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INSTITIÚID TEICNEOLAÍOCHTA PHORT LÁIRGE

An Evaluation of Phase 2 of the GAA Healthy Club Project

By

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Honesty Statement

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.

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Abstract

Introduction: The GAA, in partnership with the HSE, have developed the 'GAA Healthy Club' project. A pilot phase of the project was evaluated (Lane et al., 2015) and findings supported the delivery of health promotion through the GAA club setting. In Phase 2, the overall objectives of the evaluation were; (i) to assess the impact of healthy club initiatives on the health of individuals and communities, and (ii) to assess the impact of the project on the daily workings of the GAA club unit.

Methods: 60 clubs took part in Phase 2 of the 'GAA Healthy Club' project along with 27 control clubs. Mixed methods were used to gather data. Clubs completed a Healthy Club Questionnaire adapted from an index developed by Kokko et al., (2009) at baseline and at the end of Phase 2. The Healthy Club Index indicates the health promotion orientation of a sports club and includes a number of sub-indices such as Policy, Ideology, Practice and Environment. Clubs also self-reported on their overall activity at the end of the 18 month project. Finally, in order to assess objective I a focused evaluation was carried out on three initiatives in the areas of physical activity (PA), healthy eating and community development. Questionnaires, Interviews and FGDs were used to evaluate these initiatives.

Results: At follow up, intervention clubs showed significant improvements in overall health promotion orientation (PRE: 18.24, POST: 25.40), while control clubs showed little change (PRE: 22.28, POST: 22.25). Significant improvements were also evident across the sub-indices. Overall, it was notable that a sense of clarity and purpose existed in clubs, but did so within resistance, which clubs actively worked to overcome. The PA initiative included the delivery of the Men on the Move programme with participants reporting an average 2kg weight loss and improvement in cardiorespiratory fitness that was maintained up to 26 weeks. Waist circumference dropped by 3-4 cm and again this was maintained up to 26 weeks. Of the 3 clubs who engaged in the healthy eating evaluation, 2 had adopted healthy eating guidelines and the third club was in the process of developing their guidelines. Across all clubs in the evaluation, 52% had partially or fully implemented these same guidelines.

Conclusion(s): The GAA club displays an affiliation and commitment to health promotion that identifies it as an ideal setting for delivering health interventions. Specialist agencies

should be encouraged and supported to partner with these sports clubs to ensure the delivery of evidence based, effective initiatives.

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List of Abbreviations

ASAP Alcohol and Substance Abuse Prevention Programme
BMI Body Mass Index
CHD Coronary Heart Disease
CHPAS Coaching Health Promoting Activity Scale
CSPPA Children's Sport Participation and Physical Activity Study
DEXA Dual Energy X-ray Absorptiometry
ENHPS European Network of Health Promoting Schools
ESRI Economic and Social Research Institute
EU European Union
FFIT Football Fans in Training
FGD Focus Group Discussion
GAA Gaelic Athletic Association
H&W Health and Wellbeing
HBSC Health Behaviour in School Aged Children Study
HCF Healthy Club Framework
HCI Healthy Club Index
HCP Healthy Club Project
HCQ Healthy Club Questionnaire
HELPA Health Enhancing Leisure Time Physical Activity
HEPA Health Enhancing Physical Activity
HP Health Promotion
HPSC-I Health Promoting Sports Club Index
HSE Health Service Executive
HSEDP Healthy Sporting Environments Demonstration Project
HWE Healthy and Welcoming Environment
INDI Irish Nutrition and Dietetics Institute
LSP Local Sports Partnership
LTPA Leisure Time Physical Activity
MoM Men on the Move programme
MPA Moderate Physical Activity
MVPA Moderate to Vigorous Physical Activity
PA Physical Activity
PAPA Promoting Adolescent Physical Activity
PHA Public Health Agency
PICSAR Participation in Community Sport and Recreation
RSA Regional Sport Assembly
SCforH Sports Clubs for Health
SLSA Surf Life Saving Australia
SPSS Statistical Package for Social Sciences
SSA State Sporting Association

SSO State Sporting Organisations
UNOSDP United Nations Office on Sport for Development and Peace
VicHealth Victorian Health Promotion Foundation
VPA Vigorous Physical Activity
WHO World Health Organisation
WIT Waterford Institute of Technology

Chapter 1 Introduction

1.1 Background

In 2013 the Department of Health published a framework for improved health and well-being for Ireland for the years 2013-2025. The framework was titled 'Healthy Ireland' and it recognised sport as an important vehicle and partner for promoting health. Sport engages a vast number of people in Ireland and the world. The Irish Sports Monitor 2017 showed that 42% of the population participate in sport (Sport Ireland, 2017). Also 10% of Irish people take part in sport in a voluntary capacity such as a coaching or administrative role; while 43% are involved in sport in a social capacity such as spectating at games or events. Despite this engagement in sport only 32% of adults in Ireland meet the minimum recommended physical activity guidelines.

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 (WHO, 1986). The settings approach to health promotion reflects this as it is based on understanding, appreciating, and working with the settings where people are educated, work, and live to positively impact health behaviours. Indeed, 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*'. The focus needs to be placed on the social, environmental, economic and policy determinants of health rather than the individual alone. The health promotion settings approach is therefore directed towards 'changing environmental conditions and organisational cultures' along with '*personal and social development through information and education*' (Geidne et al., 2013) facilitating health-related skills to be acquired throughout life. Cities, schools, workplaces, prisons and health care institutions are all examples of where a settings based approach to health promotion has been utilised.

Kokko et al. (2004) advocated the use of sports clubs as another setting to promote health. Sports clubs are settings in which youth/adolescents and adults can actively

participate in sport and/or contribute to participation through their actions e.g. coaching (Kokko et al., 2009). Competitive sport may typically be perceived as the focus of many sports clubs. However, Casey et al., (2009) found an increasing number of people interested in other ways of engaging in physical activity aside from competitive sport, thus presenting an opportunity for sport to provide a contribution to overall population physical activity levels and in turn to public health. In addition, 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 all policies, thereby infiltrating into the day to day running and activities of a sports club creating a health promoting club culture beyond the promotion of physical activity. Participation in regular physical activity has many health benefits and sports clubs are a key setting for the promotion of physical activity but also for societal interventions regarding health given the number of members they attract and the increasing number of young people they engage (Geidne et al., 2013). By opening up to the wider community, facilitating healthy behaviours and presenting a more inclusive and family friendly environment clubs may widen their membership and volunteer base as well as attract potential sponsors (VicHealth, 2014).

Research around the concept of health promotion through sport is in its infancy. In Europe, a set of guidelines for Sports Clubs for Health (SCforH) was published in 2009 (Kokko et al., 2009) with a most recent update in 2017 (Koski et al., 2017). The importance of physical activity for health is the basis for the framework with agreement that sports clubs should be able to provide health related physical activity and general health promotion programmes. SCforH is a HEPA Europe working group co-led by Mr Sami Kokko University of Jyväskylä, Finland, Ms Aoife Lane, Waterford Institute of Technology, Ireland, Ms Ulla Nykänen and Mr Timo Hämäläinen, Finnish Sports Confederation (VALO) (WHO Europe, 2018). The group works closely with the Association for International Sport for All (TAFISA). The group have developed a set of guidelines which acts as a framework for clubs to be able to provide health promoting physical activity. Interventions to promote health in sports club are being developed

and evaluated. The Victorian Health Promotion Foundation (VicHealth) in Australia have invested in the Healthy Sporting Environments Demonstration Project (HSEDP) and found that clubs had made some important developments in relation to institutional change but health behaviour change had scarcely been impacted (Nicholson et al., 2013). The Good Sports programme in Australia (Crundall, 2012) and the Football Fans in Training (FFIT) programme in the UK (Bunn et al., 2016) have also both demonstrated the potential that sports clubs can play in delivering health promotion. EuroFIT, an extension of the FFIT programme to other European countries, is currently under evaluation (van de Glind et al., 2017). Similarly, HockeyFIT, an adapted version of the FFIT programme has been evaluated and shown to have health promoting potential among hockey fans (Petrella et al., 2017).

In Ireland, the Healthy Club Project (HCP) is an attempt by the GAA (Gaelic Athletic Association, 2018a) to integrate health promotion into the day to day running of sports clubs. The GAA promotes Gaelic games throughout the 32 counties of Ireland and across the world through a grassroots network of volunteer led clubs (Gaelic Athletic Association, 2018b). 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 (Gaelic Athletic Association, 2018b). 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, the GAA Social Initiative and the GAA Respect 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. The GAAs Respect campaign aims to promote Gaelic games in a positive manner and to ensure an enriching environment is provided which is conductive to ensuring all participants reach their full potential. In the most recent strategic plan 2018-2021, the GAA highlighted their willingness to improving the health and wellbeing of players, members, coaches and administrators through education and policy development (Gaelic Athletic Association, 2018c) with the HCP identified as a flagship initiative through which to achieve this goal.

The GAA HCP is based on the above mentioned 'settings approach'. A four pillar framework was developed to help clubs deliver health promotion sustainably. The four pillars which support the healthy club framework include: Policy, Programme, Partnerships and Club. Policy relates to the setting up of a healthy club project team, appointing a healthy club officer and having healthy club ideals written into the club's constitution and regulations. Club relates to the establishment of a physical and cultural environment that represents healthy ideals. Partnerships are those developed with internal and external stakeholders and agencies, while programmes are to be delivered on various health topics such as physical activity, healthy eating and social inclusion (Gaelic Athletic Association, 2018a). An evaluation of Phase 1 of the HCP provided support for this type of initiative in terms of the positive impact on the health orientation and practice of participating clubs (Lane et al, 2015). In Phase 1 there were 72 health promotion initiatives run by the 18 clubs that participated across seven target areas including physical activity, health awareness and emotional wellbeing. These initiatives led to positive impacts on peoples' behaviour according to case study findings. Participants noted improved cookery skills resulting from a healthy food programme; smokers attitudes were positively influenced due to the adoption of anti-smoking policies; and health and wellbeing classes led to improved feelings of physical and mental health according to focus group feedback from some participants. Case studies also revealed positive perception of participants and the club around health promotion and also showed the value of partnerships with public health service providers like the Health Service Executive (HSE). Clubs that participated in Phase 1 of

the HCP showed significant improvements in their health promotion orientation (Lane et al., 2017). Feedback from club and community representatives suggested that the project had an extremely positive impact on attitudes to health as well as engagement with the club and health behaviours. Clubs delivered 72 initiatives during Phase 1 on a range of different health topics. Over 60% of these were deemed to be of at least moderate impact, meaning they incorporated at least 3 pillars of the healthy club framework.

Some of the key recommendations from the Phase 1 evaluation included; the development of a healthy club policy, continued and enhanced engagement with appropriate partners, adequate training for club officers to help build capacity, development of a suite of evidence based initiatives for clubs to deliver, and a greater alignment and integration of health promotion with the core business of coaching and games. Phase 2 is a continuation of the initiative involving 60 clubs. These clubs will self-select some health promotion activity but will also take part in initiatives developed by the GAA.

1.2 Purpose of the study

The purpose of this research is to assess the impact of the HCP on the health promoting orientation of GAA clubs across Ireland. The key areas of policy, ideology, practice, and environment of participating clubs will be monitored to assess the impact of the project. The impact of a number of initiatives that clubs engage in will also be assessed. This project aligns with the Healthy Ireland framework which highlights the importance of multi-sectoral partnership and community empowerment. Outcomes from this evaluation of the HCP will facilitate further refinement and development of health promotion in the GAA.

1.3 Study Aim

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

1.4 Research Questions

1. What is the impact of the Healthy Club Project on the daily workings of the GAA club unit? How was the HP orientation of clubs affected, and what was the effect of

the HCP on specific aspects of the clubs including facilities, programmes, and partnerships.

2. What is the impact of Healthy Club initiatives on the health of individuals and communities? How did the PA, healthy eating, and community development initiatives impact clubs and their members particularly with respect to the four pillars of the HCP framework; plan, partners, club, activity?

1.5 Overview of Thesis

Chapter 1 provides an introduction to the research and its context.

Chapter 2 presents the most relevant literature in the area of health promotion in sport clubs. Other topics detailed in this chapter include the settings approach to health promotion, the benefits of engaging in sport, and the previous work the GAA has engaged in to promote health.

Chapter 3 details the methodological approach to the data collection and analysis undertaken in this thesis.

Chapter 4 highlights the results and findings from the evaluation of Phase 2 of the GAA's HCP.

Chapter 5 discusses the findings of this thesis with reference to the relevant previous literature in the area.

Chapter 6 brings the thesis to a conclusion.

Chapter 2 Literature Review

2.1 Introduction

Healthy Ireland is a Government-led initiative which aims to create an Irish society where everyone can enjoy physical and mental health and wellbeing to their full potential, and where wellbeing is valued and supported at every level of society (Department of Health, 2013). Many of the factors that influence a person's health and wellbeing are determined by social, environmental and economic policies beyond the direct responsibility of the health sector. Thus a partnership approach is necessary to achieve a healthier Ireland and settings outside the health sector play a vital role.

A goal of Healthy Ireland, the country's national strategy for health and wellbeing, is to increase the proportion of Irish the population who engage in regular physical activity as well as improving other aspects of health behaviour. In light of this, a key theme of the Healthy Ireland strategy is for organisations from various sectors to engage in health promotion. The Gaelic Athletic Association is one such sports organisation that is promoting health and well-being among its members through the Healthy Clubs Project (HCP). The purpose of the GAA HCP is to develop health promoting sports clubs through a settings approach to health promotion. In this literature review, the settings approach to health promotion will be introduced. The various settings in which health promotion can be applied will be explored. A closer look will be taken at the potential of sport as a setting for HP and the development of a framework for sports clubs to do this. Some practical examples of sport based HP are then described. Finally, health promotion in the GAA will be discussed.

2.2 Settings Approach to Health Promotion

The Ottawa Charter, published in 1986 by the WHO is a seminal publication regarding health promotion (WHO, 1986). It states that health promotion involves enabling people to increase control over and to improve their health and that it requires co-ordination among various sectors and organisations, rather than being the function of the health sector alone. The Ottawa Charter is oriented around five key principles; building healthy public policy, creating supportive environments, strengthening community actions, developing

personal skills and reorienting health services. Later, the Jakarta declaration (1997) identifies 5 priorities for health promotion into the 21st century. These are; the promotion of social responsibility for health, an increase in investments for health development, an expansion of partnerships for health promotion, an increase in community capacity and empowering the individual, and securing an infrastructure for health promotion (WHO Jakarta Declaration, 1997). This leads to policy makers targeting various aspects of influence on people's behaviour by adapting and modifying the settings in which they live (Casey, 2012). Consequently, from an Irish perspective, one of the high level goals described in the Healthy Ireland framework is to ''*create an environment where every individual and sector of society can play their part in achieving a healthy Ireland*'' (Department of Health, 2013). The settings approach to health promotion centres around creating a more supportive environment that enables the individual to make healthier choices (Whitelaw et al., 2001).

Whitelaw proposed five different models for settings based health promotion (Whitelaw et al., 2001). They are passive, active, vehicle, organic and a comprehensive/structural model. The passive stage involves the setting acting as a passive vehicle for an individual oriented approach. The models represent a continuum whereby the setting becomes ever more supportive of the health of groups and individuals through its policies, operations and ethos. Some settings may not be traditionally linked to health promotion, and this is true of the sports club setting. Understanding the characteristics and ethos or orientation of the setting before any health promotion initiatives begin will enhance sustainability. There needs to be a balance between the expectations of what can be achieved under controlled conditions as reported in the literature compared to what is practically achievable in real world settings by lay-health promotion practitioners. Kokko et al., (2013) in his work on developing healthy club frameworks stated that a settings approach is only underway when those within the setting are actively pursuing the health agenda rather than some internal actors passively working with external influencers. Overall, long term vision is needed when adopting settings approaches so they are sustainable, despite some perceived need for 'early successes' (Whitelaw et al., 2001).

Kokko et al., (2013) advocates the use of labelling settings as ''*health promoting*'' rather than ''*healthy*'', as it describes a dynamic process toward making them more healthful

rather than the 'static' connotations of the term healthy. Kokko's observations reflect the process above, which suggests a fluid, broad and all-encompassing approach to health promotion within the setting. There are a wide range of initiatives that are run under the headline of the settings approach with community based health interventions identified as having great potential in tackling health problems in various populations (Edwards, 2015). Community based approaches do not focus on individual behaviours or specific disease, rather the focus is on building a framework and structure that can respond to various issues as they become apparent in the community (Burnett, 2006). The determinants of an individual's health still need to be recognised when developing and implementing the settings approach through community interventions. Cultural, social, economic and other environmental determinants need to be addressed for people to have the greatest opportunity to take control over their health (Kokko et al., 2013). Cultural determinants relate to the value of health promotion within a setting and can be recognised through policies and operating guidelines. These can dictate the importance that is placed on health promotion in a setting by various actors such as managers and coaches. Economic determinants relate to the link between financial resources and practical resources such as time and know how in order to deliver health promotion in a sports club. For example, do coaches have the adequate expertise to deliver healthy eating information to club members. Other environmental determinants then, relate to providing a healthy and welcoming physical and social environment e.g. providing a smoke free environment for youth activities to take place.

Dooris (2013) interviewed a number of key actors in the development of the healthy settings movement. There was the belief that the theory behind the movement is underdeveloped as a result of inadequate funding. There was also a consensus that theory has followed practice in this area and that a greater emphasis is needed on research and evaluation. Those involved felt that the healthy settings approach has been adopted in some areas on a local and national level in terms of explicit policy development which is encouraging. Despite this there appears to be some variation in many areas too, particularly due to cultural and political disparities, as well as varied success of the settings approach in different settings. Community based programmes and policies aimed at promoting health need a multi-sector approach which involves various settings, to

succeed. Opportunities exist in this space for settings to share success stories, develop partnerships, and share common challenges. More recently, Torp et al., (2014) suggested that the core business of a setting is a key determinant of health and can often be overlooked. It is important that research and evidence supports the benefits that health promotion may have for the core business of a setting whether this be playing and coaching games in a sports club or teaching and learning in a school.

2.2.1 Schools, Workplaces, Cities and Communities as Settings for Health Promotion

Settings based approaches to health promotion have been widely reported and vary from passive to structural/comprehensive approaches. The North Karelia Project was a community based strategy to prevent coronary heart disease in Finland (Puska et al., 1985). It was set up in response to a growing number of people experiencing coronary health issues. The project was developed by Finnish health authorities along with WHO experts and community representatives. Strategies used to change behaviour in the community were education of people to recognise the link between their behaviour and their health, training to adopt healthier actions, social support to maintain and sustain healthy behaviours, and environmental changes. A ten year follow up study showed encouraging changes in health behaviours of community members. Significant reductions in smoking among men and women were noted as well as favourable dietary changes. Also, Coronary Heart Disease (CHD) mortality reduced significantly in the area among men and women. The encouraging trends continued even after 25 years according to Puska (2002). By 1995, annual mortality rate of CHD in middle aged men had reduced by 73% from before the programme was established. A similar trend was evident among women in the North Karelia area.

The European Network of Health Promoting Schools (ENHPS) was established by the European Commission, Council of Europe, WHO Regional Office for Europe. The WHO identified schools as an effective place to target health education initiatives due to the ability to target whole communities in one setting with access to children and their families (Burgher et al., 1999). Langford et al., (2015) conducted a review the WHO's Health Promoting Schools Framework. This framework involved schools promoting health in 3 domains; school curriculum, ethos and/or environment, and families and/or communities. Studies were included from North America, Europe, Australasia, as well as some middle to

low income countries. Results showed that students experienced modest improvements in BMI levels and physical activity levels, while levels of smoking and reports of bullying were reduced. No significant effects were found in other areas of health promotion such as alcohol use, dietary choices, and mental wellbeing.

Along with schools, a number of other priority settings including workplaces have been identified by the WHO (WHO, 2018). Workplaces can directly influence a range of well-being factors such as physical, mental, social and economic. They present an ideal setting to target and support the well-being of a large number of people. In another area Malik et al. (2014) conducted a systematic review of workplace health promotion initiatives aimed at improving physical activity. Six of the studies were direct physical activity interventions where four showed evidence of improved physical activity levels following the intervention. The majority of the studies reviewed were based on providing health promotion information and education to participants. Twenty nine out of thirty nine of these studies found an improvement in physical activity levels following intervention.

Elsewhere Plotnikoff et al., (2015) explored the effect of health promoting interventions aimed at university students. In particular interventions targeting physical activity, nutrition, and healthy body weight were reviewed. The majority of studies included were conducted in the United States. Twenty nine studies targeted physical activity, of which 18 showed significant improvements in participant physical activity levels. Twenty four studies were included which reported nutritional outcomes. Half of these studies showed an improvement in the nutritional habits of participants. Twelve of the studies assessed participant body composition. Four of these studies showed a significant improvement in the body composition of participants either through Body Mass Index (BMI) or body weight measurement.

The WHO European Healthy Cities is a project engaging governments in health development and promotion. Almost 100 cities are involved and there are 30 national networks of healthy cities in the European region (de Leeuw et al., 2014). The main aim of the project is to put health high on the agenda of city governments with political support, capacity-building and multi-sector partnerships. The framework for the project includes 4 priority areas, i.e. address the determinants of health for all citizens, integrate European

and global health priorities, social and political actors must realise that health needs to be on the agenda and the final priority is to foster good governance and integrated planning for health. An evaluation of Phase IV showed that most cities have developed a healthy city profile which provides a useful guide for future planning (Tsouros and Green, 2009). Most cities are committed to updating this every 3-5 years. Involving and empowering communities is important in developing a healthy city. In promoting health equity, 24 cities had targeted health services, 24 had targeted vulnerable groups and 21 had targeted wider determinants.

The settings approach has evolved from schools and workplaces to cities, but also to prisons, hospitals, universities etc. The approach in universities has been more of a passive one where the setting has been used more as a vehicle to target people rather than changing the setting. To be effective, the settings approach requires the setting to be targeted and changed rather than merely targeting the people in that setting. A settings approach is relevant in any context where people gather and can be influenced with health messages. One of the more recent settings to focus on health promotion is the sports club.

2.2.2 Sport and Sports Clubs as a Setting for Health Promotion

Many sports policies around Europe are guided by the 1975 Sport for All Charter (Council of Europe, 1975). This charter recognised the important role that sport plays in human development and also stated that sport should be related to other areas of planning and policy development such as health and education. Later, the UN Office on Sport for Development and Peace (UNOSDP) was set up in 2001 under the premise that sport can be used as a vehicle for education, health and social change. This body has urged sports organisations all over the world to understand the influence and responsibility they have regarding health education and health improvement (Fuller et al., 2014). More recently The Lisbon Treaty (2009), and the European White Paper on Sport (2007) have been seminal publications for European sport policy (Scheerder et al., 2011). The White Paper included a commitment to promote sport as a health enhancing physical activity (HEPA), noting the potential contribution of sport to population health.

2.2.3 Physical Activity for Health

HEPA is defined as physical activity for health benefits; specifically a minimum of 150 minutes of at least moderate intensity PA per week for adults, and 60 minutes of moderate to vigorous PA per day for children (WHO, 2010). There is considerable evidence supporting the benefits of PA to health. A review carried out by Warburton et al., (2006) concluded that there is strong evidence that physical activity (PA) is effective in reducing many diseases such as cardiovascular disease, cancer, diabetes, depression, and obesity. More recently, Reiner et al., (2013) conducted a review to investigate the long term health benefits of PA. This review targeted long term interventions measuring the effect of PA on conditions such as weight gain and obesity, coronary heart disease, type II diabetes, and dementia. Studies included were those with a follow up period of 5 years or more and n=500 or more participants. Eighteen studies were included overall. Results showed that engaging in PA had a beneficial effect regarding the health conditions that were investigated. A review by Poitras et al., (2016) examined the relationship between PA and a number of health indicators among children aged 5 to 17. n=162 studies were included in the review and findings showed PA to be positively associated with a number of health indicators such as cardio-metabolic risk factors, body-fat, aerobic fitness, and other cognitive and social indicators. More robust evidence was presented for engaging in moderate to vigorous PA compared to low intensity PA. Elsewhere, Hupin et al., (2015) reviewed the health benefits of MVPA among adults over the age of 60. Nine studies were reviewed with a total of n=122,417 participants and an average follow up period of 9.8 years. Overall the study showed an inverse relationship between mortality and Moderate to Vigorous Physical Activity (MVPA), with a 22% reduction in mortality for those engaging in even low doses of activity. Greater benefits were shown to accrue to those engaging in greater amounts of MVPA. McKinney et al., (2016) noted that it cannot be overstated how beneficial PA is, and encouragement of PA should be a key health care policy.

The US PA plan 2010 (U.S. Dept. of Health and Human Services, 2010) and the global advocacy plan for PA (Blanchard et al., 2013) both name sport as one of the seven best sectors of investment for PA to enhance the health of nations (Khan et al., 2012). Evidently, there is a belief that sport is beneficial for health.

2.3 Sport and Health

2.3.1 Health Benefits of Sport for Children

Much of the health benefits of sport are linked to those associated with PA. Vella et al., (2013) investigated the association between sports participation and a number of health behaviours. Over n=12,000 Australian adolescents took part in this study. Results showed higher levels of sports participation were associated with a greater likelihood of achieving national PA recommendations (OR = 2.07). A further study by Golle et al., (2014) monitored a number of physical fitness measures of German children over the course of a 4 year period. Participants involved in the study (n=172) were aged between 9 and 12 years old. Measurements were taken annually over a four year period. Physical fitness was assessed with a 9 minute run. Results showed kids who participated in sports clubs had significantly higher levels of physical fitness compared to those not participating in sport. Later, in a longitudinal study Telford et al., (2016) investigated the influence of sport club participation on physical activity, physical fitness, and body composition. Participants were Australian adolescents from ages 8 to 16. Boys (n=134) and girls (n=155) took part in the study. PA was measured by pedometers or accelerometers. Physical fitness was assessed using a 20m shuttle run test. Finally, body composition was assessed using Dual Energy X-ray Absorptiometry (DEXA) scan. Measurements were taken when participants were aged 8, 10, and 12. Results showed that PA levels were significantly higher at all age groups among sports club participants compared to non-participants. In addition, physical fitness levels were significantly higher among sports club participants, and girls who participated in sports clubs exhibited significantly lower levels of body fat, with a 2.9% reduction being found.

In another study, Marques et al., (2016) explored the association between organised sports participation and amount of time spent in PA and the intensity of that physical activity. Participants were Portuguese children (n=973) between the ages 10 and 18. Organised sport participation was self-reported and accelerometers were used to assess time and intensity of PA. Those who took part in organised sport were significantly more likely to accumulate the recommended amount of PA (OR = 1.64). Those involved in sports participation also spent significantly more time in MPA, VPA, and MVPA compared to those not involved in organised sport. Similarly, Hebert (2015) found that soccer participation was significantly associated with greater overall moderate to vigorous PA as well as significantly greater chance of reaching recommended PA levels. Participation in handball

at least 2 times per week can be seen to lead to similar associations. Specifically, children participating in soccer have a greater chance of meeting recommended PA levels of 60 min MVPA per day compared to their peers who do not participate in organised sport. Also, children participating in handball 3 or more times per week are more likely to meet recommended levels of PA compared to their peers who do not participate in organised sport. No significant trends were apparent for other sports. Wold et al., (2013) looked at a sample of 10 to 14 year olds from 5 European countries. A soccer playing sample was compared against a reference sample. Engaging in MVPA four or more times a week and having excellent subjective rated health were significantly higher among soccer playing boys in all five countries and among girls in 3 countries. In a similar investigation, Van Hoye et al., (2014) looked at soccer players in 3 European countries. Players from the 3 countries had an average of 122 minutes per day of MVPA. However they also exceeded recommended sedentary time guidelines.

2.3.2 Health Benefits of Sport for Adults

Oja et al., (2015) investigated different types of sports and the health benefits they bring for adult participants. This review explored original observational studies and intervention studies with healthy adult participants and non-participant control groups. Sixty nine eligible studies were included. Results showed jogging/running to be associated with reductions in a number of mortalities. An improvement in aerobic fitness and cardiovascular function, and reduced weight gain was also associated with jogging/running. Swimming was associated with a reduction in all-cause mortality. Soccer was associated with improvements in aerobic and metabolic fitness as well as cardiovascular functions at rest.

An Australian report on Sport and Social Capital in 2012, reported that the highest rates of participation in sport or physical recreation were associated with high levels of excellent self-assessed health (83%). Lowest rates of participation were evident for those who report their health to be poor (47%). Participation rates were lower for those with a disability or chronic medical condition (68%) than for those who did not have such a condition (79%) (Australian Bureau of Statistics, 2012). A report published in the UK on the social impacts of culture and sport showed that those who participated in sport were 14.1% more likely

to report their health as being good compared to those who did not participate in sport (Fujiwara et al., 2014).

2.3.3 Sport and Emotional Health and Wellbeing

Exercise has been shown to be useful in treating diagnosed conditions such as depression and can aid in reducing stress and anxiety also (Mikkelsen et al., 2017). In a review of the relationship between exercise and mental well-being, it was found that regular exercise can help reduce anxiety levels while those who are physically inactive exhibit higher levels of anxiety. Also, regular exercise has been shown to reduce levels of depression and stress. Eime et al., (2013) reviewed the psychological and social benefits of sports participation for adults. Eleven studies were included as part of this review. The most commonly reported benefits of sports participation were greater well-being and reduced levels of distress and stress. The researchers also conducted a review into the same issue for children and adolescents. In this case the most commonly reported benefits of sport participation were greater levels of self-esteem and social interaction, and a lower prevalence of depressive symptoms. For all, involvement in club or team sport appears to convey greater benefits than individual activities due to the social nature of these environments. Jewett et al., (2014) found that students who participated regularly in secondary school sport showed significantly higher self-reported mental health, and lower depressive symptoms compared with those who never participated in secondary school sport. Similarly, Vella et al., (2015) showed that children who dropped out of extra-curricular sports exhibited greater mental health difficulties relative to children who maintained participation in extra-curricular sport. It was recommended that sport programs that aim to enhance mental health should be age-appropriate, promote empowerment and autonomy, and provide opportunities to develop relevant skills.

2.3.4 Sport and Nutrition

Dortch et al., (2014) explored the association between sport participation and dietary behaviours among school children in the United States. Over n=5,000 children took part in the study. Self-report questionnaires were used to assess sports participation and dietary habits. Significant associations were found between number of sports teams and healthy dietary behaviours. Boys who were involved in three or more teams were more than two times as likely to eat green vegetables or fruit compared to those that were not involved in

any teams ($p<0.05$). Boys on three or more teams were also less likely to drink carbonated drinks (OR=.58, $p<0.05$), as were those involved in one team (OR=.74, $p<0.05$) compared to those on zero teams. For girls, likelihood of consuming green vegetables increased as the number of sports teams increased. Girls on three or more teams were also nearly twice as likely to consume fruit (OR=1.96, $p<0.05$) compared to those on no teams. The researchers used a Healthy and Unheathy Food indices to assess the number of healthy and unhealthy foods the children consumed. For all, there was a positive correlation between the number of sports teams they engaged in and their score on the Healthy Food Index. Despite this, no significant difference was apparent between unhealthy eating index and number of sports teams that children were involved with, suggesting that unhealthy eating habits may be universal among children. Vella (2013) found similar results in Australia, with adolescents who participated in sports having a greater likelihood of meeting fruit and vegetable eating guidelines. Similarly, participation in organised sports had no association with unhealthy dietary behaviours such as eating high fat foods and consuming sugary drinks. Students who participated in greater than 210 minutes of sport per week were at least 32% ($p<0.05$) more likely to comply with fruit and vegetable eating guidelines compared to those who participated in less than 60 minutes per week. Parent's attitudes toward the delivery of sport were found to be mostly positive; however the worst performing areas according to them was the availability of food and drink in sports clubs canteens and the behaviour of parents at games (Kelly et al., 2010). Parents of youth participating in basketball in Minnesota took part in focus groups to share their perceptions about the food environment in youth sports (Thomas et al., 2012). Parents felt that youth often consume unhealthy foods and beverages during sports activities. They felt that healthy foods were not widely available in sports settings and unhealthy food and drinks were widely available in these settings.

2.3.5 Sport and Alcohol and Drug Misuse

Of note is that participation in sport is often linked to other unhealthy behaviours, such as excessive alcohol consumption. Lisha and Sussman (2010) investigated the association of sports participation with alcohol use and a number of other unhealthy behaviours such as tobacco and drug use. In this review, 34 studies were included. Most studies were conducted in the USA and participants were either collegiate or high school athletes. In 22

of 29 studies focusing on alcohol, results showed that sports participation led to higher levels of alcohol consumption compared to those not participating in sport. Of the studies related to drug and tobacco use, most reported negative associations between these behaviours and sports participation. From an Irish perspective, alcohol consumption was found to be high among male GAA players (O'Farrell et al., 2010). Over half (53.1%) of the players in this study reported regularly binge drinking. An Alcohol Use Disorder Identification Test (AUDIT) questionnaire was used in this study to assess the level of harmful alcohol use. Using this measure, a score of 8 or greater is indicative of harmful alcohol use. Nearly three quarters of participants had a score of 8 or greater in this study. A later review in this area found a significant relationship between sports participation, consumption of alcohol, and violent behaviour (Sonderland et al., 2014). Most of the 11 studies included were based in North America and participants were collegiate athletes. In relation to alcohol use, a review by Rice et al., (2016) showed a higher level of alcohol use among athletes compared to the general population.

In Australia, there appears to be strong public support for reducing the ties between sports clubs and alcohol (Tobin et al., 2012). Kingsland et al., (2013) investigated the association between alcohol management practices and consumption in 72 community football clubs in Australia. Club officials engaged in a telephone survey and detailed the club alcohol management strategies. n=1428 club members also took part in a telephone survey and detailed their alcohol consumption. Results linked a number of alcohol management practices to risky alcohol consumption. Members were more than twice as likely to consume alcohol at risky levels at clubs that served alcohol to intoxicated people, held a happy hour, or had alcohol presented as awards. Members of clubs with smaller membership (<150) had significantly higher chances of drinking alcohol at risky levels in comparison to members of larger clubs.

Kwan et al., (2014) reviewed longitudinal studies investigating the association between sports participation and alcohol and illicit drug use. This review of longitudinal studies, mostly conducted in the USA included 17 studies. The studies were all investigating the behaviours of youth and adolescents. There was consistent evidence pointing to a positive association between sports participation and alcohol consumption. On the other hand, most studies found sports participation to be inversely associated with illicit drug use. In

Finland, Kwok Ng et al., (2017) looked at the prevalence of substance use in youth sports. In particular the use of alcohol, snuff and tobacco was investigated. Participants (n=671) were aged between 14 and 16 and participated in the 10 most popular sports in Finland. Results showed that in all cases, girls who were participating in organised sports were less likely to be exposed to these substances. Boys had a greater level of alcohol use (OR=1.29, $p<0.05$) and a much greater level of snuff use (OR=5.61, $p<0.05$) compared to girls. Boys however were found to have less experience of smoking (OR=.9, $P<0.05$) when involved in sports compared to girls.

