Ulster, OGM 2015) about this exercise, but in the interim have realised it was a *'bonus'* (Ulster, OGM 2015) when applying for funding. Other clubs maintained this practice, using feedback from events to guide the delivery of future projects, which was mutually beneficial for the club and community.

*'The feedback from the nights was good for us....we were able to plan the next event from the feedback you know which was great.'* (Munster, OGM 2015)

*'We did a feedback questionnaire...and organised workshops off that. They gave the feedback on what they wanted and they were delighted.'* (Connacht, OGM 2015)

Clubs worked in different ways to communicate with the community through e-newsletters, advertising in the local clubhouse, using the HCP flag, and disseminating the HCP message at all club meetings.

#### ∇ *Evolution of the HCP*

The club experience evolved in different ways throughout the duration of the project. At the beginning, clubs themselves seemed unsure of how the HCP would manifest.

*'Defining the project is probably very difficult as well'. (Leinster, OGM 2015)*

*'Getting my head around this has been the biggest thing' (Leinster, OGM 2015)*

It was also clear that clubs did not foresee the amount of *'administration to be done'* (Ulster, OGM 2015) which wasn't something they had *'signed up for'* (Ulster, OGM 2015) and became a source of discontent.

*'I suppose what we might have mentioned before was all the sort of paperwork and labour that was involved in it, we didn't expect that you know' (Connacht, OGM 2015)*

However, as the HCP progressed clubs felt that they did not have to engage in as many administrative tasks, *'this last year that has eased off' (Ulster, OGM 2015)*, moving instead to more of what they perceived as effective face-to-face engagement.

*'...we were just form filling you know again and again. Whereas the last 12 months it's all about just the clubs doing the work and coming in and talking about what they're doing and sharing their experiences and we have learned so much more from that.'*(Ulster, OGM 2015)

The club culture around health promotion also appears to have progressed. At the outset it was remarked that *'the GAA club is about performance' (Leinster, OGM 2014)* and should be *'concentrating on the on the field stuff' (Leinster, OGM 2014)*. There was initially a sense that *'health promotion it is not part of our role, we are coaches and mentors and we are parents and whatever else' (Connacht, OGM 2015)* and the HCP was just seen as an *'extra task (Connacht, OGM 2015)'*, but now clubs see that developing HCP activity can support the core activities of the club.

*'It has made a major impact on the way the club is progressing.'* (Munster, OGM 2015)

*'...it is a football club at the end of the day but it can do so much more as well' (Leinster, OGM 2015)*

*'I would like to think that it has brought in a kind of attitude that healthy things should be part of the club' (Leinster, OGM 2015)*

Some clubs envisage that the HCP will eventually seamlessly merge with the daily club activities and be *'just engrained as part of it' (Leinster, OGM 2015)* instead of *'necessarily saying this is all to do with the healthy club project' (Leinster, OGM 2015)*.

After phase one of the HCP it is notable that clubs feel health promotion *'is part of the conversation now' (Munster, OGM 2015)*, whereas before *'it wouldn't have been' (Munster, OGM 2015)*.

#### 4.4.4 What did the HCP lead to?

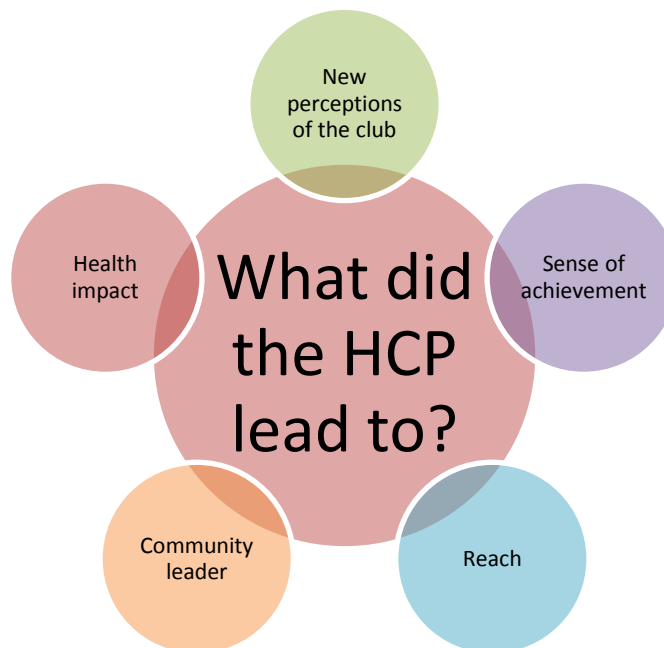


Figure 16 What did the HCP lead to?

##### ▽ *New perceptions of the club*

When it comes to promoting and enhancing the health and wellbeing of people, clubs' feel they have moved from being 'reactive'(Munster, OGM 2015) to becoming 'proactive' (Munster, OGM 2015). Involvement in the HCP changed how the club was perceived in the wider community, but also internally.

*'It sort of put a different light on the club that the GAA we're not just about collecting money at the gate going into an u/12 or u/14 that we are about getting out into the community.'* (Munster, OGM 2014)

*'I can see more than ever now that we have so much to offer people you know in the community rather than just hurling and football.'* (Munster, OGM 2015)

*'The feedback from the fit walk was that people felt friendly and welcoming'* (Leinster, OGM 2015)

*'...it made us more aware of what's going on like it is not all about playing football'* (Munster, OGM 2015)

##### ▽ *Sense of achievement*

The way clubs went about promoting health was individual to each club's own needs and circumstances. For some clubs, it was more practical to undertake *'small things'* (Leinster, OGM 2014) and *'gradually build it then'* (Leinster, OGM 2014), while others facilitated *'big projects'* (Leinster, OGM 2014). No matter how clubs went about realising the HCP there was a clear sense that clubs were *'happy with what we (clubs) have done'* (Munster, OGM 2015) and exceeded their own expectations in some cases.

*'We are very proud of all we have achieved...I'm very happy to reach this far and got all done what we have got done. I really didn't expect we would get all covered what we did you now'. (Connacht, OGM 2015)*

*'I think we have gone beyond what we thought we would achieve you know'. (Connacht, OGM 2015)*

*'We have achieved some and we always reaching to achieve others...it is always proactive'. (Leinster, OGM 2015)*

Involvement in the HCP also contributed to members gaining valuable skills.

*'...we are just volunteers we're nothing else but we have more knowledge than we had before so you can't maybe help someone but you can point them in the right direction' (Ulster, OGM 2015)*

*'I'm in the club a long time and I have learned an awful lot from this you know stuff that I wouldn't have' (Leinster, OGM 2015)*

## ∇ Reach

One of the principles of the HCP is reach, whereby clubs promote and support the wellbeing not just of players but also of the non-playing members such as parents, retired players, and members of the local community. Previously, there was a situation that once you ceased to be an active playing member there was little reason to stay in the club as *'there was nothing really for you once you quit'* (Ulster, OGM 2015). For others who were never involved in playing Gaelic games there was a sense that there was nothing else for them to get involved in.

*'They sort of say well I don't play hurling, I don't play football, I don't play camogie, we don't have handball so I can't get involved'. (Munster, OGM 2014)*

The HCP seems to have given another dimension and focus to club activities in addition to on the pitch duties. It is about trying to *'dispel the myth'* (Munster, OGM 2014) that non-playing members have no part in a GAA club.

*'...once you quit playing football what did you have before, now you have the health and wellbeing and all this kind of thing' (Ulster, OGM 2015)*

*'...it has certainly a couple of people to the club that maybe left it and came back and they are retired and they have something to do and it's an interest. So yeah there is a whole different side to it than just the games' (Leinster, OGM 2015)*

Facilitating and promoting initiatives that reflect the health needs of the wider community is something which has helped to get people inside the GAA's gates and raise awareness of clubs' commitment to the health and wellbeing of both playing and non-playing members.

*'We had a couple of people as I said came to the suicide or survive and they wouldn't be involved in the club or actually didn't even know how near they were to the club and when they came they were like this is great' (Leinster, OGM 2015)*

*Well I think the Action Cancer big bus particularly last year was brilliant for bringing people in through the gates that would never target our doors normally'. (Ulster, OGM 2015)*

*'...there were a lot of attenders who had no attachment to any GAA club'. (Munster, OGM 2015)*

While it is clear the initiatives being hosted and/or run by clubs has had an impact on increasing the number of people coming through the club gates, it is hard to establish however if this will result in a surge of new faces becoming fully paid up club members.

*'Whether they join membership for the year then with the club I don't know'. (Connacht, OGM 2014)*

Distributing short feedback questionnaires to attendees on the conclusion of initiatives was a worthwhile way of clubs assessing the programme but also planning the direction in which to move forward.

*'...we were able to plan the next event from the feedback you know which was great'. (Munster, OGM 2015)*

*'And we did a feedback three question questionnaire that night in a private box you put in your details and from that then we organised workshops off that. They gave the feedback on what they wanted and they were delighted'. (Connacht, OGM 2015)*

As one club sums up, the HCP has given them a way of reconnecting with their community and has seen them progress from *'being criticised for not being linked to the community to winning community organisation of the year'. (Leinster, OGM 2015)*

*'The real benefit is your standing in the community well for us it was. Our profile has changed in the community and now we are back right slap bang in the middle and people want to be part of us and want to know what's going on and when's the next event? You know we had lost that for a long time'. (Munster, OGM, 2015)*

## ▽ Community Leader

Over the course of phase one of the HCP clubs have, in some cases, become community leaders with respect to health issues, and other community organisations are *'beginning to look at us (clubs) now'* (Connacht, OGM 2014). Initially, clubs were brainstorming to come up with innovative and impactful ways of addressing health concerns, but as the project gathered momentum more and more ideas were being pitched to the committee from external sources.

*'Just take the example of the farm safe talk that we are coming up with like. We were approached to do this like, whereas before we were trying to think of things to come up with. It is becoming a lot more aware of in the area and that is a great example to see someone coming to us to look for us to do something'. (Connacht, OGM 2015)*

*'And I just wasn't expecting it but I find as the project has gone on because we have the title for the project people were coming up. I found that SELB youth project sort of came to us and that's worked really well' (Ulster, OGM 2015)*

The HCP is providing an avenue to promote health within communities that may not have existed or been as visible before but is clearly valued.

## ▽ Health Impact

The HCP has helped to empower people and provided them with the opportunity to take control of their health, be it a healthy cooking class: *'I couldn't boil an egg. I'd be useless and we learned an awful lot'* (Leinster, OGM, 2015), information on mental health: *'There was a booklet there young adults mental health stories or something like that, we have that out here in the corridor and it flew off the shelves'* (Leinster, OGM, 2015), or exercise classes: *'I suppose you are seeing that they never exercised before all of a sudden they started playing football, then they were doing exercise classes and yoga'* (Connacht, OGM 2015).

There also inspiring individual stories:

*'I got a great example of it there just before the new year we teamed up with a cycling club, the local cycling club in the area and one lad had never more or less cycled. He is a fairly large lad you know. He has continued on cycling now he is actually going joining the club on Friday night so he is. On the 6<sup>th</sup> of March he is going to do 100 kilometres and he was barely able to do 100 yards that time'. (Connacht, OGM 2015)*

Over the course of phase one of the HCP clubs have also noticed a growing awareness around health and wellbeing in their community.

*'Like I even see my own kids they know about health and wellbeing or know it is important to exercise and eat right it is just to keep that going'. (Connacht, OGM 2015)*

Fostering this type of awareness and encouraging healthy attitudes is key to insuring a positive and sustainable health impact.

#### 4.4.5 Challenges



Figure 17 Challenges

#### ∇ Finance

Financial support is an essential component of the start-up of any new enterprise, and in this instance clubs appeared to be reliant on being self-sufficient and obtaining support from the Executive committee and local community entities.

*'Well it's just the good will of committee.'* (Leinster, OGM 2014)

*'Well we kind of have to finance ourselves...'* (Ulster, OGM 2014)



*'...they (new local hotel) were trying to create an impression locally so they subsidised it to a degree and also a local professional who totally agreed with what we were doing also financially supported us.'* (Munster, OGM 2014)

There was an awareness that the concept and existence of the Healthy Club is to break even, not to make money, or *'squeeze the life out of your own community'* (Ulster, OGM 2014), or be a financial hindrance to clubs, with one club emphasising that programmes were run with *'no cost to the club'* (Munster, OGM 2014). In practice however, this has meant clubs have had to self-fund projects which has *'kept everything small'* (Ulster, OGM 2015). *'Finance is a block'* (Connacht, OGM 2015) when it comes to scaling up projects and without sourcing grant aid clubs themselves would struggle to cover the costs. As one club points out *'when you have to provide a venue you know it is still money'* (Munster, OGM 2015).

*'We have been very fortunate with the awards for all scheme. We got funding the last three years from them and touch wood for four coming up. But if we were unsuccessful at getting funding we wouldn't be able to generate that resource.'* (Ulster, OGM 2015)

#### ∇ Human Resources

Clubs were required to set up Healthy Club Committees to drive the HCP, and while all clubs succeeded in establishing these committees, recruiting people *'with the time to devote to it that it needs'* (Ulster, OGM 2015) proved difficult.

*'...getting people to help is our biggest barrier.'* (Connacht, OGM 2014)

*'...getting the right people who are not coaching two teams and driving the bus and doing whatever you know.'* (Ulster, OGM 2015)

*'He (Healthy Club committee member) stepped down initially as administrator and then completely. He can't give the time and hasn't been able to go to any of the meetings and he is involved in a lot of other things.'* (Connacht, OGM 2014)

There is a feeling that *'everybody wants to support it but nobody will come to the meeting or anything like that'* (Connacht, OGM 2014). Without active committee members the workload fall backs on the same *'few core'* (Munster, OGM 2014) who are already overburdened.

*'It has kind of fallen back on the same few every time'* (Munster, OGM 2014)

*'We could probably do with more people being involved in it and as and all as we tried you still maybe end up with the same cohort of people like'. (Munster, OGM 2015)*

One club even considered *'not going ahead with it a few months ago'* (Connacht, OGM 2014) because of lack of manpower. Sustainability has also been an issue brought up by other clubs.

*'Manpower is the real challenge and I would have a concern about the sustainability of it going forward after the end of the period. Where is that next person coming from that can pick up the mantel?' (Leinster, OGM 2014)*

*'...if you don't get the committee members it is going to die. And if you ask me at the moment will it die I would say yes'. (Connacht, OGM 2015)*

So far for clubs it has been a case of *'tapping people on the shoulder and saying will you come on board?'*(Munster, OGM 2014) It is hoped however, that the more health promotion activities the club are seen to do, the more interest and momentum it will generate, which with any luck will translate into more active committee members.

#### ∇ Workload

There was an understanding from clubs that the HCP was a pilot scheme and in order to evaluate the progress of the project there would be some level of administrative work. The sheer volume of paperwork did however become a particular bone of contention with clubs.

*'I would just say they could reduce the number of reports you have to do. There is too much reporting'. (Ulster, OGM 2014)*

*'As I said before it is a voluntary organisation, it is a voluntary group and we are busy ourselves in our own lives and to be sitting down like I know personally I sat down at computers till two in the morning doing progress reports'. (Connacht, OGM 2015)*

From the perspective of one of the dropout clubs, it is interesting to hear that yes health promotion *'is continuing in the club and it will continue because I think a lot of us find it very important'*, but it was *'the paperwork that turned me off'*.

*'Personally I couldn't do it because I was just so busy I couldn't do the paperwork'. (Dropout club)*

*'It just got too much with the work load' (Dropout club)*

Reflecting on their HCP journey thus far, clubs weren't shy to mention the extra workload it brought, but overall clubs concluded that the HCP had added to their club in a very positive

manner. The HCP allowed clubs to see the value in promoting health and gave clubs the tools to go about doing so.

*'Overall I would have to say even though it was extra work it was definitely worth it and a good thing for the club to do and we are the better of it'. (Connacht, OGM 2015)*

*'I think we will do more and we will do it better with the community because of the involvement in the healthy club project'. (Ulster, OGM 2015)*

#### 4.4.6 Recommendations



**Figure 18 Recommendations**

#### ∇ Support network

There was a concern that the operational group meetings would cease at the end of phase one and that subsequent learning that took place in these forums may be lost. Clubs suggested continuance of some engagement platform and were keen to be involved as mentors/advisers to new clubs recruited to phase two.

*'I think a network of some sort, a local network between local clubs would be hugely beneficial'.  
(Munster, OGM 2014)*

*'So I think in terms of going into the future it would be really, I think it would be really important that something is put in place to allow clubs to talk to each other and learn from each other on an on-going basis'. (Munster, OGM 2015)*

In an ideal situation, clubs would also like more practical supports from Croke Park. Be it visual representation from Croke Park to help give greater emphasis to the HCP locally: *'Even on our launch or something to have them (Croke Park) that night. You're trying to convince the community look what we are doing'* (Connacht, OGM 2014), or having high profile GAA figures available to speak on various health topics.

*'We would sort of be looking for hard resources...a person to come down from Croke Park or wherever that is experienced and can give the talks or give the education whatever it may be'.  
(Connacht, OGM 2015)*

*'...having people like that (high profile GAA player who wrote a blog about his struggles with depression) involved that maybe could go around and speak because you would find players would relate so much more to someone like him'. (Ulster, OGM 2014)*

#### ▽ Infrastructure

Both the clubs and the GAA Community and Health Team acknowledged the need for the Healthy Club Committee to be integrated into the overall structure of the club. For this transition to be made possible the Executive committee in each club must be on board with the HCP concept.

*'There is certain areas that the club need to do for example getting buy-in from the executive committee...get that buy-in straight away rather than trying to preach it and get it'. (GAA Community and Health Team member)*

*'You need the trustees and the officers and the executive committee one hundred percent behind you. You definitely need them. (Leinster, OGM 2014)*

One suggestion is that clubs *'get a signage from your chairperson or executive saying yes we are willing to support a committee so there is something in concrete'* (GAA Community and Health Team member)

Critically, clubs linked sustainability of the HCP with support from the club and community. This included more support from the executive where it was lacking, but also recruiting new members to the HCP team.

*'If there's no team we can't do it...is it sustainable to keep the same project together because they have worked hard for the last two years.'* (Healthy Club Committee member)

The over reliance on the same people meant that some HCP team members were regularly *'burnt out'* and *'people were being stretched too thin'* (Leinster, OGM 2015). Going forward, clubs highlighted a need to try and target *'people outside of the normal committees'* (Leinster, OGM 2015) and bring in new faces and fresh ideas to avoid any staleness creeping in to the project.

*'And I think as well what we need to ensure is that you do have all the time enthusiastic people coming in and especially youngish people with good ideas who will keep a freshness in the whole initiative.'* (Munster, OGM 2015)

Engaging with the community is a priority area of the HCP, and if clubs are to meaningfully link with their communities you also *'need people from the community'* (Leinster, OGM 2015).

## 4.5 Evaluation of Initiatives

### 4.5.1 Community health needs

In the community needs assessment, respondents were asked to identify priority action areas specific to their community. Table 13 shows that smoking, social inclusion, mental health and alcohol were rated as the top priority action areas.

Table 13: Priority action areas

Topic areas	Priority Rating (lower score=higher priority)
Physical Activity	4.6
Mental Health/ emotional wellbeing	5.5
Bullying	5.2
Diet and Nutrition	5.1
Social Inclusion	6.1
Alcohol	5.4
Smoking	7.2

The baseline HCQ asked clubs to indicate the extent to which the club has previously provided information across a range of specified topic areas. The most common area for clubs to have provided information on was physical activity (75%), followed by injury prevention (56%), health promotion (56%), and diet/nutrition (50%). Responses were low for alcohol awareness (12.5%), anti-smoking (12.5%), drug awareness (12.5%), anti-doping (6%), sleep (6%), hygiene (6%) and violence (6%). While all clubs do engage in some form of health promotion practice, according to the community needs assessment up to 42% of their respective communities are not aware of these programmes or initiatives.

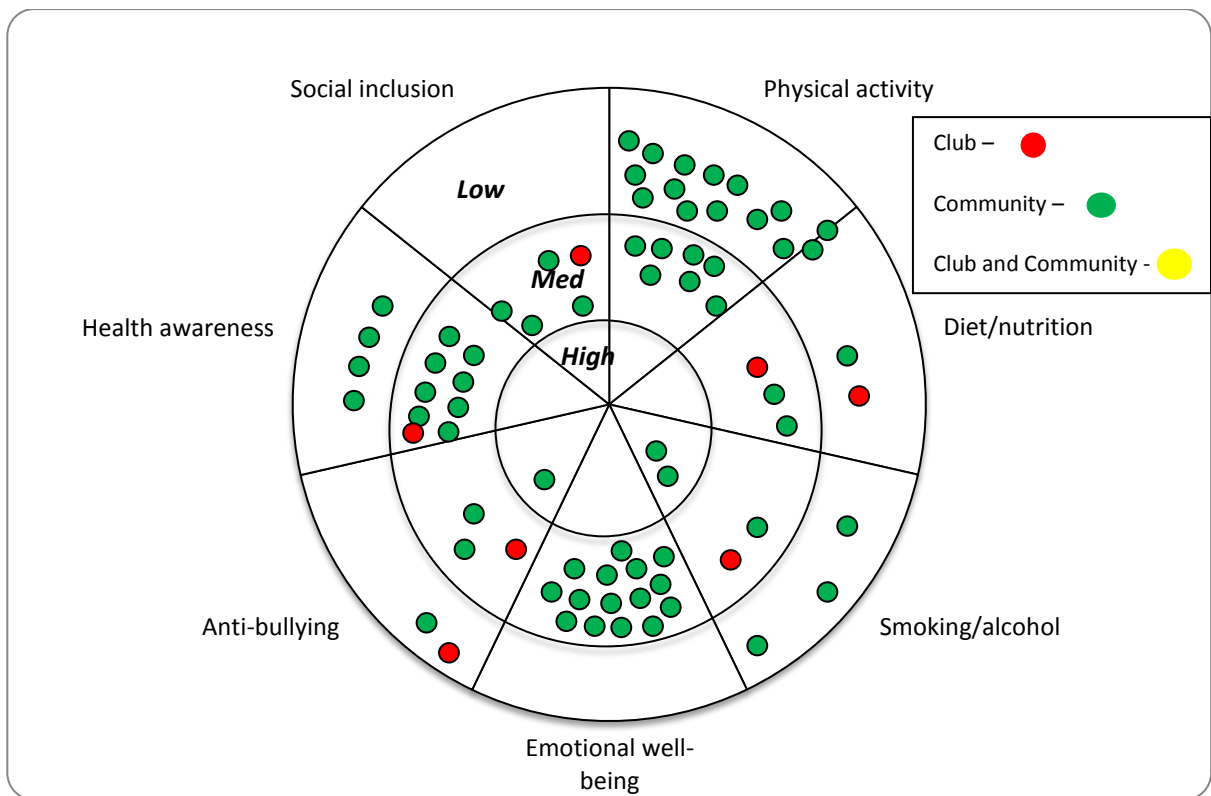
#### **4.5.2 Initiatives provided by clubs (action plan analysis)**

In total, 72 initiatives were planned across 15 clubs (Appendix 14). Initiatives were funded by many sources including the club Executive, sponsorship, through grants, and from the participants themselves, while all clubs at follow up indicated they evaluate all of their activity. Table 14 shows that planned initiatives were highest in the area of physical activity, followed by emotional well-being, and health awareness. Taking the impact rating scale into consideration, we notice that while 22 initiatives focused on physical activity, the majority (68.2%) of these were of low impact, typically due to the fact that partnerships did not play a significant role in the rolling out of initiatives. Improving levels of impact were seen for health awareness campaigns, with nearly 70% of initiatives reaching an impact level of medium, and 100% of emotional well-being initiatives achieved a medium impact level. Bullying and alcohol/smoking awareness initiatives were pursued by a smaller proportion of clubs 8.3% and 9.7% respectively. However, on review we can see that in relation to impact both these areas attained an impact level of high. One of the six (16.7) anti-bullying initiatives and 2 of 7 (28.6) alcohol/smoking related were deemed to be or high impact due to the inclusion of all four elements of the Healthy Club implementation framework. Overall, 4.2% of initiatives were rated as high impact, with the majority (59.7%) rated as medium impact, and the remainder (36.1%) low impact.

Table 14: Planned and Perceived Impact of Initiatives

	<b>Planned Initiatives – OGM, Action Plans % (n)</b>	<b>High Impact % (n)</b>	<b>Medium Impact % (n)</b>	<b>Low Impact % (n)</b>
<b>Physical Activity</b>	30.6 (22)	0	31.8 (7)	68.2 (15)
<b>Emotional wellbeing</b>	19.4 (14)	0	100 (14)	0
<b>Health Awareness/ first aid</b>	18.1 (13)	0	69.2 (9)	30.8 (4)
<b>Anti- bullying</b>	8.3 (6)	16.7 (1)	50 (3)	33.3 (2)
<b>Diet and Nutrition</b>	6.9 (5)	0	60(3)	40 (2)
<b>Social Inclusion</b>	6.9 (5)	0	100 (5)	0
<b>Alcohol/Smoking</b>	9.7 (7)	28.6 (2)	28.6 (2)	42.9 (3)
<b>Total</b>	72	4.2 (3)	59.7 (43)	36.1 (26)

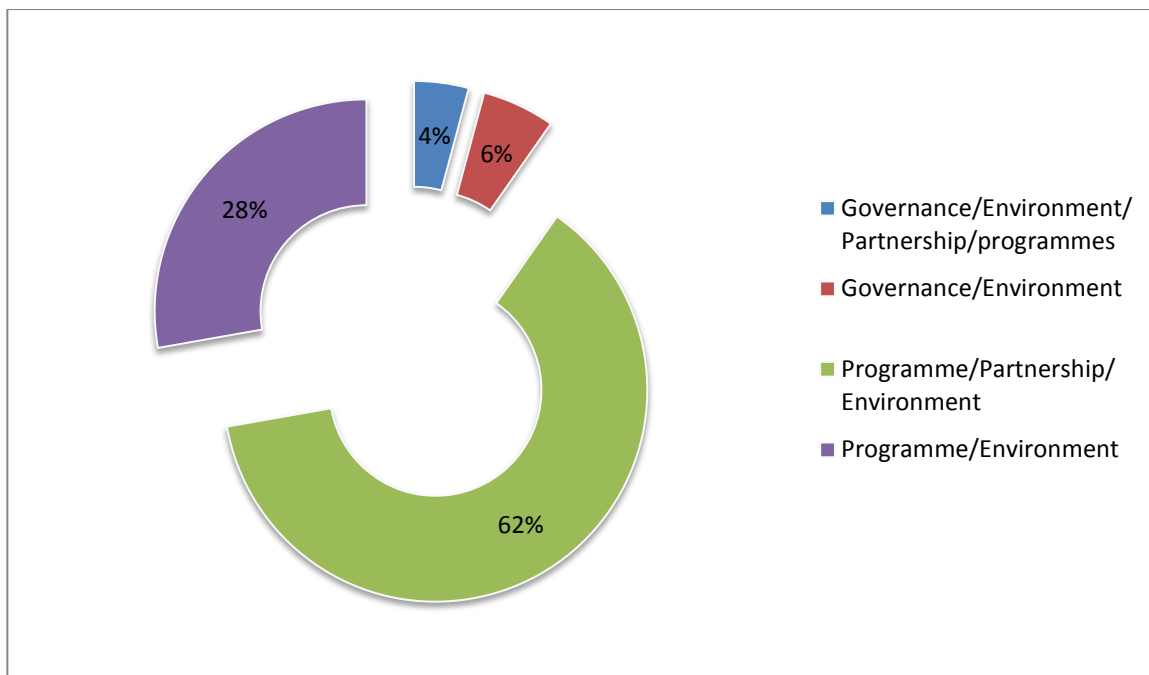
A schematic of the impact rating for each of the initiatives across the seven target areas is presented in *Figure 19* below. Visible on the schematic is the distinction between club (red dots), community (yellow dots) and both club and community (green dots) as target groups. Seven initiatives targeted club members only with three of those initiatives focusing on coaches/mentors or officials. Of the 72 initiatives, 11 were aimed at young people in the club and community, three focused on getting elderly members of the club and community involved, and two initiatives were specifically run for men.



**Figure 19 Impact of initiatives**

Figure 20 below indicates that the HCP included 45 initiatives that combined partnership, programme and environment, 20 initiatives that combined programmes and environment, and smaller numbers of initiatives targeted governance and environment (4). In total, three initiatives covered all four elements of governance, environment, programme and partnership. The range of partners included entities such as schools, Local Sports Partnerships, the HSE, Foróige, and local health professionals.





**Figure 20 Healthy Club Framework Assessment of Initiatives**

In the follow up HCQ, clubs (n=12) were also asked to indicate areas of health promotion that they had targeted during phase one of the HCP. In total, clubs reported 120 initiatives. There was therefore some distortion between the action plans and the initiatives reported in the follow up HCQ. Physical activity intervention initiatives proved to be most popular, followed by social inclusion, and emotional well-being. The general club and community were again the main focus of initiatives with 54 and 55 of the 120 initiatives open to youth and coaches/mentors/officials respectively. Encouragingly, all of the clubs (n=12) indicated they did measure or evaluate the outcomes from their health promotion initiatives. Thirty six (36) future campaigns were also proposed by clubs in the areas of smoking, physical activity, diet/nutrition, social inclusion, alcohol and drug awareness, stress management, weight control, cancer screening, health screening, emotional well-being, and first aid training.

Probed as to why promoting health and wellbeing was important in their club and community, improving morale and engagement and the club image, as well as player safety, and attracting and retaining members were deemed the main drivers for 80% of clubs. Improving on pitch results rated lowest as a motive for health promotion.

Additionally, in the follow up HCQ, clubs were asked to self-rate the impact of initiatives on different topic areas. Table 15 shows that change was observed across many health domains, but was most notable for physical activity and emotional wellbeing.

Table 15: Club Self Rated Impact of Initiatives

<b>Topic Area</b>	<b>Some/Large/Gr eat Deal of Change % (n)</b>
<b>Physical Activity</b>	100 (12)
<b>Emotional Wellbeing</b>	83 (10)
<b>Alcohol + Drug Abuse</b>	75 (9)
<b>Diet + Nutrition</b>	75 (9)
<b>Inclusion</b>	72(9)
<b>Smoking</b>	66(8)
<b>Health &amp; Safety</b>	58 (7)

#### **4.5.3 Individual initiative evaluations**

A total of seven initiatives run by HCP clubs were selected for evaluation (Appendix 15).

##### **4.5.3.1 Healthy Food Made Easy (HFME)**

The HFME programme, which aims to provide nutritional knowledge and practical cooking skills, was delivered in partnership with the South Dublin County Partnership and the HSE. Overall, 28 people signed up to the course; only two dropped out representing a participation rate of 93%. A total of 16 people (3 males and 13 females) took part in the evaluation of the programme; ranging in age from 37 to 90 years. The majority were club members (75%, n=12); the remaining four were non-members.

##### *Changing Perceptions of the Club*

Of note, was that all participants felt that the initiative changed their perception of their clubs attitude to health, and that 92% (n=11) of participants felt their perception of their

club had changed. Specifically, participants indicated that what changed for them *'was the health aspect. I wouldn't have felt healthy enough to come up and join the GAA'*; it was felt that *'the GAA club like you had to be fit and you had to be playing sport you know'* and this prevented them from being involved in the club. Now, there was a perception that *'there's something for everyone in it (the club)'*.

Participants indicated that the club seemed to embrace a new philosophy, where *'sport was once a priority'*, it was now apparent that *'people are the priority.'* Almost two thirds of respondents (63.9%, n=7) experienced social benefits from taking part in the HFME programme. There appeared to be a disconnect between the aforementioned perception of the club as a sport only entity and one that has something to offer the wider community, including a social outlet.

*'See the club is about family and enjoyment and sport actually is important but what people don't realise is it's also a social outlet and people back away from it thinking that's a club I can't go up there but that's an Irish thing.'* (HFME participant)

#### *Gateway to Involvement*

It appeared that Healthy Club initiatives were an effective recruitment opportunity for the club. The club previously ran a walking group and it was noted that *'the walking in the club is especially welcoming it's non-threatening to everyone coming'*, and *'that it was a great ice breaker for anyone new coming into the club'* (HFME Participant) and participants were very thankful of being part of the group:

*'It was you who really brought me into the club for that walking and so thanks so much.'* (HFME participant)

There was very much an understanding that the HCP was about community, about getting people involved, and the group were pleased to see it up and working in their club.

*'It's getting to know people, it's getting people involved having a chat going around and getting more people involved in the club.'* (HFME participant)

#### *Impact of the HFME Programme*

The HFME programme was very well received by participants, with all respondents to the evaluation indicating that it was very good or excellent and that they had learned about healthy eating. This was reflected in the focus group when participants stated that they

know had *'the knowledge to read food labels'*, that they *'know what they're looking at and understand it'*, and noted that they *'stop and think before you cook now.'* The majority (93%, n=13) of participants felt their cooking skills had improved and had applied these skills in their home environment, while 83.3% (n=10) felt confident in following a recipe.

On a broad scale, the impact of the HCP was considered with requests and support for more activities; specifically more walking, a healthy heart programme and healthy food sponsorship for summer camps. Participants were vocal and confident about their belief that the initiative overall could have a long term impact; remarking that the current batch of young people in the club would *'be a healthier generation'* and that *'it (HCP) will always be there.'*

The HFME programme had an impact on the awareness, perceptions and behaviours of the participants in relation to health. One participant remarked *'how many of us throw sweets into their kids to shut them up'*, but now due to the knowledge they have accrued *'because you know what are the bad fats and what are the good fats and stuff like that you're going to be like nah have that instead.'* Some of the group also commented on being more active:

*'Well I've actually started running now. I'm running the last 5 weeks now which I was never even thought of doing. I started running now because of this. I'm fitter now.'* (HFME participant)

*I find when I'm working now I'll leave the car and walk.'* (HFME participant)

An interview was also conducted with the programme facilitator. Interestingly, the participants noted that he had also become more engaged in the club due to his involvement in the project, having previously never been in the club before. The facilitator remarked on the reach of the GAA club, its role in social inclusion and the fantastic *'health promotion opportunity'* the GAA club presents. The ethos of the HCP in the club and the nature of interaction and engagement appeared to have a profound impact on the facilitator.

*'It's been a huge turning point for me... the people and getting a bit more insight into the organisation of the GAA and to realise how its project could be potentially far reaching in terms of health promotion, could be unbelievable. It has done something for me in a very good way.'* (HFME facilitator)

#### 4.5.3.2 Anti-Smoking Policy

Anti-smoking was one priority area identified by the community survey which the club in question decided to address through the development and implementation of an anti-smoking policy. An interview conducted with the leader of the Healthy Club Committee explained that *'...we got the feedback and identified our priorities. And the no smoking policy was one of the priorities'*. A policy was the chosen approach as the committee believed that *'we have to regulate what we are trying to do so we needed to be clear on what we were trying to achieve'*.

*'I'm also a firm believer that a policy doesn't sit on a shelf it has to be disseminated throughout the club'*. (Healthy Club Committee member)

The policy aimed to create a smoke free pitch and dressing room area to encourage a healthier club culture and positively impact upon smoking behaviour. Overall, 41 participants took part in the evaluation process, 62% of questionnaire respondents stated they were a member of the club. The majority (83%) identified as non-smokers with 17% identifying as smokers.

##### *Impact of the Initiative*

The questionnaires revealed that the majority of respondents were aware of the anti-smoking policy, with only 20% (n=8) not aware of the policy. Of those who were aware of the policy the most popular channel of awareness was through receiving club texts on the issue followed by word of mouth. The club had also placed five no smoking signs and two explanation signs around the club grounds with more signage planned to raise awareness.

To ensure the message was clearly received and interpreted at all levels *'...the chairperson has sat and spoken with all of the adult selectors and the chairperson of the coiste na nog has spoken with all the trainers of the underage. So that is how the information has been disseminated down'*. (Healthy Club Committee member)

Despite this, questionnaire responses indicated that 29% of participants had not seen any signage relating to the anti-smoking policy but 76% were able to correctly identify the content of the clubs new policy.

As with any GAA club one of the biggest challenges to enforcing a policy *'...is people coming from outside, teams coming from another district who aren't aware of it'* (Healthy Club Committee member). With regard to enforcing the policy, the committee feel *'...it's essential we push this, that we approach people in a courteous and respectful manner, non-confrontational, appealing to their better sense of judgement and we haven't had a problem'* (Healthy Club Committee member).

The policy aimed to have a positive impact on the smoking behaviour of people attending the club grounds. Encouragingly, the questionnaires reveal that of the 17% of those who do smoke 86% (n=6) said the policy has had a positive effect on their smoking behaviour at the club grounds, with the majority of those going on to say it has had a positive effect on their smoking in general.

The implementation of the anti-smoking policy and the efforts to raise its awareness has meant 73% of questionnaire respondents felt their perception of the clubs attitude to health had very much changed. The Healthy Club Committee is also hoping their efforts to create a healthy club culture *'...will attract new under players because there is so much more awareness now around smoking and parents of young kids will be attracted to the fact it is a smoke free environment'* (Healthy Club Committee member).

When asked if they were in favour of the policy, the overwhelming majority (90%) of respondents specified they were very much in favour of the policy with 88% highlighting they would be very much in favour of a no smoking policy on all GAA grounds.

#### **4.5.3.3 'How are you feeling today?'**

According to one Healthy Club Committee member, the area in which the club is situated has seen a rapid influx of people over the last number of years, increasing *'from 3,000 to 20,000 in the last 10 years and still going'*. However, the infrastructure needed to accommodate such a growth in population has lagged behind and the community has become disjointed with no *'central point'*. The Healthy Club Committee felt *'...that within the community we felt we weren't as much of a factor as we would like to be'*. The club subsequently developed their *'How are you feeling today?'* programme, with the help of

the Genio Trust to give their community a focal point again, while at the same time providing personal development skills through initiatives such as mindfulness classes, health and nutrition classes, dance classes, card games, and facilitating a men's shed on their grounds.

*'We all knew somebody that needed help and as a club the club felt they could reach out and help these people that weren't involved in the club but were part of our community thus giving the club more focus within the community not just from a football base but from a community development base'. (Healthy Club Committee member)*

The classes are open to everyone in the community and are generally run on weekday mornings 10-12am with the exception of the cards which is held in the evening. The mindfulness class has over 120 people 'on the books' with 30-40 people attending weekly. Fourteen participants (5 males and 9 females) from different 'How are you feeling today?' classes took part in a focus group and completed a questionnaire.

#### *Changing Perceptions of the Club*

Focus group members ranged in age between 32 and 71, with one committee member remarking '*...there are people in their 20s coming on a Tuesday morning. So there is a big age spread, not just as you might think for the older generation there are younger people and there are a few men coming*'. Club members were notified of the programme over text, while having children in the club also helped to create awareness of the programme. The majority (n=10) of the questionnaire respondents were not members of the club. For these people with no previous connection to the club, word of mouth proved to be most powerful factor in recruiting participants to the programmes, which they themselves have continued.

*'That's what happened really people were telling each other and it just filtered through'. (How are you feeling today participant)*

The fact the programme was aimed at community development meant that '*the club opened up not just to GAA people but opened up to everyone*' (Healthy Club Committee member). As one member of the Healthy Club Committee explained '*The objective is that the people of the community see the club as their community. That we are X community GAA football club right but we are not just about football we are about the community. We*

*are part of community and we want the community to be part of us'. This evidently translated back to participants.*

*'...once I heard it was for the community and for people I thought it was a wonderful thing'. (How are you feeling today participant)*

*'...you didn't have to be a full GAA player. I joined the photographic club at the start here and then I started to play cards'. (How are you feeling today participant)*

It is subsequently unsurprising that 75% of respondents agreed the programme changed their perception of the clubs attitude to health for the better and had an excellent impact on changing their view of the GAA in general. The effort the Committee put into opening up the club to wider community, some of whom were *'never inside the gates'* (How are you feeling today participant) before, was welcomed and appreciated by participants.

*'In the early stages of the programme I used to stand outside the front door and welcome everybody just to make them feel part and feel welcome and that meant a lot to them you know that this is a strange place to us and to be welcomed into it and several of the women spoke to me afterwards about it that it just changed their perception of the place'. (Healthy Club Committee member)*

#### *Impact of the Initiative*

The overall perception of the initiative was positive with 93% indicating that they really enjoyed their sessions and 86% stating that the content was excellent. Furthermore, at least 80% of all participants felt that the initiative had a good/excellent impact on their awareness, knowledge and skills around maintaining health and wellbeing. This was reflected in the focus group when participants stated that *'...it's changed my life. It really has'*, and *'I'm retired I had a lot of problems with depression so to get involved helped me enormously'* (How are you feeling today participant), and *'it just changed my life for the better it gave me a different outlook'* (How are you feeling today participant).

Benefits of the programme extended to impacts on physical and mental health. For some participants it was practical things like *'I can now lift my arm for instance. That's from coming to the mobility classes. And I had a brain haemorrhage shortly after my husband died a few years ago and my balance was affected and it has really improved. I can put my pants on now standing on one leg I'm not wobbling all over the place'* (How are you feeling today participant) which have improved their standard of living.



Not alone do the classes have a direct impact on the participants, but the information and knowledge they receive is being passed onto family and friends *'...the nutrition it trickles out as well because you go home you have more information and about nutrition you have learned new things. You will cook better food for your family' (How are you feeling today participant).*

*'And the more parents you get doing the courses they will see that and bring home the information'.  
(How are you feeling today participant)*

### *Increasing Involvement*

Interestingly, as well as the many benefits the programme has brought to the participants and the wider community, the club is also seeing benefits as the participants noted that they had become more engaged in club activities due to their involvement in the project. The questionnaire revealed that since taking part in the 'How are you feeling today?' programme 92% of participants had joined in social activities in the club and 82% had continued or increased support for club fundraising. This is backed up by the focus groups where it was remarked that *'I would like to get more involved (in the GAA club) and I would like the kids well my youngest daughter more involved as well' (How are you feeling today participant).*

*'...I just asked for information on the summer camp because I wasn't really involved in the GAA but I just think it is fantastic that it has spread more into the community'. (How are you feeling today participant)*

It was very much apparent among focus group participants that this initiative showed that the *'GAA were opening their gates to the community'* and that this new endeavour instigated a *'transformation to the parish.'*

### *Cost*

One factor that did arise numerous times during the focus group discussion was the issue of cost. As the programme was funded it was free for participants to attend and this may have been one of the critical factors in getting the programme off the ground as *'...the fact it was free I thought well I don't have to feel guilty as a housewife about spending money on myself' (How are you feeling today participant).*

*'I'll do it, it's free, brilliant I'll try it. That was a great incentive and I can say as well it changed my life. (How are you feeling today participant)*

*'There was a bus put on then, a free bus, so that helped the people. So when I heard it was free I said here we go...'* (How are you feeling today participant)

It is something to keep in mind when planning other programmes and as one participant says *'but just the fact that it initially brought everybody out because we thought there is nothing to lose, then it might continue even if it was initially free'*.

#### **4.5.3.4 SOAR**

The Healthy Club Committee in one particular club partnered with SOAR and local schools to deliver workshops around emotional wellbeing to local children. SOAR is a foundation which delivers early intervention wellness workshops to young people, aiming to empower young people to thrive, believe in themselves and fulfil their true potential within a safe and supportive environment.

The Committee explained that *'everybody has been affected by suicide in some way shape or form and unfortunately it is happening more and more. We wanted to do something about it...we were looking for something for the young ones and it was prevention, to give them the tools to not get into that situation in the first place. Talk to someone before it goes too far, before it gets out of your control'*.

Fourteen of the 230 participants who took part in the workshop were present for the evaluation. The average age of participants was 13 years ranging from 11 to 17 years. Females made up 79% of the group, males 21%. Participants were also asked if they were juvenile members of the club, 79% responded yes they were a juvenile member of the club, 21% were not a member of the club. When asked to rate their enjoyment of the workshop ten participants said the workshop was either good or very good with 4 participants indicating they found the workshop excellent.

#### *Changing the Perception of the Club*

The Healthy Club Committee acknowledged that linking with schools helped to get people, especially parents, talking about the GAA club in a positive manner. *'It definitely raised the profile of the club you know it was in all the papers and people were asking us about it'* (Healthy Club Committee member). The committee felt getting schools involved would

mean a broader section of the community could be reached and more people would benefit. *'If you want to pull everyone along with you, if you want to have a better community you have to try and pull in every section of the community. So that's why we felt the schools needed to be included'* (Healthy Club Committee member).

One member of the Healthy Club Committee honestly explained how the *'...healthy club to me used to mean we didn't win the championship but were still in with a chance of winning the league'* but having been involved projects such as the SOAR initiative and seeing the positive impact it had on the young participants and the community at large their *'view on the healthy club has kind of changed you know'*.

#### *Impact of the Initiative*

The student focus group revealed that the workshop had impacted positively on their confidence with nine out of 14 participants specifically alluding to this. Improvements in confidence manifested in different ways, including assurances that *'everybody feels the same, has the same fears and not to worry'*, the confidence to *'express yourself'*, *'be nicer to people'*, *'respect everyone because you never know what they are going through'*, *'set goals'* and *'try new things'*. This experience also generated a greater sense of community among the participants, with respondents suggesting that it *'brings everyone together'* and makes for a *'better community'*.

*'I think it will help in the future because you will be more confident and get more involved in the community'.(SOAR participant)*

The Healthy Club Committee themselves felt *'...yeah a few people definitely got a lot a lot out of it and others obviously just the positivity and the manner and the chat and the answers and all rest and really enjoyed it. Definitely there were a couple who were benefited extremely from it'*.

#### **4.5.3.5 Operation TransFAUGHmation**

The club were re-evaluating their position after having *'kind of stopped winning'* and realised that *'yes football is our core but in order to be a good club there had to be a whole lot of other things going on. And we kind of made a development plan and part of the*

*development plan was getting into the community' (Healthy Club Committee member).*

This new focus was supported and shared by the club executive.

*'...you realise as a club you have more of a responsibility to your members than just on the playing field. You know there is so many other things going on in their life and I think that members spend more time in their club that they do anywhere else. So as an executive if we can kind of do anything to help people if they are struggling or just the likes of the fitness programme just to give another avenue for the people that it's not just playing football there is other stuff going on and we are here to help and everybody is welcome'.(Healthy Club Committee member)*

Operation TransFAUGHmation is a 12 week physical activity/fitness initiative aimed at increasing health awareness and helping the community to become a healthier place. 'A fun way to a healthier lifestyle' is Operation TransFAUGHmations tag line. This was the clubs fourth year running the initiative having first run it on a trial basis in 2011. The initiative has grown in popularity year on year with 238 people taking part in the event in 2014. Of those 238 participants 191 were women and 47 men. The initiative is open to everyone, with club members only accounting for 25% (n=60) of participants. Fitness classes are run 3 times a week for the duration culminating in a 5k charity fun run/walk. This year 755 people lined out to take part in this event. Whilst weight loss is not an emphasis of Operation TransFAUGHmation, there is an option to be weighed in each week for anyone who wishes to track their weight. The largest weight loss for men was 8lbs and 17lbs for women.

Twenty participants completed a questionnaire and 5 participants from the initiative, 2 male and 3 female took part in the focus group discussion. Although the average age of participants who completed the questionnaire was 39 years, the initiative involves people from 16 years of age right up to 70. The majority (75%) of respondents agreed that the initiative involved both club and community members and was well advertised with the most popular form of advertising being word of mouth. Two of the participants in the focus group also revealed '*...we are from a different club and we travel about 40 minutes to get here. And now we have got buddies'*.

#### *Changing Perception of the Club*

Three quarters of respondents said the initiative had very much changed their perception. The focus group found that participants were of the impression that '*the GAA club here seem very progressive and that fitness is on the agenda and they want to keep it going'*.

*'I think they are doing it to help other people. That is they type of people they are, they are always out there to help others they don't be thinking of themselves they really don't'. (Operation TransFAUGHmation participant)*

Participants were also impressed that the GAA clubs *'are leading by example anyway because you know no other clubs are doing it....I would love to hear of other counties taking it on it would be brilliant'* (Operation TransFAUGHmation participant).

From the outset, part of the clubs development plan aimed to get the club *'into the community'* and become more relevant within their membership. This objective has begun to be realised as the Healthy Club Committee have found that Operation TransFAUGHmation *'has established us firmly within the town'*.

#### *Impact of the Initiative*

Eighty percent (80%) of respondents rated the initiative as excellent, with 55% claiming the initiative increased their awareness around health. The focus group analysis found the initiative was a great way of exposing people to new exercises they mightn't have tried before *'like on the Friday night it could range from Irish dancing to kickboxing you know you try all different things that you would never do otherwise'* (Operation TransFAUGHmation participant).

The questionnaire also highlighted that compared to 12 weeks ago 45% of respondents think they are more active and 55% think they are much more active. The focus group backs this up with participants pointing out *'I couldn't run and now I can do the 5k like. As you said we have never run before and now like running not a bother'*. Questionnaire data also revealed there was a sense that the initiative was a building block to further participation in physical activity:

*'To be able to get to do longer marathons would be our aim. Doing a 5k, the next one will probably be 10k and keep moving up a bit'. (Operation TransFAUGHmation participant)*

The success of Operation TransFAUGHmation has also led to many spin off groups:

*'In January Jazza one of the instructors starts a 30 day challenge. So it is 30 minutes for 30 days for €30 and that money all goes to charity. And then it finishes in January and there is another 12 weeks programme which was a spin off from the walking club, it's called the Mucknomovers and they do 12 weeks of sort of running and walking and they finish with a pyjama 5k. And that brings us right back to September when we start all over again'.(Healthy Club Committee member)*

People also had personal goals and targets they wanted to achieve, identifying the initiative as *'something for yourself really'* (Operation TransFAUGHmation participant).

*'So I came that first year and I lost 29 pounds and maintained it. Then this year I've come back and I have lost 25 and a half pounds so far. Yeah I've 9 stone 10 and a half pound so far. I have gone down 3 dress sized since I started the programme this year'. (Operation TransFAUGHmation participant)*

*'I would never have even dreamt it only for Operation TransFAUGHmation, losing all the weight and they do they boost your confidence. They boost your self-esteem. I walk down the town now with my head held high'. (Operation TransFAUGHmation participant)*

The social aspect to the initiative was also a very important element for people.

*'You make loads of friends, it is a very very friendly environment. The craic is 90 all the time. This is my social outing...'. (Operation TransFAUGHmation participant)*

*'...we came up here and we didn't know anybody and now everybody knows our names'. (Operation TransFAUGHmation participant)*

*'You see them on the street and you wouldn't even know them so say hello to but now we are all friends on facebook'. (Operation TransFAUGHmation participant)*

#### **4.5.3.6 Cork Beats Stress**

The stress control programme 'Cork Beats Stress' consisted of a workshop one night a week for six weeks and was hosted by two HCP clubs in partnership. Facilitated by a qualified HSE psychologist, the programme equipped participants with the skills needed to cope with stress and provided participants with take home booklets on stress management. Over the six weeks the average nightly attendance was 161 people; 25% of programme participants were male. This initiative represented a relatively novel engagement in the HCP as the programme was designed and facilitated entirely by the HSE.

#### *Partnership Development*

As one of many urban areas that suffered heavily during the recession *'a lot of people are unemployed and stuff and mental well-being is hugely important'* (Healthy Club Committee member). For one of the host GAA club it was *'an opportunity and something that they could give to benefit the community so it made perfect sense for them'* (Healthy Club Committee member).

Realising there was a need to become more proactive in the community, the partnership with the HSE south actually came about by accident. Using signage on the club grounds to create awareness around the HCP, the Healthy Club Committee attracted the attention of a psychologist working within the HSE. *'Well I suppose I am from X myself and I was in X GAA club one day and I saw a sign about their healthy club so that is what kicked the whole thing off basically'* (Cork Beats Stress Facilitator).

From the HSE's perspective they also felt a need *'to try and think about how we deliver our services and try to come up with a new way of doing this'*.(Cork Beats Stress Facilitator)

*'we were finding basically was that we were waiting lists backed up out the door couldn't not enough staff to cope so we knew we needed kind of a new way of doing things'*.(Cork Beats Stress Facilitator)

Given the GAA's background and membership, the HSE also felt that partnering with such a trusted sporting organisation would help them to engage more with men, a group the HSE find difficult to access.