Much of the negative impact of alcohol consumption is apparent among sports fans/spectators. In America, Nelson and Wechsler (2003) investigated alcohol related behaviour among collegiate sports fans compared to non-sports fans. A higher percentage of sports fans were found to engage in binge drinking compared to non-sports fans. Of those who consumed alcohol, sports fans were more likely to engage in antisocial behaviour such as getting into arguments and vandalising property. Wakefield and Wann (2006) found that those who believed that alcohol consumption was a necessary aspect of the game were significantly more likely to be categorised as highly dysfunctional spectators and exhibit behaviour such as verbal aggression towards officials. Ostrowsky (2016) reviewed the association between alcohol consumption and violent spectator behaviour. While not responsible for all poor spectator behaviour, alcohol appears to play a large part in fan culture which can often lead to problematic behaviour. Evidence shows that sports fans drink significantly more on match day. Alcohol sponsorship of sport has fostered this relationship between alcohol and sport.

2.3.6 Sport and Sponsorship

Sport is synonymous with sponsorship and parents and sporting representatives believe that children are 'very' influenced by the sponsorship of elite teams and athletes (Kelly et al., 2011). Most parents are supportive of restrictive policies regarding unhealthy food and drink sponsors in sport because of a concern that this influences children's choices around health. 63% of parents supported restrictions to elite sport sponsorship while 70% supported children's sport sponsorship restrictions. A majority of children (68%) were able to recall the sponsor of their own team while almost half (47%) could recall the sponsor of their favourite elite team. Most (85%) children believe that sponsorship is due to the will

to help out the sports club and the majority like to buy their products to return the favour. Children's high level of recall in terms of sports sponsorship can be worrying and is likely linked to their product preferences.

In an examination of sponsorship of sport in New Zealand, over 75% of the organisations reviewed had no major sponsorship link with a food and beverage organisation (Carter et al., 2013). Just one third of all food and beverage sponsorship of sport was classified as unhealthy. Examples were given by sports reps where sponsors support their sponsorship with additional marketing strategies such as player of the day awards. Some of these strategies targeted children and some were identified as unhealthy sponsorships. Marketing strategies were used to promote the belief that consumption of the sponsor's product would improve athletic performance. Out of a sample of Australian football clubs, 80% had a sponsorship agreement with some organisation or brand from the alcohol industry (Sawyer et al. 2012). A review found there are positive associations between exposure to alcohol sports sponsorship and an increase in alcohol consumption (Brown, 2016). Macniven et al., (2015) examined the sponsorship of Australian sports by organisations from the food, beverage, alcohol and gambling industries. Despite the reduction in some sponsorship such as tobacco, sports still engage in some sponsorship that undermine the healthy ideology that many sports organisations have. More than 1 in 4 sponsorships appear to promote unhealthy products while team sports were observed to have higher levels of unhealthy sponsorship.

Overall, the prevalence of unhealthy sponsorship poses ethical issues due to the participation of youth in these sports. Sporting bodies being sponsored by unhealthy products and brands is effectively an endorsement of these products and brands to their participants and spectators. Unhealthy sports sponsorships may be reduced by encouraging players to only engage with healthy sponsors and products through media campaigns etc. Players would need support to pursue actions like this from policy makers. Revenue streams provided by such unhealthy brands is desirable but the associated marketing is not. Associating with sports organisations gives brands and businesses a reach to a wide audience and normalises the consumption and use of unhealthy products and services which undermines the potential health benefits of sports participation. Due to the harmful effect unhealthy sponsorships can have on children's health behaviours,

marketing strategies associated with such sponsorships should be regulated and limited. A precedent was set for replacing unhealthy sponsorship e.g. tobacco with healthy sponsorship, from the introduction of the 1990 New Zealand Smoke-Free Environments Act. In Ireland, there are moves to control alcohol and unhealthy food sponsorship. In 2015, Ireland published a Public Health Alcohol Bill (Department of Health, 2015). As part of the bill, alcohol companies are prohibited to sponsor or advertise at a sports arena or event where the majority of participants are children.

2.3.7 Sport and Injury

Nauta et al., (2014) explored the injury rates associated with physical activity engagement. A systematic review involved 8 studies with participants aged between 6 and 12 years old. The studies investigated injury rates among behaviours such as overall physical activity, active commuting, unorganised leisure time physical activity (LTPA), and organised sports activity. Injury is inherent in physical activity as results show the overall physical activity related injuries varied from 0.40 to 0.59 injuries per 1,000 hours of activity. The total number of injuries related to unorganised LTPA was higher than that reported for organised sport. However when reported per hour of activity, injury incidence was higher among sports participants. Elsewhere, Jayanthi et al., (2015) explored the injury risk that young athletes face when specialising in sport. Athletes between the ages of 7 and 18 were recruited for this investigation. Injured athletes attending medical clinics were compared to healthy control subjects undergoing sports physicals. Injury details were collected as well as hours per week spent engaging in organised sport, PE and free play, as well as the degree of sports specialisation to which they were engaged in. Over n=1100 athletes were analysed, n=822 injured and n=368 uninjured. Injured athletes reported significantly more hours of PA (19.6 vs 17.6) and of organised sport (11.2 vs 9.1) per week. Those who engaged in more sport specialisation were found to have a 27% higher chance of attaining an injury ($p<0.05$). Those engaging in organised sport to free play of a ratio greater than 2:1 hrs per week had a higher chance (OR=1.87, $P<0.05$) of obtaining a serious overuse injury. Among senior inter-county players in Ireland, on-going data collection since 2006 shows that two out of three players on a team will get injured at least once per season (Gaelic Players Association, 2014). Over 33% of players will pick up more than one injury per season. While injury is a consideration in terms of the health impact of PA and sport, it

is important to consider that the benefits of both outweigh the potential adverse effects (Powell, 2011).

2.3.8 Sport Participation and its Contribution to Health Enhancing Physical Activity (HEPA)

Eime et al., (2015) explored the contribution of sport to HEPA levels among Australians. Participants included over n=20,000 people over the age of 15. Participants were asked what type of leisure time physical activities (LTPA) they participated in over the previous 12 months as well as the previous 2 weeks. They were also asked about the frequency of their participation. Activities were categorised as health enhancing leisure time physical activity (HELPA) based on MET value. About half of all reported HELPA activities were sport activities, however when frequency of activity was taken into account, sport activities only contributed around 30% of all HELPA sessions. About half of all reported HELPA sessions and activities were conducted in an organised environment, while club based sport accounted for around one third of HELPA sports activities and 40% of sessions.

With this in mind, it may be logical to assume that health related PA is increased as a result of organised sport participation, but evidence suggests that some people compensate for an increased amount of PA in one area by reducing the amount of PA they complete in other areas (Herbert, 2015). Participating in sport does not necessarily decrease the chances of being obese or lead to reduced time spent sedentary (Marques, 2016). Recent findings in European countries have indicated that not all sports club participants reach the PA levels described in recommendations (Eiosdottir, Kristjansson, Sigfusdottir, & Allegrante, 2008; Ekelund, Tomkinson, & Armstrong, 2011; Mäkelä et. al., 2016; Van Hoye et al., 2013; Wold et al., 2013). As well as that, among sports participants, boys are more likely to reach the PA guidelines for MVPA (Knuth & Hallal, 2009; Silva et al., 2013) and engage in more VPA than girls (Garaulet et al., 2011).

Ekelund et al., (2011) conducted a review on PA among youth of 2 to 18 years. Findings revealed that sport participation appeared to contribute to greater time spent in MVPA but supplementary activity is required to meet recommended guidelines. Further to this, Makela et al., (2016) explored HPSCs in Finland and the PA levels of participants from 14 to 16 years old. Over n=2000 participants took part in the study, 57% were sports club

participants with the remainder being non participants. In total, 11.8% of girls met weekly MVPA recommendations, and 23.7% of boys. Among girls, 17.5% of sports club participants met daily MVPA recommendations, while only 5.5% of non-sports club participants met these guidelines. Among boys, 30.3% of sports club participants met daily MVPA recommendations, while only 13.4%% of non-sports club participants met these guidelines. Participation in sports clubs was positively associated with meeting MVPA and VPA recommendations. However, only 24.2% of sports participants met the MVPA guidelines. An important point for parents and others to note is that a child who participates in sport is not automatically active enough due to this participation (Telford et al., 2016), which is a challenge for the sport and health sector.

2.4 Value of Sport

Sport is beneficial for health, reports good participation rates, and therefore as a setting presents an opportunity to positively influence vast numbers of people. Indeed, The EU White Paper on Sport recognises that sport has a vital role to play in society. As well as enhancing public health, sport has an important role to play as an educational environment and can promote social inclusion and integration (Commission of the European Communities, 2007). Kokko et al., (2010) noted that sports clubs that cater for youth have opportunities and obligations with respect to health promotion. These obligations may be moral and ethical as most clubs are voluntary non-profit organisations. Obligations also arise from receiving state funding to sustain their activities. This should lead to clubs recognising their role in HP and engage in activities to promote health. As well as improving health education and behaviour, a health promotion orientation in a sports club can also lead to improved sports performance. Overall, it appears that sport and PA can be used as a non-formal education platform (Kantomaa et al., 2016) with a considerable societal value.

Social capital is one of the most important products of sports clubs and equally is a major health promotional tool (Kokko et al., 2009). Social capital refers to the value of a network or organisation and the reciprocity that goes along with it (Putnam, 2001). There are many forms of social capital and this can take the shape of formal committees or informal meetings and get togethers. Tonts (2005) investigated sport and social capital in rural Australia. The area of focus was a western Australian region with a number of small towns

which had experienced socio-economic upheaval and population decline. Face to face interviews with residents including representatives from sport organisations, voluntary organisations and local government and questionnaires were completed by households. 61.5% of the population took part in at least one sport. When asked what the most important aspect of sport was in their local area, 82% of households said social interaction, 93% felt sport was a good way to stay in touch with neighbours and friends and 91.2% thought sport was important to develop a local sense of community. Light (2010) examined social and personal development of children through sport. The focus of this study was a swimming club in Sydney, Australia. Children between 9 and 12 took part. N=33 responded to a questionnaire and n=20 took part in an interview. Training, competition, and social activities were identified as factors contributing to the children's development. These activities were associated with the children developing social skills and a sense of identity. For all participants, friendships were an important factor in their club life and a key reason for their continued participation in the swimming club.

In another Australian example, D'Arcy (2014) examined how social capital develops through relationships in a club at community level. The focus of this study was Surf Life Saving Australia (SLSA). Members (n=63) of surf clubs both urban and rural took part in focus groups. Participants included SLSA staff, board members, and club volunteers. Results strongly suggested that social capital was developed through relationships at club level. The club was also seen as family oriented and as having a supportive organisational culture. Strong themes that emerged were the development of shared social values and standards in the club, and a feeling of belonging. Development of values such as pride, respect, reliability, helping others and giving back to the community were important and linked to social capital. Community and individuals benefitted from sports club engagement and could influence the rest of the community positively through the effective transfer and leveraging of social capital. Meanwhile, Seippel (2006) explored sport and social capital from a European perspective. Data was collected from a random selection of Norwegian citizens aged between 16 and 85. n=1695 responses were received from mailed questionnaires. Over a quarter of those who responded were members of a voluntary sport organisation. Results show that membership of a voluntary sporting

organisation was associated with greater interest in politics and engagement in political activities.

Social capital can manifest itself in the many volunteers and supporters that are involved in sport. Sport and physical recreation organisations attract large numbers of volunteers, 14% of the adult population in Australia (Australian Bureau of Statistics, 2013) while an EU Eurobarometer report on sport and PA (European Commission, 2014) showed that 7% of EU citizens engage voluntarily in supporting sports activities. The Irish Sports Monitor (Irish Sports Council, 2015) showed that 12.9% of Irish people volunteer in supporting sports activities. The report also shows that just under half of the population participate in sport regularly on a social basis. This social participation is measured in three contexts – attending events, volunteering, and club membership. Kay and Bradbury (2009) looked at how volunteering in sport can lead to the development of social capital in the UK. Data was taken from the Step into Sport program where young people aged 16+ are trained in sports leadership and provided with opportunities to volunteer in sport. 80% noted an improvement in communication skills and 85% noted an increase in confidence. The greatest benefits appeared to be attained by those who accumulated the greater number of volunteering hours.

Overall, the case for sport as a setting for health promotion appears strong; it has a positive impact on health for those who take part yet participation rates can be poor. The reach and value of sport extends beyond those willing to take part in activities with volunteers attracted to and benefiting from the sport environment. To this end, considerable work has been undertaken to establish a framework around which to build on the potential of sport as a setting for health promotion.

2.5 Participation in Sport

The WHO Global Recommendations on PA for Health state that children and young people under 18 should engage in at least 60 minutes of MVPA daily (WHO, 2010).Most of this activity should be aerobic. Vigorous activities that strengthen muscle and bone should also be performed at least three times a week. For adults between 18 and 64, at least 150 minutes of moderate aerobic PA should be accumulated per week. Bouts of at least 10 minutes of aerobic exercise are recommended. At least twice a week, adults should engage

in muscle strengthening activities. For additional health benefits, it is recommended that adults engage in greater amounts or higher intensities of PA. Those over 65 are encouraged to engage in similar activities as well as adding mobility and balance exercises to prevent falls on three or more days per week. Ireland's PA guidelines are broadly in line with those of the WHO (Department of Health, 2014). Overall, in Ireland 32% of people are defined as being sufficiently active and meeting PA guidelines (Department of Health, 2016). The Children's Sport Participation and Physical Activity Study (CSPPA) report showed that only 19% of primary and 12% of post primary pupils in Ireland were reaching the minimum PA recommendations (Woods et al., 2010). Among this cohort of 10 to 18 year olds, girls were shown to be less likely than boys to reach the recommended guidelines (10% vs. 18%). For primary school kids, engaging in extra school sport or PA led to a significant increase in the days per week that they met the recommended PA guidelines. Similarly with post primary school students, engaging in extra-curricular sport or PA was a significant indicator of reaching daily bouts of 60 minutes or more of MVPA.

Sport Ireland published a report in 2017 detailing participation rates and trends for sport and PA in Ireland (Sport Ireland, 2017). The report detailed the active participation rates in sport and physical activity among Irish people. It showed that 42% of Irish people said they had participated in sport in the last seven days. The 2015 report showed that 45% of Irish people aged 15 and over regularly participated in sport which was a decline from a previous report in 2013 (47.2%) but similar to 2011 (44.8%). Numbers of people engaging in team sports have declined while some individual pursuits such as gym activities have seen an increase. Reductions in sport participation were more prevalent among older people and those in a lower socio-economic cohort. Males were more likely to participate in sport than females, with running as one of the most popular activities across genders. Women also found swimming attractive and soccer was one of the most popular sports among men. Engagement in sport at high or moderate levels of intensity dropped steadily after the age of 30. The 2017 Growing Up In Ireland report on 7 to 8 year olds showed that only 14% engaged in '*games with some PA'* daily while 21% engaged in '*games with a lot of running'* daily (ESRI, 2017). Boys were more likely to play physically active games. '*Games with a lot of running'* were played by 27% of boys compared to 14% of girls, while 15% of boys engaged in '*Games with some PA'* compared to 14% of girls. The Health Behaviour in

School Aged Children (HBSC) study looked at trends among 10 to 17 year olds in Ireland from 1998 to 2014 (Keane et al., 2017). In 2014, 15 year olds in Ireland were above the international average for engaging in vigorous exercise 4 or more times per week (44.2% vs 37.6%).

In Europe, sports participation has remained at a fairly constant level over the last 10 years (Kokolakakis et al., 2012). The Eurobarometer survey (European Commission, 2014) captured the activity of people from 28 member states across Europe. 41% said that they exercise or play sport at least once a week and almost three quarters of Europeans (74%) said they were not a member of an exercise or sports club. In Australia, the AusPlay report revealed that across 2015-2016, 87% of Australians of 15+ years had participated in some sport or physical activity (Australian Sports Commission, 2016). Overall, men play sport or engage in exercise or physical activity more than women. As people age, the amount of regular activity they do appears to decrease. Similar results have been noted in England, as adults participate less in team sports and exercise as they age (Belanger et al. 2011). Social differences are evident as those in higher socio-economic classes tend to be more engaged in sport. It was noted in Australia that there is a growing trend in non-organised social sport and physical activity participation (Nicholson et al., 2013). Social sport, anywhere, anytime, less formal has become more popular, which suggests that that organised sport and club activities are contributing less to overall population PA.

Sports participation rates have been rising over the last few decades. However, there seems to be more variation and fragmentation in the way people participate in sport (Borgers et al., 2013). In a review of global physical activity and sport participation, Hulteen et al., (2017) examined 64 articles regarding 47 countries. Running and walking were consistently participated in globally, while soccer was the only team sport that was consistently participated in all regions and by all age groups. Team sport participation was low among adults in all regions. Individual physical activities were more popular than participating in team sports across all regions for adults. Among adolescents, swimming and running were the most popular activities in most regions.

In Ireland and worldwide, sport remains popular but participation rates vary and typically are lower among females and decrease with age. Challenges remain in making sport for all a reality and reducing the drop out associated with sport.

2.5.1 Drop out From Sport

As noted above, there is a steady decline in sport participation as age increases; in Ireland over 80% of 16-19 year olds participate in sport while only 32.8% of 55-64 year olds do so. Much greater numbers drop out of engaging in team sports compared to individual sports (Sport Ireland, 2015). The major factors cited by people who dropped out of sport were work (26%) and family (22%) commitments, as well as injury (24%) and lack of interest (20%). Furthermore, many of those who participate in sport begin in their adolescence with high intensity team games. As they age they either drop out of sport or engage in some kind that is less physically intense and less team-oriented. Individual sports like running and cycling are much more likely to be taken up in adulthood whereas team sports are more likely to have been played since youth. The Sporting Lives report in Ireland showed that drop out from sport among adolescents was mostly due to drop out from team sports, while individual sport participation did not see much of a drop off with age (Lunn and Layte, 2008). 76% of over 18s or adults participating in sport were doing so in an individual sport as opposed to a team sport. A higher socio-economic status was associated with a lower likelihood of dropping out of sport in young adulthood and more likely to take up a new sport (Lunn, 2006).

The Irish Sports Monitor 2008 reported that in primary school, gaelic football, soccer and swimming are the most popular sports (Lunn and Layte, 2009). Those who don't play sport reported a lack of time and a lack of perceived physical competence as the main barriers to their participation. 70% of those who play sport report meeting people as being a reason for their participation. Lunn et al., (2013) found that in Ireland by the end of primary school when children are aged 10-12, most (88%) are engaged in extra-curricular or extra-school sport. Between the ages of 18 and 22 appear to be when individuals are particularly likely to drop out of sport. Other evidence from Australia, showing children's motivation to engage in sports found that they participate to have fun and to socialise (Australian Sports Commission, 2013). Further, most Australians (63%) regard physical health or fitness as their biggest motivation to participate in sport (Australian Sports Commission, 2016). Fun

or enjoyment (55%) and social reasons (32%) are also important motivations for participation. The main barrier to participation in sport or physical activity for adults is lack of time. For young children the main barrier is their parents' perception that they are not old enough to take part. Sports clubs are the primary avenue for Australian children to be active.

Similar motives were evident in Europe. The main reason for participating in sport or exercise was for health reasons. A lack of time was the main reason given by people for not engaging in sport (European Commission, 2014). Balish et al., (2014) showed that greater age correlates highly with sport drop out. Other factors that correlated highly with sport drop out were lack of motivation, lack of autonomy, and lack of perceived competence. Crane and Temple (2015) presented similar motives and barriers among children and youth. Interpersonal reasons for drop out were most frequently having other interests, and pressure from others such as coaches and parents. Structural reasons for dropout were mainly injury and time requirements such as travel time and training time. All of the discussion above presents factors that need to be recognised and addressed in an effort to maintain and increase participation levels.

Elsewhere, Gardner and colleagues (2016) explored adolescents' perception of the social climate in sport i.e. the influence of parents, coaches and peers, in sports clubs and the relationship this has to their enjoyment and participation. Over n=300 Australian adolescents that were members of sports clubs took part. Those who fell into the positive social climate profile expressed the greatest levels of enjoyment and intent to participate in future while those in the diminished social climate profile reported relatively lower levels in both measures. Those in the positive coach relationship quality profile also noted high levels of enjoyment and intent to continue participating even though their relationships with parents and peers were deemed to be lower scoring. Finally, other interesting evidence showed that when boys and girls were aligned for biological age, the effect of chronological age and sex on attrition rates in PA and sport is attenuated. Public health strategies aimed at reducing adolescent dropout may therefore have more success if they target biological age of participants (Cairney et al., 2014).

The findings outlined above suggest that coaches have a major influence on adolescent's enjoyment and participation in sports. Despite this, it is important not to discount the potential of parental and peer relationships in influencing the enjoyment and participation of adolescents in sport. Both parents and coaches have a responsibility to guide children towards healthier activities and behaviours (Vella, 2015). Understanding the attitude of parents toward the delivery of community sport is important in overcoming potential obstacles to participation and may help in effecting structural changes, which may lead to a more inclusive environment for children to participate in (Kelly et al., 2010).

2.6 Developing a Framework for Sport as a Setting

2.6.1 Sports Clubs for Health Guidelines

A set of guidelines for Sports Clubs for Health (SCforH) was published in 2009 (Kokko et al., 2009). The importance of PA for health is the basis for the framework with agreement that sports clubs should be able to provide health related physical activity programs. Five stages were detailed in the document for setting up a SCforH programme. Stage 1 revolved around preparation and identifying potential stakeholders such as health organisations, sports federations, schools, universities, and non-profit organisations and making them aware of the benefits of sport as a contributor to PA. Stage 2 involved developing a SCforH programme and how best the sport sector can deliver health enhancing physical activity (HEPA), and meet the requirements of the health sector. Stage 3 related to designing the SCforH programme with clear aims. Various stakeholders, experts and participants should be invited to develop the program and as a result develop an ownership of the program. Stage 4 involved implementing the programme. Organisational structure and an appropriate timeline need to be established and all participants and actors should be kept informed and engaged throughout the programme. Finally, stage 5 was about recognising the importance of evaluation. The evaluation should be used to inform and improve the programme. Feedback from the evaluation should be disseminated to stakeholders and can be used in support of financial applications to further the programme.

In 2011, a second set of guidelines were published for SCforH (Kokko et al., 2011). These guidelines were aimed at clubs to help them develop health oriented activities. Guidelines were based around the fact that sports clubs' core business, getting people moving is

health promoting but clubs could invest in more health promoting activities that align with their core business. A further aim of these guidelines was to promote cooperation between the sport and health sectors. The guidelines for clubs were also refined to 3 stages. Stage 1 involved planning for a SCforH programme. It is important that clubs identify support and establish that there is a will for such a programme to exist. Acknowledging and recognising the health promotion profile of your sport is also important. Clubs need to map the resources that are available to them and ensure a quality sustainable program can be delivered. Clear aims and objectives also need to be agreed upon. Stage 2 related to implementing the programme. Clubs need to market and advertise the programme so people are aware. Competent leaders need to be recruited to deliver the programme and supported appropriately. Activities should be monitored throughout the program and data gathered. The third and final stage of the guidelines involved the clubs documenting and communicating. Details of the programme should be recorded and evaluated and the programme success should be shared and communicated with others.

Later, in 2013 the Council of the European Union concluded that SCforH be one of 23 indicators used to monitor HEPA levels and policies in European Union member states (The Council of the European Union, 2013). Following this, the latest SCforH guidelines were published in 2017 (Koski et al., 2017). Again it is acknowledged that sport has the potential to reach so many people and promote HEPA and health in general though their activities and adoption of these guidelines may increase participation and improve the health of those participants. The 7 guiding principles for the SCforH approach are detailed. These include delivering activity that has a strong evidence base behind it and ensuring qualified and competent personnel lead the programme and should be given adequate support. Clubs should focus on incorporating health promoting activity into their current activities and core business and there should be minimal or no health or injury risks involved in the programme and it should take place in a healthy environment without any marketing or advertising from unhealthy businesses such as alcohol or smoking. Finally, the programme should empower the participants and be an enjoyable experience. A 4 stage application model is also detailed for clubs. This highlights similar advice from previous guidelines. Clubs should assess, plan, implement, and evaluate their programmes. The conceptual

framework for the SCforH approach is also detailed. The approach places great emphasis on health enhancing sports activity and health enhancing exercise as well as outlining the potential to influence other areas of people's health.

2.6.2 Proposed Framework for Health Promotion in a Sports Setting

Kokko et al., (2006) aimed to develop a set of the most relevant standards for health promotion in a sports club setting. Three rounds of the Delphi method were used in an iterative process with experts from the health and sport sector. Standards suggested were based on the existing theory and literature, mainly from the Ottawa Charter (WHO, 1986). At the end of the process, 22 standards were presented. These were grouped under 5 headings; Health promotion policy, Environmental health and safety, Community relations, Health education and individual skills, and Health services. Clubs were assessed using the 22 standards in the HPSC index developed by Kokko et al., (2006). Further refinement of the standards led to the development of a Health Promoting Sports Club Index (HPSC-I). This led to the 22 standards being divided into four categories; Policy, Ideology, Practice and Environment (Kokko et al., 2009). Policy related to written regulations and guidelines of the club e.g. '*The sport's clubs regulations include a written section on well-being'*. Ideology involved the clubs orientation toward fair play, respect and maximum participation e.g. '*The sports club promotes the 'everyone plays' ideology'*. The practice sub-index focused on practical health promoting activities such as coaching practice and injury prevention practice e.g. '*The sports club assures that health education is carried out'*. Lastly, the Environment category addressed the provision of a safe and healthy physical and cultural environment by the club e.g. '*The sports club provides a sports environment that is free of intoxicants during junior activities'*. The four categories combine to give an overall picture of the health promoting orientation of a sports club. The need for a policy context, provision of education and activities and partnerships are all factors reinforced by Kelly et al., (2010; 2011) and Meganck et al., (2015).

Geidne et al., (2013) specifically reviewed the key issues involved in developing a youth sports club as a health promoting setting and a framework for doing so. The review reiterated the importance of the 5 areas for development set out in the Ottawa charter mentioned previously. The review reveals there is plenty of opportunity for promoting health through the sports club but this does not happen automatically. Sports clubs need

to be a healthy and supportive environment with activities catering for all age groups. Adults, coaches, and parents need to give appropriate guidance to younger club members. Policy development should be an on-going part of the discussion in a club and the policies should align with the core business of a club. As well as that, clubs need to look externally and develop partnerships with schools and other sports organisations.

Kokko et al., (2013) conducted a review of settings engaged in health promotion with a focus on the similarities that exist with sports clubs and other settings. Firstly, activities of clubs were viewed on three levels. The macro level relates to the overall guiding policies and values of the club. The meso level represents the actions and activities of club leaders and officials, often in support of actors at the micro level. Micro level actors include coaches and their actions in facilitating and supporting club member's activity. The cultural, social, economic and physical determinants of health then exist on each level. Cultural determinants are associated with how important health promotion is regarded in the club through its policies and operations. At a meso and micro level this relates to officials and coaches and how important they see health promotion as being. Economic determinants relate to monetary resources that are available and used to deliver time and expertise toward health promotion. For example, are coaches educated and informed on health promotion. Environmental determinants relates to physical and social environments that are safe and healthy for individuals. The Ottawa charter has provided the framework for action for health promotion in the sport and other settings with multi-level action required for change. A typology for clubs to develop as health promoting settings was also outlined. This was a 3 stage model adapted from Whitelaw et al., (2001). Stage 1 was the passive education model where the club provides education to members on specific health related issues with help from external experts. Stage 2 required the club to become more active where individuals are supported to change their behaviour. In the club, coaches and other actors are educated on health promotion issues. Stage 3 was the club society development model where the focus moves to one of organisational change. Club policies and practices are the target of change and they in turn will continue to support the health behaviours of individuals.

Later Kokko (2014) outlined guidelines for youth sports clubs to follow when delivering health promoting activities. Most of the advice followed the SCforH principles. The

guidelines were divided into two categories, policy and practice. Policy relates to the guidelines that are the basis of the club activity and writing health promoting aims in a 'language of sport'. Clubs should subsequently prioritise their health promotion area of work. Physical activity may be one but other possible areas of work include healthy eating, mental well-being, and anti-smoking. Working with other clubs to share ideas and promote health is suggested. The area of practice relates to the daily activities of the club, mainly the coaching and games. As a result coaches need to be involved and committed to health promotion. An action plan should be developed to implement the policy aims. Coaches and other officials should be educated and guided on the policy aims and how to implement them.

Outside of this potential framework there are other factors to be considered when developing the club into a setting for health promotion. Firstly, the club must consider sustainability. There is a danger that health promotion activities may come to a conclusion once initial funding and interest has stopped, and strategies to avoid this must be developed (Casey, 2009). To overcome this, it is important that there is collaboration between the partners involved in the health promotion activity, that capacity building approaches are used to help develop in house activity (Casey, 2009; 2012), to generate dissemination policies so that activities become widely available (Owen et al., 2006) and by keeping health promotion high on the agenda of sports clubs, usually through leadership and support from sports federations (Meganck et al., 2014). Among State Sporting Organisations in Australia, larger organisations were found to have greater capacity to deliver health promotion to their members through sport due to their large membership base. These organisations were able to engage in using mentors and club development programs and rewards systems for their members. Organisations with smaller memberships and more volunteer reliance were more dependent on resources and funding which does not seem sustainable. Larger organisations, despite their capacity, lacked the expertise to design and evaluate initiatives for various populations and for various health issues (Casey et al., 2011). There has been considerable work around developing a framework for HP through sport, and equally many real world attempts to deliver HP through sport. This work started in Australia before more recent activity in Europe.

2.7 Sport based HP in practice

2.7.1 Australia

Corti et al., (1995) was one of the first to investigate sports organisations and their health promotion behaviour. In this study, sports organisations that had received funding from Healthway were investigated. Healthway was an independent funding body that provided funding to organisations on the basis that they implement health promoting reforms in a number of areas. Results showed that after 18 months of funding, sports organisations had significantly improved their smoke free policy activity and healthy food options activity. Later, The Healthway Healthy Club Initiative was developed in Australia and involved the sponsorship of community sports clubs in an attempt to promote healthy practices and policies (Mills et al., 2008). Over n=1400 clubs have taken part so far. Clubs were provided with a '*Healthy Club Kit'* which included signage, posters, and an information and policy booklet. The project was successful in promoting smoke free environments, sun protection, alcohol and nutrition programmes in participating clubs.

Dobbinson et al., (2006) investigated sports clubs in Australia and their health promotion policies. Club representatives from n=640 clubs completed a phone interview. They were asked about 5 areas of health promotion policy development; smoke free, sun protection, healthy catering, injury prevention, and responsible alcohol management. Seven out of every ten clubs that had a bar had a written policy on responsible alcohol management. Written smoke free policies were evident in just over one third of clubs. Only 2% of clubs had a policy for all five areas. When asked about potential barriers to developing health promotion policies, 47% expressed the need for more support and guidance from health agencies and 45% suggested that they could do with the use of sample policies. In a similar investigation, Eime et al., (2008) contacted executive officers of State Sporting associations (SSAs) in Australia. Surveys and interviews were used to assess the activity of sports clubs in implementing healthy and welcoming environment (HWE) policies and practices. Executive officers representing n=51 SSAs took part and 97.2% agreed that creating a HWE would facilitate an increase in participation. They expressed concern at having limited capacity in controlling what clubs do at grass roots level. Most SSAs reported having a policy across the 5 areas of focus including smoke free, alcohol management, injury management, sun protection, and healthy eating.

Casey et al., (2009) explored the development of sustainable health promotion programs in sport organisations. In Victoria Australia, a scheme called participation in community sport and recreation (PICSAR) was set up by VICHealth, an Australian department of health organisation (VicHealth, 2013). Clubs were encouraged to build capacity and engage with priority communities through establishing effective partnerships, developing inclusive policies, developing appropriate programs and providing training for staff and volunteers. The PICSAR scheme was implemented by regional sport assemblies (RSAs) which are government sponsored non-profit organisations. Importantly, the PICSAR scheme aligned with the values and aims of the RSAs such as capacity building, partnership development, and promoting participation in physical activity and was successful in all of these areas. Also the scheme complemented and supported existing programs that were active in RSAs and allowed the expansion and growth of these programs. The development of program champions was another factor that helped the successful adoption of the scheme. Many participants noted social as well as physical benefits and increased confidence while families reported an increased opportunity to participate together while targeting diverse populations raised the profile of clubs in their communities (VicHealth, 2013).

The Healthy Sporting Environments Demonstration Project (HSEDP) is aimed at helping community sports clubs in Australia become healthy sporting environments through policies and structures aimed at smoking, alcohol management, healthy food, sun protection, injury prevention, and creating inclusive environments for all sexes and races (Nicholson et al., 2013). Clubs were required to engage in responsible serving of alcohol, make healthy food choices available, make smoke-free venues a reality, integrate injury management strategies as part of their safety plan, and include those from diverse backgrounds in a safe and welcoming environment. An evaluation conducted over 2 seasons found that delivering minimum standards for these key areas did not result in a positive change in health or social effects but improvements in standards across these areas The capacity of clubs to deliver the changes in the HSEDP depends on a number of issues including volunteers taking ownership and championing the idea. As well as this the management committee need to support the project and deliver good governance in clubs to implement policies and decisive action. Club capacity benefits if an intervention such as

this is seen as a whole club commitment rather than a project for one person or one group to command.

Casey et al., (2011) explored the organisational readiness and capacity building strategies of sports organisations (SSOs) to promote health. Larger SSOs tended to indicate having larger levels of organisational capacity to promote health, largely due to a greater membership base, professional staff, and strong partnerships with government agencies and sponsors. Smaller SSOs meanwhile indicated lower levels of organisational capacity to promote health and had a greater reliance on voluntary activity. In a further study, Casey et al., (2012) looked at SSOs in Australia and their capacity to deliver health promotion activity. Sports organisations involved were part of a Vichealth partnership for health scheme where funding was received on the basis of developing healthy environments. The average capacity for health promotion increased significantly by the end of the scheme. Significant increases were noted in smoke-free policy and practice, and injury prevention policies. The existence and implementation of healthy eating policies and practices were the least prevalent.

The Good Sports Program is aimed at creating healthier and more inclusive environments in Victorian sports clubs (Kingsland et al., 2013). The intervention involves a 3 level accreditation approach consisting of 16 strategies in total that clubs aim to adopt. For example, level 1 requires clubs to always have a management committee member present when alcohol is being served. Level 2 requires clubs to make non-alcoholic and low-alcoholic drink options available. Level 3 requires clubs to have a written safe transport policy. Clubs involved in the program benefitted from increased levels of income and membership while diminishing their reliance on alcohol as a source of revenue (Crundall, 2012). Previously, club representatives from various sports across Australia were contacted to assess how amenable they would be to participating in alcohol interventions (Duff & Munro, 2007). A great majority (95-99%) of club representatives believed that the sports club was a key setting to promote healthy behaviour, that responsible alcohol management strategies are put in place, and that this is the clubs responsibility. In a further study, Kingsland et al., (2015) conducted an alcohol management intervention in community sports clubs using the Good Sports model. This was a randomised control trial involving n=88 Australian community football clubs. Follow up data showed intervention

clubs to have significantly lower risk of alcohol related harm, lower consumption risk and lower dependency risk.

Wolfenden et al., (2015) conducted a randomised control trial improving the availability of healthy food and beverages at n=85 community football clubs in Australia. The intervention aimed to improve the availability of fruit and veg as well as non-sugar sweetened drinks. Results showed that intervention clubs reported a significant increase (OR=5.13, P<0.05) in the availability of fruit and vegetables in their canteens compared to control clubs. No difference was apparent in non-sugar sweetened drink availability. The use of meal deals and price promotions increased significantly (OR=34.48, p<0.05) among intervention clubs compared to control clubs. Members of intervention clubs noted purchasing significantly greater amounts of fruit and vegetables (OR=2.58, p<0.05) and non-sugar sweetened drinks (OR=1.56, p<0.05) compared to those in control clubs. Finally, no significant difference was noted in annual revenue from food and non-alcoholic drinks between intervention and control clubs.