*'I suppose there is a massive male membership and we find it very hard to deliver our services in such a way that it allows men to engage with us'*. (Cork Beats Stress Facilitator)

The partnership therefore *'met a lot of the goals of the healthy club at the same time so both our goals were being meet we'll say by coming together'* (Cork Beats Stress Facilitator). Importantly, it was also the first time *'nationally or internationally as far as we are aware where like a public mental health service like a psychological intervention has been delivered through a major sporting organisation so that is something important like something new and it is something that's ground breaking'*.(Cork Beats Stress Facilitator)

Tackling any uncharted waters can bring numerous challenges given there is no template to follow and both organisations had to bear this in mind.

*'Yeah, well I suppose like anything kind of breaking new ground was kind of hard and we didn't have a master plan to follow, we didn't have a template that we could follow so we were kind of creating it as we went along'*. (Cork Beats Stress Facilitator)

### *Terms of Reference*

It was paramount that *'that the clinical accountability rested with the HSE'* (Cork Beats Stress Facilitator) while the GAA club managed the operational side of things.

*'So it was about the venue, providing venues, providing promotion, getting word out about it that was the key pieces I suppose for the GAA and the kind of organisational issues'. (Cork Beats Stress Facilitator)*

In terms of advertising the programme the Healthy Club Committee found *'word of mouth is nearly better that's what it's all about'*. The club, especially the club PRO, put a lot of effort into raising awareness of the programme. *'Our PRO put a lot of work into papering it, we got onto Red FM the local radio station, all those things.'* There was also an effort to engage high profile figures to launch the initiative and get some publicity through national media.

### *Changing Perceptions of the Club*

Not alone has the success of the programme given *'the profile of the GAA club in the community a huge boost...'* (Healthy Club Committee member) the programme also impacted upon local community members.

*'And I mean there were so many kind of stories of like afterwards like anecdotally in a way of like club members who benefited or local people who you know really benefited as a result'. (Healthy Club Committee member)*

The club were seen to be taking an interest in the community as a whole and showcasing that health promotion was an important part of the clubs culture alongside on the pitch activities.

*'It is great to be able to be seen that you're giving back something'. (Healthy Club Committee member)*

### *Impact of the Initiative*

There is still a stigma associated with mental health, and it can be difficult for people to engage with the topic. In this instance, the fact that the programme was backed by the GAA meant *'people had the confidence to go to it because it was linked to the GAA and I'd say if it was just a HSE run thing on its own they wouldn't be'* (Cork Beats Stress Facilitator). This sentiment was echoed by the HSE in their evaluation of the initiative, which revealed a number of key *'GAA factors'* relating to the model of service delivery. Firstly they found delivering the programme in a community setting backed by the local GAA club *'broke*



*down stigma for people so and a lot of that was to do with the GAA'. The fact the programme 'was local was massive, the fact that you know that people recognised other people from their own parish, from their own'. Finally the evaluation found 'that people assumed it was more geared towards men because it was being delivered to the GAA so we more than doubled our male our rate of male attendees'.*

Finally, actual behaviour change was evident as the HSE evaluation reported that *'not only did people's mental health improve, not only did rates of anxiety go down, rates of depression go down, stress go down, their perceived quality of life went up significantly'* (Cork Beats Stress Facilitator). Having a six week programme meant people got used to the routine of giving an hour or two up on Wednesday night, so upon completion of the programme, the club *'organised a walking group at the same time on a Wednesday night. People that were on the stress course were able to go walking for an hour or so on a Wednesday night'. (Healthy Club Committee member)*

#### **4.5.3.7 Anti-Bullying**

The community needs assessment carried out by this particular GAA club highlighted a demand for the issue of bullying to be addressed. Alongside developing and launching an anti-bullying policy, the club also ran an anti-bullying workshop 'GAA Tackling Bullying programme' for coaches and club officials. Local primary and secondary schools had previously held anti-bullying initiatives for parents and children so from a 'GAA perspective' the club decided *'we would tackle it from that side, mentors, coaches and anyone else that may be interested, the players etc.'*(Healthy Club Committee member) The workshop was facilitated by a qualified anti-bullying GAA tutor and aimed to create awareness among officials and empower them with skills and knowledge to effectively deal with an issue of bullying should one arise. A questionnaire was distributed and completed by all participants (n=21).

#### *Changing Perceptions of the Club*

Fourteen (n=14) participants commented the workshop had positively changed their perception of the club. Some participants chose not to answer this question justifying their

choice by generally commenting *'No it didn't change. The clubs attitude to health is fantastic'*.

*'No, it's brilliant but I am very proud even more now of it after tonight'*.(Anti-bullying participant)

*'Would have felt club had an excellent attitude to health'*.(Anti-bullying participant)

The club used the HCP to combine each of the four codes in their community. Accordingly, the anti-bullying initiative recruited participants from each playing code.

*'...we have 4 separate committees if you know what I mean there is a chairperson, secretary and treasurer to each of those but we are all X we are all the one club you know what I mean. So we put it that each of the four had to submit five people and a minimum of 5 people...'* (Healthy Club Committee member)

Overall, the club indicated that this approach *'worked well'* mainly because they had *'good people'* from each code. Previously there had been conflict between codes in the club but now with this project *'everybody is on board'* (Healthy Club Committee member).

### *Impact of the Initiative*

Data gathered from the questionnaire showed that of the 21 participants, nine were male and 12 were female, with 100% of attendees being full members of the club. The average age was 42 years and ranged from 23 years to 59 years. All the four sections of the club, hurling, football, camogie, and ladies football were represented at the workshop by either a club official (24%), coach (14%), parent (10%), player (5%), or those with a dual role (47%) e.g. a parent who also coaches. The club officials who attended included the football chairperson, camogie club development officer, club PRO, treasurer of the hurling club, minor football secretary and a member of the club executive, alongside a number of underage coaches.

The workshop was well advertised through the Healthy Club Committee with the majority (67%) of participants finding the initiative very useful. The Healthy Club Committee made a conscious effort to make sure *'everybody and every angle at least they are aware of it'* sighting *'Communication and advertising'* as key tools in generating this awareness (Healthy Club Committee member).

Respondents of the questionnaire rated the workshop as either excellent (n=11) or very good (n=10) and while all participants indicated that they at least moderately (n=3), if not a lot (n=7) or very much so (n=11) were equipped with the skills to deal with an issue of bullying should the situation arise. Again the majority (71%) of respondents agreed that the workshop had very much raised their awareness of bullying and increased their knowledge of anti-bullying (67%), with participants now clearly understanding the different types of bullying. The Healthy Club Committee additionally viewed the workshop as a success remarking *'I think it worked great you know it created a lot of awareness' with 'good reaction from the club'*.

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## Chapter 5 Discussion

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### Introduction

The aim of this study was to evaluate the potential of an Irish GAA sports club as a setting for health promotion. The settings approach to health promotion has previously been applied in a wide range of environments including communities, schools, and workplaces. The concept of a sports club as an additional setting for health promotion has recently emerged but little evidence exists on the effectiveness and practicality of this unit as a setting to promote health. The purpose of this research was to therefore assess the effect of the GAA Healthy Club Project (HCP) on key outcome markers including club policy, practice, ideology and environment, as well as examining the process of becoming a Healthy Club from the perspective of all stakeholders involved in the roll out of the project.

An evaluation of the health promotion activities of any Irish sports club is unique with no prior frame of reference established. This underpins the significance of this study's findings in filling a gap in the existing literature. This study profiled the health promotion status of Irish GAA clubs and identified the potential of the sports club to promote health within their membership and the wider community. In addition, the process of how clubs developed their Healthy Club ethos was documented enhancing the understanding of the support structures required and the challenges faced by clubs. The findings from this study therefore have the potential to make an important contribution towards informing sports club oriented health promotion interventions more generally.

This chapter will summarise the key findings which emerged during the study. In order to effectively answer the research questions put forward both quantitative and qualitative themes will be discussed. These will be argued under the following four headings;

- 1) The potential of the GAA club as a setting for health promotion;
- 2) The development of a Healthy Club;
- 3) Partnerships in the HCP;

4) Perceived effect of the HCP (as self-report data were collected in this study, it is only the perceived effect of the HCP that can be ascertained).

As outlined in the previous chapter, 12 community based GAA clubs provided baseline and follow up HCQ data, a retention rate of 75%. Following Phase I of the HCP, data showed a progression in clubs from being moderately health promoting to high health promoting. No clubs were considered low health promoting at follow up compared to 25% (n=3) at baseline. Clubs also improved their scores across the policy, practice, environment and juvenile (u18) coaching environment sub-indices, contained within the Healthy Club Questionnaire health promoting index. Ideology was the only exception which saw a non-significant decrease but remained the highest scoring of the indices. Policy scored lowest of all the indices.

Results of the focus groups showed that participation in the HCP reflected the sense of responsibility clubs feel towards their community, while also allowing clubs to remain relevant and attractive sporting and social settings at a local level. The process of developing a Healthy Club was optimised when club support was forthcoming, idea generation was organic and relevant, clubs had a HCP support network and through the recruitment of a large number of diverse individuals, with useful skill sets to the project team. Community links and partnerships with local service providers are also fundamental to the HCP. Challenges generally related to funding sources, the extra workload the HCP created, and the ability to attract new members to the Healthy Club Committee who are willing to dedicate their time and expertise to the HCP.

In total, clubs (n=16) planned 72 different initiatives across a wide variety of topic areas (physical activity, diet/nutrition, health awareness, emotional well-being, social inclusion, anti-bullying, smoking/alcohol). These initiatives were intended to address the community health concerns as expressed in the community needs assessment. What was revealed from the evaluation was that these initiatives simultaneously benefited the club by improving accessibility and offering a gateway into club activities for people not typically involved in the sporting side of a GAA club. This is important if health promotion is to benefit whole communities as the club setting offers access to parents, families, and friends, similar to schools (World Health Organisation, 1999). It was also very apparent that

initiatives had a positive effect on the participants' perception of the club and again indicated the value of partnering with public health agencies.

## **1) The potential of the GAA club as a setting for health promotion**

Traditionally sport is associated with positive health related behaviours, with the physical activity aspect of a sports club acting as a driver to get people initially involved in the club activities (Koski, 2008). At a national level, figures for those involved in sport in Ireland have been on the increase. The Irish Sports Council (2011; 2013) reported that 34% of the adult population participated in sport in 2009, rising to 47.2% by 2013. The proportion of children involved in sports, external to school activities is also substantial at 83% for 10-12 year olds and 69% for 12-18 year olds (Woods et al., 2010). Most recently, the Irish Sports Council (2013) stated that 75% of 16-19 year olds participated in sport. A person's health and wellbeing already has the potential to be positively influenced through sport clubs, as the physical activity inherent in sport contributes to the prevention and reduction of diseases associated with inactivity and obesity, and can also positively impact on social and emotional wellbeing (World Health Organisation, 2011). Despite this, it has been extensively reported that internationally many children and adults fail to meet the recommended physical activity guidelines and Ireland is no exception (Herbert et al., 2015, Morgan et al., 2008; Woods et al., 2010). Only 41% of Irish adults do moderate or vigorous physical activity for at least 20 minutes three or more times a week, while 1 in 5 people in Ireland are considered physically inactive (Morgan et al., 2008, Khan et al. 2012, World Health Organisation, 2011). Woods et al. (2010) established that less than 20% of Irish 10-18 year olds met the physical activity recommendations, a figure which has been stagnant since 2004. Organised leisure time sport has been presented as a viable opportunity to increase the likelihood of young people meeting physical activity guidelines to contribute to overall health enhancing levels of physical activity (Marques et al., 2005, Herbert et al., 2015, Eime et al., 2015). Studies have also shown that participation in sport contributes to health enhancing physical activity. It is clear that in an Irish context, sports participation does not always equate to sufficient engagement in physical activity, thus sports clubs

must be mobilised to play their role in increasing physical activity across various population groups.

In addition, as Geidne et al. (2013) allude, given the popularity of sport there is the potential for societal intervention on the broader concept of health. In this study, it was apparent that non-playing members make up 30% of the total membership in a club, thus social involvement in sport is evidently not limited to the length of one's playing career. Similarly, coaching and administration roles are not defined by age. Therefore, sports clubs have the potential to influence physical activity and general health in both playing and non-playing members. The average membership across the 12 participating GAA clubs in this research was 654 per club. Thus, the reach of community based sports clubs such as the GAA is significant and clubs are important targets for health promotion campaigns. The supplementary health promoting potential of sports clubs is vast if these efforts can be supported by policies, practices and environmental change where a culture of health enhancing behaviour can be generated and sustained (Jackson et al., 2005).

To reach an extensive level of health promotion across the board there are many areas for clubs to improve upon, which is being supported in this instance by the GAA through the implementation of a systematic and comprehensive health promotion intervention within its club structure. At the outset of the HCP, it was encouraging that clubs had an existing orientation towards health promotion; baseline analysis showed that in general the majority of clubs were operating at a moderate level in relation to health promotion, although scores did vary greatly. Only 19% of clubs were considered low health promoting with the remaining 31% deemed to already be functioning in a high health promotion capacity. Kokko et al. (2009) in their baseline analysis of the health promotion status of Finnish youth sports clubs likewise found clubs were on average moderately health promoting. Interestingly, Meganck et al. (2014) found sports clubs in Belgium did not score well on the health promotion index with three in five clubs categorised as low health promoting with only 18% of clubs making the high health promoting grade.

In relation to the different sub-indices of health promotion assessed in the health promoting index, clubs scored strongest for ideology and philosophy, similar to Kokko et al.

(2009) and Meganck et al., (2014), specifically for the Respect and Go Games principles which are already inherent in the GAA. Performance was weakest in terms of club policy for health promotion and the formal acknowledgement of health promotion in the club constitution and regulations. It is fair to say that the standards relating to health promotion policies consisted of some new and demanding concepts. For example, the lowest recognised standard at baseline (0.23, 0.27) was 'Health and wellbeing ideals are written in the club's constitution and regulations' and 'The clubs regulations contain a written section on wellbeing and/or health promotion/ health education/ healthy lifestyles'. Wellbeing/health promotion/health education/healthy lifestyles have never being previously advocated by the GAA as an obligatory section in a clubs constitution so it is understandable that clubs would score poorly on these standards at baseline. On average, clubs again scored moderately when it came to the practice, environment and juvenile (U/18) coaching environment standards in the health promotion index. Good scoring for a safe physical environment and a smoke and alcohol free juvenile environment reflects the success of mandatory action in these areas, such as the Alcohol and Substance Abuse Prevention programme (ASAP) and GAA Health and Safety Policy which is governed at national level by the GAA and complemented by 2004 Irish legislation which banned smoking in the workplace and in enclosed public spaces. Clubs acknowledged the importance of a smoke free environment with one club embarking on a policy and environment oriented initiative in this area. Low scores for a focus on success at underage are positive and reflect the clubs' commitment to the GAA Go Games initiative and the 'every child gets a game' philosophy. Kokko et al. (2009) similarly found that ideology received the highest mean score followed by environment. Again the average policy and practice scores for youth sports clubs in Finland were below the midpoint of the scale.

The fact that all clubs self-selected to take part in the HCP reflects that engagement in the initiative was a natural progression of work already underway in their clubs and that the project reflected the sense of community responsibility inherent in clubs to address the health and societal concerns of the club and extended community. Club members spend a large amount of their time engaged in club activities be it playing, coaching, administration duties, ground keeping or socialising; therefore in the spirit reciprocity, there is a need for



the club to play its part in supporting its membership to the best of its ability. This type of social responsibility felt by clubs was reflected in the amount and variety of health topics previously addressed by clubs. Clubs also had some experience with the GAA's Alcohol and Substance Abuse Prevention (ASAP) programme and were looking for ways of progressing this work so that it could be expanded into a more holistic health promotion model. With 72 initiatives planned over the course of phase one, clubs evidently used the HCP to expand and progress this work. While grounded in competitive sport the HCP was seen as a way of showcasing what clubs can offer to the community in addition to on the pitch activities. Other clubs remarked on the potential for growth and improved playing performance that could be associated with health promotion activity. In Australia, the majority (97.2%) of Executive Officers for Australian State Sporting Assemblies felt the creation of a supportive environment would facilitate increased membership alongside the traditional lure of sports competition (Eime et al., 2007). However it was the conversion from awareness to actual club based behaviour change where community sports clubs struggled as there was no well-structured process established to guide clubs (Eime et al., 2008). It is in translating awareness to action that clubs need to be supported.

Having previously been a somewhat ad hoc activity the structure, guidance and framework brought by the HCP was welcomed by clubs. Enthused and impassioned by the concept of promoting health more broadly in their club, clubs were initially uncertain as to exactly how the HCP would unfold. This was compounded by the fact that up until now the priority focus of the GAA clubs was on performance and results. The GAA is the largest sporting organisation in Ireland and is steeped in tradition in most parishes throughout the country. To engage the wider "non GAA" community clubs, focus groups with Healthy Club Committee representatives revealed they had to work hard to try and dispel the myth that GAA clubs only existed to serve athletic needs. Involvement in the HCP itself helped to show that clubs were being progressive when it came to matters of health and wellbeing. Awareness that clubs were valuing health promotion was created through this association and felt both locally and also internally by club members. Using the community needs assessment to guide activities was beneficial here, in that initiatives reflected the health needs of the community and encouraged the GAA and non-GAA communities to connect.

It should be noted that all coaches, staff and management in GAA clubs work in a voluntary capacity where the core business primarily revolves around sports competition. Similar to findings reported by Dobbinson et al. (2006) on Australian sports clubs, some health promotion policies are in place and being recognised by GAA clubs, however this varies between clubs possibly due to the voluntary context. Interestingly, club size or geographical location did not have an influence on the prevalence of health promotion activity or on the changes over time, suggesting the diversity between clubs had less to do with the club's background and more to do with the devotion of volunteers who drive the HCP on the ground. With some small clubs reaching the highest health promotion level similar to what Kokko (2010) found in Finland, health promotion activity is not determined by size but is a question of the will and commitment of the club volunteers and its executive.

The concept of 'setting' is fundamental to health promotion (Kokko et al., 2013). The sports club as a setting for health is a novel concept, and while the evidence at this early stage is still tentative there are many similarities between it and other well established and well-studied settings. For example, one of the features of settings based health promotion is the focus on environmental factors and organisation change (Kokko et al., 2013). The HCP likewise, focused not just on the individual but rather on making the sports club surroundings conducive to encouraging healthy behaviours supported by club management and directed at a national level. The HCP implementation framework emphasises the environment and governance along with partnerships and programmes. In a move to provide direct support for clubs in Australia, the Healthy Sporting Environments Demonstration Project (HSEDP), supported by VicHealth, led to positive steps in relation to institutional change and actual delivery of health promotion (Nicholson et al., 2013). To this end, GAA clubs are required to have an Executive committee to oversee the running of a club with the remit to introduce policies and practices to support healthy behaviours. At baseline the majority of clubs had not taken the initiative themselves to introduce a formal health promotion policy suggesting a need for guidance and direction at a national level. In the interim, the leadership and investment offered by the GAA, in partnership with a state agency for health has been hugely commendable, through the funding and roll out of the

HCP but also through the mandatory establishment of a Health and Wellbeing Officer in all grassroots clubs.

Kokko and colleagues presented a conceptual framework for health promoting sports clubs (HPSC), identifying layers of activity at the macro, meso and micro level; from the policy and orientation of a club to, support for, and action around health promotion in daily club operations (Kokko et al., 2013). A governance model to support this is now being generated in the GAA. Literature has also noted the unique opportunities associated with adopting health promotion in a sports club setting. Kokko et al. (2006) describe how a sports club does not only interact with players, but also their families, supporters and of course spectators. This study clearly demonstrates the opportunity to deliver health promotion more broadly, given that 30% of a GAA clubs total membership is made up of non-playing members. In addition, the informal education setting provided by sports clubs allows health enhancing behaviours to be fostered, as children and adolescents voluntarily participate in club activities unlike a school setting for example. Additionally, Poland, Green et al. (2000) express that appropriate settings for youth health promotion reflect both the places and people youth spend a significant amount of time and who can influence them e.g. sports coaches. While GAA clubs did struggle with aspects of policy and practice at baseline, they have previously shown positive regulation in relation to alcohol and smoking behaviour indicating the potential to further extend this remit. Hunt et al. (2013) realised sports clubs present 'highly valued and unthreatening' locations in which to target population groups such as male sports fans which can be otherwise hard to access. As experienced by the FFIT programme in Scotland, a sports club setting may also help to reduce cultural stigmas around attending health interventions (in their case weight management support) and provide an opportunity for people with a common interest in sport to meet (Wyke et al., 2015). The GAA is one of the most trusted organisations in Irish society and has access to up to half a million members across the country (Gaelic Athletic Association, no date). During the focus groups, partners revealed that delivering a programme backed by the local GAA club was instrumental in breaking down stigmas and encouraging a larger cross section of society to attend, particularly men. The GAA club therefore presents a very real and immediate opportunity to promote a culture of health

promotion supported through policy, and to access sections of the population who maybe otherwise difficult to reach.

In summary, taking the baseline findings of this study into consideration, Irish GAA clubs can on average be considered moderately health promoting but there is room for much development when it comes to comprehensively integrating health promotion into the daily activities of a sports club. Taking a targeted, supported, and systematic approach can help clubs to fulfil their health promotion potential.

## **2) The development of a Healthy Club**

The initial stages of becoming a Healthy Club were characterised by the development of a Healthy Club Committee, gaining executive support for the concept of health promotion in a sports club, accessing national and regional assistance from the GAA and other participating clubs, extending the reach of the project into the community, carrying out a community needs analysis and generating finance. In order to create healthy sporting environments Nicholson et al. (2013) found several factors come into play, remarking that the capability of a sports club to redirect motivations was heavily dependent on the commitment of the volunteers involved. In a voluntary organisation such as the GAA, it can be difficult at times to attract people on new committees, be they new faces or existing club members. All participating GAA clubs were required to set up a Healthy Club Committee. The size of Healthy Club Committees varied considerably and it was not unusual for the work to fall back onto a small cohort of individuals. An overreliance on the same people caused burnout in some instances; therefore if clubs are to help address community health needs, all sections of the club and community should have a representative on the Healthy Club Committee.

To capitalise on the HCP, volunteers must be supported by management and a strong governance structure (Nicholson et al., 2013). Leaders need to embrace change and view it as a whole club project rather than just an offshoot taken on by a small subset of members. If leaders remain separate to the operations of a project such as the HCP, any progress made will only be superficial and not sustainable (Amis et al., 2004). The focus group discussions revealed that support of the Executive committee was central to the roll out of

the HCP. This was achieved in most, but not all clubs, by having an Executive member sitting on the Healthy Club Committee. Having the backing of the Executive meant the healthy club committee appeared in club reports and on the agenda for club AGM's and helped to give the project credibility among other club members. Clubs in some instances however, felt there was a lack of recognition received from their club Executive committees.

The fact that the HCP was a 'real world' project meant there was a need to have an element of participatory action research within the HCP. As the project was also a pilot scheme, it was important to involve all stakeholders and evaluate each step of the process to inform best practice. It is particularly useful in this context as the objectives of the HCP all relate to supporting, encouraging and facilitating clubs in the development of a Healthy Club. This approach meant that clubs would receive guidance on best practice at all stages of the development of their Healthy Club. For example, to rectify the lack of recognition being received for clubs' Executive committees, the GAA's Community and Health Team met with club Executives to support and properly educate the Executive committees as to the purpose and potential benefits of encouraging healthy behaviours within their clubs. The feedback from clubs was that these discussions between the club Executives and the GAA Community and Health Team made a significant difference in helping the change the mind-set of some administrators. This type of visible input from the GAA, which aligned the HCP with ideals of the organisation, helped the project to gain far more credibility than if it was just the Healthy Club Committee pushing the idea.

As Dooris (2004) explains, to ensure policies and actions are given the best chance of success in any setting they need to reflect the organisations core values; in the GAA's case, amateurism, inclusion, community identity, and sporting performance. While there is limited evaluation in a sports club setting, greater institutionalisation has been found in community based health promotion programmes and workplace interventions whose current organisational interests match the goals of the health promotion programme (Casey et al., 2008, Weisbrod et al., 1992). For the long term future of the HCP, the Healthy Club Committee needs to be integrated into the overall structure of the club and this can only happen if the Executive are fully committed to the goals of this project. As Kokko et al. (2011) point out, a health promoting sports club is one that recognises health as one of the

main operating philosophies. Education, communication and the inclusion of all club stakeholders are therefore critical to the sustainability of the project. Nicholson et al. (2013) found clubs in the HSEDP faced similar challenges around getting recognition. Establishing whole club support at the inception of the project may have helped to alleviate this problem and allowed it develop more so as a core activity of the club. Referring to the school setting Steward-Brown (2006) similarly expressed that approaches involving the entire school were the most effective. In their experience with workplace health promotion initiatives, both Chu et al. (2013) and Jorgensen et al. (2013) refer to the support of senior management as being an essential factor in the success of health promotion projects from both a pragmatic and a symbolic perspective. In order to “sell” the HCP concept to Executive members and community partners, the Healthy Club Committees had to fully understand the project themselves. On occasion, clubs struggled with the scope and the seemingly endless possibilities of the project. It is worth noting therefore that serious thought is necessary when considering how best to implement the HCP in each individual club.

From the perspective of the clubs, one major factor that helped to keep motivation high and ideas flowing was regularly meeting with other HCP clubs. It was in these operational group meetings, that clubs could discuss their challenges, share their experiences, and identify opportunities with the people who shared their journey. Clubs felt it was in these meetings their most productive work was done and stressed that they would like to see a continuation of these operational group meetings so as to not miss out on the invaluable learning which take place during these types of discussions. In order to be sustainable in the long term, it is essential that clubs develop the skills to become somewhat self-sufficient and regional group meetings offer clubs a platform to share skills and knowledge. As Kegler et al. (1998) point out, a fundamentally weak structure will struggle to cope once higher level support diminishes. It is important that the participating HCP clubs do not become too complacent or reliant on the higher level support from GAA headquarters as this support is likely to reduce if the project is rolled out further. Peer support is therefore a much healthier and more sustainable alternative. Peer support offers a chance to share local knowledge and experiences that may be absent from national organisations particularly when it comes to aspects like practicality and social and emotional assistance

(Boothroyd and Fisher, 2010). Support from national bodies should in no way be disregarded, with peer support complementing and enhancing that work while helping to avoid an over-reliance on high level structures whose support will justifiably lessen in time.