While Australia has led the way in terms of health promotion through sport, considerable work has since been undertaken across Europe.

2.7.2 Europe

The Sports Club for Health Guidelines (Koski et al., 2017) mentioned previously reflected work being undertaken in Finland in this area. The guidelines prompted further analysis of the role of sports club in promoting health, beyond just promoting PA. As noted earlier, Kokko et al., (2006) produced a set of Health Promoting Sports Club Standards (HPSC) incorporated into an index, which could be used to measure the health promotion orientation of sports clubs. Several research studies have since used this index. In light of this Kokko et al., (2009) aimed to assess the health promotion orientation of youth sports clubs in Finland. In this study, n=97 clubs that delivered four sports were assessed; soccer, ice-hockey, track and field, and cross country skiing. The average overall HPSC index score for youth clubs in Finland was 12.5, which was deemed a moderate orientation and the variation between clubs was large. One in four clubs had a high HPSC status. Clubs that were certified by the Young Finland Association were two and a half times more likely to have a high HPSC status compared to non-certified clubs. Clubs scored low in the policy

index and high in the ideology index. Only one out of ten clubs reached a high status in the environment category. Finally, clubs scored the lowest in the practice category.

Meganck et al., (2015) investigated the health promotion profiles of sports clubs in Flanders, Belgium. n=253 youth and adult sports clubs took part in the online survey using the HPSC index mentioned earlier. In general youth clubs were more strongly oriented toward promoting health than adult clubs. Most scored well in the ideology category with practice the worst score with 55.1% of youth and 91.8% of adult clubs deemed low health promoting. Club representatives were also asked about motives for engaging in health promotional activity. Clubs responded to statements such as healthy athletes perform better, and our club wants to take up its responsibility to the community. Motives appeared to be more strongly appreciated in youth clubs as opposed to adults clubs. Motives were also supported more strongly by youth clubs with a higher health promotion orientation. Barriers included lack of internal and external support and lack of funding. Respondents suggested that none of the barriers were important factors in not engaging in health promotion as part of the club policies and practices.

Van Hoye et al., (2015) investigated health promotion activity in n=125 French sports clubs using an adapted HPSC index. Analysis revealed that 40% of coaches believed their club to be of a high health promotion orientation, 32% were in the moderate category and 28% were in the low category. Ideology and environment indices scored highest while a partnership index scored the lowest. In comparison to Finnish clubs, there was no significant difference between overall HP score, practices and ideology index. French clubs appeared to emphasize environment activities more and policy activities less than Finnish clubs. On average, coaches perceived that over two thirds of the health promotion activities detailed in the HPSC Index were part of their club aims. Lowest scoring individual items were '*My sports club ensures that sponsorship respects health promotion*' and 'My sports club provides education on health issues or makes provision for its members to receive such education'.

Lane et al., (2017) presented results from a health promotion programme in an Irish sporting context. The Gaelic Athletic Association (GAA) is the governing body for gaelic games in Ireland and have developed the Healthy Clubs Project. Questionnaires included

the HPSC Index again adapted from Kokko et al., (2009). On average clubs were ranked as having moderate health promotion orientation. Clubs also scored moderately in the practice and environment sub-indices, higher in the ideology category and lower in the policy category. Bigger clubs scored higher on average in all categories. Individual items in the policy category scored low such as '*Health and Wellbeing ideals are written in the club's constitution and regulations*'. Items in the ideology category scored highly such as clubs implementing the 'Go games initiative' where maximum participation is prioritised over competition for younger players. Also some environment items scored well in terms of fair play and coaches showing a good example. While 69% of clubs agreed on the importance of developing partnerships, the manifestation of this into formal partnerships was not evident. Clubs felt that this project was a welcome structure to develop the good work already taking place in clubs. The reach and responsibility that clubs have to their members and communities was also an important factor in clubs supporting this project.

Separately, other activities related to sports club based health promotion have been underway across Europe. The European Healthy Stadia Network is a program that supports sports organisations and stadia operators to develop and implement health promoting policies and practices to enhance the health of those who engage with sports stadia across Europe. Drygas et al., (2011) examined the policies and practices that are implemented across sports stadia in Europe as part of the Healthy Stadia initiative. Data was collected from n=88 stadia across 10 countries. All stadia were active in at least one area of health promotion; 55% had a tobacco policy and 40% prohibited smoking in the stadium. In the area of healthy eating and healthy food options only n=16 stadia had a policy. Due to sub-contracting of catering duties, most said they have little control over this aspect of health promotion. In terms of physical activity, 47% had a policy for staff, visitors or members of the local community. A recent review has highlighted that a rigorous body of evidence is needed to support the agenda of the healthy stadia and that academic partners need to be involved with clubs and sports governing bodies when designing and implementing projects of this nature (Parnell et al., 2017).

Pluim et al., (2013) explored the development of n=10 healthy tennis clubs in the Netherlands. Provision of healthy foods was a consistent theme in clubs. However, none of the clubs had a formal healthy eating policy possibly due to lack of support from key

individuals like board members and the short shelf life of healthy foods. Another important theme emerging was injury management. Clubs engaged very little in this area with respect to programs or policies. A major reason for this was the lack of a key individual taking responsibility for the area of work. Most board members were happy to just provide a basic first aid service and felt that dealing with injuries was the coach's responsibility. The final area of work highlighted was social health. None of the clubs had policies or programmes in the areas of fair play, or inclusion of immigrants or lower socioeconomic groups. Board members felt that policies on these issues would empower the clubs. Overall, intent in relation to health promotion was apparent but follow through was limited.

Hunt et al., (2014) investigated a health promoting programme for male football fans in Scotland. The Football Fans in Training programme involved Scottish football clubs promoting physical activity and health advice for men; 90 minute sessions took place every week for 12 weeks. Men aged 35-65 who had a BMI above 28 took part in the programme. N=747 participants took place in this RCT where data was collected at baseline, 12 weeks and 12 months timepoint. Results show that 78.9% attended at least half of the sessions during the activity phase. At 12 months post baseline the average weight loss among the intervention group was 5.56kg compared to a corresponding figure of 0.58kg in the control group. Differences between groups in terms of weight loss, waist circumference, BMI reduction, bodyfat percentage and blood pressure were all significantly in favour of the intervention group. Significant differences were also noted in self-reported physical activity, fruit and veg consumption, and alcohol consumption in favour of the intervention group. Bunn et al., (2016) explored the experiences of the participants in the FFIT programme. Being with other men of similar experiences and having shared beliefs and interests was a key driver of the programme's success. Participating with other men that supported the same football club and had similar body weight issues strengthened group interaction and allowed the masculine competitiveness to be set aside. Men were able to openly discuss health and diet issues which would be limited in most other settings. Challenging the unhealthy male stereotype of drinking excessive alcohol for example allowed the men to practice and discuss health enhancing behaviours together. The FFIT programme is a scalable programme that can be implemented in other football clubs (Hunt

et al., 2016). Indeed, this has already taken place as FFIT has informed the development of a similar programme called EuroFIT (van de Glind et al., 2017). Emphasis in this program will shift from weight management, to physical activity promotion and reducing sedentary time. Tools will be used to monitor the activity of participants in these areas. The effectiveness of this program will be monitored with trials taking place in a number of European countries such as Netherlands, Norway, Portugal and the UK.

The FFIT programme has also informed a similar programme aimed at hockey fans. HockeyFIT is a Canadian programme aimed at male ice hockey fans in an attempt to promote health behaviours (Petrella et al., 2017). Eighty male hockey fans between 35-65 years with a BMI at or greater than 28 took part in this 12 week programme. The participants took part in 90 minute weekly sessions involving information dissemination and group based physical activity. After the 12 week programme, intervention participants had lost an average of 3.6kg ($p<.05$), significantly more than the control group ($p<.001$) and maintained this weight loss after 12 months. Also compared to the control group after 12 weeks, the intervention group were almost 2.5 times more likely to consume fruits and vegetables at least 3 times per day.

2.7.3 Coaching Related HP

Coaches have indicated that they believe health promotion is an important factor in sports club activities (Van Hoye et al., 2015). The fact that some coaches see this as a relevant activity suggests an opportunity for HP in sports clubs but they also noted that they are not given adequate guidance and education from their clubs on health promotion issues. It was observed that coaches who appear to have more self-determined motivational coaching status are those who perceive that their clubs are very active in the HP space. The self-determination theory is based on the premise that there are two types of motivation; self-determined and controlled (Deci and Ryan, 2008). Self-determined motivation can take the form of doing something for its inherent appeal or doing something because it aligns with your values. Controlled motivation however relates to doing something because you feel pressurised into doing it either internally or externally. McLean and Mallett (2012) found a positive association between coaches' self-determined motivation and personal accomplishment, well-being and mastery goal orientation. In addition,

coaches controlled motivation was found to be negatively or not significantly associated to these factors.

Promoting Adolescent Physical Activity (PAPA) is a project funded by the European Commission. The aim is to promote adolescent mental, emotional and physical health through involvement in sport. There is a coach education programme as part of the project to enable coaches to create the appropriate environment for adolescents (Duda et al., 2013). As part of the PAPA project Fenton et al., (2016) examined the motivational climate created by coaches in youth sport and its impact on participants. Athletes and coaches from football, netball, and hockey clubs in England participated in the study. Athletes were aged between 9 and 16. Accelerometers, questionnaires and other tools were used to collect data. Results showed that a perception of an empowering motivational climate created by coaches was significantly and positively related to autonomous motivation and enjoyment of sport participation by the athletes. A feeling of autonomous motivation was significantly and positively associated with enjoyment of sport participation and daily moderate to vigorous physical activity (MVPA). Enjoyment of sport participation had a significant positive relationship with daily MVPA and daily MVPA had a significant negative association with body fat percentage.

Youth mainly engage with coaches in sports clubs, and health promotion practice mostly relates to the coaching practice (Kokko, 2010). A contradiction may be evident however, with coaches placing a greater emphasis on winning. It is suggested that club policies and practices should be explored and developed in line with the coaching practice in order to develop healthy practices in sports clubs. Kokko (2010) has found that Finnish sports clubs were fairly passive in guiding their coaches toward health promoting activity. Sports clubs were more concerned with sports performance than health promotion which is understandable. Sports clubs who had a higher health promoting status were associated with being much more active in guiding their coaches towards engaging in health promotion activities. Development of greater health promoting standards at club level is therefore recommended by Kokko (2010). The links between health promotion and sports performance need to be communicated to coaches and better understood for them to grasp the importance of these issues.

Kokko et al., (2015) explored the health promotion activity of coaches. Data was collected in 2007 from 4 sports. Coaches (n=240) and young athletes (n=646) from n=97 clubs completed questionnaires. The coaches involved coached boys between the ages of 14-16 and the athletes were of a corresponding age. Coaches were asked to estimate their health promotion activity and athletes were asked for their perception of coach activity in this area. Three areas were focused on; performance related health promotion such as training and competition, non-performance related health promotion such as other time spent in the club, and other health topics. In the area of performance related health promotion the coaches estimated their activity to be much higher than the athlete's perception of the same. For non-performance related health promotion there was no significant difference between coach and athlete perceptions. Athletes did perceive the coaches activity to be lower than the coaches estimated however. Finally, for health topics the athletes rated the coach's activity much lower overall than coaches estimated themselves.

Later, Van Hoye et al., (2016) explored coach's health promoting activities and their potential impact. At least five 8-14 year olds from n=15 clubs in France took part and a total of n=59 teams were represented. A coaching health promoting activity scale (CHPAS) was developed. Players used this to rate the health promoting activity of their coaches on a scale from 1 to 5. The sub groups were respect for oneself and others, healthy lifestyle, and substance use. On average, players rated their coach's health promotion activity 3.44. The highest area was respect for oneself and others, followed by healthy lifestyle, and substance use. A higher overall score was positively associated with player's enjoyment of sport, self-reported health as well as negatively associated with intention to drop out. Higher coach activity in the category of respect for oneself and others was associated with greater enjoyment, self-esteem, and health as well as a lower intention of drop out. Players who rated their coaches higher on healthy lifestyle activity appeared to have less enjoyment. Similarly, Casey et al., (2017) found that sports clubs with a welcoming environment as well as a smoke free environment and injury prevention strategies were positively associated with participation among adolescent girls. Sports organisations should prioritise the development of environments like these and developing partnerships with health promoting organisations.

In a related study, Van Hoye et al., (2016) explored coach's perceptions of health promoting activity in their club as well as officials guidance on such activity. Ten French football clubs took part, with n=68 coaches completing questionnaires and n=10 officials taking part in interviews. An adapted version of the HPSC index was used including a partnership category. Results showed that coaches recognised healthy ideology the most, followed by partnership, environment, practice and policy. Officials appeared to believe that sport is automatically healthy and participation is sufficient to enhance health. When recruiting coaches, healthy role models were preferable. Few written policies were mentioned by officials, with no club having a committee to deal with health promotion. Only n=2 out of n=10 clubs had regular activities regarding health promotion, and both were based on improving sports performance. Coach education appeared to focus on sport performance with little regard for health promotion. Official's guidance appeared to match that of coach's perceptions in the ideology category. Clubs promoted fair play and personal development of their players.

2.8 Barriers and facilitators to HP in sports clubs

Crisp and Swerissen (2003) employed a case study approach to examine the structural change in Australian sports clubs in relation to a number of health promotion areas. Sport organisations in Victoria received funding from VicHealth with the understanding that they would provide smoke free environments, responsible alcohol management practices, healthy eating options, and sun protection guidance. Ideally, this would involve the development and implementation of polices. Representatives from clubs, state sporting organisations, and supporting health agencies were interviewed. According to their feedback, the most important supports included support in the development of policies and appropriate training. Barriers to implementing structural changes included there being more important things than health promotion, and the perceived cost. Without a systematic and shared approach, the burden of effecting structural change generally falls on an individual, an issue that has also been identified in more recent research (VicHealth, 2013; Meganck et al., 2015). Club members detailed the existence of unwritten rules like not smoking in front of children, despite the absence of formal written policies.

It is not easy to achieve such structural changes in sporting organisations (Crisp and Swerissen, 2003). Some areas of change will most likely be easier to achieve than others.

For example, it has proven much easier to develop smoking and sun protection guidelines in Australian sports clubs compared to healthy food policies (Ware & Meredith, 2013; Crisp and Swerissen, 2003). This research also found that programs should be linked to other programs and services to maximise positive outcomes. Activities that are expensive and do not capture the interest of the wider community can cause exclusion. Labelling a program as a health program rather than a sports program can inhibit participation. Less buy in is to be expected when the target community does not engage in the process of program development. Many of the encouraging effects of sports participation are indirect and observed over a long period of time, therefore it is difficult to make a causal link between a program and specific outcomes.

Among youth sports clubs in Flanders, 33% of those surveyed made the point that HP was not a priority in their club and this acted as the biggest barrier to HP (Meganck et al., 2015). Multi-sport clubs appear to fare better in promoting health than clubs who focus on a single sport. Further, clubs that focused on both recreation and competition fared better than those who focus just on one of these aspects. Non-monetary recognition such as a healthy clubs badge, label or flag could be an incentive for clubs to improve their public image and attract new members (Kelly et al., 2014). Some of the barriers to HP in sports clubs are lack of time, and lack of support from the government. Lack of time may stem from a lack of expertise and time management in health promotion activities. Some strategies to overcome these complaints are to include health promotion education for club representatives arranged by sports governing bodies. A health professional joining the board or committee is another strategy to build the expertise within the club. For youth sports clubs, one of the most consistent predictors of health promoting activity is the perceived motives the clubs have (Meganck et al., 2016). Emphasis can be put on the will to improve public health, the potential to be better than other clubs in this field, potential for increased membership, and better performance from playing members.

Lack of resources has been found to be a significant predictor of clubs health promoting activity. Financial rewards are suggested as a way to manoeuvre around this obstacle and this would also serve as an incentive (Kelly et al., 2014). Other methods to increase resources could be to develop educational programmes for club members and partner with health care organisations in this venture. Additionally clubs could avail of ready-made

health promotion packages developed by health experts with the help of sports organisations and representatives. These packages could detail how to develop policies, engage in effective fundraising, or could give examples of successfully run activities from other clubs (Meganck et al., 2016). Leenaars et al., (2015) reviewed interventions between the primary health care sector and the sports sector to promote PA and the facilitators and barriers that appeared in such initiatives. Health professionals' lack of knowledge about physical activity and sport professionals' lack of knowledge about healthcare were seen as barriers. Effective communication, clarity of roles, leadership skills and trust were seen as facilitators to effective collaboration between healthcare and sport sectors.

2.9 Health & Wellbeing in the GAA

The Gaelic Athletic Association (GAA) is the largest sporting association in Ireland. Almost a quarter of the Irish population are members of the association. There is a GAA club in almost every community in Ireland and the club represents a perfect setting for health promotion. Among the core values of the association are social inclusion and community development. For at least the last decade, the GAA has had experience in delivering health promotion to its members and the wider community. The first steps towards formalising health promotion occurred in 2006 when the GAA established the Alcohol and Substance Abuse Prevention (ASAP) programme, delivered in conjunction with the HSE. This was in response to a report that alcohol misuse amongst n=700 male GAA players in Ireland (mean age 24 years) was higher compared with a similar cohort of the general population O'Farrell et al. (2010). Recommendations included limiting alcoholic sponsorships, preventing the availability of alcohol to those under the legal age, and an assessment and intensification or reconfiguration of the GAA ASAP programme. Eventually, it was apparent that a broader approach to health promotion was required in the GAA to deal with all aspects of health promotion rather than just a focus on one single aspect. As a result the GAA Healthy Clubs project was established to explore the potential of the GAA club as a setting for promoting health. The Healthy Clubs project is based on the settings approach to health promotion and the framework focuses on four pillars; club, plan, partnerships and programs.

Sixteen clubs took part in the initial phase of the project. An evaluation of Phase 1 of the project suggests that the GAA club is a viable setting for health promotion (Lane et al.,

2015). The health promoting sports club index (HPSC-I) was used and adapted to suit a GAA club setting. Results showed that clubs who engaged in the Healthy Clubs project improved their overall health promoting orientation. Policy, Practice and Environment sub-indices all scored higher in these clubs as a result of engaging in the Healthy Clubs project. As well as this, club and community representatives commented on the positive impact that they observed in the clubs. They noticed better attitudes toward health in the club and community as well as greater engagement with club activities. Overall, 72 initiatives were delivered on a variety of health topics. 60% of these were deemed to have a moderate impact, 36% had a small impact and 4% had a high impact. Many of the recommendations from the Phase 1 evaluation have been acknowledged and addressed in Phase 2 of the project. Some recommendations include; development of a healthy club policy, development of a communication network for clubs to use, better guidance for clubs to source funding, development of officer training, development of a suite of initiatives which are in line with best practice and finally a more controlled evaluation to measure the impact of the project (Lane et al., 2015).

The leadership and investment in health promotion by the GAA indicate their dedication to this area of work. There is a community and health department at national level as well as '*health and wellbeing'* structures at national, provincial, county, and club level (Lane et al., 2017). It is important for GAA clubs to engage with the wider community to develop resources and support as they are a volunteer based entity. Phase 2 of this project involves a larger number of clubs getting involved in health promotion. At the outset of this new phase, it was noted that clubs need to develop meaningful partnerships, gain executive support, and work to embed health promotion into the coaching practice and the daily activity of the club (Lane et al., 2017).

2.10 Summary

Despite sport being advocated so strongly to tackle health issues, its ability to result in positive health outcomes for the individual is still unclear (Edwards, 2015). Sport frequently relies on public investment to manage and sustain activity largely because of anecdotal and often intangible societal impact. Increasingly sport will have to justify its role in the community through explicit benefits such as capacity building, and behaviour change to warrant such funding. Currently, sport's ability to deliver community capacity is

not automatic and needs to be managed appropriately for best health results to be realised, and managers and leaders in sports organisations need to ensure that research supporting the interventions is evidence based.

It is important to note that sports organisations have traditionally focused on providing competition and encouraging participation so this emphasis on health promotion is a new challenge for them (Casey, 2009) and changing their orientation towards HP at a macro level may take some time. Research examining the implementation of health promotion policies and practices in sport has been limited and standardised and rigorous evaluation tools have not been used (Kokko et al., 2009). Also, there is limited research on the sustainability of health promotion programs within sports clubs (Casey et al., 2009). It is important that such health interventions are developed with cultural and social practices in mind in order for the behaviour change to be sustainable (Bunn et al., 2016). The GAA Healthy Club Project is an initiative led by a national sporting organisation striving to embed health promotion ideals into the daily workings of clubs, and essentially harnessing the potential that already exists in these clubs who are at the centre of social and cultural life in Ireland. The purpose of this research is to evaluate Phase 2 of the GAA Healthy Club Project.

Chapter 3 Methodology

3.1 Research Approach

An applied research approach, specifically evaluation research was employed to evaluate Phase 2 of the GAA's HCP. Evaluation research aims to find solutions to problems, evaluate existing practices and policies, and assess the requirement for new approaches and programs (Sarantakos, 1998). This was deemed the appropriate approach as the aim of the HCP was to equip GAA clubs with the energy, structures, knowledge and skills to address the health and well-being needs of their club and community. Specifically, a quasi-experimental design was used to evaluate Phase 2 of the GAA's HCP. This approach was necessary as randomisation of clubs into an intervention and control group was not possible, which is often the case with health promotion research (Salazar et al., 2015) and the HCP itself was a broad, wide ranging, club level intervention rather than a standardised provision. Within this, case study designs were also used to evaluate initiatives delivered by clubs.

3.2 Study Design

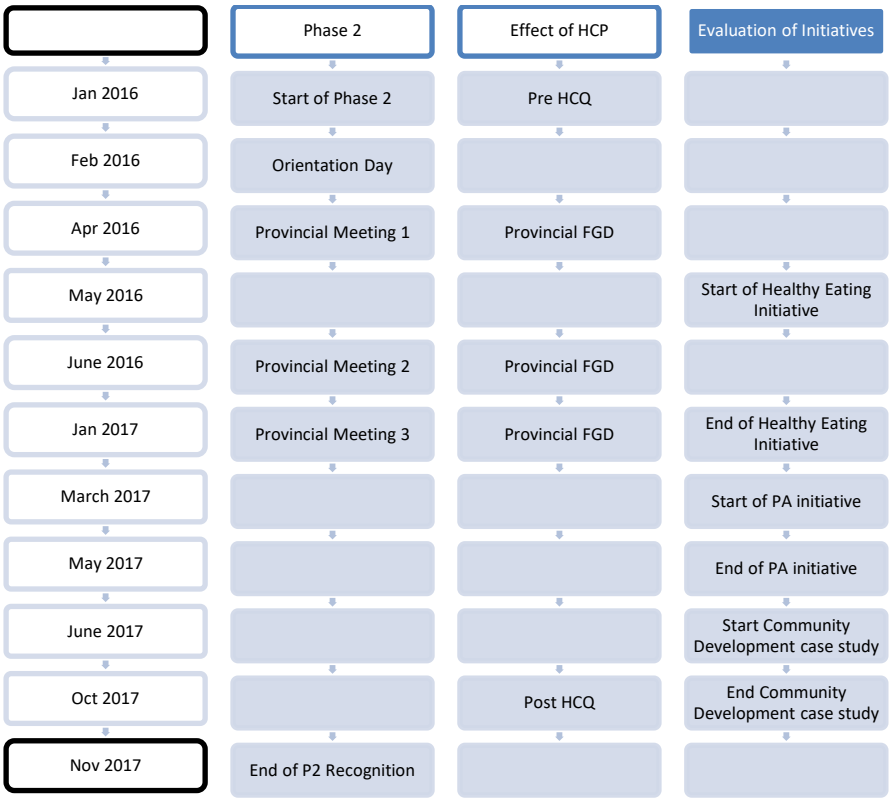
The GAA's HCP is a settings based health promotion initiative designed to support and enable GAA clubs across Ireland to promote health and well-being for their members and communities. Phase 1 of the HCP ran from March 2013 to March 2015 and involved n=18 GAA clubs. An evaluation of Phase 1 of the HCP delivered encouraging results and demonstrated that GAA clubs are a viable setting for health promotion (Lane et al., 2015). This particular evaluation focused on Phase 2 of the HCP which ran for 20 months from January 2016 to September 2017 and included n=60 Healthy (intervention) clubs, and n=27 control clubs. Clubs across Ireland were invited to apply for Phase 2 of the HCP by completing an expression of interest form and returning this to the GAA Community and Health Department. Clubs were made aware of the opportunity to participate in the HCP through email from county PROs, the GAA newsletter, and the GAA Community and Health website. One hundred clubs declared their interest and the GAA subsequently appointed a sub-group of the Healthy Club Steering Committee to screen all applicants and select which clubs should take part. Clubs applications were viewed favourably if they demonstrated a previous record of engaging in health promotion activity and if they appeared to possess the capacity to participate in the programme. Having at least one club

from each county was also a goal during the selection process for Phase 2. This selection process was agreed upon by the National HCP Steering Committee. Sixty clubs representing all 32 counties were selected to take part in Phase 2 including n=16 clubs that had also participated in Phase 1, as well as an additional n=44 clubs new to the Health club experience. Control clubs were recruited through direct e-mails to club secretaries and included clubs who applied for Phase 2 but were unsuccessful at this stage.

Healthy clubs were invited to an Orientation day (February 2016) and received a health and wellbeing manual with resources and information on developing a healthy club. This manual included information on how clubs experienced Phase 1, success stories from Phase 1, and a description of the 4 pillar Healthy clubs framework emphasising the importance of each pillar in a sustainable approach to health promotion. On orientation day clubs were asked to rank the topics of PA, Healthy Eating, and Community Development in order of importance to them. This gave the GAA Community and Health Department and the WIT research team an indication of the priorities of the clubs. Healthy clubs also had the opportunity to attend provincial meetings on three separate occasions during Phase 2(Appendix 5d). These meetings were an opportunity for Healthy club representatives to discuss any potential issues they were having and learn from the success and failures of other clubs. Finally, Healthy clubs had access to the Healthy Club Portal, an online portal where clubs share their experiences in a discussion forum, add events to a healthy club calendar, and add photos and updates illustrating their progress throughout Phase 2. Control clubs did not receive access to these resources and forums and were just asked to complete the HCQ at baseline and follow up.

A mixed methods approach was used to evaluate Phase 2, which in the case of health promotion research, is often desirable (Salazar et al., 2015). The major focus during this research was on outcome evaluation. Quantitative research was used to assess the impact of the project as a whole and some key initiatives that took place during the project, namely Healthy Eating, Physical Activity (PA) and Community Development initiatives. Quantitative methods, namely surveys and questionnaires were used to gather information to assess the impact of the HCP on clubs, communities and individuals involved. Qualitative research methods were then used to complement and provide context to the quantitative findings. The use of qualitative methods through focus group

discussions (FGDs) and one-on-one interviews was a useful strategy to gather the perceptions and experiences of the various stakeholders and participants involved in the HCP. An element of process evaluation was included to check how the overall HCP and particular initiatives were delivered. When combined, process and outcome evaluation can give us a better understanding of which activities have the greatest impact which allows for the appropriate allocation of resources and also highlights where change needs to take place (Salazar et al., 2015). The overall framework for the evaluation is presented (*Fig 3.1*) and described further below.



Legend: HCP=Healthy Club Project, HCI=Healthy Club Index, FGD=Focus Group Discussion, H&W=Health & Wellbeing

Fig 3.1 Evaluation Framework

3.3 Participants

3.3.1 Governance

3.3.1.1 GAA Community and Health Team – the GAA Community and Health Department employs four people, including a National Healthy Club Project Co-ordinator. The team is based in Croke Park and communicates with clubs regularly through phone and e-mail. The

National HCP co-ordinator was the main point of contact for clubs in the department for providing guidance, resources, and support. Members of the team took part in interviews to give feedback relating to the PA and Healthy Eating Initiatives, and the HCP Phase 2 overall.

3.3.1.1 GAA Healthy Club Steering Committee – the GAA Healthy Club Steering Committee consists of representatives from the GAA, HSE, and academic institutions. The role of the committee is to monitor the progress of the project and provide expert advice and guidance to maintain and develop a sustainable and successful programme. The chair of the steering committee is Biddy O'Neill, HSE Health Promotion.

3.3.1.3 Healthy Club Officers – the GAA encourages all clubs to appoint a Healthy Club Officer. Clubs in Phase 2 of the HCP were required to appoint a Healthy Club Officer to meet the Healthy Club criteria set out by the GAA. Healthy Clubs were also encouraged to establish a Healthy Club Project Team. It was envisaged that this would be comprised of club members but also non-members who possessed various skill-sets relevant in the health and well-being space. Healthy Club Officers and Project Team members were interviewed and took part in focus groups during Phase 2. As well as this, a sample of n=10 club Healthy Club Officers/Project Team Members took part in interviews to give their feedback regarding specific initiatives run during Phase 2.

3.3.1.4 Executive Committee Members – in line with GAA regulations, all clubs have elected executive committees which manage the overall business of the club. These committees are comprised of a Chairperson, Vice-chairperson, treasurer, secretary etc. Executive committee members from a number of clubs (n=5) were interviewed and invited to give their feedback in relation to specific initiatives that were rolled out in their club.

3.3.2 Key Partners – partners were vital to the growth and success of the HCP during Phase 2 offering support and resources in various areas of work that clubs choose to focus on. They are also a key factor in the framework that guides the HCP. Clubs were encouraged to engage with local partners throughout the project. Key partners that engaged at the club level during Phase 2 included St. Angela's College and the network of Local Sports Partnerships (LSPs). St Angela's college were responsible for developing the Recipes for Success programme which was a key component of the Healthy Eating initiative while LSPs

led the delivery of the Men on The Move programme across three clubs. A representative (n=1) from St. Angela's took part in an interview and gave feedback regarding the development and delivery of the Recipes for Success programme. A representative from the LSP in each county where Men on the Move was rolled also out took part in an interview (n=3).

3.4 Effect of the HCP - Overview

A key aim of the research was to assess the impact of the HCP on the day to day activity in the club setting. Participating healthy clubs and control clubs completed a pre and post Healthy Club Questionnaire to investigate if, and how the health promotion orientation of clubs changed over a 20 month period. The Healthy Club Questionnaire included a validated health promotion sports club Index originally designed by Kokko et al., (2009) that measures the policy, ideology, practice, and environment of the club in relation to health promotion. This index was also used during the Phase 1 evaluation so there was comparable data from Phase 1 clubs. The Healthy Club Questionnaire is explained in detail in this Chapter in Section 3.6.1 and details about its development can be found in Section 2.5.2 of the Literature Review. A Coaching Environment Questionnaire was also included as part of this Healthy Club Questionnaire. This questionnaire was originally developed by Meganck et al., (2014) and the wording was adapted to suit a GAA club setting. Qualitative data was also used to add context to the quantitative data. Club officers of Healthy Clubs participated in regional meetings during Phase 2. Here, focus group discussions were held and participants shared their experiences and perceptions on how the project was impacting their own club. At the end of Phase 2, an interview with the GAA National Healthy Club Coordinator was conducted to better understand how the GAA felt the HCP was impacting clubs.

3.5 Evaluation of HCP Initiatives - Overview

Following the evaluation of Phase 1 the GAA decided that Phase 2 would need a focused evaluation on a number of topic areas. Based on consultation with the national steering committee and the feedback from clubs in their expression of interest forms, the GAA decided to focus on the areas of Physical Activity, Healthy Eating, and Community Development.

Process evaluation was employed to assess how initiatives were developed and delivered. Information regarding resources used, participants engaged, collaborating partners, policies developed, and programme content was collected by the research team (Masters student and supervisors from WIT) using qualitative and quantitative methods. Clubs also had the opportunity to evaluate their own work using the evaluation resources contained in the healthy club manual. Collection of this information allowed clubs to reflect on their work and replicate the process as well as share this information with other clubs. Linking the process to outcomes is also important as clubs can alter their process if necessary based on the outcome of the program. Outcome evaluation was carried out to assess the impact of the initiatives on participants' behaviour, attitudes, and awareness. Finally, the follow up healthy club questionnaire completed by clubs at the end of Phase 2 presented an overall picture of how many initiatives clubs delivered and in what areas of work.

3.5.1 Healthy Eating Initiative-Development and Implementation

During Phase 2 of the HCP the GAA Community & Health Department in consultation with the research team developed a Healthy Eating initiative which was piloted in a number of clubs for evaluation purposes. The initiative was developed with the 4 pillar HCP framework in mind. In terms of policy, clubs were encouraged to develop or adopt healthy eating guidelines. Recipes for Success, a cookery workshop developed by St. Angela's College which previously had not been evaluated, served as the program for this initiative. Clubs engaging in this program were required to develop partnerships with their local secondary school and home economics teacher who would deliver the program and were supported to deliver a talk from an Irish Nutrition and Dietetics Institute (INDI) approved Nutritionist. Six participating Healthy clubs were selected to take part in the healthy eating initiative evaluation during phase 2. Three of these clubs took part in the intervention and three acted as control clubs. For the duration of the healthy eating initiative evaluation, the control clubs did not have access to the cookery workshop and did not receive a healthy eating talk from an INDI nutritionist but did have access to these resources following the completion of the healthy eating initiative evaluation. The clubs were selected based on their lack of work in the area of healthy eating previously and on their intention to do more work in this area which they had indicated on the Phase 2 orientation day. The clubs were selected and contacted by the Community and Health team in Croke

Park with advice from the research team. There were a subsequent total of n=36 individual respondents from intervention clubs and n=40 from control clubs. Most participants were under the age of 18 as this was the age group the workshop was aimed at. The n=36 respondents from intervention clubs were those who had taken part in the cookery workshop and had also attended the healthy eating talk. Meanwhile the n=40 respondents from the control clubs did not have access to the workshop or the healthy eating talk.

3.5.2 Physical Activity (PA) Initiative-Development and Implementation

The GAA also promoted a new PA Initiative during Phase 2. This initiative was also based around the 4 pillar HCP framework. In terms of policy, clubs were encouraged to adopt or develop a set of guidelines in the area of PA. Men on the Move (MoM) was the program that clubs engaged in as part of this initiative. As part of this program clubs engaged with their Local Sports Partnership who delivered or coordinated the roll-out of the program, and clubs were encouraged to develop ancillary activities in the area of PA. Three healthy clubs were selected to take part in the PA initiative (Men on the Move) during Phase 2. The clubs were selected based on their lack of work in the area of PA previously and on their intention to do more work in this area which they had indicated on the Phase 2 orientation day. Also taken into account when selecting clubs, was the capacity of the various Local Sports Partnerships around the country to run the MoM programme. Again clubs were selected and contacted by the Community and Health team in Croke Park with advice from the research team in WIT. Among the three clubs, a total of n=82 men signed up to take part in the MoM programme. No control clubs were involved in the Men on the Move evaluation.