Another feature of the HCP research approach was the omission of predefined standards or target areas that all clubs were expected to adhere to. This is in contrast to other programmes such as the HSEDP in Australia which prescribed six standards for community sports clubs to focus on (healthy eating, responsible use of alcohol, reduced tobacco use, sun protection, injury prevention, safe and inclusive environment), the Good Sports programme with guided clubs on responsible alcohol management practices, or FFIT which looked solely at physical activity in the sports club setting. In the HCP, clubs were guided by the needs of their individual communities. The North Karelia project highlighted the importance of organic ideas whereby the unique needs of a particular setting are best addressed using local resources (Puska et al., 1985). What this translates is the idea of community based initiatives prospering when they involved the community they aim to serve. In other words, health promotion programmes should be comprehensive, participatory and empowering and should strive for capacity building (World Health Organisation, 1999).

The community needs analysis used in the HCP aimed to identify priority action areas specific to their own communities. The most commonly identified priority area was smoking, followed by social inclusion and emotional wellbeing. The lowest rated areas were physical activity and diet/nutrition. When clubs were asked in the baseline HCQ to indicate the areas they had previously provided information on, three of the four most commonly recorded areas included physical activity, diet/nutrition, and injury prevention but none of the top four actions areas which were identified in the community needs assessment. This is an understandable finding given that physical activity is at the heart of every sports clubs. It is therefore an area sports clubs may be most comfortable addressing and most equipped to facilitate. Diet/nutrition and injury prevention are also an important component of competitive sport contributing to performance and so it is not surprising these topics had been previously well provided for by clubs. Issues where clubs felt they lacked the skillset to promote themselves and had less to do with sports performance and on the pitch activities were covered less. Even though physical activity was still the most

common area for clubs to tackle during phase one of the HCP, there was a clear acknowledgement of the need to take a more holistic approach when it comes to promoting health, with clubs now targeting areas such as emotional wellbeing and anti-bullying in their action plans reflecting the needs of their community. It has been reported that one in six young people in Ireland struggle with their mental health (Cannon et al., 2013). With this in mind, Eime et al. (2010) suggests that compared to undertaking leisure time activities or other types of physical activity, participation in sport stimulates and enhances better mental health in youth due to the positive exchanges and connections with peers and adults in the club setting.

It is natural that clubs would face some challenges given this was most probably their first attempt at formalising their health promotion activity. The most notable challenge experienced by clubs in the initiative was the recruitment of people to assist with the administration and delivery of the project, which was related to concerns about the burden of work on committee members, the level of administration involved, and the subsequent sustainability of the project, which is typical of settings based health promotion. Getting support for the project was not a difficult task, however getting people to devote time to the project prove more problematic and is a source of concern for clubs going forward. Allied to this the paperwork and reports associated with the HCP were seen to place an extra workload on the Healthy Club Committee, again reaffirming the need to have an active team-orientated committee. As demonstrated by one of the dropout clubs, the problems arose when all the work was falling back onto one person, reiterating the need to share the workload, something also witnessed in the HSEDP (Nicholson et al., 2013). Given that 91% of clubs agreed with the statement 'there will be support for this project if it continues', clubs' fears around the future of the project are not concerned with support so much as the actual commitment of time, resources and effort needed to continue with the project. As demonstrated by the HSEDP there is no quick fix to a challenge such as this but the fact that support exists for the project, albeit only superficial for now, is a positive and may help turn to tangible support in time (Nicholson et al., 2013).

It is important to note that the initiative evaluations presented in this study indicated that the successful delivery of programmes did manage to attract new faces, changed many individuals' perception of their local GAA club for the better, and offered a gateway for



greater involvement in this element of club activities. Rowland et al., (2014) suggests that effective alcohol management programmes contribute to how safe people feel in a sports club setting and subsequently the extent to which they participate in that setting. In a case study of one HSDEP club, it was clearly evident that embracing health promotion activities led to an enhanced reputation and profile within the community (VicHealth, 2013). In a bid to ensure health promotion is open and accessible to all, clubs have tried to run their initiatives at little or no cost to the participants. Without sufficient financial resources, clubs feel limited in the health promotion activities they can offer. In the HSEDP evaluation 74% of participating clubs indicated that financial incentives were a key factor in joining the project (Nicholson et al., 2013). Wealthier clubs were more likely to suggest the financial incentive was less of an influencing factor. The HCP had no directly available financial incentives or support linked to the project. Grant aid and funding from the club Executive may be short term solutions but as grants must be applied for each year, if an application is unsuccessful the club Executive may not have the resources available to finance projects and health promotion may become stagnant and seen as unsustainable. The VicHealth Participation in Community Sport and Active Recreation (PICSAR) evaluation points towards an underestimation of human and financial resources as characteristics often linked to projects that have the greatest difficulty engaging their community (Smith et al., 2011).

To conclude, the development of health promotion activity among GAA clubs is based on the formation of a proactive Healthy Club Committee which is equipped with the expertise, personnel and local insight to generate and run relevant health initiatives. The club executive needs to recognise and support the Healthy Club Committee and include health into the daily business of club activities. Inchley et al. (2006) view the integration of initiatives into the on-going life of a setting as crucial in the sustainability of a health promotion programme. One way of helping to ensure this, is to have a representative of the executive committee as a member within the Healthy Club Committee. Guidance and direction from the national governing body are necessary to get the ball rolling when initiating health promotion activity. However, it is peer support which will allow clubs to sustain and become self-sufficient in health promotion from the grass roots up.

### **3) Partnerships in the HCP**

Partnerships were a key pillar of the GAA Healthy Club implementation framework and their importance is affirmed in both the WHO Jakarta Declaration (1997) and the Bangkok Charter for Health promotion (2005). Partnerships are a key principle for health promotion initiatives if knowledge and skills are to be combined effectively (Harden et al., 1999). It was never assumed that clubs would be the sole providers of health promotion activity in a community but rather that they would link with specialist service providers to support the delivery of a range of health initiatives. The concept of partnerships is one which has most definitely evolved over the course of phase one of the HCP. At the beginning clubs didn't see the value in spending time establishing these more formal links. This was also hampered by the fact that clubs had little knowledge of how best to identify or approach potential partners. The process of formalising a partnership was seen as an extra piece of work and was unfamiliar territory for most clubs. Clubs were so enthusiastic about the HCP that they wanted to begin work and as a result, the value a partner could add was sometimes disregarded. As the HCP progressed however, clubs realised that in order for the HCP to be sustainable a symbiotic relationship with local partners was necessary. Smaller local level partnerships were most valued by clubs, as linking with national level agencies was seen to add an extra layer of complexity. This is a view supported by Kegler et al. (1998) who agrees partnerships benefit more from local knowledge than being dependant on staff higher up the chain.

Interviews conducted with a selection of external partners involved in the roll out of club initiatives, likewise highlighted the lack of a template to follow. For partners, it was important to have roles and responsibilities clearly defined and communicated. All partners acknowledged that linking with GAA clubs presented a gateway into Irish society which otherwise would have been difficult to reach, echoing Smith et al. (2011) where it was agreed that sports and recreation organisations are unrivalled when it comes to accessing wider population groups. In this respect the relationship between GAA clubs and their partners proved to be mutually beneficial and well worth the extra effort. The experience of GAA clubs is not dissimilar to that of sports clubs in Australia involved in the PISCAR programme which found successful partnership possessed common traits including a good

working relationship, a clear purpose, effective communication, shared resources and was mutually beneficial (Smith et al., 2011).

The HCQ data revealed that the most popular partnership for the participating GAA clubs was, unsurprisingly, that with other GAA codes. Engagement with partners across the board, in particular with players and health professionals, improved following clubs involvement in phase one of the HCP. Engagement with parents remained lowest however at 25%. Although all sections saw an increase, there is much room for further improvement when it comes to targeting specific populations like older adults, minority groups and indeed parents, coaches and players. As indicated in the initiative evaluations, having a child taking part in a club is an important gateway to club involvement for parents. This suggests that clubs need to actively engage with parents to recruit more members from this diverse base that likely contains a variety of useful, desired skill sets that could support club activities, particularly given the challenge several clubs reported in relation to recruiting support for the delivery of the HCP. Clubs also engaged well with local schools and the general community and did acknowledge the importance of partnerships in a GAA context. However, the formalisation, manifestation and process of partnerships were less clear and unsurprisingly, transpired to be a challenge for many clubs taking part in the HCP.

The initiative evaluations highlighted that clubs often looked to the community when it came to establishing a target group for their health promotion activities. Again this was in a bid to remain relevant in the community, to be seen to be proactive and keeping ahead of the competition when it came to wellbeing, and hopefully to attract new members, with 90% of initiatives not exclusive to either club or community but incorporated both parties. Servicing the wider community is an important part of the HCP, however it would be remiss to overlook the club members, especially players, given they are the cornerstone of a club's sporting activity, and sport and physical activity are important draws into the sport club setting for many people. The majority (n=69) of initiatives combined the delivery of a programme with some level of partnership with a relevant local or national entity such as the HSE, LSP, Foróige and local health professionals. Some targeted and tailored initiatives may be required to engage disadvantaged groups, where clubs may need to work specifically with partners who have access to and an understanding of the target group as

they are better equipped with the skills and knowledge needed to enable these groups to participate in health promotion programmes (Smith et al. 2011).

In summary, the most fundamental and important partnership is between the GAA club and the community and is prevalent throughout this evaluation; the healthy club concept can, will and already has forged and strengthened new and existing partnerships with the community. Beyond this, there is still a lack of clarity about how to formalise and manage partnerships, particularly with national sport and health agencies.

#### **4) Perceived effect of the HCP**

Over the duration of phase one of the HCP, clubs improved upon their baseline health promotion score, moving from being on average moderately health promoting to high health promoting. At follow up, no clubs were considered to be low health promoting with all clubs categorised as either moderate (n=6) or high (n=6) health promoting. No clubs reached the maximum score of 34.00 but increases were seen across all the health promotion sub-indices with the exception of the ideology index. Having improved significantly from baseline, policy still remained the weakest indicator of health promotion activity. While clubs improved by the end of phase one, making amendments or additions to a club's constitution may have been a bureaucratic challenge for some clubs, needing backing and ratification from the club Executive, and so the sanction of policies may have suffered. As Kokko (2010) found in their analysis using the same instrument, the ideologies section contained two well-known standards and the environment contains seven relatively well-known and pre-existing items, whereas the policy index consisted of lesser known activities. The policy index in their study contained some of the lowest scoring individual standards suggesting the need in Finland and Ireland for health promotion oriented policies. Not only did this section score lowest on the health promotion index, very few policy related initiatives were outlined in action plans. Governance, which encompasses policy, was considered in only 10% (n=7) of initiatives provided by clubs. They included four initiatives, which combined governance and environment, and three initiatives that covered all four elements of the Healthy Club framework (governance, environment, programmes and partnerships). In most cases the environment

acknowledged refers to the sociocultural environment as opposed to the physical or built environment.

The environment element of health promotion index was good for the physical environment (playing facilities), which along with funding challenges may explain the lack of subsequent action planned by clubs in this context. Similarly, few clubs planned to specifically address the coaching environment, which was an aspect of health promotion that clubs scored weakest on. Sport Scotland, the national agency for sport in Scotland, highlights the importance of engaging with coaches if a positive environment is to be created for youth and during the 2014/2015 year invested £786,000 in the development and delivery of coaching programmes (Sport Scotland, 2015). The European PAPA (Promoting Adolescent Physical Activity) project also focuses on the importance of the coaching environment in creating an empowering climate leading to improved health and wellbeing (PAPA, 2015). Beyond Go Games and the 'every child gets a game philosophy' health promotion did not appear to be embedded in the coaching environment. Engagement with coaches and parents and the provision of a healthy coaching environment such as healthy food options after sporting activities and health promotion beyond sports performance persisted to be less well-established indicators of health promotion in participating clubs. Young et al. (2013) recognised that teachers needed to embody a strong sense of ownership in order to introduce change and sustain reform in a school setting. Likewise it is crucial that authority figures such as coaches, who are role models and influencers for youth in a sports club setting, embed healthy practices into the coaching environment if there is to be a positive change in club culture. The social and cultural environment was much better addressed as the local community was fundamental to, and appeared to underpin the initial roll out of the HCP.

Finally, there was a significant increase in the practice index between baseline and follow up, although clubs on average did not progress out of the moderate category. Kokko (2010) found that standards relating to practices were less recognised and felt this may have been due to lack of underlying policies in the first instance. Similarly in the HCP, clubs struggled in the policy section and this may have had a knock on effect in limiting the amount of progress that could be achieved in relation to practices. If clubs do not have guiding policies in place, the practices which should be outlined in those documents cannot therefore exist

and cannot be implemented. This means that the standards regarding practice, comprised of activities which were less well established in clubs. If there has not been a culture previously created which supports this type of activity, it is understandable that clubs would struggle with such requirements over the duration of phase one of the HCP. The successful formation of health promoting schools, as indicated by Young et al. (2013), hinged on the creation of policies and the enforcement of supporting practices.

In order to achieve a high impact rating, clubs needed to include all four elements of the Healthy Club framework in their initiative delivery. Given governance was often omitted it is not surprising that only three initiatives attained a high impact rating; these were achieved in the areas of anti-bullying, anti-smoking and alcohol awareness. According to the impact rating scale, physical activity had the greatest proportion of low impact initiatives compared to any other health topic. This was typically due to the fact that clubs did not involve partners or governance structures in their physical activity interventions, as clubs possibly felt most proficient in this area themselves. There is a current lack of evidence surrounding the effectiveness of health promotion interventions delivered through sports clubs. A recent review of literature looking at health promotion in sports clubs and behaviour change fails to identify any studies which actually guide the use of policy interventions used in sporting settings (Priest et al., 2008). It is unsurprising then, that Kingsland et al. (2015) report that sports clubs continually fail to comprehensively or consistently implement evidence based practices, or that Finch et al. (2012) found scientific based injury prevention is not translated into coaching sessions although coaches seem aware of the benefits. Casey et al. (2012) reported increased organisational capacity among national sporting bodies, and good evidence for policy and practice at national level, but this was not always translated to club activity.

While overall behaviour change was not captured rigorously in this project, there were several positive outcomes from the various case studies of initiatives carried out by clubs. Policy based interventions, while very much underutilised by HCP clubs, can be beneficial. During the HCP, an initiative evaluation was carried out with one club who successfully implemented an anti-smoking policy on their club grounds. Over 80% of smokers were in agreement that the anti-smoking policy had had a positive effect on their smoking

behaviour at the clubs ground but also in general circumstances. Levels of awareness, and smoking behaviour were considerably impacted by the introduction of an anti-smoking policy. Respondents stated their perceptions of their club's attitude towards health had changed for the better. All of the initiatives evaluated contributed to increasing participants' knowledge, awareness, and skills around health and wellbeing, which manifested in practical ways, helping to improve the quality of people's lives. One initiative resulted in participants feeling more confident in their healthy cooking skills and application of these skills at home. Participants from the anti-bullying initiative felt they now had the skills to effectively deal with an instance of bullying should it arise. The FFIT programme, which focused on physical activity, reported significant reductions in weight and improved healthy living behaviours in the intervention group compared to the control group (Hunt et al., 2013). With no control group in the present study the internal validity is weakened.

As Crundall (2010) and Kingsland et al. (2015) demonstrated with the Good Sports program, improved management strategies, in their case concerning alcohol, can lead to benefits beyond positive behaviour change such as improved perceptions of the club - the club more likely to be viewed as family friendly and welcoming - and can ultimately lead to increased club sustainability through increased membership and overall involvement. A sports club such as the GAA can only survive as long as it generates the revenue to do so. At follow up, clubs reported a 35% increase in total membership, accounted for by an average increase of 61 playing members and 78 non-playing members. This was also supported in focus group discussions where themes such as new faces, new perceptions of the clubs, and increased support for club activities all emerged. Some participants spoke of how they had joined in more club social activities and were more likely to support club fundraising efforts. In addition to resonating internally with participants, there are also visible examples of positive health impacts referred to by representatives of the Healthy Club committees in many counties, including increased activity levels, weight management, and a reduction in harmful behaviours such as smoking. In the follow up HCQ, seven of the 12 HCP clubs also agreed that 'more people are joining/becoming involved in club activities.' Health promotion initiatives in sports clubs may therefore help club sustainability through encouraging membership from those who may not necessarily be

looking for a competitive outlet but rather alternative ways of engaging in physical activity (Casey et al. 2009a).

Similar to the HCP, the HSEDP showed clubs had made significant progress across each of its six standards, excluding the responsible use of alcohol standard which saw an insignificant increase (Nicholson et al. 2013). A major finding from the HSEDP was that this progress at an organisational level had not yet been reflected in members' behaviours or attitudes. Behaviour change was not captured in the scope of this study, so while improvements in health promotion activity are very much desirable, it cannot be assumed that the improvements in orientation of GAA clubs towards health have led to changes in behaviours among its membership. When Healthy Club Committee members took part in a focus groups at the end of phase one of the HCP, they were asked what three words they would most associate with their experience of the project. The overriding response was that the HCP had enabled clubs, to reconnect with the community, establish new links within the community and welcome new faces into the club. A similarly encouraging impact was also observed by HSEDP clubs who when surveyed, identified the words positive and support most often when reflecting on their experience (Nicholson et al. 2013). The HCP was also characterised by words such as enjoyable and positive. However, it is clear aspects of the project proved challenging for clubs especially undertakings such as the paperwork and the additional work load mentioned above. Throughout the course of phase one, it was obvious that clubs have consciously focused on sharing a positive health influence with the wider community alongside their own membership base. The focus groups revealed that clubs feel they have become a leader in their community, with respect to addressing prevalent health topics that may sadly otherwise be left by the wayside. This sentiment is supported by the follow up HCQ in which all 12 clubs agreed their involvement in the project has helped them to focus on health issues in ways they could not have done otherwise.

Over the course of phase one of the HCP, clubs have clearly moved to a broader recognition that the GAA has the capacity to enhance physical, emotional and social health. Commenting on the overall effect of the HCP, the follow up HCQ captures how clubs have definitely felt a shift in culture, with health now becoming more of a priority within clubs. Overall clubs feel their involvement in the HCP helped to change their club for the better



and over 80% of clubs would sign up for the project again. There is a strong sense that people's attitudes towards health have changed as well as the HCP positively impacting upon club culture. Nicholson et al. (2013) likewise found a similar pattern where HSEDP clubs felt they have become a better environment with an improved culture of health promotion having taken part in the project. The HSEDP allowed clubs to tackle areas of health it would not be possible to otherwise address and clubs would warmly embrace another chance to get involved in such a project. In comparison, Meganck et al. (2014) in a baseline analysis of youth sports clubs in Flanders found that only one third of clubs cited health promotion as a priority in their club. This presents the case that in order for clubs to realise the potential they hold in relation to health promotion, they need to be supported and guided through targeted programmes endorsed by governing bodies or an organisation of similar status. Reflecting on their HCP journey, focus groups captured an overwhelming sense of pride when looking back on all they have achieved, often surpassing their own expectations. It was also acknowledged that the HCP had allowed both Healthy Club Committee members and participants to gain valuable life skills they would otherwise have missed out on.

Changing perceptions was a very apparent theme during the HCP initiative evaluations. Participants were not shy in revealing the fact that having taken part in health promotion initiatives organised by their local GAA club, their own attitude towards the GAA's relationship to health changed for the better. In many cases, not only did their perception of the club change, their whole view of the GAA as an organisation was altered which is positive for both the clubs and the GAA organisation as a whole. Furthermore, the findings clearly indicate that participants increased their knowledge and skill levels concerning specific areas of health, having attended health promotion initiatives organised by their club. It is acknowledged that the results from this study are somewhat speculative given the lack of a comparison group in the HCP to truly assess the effect of these initiatives.

In summary, this section clearly illustrates the effect and potential of the HCP across a wide variation of areas through skill development and education but also in terms of the benefit to the club through increased membership and support for club activities. The HCP seems to have been an overwhelmingly positive experience for all involved. For clubs, it has presented a real opportunity to give back to and help its local lifeblood. Overall, the HCP

clubs have taken a more holistic approach to health allowing club members and community members to unite and benefit substantially from a healthy club culture.

## **Limitations**

A number of limitations are present within this study which may have affected interpretation of results and merit consideration.

Firstly the study relied on self-report data including both quantitative (questionnaires) and qualitative (interviews/focus groups) sources. The limitations of using self-report are well established; people may not always be truthful and may want to depict their club in the more positive light.

Another limitation was that there was the lack of a control group against which to compare changes in health promotion activity over the two year period. The addition of a control could also have added to the strength to this study as any changes found could be linked to intervention effect. However, without a control group this is not possible and changes may be due to external influences. The HCP took place in the 'real world' where the focus was on exploring the transferability and generalizability of the project and internal validity was subsequently sacrificed.

Finally, this study involved self-selection sampling whereby clubs decided entirely by themselves if they wished wanted to take part in the HCP through an expression of interest application. Some self-selection bias may therefore be unavoidable as participation may reflect some inherent characteristic of clubs who volunteered for the HCP.

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## Chapter 6 Conclusion

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There has been a growing concern in the literature that the health sector, working in isolation, cannot adequately shoulder the responsibility of improving public health (Lloyd et al., 2007). As stated by the Ottawa Charter 'health is created and lived by people within the settings of their everyday life, where they learn, work, play and love' highlighting the importance of a combination of settings in the delivery of health promotion (World Health Organisation, 1986). Previous literature has acknowledged the role of settings such as schools and workplaces in promoting health but there has been little investigation into the health promotion potential of a sports club. Sports clubs play a pivotal role in Irish society and their activities on and off the field reach a large and diverse cross section of the population from players, to parents, coaches, and supporters. Along with the physical environment presented by a sports club, the social, cultural and organisational environments are undeniable, and offer great promise in supporting and sustaining a more holistic approach to health, warranting the need for further investigation.

This study aimed to fill a gap in the existing literature by investigating the viability of an Irish GAA sports club as a setting for health promotion. This study evaluated the implementation of a health promotion project in GAA sports club settings, investigating the effect of the HCP in relation to policy, practice, ideology, environment and the juvenile coaching environment. The process of developing a Healthy Club and the outcome of a selection of health promotion initiatives delivered by clubs were also explored.

On completion of phase one of the HCP, half of clubs (n=6) were classed as high health promoting, an improvement of 25% compared to baseline. No clubs were categorised as low health promoting at the end of phase one compared to 25% at baseline. Improvements were seen across all the health promotion index sub-indices, with the exception of ideologies, which remained relatively consistent and scored highest overall. Policies remained the lowest scoring sub-index at both time points.

The development of a Healthy Club was characterised by the establishment of community links and partnerships with local service providers. The commitment of volunteers and gaining the support of the Executive committee were also an integral part of the HCP process. Challenges included funding, the additional workload and recruitment of additional volunteers with a desirable skill set. Club and community representatives remarked on the effect HCP health initiatives had on changing perceptions of the club, positively influencing attitudes to health, as well as increasing engagement with club activities and health behaviours. There was a firm acknowledgement of a place for health promotion in club activities at the end of the project.

The elements required for the successful development and implementation of a health promotion project in a sports club setting are not all that dissimilar from the factors required in other locations such as schools, workplaces and communities. Each setting follows a comparable pattern in that they are all grounded in the will and commitment of volunteers, the need for support and ownership from senior management, and involving all the relevant stakeholders through working in partnership to pool knowledge, skills, and resources, and of course consulting the target group as to their health needs and demands rather than delivering generic and prescriptive programmes (Young et al., 2013; Chu et al., 2000, Jorgensen et al., 2013, Puska et al., 1985).

The research results represented here suggests that community based volunteer led sports clubs such as the GAA are already on the ladder in terms of offering health promoting activities, even if they were not formally recognised as such. The GAA HCP gave clubs an opportunity to formalise, and broaden their health promotion activities under the guidance of the GAA Community and Health Team, ultimately leading to clubs improving their health promotion status and their relevance in the community. The results of this study provide support for the role of sports clubs in promoting health given the positive effect on the health orientation and practice of participating HCP clubs. Phase II of the HCP will extend to 50 clubs prior to further roll out in Phase III and subsequent national dissemination. At this stage, it is clear that the GAA club is a viable setting for health promotion activity but focus should be steered in Phase II towards the identification of an isolated impact of evidence-based initiatives on specific health behaviours.

The HCP opens up the possibility of launching and sometimes in this instance, rejuvenating sports clubs as a setting to promote health through the inclusion of health into the club's agenda in a way that is innovative, relevant and mutually beneficial. The GAA has moved to appoint a health and wellbeing officer in every GAA club throughout Ireland, supported by a county committee, provincial workgroup and full time staff at national level. Through incorporating health promotion into the governance structure of a GAA club, and supporting this at all layers of the organisation, there is great potential to reach the entire membership and wider community served by that club. It also presents an opportunity for typically hard to reach cohorts such as men and disadvantaged groups, to positively engage in health promotion be it as players, mentors, officials, spectators, parents or general club and community members. Building relationships, capacity building and working for the benefit of the community have all been evidenced in the HCP and it is this potential for community engagement which emphasises the GAA's application as a health promoting setting and portrays its immense potential to positively influence population health. This sentiment is reinforced by the partnership of both the HSE and Irish Life with the GAA HCP. The GAA as the country's leading sporting and cultural organisation has a unique capacity to impact society across Ireland and beyond – the HCP extends this impact to health and is an exciting opportunity to activate and achieve Healthy Ireland goals.

The unique position of the GAA in Irish society and its associated ideals of community, inclusion and volunteerism make the organisation well placed to contribute to the development of communities where everyone has a chance to be healthier. The GAA HCP represents a novel way of carrying out health promotion in Ireland, and strikes a natural balance between the health agenda of the HSE and the core business of the GAA club. It reflects a meeting point between the 'push of health' and 'pull of the club'. This pilot evaluation has provided support for this type of initiative in terms of the positive impact on the health orientation and practice of participating clubs. There is a clear commitment from the various layers in the GAA to support this work, which is fundamental to wider dissemination and integration into the daily workings of the organisation.

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## Future Recommendations

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There are a number of practical recommendations emanating from this evaluation that can inform and support the next phase of the HCP.

**Healthy Club Policy:** in the present study, clubs displayed significant effort, commitment and dedication in their efforts to build partnerships and deliver health initiatives for the good of their community. From this point forward, it is imperative that health promotion becomes embedded in the philosophy of the club if it is to have a sustained relevance and greater impact beyond this pilot stage. The development of a mandatory Healthy Club policy may help to position health on the working agenda of clubs and ensure health promotion activity is embedded into the core business of the club. It is important that the HCP is viewed as a whole club commitment from the outset if the project is to be sustainable.

**Executive Committee Support:** another crucial support factor, if health promotion activities are to be recognised, is the backing of the Executive committee. To generate this support at Executive committee level, it is important that health promotion is packaged for clubs as an activity that can benefit the club in its day-to-day remit of playing, coaching and administration, as well as increased community engagement.

**Peer Support:** it was very evident that HCP clubs found regional operational groups meetings to be an invaluable source of peer support. Heading into the future, as the project is further rolled out and support from the GAA Community and Health Team will inevitably be diluted, it is important that a support network is in place for clubs so they can continue to share their ideas, knowledge, and experiences.

**Partnerships:** during phase one of the HCP, partnerships were revealed to be a key component of the Healthy Club process. While partnerships may have been an important component, on the whole it was a new experience for clubs and there was a distinct lack of clarity as to how clubs should go about developing these partnerships. With this in mind, the GAA Community and Health Team should consider creating a resource toolkit for clubs

on how clubs can attract, form, sustain, and mutually benefit from partnerships in order to enhance this work.

In total, 72 initiatives were delivered by HCP clubs, which reflects the investment and commitment of clubs. The vast majority (90%) of initiatives were directed at the general community; targeting specific groups, such as coaches and players did not seem to be a priority. If health promotion is to be integrated into the club agenda, it is important that it reaches the current core activity of the club, which is coaching and games. Coaches and officials are the main conduit for messages to playing members, so future HCP activity must consider up skilling these individuals in order to help promote healthy behaviours among players. In a juvenile context, it is also important to engage further with parents to ensure the health initiatives are implemented and sustained beyond the playing environment.

Resources: a complete toolkit that will help to ensure transparency from the outset of Phase II covering all of the areas mentioned above and initial informed commitment must be provided by clubs prior to engagement.

Further recommendations exist in relation to the next phase of research aligned with this project, which will be incorporated into Phase II of the HCP.

Comparison Group: the lack of a comparison group within this study is a major limitation, which limits an assessment of the internal validity of the initiative. While it appears that the HCP positively impacted on membership, awareness of health issues and behaviours, this cannot be isolated as a direct outcome of the HCP. Future studies should seek to demonstrate that the intervention was effective in the GAA club setting through the use of a control group within a cluster randomised controlled study design.

Targeted Behaviour Change: in this pilot phase, clubs self selected to intervene on often several topic areas due to the wide scope of the HCP in relation to improving health and wellbeing. To capture the impact of this work, it is recommended that clubs target one particular behaviour that is identified as a priority at national level, and that this is evaluated using the aforementioned cluster controlled design.

Evaluation: continued evaluation of the evolving governance model for health and wellbeing in the GAA should be supported, particularly how the HCP grows and assimilates with the broader health and wellbeing structures and activities in the association.



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# Appendices

1. Healthy Club Questionnaire (HCQ) Baseline
2. HCQ Follow up
3. Consent Form
4. GAA Community and Health Team Interview Guide
5. Regional Operational Group Meetings Focus Group Topic Guides (Both time points)
6. Dropout Interview Guide
7. Executive Committee Interview Guide
8. Healthy Club Committee Focus Group/Interview Guides
9. Participant Focus Group Topic Guide
  - 8a. SOAR programme
  - 8b. 'How are you felling today' programme
  - 8c. Healthy Food Made Easy (HFME)
  - 8d. Operations TransFAUGHmation
10. Partner Interview Guide
  - 9a. HSE
  - 9b. LSP
  - 9c. SOAR
  - 9d. HFME
11. Participant Questionnaires
  - 10a. Anti-smoking
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  - 10c. 'How are you feeling today'
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12. Ethical Approval
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14. Initiatives by Topic and Club
15. Individual Initiatives Selected for Evaluations

## Appendix 1

### Healthy Club Questionnaire (HCQ)



## **HEALTHY CLUB INDEX**

### ***Club Self Assessment Questionnaire***

***Ideally this will be completed by your Healthy Club leader with assistance from additional club officers if required***

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Completed By:

**Part 1 - Healthy Club membership Characteristics**

1. Can you complete the following in relation to your club?

Club Name: \_\_\_\_\_

Town: \_\_\_\_\_

County: \_\_\_\_\_

Province: \_\_\_\_\_

2. Please complete the following table about the membership of your club in as much details as your available records allow?

		Male	Female	TOTAL
Adult Playing				
Adult Non-playing				
Youth				
Youth Age Groups	15 - 18			
	12 - 14			
Child				
Child Age Groups	8 - 11			
	6 - 8			
	< 6			
<b>TOTAL</b>				

3. What codes are available in your club (please tick all that apply)?

	Men's Football	Ladies Football	Hurling	Camogie	Handball	Rounders
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
No of Teams:						

4. Please indicate what types of membership your club offers and the cost of each.

Membership Type	Cost



Full	<input type="checkbox"/>	
Associate / Social	<input type="checkbox"/>	
Leisure	<input type="checkbox"/>	
Juvenile	<input type="checkbox"/>	
Family	<input type="checkbox"/>	

5. Does your club have a strategic plan?

Yes	No
<input type="checkbox"/>	<input type="checkbox"/>

If yes, what is the time frame of the plan? \_\_\_\_\_

6. What is the proposed date for your AGM in 2013? \_\_\_\_\_

7. Please outline the organizational structure of your club using the example given in appendix 1.

## Part 2 - Healthy Club Index

**Health Promotion is defined as efforts taken to help people to take control over and improve their health, which includes their physical, mental, social and emotional wellbeing.**

8. To what extent do the following describe your clubs activities.... **Please tick one box per question**

*(1=does not describe the club at all, 2=describes the club very little, 3=describes the club to some extent, 4=describes the club well, 5=describes the club very well)*

### Policies

	1	2	3	4	5
The clubs regulations include a written section on well being and / or health promotion / health education / healthy lifestyle					
The clubs regulations include a written policy on substance misuse (ASAP policy)					
Health and well being ideals are written in the clubs constitution and regulations					
The club health promotion activities are evaluated in the Annual Report					
The club collaborates with other sports clubs and / or health professionals on health issues					
The club assures that its sub committees have agreed regulations and practices					
Health promotion is part of the coaching practice					
Training pitches and schedules are distributed fairly across all teams in the club					

### Ideology

	1	2	3	4	5
The club promotes the 'Go Games' <sup>1</sup> principles					

---

<sup>1</sup> Go Games are small-sided versions of Hurling and Gaelic Football which have been devised for children up to and including 11 years of age. They have key underpinning principles designed to ensure everybody plays, and activities optimise the level of fun, friendship, fair play, and achievement derived by participants. A full outline of the principles of the Go Games is available in an appendix to this document.

The club promotes the 'Respect Initiative' <sup>2</sup>					
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### Practice

	1	2	3	4	5
The clubs Executive Committee discusses its regulations with coaches and parents at regular intervals					
The club pays particular attention to coaches/instructors interaction skills					
The club provides education on health issues or makes provisions for its members to receive such education					
The club promotes individual growth and development					
Sports injuries are comprehensively dealt with (including the psychological effect of injury)					
The club reviews and communicates treatment policies in the case of a sports injury					

### Environment Index

	1	2	3	4	5
The club assumes its fair share of responsibility for a safe sports environment (eg: reviews the sports environment yearly)					
The club provides a sports environment that is smoke free during juvenile activities					
Coaches and other officials give a good example through their own behaviour					
Respect for the referee is evident at all levels in the club (players, coaches, administrators)					
Possible conflicts (eg bullying) are monitored and dealt with					
In coaching, there is a health promoting element beyond sports performance					
Healthy food options are made available following sports activities					

### Juvenile (U18) Coaching Environment

	1	2	3	4	5
All juvenile events are held in an alcohol free environment					
The club promotes maximum participation adopting an 'every child gets a game' policy					
The implementation of 'everybody plays' policy is dependant on the importance of the competition					
The implementation of 'everybody plays' policy is hindered by					

<sup>2</sup> The GAA Respect Initiative has been developed to ensure that Gaelic games are promoted in a positive manner that is conducive to ensuring all participants achieve their full potential. This underlying approach will help to underpin the values of the Association: player centred, family orientated, and community based. Full support material for the GAA Respect Initiative are available on [gaa.ie/respect](http://gaa.ie/respect)

parents expectations of success by winning					
The implementation of 'everybody plays' policy is hindered by other clubs reluctance to adopt a similar approach					
The club measurement of success is winning underage tournaments					
The club perceives that success can only be achieved by having the best players on the pitch at all times					
The club selects and approves coaches who have accredited coaching qualifications					
The club specifically identifies suitable and qualified coaches for juvenile coaching positions					
The club does not tolerate the use of bad language					
The club enforces a fair play policy					

9. Do you ensure that all of your coaches have certification from the GAA/Camogie/Ladies Football coaching education framework?

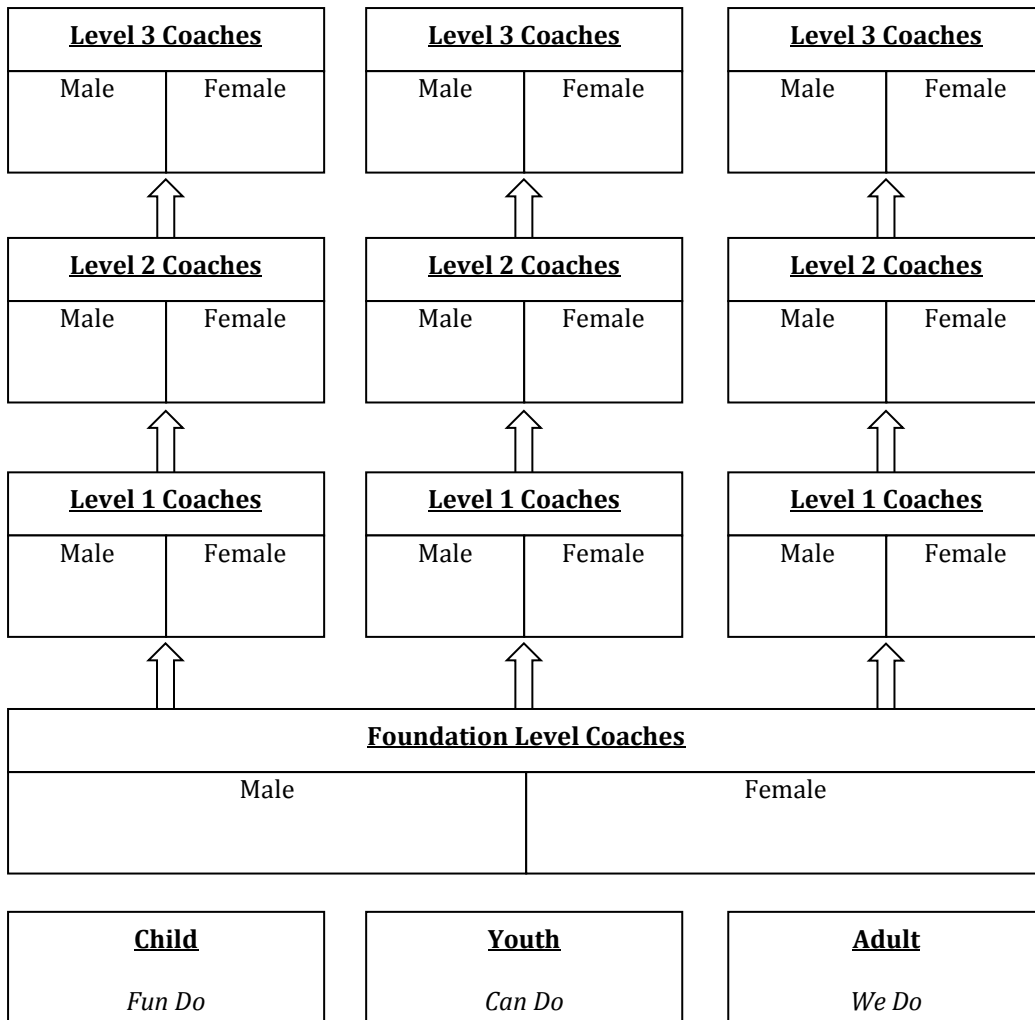
Yes	No
<input type="checkbox"/>	<input type="checkbox"/>

10. Please outline the number of coaches your club has within each stage of the Coach Education Model <sup>3</sup> for the GAA codes you offer.

**Men's Football & Hurling**

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<sup>3</sup> Throughout all codes of the GAA, a similar Coach Education Model is in place, each based on a number of levels, starting with foundation and then moving up to Level 3 at the top. The GAA Coach Education model for men's football and hurling, which is also spilt into three coaching streams, is the most advanced of these. The remaining codes follow the same structure with a foundation level and level one, although for some codes, these have been given specific names (see Appendix 2 of this document for more infomration relating to all codes Coach Education Models).



**Ladies Football**

	<b>Male Coaches</b>	<b>Female Coaches</b>
<b>Foundation (FUNDamental)</b>		
<b>Level 1 (Raising the Bar)</b>		

## Camogie

	Male Coaches	Female Coaches
<b>Foundation (Camán Get a Grip)</b>		
<b>Level 1 (Camán Get Hooked)</b>		

## Handball

	Male Coaches	Female Coaches
<b>Level 1</b>		
<b>Foundation</b>		

### ***Part 3 - Facilities Audit***

11. How many playing pitches do you have at your club's facilities? \_\_\_\_\_

12. Does your club facility have the following? (***Please tick all that apply***)

	Facility	
<input type="checkbox"/>	Clubhouse / club bar	
<input type="checkbox"/>	Community centre	
<input type="checkbox"/>	Running / walking track	
<input type="checkbox"/>	Floodlights	
<input type="checkbox"/>	Dressing rooms	No. of dressing rooms: _____
<input type="checkbox"/>	Kitchen Facilities	
<input type="checkbox"/>	Public toilets	
<input type="checkbox"/>	All weather pitch	
<input type="checkbox"/>	Ball wall	
<input type="checkbox"/>	Tennis courts	

<input type="checkbox"/>	Basketball courts
<input type="checkbox"/>	Access to clean drinking water
<input type="checkbox"/>	Other _____

13. How would you rate your Facilities overall? **(Please tick)**

Excellent	Good	Fair	Poor
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

14. Does your club facility have any Full / Part-time / Voluntary staff? **(Please tick)**

Yes	No
<input type="checkbox"/>	<input type="checkbox"/>

If Yes please specify the number in each case:

	Number of Staff		Number of Staff
Full-time Paid		Voluntary	
Part-time Paid		FAS CE Scheme	

15. How many hours per week are your playing facilities (pitches, walking / running tracks) open to the Community? \_\_\_\_\_

16. How many hours per week are your non-playing facilities (community centre / clubhouse etc.) open to the community? \_\_\_\_\_

17. Apart from sport participation is your facility used for any other purpose? **(Please tick any that apply)**

<input type="checkbox"/>	General Community Use
<input type="checkbox"/>	Talks
<input type="checkbox"/>	Community Events
<input type="checkbox"/>	Community Arts
<input type="checkbox"/>	Other

Please give details:

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18. How accessible do you feel your facilities are to people with disabilities?

Excellent	Good	Fair	Poor
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

19. Please indicate, where applicable, which of the following measures your club has taken to improve access for people with disabilities.

<input type="checkbox"/>	Wheelchair access to ground level
<input type="checkbox"/>	Wheelchair access to upper levels
<input type="checkbox"/>	Suitably designated parking spaces
<input type="checkbox"/>	Consideration with doors & corridors
<input type="checkbox"/>	Toilet access
<input type="checkbox"/>	Spectator areas
<input type="checkbox"/>	Consideration with light switches
<input type="checkbox"/>	Changing areas
<input type="checkbox"/>	Other

Please give details of any additional measures your club has taken to increase accessibility for disabled persons:

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#### ***Part 4 – Programmes Audit***

##### **PROGRAMMES DEFINITION**

20. To what extent has the club provided information on the following topics:  
*(Please tick one box per topic)*

Topic	Not at all	To some extent	Moderately	Very Much
General physical activity				



Diet/Nutrition				
Anti-Smoking/smoking cessation				
Alcohol awareness				
Drugs awareness				
Anti-bullying				
Anti-Doping				
Sleep				
Hygiene				
Injury prevention				
Violence				
Sexual health				
Mental health promotion				
Social media use				
Social Inclusion				
Personal development				
Health promotion				

**Part 5 – Partnerships Audit**

**A partnership is defined as people or organisations working collaboratively, characterized by shared goals and clear working relationships.**

21. Please rate your agreement with the following statements: *(Please tick one box per question)*  
*(1=strongly disagree - 5=strongly agree)*

	1	2	3	4	5
The club holds discussions with coaches about club matters					
The club holds formal discussions with parents about club matters					
The club holds formal discussions with playing members about club matters					
The club collaborates with club members who are health professionals to actively promote health issues within the club					
The club collaborates with the wider non GAA community					
The club facilitates external agencies to promote health (Foroige, Pieta House etc)					
The club collaborates well with other GAA codes in the community					

22. Please rate your agreement with the following statements: (*Please tick one box per question*)  
 (1=*strongly disagree* - 5=*strongly agree*)

	1	2	3	4	5
The club recruits members in local schools					
The club provides coaching in local schools					
The club collaborates with local community development groups					
The club runs open days for the community					
The club engages with older/retired members of the community					
The club engages with minority groups in the community					
The club helps to deliver community events (community games)					
The club delivers family fun days					
Partners have always been an important part of the club					
Roles, responsibilities and expectations are agreed with partners					
Regular meetings are held with partners					
Partners sit on committees in the club					
Contact with partners is mostly informal					
There is no need to formalise the partnership process					
Formalising the partnership process takes too much time					
Club members actively seek new partners					

If you have other types of engagement with the local community, please detail below:

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23. Please consider the three most important partnerships (see definition above) for your clubs and tick what each of the partners brings to your club? (*Please tick all that apply*)

	Partner 1	Partner 2	Partner 3
Sponsorship			
Other financial support			

Medical support			
Facilities			
Coaching support			
Administrative support			
Mentoring			
Facility maintenance			
Other:			
Other:			
Other:			

**Part 6 – Communication**

24. In relation to club communication, please indicate which of the following you use, its effectiveness and how the club utilises each.

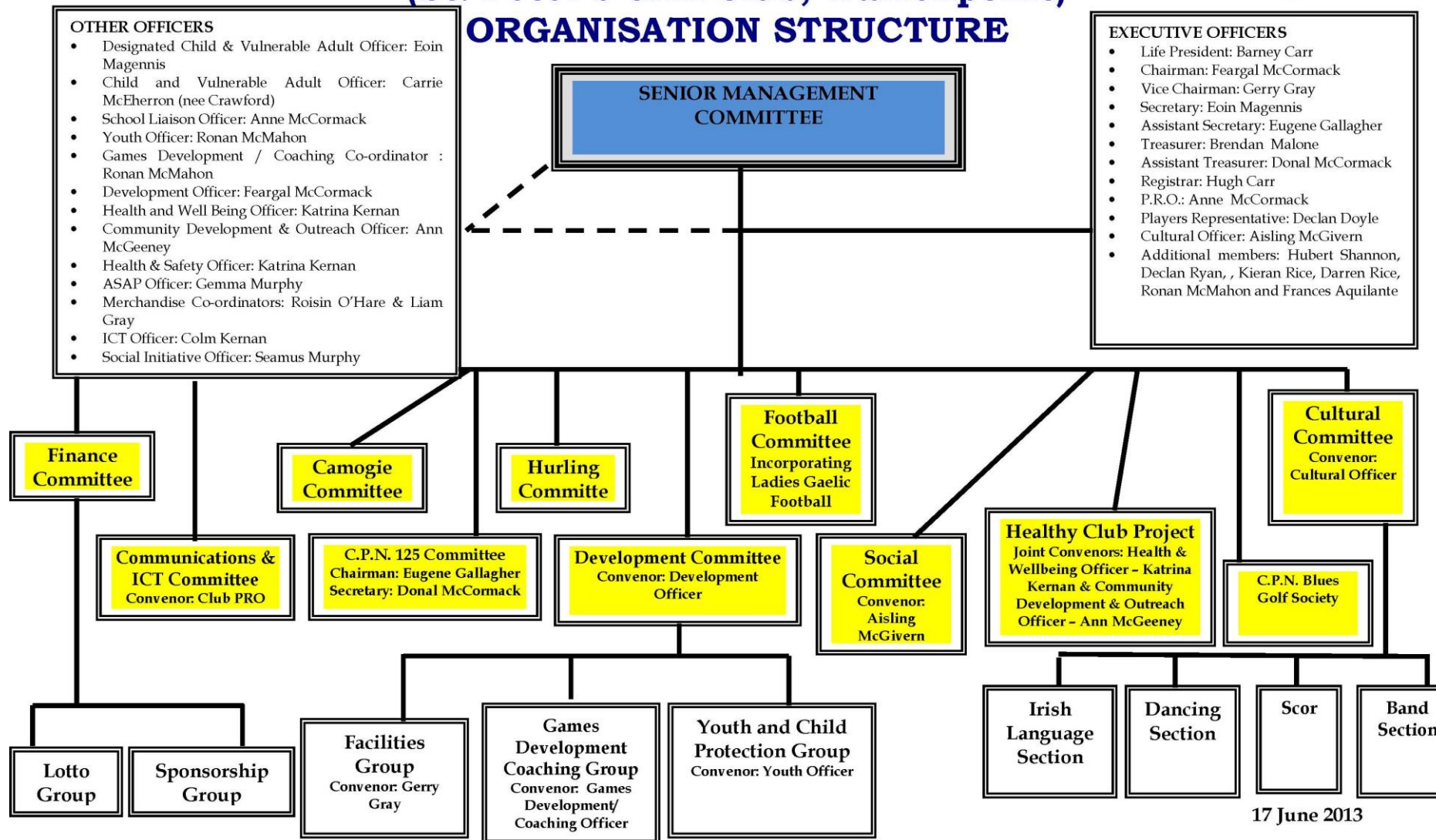
25.

	<b>Facebook</b>	<b>Twitter</b>	<b>Newsletters</b>	<b>Website</b>	<b>Texting Service</b>	<b>Local media (newspapers/radio)</b>
The club uses this medium						
Number of followers/uptake						
Number of administrators						
Frequency of updates						

Sample 1



**Cumann Pheadair Naofa C.L.G.  
(St. Peter's GAA Club, Warrenpoint)  
ORGANISATION STRUCTURE**



17 June 2013

## 1. Defining GAA Go Games

Go Games are small-sided versions of Hurling and Gaelic Football which have been devised for children up to and including 11 years of age. The following are the key underpinning principles of Go Games:

- All participants play in the full game.
- Participant needs are catered for, where possible, on the basis of two year age cohorts i.e. U.7, U.9 & U.11 in a manner consistent with the ethos of Go Games.
- Activities are structured in a manner which optimises the level of fun, friendship, fair play and achievement derived by participants.
- Participants train and play in a safe, supportive and stimulating environment where they are encouraged to risk error, to learn and to derive maximum enjoyment from their involvement.
- Players master the basic skills of Hurling and Gaelic Football and experience the sense of accomplishment, which derives from acquiring playing proficiency on the left and right hand side of the body.
- Everybody involved in Go Games, whether as players, parents/guardians, spectators, mentors, teachers, officials etc., should adhere to the key underpinning principles and give expression to the GAA 'Give Respect, Get Respect' initiative.

For more information visit <http://www.gaa.ie/youth-zone/gaa-go-games/>

## 2. Defining Coaching courses across all codes

### Men's Football & Hurling



For more information visit <http://www.gaa.ie/coaching-and-games-development/coaching/coach-education/>

## ***Ladies Football***

**Foundation/FUNDamental Course:** This is the first course on the Coaching Ladder. FUNDamentals is a foundation level course designed as an introduction to good coaching, no matter what age group you are starting to coach with. It is a fun, dynamic and informative course designed by coaches for coaches.

**Raising the bar- Level 1:** The next step on the coaching ladder is Level 1 coaching course. Coaches must have completed their Ladies Gaelic Football 'FUNDamentals' course prior to undertaking the Level 1 course, have a minimum of one year's coaching experience to participate on this and be 18 years of age or older.

**For more information visit:** <http://ladiesgaelic.ie/coaches/coaching-courses-and-workshops/>

## ***Camogie***

**Foundation course (*Camán Get a Grip*):** This 8 hour course over 2 days is an introduction to coaching and is the first step on the coaching ladder. The course qualifies coaches to coach 6-9 year old Camogie players.

**Level 1 Course (*Camán Get Hooked*):** This level 1 course is of 20 hour duration and qualifies coaches to coach 10-14 year olds. Applicants must be 18 years of age and have completed the Camán Get a Grip course or GAA Foundation Child Award.

**For more information visit:** <http://www.camogie.ie/development.asp>

## **Handball**

**Level 1 course:** The course aims to enable the coach to introduce handball correctly, and develop game play to adult and child beginners in a safe, enjoyable and progressive way.

**For more information visit:** <http://www.gaahandball.ie>

## Appendix 2

HCQ Follow up



### **HEALTHY CLUB INDEX**

#### ***Club Self Assessment Questionnaire***

***Ideally this will be completed by your Healthy Club leader with assistance from additional club officers if required***

Date of Completion:

\_\_\_\_\_

Completed By:

**Part 1 - Healthy Club membership Characteristics**

1. Can you complete the following in relation to your club?

Club Name: \_\_\_\_\_

County: \_\_\_\_\_

2. Please complete the following table about the membership of your club in as much details as your available records allow?