3.5.3 Community Development

Three case studies captured the work that clubs engaged in in the area of community development during Phase 2 of the HCP. Various initiatives developed by clubs themselves were run throughout Phase 2 of the HCP in the area of community development and case studies were conducted focusing on four clubs. Clubs were encouraged to engage in Community Development throughout Phase 2 by the GAA Community and Health Department and align their actions to the 4 pillar HC framework. Clubs were provided with anti-smoking signage to erect on their grounds while a range of template policies were

offered to clubs e.g. Smoke-free policy, Health and Wellbeing statement, Social Inclusion policy. In total, three cases studies were conducted. In one case a focus group was conducted with a member of the club H&W team as well as a number of participants (n=14) from an active retirement group. In the second club where an intergenerational initiative involving the club, a local nursing home, and the local primary school was being run, a focus group was conducted with a representative from each of the three partners involved. Finally, a case study looking at making a club smoke free was conducted. Interviews were carried out with the Healthy Club Officers of two clubs, one of which was successful in going smoke free, while the other club was unable to go smoke free. To evaluate these initiatives that were delivered by clubs, process and outcome evaluations and qualitative and quantitative research methods were employed, or directed towards to participants, club officers, partner organisations and GAA representatives. No control clubs were involved in the Community Development case studies. The WIT research team consulted with the GAA Community and Health Department who indicated which clubs would be most suitable to take part in a case study based on the their level of engagement with the project and their success in adhering to the 4 pillar framework.

3.6 Data Collection

3.6.1 Club Characteristics – it was important to establish at baseline some basic club characteristics regarding membership, games offered, club facilities, coaching structure, communication channels, and programmes offered in the health and well-being space. The baseline HCQ was used to gather this information. Analysis of the follow up HCQ allowed a comparison and showed what changes, or lack thereof occurred in each club and overall during the course of Phase 2.

3.6.2 Impact of the HCP on the GAA club – as mentioned above, a pre and post HCQ was completed by clubs during Phase 2. This assessed how the HCP impacted on the health promotion orientation of clubs, on partnerships within the clubs, on potential barriers to health promotion within the clubs, and health promotion activity within the clubs. A pre and post coaching environment questionnaire was also completed by clubs. As well as this, FGDs and interviews were conducted throughout Phase 2 to gather feedback from various actors on the impact of the HCP.

3.6.3 Impact of Initiatives – pre and post questionnaires were used to evaluate if and how the Physical Activity, Healthy Eating and Community Development Initiatives impacted on the awareness, attitudes and health behaviours of participants. FGDs and interviews were also carried out with the various actors involved in coordinating and delivering these initiatives.

3.7 Data Collection Tools

3.7.1 Healthy Club Questionnaire (Appendix 1)

The main component of the HCQ was the Healthy Club Index (HCI), which was used to assess the health promotion orientation of a sports club and how it changed over the duration of the HCP. This likert-scale type index was also used in the evaluation of Phase 1. This tool (Health Promoting Sports Club Index- HPSC-I) was originally developed by Kokko et al., (2009) to assess the health promotion orientation of Finnish sports clubs. A Delphi method was employed where a group of experts developed a list of 22 standards to assess the health promoting orientation of Finnish sports clubs. These 22 standards were divided across 4 sub-indices: Policy, Ideology, Practice, and Environment.

Policy relates to the policies and regulations that clubs have developed and adopted on each health topic such as PA, healthy eating, mental fitness etc. Ideology relates specifically to the way clubs promote two GAA initiatives; the Go Games initiative and the Respect Initiative. 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. Some of the key principles underpinning the Go Games initiative are maximum participation, fun, friendship, and a positive learning environment. The Respect initiative aims to promote positive behaviour and to ensure that an enriching environment is provided for the promotion and development of Gaelic games. Practice relates to the communication and education that clubs engage in when addressing various health issues. Environment relates to the provision of a physical and cultural environment that supports health promotion.

Prior to Phase 1 the Healthy Club Steering Committee agreed to use this index in evaluating the HCP but suggested to suit a GAA club setting. This led to a revised 34 standard Index. Changes included altering both standards in the Ideology sub-index; one to include reference to the Go Games principles, and the other to include reference to the

Respect initiative, both described earlier. As well as this, one new sub-index was added to the HPSC-I to specifically assess the Juvenile Coaching Environment in the GAA club setting. This new sub-index included 11 standards and related to the juvenile policies of 'everybody plays' and the environment in which they were implemented. The HCQ also gathered club characteristics and information regarding club facilities, programmes, partnerships, communication, and perceived barriers to health promotion.

Overall, the HCQ consisted of 7 different parts. Part 1 captured club membership characteristics such as number of members, type of membership offered, and various officers appointed in the club. Part 2 was the HCI described previously. Part 3 was a facilities audit which assessed type and availability of facilities to the club and its members. Part 4 captured what areas of work a club has been engaged in regarding health e.g. PA, healthy eating, anti-smoking etc. Part 5 was a partnerships audit which looked at the way clubs engage with various partners both internal and external to the club. Part 6 assessed the various channels of communication that a club may use such as Facebook, Twitter, local media etc. Part 7 assessed potential barriers to health that a club may perceive as challenges on their journey to becoming more health promoting. This section included an index adopted from Meganck et al., (2015). The index is based on 3 main barriers to health promotion practice; lack of interest, lack of man power, and lack of resources. Based on these 3 areas, Meganck and colleagues developed a list of 9 potential barriers to clubs health promotion policy and practice.

The follow up HCQ (Appendix 2) completed by intervention clubs included an additional part labelled Healthy Club Activity. This part included sections dedicated to all the main areas of work that clubs engaged in during Phase 2. Here clubs could detail their activity in the areas of PA, healthy eating, mental fitness, gambling alcohol and drug education, training and professional development, anti-bullying, anti-smoking, and community development. One section was removed from the follow up HCQ, the communication section.

The Healthy Club Questionnaire, including the Coaching Environment Questionnaire was distributed by the GAA Healthy Clubs coordinator to all Healthy clubs (n=60) and via e-mail. Control clubs (n=38) were sent the same HCQ via e-mail by the evaluation team. These e-

mails contained the questionnaire as an attachment so clubs could print out the questionnaire. It also contained a link where clubs could complete the survey online. Healthy Club Officers were encouraged to complete the questionnaire with the help of their Health Club Project Team members and other club officers. The baseline questionnaires were distributed to clubs in February 2016 and were completed and submitted during the period February-May 2016. Respondents were encouraged to seek support if needed from the Community and Health department and from the research team in WIT. Follow up questionnaires were distributed in a similar manner in October 2017 and were completed during the period October-December 2017. Again, the Healthy Club Officer in each club was encouraged to complete the questionnaire with support from their Health Club Project Team members and other club officers. In some cases, the Healthy Club Officer may have been replaced during Phase 2 and therefore a different respondent may have completed the HCQ at follow up.

3.7.2 Coaching Environment Questionnaire (Appendix 3)

Clubs also completed a coaching environment questionnaire to assess the health promotion guidance given to their coaches. This was a tool originally developed by Kokko (2010) to assess coaches' activity concerning non-performance related health promotion. This likert scale type tool consisted of 14 statements related to HP. The tool included statements such as ''Health issues are discussed with parents'' and ''Education is provided on substance use''. Clubs rated their performance on each statement from 1 (not at all) to 5 (very much). This questionnaire was completed by clubs at baseline and follow up.

3.7.3 Regional Focus Group Discussions (Appendix 5)

Qualitative data were collected through FGDs at each regional meeting. These meetings were held three times in each of the four provinces over the course of Phase 2; further detail is presented in the table in Appendix 5d. The initial round of FGDs captured the reasons for health and wellbeing in the GAA and what place if any, it has in the organisation. The second round dealt mainly with the launch of the HCP in the clubs and the support or lack thereof so far. The final round of FGDs aimed to capture what the clubs had achieved during their first year as a Healthy Club in terms of policies, programs, and partnerships.

The discussion started with a brief introduction from all participants. The moderator introduced the topics and steered the discussion back toward the topic if necessary. The moderator allowed conversation to flow as long as the discussion did not veer away from the topic at hand. FGDs were recorded and transcribed. The topic guide of questions was established using guidelines from Krueger and Casey (2009). The focus group topic guide used in the first round of regional FGDs aimed to understand how clubs experienced the initial establishment and delivery of the HCP. The topic area covered included why clubs took part, their experience of Orientation day, and trying to get the ball rolling in their club. The topic guide for the second round of FGDs focused on embedding the HCP in the club and what progress clubs had made here. Issues discussed included the Healthy Club launch, challenges faced, and the impact of the project so far. The topic guide for the final round of FGDs focused on the progress clubs had made in adhering to the HCP framework. Topics discussed included policies, partners, and health promotion and the core business of the club.

3.7.4 GAA National HC Coordinator Interview (Appendix 4)

A one on one semi structured interview was conducted with the National HC coordinator at the end of Phase 2. The aim of the interview was to gather the thoughts and feedback of the coordinator based on their experience during Phase 2. The main topics of the interview included the apparent changes in club activity and awareness toward health promotion, whether executive committees are taking the idea of health and well-being seriously in their club, and what interest there has been from other clubs to join the Healthy Club project. Other areas covered included the sustainability of the project for all clubs and what challenges were faced by clubs and the GAA during Phase 2. Members of the GAA Community and Health department also took part in two further interviews; one concerning the Healthy Eating initiative and the other relating to the Physical Activity Initiative. Comments from these interviews were used to assess the impact and structure of these initiatives.

3.7.5 Healthy Eating Initiative

3.7.5.1 Participant Questionnaires (Appendix 7e)

Participant questionnaires gathered information on demographics, awareness, knowledge, feelings, and behaviours. In the evaluation of the healthy eating program, St Angela's College took the lead in distributing and collecting the questionnaires to those who participated in the Recipes for Success cookery workshop. Participants completed a questionnaire before and after they completed the workshop. Most participants were under the age of 18 as this was the age group the workshop was aimed at. Control clubs were approached by the evaluation team and members completed a similar pre and post questionnaire.

3.7.6 Physical Activity Initiative

3.7.6.1 Physical Measures (Appendix 6e)

In the evaluation of the physical activity program, Local Sports Partnerships in counties of participating clubs were largely responsible for collecting much of the quantitative data. This information was then passed on to the evaluation team at WIT. Participants of the Men on the Move program were measured for height, weight, BMI, and waist circumference. Participants also ran a timed mile to assess physical fitness. These measures were recorded and entered in Section A of the questionnaire for each corresponding participant.

3.7.6.2 Participant Questionnaire (Appendix 6e)

Participants gave written consent to take part in the programme and completed sections B to G of the questionnaire. A PAR-Q form was also completed by participants as a safety measure. Section A was completed by the nurse who took the participants physical measurements and by the LSP representative who timed the mile run for participants. The protocol for testing the mile run is detailed in appendix e. Section B asked for information such as date of birth, ethnicity, level of education, and marital status. Section C asked the participants to rate their health on a five point scale from excellent to poor. Section D measured how much physical activity performed each week. Section E assessed lifestyle habits like eating, drinking, and smoking. Section F measured subjective feelings in areas such as confidence, happiness, and optimism. Finally, Section G assessed social well-being through questions relating to friendships and attendance at social events. These measurements took place at baseline, at the end of the 12 week program, and 26 weeks

post baseline. The questionnaires completed by the men at baseline and at follow up are available in appendix e. These questionnaires were developed by the Men on the Move evaluation team in WIT.

3.7.7 Other Interviews and FGDs (Appendices 6-10)

An additional twelve Interviews and eight FGDs were carried out with HC Officers, Project Team Members, Executive Committee representatives and Initiative participants to identify their experience of the initiative that they took part in. For the Community Development initiative the data collection was purely qualitative. This included two FGDs and two interviews with Healthy Club Officers. The main topics addressed were the level of support in the club for health and well-being, policy development, engagement with partners, impact and success of initiatives, barriers to success, and future sustainability. Further details such as times, dates and topic guides for the qualitative data collection can be found in the appendices 6-10.

3.7.8 Key Partner Interviews (Appendix 9)

In order to gather the feedback and opinions of key partners involved in various initiatives, six partners took part in either a semi structured interview or a FGD. Feedback from these evaluations allowed us to understand the perspectives of the facilitators involved in the initiatives and the practical implications of working with healthy clubs. Four partner interviews took place in total. These were either conducted in person or on the phone. One interview took place with St. Angela's College who developed the Recipes for Success workshop for the healthy eating initiative. This interview took place after all participating clubs had engaged in the workshop. Three interviews were conducted with representatives from the three LSPs (Galway, Mayo and Limerick) who delivered the Men on the Move program as part of the PA programme. In the community development case study evaluation, one club engaged in a FGD which involved two of their partners; a representative from the local nursing home and a representative from the local primary school took. The main topics of these discussions were to assess how these partners became involved in each respective programme, the successes and challenges they faced, how they experienced working with the GAA, and how sustainable they felt their programme was and what they might change about it in the future.

3.8 Ethical Considerations

All clubs consented to take part in the study through their expression of interest form submitted to the GAA, and all aspects of the evaluation were approved at national and club level. As well as this, informed consent was gathered from all interview and focus group participants. All participants in interviews and FGDs received a topic guide and a brief of the research and understood that their participation was voluntary and they could withdraw at any time (Appendix 4-10). Consent forms (Appendix 11) were completed by all participants, including those in evaluated programs such as Men on the Move and Recipes for Success. Interviews and focus groups were recorded and stored securely on a password protected computer in WIT. Questionnaire results and qualitative transcripts were stored securely on a password protected computer in WIT. Physical copies of participant forms were stored securely in a locked filing cabinet in WIT. To protect individual privacy, no identifiers were used in interviews and FGDs. The study was approved by the Research Ethics Committee of WIT.

3.9 Data Analysis

Quantitative data from Phase 2 was entered into Statistical Package for Social Sciences for analysis (SPSS 21.0). This included data from the healthy club questionnaire, the coaching environment questionnaire, and the participant questionnaires from the healthy eating and physical activity initiative. For the HCI, among the 5 categories there were 34 statements in total. Each statement in the index was scored on a 5 point likert scale from 1 to 5. For the analysis, this scale from 1-5 was altered to 0-1 i.e. 1 became 0, 2 became 0.25, 5 became 1 etc. This resulted in the overall range of scores on the index being between 0 and 34. This followed the methodology laid out by Kokko et al., (2009) in analysing the HCI data. Higher levels of health promotion activity were indicated by higher scores here. A score of 0 on any statement meant this 'does not represent the club at all'. A score of 1 meant this 'represents the club very well. The scores from each of the sub-indices (policy, ideology, practice, environment, and juvenile environment) were added together and an overall HP orientation score was calculated for each club. Clubs were classified as low, moderate, or high health promoting clubs in line with a similar classification system developed by Kokko et al., (2009). As mentioned earlier, overall scores ranged from 0-34. Clubs who scored 23 or more were deemed to be in the high HP category. Clubs scoring

between 17 and 22.99 were categorised as moderately health promoting. Clubs scoring lower than 16.99 were categorised as low health promoting. Each of the five sub-indices were also categorised into these 3 ratings. For policy, the high HP category was for clubs scoring higher than 6, while the low HP category was for clubs scoring lower than 3.99. For ideology, a high HP score was given to clubs scoring greater than 1.72. In the case of practice, a high score was awarded to clubs scoring greater than 4.5. In the environment index, a high score warranted a score of greater than 5.3 while a low score was anything lower than 3.49. Finally in the juvenile environment category, the cut off points for high and low categories were >8.25 and <5.49. Statistical changes in each sub-index and for the overall score were calculated using paired sample t-tests. Clubs were also categorised based on their size which was based on membership numbers. Clubs were categorised as either small (<400 members), average (401-700 members), or large (>701 members). Data was checked for normal distribution and Paired sample t-tests were used to determine statistical changes and levels of significance. Descriptive statistics, crosstabs, and frequencies were also used to present categorical data and show the average and scoring spread of scoring among clubs.

The analysis of the barriers (part 6 of the HCQ) involved the calculation of three barriers indices (lack of internal support, lack of external support and lack of resources) in line with previous work from Meganck et al., (2014). The score for each index was calculated by calculating the average score of the sum of statements making up that index. The analysis of the coaching environment questionnaire (Appendix 3) involved the reduction of the 5 point likert scale from 1-5 being re-coded to a two point scale (Kokko, 2010). A score of zero was given to statements that received answers of 'not at all' to 'moderately' while a score of 1 was given to statements that received the 'much' and 'very much' responses. Given the fact that there were 14 statements in the questionnaire, clubs could subsequently score between 0-14. In line with guidelines from Kokko, 2010) clubs were then categorised as passive, fairly active, or active. Cut off points were <3.33 for passive, 3.34 to 5.00 for fairly active, and <5.00 for active clubs. Again, data was checked for normal distribution and Paired sample t-tests were used to determine statistical changes and levels of significance.

Interviews and FGDs were transcribed directly following recording. All the FGDs and interviews were conducted by the researcher, initially in the presence of the main supervisor. The data were transcribed verbatim by the researcher. Transcripts were reviewed and compared against the original audio to ensure accuracy. Thematic analysis was conducted on the transcribed data by the researcher. Each transcript was listened to and read so the researcher had a full understanding of the content. Codes were then identified to reflect the most salient and meaningful issues that arose in the conversations. Codes were then interpreted and themes were identified based on patterns and recurring topics. Data for each theme was then collated. Themes were reviewed and if necessary broken into sub-themes or discarded. Each theme was then defined and named. Themes that emerged and were unexpected were included as well as those that were sought or expected. Transcripts and themes were reviewed by the project supervisors and agreed upon. Relevant quotes relating to these themes have been selected and presented in the results section. In addition, key quotes from FGDs and interviews which were deemed to provide insight relating to key aspects of the research are also presented in the results chapter.

Chapter 4 Results

4.1 Characteristics of Clubs

Clubs were recruited using a similar process to Phase 1, i.e. clubs responded to an expression of interest call circulated by the GAA and subsequent applications were scored using criteria agreed by the National HCP Steering Group. In order to recruit a representative sample, this involved rating applicants based on club size, club location, and previous level of health promotion activity. All Phase 1 clubs were eligible for inclusion in Phase 2 and control clubs were also identified using a convenience method jointly by the evaluation and GAA Community and Health teams. *Table 4.1* gives an overview of the number of clubs involved in Phase 2, and their engagement throughout the project. A total of n=60 clubs across all 32 counties, from urban and rural areas and ranging in size and current health promotion activity were recruited to the project. At baseline, 92% of these clubs engaged with the evaluation process (n=55). *Figure 4.1* shows the location of these clubs. At the end of Phase 2 a Healthy Club Questionnaire (HCQ) was distributed once again. Among healthy (intervention) clubs, n=30 responded to this follow up HCQ, while n=10 control clubs responded to the follow up questionnaire. Clubs that responded to questionnaires may not have answered every individual question therefore it is important to note the number of respondents to each question when viewing the results throughout this chapter. Response rates are presented throughout the text and in the various tables.

Table 4.1 Overview of Engagement and Selection of Participating Clubs

Healthy Clubs (intervention)		*Control Clubs*	
Applicants	100	Recruited	27
Recruited for Phase 2	60 (16 from Phase 1 plus 44 new clubs)		
Completed Pre HCQ	55	Completed Pre HCQ	27
Completed Post HCQ	30	Completed Post HCQ	10

Completed Pre Coaching Environment Q	51	Completed Pre Coaching Environment Q	11
Completed Post Coaching Environment Q	12	Completed Post Coaching Environment Q	0
Initiative Evaluations			
Healthy Clubs involved in Healthy Eating initiative	6 (3 intervention clubs and 3 acting as controls)		
Healthy Clubs involved in PA initiative	3		
Healthy Clubs involved in Community Development Case Study	4		

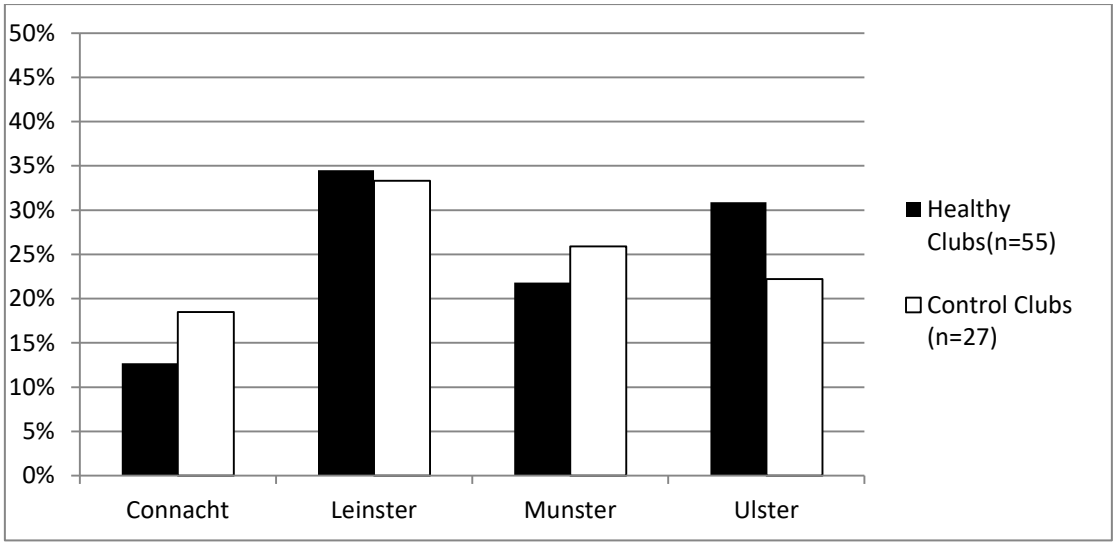


Figure 4.1 Participating Clubs by Province

Table 4.2 shows the membership characteristics for participating clubs. The average playing membership was higher across Phase 1 clubs (n=412) and similar among Phase 2 clubs (n=308) and control clubs (n=318). Similarly, Phase 1 clubs had a higher mean number of non-playing members (n=217) compared to Phase 2 clubs (n=167) or control clubs (n=183).

Table 4.2 Membership Characteristics of Participating Clubs

		Phase 1 (n=14) Average (Min – Max)	*Phase 2 (n=40) Average (Min-Max)*	*Control (n=26) Average (Min-Max)*
Membership	Playing Members	412 (156-1337)	308 (140-1531)	318 (63-1277)
	Non Playing Members	217 (25-531)	167 (6-571)	183 (30-617)
	Total Membership	629 (228-1781)	468 (160-1970)	502 (150-1894)

All n=55 healthy and n=27 control clubs had dressing rooms and pitch access (*appendix 14*). Running/walking tracks were available at approximately 38% of clubs, floodlights in 70% and all weather pitches in 26% of clubs. Overall, 75% (n=41) of healthy clubs rated their facilities as excellent or very good, similar to 82% (n=22) of control clubs. In relation to disability access, a lower proportion 55% (n=30) of healthy clubs, and 74% (n=20) of control clubs) rated accessibility to club facilities as excellent/good. Clubs outlined how their facilities were used for other purposes. General community events took place in 67% (n=37) of healthy clubs and 74% (n=20) of control clubs. Talks took place in 49% of clubs, classes in 54%, and other sports in 39% with minimal difference between intervention and control clubs.

Club membership was available in different forms; full membership in all clubs, social membership in approximately 70% (n=57) of clubs, and finally juvenile and family membership options in 90% (n=74) of clubs. As shown in *Figure 4.2*, among healthy clubs, 58% (n=32) offered Men's Football to their members, 53% (n=29) offered Ladies Football, 40% (n=22) offered Hurling, 42% (n=23) offered Camogie, and 13% (n=7) offered Handball or Rounders.

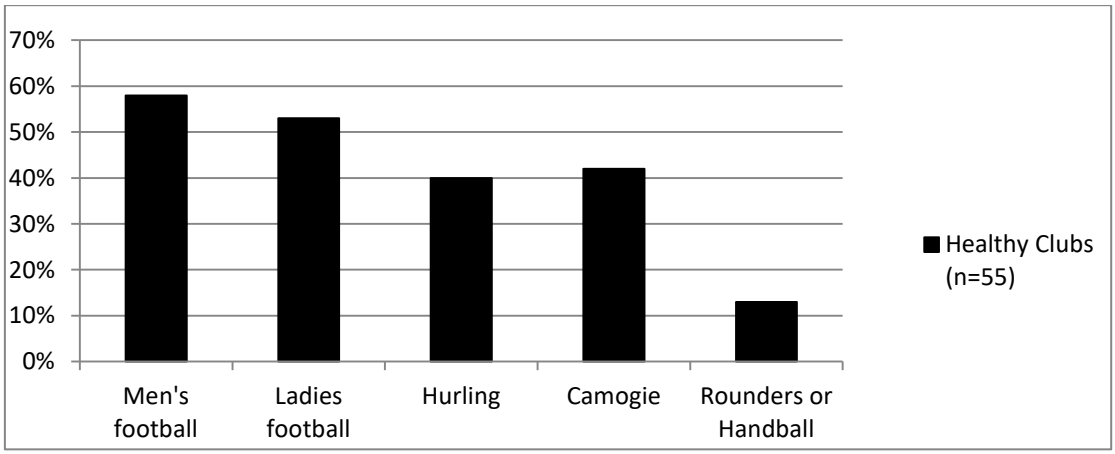


Figure 4.2 Games Available in Participating Clubs

The majority of clubs ensure that their coaches were certified; 71% (n=39) of healthy clubs and 82% (n=22) of control clubs. More detail on the number of coaches in participating clubs can be found in appendix 15.

Over 90% of clubs used Facebook, with a high number also using local media outlets such as newspaper and media. Newsletters appeared to be used less. In addition, a theme of 'communication' was one that emerged during provincial FGDs with Healthy Club Officers. Clubs described their use of social media platforms like Facebook and how they had set up their own club page for health and well-being:

'we've advertised it well and…we have our own Facebook page and we'll promote it and we have a good few people who liked it and shared it, you know so it's really really good at the moment.' (HC Officer in a Provincial FGD)

Clubs also noted how handy some services like Whatsapp were compared to the Healthy Club Portal which was not so accessible.

'The portal was i think meant to be supporting us and i think we're missing a lot of what is going on and we could be supporting each other with a Whatsapp group.' (HC Officer in a Provincial FGD)

4.2 Baseline Health Promotion Orientation of Participating Clubs

A HCQ, which incorporated an index developed by Kokko et al., (2009) was used to assess the baseline and follow up health promotion characteristics of participating clubs. Questionnaires were completed by the Healthy Club Project Team in each club. For the health promotion index (HCI), 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).' These scores were subsequently categorised into 'low', 'moderate' and 'high' (Appendix 12). *Table 4.3* indicates that clubs scored highly in relation to ideology (i.e. philosophy, ethos underpinning the club), and moderately in terms of practice, the environment and their overall score. The policy domain represents the weakest element of health promotion in the clubs at baseline. A comparison of all intervention clubs against control clubs revealed a significant difference in the ideology index only. Finally, 95% of Phase 2 clubs had appointed a Healthy Club Officer compared to 82% of control clubs.

Table 4.3 Health Promotion Characteristics of Healthy Clubs and Control Clubs at Baseline (n=82)

	Healthy Clubs (n=55)		*Control (n=27)*	
	Average	*Health Promotion Category*	*Average*	*Health Promotion Category*
Policy Index (range 0-8.0)	4.25	Moderate	3.71	Low
Ideology Index (range 0-2.0)	1.61	High	1.85*	High
Practice Index (range 0-6.0)	3.34	Moderate	3.38	Moderate
Environment Index (range 0-7.0)	4.48	Moderate	4.97	Moderate
Juvenile Environment Index (range 0-11.0)	6.6	Moderate	7.02	Moderate
Overall HP Index Score (range 0-34.0)	20.27	Moderate	20.94	Moderate

***p<.05 Healthy Clubs v Control Clubs**

There were significant differences between Phase 2 and control clubs in relation to ideology and environment but overall classifications were similar across both groups. Phase 1 clubs had a significantly higher policy score compared to control clubs (*Table 4.4)* and understandably scored higher than Phase 2 clubs at baseline.

Table 4.4 Health Promotion Characteristics of Phase 1 and Phase 2 and Control Clubs at Baseline (n=68)

	Phase 2 (n=41)		*Phase 1 (n=14)*		*Control (n=27)*	
	Average	*Health Promotion*	*Average*	*Health Promotion*	*Average*	*Health Promotion*

		Category		*Category*		*Category*
Policy Index (range 0-8.0)	3.89	Low	5.27*	Moderate	3.71	Low
Ideology Index (range 0-2.0)	1.59*	High	1.64	High	1.85	High
Practice Index (range 0-6.0)	3.21	Moderate	3.73	Moderate	3.38	Moderate
Environment Index (range 0-7.0)	4.30	Moderate	4.98	Moderate	4.97*	Moderate
Juvenile Environment Index (range 0-11.0)	6.41	Moderate	7.14	Moderate	7.02	Moderate
Overall HP Index Score (range 0-34.0)	19.42	Moderate	22.77	Moderate	20.94	Moderate

***p<.05 Phase 1/Phase 2 v Control Clubs**

4.3 RQ1: Overall Effect of the HCP

4.3.1 Start-up phase of the project

Two focus groups carried out in January and April 2016 were used to collate the experience of Healthy Club officers within clubs of the early period of Phase 2 of the project, from application, through to the collective launch of the HCP on May 8th. Overall, it was notable that a sense and clarity of purpose existed in clubs, but did so with some resistance, which clubs actively worked to overcome.

Figure 4.3 Experience of Phase 2

4.3.1.1 Affiliation and Commitment

Similar to the pilot phase of the project, participating clubs recognised the '*platform to promote health'* and an '*onus to take this role'* within the GAA, particularly in the context of societal change in Ireland. Clubs noted that the '*GAA is a lot more than games*' and that health is a '*natural partner to sport*'. The Orientation Day at the outset of the project was overall a positive experience for clubs who noted in particular the contributions from other clubs and the ideas that were shared. Clubs were '*energised'* following this introductory day, they were motivated, and remarked that the day was '*professional'* and that there was a *'long term vision*' for the project within the GAA. The collective launch date of May 8th was a success, giving clubs a chance to get the '*healthy clubs name out there',* to share the purpose of the initiative and to generate support for the project. Overall, clubs displayed an affiliation with the health agenda and a commitment to action.

A theme of 'reach and responsibility' was evident as club members acknowledged that health and well-being was an important issue and that GAA clubs are in a unique position to affect people's health behaviours.

'I think that health is everybody's business, we've a responsibility to look after ourselves and to look after others.'(HC Officer in a Provincial FGD)

'I think it definitely is, because especially in a rural area it's...it's where kind of everyone meets.' (HC Officer in a Provincial FGD)

4.3.1.2 Resistance

Resistance, mostly passive, was expressed at both focus group sessions. Initially, healthy club officers described their perceptions of the project as '*scary', 'frightening'* and were a little '*overwhelmed'.* Back in the club setting, there was some '*scepticism'*, a notion that this was an '*extra chore'* and would be a *'hard sell'.* It was noted that this type of work may not fit in with the overall focus of a sporting club, and that it may bring unwelcome or unwarranted responsibility to the club, particularly from older members. This manifested as officers feeling they were having meetings with themselves, and a lack of engagement from some members of the club. It was noted that there was an '*old school mentality expecting it to fail',* and an observation that;

'*a segment of people no matter what you do will pick holes and don't see the positives'(HC Officer in a Provincial FGD)*

A club remarked on a sense of '*passive resistance'* where good intentions and enthusiasm exists but in the context of begrudgery and killjoy behaviour.

4.3.1.3 Progression

The GAA is iconic among Irish society, linked indelibly with legacy, history, and tradition. Clubs noted that change for any cultural entity is challenging, and this essentially accounted for much of the resistance detailed above.

While some clubs were a little overwhelmed at the outset of the project, there was a realisation that there were a number of things already in place in clubs and communities and that much of the work of the club unit was to act as a *'window'* for this activity to the wider community. It was remarked that club is not a *'panacea to deal with all of the problems that are out there*', that it is doing its fair share of work already but could work to involve the wider community and be a conduit for national health promotion initiatives.

Despite some hesitancy, clubs expressed that they were '*open for business',* and were committed to being *'inclusive'.* Also, clubs appeared extremely pragmatic and measured about their efforts. Clubs noted that they were '*slowly plodding away', 'chipping away',* getting *'other people on board',* recruiting '*doers',* integrating health into the club development plan, identifying needs within their respective communities, and finally innovating around how to position this new type of activity, with new people within a traditional organisation. An example of the latter is dispensing with the notion of a committee and forming a *'workforce for health and wellbeing*'. In fact the GAA were

supportive of this, proposing the development of a Healthy Club Project Team. Overall, the message around *'small steps'*, which was an important learning from Phase 1 appeared to have resonated with clubs. As a result clubs remarked that people were '*drifting towards'* healthy club activity, and consequently many new people were now involved in the club.

4.3.2 Club Characteristics at Follow Up

All clubs who engaged with the follow up phase of the project had appointed a Healthy Club Officer, which is an indicator of the dissemination of this concept throughout the structures of the GAA. All of the intervention clubs had established Healthy Club Project Teams; this reduced to half of the control clubs. The level of interest in the project was noted by clubs, while another club member pointed out the importance of getting the right people on your committee.

'one of the big things that stuck out for me was that people just wanted to be asked and I think it was the way people were asked, they wanted to be, there's a huge amount of, I suppose, experience within the club that we probably don't tap into anyway, you know, so that's one thing that stuck out to me, people wanted to be asked' (HC Officer in a Provincial FGD)

'you can have loads of people on the committee but you have to get doers, get doers. You can have talkers but not actually do something.' (HC Officer in a Provincial FGD)

At follow up, clubs were asked if they evaluated their health and wellbeing programmes over the past 24 months. Among healthy clubs, 33% (n=11) said they rarely or never did, while the remaining 67% (n=22) said they sometimes or often did. Among control clubs, half (n=5) said they rarely or never did while the remainder said they sometimes or often did.

Total club membership increased by approximately n=30 members between baseline and follow up in healthy clubs and stayed relatively similar in control clubs. It was also noted in group discussions that clubs were opening up to the community and attracting non-members to the club.

'Well there's a mix, they're not all members, no. The idea was to get all the community involved, you know….but the amount of people we didn't know that were living in the area that actually came and got involved.' (HC Officer in a Provincial FGD)

Among healthy clubs at follow up, almost 70% (n=23) had both a member of the club executive on their Healthy Club Project Team, and a member of the latter on the Club Executive. The remaining 30% (n=10) of clubs had a member of the club executive on their Healthy Club Project Team. Among control clubs, 40% (n=4) had both while 20% (n=2) had neither.

Among healthy clubs at follow up, over 50% (n=18) of clubs said that health and wellbeing issues are discussed at the AGM and are also discussed regularly at board meetings while compared to 20% of control clubs. These findings are supported by a theme of 'executive support' that emerged during provincial FGDs.

'I suppose we're really happy in that after a couple of years of slogging away and, listening to other people that, kind of the health and well-being thing is really getting embedded into the club. So the executive are really taking it on board and at every monthly meeting there is a monthly report and we get 10 or 15 minutes and everyone is kind of buying into it now.' (HC Officer in a Provincial FGD)

The GAA Healthy Club Co-ordinator commented on the huge amount of activity that clubs were engaging in and the support that it required from club executives.

'With the amount of initiatives that were rolled out and everything the clubs achieved, there must have been support from club executives to get them that far.'(GAA Healthy Club Coordinator in a one-to-one interview)

Figure 4.4 shows that ratings of facilities improved in intervention clubs over the duration of the project, both in terms of overall perceptions and in relation to disability access. At follow up, 76% (n=25) of healthy clubs said they added to their club facilities over the previous 24 months, while 50% (n=5) of control clubs said likewise. Among healthy clubs,

n=7 clubs added a walking track, n=5 added a gym, n=4 added a ball wall, while n=3 clubs each added floodlights, dressing rooms, kitchen facilities, and an all-weather playing pitch. Among controls, n=2 clubs added floodlights while, n=1 club each added kitchen facilities, an all-weather pitch, a gym and a walking track. The advantage of having a walking track was noticeable from comments made by club members.

'We're lucky we have a walking track around our few pitches and they meet up and do their walk' (HC Officer in a Provincial FGD)

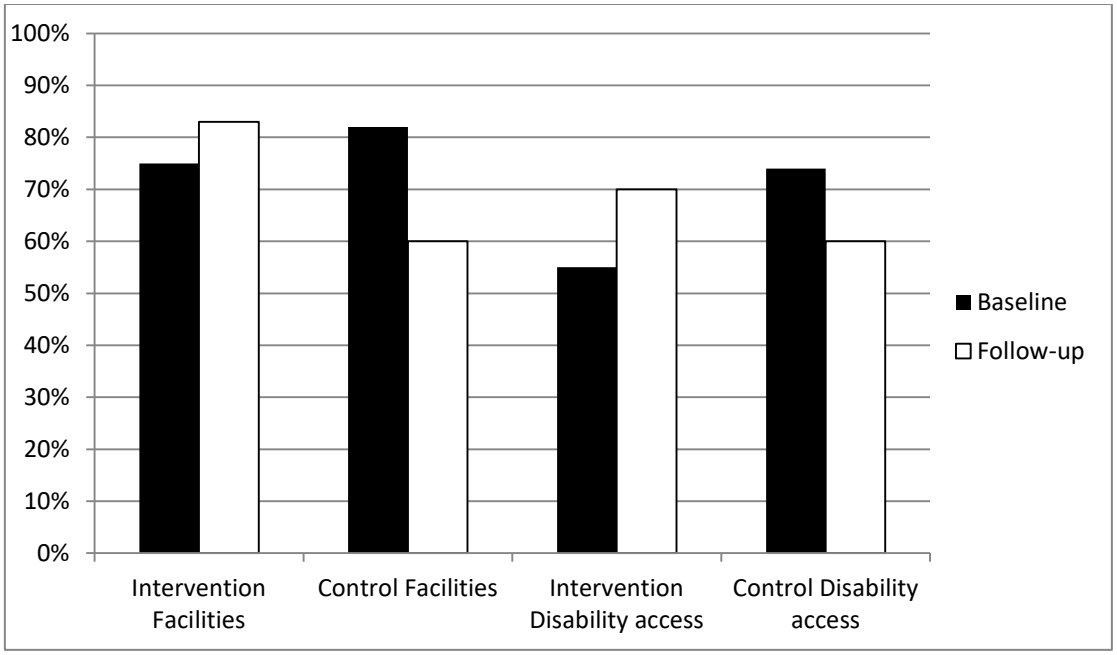


Figure 4.4 Facilities Rating at Baseline and Follow Up

4.3.3 Health Promotion Characteristics of Participating Clubs at Follow Up

A comparison of HCI scores over time indicated significant improvement in the health promotion orientation of intervention clubs compared to control clubs. Overall, intervention clubs showed a significant increase in health promotion orientation despite remaining in the moderate health promotion orientation category (*Table 4.5*). Most notably, intervention clubs moved from low to high health promoting for policy. Equally, there was a shift from low to moderate health promoting for practice and moderate to high for the environment domain and a significant improvement in ideology and juvenile

environment. This reflects the commitment of clubs to integrating health and wellbeing into their daily activities.

Table 4.5 Baseline and Follow up Health Promotion Characteristics of Healthy and Control clubs

	Healthy Clubs (n=30)		*Control (n=10)*	
	Baseline	*Follow Up*	*Baseline*	*Follow Up*
Policy Index (range 0-8.0)	3.73	6.10*	3.95	3.85
Ideology Index (range 0-2.0)	1.45	1.85*	1.88	1.88
Practice Index (range 0-6.0)	2.85	4.35*	3.65	4.23
Environment Index (range 0-7.0)	4.04	5.65*	5.40	5.42
Juvenile Environment Index (range 0-11.0)	6.18	7.43*	7.40	6.87
Overall HP Index Score (range 0-34.0)	18.24	25.40*	22.28	22.25

***p<.05 Baseline v Follow Up**

Phase 2 clubs demonstrated the greatest change across all domains of the HCI (*Table 4.6*). Understandably, Phase 1 clubs despite higher baseline scores, also improved between baseline and follow up.

Table 4.6 Baseline and Follow up Health Promotion Characteristics of Phase 1 and Phase 2 Clubs

	Phase 1 Clubs (n=7)		*Phase 2 Clubs (n=23)*	
	Baseline	*Follow up*	*Baseline*	*Follow Up*
Policy Index (range 0-8.0)	4.75	6.03	3.41	6.13*

Ideology Index (range 0-2.0)	1.32	1.71	1.49	1.89*
Practice Index (range 0-6.0)	3.32	4.32	2.70	4.36*
Environment Index (range 0-7.0)	4.42	5.21	3.92	5.78*
Juvenile Environment Index (range 0-11.0)	6.61	7.64	6.04	7.37*
Overall HP Index Score (range 0-34.0)	20.42	24.93*	17.58	25.53*

***p<.05 Baseline v Follow Up**

4.3.3.1 Analysis of Individual Health Promoting Standards

Table 4.7 illustrates the scores for the individual factors assessed 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. As indicated above, scores for the policy domain are among the lowest across all indicators of health promotion in the clubs at baseline but improved significantly at follow up. There were also notable increases in practice and environment scores among Phase 2 clubs around interaction with coaches and parents, the provision of health education opportunities and healthy food options, and the development of smoke free environments. Of note were above average scores for selecting accredited, suitable coaches but there remained an allegiance to defining success by winning; these factors did not demonstrate any improvement over time. Also, barriers to implementing the 'everybody plays' policy increased significantly in Phase 2 clubs over time, possibly indicating a greater attempt to adhere to this policy and thus greater resistance from parents and other clubs. The table in appendix 12 compares Phase 2 clubs with control clubs.

Table 4.7 Sub Components of Health Promotion Characteristics for Healthy Clubs and Control Clubs

	Healthy Clubs (n=30)	*Control (n=10)*

	Average (0-1)		*Average (0-1)*	
	Baseline	*Follow Up*	*Baseline*	*Follow Up*
The clubs regulations include a written section on well being and / or health promotion / health education / healthy lifestyle	.32	.75*	.38	.43
The clubs regulations include a written policy on substance misuse (ASAP policy)	.48	.74*	.38	.43
Health and well being ideals are written in the clubs constitution and regulations	.23	.66*	.25	.25
The club health promotion activities are evaluated in the Annual Report	.38	.79*	.20	.28
The club collaborates with other sports clubs and / or health professionals on health issues	.48	.75*	.63	.50
The club assures that its sub committees have agreed regulations and practices	.54	.73*	.53	.53
Health promotion is part of the coaching practice	.53	.79*	.72	.69
Training pitches and schedules are distributed fairly across all teams in the club	.75	.89*	.90	.83
The club promotes the 'Go Games' principles	.78	.94*	.98	.95
The club promotes the 'Respect Initiative'	.69	.91*	.90	.93
The clubs Executive Committee discusses its regulations with coaches and parents at regular intervals	.48	.69*	.43	.63
The club pays particular attention to coaches/instructors interaction skills	.53	.75*	.65	.75

The club provides education on health issues or makes provisions for its members to receive such education	.41	.76*	.60	.65
The club promotes individual growth and development	.47	.74*	.73	.78
Sports injuries are comprehensively dealt with (including the psychological effect of injury)	.49	.71*	.63	.80
The club reviews and communicates treatment policies in the case of a sports injury	.48	.70*	.63	.63
The club assumes its fair share of responsibility for a safe sports environment (eg: reviews the sports environment yearly)	.71	.83*	.85	.78
The club provides a sports environment that is smoke free during juvenile activities	.54	.83*	.78	.85
Coaches and other officials give a good example through their own behaviour	.68	.87*	.88	.83
Respect for the referee is evident at all levels in the club (players, coaches, administrators)	.58	.79*	.83	.80
Possible conflicts (eg bullying) are monitored and dealt with	.62	.83*	.80	.85
In coaching, there is a health promoting element beyond sports performance	.55	.83*	.73	.80
Healthy food options are made available following sports activities	.37	.68*	.55	.53
All juvenile events are held in an alcohol free environment	.79	.88	.85	.88

The club promotes maximum participation adopting an 'every child gets a game' policy	.67	.83*	.88	.83
The implentation of 'everybody plays' policy is dependant on the importance of the competition	.35	.37	.30	.33
The implementation of 'everybody plays' policy is hindered by parents expectations of success by winning	.40	.55*	.60	.38
The implementation of 'everybody plays' policy is hindered by other clubs reluctance to adopt a similar approach	.33	.46*	.45	.40
The club measurement of success is winning underage tournaments	.60	.63	.50	.65
The club perceives that success can only be achieved by having the best players on the pitch at all times	.60	.65	.78	.63
The club selects and approves coaches who have accredited coaching qualifications	.62	.78*	.75	.68
The club specifically identifies suitable and qualified coaches for juvenile coaching positions	.64	.77*	.78	.63
The club does not tolerate the use of bad language	.58	.73*	.70	.68
The club enforces a fair play policy	.64	.81*	.83	.83

***p<.05 Baseline v Follow Up**

As part of the HCQ participants were asked to rate their agreement on a series of statements relating to the impact of the intervention on a variety of aspects of the club. The information in *Table 4.8* below confirms the positive impact of the project on clubs with almost all clubs agreeing on benefits across culture, attitudes and engagement.

Table 4.8 Overall Impact of the HCP on Participating Clubs

	% Agree (n)
Health has become more of a priority in the club	97 (29)
People's attitudes to health have changed	97 (29)
Our club is better as a result of being involved in the project	100 (30)
The profile of the club/community has been raised	97 (29)
The project has addressed all sections of the club	97 (29)
Involvement in the project has helped our club focus on health issues in ways we could not have done otherwise	100 (30)
More people are joining/becoming involved in club activities	83 (25)
Knowing what we know now, would we sign up again	97 (29)
The culture of the club has changed for the better	93 (28)
There will be support for this project if it continues	100 (29)

Evidence of the impact of the HCP was also highlighted during the provincial FGDs where a theme of 'impact on club' emerged'.

'It's got a good name the Healthy Clubs, people want to be involved in it, want to be seen.' (HC Officer in a Provincial FGD)

'From an overall club perspective I think over time it has certainly grown and started gathering momentum in terms of the general knowledge around the community and the parish.' (HC Officer in a Provincial FGD)

'I think it's improved the maybe, standing of the club in the community and made it more community orientated than just the club.' (HC Officer in a Provincial FGD)

4.3.4 Healthy Club Activity

The National Healthy Club Steering Committee developed a framework around which to deliver settings based health promotion in GAA clubs (*Fig* 4.*5)*. It was expected that clubs

would select from the health priorities set out by the GAA (physical activity, healthy eating, mental fitness, community development, gambling, alcohol and drug education, and training and personal development) while also considering their own community needs and deliver initiatives encompassing all four elements of the framework below. Specifically, clubs were advised to develop a *Plan,* which refers to policies and/or action plans; recruit *Partners* to assist with the delivery of the initiative; identify an *Activity* focused specifically on behaviour change and finally consider a wider impact on the *Club,* physically and culturally.

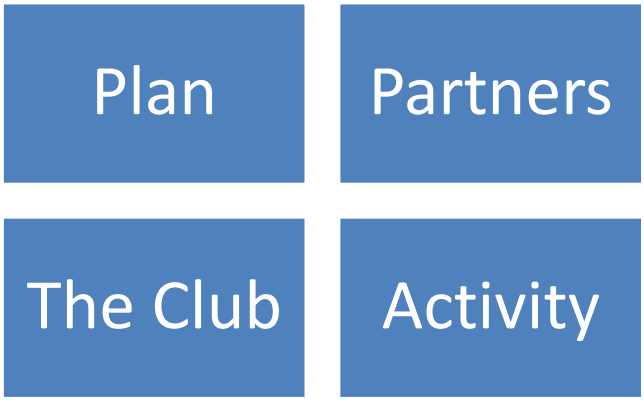


Figure 4.5 Framework for Settings Based HP in GAA Clubs

Clubs were active across all of the priority health areas. The greatest activity was around physical activity and healthy eating, followed by mental fitness, training and personal development and community development. As part of the HCQ participants were asked to detail the number of initiatives that their club took part in under the various areas of work during Phase 2. *Table 4.9* below, captures the extent of this healthy club activity.

Table 4.9 Summary of Healthy Club Activity during the HCP (n=33)

	Proportion of Clubs % (n)	*Minimum No. of Initiatives*	*Maximum No. of Initiatives*	*Mean No. of Initiatives*
Physical Activity	97 (29)	1	10	4
Healthy Eating	93 (28)	1	6	2
Mental Fitness	80 (24)	1	4	2

Gambling, Alcohol and Drug Education	47 (14)	1	2	1
Training and Personal Development	70 (21)	1	6	3
Anti-Bullying	33 (10)	1	1	1
Anti-Smoking	57 (17)	1	3	1
Community Development	63 (19)	1	6	2

In the context of the Healthy Club Framework (HCF), all of the initiatives involved an activity, while clubs self-reported on policy change, partnership and how the broader club environment was impacted by healthy club activity. Where clubs had rolled out a programme in a particular area of work during Phase 2, they were asked to indicate if they had also engaged in policy, partner or club development in that area. Feedback from clubs in relation to this is detailed in Table 4.10 and this highlights the success clubs had in adhering to the guidelines of the 4 pillar HC framework. The club column here relates to changes to the physical environment of the clubs, and to the club's awareness, understanding and support in the area of health. All scores are presented as proportions of the number of clubs who delivered initiatives in the respective topic areas.

Table 4.10 Healthy Club Framework and Initiatives (n=30)

	Policy (Plan) (% Yes, n)	Partnership (% Yes, n)	Club (% Yes, n)
Physical Activity	48 (14)	100 (29)	100 (29)
Healthy Eating	57 (16)	79 (22)	93 (26)
Mental Fitness	42 (10)	84 (21)	100 (24)
Gambling, Alcohol	64 (9)	64 (9)	97 (11)

and Drug Education			
Training and Personal Development	48 (10)	90 (18)	90 (19)
Anti-Bullying	60 (6)	60 (6)	80 (8)
Anti-Smoking	88 (15)	59 (10)	94 (16)
Community Development	32 (6)	84 (16)	84 (16)

4.3.4.1 Policy Development

Clubs were asked to indicate which policies they had fully implemented at the end of Phase 2. *Figure 4.6* illustrates the extent of policy development in healthy clubs, in comparison to control clubs. The Healthy Club Statement and Critical Incident Plan have been well integrated with over 70% of healthy clubs reporting full implementation of these policy statements. Healthy clubs had a higher level of policy implementation in most areas, particularly in relation to the Health and Well-being statement where 85% (n=28) healthy clubs had this fully implemented compared to 10% (n=1) of control clubs. The Critical Incident Response Plan was also well implemented by healthy clubs, 73% (n=24), while again only 10% (n=1) of control clubs had this implemented.

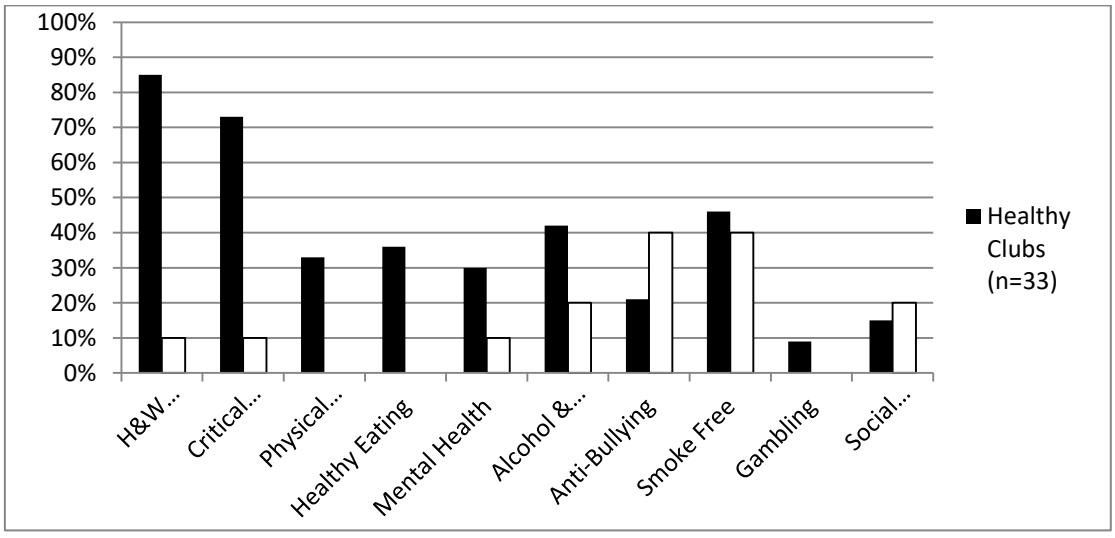


Figure 4.6 Policies with Full Implementation at Follow up

Some clubs noted their success in implementing certain policies while others were happy to point out that they previously had some work done in the area of policy implementation.

'I suppose what really worked well for us last year was our involvement trying to roll out the critical incident plan, not only for our own club but for other clubs around Laois.' (HC Officer in a Provincial FGD)

'I think we found that em, we had done a number of things already. Like, we had the drug and alcohol policy in place, we had critical incident policy.'(HC Officer in a Provincial FGD)

4.3.4.2 Partners

Clubs self-reported on their overall partnership activity and engagement at the end of the HCP. The table in appendix 16 outlines the range of partners that clubs engaged with most during Phase 2 of the HCP and in what area of work. Also detailed in the table is the target audience that clubs identified most for each area of work.

The most notable change over time was in the designation of roles, responsibilities and expectations with partners among intervention clubs. Other indicators like the importance of partners were equally strong among intervention and control clubs while the acceptance of a need to formalise the partnership process and the engagement of partners on HCP Teams were generally weak across all clubs. *Table 4.11* presents further results on the perception of partnerships.

Table 4.11 Perceptions of Partnerships in GAA Context

	Healthy Clubs		*Control Clubs*	
	Baseline % Agree (n)	*Follow Up % Agree (n)*	*Baseline % Agree (n)*	*Follow Up % Agree (n)*
Partners have always been an important part of the club	44 (24)	80 (24)	74 (20)	80 (8)

Roles, responsibilities and expectations are agreed with partners	35 (19)	60 (18)	44 (12)	40 (4)
Regular meetings are held with partners	24 (13)	40 (12)	30 (8)	40 (4)
Partners sit on committees in the club	16 (9)	37 (11)	15 (4)	20 (2)
Contact with partners is mostly informal	49 (27)	60 (18)	44 (12)	50 (5)
There is no need to formalise the partnership process	20 (11)	37 (11)	30 (8)	40 (4)
Formalising the partnership process takes too much time	15 (8)	27 (8)	26 (7)	40 (4)
Club members actively seek new partners	27 (15)	50 (15)	40 (11)	30 (3)
The club collaborates with the wider non-GAA community	47 (26)	73 (22)	70 (19)	50 (5)
The club facilitates external agencies to promote health	40 (22)	80 (24)	44 (12)	20 (2)
The club recruits members in local schools	75 (41)	90 (27)	93 (25)	100 (10)
The club provides coaching in local schools	73 (40)	87 (26)	74 (20)	100 (10)
The club collaborates with local community development groups	58 (32)	83 (25)	70 (19)	80 (8)
The club runs open days for the community	36 (20)	60 (18)	48 (13)	30 (3)
The club helps deliver community events	47 (26)	79 (23)	74 (20)	50 (5)
The club delivers family fun days	55 (30)	77 (23)	82 (22)	60 (6)

Clubs also indicated their level of engagement with local partners at the outset and end of the project (*Figs 4.7a and 4.7b*). The most notable changes were with coaches, with intervention clubs showing improved interaction with coaches over time. Interaction with other GAA codes scored well, engagement with members was relatively low at approximately 50% while parents remained a poorly engaged partner.

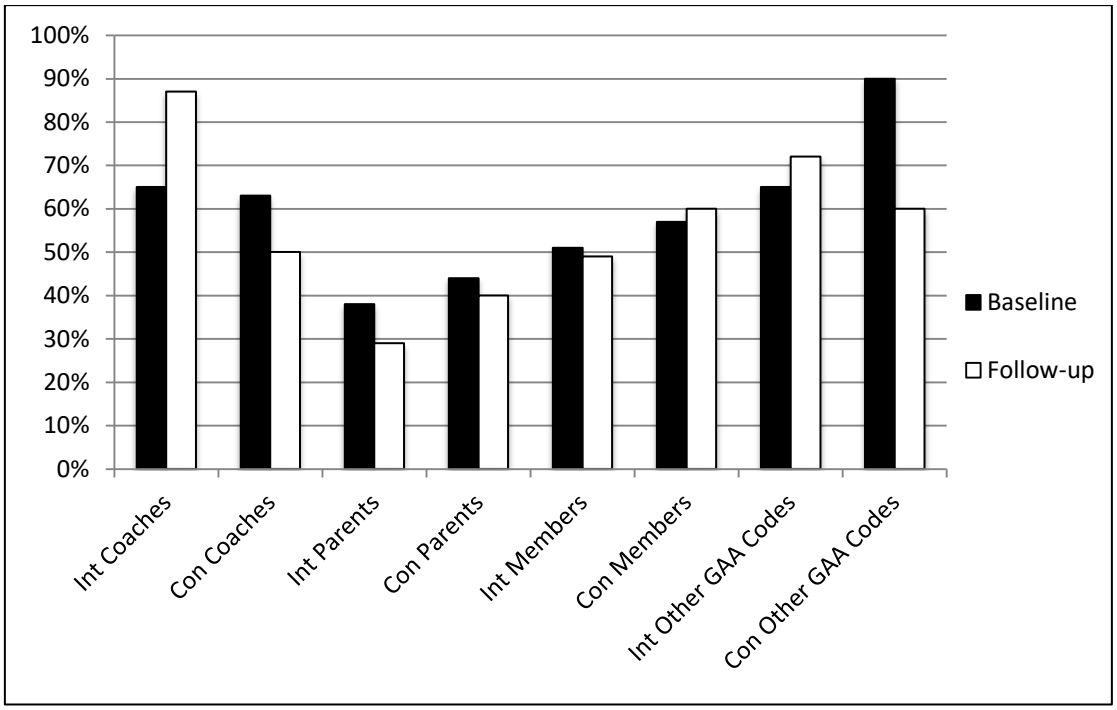


Figure 4.7a Engagements with Partners at Baseline and Follow Up

Engagement with health professionals improved in all clubs while connections with minority groups remained low. Intervention clubs improved their interaction with retired members with a comparable decrease in control clubs.

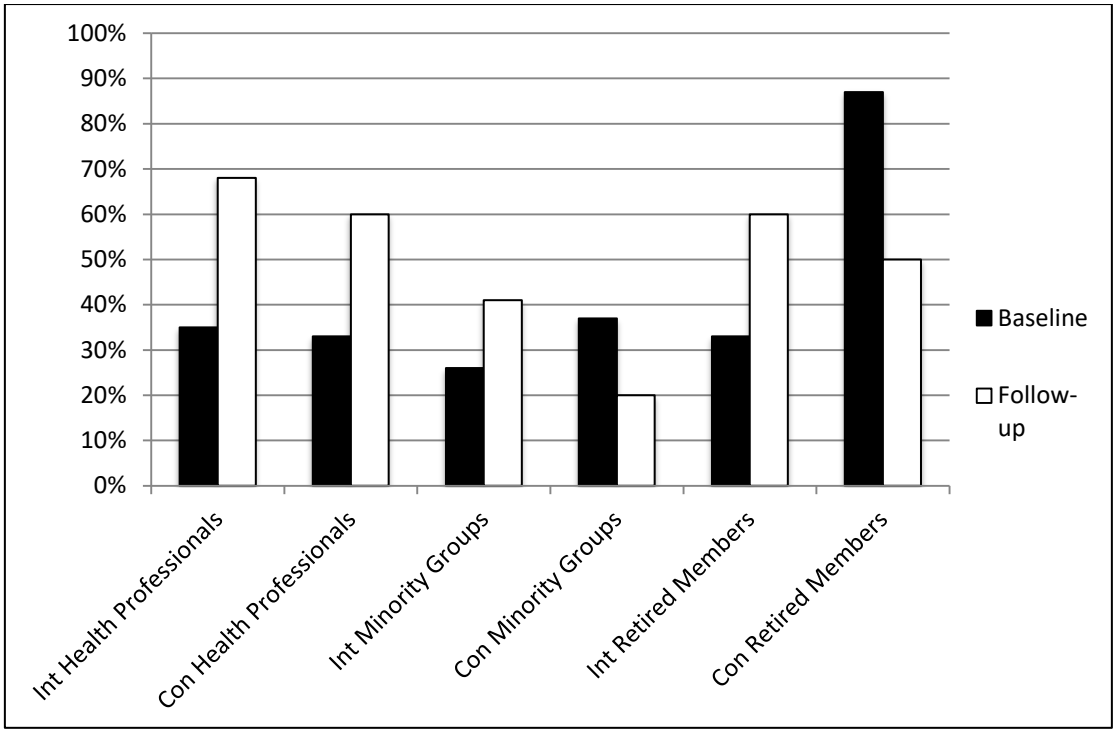


Figure 4.7b Engagements with Partners at Baseline and Follow Up

The theme of 'partners' was evident in the provincial FGDs. In FGDs, clubs noted the importance of engaging with their local partners and the enthusiasm that those partners showed when they were contacted:

'We wanted to use the partners within our community so we partnered with the local national school, the pastoral council, the nursing home, the Camogie and the hurling clubs'(HC Officer in a Provincial FGD)

'Any partner we ring up or contact, there's no problem' (HC Officer in a Provincial FGD)

'We just rang and asked them and they were mad, the fact that it was the Healthy Clubs and they were healthy products, they were mad to get involved.' (HC Officer in a Provincial FGD)

Also, one member commented on the fact that clubs often may not realise that they are engaging with so many partners, particularly internally.

'Some of it is you don't realise you are engaging maybe with the partners.' (HC Officer in a Provincial FGD)

The GAA Healthy Club Co-ordinator noted the importance of the link between club and county health and well teams and the need to strengthen these ties going forward:

'A big learning in Phase 2 is I suppose trying to engage the club and the county health and well-being committee more in Phase 3.'(GAA HC Coordinator in a one-to-one interview)

4.3.4.3 Club

At follow-up, clubs indicated which factors they considered important reasons for their engagement in health promotion. Fulfilling social and community responsibility was indicated to be an important factor by 91% (n=30) of healthy clubs while improving morale and engagement was indicated to be important by 88% (n=29). Meanwhile, only 40% (n=13) of clubs suggested that improving on the field results was an important factor in their engagement in health promotion. Clubs outlined the impact that Phase 2 of the HCP has had with respect to each area of work (*Table 4.12*). All scores are presented as proportions of the number of clubs who delivered initiatives in the respective topic areas.

In all areas of work, clubs indicated that the topic they engaged in had become more of a priority in the club. This was particularly noticeable in the area of anti-smoking where 88% (n=15) of clubs who engaged in this topic agreed with this statement. Similarly, for all areas of work over 80% of clubs indicated a greater awareness and understanding of the topic. Results varied quite a lot with respect to the physical environment reflecting club policy; 83% (n=25) of those clubs that engaged in the area of physical activity indicated that their physical environment reflected club policy, as did 82% (n=14) of clubs that engaged in anti-smoking. However, only 43% (n=10) of clubs that engaged in mental fitness agreed with this statement while just 54% (n=15) of clubs that engaged in healthy eating agreed. Similarly there were mixed responses with respect to the club providing appropriate signage and information on each area of work. Of clubs that engaged in anti-smoking, 94% (n=16) agreed with this statement. However, only 39% (n=11) of those engaged in healthy eating agreed and just 29% (n=2) of clubs engaged in anti-bullying agreed.

Table 4.12 Impact on Club Environment

Area of engagement (n)	This topic has become more of a priority in the club % (n)	There is a greater awareness and understanding of this topic % (n)	There is greater support for personal development in this area % (n)	The physical environment reflects club policy in this area of work % (n)	The club provides appropriate signage and information on this issue % (n)
Physical Activity (30)	77 (23)	97 (29)	93 (28)	83 (25)	60 (18)
Healthy Eating (28)	82 (23)	96 (27)	61 (17)	54 (15)	39 (11)
Mental Fitness (23)	70 (16)	87 (20)	74 (17)	43 (10)	74 (17)
Anti-Smoking (17)	88 (15)	82 (14)	71 (12)	82 (14)	94 (16)
Gambling, Alcohol, and Drug Education (11)	64 (7)	82 (9)	64 (7)	55 (6)	64 (7)
Anti-Bullying (7)	86 (6)	100 (7)	100 (7)	71 (5)	29 (2)
Community Development (18)	78 (14)	83 (15)	67 (12)	67 (12)	56 (10)
Training and Personal Development	78 (18)	83 (19)	74 (17)	61 (14)	43 (10)

(23)					

One club member noted the impact that the HCP has had on their club particularly in the area of anti-smoking where they had gone smoke free and erected signage.

'So I suppose the huge positive is the, at the start we went no smoking, that sort of has been, there has been a lot of movement but I suppose the most positive thing has been embedding it and having it embedded as part of the club.' (HC Officer in a Provincial FGD)

4.3.5 Coaching Environment

At baseline, 71% (n=39) of healthy clubs ensured that their coaches were appropriately certified, compared to 82% (n=22) of control clubs. This figure rose to 93% (n=28) for healthy clubs at follow up and remained stable at 80% (n=8) for control clubs (appendix 17).

As part of the HCQ, clubs completed a section relating to the guidance given to coaches on delivering health promotion during non-performance time within club activities. This questionnaire was adapted from an instrument developed Kokko et al., (2009). The results of this questionnaire are presented in *Table 4.13*; control clubs only completed the questionnaire at baseline, therefore analysis presented is limited to healthy clubs. Clubs responded by indicating if a particular statement described their club a lot. At baseline, some of the highest engagement related to coaches understanding of how their own health behaviour affected that of the youth, with 51% (n=26) of clubs indicating that this described their club a lot. Meanwhile, 41% (n=21) of clubs indicated that their coaches are encouraged to look out for any non-performance related health issues. When asked about health related information being distributed to young athletes, only 12% (n=6) of clubs indicated that this described their club a lot. A similarly low level of engagement was noted in relation to outside experts being recruited to inform athletes about health issues, 16% (n=8). At follow-up, all areas saw an increase in engagement. The majority of clubs, 83% (n=10) indicated that coaches understand how their own health behaviour affects that of the youth. Meanwhile, 67% (n=8) indicated that possible substance abuse is intervened in, a rise from 35% (n=18) at baseline. A notable increase was in relation to the recruitment of

outside experts to inform athletes about health issues. This rose from 16% (n=8) at baseline to 58% (n=7) at follow-up. One of the lowest areas of engagement was in relation to health issues being discussed with parents. At baseline only 16% (n=8) of clubs indicated that this described their club a lot while this rose to just 33% (n=4) at follow-up.

Table 4.13 Club Guidance for Coaches

	Healthy Clubs Baseline (n=51) % describes the club a lot (n)	Healthy Clubs Follow Up (n=12) % describes the club a lot (n)
Weekly PA levels are monitored	20 (10)	42 (5)
Nutrition issues are recognised during coaching sessions	22 (11)	42 (5)
Social interactions are encouraged between team members outside training/games	47 (24)	67 (8)
Exertion caused by school work is in balance with relation to training	31 (16)	42 (5)
Coaches understand how their own behaviour affects the health behaviour of the youth	51 (26)	83 (10)
Possible substance abuse is intervened in	35 (18)	67 (8)
Education is provided in substance use	20 (10)	50 (6)
Adolescent's choices are directed e.g. eating	14 (7)	33 (4)
Health issues are discussed with parents	16 (8)	33 (4)
Coaches are encouraged to look out for and recognise any non-	41 (21)	58 (7)

performance related health issues		
Health issues are discussed with athletes in connection with training	14 (7)	58 (7)
Information and lectures are given on health issues	20 (10)	50 (6)
Health related information is distributed to young athletes	12 (6)	50 (6)
Outside experts are recruited to inform athletes about health issues	16 (8)	58 (7)

Based on the compilation of responses clubs gave to each statement listed in *Table 4.16,* clubs can be categorised as passive, fairly active, or active. At baseline, there was no difference between the club guidance status between healthy and control clubs, with both categorised as 'fairly active'. Twelve Healthy Clubs responded at baseline and follow up and showed a significant improvement in coaching environment status (Table 4.16).

Table 4.16 Club Guidance for Coaches at Baseline and Follow Up (n=12)

	Healthy Clubs Baseline	Healthy Clubs Follow Up
Mean Score (range)	1.17 (0-14)	7.33* (0-14)
Category	Passive	Active

***p<.05 (Baseline v Follow Up)**

Clubs were determined to make develop the coaching environment as a health promoting one. One club member noted how their coaches had bought into the move towards health promotion in their club.

'The coaches have bought into it so it's going to actually be part of their training and they have to be at it, it's not an option, so we'll see how that goes.' (HC Officer in a Provincial FGD)

4.3.6 Overall Impact of Healthy Club Activity

Finally, 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 (HCF). As mentioned earlier, the HCF consists of four elements Plan (Policy), Environment (defined as 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), Activity and Partnerships (defined as engagements with entities external to the club). A rating of high impact was allocated to initiatives that encompassed all four elements of the framework. A rating of 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 HCF in their implementation. The majority of initiatives were medium to high impact, with limitations mostly in the plan (policy) and partnership element of the HCF (*Table 4.15*).

Table 4.15 Impact of Initiatives

	High Impact % (n)	Medium Impact % (n)	Low Impact % (n)
Physical Activity	48 (14)	52 (15)	-
Healthy Eating	46 (13)	36 (10)	18 (5)
Mental Fitness	38 (9)	46 (11)	16 (4)
Gambling, Alcohol and Drug Education	50 (7)	14 (2)	36 (5)
Training and Personal Development	48 (10)	33 (7)	19 (4)
Anti-Bullying	20 (2)	40 (4)	40 (4)
Anti-Smoking	53 (9)	29 (5)	18 (3)
Community Development	33 (7)	50 (9)	17 (3)

4.3.7 Barriers to Health Promotion

Clubs indicated whether certain barriers were an issue for them in promoting health using questions developed by Meganck et al., (2014). A lower score indicated disagreement with a potential barrier while a higher score indicated agreement with a potential barrier; scores ranged between 1 and 5. Lack of resources appeared to be the most troublesome barrier for clubs, with lack of internal support being the least troublesome. At follow up, clubs perception of lack of internal support and lack of resources as barriers declined, while their perception of lack of external support increased. Control clubs experienced an increase in perception of all three categories of barriers (*Table 4.16*).

Table 4.16 Barriers at Baseline and Follow Up

	Healthy Clubs (n=28)		*Control Clubs (n=10)*	
	Baseline Average	*Follow Up Average*	*Baseline Average*	*Follow Up Average*
Lack of Internal support	2.43	2.25	2.43	2.67
Lack of External support	2.86	3.00	2.5	3.00
Lack of Resources	3.45	3.21	3.17	3.77

Over the duration of the HCP, both Phase 1 and Phase 2 clubs saw a decrease in their perception of lack of resources as a barrier (*Table 4.19*). Lack of internal support appeared to increase as a barrier for Phase 1 clubs with lack of external support more relevant for Phase 2 clubs.