	Male	Female	TOTAL
Adult Playing			
Adult Non-playing			
Youth 6-18			
<b>TOTAL</b>			

3. What codes are available in your club (please tick all that apply)?

	Men's Football	Ladies Football	Hurling	Camogie	Handball	Rounders
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
No of Teams:						

4. What type of membership does your club offer?

Membership Type		Introduced due to HCP (Please tick if yes)
Full	<input type="checkbox"/>	
Associate / Social	<input type="checkbox"/>	
Leisure	<input type="checkbox"/>	
Juvenile	<input type="checkbox"/>	
Family	<input type="checkbox"/>	



5. Has your club appointed a Health and Wellbeing officer?                      Yes      No

6. What is the current status of your clubs health and wellbeing policy activity? *Please tick*

	Fully implemented	Partially Implemented	Complete but no yet implemented	Nothing in place but plans to develop one	Nothing in place but ran numerous initiatives	No plans to develop anything
Mental Health Charter						
ASAP Policy						
Health and Wellbeing Policy						
Other:						

7. Please outline the organizational structure of your club and how the Healthy Club Committee fits into the overall structure?

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## Part 2 - Healthy Club Index

**Health Promotion is defined as efforts taken to help people to take control over and improve their health, which includes their physical, mental, social and emotional wellbeing.**

8. To what extent do the following describe your clubs activities.... **Please tick one box per question**

*(1=does not describe the club at all, 2=describes the club very little, 3=describes the club to some extent, 4=describes the club well, 5=describes the club very well)*

### Policies

	1	2	3	4	5
The clubs regulations include a written section on well being and / or health promotion / health education / healthy lifestyle					
The clubs regulations include a written policy on substance misuse (ASAP policy)					
Health and well being ideals are written in the clubs constitution and regulations					
The club health promotion activities are evaluated in the Annual Report					
The club collaborates with other sports clubs and / or health professionals on health issues					
The club assures that its sub committees have agreed regulations and practices					
Health promotion is part of the coaching practice					
Training pitches and schedules are distributed fairly across all teams in the club					

### Ideology

	1	2	3	4	5
The club promotes the 'Go Games' <sup>4</sup> principles					

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<sup>4</sup> Go Games are small-sided versions of Hurling and Gaelic Football which have been devised for children up to and including 11 years of age. They have key underpinning principles designed to ensure everybody plays, and activities optimise the level of fun, friendship, fair play, and achievement derived by participants. A full outline of the principles of the Go Games is available in an appendix to this document.

The club promotes the 'Respect Initiative' <sup>5</sup>					
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### Practice

	1	2	3	4	5
The clubs Executive Committee discusses its regulations with coaches and parents at regular intervals					
The club pays particular attention to coaches/instructors interaction skills					
The club provides education on health issues or makes provisions for its members to receive such education					
The club promotes individual growth and development					
Sports injuries are comprehensively dealt with (including the psychological effect of injury)					
The club reviews and communicates treatment policies in the case of a sports injury					

### Environment Index

	1	2	3	4	5
The club assumes its fair share of responsibility for a safe sports environment (eg: reviews the sports environment yearly)					
The club provides a sports environment that is smoke free during juvenile activities					
Coaches and other officials give a good example through their own behaviour					
Respect for the referee is evident at all levels in the club (players, coaches, administrators)					
Possible conflicts (eg bullying) are monitored and dealt with					
In coaching, there is a health promoting element beyond sports performance					
Healthy food options are made available following sports activities					

### Juvenile (U18) Coaching Environment

	1	2	3	4	5
All juvenile events are held in an alcohol free environment					
The club promotes maximum participation adopting an 'every					

<sup>5</sup> The GAA Respect Initiative has been developed to ensure that Gaelic games are promoted in a positive manner that is conducive to ensuring all participants achieve their full potential. This underlying approach will help to underpin the values of the Association: player centred, family orientated, and community based. Full support material for the GAA Respect Initiative are available on [gaa.ie/respect](http://gaa.ie/respect)

child gets a game' policy					
The implentation of 'everybody plays' policy is dependant on the importance of the competition					
The implementation of 'everybody plays' policy is hindered by parents expectations of success by winning					
The implementation of 'everybody plays' policy is hindered by other clubs reluctance to adopt a similar approach					
The club measurement of success is winning underage tournaments					
The club perceives that success can only be achieved by having the best players on the pitch at all times					
The club selects and approves coaches who have accredited coaching qualifications					
The club specifically identifies suitable and qualified coaches for juvenile coaching positions					
The club does not tolerate the use of bad language					
The club enforces a fair play policy					

9. Do you ensure that all of your coaches have certification from the GAA/Camogie/Ladies Football coaching education framework?

Yes	No
<input type="checkbox"/>	<input type="checkbox"/>

10. Do your coaches engage in any other type of coach education programme or Continuous Professional Development (CPD)? E.g. Child protection, first aid, etc...

Yes	No
<input type="checkbox"/>	<input type="checkbox"/>

8(a) If yes, please give details.

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### **Part 3 - Facilities Audit**

11. Have you made any changes to your facilities in the last year? Yes                      No  
a. If yes, please give details...

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12. How would you rate your Facilities overall? (***Please tick***)

Excellent	Good	Fair	Poor
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

13. How many hours per week are your playing facilities (pitches, walking / running tracks) open to the Community? \_\_\_\_\_

14. How many hours per week are your non-playing facilities (community centre / clubhouse etc.) open to the community? \_\_\_\_\_

15. How accessible do you feel your facilities are to people with disabilities?

Excellent	Good	Fair	Poor
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Please give details of any measures your club has taken to increase accessibility for disabled persons:

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16. Have any of your programme components involved environmental supports?

Erecting supportive health promoting signage	
Creating no smoking areas of your club	
Supplying healthy food options	
Developing walking tracks	
Installing bike racks	
Other - <i>please give details</i>	

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**Part 4 – Initiatives Audit**

17. Please tick all that apply

	Smoking	Physical activity	Diet/ Nutrition	Inclusion	Alcohol/ drugs	Stress management	Weight control	Cancer screening	Health screening	Mental/Emotional health/ wellness	First aid/ Defib training	Other
<b>Indicate the No. of programmes/campaigns (Mar 2013- Mar 2015)</b>												
<b>Method of intervention</b>												
Pamphlets or literature												
Posters or displays												
Educational classes												
Health counselling												
Policy												
<b>Target Group</b>												
Youth												
Adults												
Parents												
Coaches/officials												
General club/ community												
<b>Future programmes/ Campaigns</b>												

Other Comments:

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18. In general how have the initiatives been funded (tick all that apply)?

- Club executive
- Participant - pay as you go
- Sponsors
- Grants
- No cost
- Other

19. Do you generally measure/evaluate outcomes from your health promotion programmes?

Yes      No

20. How important are each of the following as a reason for health promotion and wellbeing in your club/ community?

	Not at all important	Slightly important	Moderately important	Very important	Extremely important
Attracting and retaining members					
Fulfilling social/ community responsibility					
Furthering the clubs work					
Improving on the pitch results					
Improving player safety					
Improving morale/ engagement					
Improving the clubs image					

21. Have you recognised a level of change in relation to health and wellbeing in your local GAA club and community in the following areas (if applicable) since the project has started:

	No change	A little change	Some change	A large change	A great deal of change
Alcohol & Drug abuse					
Mental Health					
Diet & Nutrition					
Physical Activity					
Health and Safety					
Inclusion					
Anti-bullying					
Smoking					

### ***Part 5 - Partnerships Audit***

**A partnership is defined as people or organisations working collaboratively, characterized by shared goals and clear working relationships.**

22. Please rate your agreement with the following statements: ***(Please tick one box per question)***  
***(1=strongly disagree - 5=strongly agree)***

	1	2	3	4	5
The club holds discussions with coaches about club matters					

The club holds formal discussions with parents about club matters					
The club holds formal discussions with playing members about club matters					
The club collaborates with club members who are health professionals to actively promote health issues within the club					
The club collaborates with the wider non GAA community					
The club facilitates external agencies to promote health (Foroige, Pieta House etc)					
The club collaborates well with other GAA codes in the community					

23. Please rate your agreement with the following statements: *(Please tick one box per question)*  
*(1=strongly disagree - 5=strongly agree)*

	1	2	3	4	5
The club recruits members in local schools					
The club provides coaching in local schools					
The club collaborates with local community development groups					
The club runs open days for the community					
The club engages with older/retired members of the community					
The club engages with minority groups in the community					
The club helps to deliver community events (community games)					
The club delivers family fun days					
Partners have always been an important part of the club					
Roles, responsibilities and expectations are agreed with partners					
Regular meetings are held with partners					
Partners sit on committees in the club					
Contact with partners is mostly informal					
There is no need to formalise the partnership process					
Formalising the partnership process takes too much time					
Club members actively seek new partners					

If you have other types of engagement with the local community, please detail below:

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24. Please consider the three most important partnerships (see definition above) for your clubs and tick what each of the partners brings to your club? (*Please tick all that apply*)

	<b>Partner 1</b>	<b>Partner 2</b>	<b>Partner 3</b>
Sponsorship			
Other financial support			
Medical support			
Facilities			
Coaching support			
Administrative support			
Mentoring			
Facility maintenance			
Other:			
Other:			
Other:			

### **Part 6 - Communication**

25. What tools and channels have you used to communicate your initiatives to your club and community?

Poster/ flyers	
Newsletter	
Local paper/ print media	
Local radio	
Targeted email	
Website	
Texting service	
Social media	

Finally...

26. Please rate your agreement with the following statements:

	Strongly Agree	Agree	Neither disagree or agree	Disagree	Strongly Disagree
Compared to 24 months ago:					
Health has become more of a priority in the club					
People's attitudes to health have changed					
Our club is a better club as a result of being involved in this project					
The profile of the club/community has been raised					
The project has addressed all sections of club i.e. players, parents, social members etc.					
Involvement in the project has helped our club focus on health issues in ways we could not have done otherwise					
More people are joining/ becoming involved in club activities due to the project					
Knowing what you know now, would you sign up for the project again					
The culture of the club has changed for the better					
There will be support for this project if it continues					

### Defining GAA Go Games

Go Games are small-sided versions of Hurling and Gaelic Football which have been devised for children up to and including 11 years of age. The following are the key underpinning principles of Go Games:

- All participants play in the full game.
- Participant needs are catered for, where possible, on the basis of two year age cohorts i.e. U.7, U.9 & U.11 in a manner consistent with the ethos of Go Games.
- Activities are structured in a manner which optimises the level of fun, friendship, fair play and achievement derived by participants.
- Participants train and play in a safe, supportive and stimulating environment where they are encouraged to risk error, to learn and to derive maximum enjoyment from their involvement.
- Players master the basic skills of Hurling and Gaelic Football and experience the sense of accomplishment, which derives from acquiring playing proficiency on the left and right hand side of the body.
- Everybody involved in Go Games, whether as players, parents/guardians, spectators, mentors, teachers, officials etc., should adhere to the key underpinning principles and give expression to the GAA 'Give Respect, Get Respect' initiative.

*For more information visit <http://www.gaa.ie/youth-zone/gaa-go-games/>*

## Appendix 3



### Informed Consent Form



#### Study Background

The 'GAA Healthy Club' initiative aims to "highlight and re-enforce the great work already being done by clubs while assisting them in identifying and responding to the most important health issues amongst their membership and in their community" (GAA 2013). Charting the process of the development of a Healthy Club and translating it into a practical 'how to' guide is a key goal of this proposed evaluation, leading to the creation of a sustainable model for all clubs. This research, which is supported by the GAA is being conducted by Dr Aoife Lane, Dr Niamh Murphy and Alex Donohue from Waterford Institute of Technology.

#### Procedures

You are being invited to participate in a focus group lasting approximately one hour. Participants will include members of your healthy club committee and associated partners, which may include club administrators, players, parents, coaches, volunteers and other community representatives. Participants will be asked to discuss their engagement in and experiences of the process of developing a Healthy Club. The focus group discussion will be conducted by the research team and will be audiotaped for accuracy. Audio-recordings of the focus groups will be kept on a password-protected computer in WIT. After the focus group recording is transcribed it will be destroyed. The typed transcription will be kept on the password-protected computer and any printed copies will be kept in a locked file cabinet in WIT. Participation in this study is entirely voluntary and you may withdraw from the study at any point. Club or individual participant identity, or other personal information, will not be revealed or published.

*I have read and understood the information in this form. My questions and concerns have been answered by the researchers, and I have a copy of this consent form. Therefore, I consent to take part in this research project*

**Print Name:** \_\_\_\_\_

**Signature:** \_\_\_\_\_

**Date:** \_\_\_\_\_

**Researcher:** \_\_\_\_\_

If you have any further questions about this research, you can call Dr. Aoife Lane on 051-302158 or email [alane@wit.ie](mailto:alane@wit.ie).

## Appendix 4

### Focus Group Topic Guide – GAA Community and Health Team

This focus group is being carried out by the WIT evaluation team on the GAA's Healthy Club project. This is a group discussion focusing on experiences, attitudes and reflections of your involvement in the project thus far. It is an opportunity to make your views known and your feedback is an important component in the future development and wider roll out of the Healthy Club project. As much learning will be gained from understanding what hasn't worked as understanding what has worked. To keep an accurate record of your comments, we will be audio recording the focus group, and tapes will be transcribed following the session. Everything that is shared in the focus group is strictly confidential. Participant's or club identity or other personal information, will not be revealed or published. Your participation is voluntary and you may withdraw from the group at any point.

#### 1) Opening question

Do you think the HCP has helped clubs to become more conscious of/active in promoting health?

- Change in club culture?
- Taken seriously by executive committees?
- From your experience do you think a healthy club is achievable for all GAA clubs?
- Impact

#### 2) Expectations

When you look back to the beginning has the project run how you envisaged it would run?

- Meet your expectations?
- Has your perception of the project changed over time?

#### 3) Challenges

What were the challenges from an operational point of view?

What were the big issues for clubs? (from the feedback you receive)

#### 4) Sustainability

How do you think clubs will cope with sustaining the project?

Has the HCP generated much interest outside of the 18 pilot clubs?

#### 5) Learnings

What are the key learnings for phase 2?

- What do you need/what do clubs need?

- If you were starting the project over again what would you do differently?

## Appendix 5

### **Focus Group Topic Guide – Regional Operational Group Meetings (time point 1)**

This focus group is being carried out by the WIT evaluation team on the GAA's Healthy Club project. This is a group discussion focusing on experiences, attitudes and reflections of your involvement in the project thus far. It is an opportunity to make your views known and your feedback is an important component in the future development and wider roll out of the Healthy Club project. What has worked for one club may not have worked for another club and vice versa and so participants should feel confident in agreeing to differ. As much learning will be gained from understanding what hasn't worked as understanding what has worked. To keep an accurate record of your comments, we will be audio recording the focus group, and tapes to be transcribed following the session. Everything that is shared in the focus group is strictly confidential. Participant's or club identity or other personal information, will not be revealed or published. Your participation is voluntary and you may withdraw from the group at any point.

To open our discussion, can we start by introducing ourselves, the club we represent and your role within that club?

#### *1) Opening Question*

Is health really the GAA's business?

#### *2) Origin of the Healthy Club Idea*

Tell me how your club came to be involved in the Healthy Club project?

- Main driving force? (People)
- Benefits for the club?
  - Seen as a way of addressing the health needs within the local community or was it a more pragmatic response (a way to get new members, earn money, and build a better relationship with local community)?
- Any previous health promotion activities?

#### *3) Start-up Process*

Can you tell me about the initial start-up phase of the Healthy Club project?

- Interaction with Croke Park and other clubs
- Needs assessment process

Can you tell me about your current stage of development?

- Action planning process
- Level of engagement/decision makers
- Club/community support

#### 4) Support

Overall, how have you found the level of support from Croke Park?

- Support – mentoring, logistics, acknowledgement
- Regional group meetings/meeting with other clubs
- Any gaps in support provision?

How has the support been for this project from within your own club and community?

- Buy in from Executive committee
- Attracted new volunteers or fall back on same old people

#### 5) Challenges

From your experience of the Healthy Club project thus far, what have been the main challenges facing you, if any?

- Building partnerships?
- Additional workload?

What would your advice be to a new club starting off on the same process?

#### 6) Benefits

What have been the main benefits thus far arising from your involvement in this project?

- Long term sustainability?

## **Topic Guide – Regional Operational Groups Meetings (time point 2)**

This focus group is being carried out by the WIT evaluation team on the GAA's Healthy Club project. This discussion will focus on experiences, attitudes and reflections of your involvement in the project thus far. It is an opportunity to make your views known and your feedback is an important component in the future development and wider roll out of the Healthy Club project. As much learning will be gained from understanding what hasn't worked as understanding what has worked. To keep an accurate record of your comments, we will be audio recording the discussion, and tapes will be transcribed following the session. Everything that is shared is strictly confidential. Participant's or club identity or other personal information, will not be revealed or published. Your participation is voluntary and you may withdraw from at any point.

### *1) Opening Question*

What motivated you/your club to apply for the HCP?

### *2) Progress*

Has your perception of the Healthy Club project changed over time?

- Initial thoughts on the HCP / what has caused your perception to changes/not change?
- Is health promotion now seen as a core business of the club?

### *3) Policy*

Have any changes/additions been made to your clubs constitution in relation to health?

- As a result of the HCP have new health relating policies been developed and implemented?
- How do you feel you have met your ambitions/fulfilled your agenda/remit?

### *4) Support*

Has there been support for the project from within the club? In what way has the executive supported or facilitated the HCP and HC Committee?

- Executive support? Is the HCP included on the agenda at executive meetings? Will it be discussed at the annual AGM?
- Financial support
- How has club overall responded to your involvement in the project

Overall, how have you found the level of support from Croke Park?



- Support – mentoring, logistics, acknowledgement, communication, interactions
- Regional group meetings/meeting with other clubs
- Any gaps in support provision?

#### 5) Benefits

What have been the benefits to being involved in the HCP?

- Have you seen any positive changes in your club because of your involvement in the HCP?
- How far to do you think you have come in terms of achieving the targets you set out for yourself at the beginning of this project?

#### 6) Barriers

What have been the main barriers, if any, to participating the HCP?

#### 7) Partnerships

Has the HCP exposed you to working with other sections of the club you would not normally collaborate with?

- Have any partnerships been developed? (Club and community)
- What has been your experience of working with partners? Important element?

#### 8) Future

Do you think it is a sustainable investment for your club?

- Stable organisational structure?

Do you think being in the HCP has raised your clubs profile in the community?

#### 9) Final Thoughts

Has the HCP experience met your expectations?

Would you recommend this project to other clubs? Why?

What 3 words would you associate with your HCP experience?

## Appendix 6

### Focus Group Topic Guide –Drop out Clubs

This focus group is being carried out by the WIT evaluation team on the GAA's Healthy Club project. This is a group discussion focusing on experiences, attitudes and reflections of your involvement in the project thus far. It is an opportunity to make your views known and your feedback is an important component in the future development and wider roll out of the Healthy Club project. As much learning will be gained from understanding what hasn't worked as understanding what has worked. To keep an accurate record of your comments, we will be audio recording the focus group, and tapes will be transcribed following the session. Everything that is shared in the focus group is strictly confidential. Participant's or club identity or other personal information, will not be revealed or published. Your participation is voluntary and you may withdraw from the group at any point.

#### 1) Origin of the Healthy Club Idea

Tell me how your club came to be involved in the Healthy Club project?

- Main driving force? (People)
- Benefits for the club?
  - Seen as a way of addressing the health needs within the local community or was it a more pragmatic response (a way to get new members, earn money, and build a better relationship with local community)?
- Any previous health promotion activities?

#### 2) Start-up Process

Can you tell me about the initial start-up phase of the Healthy Club project?

- Numbers involved
- Club and community represented
- Interaction with Croke Park and other clubs
- Actions completed – Needs assessment? /action planning? /implementation?

#### 3) Current Status

What is the clubs current status in relation to the Healthy Club Project?

- Factors that have led to the slowdown/cessation in Healthy Club activity?

#### 4) Support

How has the support been for this project from within your own club and community?

- Buy in from Executive committee/Communication
- Attracted new volunteers or fall back on same old people

Overall, how have you found the level of support from Croke Park?

- Support – mentoring, logistics, acknowledgement
- Regional group meetings/meeting with other clubs
- Any gaps in support provision?

### 5) Challenges

What have been the most challenging aspects of implementing the Healthy Club project thus far?

- Building partnerships?
- Additional workload?
- Finance?

What made these challenges hard to overcome?

### 6) Benefits

Have there been any positives arising from your involvement in this project?

### 7) Future

Will health promotion be something the club continues to consider in the future?

- Informal manner?

What would your advice be to a new club starting off on the same process?

# Appendix 7

## Focus Group Topic Guide – Club Executive

This interview is being carried out by the WIT evaluation team on the GAA's Healthy Club project. This discussion will focus on experiences, attitudes and reflections of your involvement in the project thus far. It is an opportunity to make your views known and your feedback is an important component in the future development and wider roll out of the Healthy Club project. As much learning will be gained from understanding what hasn't worked as understanding what has worked. To keep an accurate record of your comments, we will be audio recording the discussion, and tapes will be transcribed following the session. Everything that is shared is strictly confidential. Participant's or club identity or other personal information, will not be revealed or published. Your participation is voluntary and you may withdraw from at any point.

### 1) Opening Question

In your opinion, how can health promotion benefit a club?

- On and off the pitch (is it all about the players performing)
- Any previous health promotion activities? Health related policies in your clubs constitution?

### 2) HCP

Was the Executive involved in the clubs initial submission for this HCP?

- Support the idea directly or indirectly, discussed at committee level?
- Seen as a way of addressing the health needs within the local community or was it a more pragmatic response (a way to get new members, earn money, and build a better relationship with local community)?

### 3) Relationships

Is there a good working relationship between the Club Executive and HC Committees?

- Are any members of the executive on the HC committee?
- Have members of the Executive attended initiatives run by the HC Committee thus far?

Has the HCP exposed you to working with other sections of the club you would not normally collaborate with?

- Have any partnerships been developed? (Club and community)
- What has been your experience of working with partners?

4) Support

In what way has the executive supported or facilitated the HCP and HC Committee?

- Is the HCP included on the agenda at executive meetings? Are progress reports submitted to the Executive? Will it be discussed at the annual AGM?
- Financial support

5) Barriers

What have been the main barriers, if any, in supporting the HCP and HC Committee?

6) Policy

Has a Health and Well-being Officer been appointed in your club?

- Are you aware of the policy change to develop the ASAP officer into a Health and Well-being Officer at club level?
- What role will they play in benefiting your club?

7) Progress

Has your perception of the Healthy Club project changed over time?

- Initial thoughts on the HCP / what has caused your perception to change/not change?

Is health promotion now seen as a core business of the club?

Have you seen any positive changes in your club because of your involvement in the HCP?

8) Future

Do you think it is a sustainable investment for your club?

From the viewpoint of the executive, if the GAA had a small grant or awards system in place for participating clubs would it make the project more appealing?

Do you think being in the HCP has raised your clubs profile in the community?

# Appendix 8

## Focus Group Topic Guide - Healthy Club Committee

This focus group is being carried out by the WIT evaluation team on the GAA's Healthy Club project. This is a group discussion focusing on experiences, attitudes and reflections of your involvement in the project thus far. It is an opportunity to make your views known and your feedback is an important component in the future development and wider roll out of the Healthy Club project. As much learning will be gained from understanding what hasn't worked as understanding what has worked. To keep an accurate record of your comments, we will be audio recording the focus group, and tapes will be transcribed following the session. Everything that is shared in the focus group is strictly confidential. Participant's or club identity or other personal information, will not be revealed or published. Your participation is voluntary and you may withdraw from the group at any point.

1. Opening Question
  - a. Can you tell me about the Healthy Club Committee here in.....
    - Number of committee members
    - If they have other roles in the club e.g. chairman, secretary etc.
    - if they represent the club or the community e.g. player/coach or a HSE employee for example
2. Background
  - a. How did the club become involved in the HCP?
  - b. Who was the main driver and why?
  - c. Was the club involved in any previous health promotion activity?
3. How were the HCP committee members recruited?
  - a. How did you attract (the right??) people to the project?
  - b. What types of skillsets are most desirable for working in this type of initiative?
  - c. What were your own personal motivations and skills for getting involved in this project?
4. Reach of the HCP in the club?
  - a. Have all elements of the club and/or community been exposed to the HCP?
  - b. Are there any gaps in relation to the target groups you wanted to reach?
5. Partnerships?
  - a. Have partnerships been a key feature of any of the initiatives you have run? (With whom? How the partnerships came about?)
  - b. How have you engaged with partners?
  - c. How did you find the partnership experience?

6. Challenges?

- a. What have been the biggest challenges or barriers you have faced so far, if any?
  - i. Was there difficulty in financing the project?
  - ii. What was the committee's relationship with the executive like?
  - iii. Recruitment of support?
- b. How did you resolve them, were they resolved?
- c. Have you any suggestions about how these may be prevented in the future?

7. Benefits

- a. In what ways do you feel your club has benefitted from participating in the HCP so far?
- b. Has the wider community benefited from your clubs involved in the project? In what way?

8. Sustainability

- a. When the pilot project concludes will you continue with this work and why?
- b. What would help you to continue?
- c. Is there anything you would do differently/What advice would have for a club starting out on this project?

9. Has being involved in the HCP had an impact on you?

- a. Has it impacted your family life/work life?
- b. Are you happy you took part?

## Appendix 9

### **9a. Focus Group Topic Guide – Participants (SOAR Programme)**

This focus group is being carried out by the WIT evaluation team on the GAA's Healthy Club project, which St. Mary's GAA club is taking part in. This is a group discussion focusing on experiences, attitudes and reflections of your involvement in the SOAR programme run by St. Mary's GAA club. It is an opportunity to make your views known and your feedback is an important component in the future development and wider roll out of these types of projects. What has worked for you may not have worked for another person and vice versa and so participants should feel confident in agreeing to differ. As much learning will be gained from understanding what hasn't worked as understanding what has worked. To keep an accurate record of your comments, we will be audio recording the focus group, and tapes will be transcribed following the session. Everything that is shared in the focus group is strictly confidential. Participant's or club identity or other personal information will not be revealed or published. Your participation is voluntary and you may withdraw from the group at any point.