Table 4.19 Perceived Barriers among Phase 1 and Phase 2 Clubs at Baseline and Follow Up

	Phase 1 (n=6)		*Phase 2 (n=22)*	
	Baseline Average	*Follow Up Average*	*Baseline Average*	*Follow Up Average*
Lack of Internal Support	2.78	3.28	2.33	1.97
Lack of External Support	2.92	2.83	2.84	3.41
Lack of Resources	3.22	3.17	3.52	3.23

Lack of money and time were the most commonly reported barriers to health promotion in all clubs at both time points. Lack of knowledge was a factor for all clubs at baseline but reduced considerably among intervention clubs at follow up; likely due to delivery of a two hour training session prior to the clubs participation in the HCP. Lack of interest among members, and across society was also noted. This improved over time in intervention clubs and remained relatively high in control clubs (*appendix 18*).

'Challenges' was an evident them during the provincial FGDs. Participants detailed some of the challenges they faced including funding and internal support. However, most realised that facing certain barriers is inevitable and perseverance is needed.

'No matter what you do, need a bit of funding and you know, we've a very small club and we don't have a big pocket.' (HC Officer in a Provincial FGD)

'They're more set on what's happening within the club and not on what you can bring to the wider community.' (HC Officer in a Provincial FGD)

'Maybe we're swimming against the tide to a certain extent but it's only by constantly trying and pressing the right buttons will we actually get that change to materialise.' (HC Officer in a Provincial FGD)

4.4 RQ2: Effect of Healthy Club Initiatives

As noted earlier, three areas were specifically evaluated as part of this project; namely Physical Activity, Healthy Eating and Community Development. The Physical Activity (PA) and Healthy Eating Initiatives were developed by the GAA while the Community Development initiatives varied considerably across clubs. All evaluations of initiatives were carried out in the context of the Healthy Club Framework.

4.4.1 Physical Activity

4.4.1.1 About the Initiative

The PA Initiative was largely centred around the delivery of the Men on the Move programme. This programme was developed and funded by the HSE and aims to promote PA and general wellbeing among men over the age of 30. It is a 12 week programme that includes twice weekly structured PA sessions as well as workshops on nutrition and wellbeing. The programme is delivered in conjunction with Local Sports Partnerships across Ireland.

Three healthy clubs were selected to take part in the PA Initiative during Phase 2. Clubs were selected based upon the capacity of the various Local Sports Partnerships around the country to run the programme, previous work the clubs had undertaken in the area of PA as well as the desire to do more work in this area. Clubs were selected by the Community and Health team in Croke Park with advice from the research team in WIT. Across the three participating clubs, a total of n=82 men signed up to take part in the programme; response rates were almost 100% at baseline, dropping to approximately 40% at 12 weeks and falling to as low as 20% at 26 weeks.

4.4.1.2 Plan

The GAA Community and Health team have developed a PA policy, which provides information around PA and supports a club can develop to promote PA. Overall, approximately 50% of clubs indicated that they had partially or fully implemented this policy. The Men on the Move programme did run according to previously developed and evidence based procedures. A clear protocol was in place to guide the delivery and evaluation of the programme.

4.4.1.3 Activity

As noted above, n=82 men signed up to the programme across three clubs; 65% had some or complete third level education while 71% were in full or part time employment. The average age of participants was 52 years with a range between 31 and 73. At baseline, 5% of men were in the normal weight category, 51% overweight and the remaining 44% either moderately or severely obese. 94% of participants were married while 98% lived with a partner or family.. 37% heard about the program by word of mouth, 17% through media outlets, 11% through the LSP, 27% through local club. Only 11% were smokers, with 34% being former smokers while 85% of the men drank alcohol.

4.4.1.4 Impact of Men on the Move

Data were collected at baseline, 12 weeks and 26 weeks. This included objective measures including weight, BMI, waist circumference, fitness (time to complete one mile), as well as self-report measures of PA, and other indices of wellbeing such as dietary and alcohol habits, and emotional wellbeing. N=16 participants completed all three data collection points.

Results showed significant weight loss and reduction in waist circumference, a reduction in BMI and improvement in fitness among participants *(Table 4.18)*. Men lost an average of 2kgs over the first 12 weeks and maintained this for 26 weeks. Of note was that 1 in 10 men moved to a lower BMI category over the first 12 weeks of the programme. Waist circumference dropped by 3-4 cm and again this was maintained up to 26 weeks. Also, importantly, there was a 1 minute improvement in the time to complete one mile.

Table 4.18 Objective Changes in Health

	Baseline (n=16)	12 Weeks (n=16)	26 Weeks (n=16)
Weight (kg)	90.2	87.8	88.2*
Waist Circumference (cm)	101.3	97	98.1*
BMI kg/m2	29.1	28.1	28.5*
Fitness (mins to complete one mile)	11.5	10.2	10.5*

***p<0.05 Baseline V 12, 26 weeks**

Participants also self-reported improvements in health; particularly around meeting PA guidelines (up to 12 weeks), achieving the recommended intake of fruit and vegetables, and self-rated health and mental wellbeing (*Table 4.19*). In relation to the latter, which was scored using a mental health index, population averages in the UK are approx. 51 so these participants scored higher than average and displayed a sustained increase throughout the programme. It's important to note that those who made greatest improvements and adhered most to the programme may have been more likely to participate and this should be recognised when viewing the data in Table 4.19.

Table 4.19 Self-reported Changes in Health and Behaviours

	Baseline (n=82)	12 Weeks (n=47)	26 Weeks (n=16)
Sufficiently Active ie 150 mins/week? (%)	12.5	21	12.5
At least 5 portions of Fruit and Veg/day (%)	15	30	27
Health Rating (% Excellent/Very Good)	35	49	50
Mental Well Being	55.8	57.2	58.1

Score			

LSP co-ordinators commented on the impact of the programme noting the important social aspect of the programme and the safe environment for participants to try to be active in. A Healthy club officer of one of the participating clubs also outlined his surprise at how well the programme was attended.

'this one with Men on the Move it worked out unbelievably like, i never thought it was going to be as good as it was. We were hoping for 25, 30 and you know we ended up with 60 odd.'(HC Officer in a one-to-one interview)

The participants appeared to enjoy the programme and as well as the health benefits, they also highlighted how enjoyable it was from a social perspective.

'I do a bit of walking but em, i found this is, the old walking can get a bit boring and this is a bit of craic, there's a bit more to it you know.'(MoM participant in a FGD)

Participants self-reported how they were feeling over the previous two weeks in relation to certain aspects of their lives (*Table 4.20*). One of the highest rated feelings was a feeling of usefulness. At baseline, 84% (n=69) reported a feeling of usefulness over the previous two weeks. This fell to 82% (n=37) after 12 weeks and rose to 94% (n=15) after 26 weeks. Feeling good about oneself in the previous two weeks was a feeling often experienced by 73% (n=60) of men at baseline. This rose to 80% (n=36) at 12 weeks and 81% (n=13) at 26 weeks. Having energy to spare was reported as a feeling often experienced in the previous two weeks by just 34% (n=28) at baseline. This rose to 51% (n=23) at 12 weeks and 56% (n=9) at 26 weeks. Another area that saw a sharp improvement was a feeling of dealing with problems well. At baseline, 62% (n=51) of men reported feeling this way often over the previous two weeks. This figure rose to 71% (n=32) at 12 weeks and 94% (n=15) at 26 weeks.

Table 4.20 Subjective Feeling in the Previous Two Weeks

Feeling in last two weeks	Baseline (n=82) % often (n)	12 weeks (n=45) % often (n)	26 weeks (n=16) % often (n)
Feeling optimistic about the future	72 (59)	80 (36)	88 (14)
Feeling useful	84 (69)	82 (37)	94 (15)
Feeling relaxed	57 (47)	71 (32)	81 (13)
Feeling interested in other people	70 (57)	60 (27)	94 (15)
Had energy to spare	34 (28)	51 (23)	56 (9)
Dealing with problems well	62 (51)	71 (32)	94 (15)
Thinking clearly	74 (61)	78 (35)	88 (14)
Feeling good about myself	73 (60)	80 (36)	81 (13)
Feeling close to other people	77 (63)	78 (35)	94 (15)
Feeling confident	74 (61)	78 (35)	88 (14)
Able to make up my own mind about things	78 (64)	80 (36)	88 (14)
Feeling loved	84 (69)	82 (37)	94 (15)
Interested in new things	78 (64)	80 (36)	94 (15)
Feeling cheerful	78 (64)	80 (36)	81 (13)

4.4.1.5 Partners

Interviews were carried out with three Local Sports Partnership Officers. All agreed that the GAA club was a good setting for Men on the Move for a number of reasons. Firstly, the

club presents facilities a meeting place for this type of programme. Secondly, the club provides access to a typically hard to reach target group of adult males and finally, the programme provided a very real, strong partnership between the LSP and the GAA that could be extended to more clubs.

'I think it will be a very strong case for other clubs to get involved…..once they hear word of mouth, you know you can't put a price, you know you can't put a label on that, that'll spread like wildfire and you'd hope it would create more opportunities going forward.'(LSP Officer in a one-to-one interview)

The LSPs were also aware of the benefits to the club in terms of new members but also the value for clubs in seeing the 'bigger picture' and extending themselves beyond their playing populace. LSPs also commented on the importance of the club leading the programme, and in particular having a 'local leader' or champion, driving the initiative from within rather than having an 'external group coming in trying to influence.' There was a sense of the club requiring ownership of the programme for it to be really impactful. In line with this, LSPs were keen to suggest that clubs should display and generate interest in their community before contacting the LSP to ensure the viability of running the programme.

Clubs also commented on their engagement with LSPs, noting that it was a positive experience. One club executive of a participating club acknowledged how pleasing it was to work with the LSP.

'we got on very well with them and he organised for us, the nurses on the two nights for testing and that, they were organised and that and he made sure everything was set up, so yeah i was delighted with them, they were good to work with.'(Club Executive Officer in a one-to-one interview)

A challenge relevant to LSPs was that men called for greater variety in exercise throughout the programme. A future roll out of Men on the Move may look to develop new programmes for participants. The co-ordinators did discuss the sustainability of the Men on the Move/GAA partnership and noted the challenge of funding. It was suggested that

the partnership be formalised and a shared funding model proposed for the programme with a contribution from participants included.

4.4.1.6 Club

An interview with club executives revealed very favourable comments about the Men on the Move programme. Of note was that the club felt they were a very relevant setting for this type of initiative and were planning to continue their PA work with men as well as hoping to run the Men on the Move programme again. Clubs remarked on the usefulness of their facilities to run indoor and outdoor activities and also noted health related changes across their club. They also observed new people in the club and remarked, anecdotally on the beneficial impact on participants;

'It's got people, it's got lads there now that would never have been active involved in exercise as well, a couple of the lads there now that did a 5k in the middle of the men on the move and the two lads wouldn't have, excuse the, they wouldn't have walked from one side of the pub to the other beforehand, you know.' (HC Officer in a Provincial FGD)

Feedback from the GAA Healthy Clubs Co-ordinator was mainly positive about the programme. In particular, there was a demand for a programme like this to engage men and this model appears to be a sustainable one.

'A lot of clubs even before we did men on the move would have been looking for advice or how to deliver programs to engage men in general.'(GAA HC Coordinator in a one-to-one interview)

'It can be very sustainable because you have the partnership with the LSPs and the local clubs is really strong and it's kind of opened up the doors for them to roll out different initiatives as well as furthering the men on the move.' (GAA HC Coordinator in a one-to-one interview)

4.4.2 Healthy Eating

4.4.2.1 About the Initiative

The GAA Healthy Eating Initiative comprised of different elements: implementation of healthy eating guidelines in the club, delivery of a healthy eating talk from an Irish Nutrition and Dietetic Institute (INDI) Nutritionist and the Recipes for Success Programme, which is delivered in partnership with St Angela's College, Sligo. The programme is delivered in an informal education environment, in a school setting with the support of a local Home Economics teacher. One of the executive officers from a participating club explained the interest they have in this area and their hope to instil good dietary habits in young members so they have those skills for life.

'to try and build up the habits when they are young so when they do hit senior level, even if they are not playing football at that stage or involved in sport, that they still have that lifestyle that will affect them going forward. That's what we're trying to do anyway'
(Executive Officer in a one-to-one interview)

4.4.2.2 Plan

The GAA have developed healthy eating guidelines. Clubs were encouraged to adopt these guidelines and alter them to suit the requirements of their club. Of the n=3 clubs who engaged in the healthy eating evaluation, n=2 had adopted healthy eating guidelines and the third club was in the process of developing their guidelines. Across all clubs in the evaluation, 52% had partially or fully implemented these same guidelines.

'we basically used the guidelines that the GAA had already done and basically made one or two slight changes to ours and that was it'(HC Officer in a one-to-one interview)

4.4.2.3 Activity

N=26 out of n=60 healthy clubs took part in the Recipes for Success programme. Three of these clubs took part in the evaluation process (n=36 participants), while three clubs not taking part in the Recipes for Success programme were recruited as controls (n=40 participants). The majority of players involved in both groups were male (n=32 intervention, n = 30 control) and aged between 15 and 18. Most played juvenile/minor (95%, n=31 intervention, n = 36 control) for their clubs.

Almost 90% of participants in both groups said they were responsible for preparing their own breakfast and snacks, lower at 70% for lunch and again at 36.5% for dinner. In cases where participants were not responsible for preparing their own food, their parents were responsible for doing this in the majority of the cases (98.3%).

4.4.2.4 Impact of the Recipes for Success Programme

Anecdotally, the Recipes for Success programme itself is deemed to have an excellent initial impact and engages partners within the community but should be viewed as just one component of a clubs approach to Healthy Eating.

Evaluation of the controlled impact of the programme was hindered through the lack of a standardised questionnaire for intervention and control clubs. Among intervention and control participants, there was no change in cooking responsibility (cooking their own breakfast (90%), lunch (70%) and dinner (40%) between pre and post.

Among intervention participants, there was an increase in participant's perceptions of their diet and its appropriateness to their needs as a GAA player (44% - 56%). Participant's interest in nutrition increased from 62% to 72% following the programme while knowledge of nutrition almost doubled from 30% to 56%. Each of the participating clubs also delivered a talk from an INDI Nutritionist.

4.4.2.5 Potential Changes

A potential development of the program could be to engage in some sort of follow up day, as suggested by a player: '*if we met up another day and tried something else instead of just doing it as a once off' (Player in a FGD).*

4.4.2.6 Club

Many clubs expressed their success in introducing fruit and water, particularly to juvenile teams, in one case in partnership with a local supermarket. This is a good example of extending the Healthy Eating concept beyond the Recipes for Success programme, and had a positive impact: *'the kids now as soon as training is over they want their water, they want their fruits' (HC Officer in a one-to-one interview).*

Educating and involving parents is an area for development for clubs engaging in Healthy Eating, as they have a major influence on the eating habits of their children. One player

noted that parents should get more involved in an initiative like this; *'parents often aren't as much a part of the club as the players and the coaches, so maybe just to try to tie them in more' (Player in a FGD).*

While aware that a change in culture will take time, clubs are hopeful that this approach to healthy eating will be the norm in the future and they are glad to be leaders in this space.

'It's been great, our name is nearly everywhere and all, we're in the paper and all on Facebook and Twitter' (HC Officer in a one-to-one interview)

It'll be normal in a few years'(HC Officer in a one-to-one interview)

'It almost gives the club more of an identity because it's a bit different to other clubs' (HC Officer in a one-to-one interview)

4.4.2.7 Partners

Clubs who engaged in the Recipes for Success workshop were required to find a local secondary school and Home Economics teacher willing to host the workshop. The three clubs who engaged in the healthy eating initiative had no problem in doing this with one noting *'that it is a great facility to have going forward' (HC Officer in a one-to-one interview).*

St. Angela's engage in this project voluntarily as an added workload for them. Both the Croke Park and St. Angela's contact points mentioned this as a challenge. The key learnings in delivering the Recipes for Success programme has been to get the set up right in terms of having a central database of clubs, schools, dates and times so that everybody is working in unison to deliver an initiative that is essentially a voluntary activity for all involved.

An executive officer of a participating club noted his aim in trying to bring the coaches on board with healthy eating, while another highlighted how engaging in this programme could influence parents.

'I'm trying to introduce myself as coaching officer, is a nutrition side where the coaches would come in and for the different underage teams and we would brief them on healthy

eating policies and different things and then get them to pass it on to the players.'(Executive Officer in a one-to-one interview)

'You'd hope to have a knock on effect within their own homes, that their parents see them eating healthy things, they'd be more inclined to be buying better sources of food as oppose to junk food i suppose.' (Executive Officer in a one-to-one interview)

Meanwhile, one of the players who participated in the workshop highlighted the fact that involving parents in the programme could be a development for the programme in the future.

'I thought maybe there could have been more involvement from parents because the involvement from coaches, people on the committee, players has been really good but i think that parents are been slower to get involved and haven't probably been as involved in the activities so maybe that aspect.' (Player in a FGD)

4.4.3 Community Development

Clubs largely personalised their work in Community Development. The case study below incorporates activity across four clubs who identified this topic area as a key part of their engagement in the HCP. Two focus groups and two interviews were used to collect data.

4.4.3.1 About the Initiatives

One GAA club developed a suite of activities around the area of Community Development. These included Nursing Home visits in partnership with the local school, a Lunch Club for older members of the community, card games and singing nights. In addition, this particular club became 'smoke free', which was similarly undertaken as a priority issue for several other Phase 2 clubs. A second club went smoke free as part of their Community Development initiative, while a third club endeavoured to go smoke free but could not make this a reality. Finally, a fourth club developed an active retirement group.

4.4.3.2 Impact of the Initiatives

Feedback from the all participants revealed hugely positive experiences. The partnership between a club, school and nursing home yielded hugely rewarding engagements between young and older people in a community.

'The kids love it, the residents love it, and it's great for the children to see, you know to see older people. A lot of them their grandparents might have passed away and they don't have a connection with the elderly so I've had nothing but positive things to say about it.' (School Principal in a FGD)

Equally, visits to the Nursing Home were rewarding for one of the Healthy Club volunteers:

'I mean the evenings I'm coming over here to visit, I'm excited as I'm thinking, 'god, what fun will we have this evening' (HC Officer in a FGD)

The Active Retirement group was '*about social inclusion and getting people out of their houses and making sure everyone is, you know has someone to talk to, that kind of thing*.' The initiative included several trips, which was supported with funding from the Club Executive. Of note was this club identified active aging as a priority area and have committed to working on similar club defined issues going forward. As part of their active retirement strategy, the club have engaged with a range of partners including Rural Link, other active retirement groups, their local library and their local council. This club also went smoke free during Phase 2.

4.4.3.3 Smoke-free Activity

Finally, several clubs went smoke free during Phase 2 of the HCP with one particular club facilitating a review of their transition to a smoke free club. The club worked hard to integrate the whole community in their move to smoke free; running a colouring competition in schools, displaying children's art in the local churches, doing a media campaign with a club juvenile team as well as holding a talk from a Smoking Cessation Officer with the Club Executive. The healthy club officer of the club described how well partnering with the school worked.

'So they designed their own poster and we worked with the principal in the school and they were delighted because they can incorporate it into their curriculum as well.'(HC Officer in a one-to-one interview)

This led to a trouble free adoption of the Smoke Free Policy. Implementation of the policy was supported by a PA announcement at all games and the distribution of cards showing the clubs commitment to a smoke free club environment. As well as this, anti-smoking signage has been erected to show that the club ground is a smoke free area.

The HC Officer of another club shared a contrasting story where he struggled to get support among his clubs executive committee to make the club smoke free. Executive members felt that policing this would be too challenging: *'the reason given was policing' (HC Officer in a one-to-one interview)*

However, the GAA Healthy Club Co-ordinator noted her surprise at how successful many clubs were in going smoke free. She also commented on looking towards the future sustainability of the HCP and acknowledging the need to provide clubs with packaged initiatives for the various areas of work.

'Like those success stories were great like, and I suppose I wouldn't have maybe expected 29 clubs to go smoke free either so yeah I think if you can make a package for a club and give it to them so that it's, any club can roll with it I think it's makes their life a lot easier.'(GAA HC Coordinator in a one-to-one interview)

Chapter 5 Discussion

The aim of this study was to evaluate the impact of Phase 2 of the GAA Healthy Club Project (HCP) on the health promotion orientation of GAA clubs and to investigate the effectiveness of a number of specific initiatives, in the areas of physical activity, nutrition and community development. The settings approach to health promotion has previously been implemented and evaluated in other environments such as schools, cities and workplaces, with the sports club recently emerging as an impactful setting, albeit with limited supporting evidence. An evaluation of Phase 1 indicated that the HCP is a viable setting for health promotion (Lane et al., 2016).

Main findings revealed a significant improvement in the health promotion orientation of intervention clubs compared to control clubs. Most notably, intervention clubs moved from low to high health promoting for the policy domain and from low to moderate health promoting for practice, moderate to high for the environment domain with a significant improvement in indicators for ideology and juvenile environment. Phase 2 clubs demonstrated the greatest change across all domains of the Healthy Club Index (HCI) but Phase 1 clubs also improved between baseline and follow up. Results from the regional focus groups showed that participants expressed a feeling of responsibility by clubs to deliver health promotion to their members and community, as well as developing as sport and social settings. In Phase 2, clubs were active across all of the priority health areas delivering over 300 initiatives with varying levels of alignment with the Healthy Club Framework (HCF). The greatest activity was in the physical activity and healthy eating domains, followed by mental fitness, training and personal development and community development. Findings suggest that many programs worked well in partnership with other actors and organisations while overall policy implementation remains low in many topic areas. Evaluation of initiatives showed some encouraging changes in participant's attitudes and behaviours, as well as encouraging feedback from participants and other stakeholders.

The remainder of this chapter will summarise the key findings of this study across three main discussion points;

1. **Meaningful Impact of the HCP on Clubs and Individuals**

2. **Integrating Health Promotion into the Core Business of the GAA Club**
3. **Sustainability; Moving to all GAA Clubs**

5.1 Meaningful Impact of the HCP on Clubs and Individuals

5.1.1 Impact on Clubs

A comparison of HCI scores over time indicated significant improvement in the health promotion orientation of intervention clubs compared to control clubs. Overall, intervention clubs showed a significant increase in health promotion orientation despite remaining in the moderate health promotion orientation category. Kokko (2010) noted that a moderate orientation indicates there is more potential and room for improvement for sports clubs to realise their health promoting role. These results both demonstrate how much GAA clubs already contribute to the health of members in a range of ways, not just physically through their core business of sport but also socially and mentally, while also showing that there is potential for further growth and improvement in the area of health promotion. Equally, control clubs were moderately health promoting at baseline but showed no subsequent change over time. The fact that control clubs self-selected to take part in the study suggests that they already had an interest in the area of health and well-being to begin with, which is likely innate in all GAA clubs. Also some control clubs were selected from those who had unsuccessfully applied to take part in the HCP. As such, it was not a surprise that control clubs had a moderate orientation towards health promotion at the outset of the project.

Results from this study can be compared to similar studies in other countries. Kokko et al., (2009) carried out a baseline assessment of the health promotion orientation of youth sports clubs in Finland using the original HPSC Index consisting of 22 statements. In a similar fashion, clubs were categorised as low, moderate or high health promoting. It was found that on average clubs had a moderate orientation toward health promotion. Club officials were found to be twice as likely to categorise their club as higher health promoting compared to coaches. In Belgium, the same index was used by board members to indicate the health promotion orientation of their youth sports clubs (Meganck et al., 2014). On average, clubs were mostly in the low health promoting category. Similarly in France, van

Hoye et al., (2014) investigated the health promotion orientation of n=125 sports clubs using an adapted HPSC index with 28 items. Coaches responded to this evaluation and results showed that 40% rated their club as high health promoting, 32% as moderately, and 28% as lower health promoting.

Phase 2 clubs demonstrated the greatest change across all domains of the HCI. Understandably, Phase 1 clubs scored higher at baseline in all areas in comparison to Phase 2 clubs. Importantly, these clubs also improved between baseline and follow up, suggesting space for continued growth in health and wellbeing across all clubs regardless of their starting point. This demonstrates that the HCP is working well to harness the energy that exists in GAA clubs to work in this area. Phase 2 clubs showed a significant improvement in all domains of health promotion as well as their overall health promotion score which increased from 17.58 at baseline to 25.53 at follow up. Meanwhile, Phase 1 clubs just showed a significant improvement in their overall health promotion status and not the sub-indices, moving from 20.42 at baseline to 24.93 at follow up. Similar overall improvements were evident in an evaluation of Phase 1 of the HCP where intervention clubs moved from a score of 19.88 at baseline to 23.85 at follow up (Lane et al., 2015).

In Australia, the participation in community sport and recreation (PICSAR) programme is another example of clubs developing their health promotion orientation over time (VicHealth, 2013). Similar to the HCP, clubs were encouraged to build capacity and engage with partners, develop inclusive policies, develop appropriate programs and provide training for staff and volunteers. Participants noted the social and physical benefits and an increased confidence while families reported an increased opportunity to participate while including diverse populations raised the profile of the clubs in their community. The Healthy Sporting Environments Demonstration Project (HSEDP) attempted a similar change in clubs where minimum standards were imposed regarding the serving of alcohol, creating a smoke-free venue, making healthy food available (Nicholson et al., 2014). Despite the implementation of these standards, no significant changes were noted physically or socially according to results from quantitative club surveys.

In Phase 2 of the HCP, policy scores did not change in control clubs but intervention clubs moved from a low to a high health promotion orientation in the area of Policy which reflects the formalisation of the role of the Healthy Club Officer and the development of a Healthy Club Statement for clubs, which is a commitment by clubs towards health and wellbeing. Kokko et al., (2009) found that Finnish youth sports clubs scored low in policy also with only one fifth of club reaching a high category here. Among Belgian clubs, Meganck et al., (2014) found that 62% were in the low category for policy. In terms of governance, an important recommendation from Phase 1 was for a health and wellbeing policy to be generated and adopted by clubs in order to put health promotion on the agenda (Lane et al., 2015). The majority of intervention clubs indicated that they had fully implemented a health and well-being statement (85%), as well as a critical incident plan (73%). Importantly, this reflects support from the club executive towards integrating health and wellbeing in clubs. Using the same scoring Index among Finnish clubs, Kokko (2010) found that many of the standards in relation to policy were new and demanding for clubs and were not well recognised, suggesting a need to establish new policies. Similarly, the baseline results from this study suggest that the individual standards in the policy category were not initially well recognised by clubs. However the significant improvement in policy orientation is encouraging and reflects well on the efforts of the GAA to introduce new policies in the various areas of health promotion but also to integrate health and wellbeing into the day to day management of the club

Corti et al., (1995) investigated sports organisations that received funding from Healthway, an independent funding body in Australia aimed at promoting health. An 18 month follow up showed that sports organisations that received funding had significantly improved their smoke free policy activity as well as their delivery of healthy food options. Later this initiative was extended to community sports clubs as the Healthway Healthy Club initiative and over n=1400 clubs have taken part so far (Mills et al., 2009). A kit including signage, posters and information on policy development was given to clubs. The project has been successful in promoting smoke free environments as well as sun protection, alcohol and nutrition programmes. Again in Australia, Dobbinson et al., (2006) investigated the health promotion policy development among sports clubs in Australia. Seven out of every ten clubs that had a bar had a written policy on responsible alcohol management. Written

smoke free policies were evident in just over one third of clubs. Only 2% of clubs had a policy for all five areas of smoke free, sun protection, healthy catering, injury prevention, and responsible alcohol management. When asked about potential barriers to developing health promotion policies, 47% expressed the need for more support and guidance from health agencies and 45% suggested that they could do with the use of sample policies. In a similar investigation, surveys and interviews with executive officers of State Sporting Associations in Australia were used to assess the activity of sports clubs in implementing healthy and welcoming environment (HWE) policies and practices (Eime et al., 2006). Executive officers expressed concern at having limited capacity in controlling what clubs do at grass roots level. Most SSAs reported having a policy across the 5 areas of focus including smoke free, alcohol management, injury management, sun protection, and healthy eating. Healthy eating was a challenging area to implement practices due to the cost and shelf life of healthy food. Priest et al., (2008) conducted a review of studies investigating the impact of policy interventions in sports clubs to promote health behaviour change. No rigorous studies were found for this review indicating that more research is required in this area.

In the present study, policy implementation in a number of specific topic areas remained relatively low e.g. Physical Activity guidelines (33%), Healthy Eating Guidelines (36%), and Mental Health Charter (30%) but the implementation of a general health and wellbeing statement was high. This was reflected in subsequent improved practice scores around health education and injury management. As highlighted by Young et al., (2013) the success of the health promoting schools required both an engagement in practical activities and the implementation of supporting policies. Among GAA clubs, the lower implementation of other policies did not appear to hinder the subsequent delivery of initiatives with the greatest number of engagement reported in physical activity, healthy eating and mental health.

Ideology improved over time in intervention clubs, reflecting the GAA's commitment to the Respect and Go Games principles. In Belgium, Meganck et al., (2014) found that youth sports clubs scored highest in the area of ideology with over half of clubs having a high orientation in this area. Similarly, Kokko et al., (2009) found that the majority of Finnish youth sports clubs had a high orientation for ideology.

In the present study, indicators of the overall and juvenile specific environment improved significantly. The addition of walking tracks, gym facilities, and signage contributed to the development of the physical environment. Meanwhile, clubs indicated a greater awareness and understanding of many health issues in their clubs at follow up as well as greater support being available for personal development in the various areas of work. One of the successes during Phase 2 of the HCP was the move by many clubs to make their grounds a smoke free environment. This was reflected with a significant improvement in the standard that states 'The club provides a sports environment that is smoke free during juvenile activities'. Many clubs engaged in partnerships with smoking cessation officers in order to make this a reality. Other clubs engaged with their local schools and had students design anti-smoking posters.

The follow up HCQ indicated that clubs experienced great value from the project. All (n=30) of clubs indicated that their club is better due to their involvement in the HCP, with all clubs also indicating that this project has allowed them to focus on health issues in a way they could not have done otherwise. Perhaps adopting a similar approach to health promotion could reap positive rewards in other sports club settings and community organisations. The HC framework certainly offers a simple guide for organisations to engage in sustainable HP. 93% (n=28) clubs indicated that the culture of their club has changed for the better while 97% (n=29) clubs said that they would sign up for the project again. Also, 97% (n=29) of clubs indicated that health had become more of a priority in their club. The positive impact of the project was also captured in FGDs where club officials referred to the fact that people wanted to be involved in the project, the project had led to more recognition of the club in the community, and the project had grown and gathered momentum among clubs. Nicholson et al., (2013) noted similar findings in the Healthy Sporting Environments Demonstration Project (HSEDP) where the majority of clubs indicated that their club culture had changed for the better as a result of the project and their club is a better place due to their involvement. In Australia, the HSEDP led to significant changes in clubs adopting and implementing standards in the areas of health such as healthy foods, anti-smoking and social inclusion. Despite the introduction of these minimum standards, there was no evidence of positive behaviour change accruing as a

consequence. Similarly with the HCP, an improvement in health promotion orientation does not automatically manifest in a positive change in member's health behaviours.

5.1.2 Impact on Individuals

5.1.2.1 Healthy Eating Initiative

Among intervention participants from the Recipes for Success programme, there was an increase in perceptions of their diet and its appropriateness to their needs as a GAA player (44% - 56%). Participant's interest in nutrition increased from 62% to 72% following the programme while knowledge of nutrition almost doubled from 30% to 56%. Despite this, the initial level of knowledge and the appropriateness of diet suggest that players need education and guidance on healthy eating. Irish people in general also appear to want and need more access to healthy eating information and opportunities. The Healthy Ireland Survey 2016 (Department of Health, 2016) found that only 26% of the population eat five or more portions of fruit or vegetables daily. 60% of people indicated that they eat snack foods daily. Also, 29% of people indicated that they would like to eat more healthily.

Results from the HCQ and FGDs indicate that parents remain a poorly engaged partner among the majority of clubs. Educating and involving parents is an area for development for clubs engaging in Healthy Eating, as they have a major influence on the eating habits of their children. This overall commitment to Healthy Eating yielded a return among intervention clubs; the provision of healthy foods options following sporting activities also rose significantly from .37 to .68. However, despite this increase in recognition, this area of providing healthy food options remains the lowest recognised area in terms of the club environment. Feedback from participants and stakeholders was generally positive regarding this practical healthy eating workshop.

Other, less practical approaches to developing healthy eating have also been explored with some success. The Snack Smart program, an after-school nutrition programme was delivered in n=8 libraries to children ranging from 9 to 14 years old (Freedman and Nickell, 2010). The program was a 3 week, 6 hour series of 5 workshops and there was parental involvement. Nutrition students taught the workshops and were given resources and training. Only consumption of water showed a significant difference from pre-test to follow up. Elsewhere, Fahlman et al., (2008) investigated the impact of a pilot nutrition

intervention on school children in Michigan with a mean age of 12 years old. Teachers delivered nutrition lesson plans to the students. Teachers took part in training and then delivered 8 lessons over the course of one month around food groups, reading food labels, body image and fast food restaurants. Intervention subjects demonstrated significant improvement in healthy eating behaviours such as eating fruits and vegetables. Nutritional knowledge was also improved significantly among intervention subjects. These programmes demonstrate that educational sessions can work well and teacher led sessions are important, as is parental engagement. It is important that clubs continue to engage with such partners to sustain and develop initiatives like the healthy eating programme. As mentioned above, parents are also a key partner in developing healthy eating habits among youth club members and it is important to consider strategies of engaging parents more. Inviting parents along with their children to any healthy eating talks or workshops would be one approach. Also, distributing healthy eating resources such as recipes and cookbooks to parents as well as young club members could be a productive strategy.

5.1.2.2 Physical Activity Initiative

Three clubs participated in the physical activity initiative, which included the Men on the Move programme during Phase 2. In Ireland the Men on the Move programme was originally developed to target the level of physical inactivity among males of age 35 and above (Canavan, 2013). Given Across the three clubs participating in the Men on the Move programme, a total of n=82 men signed up to take part; response rates were almost 100% at baseline, dropping to approximately 40% at 12 weeks and falling to as low as 20% at 26 weeks. The attrition rate is disappointing but doesn't seem unusual, as a previous evaluation of the Men on the Move initiative witnessed a response rate of less than 50% by the end of the programme (Canavan, 2013). In terms of recruitment, 1% of males recruited to the pilot Men on the Move programme were in the normal weight category; this was at 5% in the current study demonstrating a slightly lower risk subject group.

Results from analysis of the present study showed significant weight loss and reduction in waist circumference, a reduction in BMI and improvement in fitness among participants. Men lost an average of 2kgs over the first 12 weeks and maintained this for 26 weeks. A similar programme run in the UK through soccer clubs (FFIT - Football Fans in Training)

reported an approximate 5kg weight loss over a 12 month period (Hunt et al., 2014). Of note was that 1 in 10 men moved to a lower BMI category over the first 12 weeks of the programme. Waist circumference dropped by 3-4 cm and again this was maintained up to 26 weeks with an overall reduction from 61% to 23% of men in the high risk category. Canavan (2013) reported a less notable change from 66% to 43%. Also, importantly, there was a 1 minute improvement in the time to complete one mile; representing an approximate 12% improvement. Canavan (2013) reported that 46% of participants in their study reduced their time by 5-20%. Participants also self-reported improvements in health; particularly around meeting PA guidelines (up to 12 weeks), achieving the recommended intake of fruit and vegetables, and self-rated health and mental wellbeing. In relation to the latter, which was scored using a mental health index, population averages in the UK are approximately 51 (Office for National Statistics, 2016) so these participants scored higher than average and displayed a sustained increase throughout the programme. Being with other men of similar experiences and having shared beliefs and interests was a key driver of the FFIT programme success (Bunn et al., 2016) and likely was important here in terms of the positive impact on emotional wellbeing.

The number of men meeting the PA guidelines was low and despite an improvement during the 12 week programme, it is clear that physical inactivity is a problem among groups like this as well as the general population. Despite an improvement at the end of the 12 week programme, only 21% of men reported meeting the recommended weekly PA levels of 150 minutes per week. This is in comparison to 40% of the general male population who are deemed to be sufficiently active according to the Healthy Ireland Survey, 2015 (Department of Health, 2015). The proportion of men who are highly active drops as age increases with 46% of those between 15 and 24 being highly active compared to only 15% of those aged 65 and above. Therefore it is important to target men as they age with appropriate and engaging physical activity programmes like this one.

Also, the 2017 Healthy Ireland Survey found that 62% of the population are overweight or obese and that 49% of the population are trying to lose weight (Department of Health, 2017). Men were more likely to be overweight or obese (70%) compared to women (53%). The most common method of trying to lose weight is exercise with 68% of people engaging in this. An important step in men's health in Ireland came in 2008 with the publication of

the National Men's Health Policy. The most recent policy update in this area came in 2016 with the launch of Healthy Ireland – Men action plan 2017-2021. In line with guidance from this policy, Richardson and Carroll (2008) acknowledged that it is important to recognise men as a target group and identifying strategies to engage men in health promotion practice. The Men on the Move programme presents an ideal method to promote healthy behaviours among men and appears to work well in a GAA club setting.

5.1.2.3 Community Development Case Studies

In this thesis Community Development is taken to mean anything that promotes solidarity and agency in line with the theory put forward by Bhattacharyya (2004). Solidarity refers to a sense of identity and a set of accepted norms. Identity can be derived from a shared place, ideology or interest while norms refer to an agreed code of conduct where any breach of this would negatively affect the community members. Agency then focuses on actors in the community having the appropriate skills, ability and capacity to take control over their community and manage it effectively. In Phase 2 of the HCP clubs engaged in a broad range of initiatives under the name of Community Development. For the purpose of this thesis, Community Development is viewed as initiatives that promote the development of social capital, social inclusion and integration at the community level.

Previous literature has indicated the potential that sport has for community development and social inclusion. As well as enhancing public health, sport has an important role to play as an educational environment and can promote social inclusion and integration (EU, 2007). Previously, the UN Inter-Agency Task Force on Sport For Development and Peace (2005) highlighted the importance role that sport can play in social development noting that sports programmes that are effectively designed can lead to people connecting with each other and learning valuable life skills. Atherley (2006) and Oliver (2014) both point out that sport does not automatically bring people and communities together and can sometimes lead to division based on class, ethnicity, or status. Sport can however be a platform for social good particularly when the focus is on building social bridges between people. In the HCP, one GAA club developed a suite of activities around the area of Community Development particularly in relation to connecting groups in the locality. These included Nursing Home visits in partnership with the local school, a Lunch Club for older members of the community, card games and singing nights. In addition, this

particular club became 'smoke free', which was similarly undertaken as a priority issue for several other Phase 2 clubs. Feedback from the all stakeholders revealed hugely positive experiences. The partnership between a club, school and nursing home yielded hugely rewarding engagements between young and older people in a community. Equally, visits to the Nursing Home were rewarding for one of the Healthy Club volunteers.

The actions of key stakeholders like players, coaches and administrators are crucial to developing the potential of sport in relation to inclusivity and breaking down cultural barriers. Previously Hoye et al., (2013) investigated the attitudes of Australians regarding sport and social connectedness. Results showed that involvement in sport leads to feeling more socially connected and that social networks developed through sport are of greater perceived value compared to networks created in non-sporting community groups. Social networks developed through sports club membership can lead to new friendships and reduced isolation, access to new experiences and opportunities, and access to support and guidance in times of hardship. Many club members suggested that their sports club was like a family or a community and that they felt like they were part of the wider community in which their club was located as a result. Tonts (2005) investigated sport and social capital in rural Australia. When asked what the most important aspect of sport was in their local area, 82% of households said social interaction, 93% felt sport was a good way to stay in touch with neighbours and friends and 91.2% thought sport was important to develop a local sense of community.

Another club in Phase 2 developed an active retirement group as part of their community development work. The Active Retirement group was '*about social inclusion and getting people out of their houses and making sure everyone is, you know has someone to talk to, that kind of thing*.' The initiative included several trips, which was supported with funding from the Club Executive. Of note was this club identified active aging as a priority area and have committed to working on similar club defined issues going forward. As part of their active retirement strategy, the club have engaged with a range of partners including Rural Link, other active retirement groups, their local library and their local council. This club also went smoke free during Phase 2 established a new walking track which the active retirement group had made good use of. Again, all participants and the healthy club officer

in this club had positive feedback about the impact of the initiative. Despite the positive feedback from stakeholders and the range of partners being engaged, both of these clubs had failed to implement a policy in the area of community development. This is one area where the GAA have not yet developed a policy template. Facilitating clubs by providing such a template would make policy adoption much easier and contribute to a more sustainable engagement in the area of community development. As noted earlier, implementing a policy sets the stage and provides guidance for running programmes in a particular area of work.

In another Australian example, D'Arcy (2014) examined how social capital develops through relationships in surfing clubs at community level in Australia. Results strongly suggested that social capital was developed through relationships at club level. The club was also seen as family oriented and as having a supportive organisational culture. Strong themes that emerged were the development of shared social values and standards in the club, and a feeling of belonging. Development of values such as pride, respect, reliability, helping others and giving back to the community were important and linked to social capital. Community and individuals benefitted from sports club engagement and could influence the rest of the community positively through the effective transfer and leveraging of social capital. This is particularly relevant in the HCP; as well as these community development focussed initiatives, there is a sense overall in the project that the GAA club is engaging itself with the wider community through this work and this is a natural responsibility and priority for the club unit.

Social capital can manifest itself in the many volunteers and supporters that are involved in sport. Sport and physical recreation organisations attract large numbers of volunteers. Volunteers and supporters make up 14% of the adult population in Australia (Australian Bureau of Statistics, 2013) while the Eurobarometer (2014) showed that 7% of EU citizens engage voluntarily in supporting sports activities. The Irish Sports Monitor (Irish Sports Council, 2015) showed that 12.9% of Irish people volunteer in supporting sports activities. The report also shows that just under half of the population participate in sport regularly on a social basis. This social participation is measured in three contexts – attending events, volunteering, and club membership. Given the large volunteer base that exists in the GAA,

the potential exists for clubs and the GAA at large to positively impact the social and personal development of its members and community, which is manifesting well through the HCP.

Finally, in another example of social cohesion, several clubs went smoke free during Phase 2 of the HCP with one particular club facilitating a review of their transition to a smoke free club. The club worked hard to integrate the whole community in their move to smoke free; running a colouring competition in schools, displaying children's art in the local churches, doing a media campaign with a club juvenile team as well as holding a talk from a Smoking Cessation Officer with the Club Executive. Implementation of the smoke free policy was supported by a PA announcement at all games and the distribution of cards showing the clubs commitment to a smoke free club environment. As well as this, anti-smoking signage has been erected to show that the club ground is a smoke free area. Previously, Hilland et al., (2015) investigated the SmokeFree Sports campaign. This involved n=8 professional sports coaches taking part in a brief intervention training workshop. Coaches reported success in delivering subtle smoke free messages during coaching sessions about the contents of cigarettes and the physical effects of smoking. However, barriers to delivering the smoke free message centred around participation and lack of attendance when attempting to deliver focused smoke free presentations. Brief intervention training can be successful but only when the message is relevant to the target group. A more comprehensive approach to delivering the smoke free message was evident in Phase 2 of the HCP as clubs attempted to follow the HCF. Despite this, more engagement with key partners like coaches, as highlighted in the SmokeFree Sports campaign may provide further success in delivering smoke free environments.

5.2 Integrating Health Promotion into the Core Business of the GAA Club

Adopting health promotion into the existing structures of a sports club is important to achieve sustainability (Casey et al., 2009). The Sports Clubs for Health guidelines also recognise that a sports club is already health promoting by getting people active but in order to develop health promotion further then these activities should be aligned with all aspect of the core business of the club (Koski et al., 2017). Similarly, Geidne et al., (2013)

also recognised the importance of aligning health promoting policy development with the core business of a sports club. It is important then to analyse the daily activities of the GAA club in terms of health promoting activities. Firstly, the GAA have approved that all clubs appoint a Healthy Club Officer; all clubs who engaged with the follow up phase of the project had followed through on this, which is an indicator of the dissemination of this concept throughout the structures of the GAA. In addition, all of the Intervention clubs had established Healthy Club Project Teams; this reduced to half of the control clubs. In terms of governance, an important recommendation from Phase 1 was for a health and wellbeing policy to be generated and adopted by clubs in order to put health promotion on the agenda (Lane et al., 2015). Another recommendation from Phase 1 was for the healthy club project team to have a representative on the executive committee. The majority of clubs in the present study had both a member of the executive on their project team as well as a seat on the executive. As well as this, over half of clubs said health and well-being issues were discussed at the AGM as well as being discussed regularly at board meetings. This suggests clubs had support from the executive level for engaging in this project which would make formalising the process much easier. When the potential barriers to health promotion are examined, this is also apparent, with a lack of interest from the club executive being suggested by very few clubs to be a barrier; 6% at baseline and 10% at follow up. To continue to develop the HCP, volunteers need to be supported by a strong governance structure (Nicholson et al., 2013). The project needs to be viewed as a whole club movement and not just an offshoot undertaken by a few people. Leaders need to engage with the HCP as if it is the core business of the club or else the project may become unsustainable (Amis et al., 2005). Health promotion needs to be recognised as one of the main operating values for a club to be recognised as health promoting setting (Kokko et al., 2011). Engagement of all stakeholders then is key to the sustainability of the HCP. Similarly, in the development of health promoting workplaces, the support of senior management was seen as vital in the success of these agendas (Chu et al., 2013; Jorgensen et al., 2013).

In terms of policy development, Dobbinson et al., (2006) found that in 78% of Australian clubs, the committee usually undertook the task of policy development task with the remainder relying on individual direction. When asked about potential barriers to

developing health promotion policies, 47% of representatives expressed the need for more support and guidance from health agencies and 45% suggested that they could do with the use of sample policies. In a similar investigation, Eime et al., (2006) found that most State Sporting associations (SSAs) in Australia have a policy across the areas of smoke free, alcohol management, injury management, sun protection, and healthy eating but lack capacity at the operational level in clubs. It is important to continue to develop and roll out officer training for those involved to continue to build capacity which the GAA did in Phase 2. Despite the claim that a lack of resources such as money and time were an issue, many clubs indicated that they engaged in monitoring and evaluation during Phase 2. A majority of clubs (67%) indicated that they sometimes or often evaluated their health and wellbeing programme. Another opportunity exists here for the GAA to engage in capacity building. Club officials could be encouraged to continue in evaluating and monitoring and could be better equipped to engage in this work.

5.2.1 Coaching

In the follow up evaluation of Phase 1 of the HCP, one of the lowest scoring areas with respect to the Environment was in relation to health promotion being recognised in a coaching environment beyond sports performance (.58; Lane et al., 2015). In the present study, the recognition of health promotion beyond sports performance rose significantly from .55 to .83. Also of note in the present study were above average scores for selecting accredited, suitable coaches but there remained an allegiance to defining success by winning; these factors did not demonstrate any improvement over time. Areas where most improvement is needed appears to be in engaging with the '*everybody plays'* policy. This appears to be a problem due to the importance that is placed on winning and the importance of the competition. Barriers to implementing the '*everybody plays*' policy increased significantly in Phase 2 clubs over time, possibly indicating a greater attempt to adhere to this policy and thus greater resistance from parents and other clubs.

Sport Scotland in 2014/2015 invested £786,000 in developing coaching practice and highlighted the importance of developing coaches that can create a positive sporting environment for young athletes (Sport Scotland, 2015). In a school setting, Young et al., (2013) found that in schools a strong and sustainable level of change in health promotion

orientation required teachers to take the lead in terms of introducing and demonstrating the new standards required. A similar case can be made for GAA clubs where officials and coaches need to take ownership and embody the change that the club is seeking to make. As previously mentioned intervention clubs made significant progress in many areas of health promotion, including some that referred explicitly to the coaching aspect of the club with an increase in the indication of coaches and officials providing good examples through their own health behaviour, as well as coaches placing an emphasis on health promotion beyond sports performance. Significantly, clubs shifted from a passive orientation in relation to guiding coaches in the area of health promotion, at the outset of the project area to an active one by the end of Phase 2.

In a baseline study of Finnish sports clubs, Kokko (2010) found that clubs were fairly passive in general in guiding coach health promotion activity. Areas that received little club guidance involved health-related information being provided to young athletes (8%), outside experts being used to tell young athletes about health issues (15%), and health issues being discussed with parents (22%). Similarly in Phase 2 of the HCP, areas that were initially poorly recognised in relation to club guidance involved the delivery of health related information to young athletes (12%), discussing health issues with parents (14%) and recruiting outside experts (16%). However, these each improved to 50%, 58% and 58% throughout Phase 2, again reflecting the positive impact on the coaching environment. An area that scored relatively high at baseline was possible substance abuse being intervened in which was 35% at baseline and 67% at follow-up; this was equally popular among Finnish sports clubs. Of note here, is the fact that the Alcohol and Substance Abuse Policy (ASAP) has been well established by the GAA and clubs have been obliged to implement this policy since its development in 2012 (GAA, 2013).

In addition, clubs indicated a high level of engagement with coaching certification. At baseline 71% of clubs said they ensured all coaches were appropriately certified, this improved to 93% at follow up and remained stable at approximately 80% at both time points in control clubs. In relation to engagement with partners, clubs most notably indicated their improvement in engaging with coaches over time, moving from 65% at baseline to 87% at follow up. Clubs also targeted their coaches when delivering some of their initiatives, particularly in the areas of gambling alcohol and drug education, anti-

bullying, and training and personal development. Currently, coaches and officials see their main role as providing sporting opportunities for their athletes and find it difficult to engage in tasks that are not related to this (Kokko et al., 2016). Therefore, the link between health promotion and the main business of sporting activity is one that needs to be emphasised. Sports coaches have previously indicated that they believe health promotion to be an important part of sports club activities but have also noted that they are not given adequate support (Van Hoye et al., 2014).

In the current study, clubs were determined to develop the coaching environment as a health promoting one and showed good progress but at the same time they need more support from a national level to make this a reality. In the evaluation of Phase 1 the importance of coaches and officials was recognised and it was recommended that these actors need to be upskilled in providing health promotion information and education to club members (Lane et al., 2015). Collaboration with the Games Development unit in the GAA was suggested as a possible strategy here but has not to this point been forthcoming. Establishing training and personal development opportunities for coaches and officials would facilitate the adoption of health promoting behaviours among GAA clubs, which is particularly relevant given the 'success' of the coach education system , as reported by clubs. Introducing health promotion as an aspect of the coach education or coach certification process may have some potential to align health promotion with the coaching practice. Duda et al., (2013) reported on a coach education programme as part of the Promoting Adolescent Physical Activity (PAPA) study. Coaches took part in an Empowering Coaching training programme in a bid to create more motivational climates for athletes to participate and receive the health benefits of sport participation. Results of the study showed that a perception of an empowering motivational climate created by coaches was significantly and positively related to autonomous motivation and enjoyment of sport participation by athletes. A feeling of autonomous motivation was significantly and positively associated with enjoyment of sport participation and daily moderate to vigorous physical activity (MVPA). Enjoyment of sport participation had a significant positive relationship with daily MVPA and daily MVPA had a significant negative association with body fat percentage. Overall, similar to Kokko (2010), more health promotion within

coaching practice is required as there were minimal specific health promotion initiatives around the core business of coaching in Phase 2.

5.3 Sustainability; Moving to all GAA Clubs

5.3.1 Generating a Workforce

This evaluation has confirmed how predisposed the GAA club is for health promotion activity, and has provided much learning around how to ensure this activity becomes a part of daily club activity again emphasising the readiness for building social capital. At the outset of the project, clubs indicated a sense of clarity and purpose and that this work belongs in a GAA club. While some clubs were a little overwhelmed, there was a realisation that there were a number of things already in place in clubs and communities and that much of the work of the club unit was to act as a 'window' for this activity to the wider community. It was remarked that the club is not a '*panacea to deal with all of the problems that are out there*', that it is doing its fair share of work already but could work to involve the wider community and be a conduit or national health promotion initiatives. Despite some hesitancy, clubs expressed that they were '*open for business',* and were committed to being *'inclusive'.* Also, clubs appeared extremely pragmatic and measured about their efforts. Clubs noted that they were '*slowly plodding away', 'chipping away',* getting *'other people on board',* recruiting '*doers',* integrating health into the club development plan, identifying needs within their respective communities, and finally innovating around how to position this new type of activity, with new people within a traditional organisation. An example of the latter is dispensing with the notion of a committee and forming a *'workforce for health and wellbeing*'. In fact the GAA were supportive of this, proposing the development of a Healthy Club Project Team.

Casey et al., (2007) mentioned the development of program champions as a factor that helped the successful adoption of their community sport and recreation scheme (VicHealth, 2013). Similarly, the capacity of clubs to deliver the changes in the Healthy Sporting Environments Demonstration Project (HSEDP) depended on a number of issues including volunteers taking ownership and again championing the idea (Nicholson et al., 2013). In the HCP, this was demonstrated by the appointment of a Healthy Club Officer and Project Team. As well as this the management committee need to support the project

and deliver good governance in clubs to implement policies and decisive action. Club capacity benefits if an intervention such as this is seen as a whole club commitment rather than a project for one person or one group to command. Club culture can act as a barrier to change especially if the change is seen as coming from outside the club and a change from the normal activity of the club. It is important that local actors and champions lead and drive changes, as oppose to more distant authorities. A shared effort is needed to improve the HP orientation of sports clubs including board members, coaches, HP experts, sports federations and governments (Meganck et al., 2014).

Other factors have been identified to maximise effectiveness in health promotion. Ware and Meredith (2013) found that programs should be linked to other programs and services to maximise positive outcomes, such as the Men on the Move programme in the HCP. Non-monetary recognition such as a healthy clubs badge, label or flag could be an incentive for clubs to improve their public image and attract new members (Kelly et al., 2014), which again has been developed in Phase 2 with the recognition of Healthy Clubs and the dissemination of associated plaques and flags. Clubs new to the HCP in Phase 2 indicated that they learned a lot from their interaction with Phase 1 clubs, particularly at orientation day and through conversing at provincial forums. This would suggest the value of a peer support or networking system moving forward. Specifically, the message around *'small steps'*, which was an important learning from Phase 1 appeared to have resonated with clubs. As a result clubs remarked that people were '*drifting towards'* healthy club activity, and consequently many new people were now involved in the club. Follow up analysis also showed that the majority (83%) of officials feel the project has led to more people joining the club or becoming involved in club activities. While membership figures overall showed only a slight increase during Phase 2, feedback in FGDs support the idea that the HCP has potential in attracting new members to the club. An evaluation of Phase 1 did find an increase in membership numbers (Lane et al., 2015). Also, Casey et al., (2009) supports the idea that new members that may want to be physically active without the competitive element may be attracted to a sports club through health promoting initiatives. Much of this learning supports the human resource element of integrating health promotion into the sports club. One of the main barriers still expressed by clubs

relates to recruiting people to help in this aspect of club activity, thus this must remain an important consideration going forward.

5.3.2 Utilising the Healthy Club Framework

The National Healthy Club Steering Committee developed a framework around which to deliver settings based health promotion in GAA clubs. This framework was designed to assist clubs in approaching health promotion in a comprehensive and sustainable manner. It was expected that clubs would select from the health priorities set out by the GAA (physical activity, healthy eating, mental fitness, community development, gambling, alcohol and drug education, and training and personal development) while also considering their own community needs and deliver initiatives encompassing all four elements of the framework below. Specifically, clubs were advised to develop a *Plan,* which refers to policies and/or action plans; recruit *Partners* to assist with the delivery of the initiative; identify an *Activity* focused specifically on behaviour change and finally consider a wider impact on the *Club,* physically and culturally.

Overall, long term vision is needed when adopting settings approaches so they are sustainable, despite some perceived need for '*early successes'* (Whitelaw et al., 2001). The Ottawa Charter is oriented around five key principles; building healthy public policy, creating supportive environments, strengthening community actions, developing personal skills and reorienting health services (WHO, 1986). These principles set the foundation for the development of the settings approach to health promotion. Inspired by the Ottawa Charter, Kokko et al., (2006) developed the Health Promoting Sports Club Index. Subsequently, this led to the 22 standards being divided into four categories; Policy, Ideology, Practice and Environment (Kokko et al., 2009). More recently, the latest Sports Clubs for Health Guidelines highlight a framework that clubs can follow to provide health promoting programmes (Koski et al., 2017). Central to this framework is that clubs map the resources that are available to them and ensure a quality sustainable program can be delivered. Elsewhere, the PICSAR programme in Australia highlights a sustainable approach where clubs were encouraged to build capacity and engage with communities through establishing effective partnerships, developing inclusive policies, developing appropriate programs and providing training for staff and volunteers (VicHealth, 2013).In reviewing the initiatives that clubs engaged in during Phase 2, all four elements of the framework were

considered. Initiatives were rated as high impact if they included all four elements, moderate impact if they included three elements, and low impact if they included just two elements of the framework. An evaluation of Phase 1 found that most initiatives were low to moderate impact (Lane et al., 2015). Encouragingly in Phase 2 the majority of initiatives were medium to high impact, with limitations mostly in the plan (policy) and partnership element of the HCP Framework. As previously noted, policy implementation was highest for general health and wellbeing policy and for gambling and drug education. Perhaps this was due to the fact that the GAA had issued template policies for clubs to adopt in these areas. All initiatives involved some type of activity and typically some reported impact on the club environment.

5.3.3 Supporting Partnerships

A recommendation from Phase 1 was to further enhance the engagement of clubs with external partners and stakeholders such as the HSE/PHA from the outset of initiatives (Lane et al., 2015). At baseline in the present study, only 44% (n=24) of clubs recognised that 'partners have always been an important part of the club', while at follow-up this rose to 80% (24). Perhaps clubs developed a sense for the important role that partners already play in their club. Also clubs may have developed a better understanding of who the different partners are in their club and how they have already been engaging with them without explicitly realising it. Formalising partnerships appeared to be less important to clubs during Phase 2. 37% (n=11) of healthy clubs at follow up agreed that there is no need to formalise the partnership process, compared to 20% (n=11) at baseline. Despite this, 60% (n=18) of clubs at follow-up indicated agreement that '*roles, responsibilities and expectations are agreed with partners*'. This was a change from 35% (n=19) at baseline. A previous study of a similar health promoting project in Australia found that successful partnerships commonly involve clear communication, a definite purpose, a good working relationship, and are mutually beneficial (Smith et al., 2011). Lack of resources was the greatest barrier to clubs at the start of Phase 2 and remained so at the end of Phase 2. Where clubs are lacking in resources it is possible that the GAA on a national level and various other partners can fill this gap. Engaging with other appropriate partners could hopefully reduce barriers that clubs appear to face in these areas.

Casey et al., (2007) explored the development of sustainable health promotion programs in sport organisations in Victoria, Australia. In the participation in community sport and recreation (PICSAR) scheme clubs were encouraged to build capacity and engage with priority communities through establishing effective partnerships, developing inclusive policies, developing appropriate programs and providing training for staff and volunteers. Importantly, the PICSAR scheme aligned with the values and aims of the regional sports assemblies such as capacity building, partnership development, and promoting participation in physical activity and was successful in all of these areas. In the current study, partnership was also a little lower than other elements of the HCF. In the area of mental health, a number of club officials commented on their hesitancy in approaching such a sensitive area due to their lack of knowledge and expertise. Not surprisingly, there was a high level of engagement with partners in this area (84%), with the majority of clubs engaging with a mental health agency. Of more importance though was the delivery of a healthy eating and physical activity initiative in partnership with specialist agencies.

Partnership was apparent in the delivery of the healthy eating initiative through the Recipes for Success programme. The Recipes for Success programme itself appeared to have a good initial impact and engaged partners within the community, such as schools and nutritionists. Many clubs expressed their success in introducing fruit and water, particularly to juvenile teams, in one case in partnership with a local supermarket. This is a good example of extending the healthy eating concept beyond the Recipes for Success programme and adhering to the HCF in engaging with a partner and making a change to the club. At the end of Phase 2, 93% of clubs had engaged in a healthy eating activity. 57% of these had implemented a healthy eating policy and 79% had engaged in some sort of partnership. Some of the more frequently engaged partners were supermarkets and schools. Results from the HCQ and FGDs indicate that parents remain a poorly engaged partner among the majority of clubs. Educating and involving parents is an area for development for clubs engaging in Healthy Eating, as they have a major influence on the eating habits of their children.

Feedback from all stakeholders was positive about the partnership involved in delivering the physical activity initiative during Phase 2. LSPs noted how the GAA club provides access to typically hard to reach men. Also, they pointed out that a strong partnership between

the LSP and the GAA club could be extended to other clubs. They also recognised the potential this type of partnership would have for reaching members beyond sports performance and attracting new faces for the club. LSPs also highlighted the importance of the club leading the programme and taking ownership. Club representatives also commented on how rewarding it was to work with the LSP. The GAA club provides a unique setting to engage adults in physical activity and reduce inactivity, particularly amongst non playing members and reengaging with past players and retired members who can benefit from such initiatives. At the end of Phase 2, 97% of clubs indicated they had delivered a physical activity programme. Of these clubs, 48% had implemented a policy and all clubs had engaged with partners. Some of the more frequently engaged partners were schools, qualified fitness instructors, LSPs and Park Run. Men are only one group, but other groups have been successfully engaged during Phase 2 through initiatives that clubs have rolled out such as operation transformation, couch to 5k, weekly walks and Park Runs.

These actions highlight the importance of the healthy club framework and how a programme delivered by an appropriate partner can be integrated into the day to day club activities. Overall, it is encouraging that clubs appear to be moving towards following the framework and delivering high to moderate impact initiatives. In order to encourage this further, clubs need access to more evidence based, specialist run initiatives like those discussed above. Previous evidence has shown that increased organisational capacity by governing bodies in relation to health promotion is not always translated to best practice at club level (Casey et al., 2012). Similarly, Kingsland et al., (2015) found that evidence based practices in relation to health promotion have failed to see implementation in sports clubs. Phase 2 has demonstrated how this can be overcome with the generation of bespoke policies and roll out of health promotion initiatives. The GAA club is an extremely useful conduit for health promotion, acting as a unique connection to communities across Ireland. Moving forward, the GAA club should be considered as a setting through which to deliver initiatives as well as encouraging clubs to engage in their own health promotion activity.

5.4 Limitations

It is important to highlight a number of limitations with this study.

A large number of Healthy clubs failed to respond to the follow up HCQ and coaching environment questionnaire. Some respondents commented on how lengthy the HCQ was. Also, while the HCQ and coaching environment questionnaire were both included in the same PDF file for participants, the online version of the coaching environment Q was sent to participants in a separate link to the HCQ. This may have contributed to a smaller response rate with respect to the coaching environment questionnaire.

Self-report data using qualitative (focus groups and interviews) and quantitative (questionnaires and surveys) methods was used as part of the study. Respondents may have given biased responses in order to depict their club or their experience in a more positive fashion. As well as this, HC Officers were encouraged to complete the HCQ at baseline and follow up. However in some clubs a new HC Officer may have been elected between responses in which case the respondent would not have been the same person which could have led to a variation in responses.

No control clubs responded to the follow up questionnaire regarding the guidance activity that club provided for coaches. Therefore the positive results generated by healthy clubs in this area cannot be attributed to an intervention effect. Recruiting control clubs proved a challenge particularly in terms of responding to follow up questionnaires. Providing control clubs with some incentive could have helped with this.

Clubs self-selected to take part in this study by completing an expression of interest application. Self-selection bias was therefore difficult to avoid and clubs who took part may have already been engaged in health promotion activities. Likewise, control clubs volunteered to take part and some of these included clubs who had unsuccessfully applied to enter Phase 2.

The physical activity initiative posed a challenge in trying to capture health behaviour change in a setting which already promotes physical activity as part of its core business. The three clubs that took part in the evaluation were selected based on the capacity of their local sport partnership to run Men on the Move and their history of running physical

activity programmes. The age restrictions on participants meant that very few if any were engaging in competitive Gaelic games in their respective clubs. This would have alleviated any confounding results that could have potentially accrued.

The evaluation of the controlled impact of the healthy eating programme was hindered through the lack of a standardised questionnaire for intervention and control clubs. Also the clubs that acted as control clubs were doing so as participants in the wider HCP and so were not true control clubs.

Chapter 6 Conclusion

Health promotion is described as the 'process of enabling people to increase control over and to improve their health' (WHO 1986). The Charter states 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 WHO glossary defines the settings 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' (WHO, 1998a). The responsibility of promoting health thus 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. The settings approach to health promotion reflects this, as it is based on understanding, appreciating, and working with the settings where people are educated, work and live, to positively impact health behaviours.

Cities, schools, workplaces, prisons and health care institutions are all examples of where a settings based approach to health promotion has been utilised in the 21st Century. Kokko et al. (2006) advocates 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). Sports clubs are settings in which youth/adolescents and adults can actively participate in sport and/or contribute to participation through their actions e.g. coaching (Kokko et al., 2009). 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. This was formalised somewhat by the development of the GAA Healthy Club Project (HCP). Evaluation of Phase 1 of this project provided support for this initiative in terms of the positive impact on the health orientation and practice of participating clubs, thus confirming the GAA club as a viable setting for health promotion (Lane et al, 2015).

The purpose of this current research was to assess the impact of healthy club initiatives on the health of individuals and communities and to assess the impact of the overall project

on the daily working of the GAA club unit. This study involved a controlled evaluation of the impact of the HCP on the health promotion orientation of clubs in relation to policy, ideology, practice, environment, and the juvenile environment. Focused evaluations were also used to assess the impact of specific Physical Activity, Healthy Eating and Community Development initiatives on clubs and individuals. Also, focus groups and interviews were used to gather feedback from various stakeholders during the study. At the end of Phase 2, all healthy clubs had shown a significant improvement in their health promotion orientation with no similar improvement among control clubs. All sub-indices (policy, ideology, practice, environment and juvenile environment) also saw a significant improvement among healthy clubs. Most notably, healthy clubs moved from low to high orientation in the area of policy and coaching guidance from clubs appeared to improve among healthy clubs. As well as this, initiatives in the areas of physical activity, healthy eating and community development led to encouraging changes among clubs and individuals. The volume of activity throughout the project is vast and reflective of the energy that exists in GAA clubs.

From a process perspective, important developments were made in the establishment of the healthy club officer role and healthy club project teams. Executive support was key to such developments as well as the adoption of policies such as the health and wellbeing policy. The success of Phase II could not have been achieved without the effort and dedication of all the volunteers involved at club, county, and provincial level. Willingness and engagement from partners was also key to the success of Phase 2 with partners such as county health and wellbeing committees, schools and Health Service Executive/Public Health Agency and Local Sports Partnerships being particularly supportive. Packaged initiatives in the areas of physical activity and healthy eating were welcomed by clubs and engaged in enthusiastically. Some challenges were met during Phase 2. Initially clubs and officers had some hesitancy about the scale of the workload while engaging men was an issue for some clubs as was recruiting volunteers and dealing with the added workload. Despite the challenges clubs were enthusiastic about the impact the project has had on their clubs. The vast majority of clubs indicated that the project had led to health becoming more of a priority in the club and had impacted people's attitudes toward

health. All clubs also acknowledged that there will be support for this project if it continues.

To conclude, GAA clubs may not formally recognise it but they already promote health through their activities. The HCP provides structure to this health promotion, with policies, guidance, training, programmes etc. This study provides support for the HCP given the positive impact on health promotion orientation as well as the impact of the initiatives particularly the physical activity initiative involving Men on the Move. Findings from Phase 1 and Phase 2 clearly support the use of the GAA club as a setting to promote health. Phase 3, which will involve an extension to 150 clubs, should focus on continuing to develop the governance structures of the GAA and refining the resources available to clubs e.g. policies and programmes, primarily through the development of further key partnerships to establish packaged initiatives.

Being the largest community-based sporting organisation in Ireland, the GAA presents a huge opportunity to promote health. 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 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. The HCP represents a practical and attractive vehicle with which to fulfil the ambition of the Healthy Ireland campaign. The GAA HCP is proving an excellent forum through which to disseminate health messages and interventions, with further evaluation recommended to measure their lasting impact on participants' health and wellbeing.

The main recommendations for the next phase of the HCP include:

1. **Formal recognition of the GAA Club as a setting for health promotion**
    - The GAA club through the HCP has established itself as a strong setting for health promotion. As such, the GAA club should be formally recognised by the Irish public health sector as a viable setting in which to deliver health promotion information and interventions, with public health promotion officers allocating working time to support clubs formally engaged in the HCP. The public health sector should provide a dedicated liaison person to assist clubs to develop, deliver and evaluate health initiatives with the GAA across priority areas such as healthy eating and emotional wellbeing.

2. **Further development of evidence-based initiatives**
    - The Physical Activity Initiative worked well in terms of the delivery and effectiveness of an existing evidence based PA intervention delivered by a specialist body, the Local Sports Partnership Network. This model is important for the GAA as they strive to extend the HCP to all clubs nationwide. In this instance, clubs have access to an initiative that works and therefore, impacts health behaviour change among communities. Based on the successful implementation by healthy clubs of the HSE's Men on the Move (MOTM) physical activity programme in Phase II, additional evidence-based interventions should be devised to respond to population health needs at community level. Healthy clubs can apply, under criteria, to make these available to their members/communities, and their delivery should be evaluated as part of Phase III. The Healthy Eating Initiative is a good test for the revised Healthy Club Framework; plan, activity, club and partner. The programme, and its related partner, is a good fit for the GAA but more attention is required to build a plan and develop broader club activity in the healthy eating area to make this a solid 'package' for clubs and a process that leads to behaviour change. The Community Development Initiatives are excellent examples of clubs harnessing energy and addressing individual community needs. While these Initiatives may be less prescribed than their PA

and Healthy Eating equivalents, they remain an important opportunity for clubs to self-select work areas as Healthy Clubs that respond to identified needs in their local communities.

3. **Partnerships**
    - The GAA should be utilised by the Irish health sectors and other specialist agencies, including the third level education sector, as a collaborating partner in the conception, development, and implementation of such evidence-based health initiatives.

4. **Further integrate health promotion into the core business of GAA Clubs**
    - Clubs need to be facilitated to further integrate health promotion into the core business of the GAA club. The majority of areas across the Healthy Club Index showed improvements over time apart from factors related to maximising participation at underage. Clubs reported barriers to maintaining an 'everybody plays' policy particularly in relation to parents and the actions of other clubs. The health promotion message is pervading into almost all aspects of the GAA club apart from that which relates to the day to day business of coaching and providing physical activity for all. Further engagement with relevant departments across the GAA such as the coaching and games department is recommended in Phase III.