#### 1) Opening question

Why do you think St. Mary's decided to run SOAR programme in the first place?

#### 2) Participation

Did the SOAR programme sound like something you would like to take part in?

- Why did you decide to take part?
- Are you a member of St. Mary's GAA club?

#### 3) SOAR Programme

How did you find the SOAR programme itself?

- How did you find the components of the programme?
- Did you feel you were in a safe supportive environment?



#### 4) Benefits

Do you think you learned skills that you can apply in your everyday life?

- Types of skills? /Take home message? /Contacts?
- What were the personal benefits gained from the SOAR programme?
- How do you think a course like this benefits/impacts the St. Mary's GAA club?

#### 6) Challenges

Were there any challenging aspects to the SOAR programme or to your participation?

#### 7) Future

Has participation in an initiative like this encouraged you to become more active within your club?

## **9b. Focus Group Topic Guide – Participants ('How are you feeling today' programme)**

This focus group is being carried out by the WIT evaluation team on the GAA's Healthy Club project. This is a group discussion focusing on experiences, attitudes and reflections of your involvement in the 'How are you feeling today' programme run by St. Colmcilles GAA club. It is an opportunity to make your views known and your feedback is an important component in the future development and wider roll out of the Healthy Club project. What has worked for you may not have worked for another person and vice versa and so participants should feel confident in agreeing to differ. As much learning will be gained from understanding what hasn't worked as understanding what has worked. To keep an accurate record of your comments, we will be audio recording the focus group, and tapes will be transcribed following the session. Everything that is shared in the focus group is strictly confidential. Participant's or club identity or other personal information, will not be revealed or published. Your participation is voluntary and you may withdraw from the group at any point.

### *1) Opening question*

Tell me about your involvement in the St Colmille's GAA club?

### *2) Participation*

What made you decide to take part in the 'How are you feeling today' programme?

- Advertised? Word of mouth? Support the club? Interest in health?

### *3) 'How are you feeling today' programme*

Why do you think St. Colmcilles decided to run the 'How are you feeling today' programme in the first place?

How did you find the programme itself?

How did you find the components of the programme?

What were the main things you learned/took from the initiative?

### *4) Adherence*

What factors helped you to stick with the programme?

### *5) Benefits*

What were the personal benefits gained from the 'How are you feeling today' programme?  
(Well-being, coping mechanisms, social support, engagement, links to other initiatives)

How do you think a course like this benefits/impacts the St. Colmcilles GAA club?

6) Challenges

Were there any challenging aspects to the 'How are you feeling today' programme or to your participation?

7) Future

Has participation in an initiative like this encouraged you to become more active within your club?

- What is the key message of the How are you feeling today programme?
- Moving forward in terms of health promotion what do you think the next steps are?

## 9c. Focus Group Topic Guide – Participants (HFME)

This focus group is being carried out by the WIT evaluation team on the GAA's Healthy Club project, which Thomas Davis is taking part in. This is a group discussion focusing on experiences, attitudes and reflections of your involvement in the 6 week Healthy Food Made Easy (HFME) course run by Thomas Davis GAA club. It is an opportunity to make your views known and your feedback is an important component in the future development and wider roll out of these types of projects. What has worked for you may not have worked for another person and vice versa and so participants should feel confident in agreeing to differ. As much learning will be gained from understanding what hasn't worked as understanding what has worked. To keep an accurate record of your comments, we will be audio recording the focus group, and tapes will be transcribed following the session. Everything that is shared in the focus group is strictly confidential. Participant's or club identity or other personal information will not be revealed or published. Your participation is voluntary and you may withdraw from the group at any point.

### 8) Opening question

Why do you think Thomas Davis decided to run the Healthy Food Made Easy course in the first place?

### 9) Participation

What made you decide to take part in the HFME course?

- Advertised? Word of mouth? Support the club? Interest in health?

### 10) HFME course

How did you find the HFME programme itself?

How did you find the components of the programme?

### 11) Adherence

What factors helped you to stick with the course over the 6 week period?

### 12) Benefits

What were the personal benefits gained from the HFME course? (diet, social support, engagement, links to other initiatives)

How do you think a course like this benefits/impacts the Thomas Davis GAA club?

### 13) Challenges

Were there any challenging aspects to the HFME course or to your participation?

14) Future

Has participation in an initiative like this encouraged you to become more active within your club?

- Moving forward in terms of health promotion what do you think the next steps are?

## **9d. Focus Group Topic Guide – Participants (Operation Transfaughmation)**

This focus group is being carried out by the WIT evaluation team on the GAA's Healthy Club project, which Thomas Davis is taking part in. This is a group discussion focusing on experiences, attitudes and reflections of your involvement in the 12 week Operation Transfaughmation run by Castleblayney Faughs GAA club. It is an opportunity to make your views known and your feedback is an important component in the future development and wider roll out of these types of projects. What has worked for you may not have worked for another person and vice versa and so participants should feel confident in agreeing to differ. As much learning will be gained from understanding what hasn't worked as understanding what has worked. To keep an accurate record of your comments, we will be audio recording the focus group, and tapes will be transcribed following the session. Everything that is shared in the focus group is strictly confidential. Participant's or club identity or other personal information will not be revealed or published. Your participation is voluntary and you may withdraw from the group at any point.

### *D. Opening question*

Tell me about your involvement Castleblayney Faughs GAA club?

- (member/parent/community member)

Why do you think Castleblayney Faughs GAA club decided to run Operation Transfaughmation in the first place and why have they continued to run for a second year?

### *E. Participation*

Have you previously taken part in Operation Transfaughmation?

What made you decide to take part in Operation Transfaughmation this year?

- Advertised? Word of mouth? Support the club? Interest in health?

### *F. Operation Transfaughmation*

Can you briefly explain to me how the programme was run? (Which days you met up, where, for how long, who facilitated the walks, any additional activities e.g. talks, I saw you hiked up Mullyash Mountain)

How did you find the programme overall?

### *G. Adherence*

What factors helped you to stick with the course over the 12 week period? (Did you get reminders?)

Are you participating in the 5k FUN run/walk?

*H. Benefits*

Were there personal benefits you gained from Operation Transfaughmation? (More active, Weight loss, health benefits, social support, engagement, links to other initiatives)

Have you developed tools to help achieve your personal lifestyle goals?

How do you think a course like this benefits/impacts the Castleblayney GAA club?

*I. Challenges*

Were there any challenging aspects to Operation Transfaughmation or to your participation?

*J. Future*

Are you glad you took part in OT?

Has participation in an initiative like this encouraged you to become more active within your club?

- Were there any main things you learned/will take away from your participation in OT?
- Moving forward in terms of health promotion what do you think the next steps are?

## Appendix 10

### **10a. Interview Guide – Partner (HSE Stress Control programme facilitator)**

This focus group is being carried out by the WIT evaluation team on the GAA's Healthy Club project. This is a discussion focusing on experiences, attitudes and reflections of your involvement in the project thus far and in particular your facilitation of the HSE Stress Control Classes for Middleton and St. Finbarr's GAA clubs. It is an opportunity to make your views known and your feedback is an important component in the future development and wider roll out of the Healthy Club project. As much learning will be gained from understanding what hasn't worked as understanding what has worked. To keep an accurate record of your comments, we will be audio recording the interview, and tapes will be transcribed following the session. Everything that is shared in the interview is strictly confidential. Participant's or club identity or other personal information, will not be revealed or published. Your participation is voluntary and you may withdraw from the group at any point.

#### 1) Opening Question

Can you tell me about your role within the HSE South?

#### 2) Stress Control

Can you explain the background and concept of the Stress Control classes to me?

- What is the aim of the stress control classes you run?
- How are the classes structured and what do they entail?

#### 3) Partnership

According to the HSE this is the first ever sport and healthcare partnership to help tackle stress in Irish communities. How did the partnership with the GAA come about?

- Can you tell me a little bit about how the partnership worked (initial contact, amount of meetings/interaction, contact points, cost etc)?
- How did you find the experience of this partnership with Middleton and St. Finbarr's GAA clubs worked overall?

#### 4) Benefits

What are the main benefits in running a programme like this – benefits of this partnership approach with a GAA club?

#### 5) Challenges

As this was a unique working collaboration were there any challenges in running the Stress Control classes with a GAA club? Middleton or St. Finbarr's?

- Looking back is there anything you would change?



6) Sustainability

Do you think the partnership with the GAA is a sustainable investment?

- What do you foresee as the long-term benefits? Will these be measurable, or measured?
- Key challenges for sustainability
- Resource implications for wider/more in-depth delivery?
- Are there any future plans to partner up with GAA clubs outside Cork?

## **10b. Interview guide – Partner (Sligo LSP)**

This interview is being carried out by the WIT evaluation team on the GAA's Healthy Club project. This discussion will focus on experiences, attitudes and reflections of your involvement in the project thus far. It is an opportunity to make your views known and your feedback is an important component in the future development and wider roll out of the Healthy Club project. As much learning will be gained from understanding what hasn't worked as understanding what has worked. To keep an accurate record of your comments, we will be audio recording the discussion, and tapes will be transcribed following the session. Everything that is shared is strictly confidential. Participant's or club identity or other personal information, will not be revealed or published. Your participation is voluntary and you may withdraw from at any point.

### *10) Opening Question*

How did Sligo LSP become involved in the Healthy Club project?

### *11) Role*

What was your role, as you saw it, in the overall project?

### *12) Partnership*

Did you partner with any clubs during phase one of the project?

- How did that come about

What services/programmes did you provide?

What was the benefit of partnering with a GAA club? / What benefit did the club get from partnering with a LSP?

### *13) Engagement*

Do you think the LSP were used optimally by clubs and/or Croke park?

Were there clear channels of communication between the clubs and the LSP?

### *14) Challenges*

What were the challenges that arose during the project?

- Linking with clubs

### *15) Future*

What advice would you give to ensure the LSP is engaged with optimally in the future?

## **10c. Interview Guide – Partner (SOAR programme facilitator)**

This focus group is being carried out by the WIT evaluation team on the GAA's Healthy Club project. This is a group discussion focusing on experiences, attitudes and reflections of your involvement in the St. Mary's GAA club SOAR workshops. It is an opportunity to make your views known and your feedback is an important component in the future development and wider roll out of the Healthy Club project. As much learning will be gained from understanding what hasn't worked as understanding what has worked. To keep an accurate record of your comments, we will be audio recording the focus group, and tapes will be transcribed following the session. Everything that is shared in the focus group is strictly confidential. Participant's or club identity or other personal information, will not be revealed or published. Your participation is voluntary and you may withdraw from the group at any point.

### *1) Opening Question*

How did you get involved with SOAR?

### *2) Partnership*

Can you tell me how the partnership with St. Mary's came about?

- How did the partnership between SOAR and the St. Mary's work?

### *3) Content*

Can you explain to type of programme you delivered?

- Structure/Content?
- Aim of the programme?
- Skills taught/ take home messages?

### *4) Benefits*

What are the benefits in running a programme like this?

### *5) Challenges*

Were there any challenges in delivering the programme?

## 10d. Interview Guide – Partner (HFME)

This Interview is being carried out by the WIT evaluation team on the GAA's Healthy Club project, which Thomas Davis is taking part in. This is a discussion focusing on experiences, attitudes and reflections of your the 6 week Healthy Food Made Easy (HFME) course you delivered to participants in Thomas Davis GAA club. It is an opportunity to make your views known and your feedback is an important component in the future development and wider roll out of these types of projects. What has worked for you may not have worked for another person and vice versa and so participants should feel confident in agreeing to differ. As much learning will be gained from understanding what hasn't worked as understanding what has worked. To keep an accurate record of your comments, we will be audio recording the focus group, and tapes will be transcribed following the session. Everything that is shared in the focus group is strictly confidential. Participant's or club identity or other personal information will not be revealed or published. Your participation is voluntary and you may withdraw from the group at any point.

### 15) Opening question

How did you get involved in the HFME programme?

### 16) Partnership

How did the partnership between your organisation and the GAA club come about?

- How did that partnership manifest?
- Is it just a south Dublin initiative?

### 17) Benefits

What have been the main benefits of partnering with the GAA club?

- Mutual?

### 18) Challenges

Were there any challenging aspects to the partnership process?

### 19) Future

Has this partnership encouraged you to link with GAA clubs in the future?

# Appendix 11

## 11a. Anti-Smoking Policy – Participant Questionnaire

<b>Name of Club:</b>	<b>Date:</b>
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**Please answer the following questions (circle your response)?**

Are you a member of St. John Volunteers GAA Club? Yes No

Do you smoke? Yes No

Are you aware St. John Volunteers have introduced a new anti-smoking policy? Yes No

If yes, how did you become aware of the policy?

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Have you seen the no smoking signage at the club grounds? Yes No

Which of the following statements best describes the no smoking policy at St John Volunteers?

Smoking is not allowed in any indoor areas

Smoking is not allowed during juvenile games/training

Smoking is not allowed, at all times at the pitch and changing rooms

*For the following answers 1=not at all/no impact; 4=very much so/excellent impact*

	1	2	3	4	n/a
Has this policy raised your awareness of smoking at GAA grounds?					
Has this policy had a positive effect on your smoking behaviour at St John Volunteers?					
Has this policy had a positive effect on your smoking behaviour, in general?					
Have you observed people smoking at St John Volunteers pitch or changing rooms since the introduction of the policy?					
Are you in favour of this new policy?					
Do you think an anti-smoking policy on all GAA grounds is a good idea?					
Has this policy changed your perception of your clubs attitude to health?					

*Overall, how would you rate the implementation of this anti-smoking policy?*

Excellent Very Good Good Fair Poor

*Have you any further comments?*

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Would you like to get involved in our healthy club activities? Yes No

Would you like to be contacted about future initiatives or club events? Yes No

**If you circled yes to either of the above, please provide your contact details below:**

**Name** \_\_\_\_\_ **Email** \_\_\_\_\_ **Contact No** \_\_\_\_\_



### 11b. Anti-Bullying Participant Questionnaire



Name of Club: Oran GAC	Date: 21/12/10
Name of Initiative: GAA Tackling Bullying Programme	

This questionnaire is completely anonymous and there are no right or wrong answers. Please answer as honestly as you can. If you have any questions, feel free to ask.

Please circle your answer or fill in the space provided.

**About you?**

- Are you?      Male                  Female
- What age are you? \_\_\_\_\_
- Are you a member of Oran GAA club?

Yes, I am a full member                  Yes, I have a social membership                  No, I'm not a member

- If yes you are a member, which discipline are you involved in?

Football                  Hurling                  Ladies Football                  Camogie

5. Are you a?    Parent                  Player                  Coach                  Club Official                  Other

Please give details \_\_\_\_\_

- Have you witnessed bullying of any kind in your area?                  Yes                  No

- What were the 3 most important things you hoped to gain from the initiative?

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**Thinking about the initiative you took part in, please answer the following (circle your response (1=not at all/no impact; 5=very much so/excellent impact))**

- Did the workshop increase your awareness of bullying                  1    2    3    4    5    don't know
- Did the workshop increase your knowledge of anti-bullying?                  1    2    3    4    5    don't know
- How useful was the workshop?                  1    2    3    4    5    don't know
- Do you now fully understand the different types of bullying?                  1    2    3    4    5    don't know

If an issue of bullying should arise, do you know feel you have the information and skills to deal with the issue effectively? 1 2 3 4 5 don't know

Do you feel the objectives of the workshop, as you understand them, were achieved? 1 2 3 4 5 don't know

*Finally,*

How did you hear about the initiative? \_\_\_\_\_

Was the initiative well advertised? 1 2 3 4 5 N/A don't know

Was there a good level of participation? 1 2 3 4 5 N/A don't know

Provide educational/promotional material? 1 2 3 4 5 N/A don't know

Did it have a clear message? 1 2 3 4 5 N/A don't know

What one message did you take away from the workshop? \_\_\_\_\_  
\_\_\_\_\_

Did the initiative change your perception of your clubs attitude to health? 1 2 3 4 5 don't know

*Overall, how would you rate this initiative?*

Excellent                  Very Good                  Good                  Fair                  Poor

If you have any other feedback that you would like to add, please do so below:  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Thank you for taking the time to participate in this evaluation.**

Would you like to get involved in our healthy club activities? Yes No  
Would you like to be contacted about future initiatives or club events? Yes No  
**If you circled yes to either of the above, please provide your contact details below:**  
**Name** \_\_\_\_\_ **Email** \_\_\_\_\_ **Contact No** \_\_\_\_\_





## 11c. 'How Are You Feeling Today' participant Questionnaire



This questionnaire is completely anonymous and there are no right or wrong answers. Please answer as honestly as you can. If you have any questions, feel free to ask.

Please circle your answer or fill in the space provided.

### About you?

1. Are you?    Male                      Female
2. What age are you? \_\_\_\_\_
3. Are you a member of St. Colmcilles GAA club?

Yes, I am a full member                      Yes, I have a social membership                      No, I'm not a member

### About the Programme?

4. Which of the following elements of the 'How Are You Feeling Today' initiative have you taken part in?

Parents and Toddlers Group	
Health and Fitness Programme for Men	
Relaxation and Meditation	
Men Shed Programme	
Art and Creativity	
Cards and Games Evening	

5. What were the 3 most important things you hoped to achieve from the initiative?

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6. How frequently did you attend the sessions you signed up to?

Often                      Sometimes                      Rarely                      Never

7. Can you rate your overall enjoyment of the 'How Are You Feeling Today' initiative?

Excellent      Very Good      Good      Fair      Poor

8. How would you rate the content of the initiative?

Excellent      Very Good      Good      Fair      Poor

9. How did the 'How Are You Feeling Today' initiative impact you, in relation to the following:

	1 (no impact)	2	3	4	5 (excellent impact)
Increase your awareness about health and well being					
Improve your knowledge about health and well being					
Provide you with the skills to improve your health and well being					
Provide a new network of support for you in your community					
Give you a greater sense of belonging in your community					
Given you the confidence to seek support for your health and well being					
Provide you with the skills to manage your health					
Change your perception of your clubs attitude to health					
Change your perception of your GAA club in general					

10. Since taking part in the 'How Are You Feeling Today' initiative, have you done any of the following?

	Yes	No
Become a member of St Colmcille's club		
Recruited/encouraged other members for the club		
Increased or started to support the club at matches		
Increased or continued your support of club fundraising efforts (lotto tickets etc)		
Joined in social activities at the club		



12. If you have any other feedback that you would like to add, please do so below:

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**Thank you for taking the time to participate in this evaluation.**



## 11d. SOAR Evaluation – Participant Questionnaire

This questionnaire is completely anonymous and there are no right or wrong answers. Please answer as honestly as you can. If you have any questions, feel free to ask.

Please circle your answer or fill in the space provided.

### *About you?*

1. Are you?    Male                      Female

2. What age are you? \_\_\_\_\_

3. Are you a member of St. Marys GAA club?

Yes, I am a full member

Yes, I am a Juvenile member

No, I'm not a member

4. What year group are you in secondary school? \_\_\_\_\_

5. What were the 3 most important things you hoped to achieve from the initiative?

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6. Can you rate your overall enjoyment of the SOAR programme?

Excellent

Very Good

Good

Fair

Poor

7. How would you rate the content of the programme?

Excellent      Very Good      Good      Fair      Poor

8. How did the SOAR programme impact you, in relation to the following:

	1 (no impact)	2	3	4	5 (excellent impact)
Increase your awareness about mental health and well being					
Improve your knowledge about mental health and well being					
Provide you with the skills to improve your mental health and well being					
Provide a new network of support for you in your community					
Give you a greater sense of belonging in your community					
Given you the confidence to seek support for your mental health and well being					
Provide you with positive life skills					
Change your perception of your clubs attitude to health					
Change your perception of your GAA club in general					



I've been feeling cheerful									
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10. If you have any other feedback that you would like to add, please do so below:

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**Thank you for taking the time to participate in this evaluation.**





## 11e. Participant Questionnaire -HFME



This questionnaire is completely anonymous and there are no right or wrong answers. Please answer as honestly as you can. If you have any questions, feel free to ask.

Please circle your answer or fill in the space provided.

### About you?

1. Are you?    Male                      Female
2. What age are you? \_\_\_\_\_
3. Are you a member of Thomas Davis club?  
           Yes, I am a full member              Yes, I have a social membership              No, I'm not a member

### About the Programme?

4. Can you rate your overall enjoyment of the programme?  
           Excellent      Very Good      Good              Fair              Poor
5. Did the initiative change your perception of your clubs attitude to health?  
           1 (not at all)              2              3              4              5 (very much so)
6. Thinking about the programme, was there a good balance between cooking demonstrations and hands on cooking?  
   Yes              No
7. Did you think there was?  
           a. Not enough hands on cooking              Just right              Too much hands on cooking
8. What do you think of the level of skills being taught?  
           a. Too basic                      Just right                      Too difficult
9. Did the initiative teach you anything about healthy eating?      Yes              No

If yes, can you list three things you learned about healthy eating:

(i) \_\_\_\_\_ (ii) \_\_\_\_\_

\_\_\_\_\_

(iii) \_\_\_\_\_

10. In relation to the following meal options, which would be the healthiest?

Breakfast	Porridge		
Lunch			
Dinner			
Snack			

**Cooking Skills and Perceived Confidence in Cooking**

11. Overall, do you think your cooking skills have improved?      Yes                      No

12. If yes, have you used any of your new skills at home?      Yes                      No

13. How confident are you in your ability to follow a recipe?

1 (very confident)      2                      3                      4 (not at all confident)

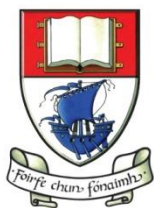
14. How frequently do you cook using/eat the following?

	Often	Sometimes	Rarely	Never
Basic Ingredients				
Assemble ready-made ingredients				
Convenience foods				

15. Without using packets, tubs, pre made sauces etc, please rate your confidence to prepare the following dishes:

	1 Very Confident	2	3	4 Not at all confident
Chilli Con Carne				
Cherry tomato and lentil soup				
Brown bread				
Fruit smoothies				

## Appendix 12



Waterford Institute of Technology

INSTITIÚID TEICNEOLAÍOCHTA PHORT LÁIRGE

### WIT APPLICATION FOR ETHICAL APPROVAL OF A RESEARCH PROJECT

Please submit this form in electronic format

accompanied by a paper copy of the required signature pages.

<b>Applicant's Name</b> ( include title Dr/Ms/Mr )  (Please note that the applicant must be available to attend the meeting)	Miss Alex Donohoe
<b>Applicant's Position</b>  Postgraduate <input checked="" type="checkbox"/> Staff <input type="checkbox"/> Research Assistant <input type="checkbox"/>  Other <input type="checkbox"/> Please specify other: _____	
<b>Please state if this research is for an award:</b> Masters <input checked="" type="checkbox"/> PhD <input type="checkbox"/>	
<b>Applicant's Student Number (if applicable)</b>	20064724
<b>Principal Investigator:</b>	Alex Donohoe
<b>Supervisor(s):</b>	Dr. Aoife Lane, Dr. Niamh Murphy

<b>Department:</b>	Health, Sport and Exercise Science
<b>Research Group:</b>	Sport Studies
<b>Phone Number:</b>	0877520025
<b>e-mail Address:</b>	alexandra.donohoe8@mail.dcu.ie
<p><b>Please list any others involved in the research (including research assistants and students, other collaborators or partner institutions):</b></p> <p>GAA – National Healthy Club Steering Committee, with representatives from the GAA, Health Service Executive (HSE) and academic/health related institute.</p>	
<p><b>Project Title:</b></p> <p>An Evaluation of the GAA Healthy Club Initiative</p>	
<p><b>Location of Research</b></p>	
1. Within WIT (Campus & Room)	Cork Road Campus, Postgraduate room in the Luke Wadding Library
2. External Components	Visits to GAA clubs (18 clubs are taking part in this study)
<b>Commencement Date:</b>	October 2013
<b>Estimated Duration of the Project:</b>	21 months
<p><b>Source of Funding for the Research:</b> Gaelic Athletic Association(GAA) in partnership with the HSE (Health Service Executive)</p> <p><b>Is there any possibility of conflict of interest between the funding agency and the publication of the research results? NO If so, please explain:</b> n/a</p>	

## **Plan & Design of Project**

**Provide a brief description in lay terms under the following headings.**

### **1. Brief rationale for research**

Health promotion is defined as ‘the process of enabling people to increase control over and to improve their health’ (WHO 1986) while the socio-ecological approach to health has highlighted the variety of factors, beyond those related to the individual, that can influence health. The responsibility of promoting health extends beyond the health sector alone and requires a collaborative effort with other settings and institutions to achieve a holistic and wide-ranging approach to promoting health and well-being. This is reflected in the settings approach to health promotion, which is based on understanding, appreciating and working with the settings where people are educated, work and live in to positively impact health behaviours. Whitelaw et al. (2001) explained how changing people’s health and health behaviours are easier to accomplish ‘if health promotion focuses on settings instead of the individual’. This approach has already been utilized in health promotion initiatives in health care institutions, schools, universities and workplaces (Kokko et al. 2009), with successful initiatives more likely to involve activity in more than one area e.g. curriculum, school/work environment/community (Barnekow et al. 2006). Kokko et al. (2006) recently advocated the use sports clubs as another setting to promote health. Sports clubs have the potential to promote and facilitate healthy behaviours and attitudes within the club but also could potentially extend their reach into local communities. The GAA is a volunteer community organisation operating throughout the 32 counties of Ireland and across the world. Being the largest community-based sporting organisation in Ireland, the GAA delivers numerous health benefits through the promotion of physical activity, social interaction and developing a civic responsibility to members and communities through its club system. There are approximately 2200 GAA clubs throughout Ireland, and thus the reach of the organisation extends into almost all communities nationwide. This combined with the GAAs philosophy of fostering a community identity, supporting inclusion for all members of society and operating on an amateur basis, and thus relying on volunteers to operate and function reinforces the suitability of the GAA club as an entity that can engage in health promotion activities. Of late, the organisation has also recognised the diverse and changing health needs of their members with a demand for assistance in areas such as: Healthy Eating and Diet, Drug and Alcohol Awareness, Mental Well-being and Resilience Development, Suicide Prevention and Response, Promotion of Health and Well-being through Physical Activity. This has led to the development of an ASAP programme and the GAA Social Initiative. The GAA’s Alcohol and Substance Abuse Prevention (ASAP) programme aims to minimise the harm caused by the misuse of alcohol and other substances, while the Social Initiative focuses on older member of the community and giving them regular and meaningful social contact allowing them to regain an enjoyable social life.

Furthermore, the GAA, in partnership with the HSE, is currently working on a project to further address these needs; the ‘GAA Healthy Club’ initiative. Based on the health promotion settings approach, the initiative aims to “highlight and reinforce the great work already being done by clubs while assisting them in identifying and responding to the most important health issues amongst their membership and in their community” (GAA 2013). The GAA Healthy Club initiative is therefore a welcome structure in further supporting and harnessing the pivotal role the GAA plays in society.

The approach focuses on a four pillar method of implementation with the aim of creating a sustainable model for all clubs.

The purpose of this research is to assess how effective the clubs are in meeting the agreed Healthy Club principles and criteria, as well as examining the 'how' of the Healthy Club process from the perspective of both the club members and the evaluation team. The outcomes resulting from the implementation of key programmes within the initiative will also be investigated.

## **2. Main purpose/aim**

The main aim of the project is to investigate the potential of GAA clubs as a setting in which to promote the health and well-being of club members as well as the wider community. This involves (i) assessing the process of the development of a Healthy Club over the duration of the initiative, (ii) the impact of the Healthy Club Programme on key outcome criteria and (iii) evaluating (process and impact) a selection of specific programmes delivered by clubs.

## **3. Population of interest**

Members and communities of GAA clubs based in Ireland

## **4. Sampling method**

Clubs taking part in this research were chosen after a call for expression of interest from Croke Park (GAA HQ). Sixteen volunteer clubs in total were chosen (four from each province) along with two case study mentoring clubs. Control clubs will also be conveniently selected by Croke Park; one from each province. Questionnaires will be completed by the Healthy Club Officer in each club while a selection of club representatives including players, parents, administrators, coaches, non-members, club partners will be recruited to take part in focus group sessions at club level. Regional focus groups will be composed of two representatives from each club who will voluntarily take part in these forums.

## **5. Procedures**

- Participating GAA clubs were chosen by the GAA officials.
- Clubs completed a community audit to identify priority areas and target groups in their community
- Clubs complete a Healthy Club Questionnaire, which will identify baseline characteristics in relation to membership, health promotion activity and key criteria for becoming a healthy club (as defined by the GAA and HSE)

- Clubs will develop and implement an action plan to guide their health promotion activity in year 1 of the initiative
- Club representatives will take part in focus groups to discuss their experiences in the initial development of a healthy club
- Site visits will be conducted with a selection of clubs to observe the daily workings of the club (coaching, facilities, administration)
- Specific programme evaluation will be conducted on a selection of programmes administered by clubs
- The Healthy Club Questionnaire will be administered at two follow up points to identify changes from baseline
- Follow up focus groups will also be conducted with clubs to discuss the process involved in implementing healthy club activities

## **6. State main data collection methods (e.g. survey, test, interview etc.)**

### *Evaluation of Healthy Club Process*

Quantitative and qualitative methodologies will be used to evaluate the process of becoming and running a Healthy Club. Utilising a quantitative methodology will generate a standardised, comparable set of data for all clubs participating in the Healthy Clubs Programme (n=16) and control clubs.

- The Healthy Club steering committee have, in consultation with key stakeholders, developed a set of key criteria for healthy clubs. These criteria will be adapted into a likert scale type index, based on a similar instrument developed by Kokko et al., (2009). This Healthy Club Questionnaire will be completed by the Healthy Club Officer and Committee. This self-evaluation will be completed by all clubs taking part in the Healthy Club initiative. The Healthy Club Questionnaire will identify baseline characteristics in relation to membership, health promotion activity and key criteria for becoming a healthy club (as defined by the GAA and HSE).

Quantitative methodology will not capture all of the activity engaged in by participating clubs nor will it assess the experiences of those directly and indirectly involved in the Healthy Club process. Therefore, qualitative data will be collected to explore the complexities of club activities using focus groups and observation.

- Experience and reflections on becoming a Healthy Club and a more comprehensive overview of Healthy Club activities will be explored by conducting a focus group with key personnel involved in the initiative, primarily the nominated Healthy Club Officer and other key committee members. Focus groups are particularly suitable in this instance as the development of a Healthy Club is very much collaborative and combined effort between a variety of individuals. Focus groups will capture the interaction between these individuals. Also, as noted earlier, it will be difficult to capture all of the work carried out in the club using the Healthy Club Questionnaire so this discussion will facilitate a broader understanding of activities that constitute Healthy Club related initiatives such as Family Fun Days and Community Games Events. Focus groups will be carried out with two clubs in every province.
- Engagement with partners is central to the success of the Healthy Club initiative and will be investigated by carrying

out focus groups/semi structured interviews with defined internal and external partners involved in the Healthy Club initiative and discussing their views on the nature, success and outcomes of the Healthy Club concept. Focus groups will be carried out with internal partners who include non-committee club administrators, coaches, parents and players. Focus groups are particularly suitable due to the nature of GAA clubs and the interaction between all individual entities within the club. The mode of data collection with external partners who include those from community or other agencies taking part in the initiative will be dependent on the amount of and access to these partners. It may be more feasible to conduct individual interviews with these partners.

- Finally, in an effort to further understand the workings of the Healthy Club, observation will be carried out over a two day period in two clubs in each province. This observation will facilitate an objective, more in-depth description of the actual environment, behaviour, interaction and activity in the club and how this relates to the defined Healthy Club strategy and philosophy of the club. Observation events will at a minimum include access and quality of facilities, coaching sessions, games, post-game activities and meetings but may also be scheduled to include the delivery of a health event or programme.

#### *Programme Evaluation (Programmes)*

A sample of programmes developed by Healthy Clubs will be evaluated; programmes will include a selection from various categories specified in the Healthy Club criteria, e.g.: health screening, diet and nutrition, inclusion, integration and respect initiatives, alcohol initiatives

- Process Evaluation: this will include an assessment of resources required to design and deliver the programme, the nature and amount of programme content, collaborative delivery, attendance and participation in the programme. Process evaluation is important in this instance for two reasons. Firstly, it will provide key guidance for other clubs interested in delivering similar programmes, thus improving the generalizability of the initiative. Secondly, programme outcomes can be linked to programme delivery, which can indicate success, or lack thereof, of certain components and effectiveness can be quantified by successful implementation and engagement as well as successful outcomes. Process evaluation will mainly be carried out using quantitative methods.
- Outcome Evaluation: effectiveness of the programme will be assessed in relation to feedback from participants, changes to club policy/practice following the programme, changes in behaviour, changes in awareness or level of education, changes in partnerships with community based organisations. Outcome evaluation will indicate if the programme is effective and should be adopted by other clubs. Outcome assessments will be carried out using quantitative (feedback sheets) and qualitative methods (pre and post interviews) with participants and programme leaders. Observation can also be used here to observe the implementation of programme outcomes in the real life context of club activities – coaching sessions, post-game activities, performance supports.



## Ethical Issues

Please state what you believe are the main ethical issues in relation to your project.

Informed Consent: clubs have agreed to take part in the study and all activities involved in the evaluation will be approved at national and club level. All participants will be asked to provide informed consent before taking part in focus groups or interviews. Passive consent will be observed for questionnaires.

Data Protection – Participant's or club identity, or other personal information, will not be revealed or published. Participants/clubs will be assigned an ID number under which all personal information will be stored in a secure file and saved in a password protected file in a computer at WIT. Hard copies of questionnaires and consent forms will be stored in a locked filing cabinet for the duration of the study.

The investigators alone will have access to the data. Data will be stored for 5 years following the completion of the project, in line with Institute regulations.

Participants – Participation in this study is voluntary and all participants may withdraw from the Research Study at any point. There will be no penalty for withdrawing before all stages of the Research Study have been completed.

Observation - observation of coaching sessions, meetings and events may be carried in selected clubs. This observation will facilitate an objective, more in-depth description of the actual environment, behaviour, interaction and activity in the club and how this relates to the defined Healthy Club strategy and philosophy of the club. Data will be collected using objective measurement tools and any recordings will be saved in a password protected computer file on a computer in WIT. Informed consent will be obtained at both club and individual levels prior to any observation.

## Risks to Persons

If the project involves any test or procedure which might carry any risk to the health or well-being of any person, please describe the risks and explain how you intend to minimise the risks.

n/a

## Qualifications

**Masters Student - Alex Donohoe** – Graduated from DCU with a first class honours degree in Sport Science and Health. My undergraduate thesis provided me with invaluable first-hand experience of the ethical considerations surrounding any research study. Here ethical approval was submitted to and approved by DCU ethics commission. Informed consent forms, plain language statements and health screening questionnaires were approved and given to all participants. Protocols for data collection were established and followed to ensure data protection. During my undergraduate degree I also carried out an evaluation of the stakeholders of youth physical activity in County Meath in collaboration with Meath Child Services Committee. I am also a player member of Buffers Alley Senior Camogie Club.

**Dr Aoife Lane** is also a member of the Centre of Health Behaviour Research in WIT and is course leader of the BA in Exercise and Health programme in WIT. Aoife has been involved in several evaluation initiatives including the Moving Hearts Programme, the Sean Kelly Cycle, the Waterford Active Schools Programme and the Women's Mini Marathon, which was the focus of her PhD. This was quite a substantial evaluation carried out over a three year period. One of the main outputs of this evaluation was the generation of 'how to' guides for groups interested in designing and evaluating health events, particularly those related to physical activity, which were published and distributed by the Irish Sports Council. Aoife has had a lengthy involvement in the GAA both from a participation (Ballinderreen, Galway) and administration perspective (current Chairperson of the National Camogie Player Welfare Committee) and thus, has direct experience and understanding of the workings of GAA clubs. She also has attended workshops on the Healthy Club concept at European Conferences.

**Dr Niamh Murphy** is an experienced researcher in the Centre of Health Behaviour Research in WIT and is course leader of the BA in Health Promotion programme delivered in WIT. One of the key roles of the Centre for Health Behaviour Research is to support evaluation of health promotion initiatives in Ireland and Niamh has led successful health promotion evaluations on community wide active travel programmes, mass events, and physical activity for socially disadvantaged groups. She is a member of the National Physical Activity Steering Group in Ireland and the European steering committee for the Health Enhancing Physical Activity (HEPA) Network. Niamh is a trained PE teacher, an active athletics coach, a former international athlete, a current recreational triathlete and active parent in O'Loughlin Gaels GAA Club, Kilkenny.

### **Commercial Partners**

If the project involves any commercial entity, please complete this section.

n/a

**Name of the company:**

**Name of contact person:**

**Are agreements required by the Company:**

**Please attach details.**

**If the researchers can anticipate any conflict of interest between the company and the research results, how will this be dealt with? Please attach any relevant correspondence.**

### **Research on Animals**

If the project involves animal subjects, please complete this section. Please attach any relevant licences.

n/a

**Are you aware of and have you understood the legislation relating to experiments involving animals?**

**Type and source of animals:**

**Number to be used:**

**Facilities and expertise required for animal care and disposal of waste:**

### **Research involving Human Participants**

If the project involves human participants, please complete this section.

**Source:** Ireland

**Age range:** 18+

**Selection criteria:** Volunteer GAA Clubs

**Exclusion criteria:** n/a

**How participants will be recruited?** Volunteer GAA Clubs were chosen by Croke Park after a call for expressions of interest, 2 clubs were chosen from each province, with 2 mentoring case study clubs also chosen.

**Will you obtain informed consent?**

Overall club consent will be acquired prior to the commencement of data collection and further passive consent will be obtained at both club and individual level prior to any the completion of questionnaires and focus groups, and observation.

**How will you protect privacy and confidentiality rights?**

Confidentiality is an important issue during data collection. Participant's/club identity, or other personal information, will

not be revealed or published. Participants will be assigned an ID number under which all personal information will be stored in a secure file and saved in a password protected file in a computer at WIT. The researcher and supervisors will only be permitted access to this file.

### **Chemical and Biological Agents**

If the project involves the use of any chemical or biological agents which might be hazardous to health or environment, please complete this section.

n/a

1. Name the agents involved and explain how they could affect the environment.
2. Explain how you will limit any risks during the project.
3. Explain how these agents will be stored.
4. Explain how they will be disposed of after the project.

## **Data Management**

**Have you read and understood the Data Protection Act 1998 & 2003?** Yes

**What aspects of the Data Protection Act 1998 & 2003 are relevant for this study?** Right to have data processed in accordance with the Data Protection Acts

**Describe your arrangements for the storage and control of confidential data.**

Participants/clubs will be assigned an ID number under which all personal information will be stored in a secure file and saved in a password protected file in a computer at WIT. All computerised data will be stored in a password protected file, on this computer. Completed questionnaires/consent forms will be stored in a locked cabinet for the duration of the study.

**Who will have access to the data?** The researcher and supervisors

**How long will it be stored?** Data will be stored for 5 years after the conclusion of the study.

**Intellectual Property**

Should this research generate any intellectual property, please describe any agreements you have made with colleagues or external partners and attach copies.

**Publication and Dissemination of Results**

This section is applicable to every project and must be completed.

All publications and outputs resulting from this study will acknowledge all members of the research team. See attached copy of the publication agreement.

**Other Ethical Implications**

If there are ethical implications of your research which are not requested in this form, please provide details

**Signatures of all investigators involved in this research**

<i>Signature:</i>		<i>Date:</i>	
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<i>Signature:</i>		<i>Date:</i>	
<i>Signature:</i>		<i>Date:</i>	
<i>Signature:</i>		<i>Date:</i>	

**Checklist**

BEFORE YOUR APPLICATION CAN BE CONSIDERED PLEASE ENSURE YOU HAVE INCLUDED THE FOLLOWING WITH YOUR APPLICATION FORM:

1. Formal description of your project including the aims and methodology for the project.	<input type="checkbox"/>
2. CVs for all researchers involved including your own CV and CV of your supervisor(s).	<input type="checkbox"/>
3. Copies of any questionnaires.	<input type="checkbox"/>
4. Topic guides.	<input type="checkbox"/>
5. Consent forms.	<input type="checkbox"/>
6. Written publication agreement.	<input type="checkbox"/>

## Appendix 13

### Health Promotion Classification Matrix

	<i>Low Health Promoting</i>	<i>Moderately Health Promoting</i>	<i>High Health Promoting</i>
Policy	<4.0	4.1-6	>6.1
Ideology	<1.0	1.1-1.5	>1.51
Practice	<3.0	3.1-4.5	>4.51
Environment	<3.5	3.51-5.25	>5.26
Juvenile Environment	<5.5	5.51-8.25	>8.26
Overall	<17	17.1-26.99	>27.0



## Appendix 14

### Initiatives by topic and by club

#### *Physical Activity (n=22 initiatives, n=14 clubs)*

<b>Club (Province)</b>	<b>Content</b>	<b>Target Group(Club, Community, both club and community)</b>	<b>Governance (G), Partnership (PA), Programme (PR), Environment (E)</b>	<b>Impact (High, Medium, Low)</b>
Annacurra (L)	Operation Transformation event	Both	PR, PA (Wicklow LSP), E	Medium
Annacurra (L)	Walking/Running club	Both	PR, E	Low
St.Colmcilles (L)	Walking Club/Running group – meet 3 evenings a week at the club grounds	Both	PR, E	Low
Thomas Davis (L)	5 week Fit walk programme	Both	PR, PA (SDCC), E	Medium
Midleton (M)	Weekly walking/running Group	Both	PR, E	Low
St.Finbarr's (M)	Weekly fitness Classes	Both	PR, E	Low
Beaufort (M)	Exercises classes (4 nights + 1 morning)	Both	PR, E	Low
Nenagh (M)	5 and 10k Run	Both	PR, E	Low
Nenagh (M)	Walking Group	Both	PR, PA (Get Ireland walking), E	Medium
Mungret St. Pauls (M)	10k Run – HC will run warm up session and training plan. HC logo on all material	Both	PR, E	Low
Mungret St. Pauls (M)	24hr fitness challenge	Both	PR (in aid of Pieta house), E	Low
St. Marys (U)	Walking Club	Both	PR, E	Low
St. Marys (U)	Biggest Loser Challenge	Both	PR, E	Low
Castleblayney Faughs (U)	Operation TransFAUGHs- mation 12 week programme, 2 exercise classes per week. 1 morning run/walk/cycle. 5k Run/Walk to complete programme	Both	PR, PA (Orla Duffy, Senior HSE Community Dietician, Gillian Oliver, BSC Physiotherapy, local businesses), E	Medium
Castleblayney Faughs (U)	Walking/ Jogging group	Both	PR, E	Low
Castleblayney	30 Day Challenge (30	Both	PR (in aid of charity), E	Low

Faughs (U)	mins exercise for 30 days raising money for charity)			
St. Peters GAC (U)	Extension of the 'little black dress challenge' into the new year. 5 wk intensive physical training	Both (Women)	PR, E	Low
St. Peters GAC (U)	10k run	Both	PR, E	Low
Oran (C)	PA and healthy eating programme. Marking out a one wall handball court at local primary school.	Both (Youth)	PR,PA (schools & Coman's Handball club), E	Medium
Oran (C)	6 wk fitness classes and advice/info on nutrition	Both	PR, PA (Club member who works for LSP), E	Medium
Oran GAC (C)	Yoga classes	Both	PR, E	Low
Eastern Harps (C)	Operation Transformation	Both	PR, PR (Sligo LSP), E	Medium

**Emotional well-being (n=14 initiatives, n=10 clubs)**

<b>Club (Province)</b>	<b>Content</b>	<b>Target Group</b>	<b>Governance(G), Partnership(PA), Programme(PR), Environment (E)</b>	<b>Impact (High, Medium, Low)</b>
Annacurra (L)	Sport not stigma programme	Both	PR, PA (Wicklow LSP), E	Medium
St.Colmcilles (L)	'How are you feeling today' programme. Developed a local care services directory booklet.	Both	PR, PA (Genio Trust - Funding), E	Medium
St. Colmcilles (L)	Relaxation classes in schools	Both (Youth)	PR, PA (Schools), E	Medium
Thomas Davis (L)	Mental Health information talks	Both (Parents)	PR, PA (Local Mental Health services), E	Medium
Midleton (M)	6 wk Stress control programme	Both	PR, PA (HSE), E	Medium
St. Finbarrs (M)	6 wk stress control programme	Both	PR, PA (HSE), E	Medium
St. Finbarrs (M)	HSE Safe Talk programme	Both	PR, PA (HSE & Middleton GAA club), E	Medium
Beaufort (M)	Promoting Lifeline Programme (Suicide prevention, counselling and support)	Both	PR, PA (Kerry Lifeline), E	Medium
Nenagh (M)	Mental Health and well-being night x2 (Conor Cusack and local speakers)	Both	PR, PA (speakers), E	Medium

St. Marys (U)	SOAR.ie Resilience and mental well-being for kids after school	Both (Youth)	PR, PA (SOAR.ie, Funded by public Health Agency), E	Medium
St. Peters GAC (U)	B+ positive programme	Both (Youth)	PR, PA (MENSSANA, P.I.P.S), E	Medium
Oran GAC (C)	Mental Health talk	Both	PR, PA (Local Psychologist), E	Medium
Oran GAC (C)	HSE Safe Talk	Both	PR, PA (HSE), E	Medium
Oran GAC (C)	Stress management class	Both	PR, PA (OPAL Centre-Opportunities for Personal Advancement in Life), E	Medium

**Health Awareness/First aid (n=13 initiatives, n=9 clubs)**

<b>Club (Province)</b>	<b>Content</b>	<b>Target Group</b>	<b>Governance(G), Partnership(PA), Programme(PR), Environment (E)</b>	<b>Impact (High, Medium, Low)</b>
St. John Volunteers (L)	Programme of education and awareness (series of talk on e.g. nutrition, drug, suicide etc.). Health and well-being policy	Both (Youth)	PR, PA(Local cardiologist, Garda, Psychiatrist, Dietician, Wexford community drug project worker), E	Medium
Midleton (M)	Cardiac Screening	Both	PR, PA (Health Screening Ireland), E	Medium
Beaufort (M)	Health Screening	Both	PR, PA (Heart aid, LAYA, local Athletics club), E	Medium
Nenagh (M)	Health Screening	Both	PR, PA (local Pharmacy), E	Medium
Mungret St. Pauls (M)	Movember	Both	PR, PA, E	Medium
Mungret St. Pauls (M)	Health Screening and information day	Both	PR, PA (Local nurse), E	Medium
Mungret St. Pauls (M)	Family Fun Day	Both	PR, E	Low
St. Johns (U)	Men's Health check (Action cancer Big Bus)	Both (Men)	PR, PA (Action Cancer), E	Medium
St. Johns (U)	Action Cancer Big Bus – health screening and promotion	Both	PR, PA (Action Cancer), E	Low
Oran GAC (C)	Developed Healthy and well-being policy	Both	G, E	Low
Eastern Harps (C)	Weekly bingo Garland Sunday Family Fun Day	Both (Elderly)	PR, PA (Garland Sunday Committee), E	Medium
Annacurra (L)	First Aid training	Club (Coaches)	PR, PA (Camogie Club), E	Medium
St. John Volunteers (L)	Purchase and training in using a defibrillator	Both	PR, E	Low

**Anti-bullying (n=6 initiatives, n=6 clubs)**

<b>Club (Province)</b>	<b>Content</b>	<b>Target Group</b>	<b>Governance (G), Partnership (PA), Programme (PR), Environment (E)</b>	<b>Impact (High, Medium, Low)</b>
St. Colmcilles (L)	Anti-Bullying Workshop	Club (Compulsory for all coaches/mentors/officers and open to all members)	PR, E	Low
Midleton (M)	2 night course	Club (Youth)	PR, PA (Feroige), E	Medium
Nenagh (M)	Anti-bullying poster campaign. Liaise with schools/community groups on Cyber bullying. Target u10/12 & U14/16 teams through team building, social activities and talks throughout the year.	Both (Youth)	PR, PA (Schools), E	Medium
Mungret St. Pauls (M)	Blue Shield Anti-Bullying poster campaign	Both (Youth)	PR, PA (ISPC Blue Shield), E	Medium
Eastern Harps (C)	Anti-bullying. Review Code Of Conduct. Ensure that Executive, Players, Coaches and Parents have access to/read/understand the code.	Both	G, E	Low
Oran GAC (C)	Anti bullying policy and campaign	Both	G, PR, PA (schools), E	High

**Diet/Nutrition (n=5 initiatives, n=5 clubs)**

<b>Club (Province)</b>	<b>Content</b>	<b>Target Group</b>	<b>Governance (G), Partnership (PA), Programme (PR), Environment (E)</b>	<b>Impact (High, Medium, Low)</b>
Annacurra (L)	School based Programme	Both	PR, PA (schools), E	Medium
Thomas Davis (L)	Healthy Food made easy. 6wk talks and demos	Both	PR, PA (SDLSP), E	Medium
Thomas Davis (L)	Healthy Food/ Fruit at summer camps. Potential Link with	Club (youth)	PR, E	Low

	Foroige Food choices Programme End of 2014			
Midleton (M)	Food map on website	Both	PR, PA (Nutritionist), E	Medium
St. Finbarrs (M)	Fruit at underage training	Club (Youth)	PR, PA (Funding from local councillor), E	Medium

**Social Inclusion (n=5 initiatives, n=5 clubs)**

<b>Club (Province)</b>	<b>Content</b>	<b>Target Group</b>	<b>Governance (G), Partnership (PA), Programme (PR), Environment (E)</b>	<b>Impact (High, Medium, Low)</b>
St. Colmcilles (L)	Men's Shed – supporting the development of men's shed for east Meath using the club grounds.	Both (Men)	PA, PR (Men's shed), E	Medium
Beaufort (M)	Elderly Exercise classes	Both (Elderly)	PR, PA (Age and Opportunity grant), E	Medium
Nenagh (M)	Transport scheme to help get elderly/ isolated to matches	Both (Elderly)	PR, PA (Local transport), E	Medium
St. Marys (U)	Cross Community - Yoga classes for the whole community using the Presbyterian church hall.	Both	PR, PA (Presbyterian community), E	Medium
Nenagh (M)	Disability awareness in sport	Club (Coaches/Officers)	PR, PA(North Tipp Sports Partnership), E	Medium

**Alcohol Awareness and Anti-Smoking (n=7 initiatives, n=6 clubs)**

<b>Club (Province)</b>	<b>Content</b>	<b>Target Group</b>	<b>Governance (G), Partnership (PA), Programme (PR), Environment (E)</b>	<b>Impact (High, Medium, Low)</b>
Annacurra (L)	Talk/ Workshop, ASAP Policy	Both (Youth)	PR, PA (Foroige/other clubs), E, G	High
Thomas Davis (L)	New policy to reduce the selling of shots in the club	Both	G, E	Low
St. Finbarrs (M)	6 wk alcohol and drug abuse programme	Club (Youth)	PR, PA (Foroige), E	Medium
St. Finbarrs (M)	Link with ASAP to train in committee	Both	G, E	Low

	member			
Eastern Harps (C)	Information session under guidance of ASAP Officer on the dangers of drugs & alcohol with keynote speakers. ASAP policy	Both	PR, PA (speakers), E, G	High
St. John Volunteers (L)	Development of a 'no smoking policy' and ASAP policy	Both	G, E (Erection of supportive signage)	Low
St. Johns GAC (U)	Run smoking cessation class(es), erect appropriate signage in support of our Smoke-Free Policy	Both	PR, E, PA (Action Cancer)	Medium

# Appendix 15

## Individual Initiative evaluations

Club Size	Munster	Leinster	Connacht	Ulster	Topic Area
Small (0-400)	N/A	St. John Volunteers Anti-smoking	N/A	St. Marys Emotional Wellbeing	Emotional Wellbeing
Medium (401-700)	N/A	N/A	Oran Anti-bullying	Castleblayney Faughs Physical activity	Alcohol Awareness
Large (701+)	Midleton/St. Finbarr's Emotional Wellbeing	Thomas Davis Nutrition/Diet St. Colmcilles General Health	N/A	N/A	Physical Activity
					Nutrition/Diet
					Inclusion
					General Health
					Anti-smoking
					Anti-Bullying