5. **Planning**
    - Throughout the available training and engagement, clubs must be encouraged and supported to plan strategically, and to embed their health promotion activity in policy change and overall club culture, to ensure greatest effectiveness.

6. **Upscaling**
    - In Phase 3, how to extend the HCP to a greater number of clubs and still monitor engagement as well as provide adequate support will be a challenge.

Appointing provincial coordinators will facilitate engagement at regional level while also supporting the up-scaling of the HCP to a national project. The appointment of Healthy Club Provincial Coordinators will help to harness the GAA structures and facilitate the continued sharing of expertise and energy at regional level. Continuing to facilitate clubs to meet up either nationally, provincially or at a county level is important also. Many officials commented on how valuable it was to meet and correspond with other clubs and discuss experiences, challenges and opportunities.

- In terms of evaluation, the tools used in Phase 2 could provide useful templates but refining these and making the questionnaire shorter would be wise as some respondents commented on the lengthy nature of the HCQ. The poor follow up response rates may have been due to this. Also, providing some incentives for control clubs to take part in any future evaluation would be wise to encourage better engagement. Access to health promotion resources or a raffle for match tickets would suitable incentives.

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Appendix 1

Healthy Club Questionnaire (Baseline)

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

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

Membership Type		**Cost**
Full	☐	
Associate / Social / Leisure	☐	
Juvenile	☐	
Family	☐	

3. Does your club have a strategic plan?

Yes	No
☐	☐

   If yes, what is the time frame of the plan? _____

4. Has your club appointed a Health and Well Being Officer?

Yes	No
☐	☐

5. What position(s) do you hold in the club?
Please tick all that apply

President	Chair	Vice Chair
Secretary	Ass. Secretary	Treasurer
Assistant Treasurer	Registrar	PRO
Coaching Officer	Health & Well Being Officer	Child Protection Officer
Coach	Players Representative	ICT Officer
Other? (Please Specify):		

6. 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.

7. 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'[1] principles					

[1] 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'[2]

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					

[2] 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

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 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					

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

Yes	No
☐	☐

Part 3 – Facilities Audit

9. How many playing pitches do you have at your club's facilities? _____

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

	Facility
☐	Clubhouse / club bar
☐	Community centre
☐	Running / walking track
☐	Floodlights
☐	Dressing rooms No. of dressing rooms: _____
☐	Kitchen Facilities
☐	Public toilets
☐	All weather pitch
☐	Ball wall
☐	Tennis courts
☐	Basketball courts
☐	Access to clean drinking water
☐	Other _____

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

Excellent	Good	Fair	Poor
☐	☐	☐	☐

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

Yes	No
☐	☐

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	

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

Days of availability	
0	
1	
2	
3	
4	
5	
6	
7	

Hours of availability	
All day	
0-4	
5-8	
9-12	
13-16	
17-20	
21-24	

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

Days of availability	
0	
1	
2	
3	
4	
5	
6	
7	

Hours of availability	
All day	
0-4	
5-8	
9-12	
13-16	
17-20	
21-24	

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

- ☐ General Community Use
- ☐ Talks
- ☐ Classes

☐ Other Sports

☐ Other

Please give details:

_____

_____

_____

_____

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

Excellent	Good	Fair	Poor
☐	☐	☐	☐

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

☐ Wheelchair access to ground level

☐ Wheelchair access to upper levels

☐ Suitably designated parking spaces

☐ Consideration with doors & corridors

☐ Toilet access

☐ Spectator areas

☐ Consideration with light switches

☐ Changing areas

☐ Other

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

_____

_____

_____

_____

_____

_____

Part 4 – Programmes Audit

Programmes are defined as an organised event or series of events

18. 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**
Physical Activity				
Healthy Eating				
Mental Fitness				
Gambling, Alcohol and Drug Education				
Training & Personal Development				
Anti-Bullying				
Anti-Smoking				
Community Development (Social Inclusion etc.)				

Part 5 – Partnerships Audit

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

19. 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

20. 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:

_____

_____

_____

_____

21. How important are the following factors when your club is deciding to establish new partnerships? (***1=not at all important, 5=very important***)

	1	**2**	**3**	**4**	**5**
Sponsorship					
Other financial support					
Medical support					
Facilities					
Coaching support					
Administrative support					
Mentoring					
Facility maintenance					
Other:					

Part 6 – Communication

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

	Facebook	**Twitter**	**Newsletters**	**Website**	**Texting Service**	**Local media (newspapers/radio)**
The club uses this medium						

Number of followers/uptake

Number of administrators

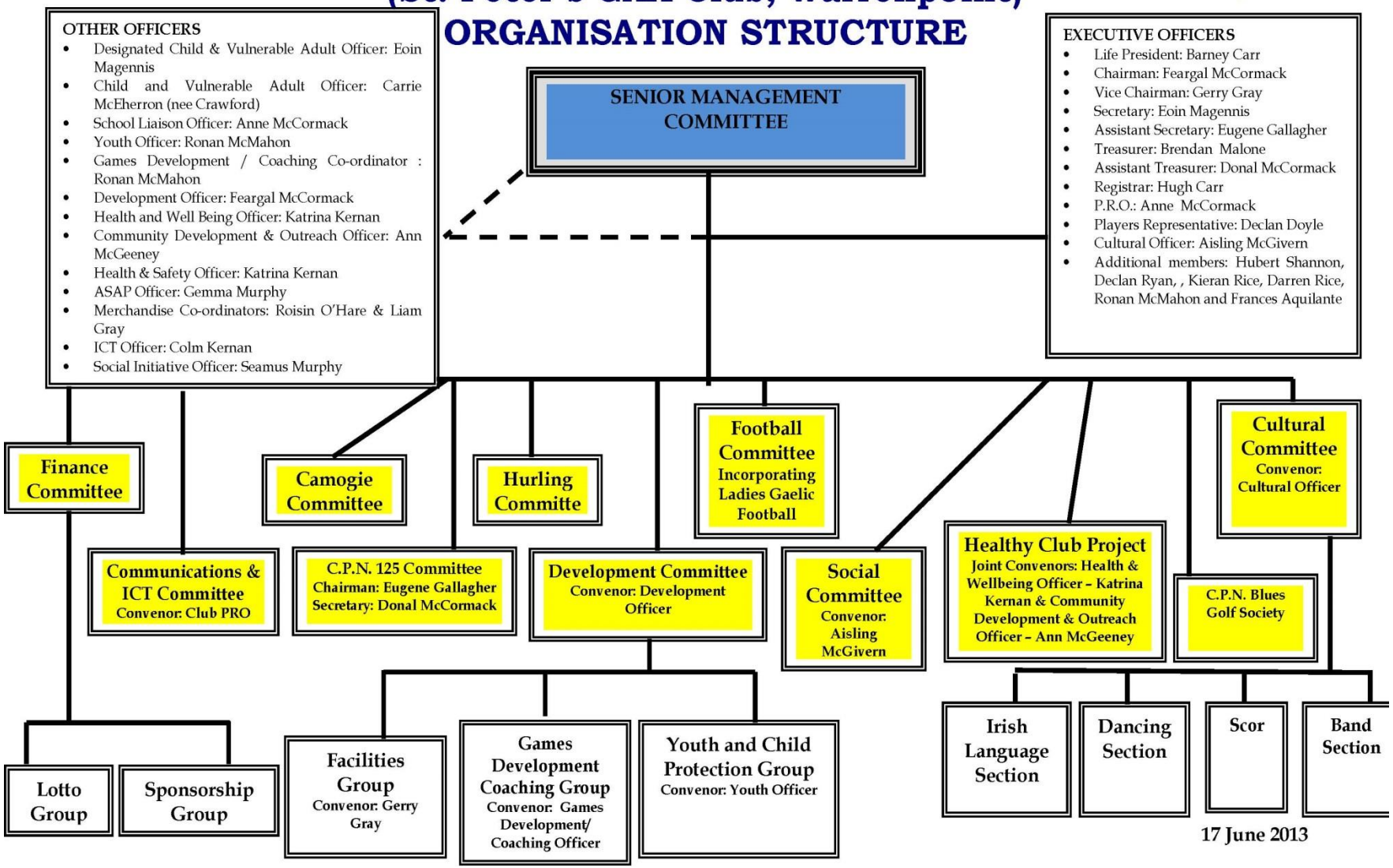
Frequency of updates

Part 7 – Potential Barriers to Health Promotion

23. Please rate your agreement with the following potential barriers to health promotion in your club: (***Please tick one box per question***)
(***1=strongly disagree - 5=strongly agree***)

	1	**2**	**3**	**4**	**5**
Lack of interest among members					
Lack of interest from the executive comittee in the club					
Health promotion is not a priority in our club					
Inadequate support from society (government etc.)					
Inadequate support from the GAA at national level					
Lack of knowledge and expertise					
Lack of money					
Lack of time					

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



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 fore, 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

Follow up HCQ

HEALTHY CLUB INDEX

Club Self Assessment Questionnaire

Ideally this will be completed by your club Health & Well Being Officer with assistance from additional club officers if required

_____

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 indicate what types of membership your club offers, and the number of each.

Membership Type		**Number of members**
Full	☐	
Associate / Social / Leisure	☐	
Juvenile	☐	
Family	☐	
Total Membership		

3. Does your club have a strategic plan?

Yes	No
☐	☐

If yes, what is the time frame of the plan? _____

4. Has your club appointed a Health and Well Being Officer?

Yes	No
☐	☐

5. Has your club established a Health and Well Being Committee/Team?

Yes	No
☐	☐

If yes, how many people are involved? _____

6. Does your Health & Well Being committee/team have the following?

A member of the club executive on the committee/team	
A seat on the club executive	
Both	
None of the above	

7. How often are health and well-being issues discussed in your club?

Discussed regularly at board meetings	
Discussed at the AGM	
Both	
None of the above	

8. 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					

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.

9. To what extent do the following describe your clubs activities.... **Please tick one box per statement** (***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'[3] principles					
The club promotes the 'Respect Initiative'[4]					

[3] 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.

[4] 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

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 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					

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

Yes	No
☐	☐

Part 3 – Facilities Audit

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

Excellent	Good	Fair	Poor
☐	☐	☐	☐

12. Did you add to your club facilities during over the last 24 months? (***Please tick***)

Yes	No

☐ | ☐

If yes, please indicate which facilities you have added:

Clubhouse		Club Bar		Community Centre	
Running/Walking track		Floodlights		Dressing Rooms	
Kitchen Facilities		Public Toilets		Playing pitch/All-weather pitch	
Ball Wall		Gym		Access to clean drinking water	
Other (please specify):					

13. Are your facilities available to the community?

Often	
Sometimes	
Rarely	
Never	

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

Excellent	Good	Fair	Poor
☐	☐	☐	☐

Part 4 – Programmes Audit

Programmes are defined as an organised event or series of events

15. How many health and well being programmes in total did you coordinate/deliver over the last 24 months? _____

16. At this point in time, to what extent do you feel the club has provided information on the following topics:
(***Please tick one box per topic***)

Topic	**Not at all**	**To some extent**	**Moderately**	**Very Much**
Physical Activity				
Healthy Eating				

Mental Fitness				
Gambling, Alcohol and Drug Education				
Training & Personal Development (Coach Education, First Aid etc.)				
Anti-Bullying				
Smoke free				
Community Development (Social Inclusion, Active Age etc.)				

Part 5 – Partnerships Audit

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

17. Please rate your agreement with the following statements: (***Please tick one box per statement***)
(***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					

18. 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:

_____

_____

_____

_____

Part 6 – Potential Barriers to Health Promotion

19. Please rate your agreement with the following potential barriers to health promotion in your club:
(***Please tick one box per statement***)
(***1=strongly disagree - 5=strongly agree***)

	1	2	3	4	5
Lack of interest among members					
Lack of interest/support from the executive comittee in the club					
Health promotion is not a priority in our club					
Inadequate support from society (government etc.)					
Inadequate support from the GAA at national level					
Inadequate support from the county H&W committee					
Lack of knowledge and expertise					
Lack of money					
Lack of time					
Lack of personnel					

Part 7 – Healthy Club Activity

Physical activity

20. Did you deliver any programme(s) in the area of physical activity?

Yes ☐ No ☐

If yes, please complete Qs 21-28

If no, please move on to Q29

21. Number of programmes you delivered in the area of physical activity? _____

Consider your MAIN physical activity programme when answering the following Qs

22. What audience(s) did you target with your main physical activity programme? (tick all that apply)

Club members		Whole community		Senior players	
Juvenile players		Parents		Families	
Children		Men		Women	
Adults		Coaches/Managers		Club officers	

Other (please specify):

23. Have you adopted a policy/guidelines in the area of physical activity?

Yes	No
☐	☐

24. Have you engaged with partners in the area of physical activity?

Yes	No
☐	☐

25. If yes, please indicate the partner(s) you have engaged with in this area:

County H&W committee		Local council		Local Sports Partnership/Sport NI	
HSE/PHA		Doctor		Nurse	
Healthcare organisation		Mental health agency		Nursing home	
Primary school		Secondary school		Other educational institution	
Other sports club		Social club		Disability services	
Local food producer		Local business		Local supermarket	
Emergency services		Park run		Rural link	
Mens shed		Qualified fitness/gym instructor		Get Ireland Walking	
Other (please specify):					

26. What was the nature of your main programme in the area of physical activity?

One off external trip/series of external trips		One off talk/series of talks		One off indoor workshop/series of indoor workshops	
One off outdoor workshop/series ofoutdoor workshops		One off indoor activity session/series of indoor activity sessions		One off outdoor activity session/series of outdoor activity sessions	
Other (please specify):					

27. The clubs work around physical activity has led to the following:

	Strongly agree	Agree	Neither agree nor disagree	Disagree	Strongly disagree
Physical activity has become more of a priority in the club					
Greater awareness and understanding of physical activity across the club					
Greater support for the personal development of all members towards physical activity					
A physical environment that reflects the clubs policy towards physical activity					
Provision of appropriate physical activity signage and information points that are visible throughout the club					

28. Any other comments you would like to make in relation to physical activity?

Healthy eating

29. Did you deliver any programme(s) in the area of healthy eating?

Yes ☐ No ☐

If yes, please complete Qs 30-37

If no, please move to Q38

30. Number of programmes you delivered in the area of healthy eating? _____

Consider your MAIN healthy eating programme when answering the following Qs

31. What audience(s) did you target with your main healthy eating programme? (tick all that apply)

Club members		Whole community		Senior players	
Juvenile players		Parents		Families	
Children		Men		Women	
Adults		Coaches/Managers		Club officers	
Other (please specify):					

32. Have you adopted a policy/guidelines in the area of healthy eating?

Yes ☐ No ☐

33. Have you engaged with partners in the area of healthy eating ?

Yes ☐ No ☐

34. If yes, please indicate the partner(s) you have engaged with in this area:

County H&W committee		Local council		Local Sports Partnership/Sport NI	
HSE/PHA		Doctor		Nurse	
Healthcare organisation		Mental health agency		Nursing home	
Primary school		Secondary school		Other educational institution	
Other sports club		Social club		Disability services	
Local food producer		Local business		Local supermarket	
Emergency services		Park run		Rural link	
Mens shed		Qualified fitness/gym instructor		Get Ireland Walking	
Other (please specify):					

35. What was the nature of your main programme in the area of healthy eating?

One off external trip/series of external trips		One off talk/series of talks		One off indoor workshop/series of indoor workshops	
One off outdoor workshop/series ofoutdoor workshops		One off indoor activity session/series of indoor activity sessions		One off outdoor activity session/series of outdoor activity sessions	

Other (please specify):

36. The clubs work around healthy eating has led to the following:

	Strongly agree	Agree	Neither agree nor disagree	Disagree	Strongly disagree
Healthy eating has become more of a priority in the club					
Greater awareness and understanding of Healthy eating across the club					
Greater support for the personal development of all members towards healthy eating					
A physical environment that reflects the clubs policy towards healthy eating					
Provision of appropriate healthy eating signage and information points that are visible throughout the club					

37. Any other comments you would like to make in relation to healthy eating?

Mental fitness

38. Did you deliver any programme(s) in the area of mental fitness?

Yes	No
☐	☐

If yes, please complete Qs 39-46

If no, please move to Q47

39. Number of programmes you delivered in the area of mental fitness? _____

Consider your MAIN mental fitness programme when answering the following Qs

40. What audience(s) did you target with your main mental fitness programme? (tick all that apply)

Club members		Whole community		Senior players	
Juvenile players		Parents		Families	
Children		Men		Women	
Adults		Coaches/Managers		Club officers	
Other (please specify):					

41. Have you adopted a policy/guidelines in the area of mental fitness?

Yes	No
☐	☐

42. Have you engaged with partners in the area of mental fitness?

Yes	No
☐	☐

43. If yes, please indicate the partner(s) you have engaged with in this area:

County H&W committee		Local council		Local Sports Partnership/Sport NI	
HSE/PHA		Doctor		Nurse	
Healthcare organisation		Mental health agency		Nursing home	
Primary school		Secondary school		Other educational institution	
Other sports club		Social club		Disability services	
Local food producer		Local business		Local supermarket	
Emergency services		Park run		Rural link	
Mens shed		Qualified fitness/gym instructor		Get Ireland Walking	

Other (please specify):

44. What was the nature of your main programme in the area of mental fitness?

One off external trip/series of external trips		One off talk/series of talks		One off indoor workshop/series of indoor workshops	
One off outdoor workshop/series ofoutdoor workshops		One off indoor activity session/series of indoor activity sessions		One off outdoor activity session/series of outdoor activity sessions	
Other (please specify):					

45. The clubs work around mental fitness has led to the following:

	Strongly agree	Agree	Neither agree nor disagree	Disagree	Strongly disagree
Mental fitness has become more of a priority in the club					
Greater awareness and understanding of mental fitness across the club					
Greater support for the personal development of all members towards mental fitness					
A physical environment that reflects the clubs policy towards mental fitness					
Provision of appropriate mental fitness signage and information points that are visible throughout the club					

46. Any other comments you would like to make in relation to mental fitness?

Gambling, alcohol, and drug education

47. Did you deliver any programme(s) in the area of gambling, alcohol, and drug education?

Yes	No
☐	☐

If yes, please complete Qs 48-55

If no, please move to Q56

48. Number of programmes you delivered in the area of gambling, alcohol, and drug education? _____

Consider your MAIN gambling, alcohol, and drug education programme when answering the following Qs

49. What audience(s) did you target with your main gambling, alcohol, and drug education programme? (tick all that apply)

Club members		Whole community		Senior players	
Juvenile players		Parents		Families	
Children		Men		Women	
Adults		Coaches/Managers		Club officers	
Other (please specify):					

50. Have you adopted a policy/guidelines in the area of gambling, alcohol, and drug education?

Yes	No
☐	☐

51. Have you engaged with partners in the area of gambling, alcohol, and drug education?

Yes	No
☐	☐

52. If yes, please indicate the partner(s) you have engaged with in this area:

County H&W committee		Local council		Local Sports Partnership/Sport NI	
HSE/PHA		Doctor		Nurse	
Healthcare organisation		Mental health agency		Nursing home	
Primary school		Secondary school		Other educational institution	
Other sports club		Social club		Disability services	
Local food producer		Local business		Local supermarket	
Emergency services		Park run		Rural link	
Mens shed		Qualified fitness/gym instructor		Get Ireland Walking	
Other (please specify):					

53. What was the nature of your main programme in the area of gambling, alcohol, and drug education?

One off external trip/series of external trips		One off talk/series of talks		One off indoor workshop/series of indoor workshops	
One off outdoor workshop/series ofoutdoor workshops		One off indoor activity session/series of indoor activity sessions		One off outdoor activity session/series of outdoor activity sessions	
Other (please specify):					

54. The clubs work around gambling, alcohol, and drug education has led to the following:

	Strongly agree	Agree	Neither agree nor disagree	Disagree	Strongly disagree
Gambling, alcohol, and drug education has become more of a priority in the club					
Greater awareness and understanding of gambling, alcohol, and drug awareness across the club					
Greater support for the personal development of all members towards gambling, alcohol, and drug awareness					
A physical environment that reflects the clubs policy towards gambling, alcohol, and drug awareness					
Provision of appropriate gambling, alcohol, and drug awareness signage and information points that are visible throughout the club					

55. Any other comments you would like to make in relation to gambling, alcohol, and drug education?

Training & Personal development (Coach education, First Aid etc.)

56. Did you deliver any programme(s) in the area of training and personal development?

Yes ☐ No ☐

If yes, please complete Qs 57-64

If no, please move to Q65

57. Number of programmes you delivered in the area of training and personal development? _____

Consider your MAIN training and personal development programme when answering the following Qs

58. What audience(s) did you target with your main training and personal development programme? (tick all that apply)

Club members		Whole community		Senior players	
Juvenile players		Parents		Families	
Children		Men		Women	
Adults		Coaches/Managers		Club officers	
Other (please specify):					

59. Have you adopted a policy/guidelines in the area of training and personal development?

Yes ☐ No ☐

60. Have you engaged with partners in the area of training and personal development?

Yes No

☐ ☐

61. If yes, please indicate the partner(s) you have engaged with in this area:

County H&W committee		Local council		Local Sports Partnership/Sport NI	
HSE/PHA		Doctor		Nurse	
Healthcare organisation		Mental health agency		Nursing home	
Primary school		Secondary school		Other educational institution	
Other sports club		Social club		Disability services	
Local food producer		Local business		Local supermarket	
Emergency services		Park run		Rural link	
Mens shed		Qualified fitness/gym instructor		Get Ireland Walking	
Other (please specify):					

62. What was the nature of your main programme in the area of training & personal development?

One off external trip/series of external trips		One off talk/series of talks		One off indoor workshop/series of indoor workshops	
One off outdoor workshop/series ofoutdoor workshops		One off indoor activity session/series of indoor activity sessions		One off outdoor activity session/series of outdoor activity sessions	
Other (please specify):					

63. The clubs work around training & personal development has led to the following:

	Strongly agree	Agree	Neither agree nor disagree	Disagree	Strongly disagree
Training & personal development has become more of a priority in the club					
Greater awareness and understanding of training & personal development across the club					

Greater support for the training & personal development of all members					
A physical environment that reflects the clubs policy towards training & personal development					
Provision of appropriate training & personal development signage and information points that are visible throughout the club					

64. Any other comments you would like to make in relation to training & personal development?

Anti-bullying

65. Did you deliver any programme(s) in the area of anti-bullying?

Yes ☐ No ☐

If yes, please complete Qs 66-73

If no, please move to Q74

66. Number of programmes you delivered in the area of anti-bullying? _____

Consider your MAIN anti-bullying programme when answering the following Qs

67. What audience(s) did you target with your main anti-bullying programme? (tick all that apply)

Club members		Whole community		Senior players	
Juvenile players		Parents		Families	
Children		Men		Women	
Adults		Coaches/Managers		Club officers	
Other (please specify):					

68. Have you adopted a policy/guidelines in the area of anti-bullying?

Yes ☐ No ☐

69. Have you engaged with partners in the area of anti-bullying?

Yes	No
☐	☐

70. If yes, please indicate the partner(s) you have engaged with in this area:

County H&W committee		Local council		Local Sports Partnership/Sport NI	
HSE/PHA		Doctor		Nurse	
Healthcare organisation		Mental health agency		Nursing home	
Primary school		Secondary school		Other educational institution	
Other sports club		Social club		Disability services	
Local food producer		Local business		Local supermarket	
Emergency services		Park run		Rural link	
Mens shed		Qualified fitness/gym instructor		Get Ireland Walking	
Other (please specify):					

71. What was the nature of your main programme in the area of anti-bullying?

One off external trip/series of external trips		One off talk/series of talks		One off indoor workshop/series of indoor workshops	
One off outdoor workshop/series ofoutdoor workshops		One off indoor activity session/series of indoor activity sessions		One off outdoor activity session/series of outdoor activity sessions	
Other (please specify):					

72. The clubs work around anti-bullying has led to the following:

	Strongly agree	Agree	Neither agree nor disagree	Disagree	Strongly disagree
Anti-bullying has become more of a priority in the club					

Greater awareness and understanding of anti-bullying across the club					
Greater support for the personal development of all members towards anti-bullying					
A physical environment that reflects the clubs policy towards anti-bullying					
Provision of appropriate anti-bullying signage and information points that are visible throughout the club					

73. Any other comments you would like to make in relation to anti-bullying?

Anti-smoking

74. Did you deliver any programme(s) in the area of anti-smoking?

Yes	No
☐	☐

If yes, please complete Qs 75-82

If no, please move to Q83

75. Number of programmes you delivered in the area of anti-smoking? _____

Consider your MAIN anti-smoking programme when answering the following Qs

76. What audience(s) did you target with your main anti-smoking programme? (tick all that apply)

Club members		Whole community		Senior players	
Juvenile players		Parents		Families	
Children		Men		Women	
Adults		Coaches/Managers		Club officers	

Other (please specify):

77. Have you adopted a policy/guidelines in the area of anti-smoking?

Yes	No
☐	☐

78. Have you engaged with partners in the area of anti-smoking?

Yes	No
☐	☐

79. If yes, please indicate the partner(s) you have engaged with in this area:

County H&W committee		Local council		Local Sports Partnership/Sport NI	
HSE/PHA		Doctor		Nurse	
Healthcare organisation		Mental health agency		Nursing home	
Primary school		Secondary school		Other educational institution	
Other sports club		Social club		Disability services	
Local food producer		Local business		Local supermarket	
Emergency services		Park run		Rural link	
Mens shed		Qualified fitness/gym instructor		Get Ireland Walking	
Other (please specify):					

80. What was the nature of your main programme in the area of anti-smoking?

One off external trip/series of external trips		One off talk/series of talks		One off indoor workshop/series of indoor workshops	
One off outdoor workshop/series ofoutdoor workshops		One off indoor activity session/series of indoor activity sessions		One off outdoor activity session/series of outdoor activity sessions	
Other (please specify):					

81. The clubs work around anti-smoking has led to the following:

	Strongly agree	Agree	Neither agree nor disagree	Disagree	Strongly disagree
Anti-smoking has become more of a priority in the club					
Greater awareness and understanding of anti-smoking across the club					
Greater support for the personal development of all members towards anti-smoking					
A physical environment that reflects the clubs policy towards anti-smoking					
Provision of appropriate anti-smoking signage and information points that are visible throughout the club					

82. Any other comments you would like to make in relation to anti-smoking?

Community development (Social inclusion, Active age etc.)

83. Did you deliver any programme(s) in the area of community development?

Yes ☐ No ☐

If yes, please complete Qs 84-91

If no, please move to Q92

84. Number of programmes you delivered in the area of community development? _____

Consider your MAIN community development programme when answering the following Qs

85. What audience(s) did you target with your main community development programme? (tick all that apply)

Club members		Whole community		Senior players	
Juvenile players		Parents		Families	
Children		Men		Women	
Adults		Coaches/Managers		Club officers	
Other (please specify):					

86. Have you adopted a policy/guidelines in the area of community development?

Yes	No
☐	☐

87. Have you engaged with partners in the area of community development?

Yes	No
☐	☐

88. If yes, please indicate the partner(s) you have engaged with in this area:

County H&W committee		Local council		Local Sports Partnership/Sport NI	
HSE/PHA		Doctor		Nurse	
Healthcare organisation		Mental health agency		Nursing home	
Primary school		Secondary school		Other educational institution	
Other sports club		Social club		Disability services	
Local food producer		Local business		Local supermarket	
Emergency services		Park run		Rural link	
Mens shed		Qualified fitness/gym instructor		Get Ireland Walking	
Other (please specify):					

89. What was the nature of your main programme in the area of community development?

One off external trip/series of external trips		One off talk/series of talks		One off indoor workshop/series of indoor workshops	
One off outdoor workshop/series ofoutdoor		One off indoor activity session/series of indoor activity		One off outdoor activity session/series of outdoor activity sessions	

workshops		sessions			
Other (please specify):					

90. The clubs work around community development has led to the following:

	Strongly agree	Agree	Neither agree nor disagree	Disagree	Strongly disagree
Community development has become more of a priority in the club					
Greater awareness and understanding of community development across the club					
Greater support for the personal development of all members towards community development					
A physical environment that reflects the clubs policy towards community development					
Provision of appropriate community development signage and information points that are visible throughout the club					

91. Any other comments you would like to make in the area of community development?

92. Did you evaluate your programmes over the last 24 months (e.g. using surveys/questionnaires)?

Often	
Sometimes	
Rarely	
Never	

93. What is the current status of your clubs health and wellbeing policy activity? *Please tick*

	Fully implemented	Partially Implemented	Complete but not yet implemented	Nothing in place but plans to develop one	Nothing in place but ran numerous initiatives	No plans to develop anything
Club Health and Wellbeing statement						
Critical Incident Response plan						
Physical Activity guidelines						
Healthy eating guidelines						
Mental Health charter						
Alcohol and Substance Abuse Policy (ASAP)						
Anti-bullying policy						
Smoke free policy						
Gambling guidelines						
Social inclusion policy						
Other (please specify):						

94. Have any of your health and well-being programmes over the last 24 months involved the development of the following environmental supports?

Erecting supportive health promoting signage	
Creating designated no smoking areas of your club	
Going completely smoke free in your club	
Supplying healthy food options	
Developing walking tracks	
Installing bike racks	
Making your club more accessible to those with a disability	
Other – *please give details*	

Finally...

95. Please rate your agreement with the following statements:

Compared to 24 months ago:	Strongly Agree	Agree	Neither disagree or agree	Disagree	Strongly Disagree
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					

Any other comments you would like to make?

We really appreciate your feedback. Thanks for your time

Appendices

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 fore, 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 3

Coaching Environment Questionnaire

Coaching Related Health Promotion

Please circulate this questionnaire to your Club Coaching Officer

Club:_____ **Date:**_____

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.

1. Please outline the number of coaches your club has for the GAA codes you offer.

Category	Level 1 Coaches	Level 2 Coaches	Level 3 Coaches
Men's Football & Hurling (Child 0-11 yrs)			
Men's Football & Hurling (Youth 12-17 yrs)			
Men's Football & Hurling (Adult 18+ yrs)			
Ladies Football			
Camogie			
Handball			

2. To what extent has your club guided coaches to recognise the following matters during non-performance time within club activities? (i.e. other than practice/competition, such as time spent in the locker room, team meetings or excursions etc.)

(***Please tick one box per question***)

(***1=not at all - 5=very much***)

	1	**2**	**3**	**4**	**5**
Weekly physical activity levels are monitored					
Nutritional/Diet issues are recognized during coaching sessions and trips e.g. sports excursions					
Social Interactions are encouraged between the team/group members outside training/games					
Exertion caused by school work is in balance with relation to training i.e. individual's total weekly exertion is in balance					
Coaches understand how their own behaviour affects the health behaviour of the youth					
Possible substance abuse is intervened in					
Education is provided on substance use					
Adolescent's choices are directed e.g. while eating					
Health issues are discussed with parents					
Coaches are encouraged to look out for and recognize any non performance related health issues athletes may have					
Health issues are discussed with the young athletes in connection with training or during sports excursions					
Information and lectures are given on health issues					
Health-related information is distributed to young athletes					
Outside experts are recruited to inform athletes about health issues					

Appendix 4

GAA Healthy Clubs Project Coordinator Interview Topic Guide

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. Introduction
   How do you think the project has influenced clubs health promotion activity during Phase 2?
   Do you think it changed the culture of clubs that have been involved?

2. Executive involvement
   How do you think executives have responded to it? Are they taking it seriously enough do you think?

3. Sustainability
   How achievable do you think a healthy club is for all clubs in Ireland?
   How sustainable do you feel the project is?

4. Reflections on Phase 2
   If you look back to the start of Phase 2, how has it gone relative to your expectations?
   So, what have been the main challenges that you faced in Phase 2?
   What challenges have the clubs faced?

5. Future plans
   What role do you see for the county health and wellbeing officers or provincial health and wellbeing officers going forward?
   What interest has there been in Phase 3 from other clubs?

6. Changes
   What other key learnings have there been going into Phase 3?
   If you were to start again would you do anything differently?

7. Any other comments?

Appendix 5a

Provincial Meeting Focus Group 1 April 2016

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.

1. Introduction
   Briefly introduce everyone

2. Health Promotion in then GAA
   Is health really the GAA's business? What's your own opinion on that and maybe what's the feedback you're getting in your own club on that?

3. Club culture
   Do you find it's a culture change in the club, like to try and communicate the change from maybe a winning mentality to a more wholesome, healthy approach?

4. Resistance
   Is there a resistance, do you find a resistance with any people or any group of people in your club?

5. Orientation Day
   Orientation day in Croke Park a couple of months ago, what was your opinion of that day?
   Was it a very informative day or was there too much info thrown at you?

6. Since Orientation Day
   Since Orientation day, has there been much progress in your club, has progress been slow or fast, how's it been?

7. Further Comments?

Appendix 5b

Provincial Meeting Focus Group 2 June 2016

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.

1. Introduction
   Briefly introduce everyone

2. GAA Healthy Club Launch
   How did your launch go?
   What did you do as part of your launch?

3. Challenges
   Have there been any challenges or barriers to the work you are trying to do?
   From executive, coaches, members etc.

4. Impact
   What impact do you feel the healthy club project is having in your club?
   Community, members, culture

5. Further Comments?

Appendix 5c

Provincial Meeting Focus Group 2 June 2016

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.

1. Introduction
   Briefly introduce everyone

2. Successes and Challenges
   Tell me what has worked well in your club as part of the Healthy Club Project.
   What has not worked so well, or been challenging?

3. Partners
   What partners are you engaging with?
   Would you say you are engaging enough with partners?

4. Policy
   How have you found developing an action plan?
   How have you found trying to develop and implement policies?

5. Core Business
   Do you feel the project is impacting the coaching and games side of the club?

6. Support
   How has the support been at a national level from Croke Park?

7. Further Comments?

Appendix 5d

Provincial Forum Focus Group Information

Location	**Attendees**	**Number of clubs represented**	**Number of Absent clubs**	**Length of FGD**
Provincial Forum 1, April 2016				
Connacht GAA Offices, Ballyhaunis	13	7	1	16:25
Leinster GAA offices, Portlaoise	21	16	4	21:22
Munster GAA offices, Limerick	17	11	2	23:09
Ulster GAA offices, Garvaghy	22	17	2	20:36
Total Forum 1	73	51	9	
Provincial Forum 2, June 2016				
Connacht GAA Offices, Ballyhaunis	11	7	1	18:16
Leinster GAA offices, Portlaoise	16	10	4	56:13
Munster GAA offices, Limerick	14	10	3	36:13
Ulster GAA offices, Garvaghy	18	12	7	53:43
Total Forum 2	59	39	15	
Provincial Forum 3, January 2017				
Connacht GAA Offices, Ballyhaunis	11	6	2	20:36

Leinster GAA offices, Portlaoise	26	17	4	47:00
Munster GAA offices, Limerick	16	13	0	40:25
Ulster GAA offices, Garvaghy	18	14	4	47:34
Total Forum 3	71	50	10	

Appendix 6a

PA Initiative Participant FGD Topic Guide

This focus group is being carried out by the WIT evaluation team on the GAA's Healthy Club project. This is an interview focusing on experiences, attitudes and reflections of your involvement in the project thus far and in particular the development and subsequent implementation of a physical activity program. 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. Are any of you members of the club?
   -Or former members / coaches?
   -Have you friends or family that are club members?
   -First involvement with a GAA club?

2. How did you hear about the program?
   -Social Media, newspaper, word of mouth, medical professional

3. How do you feel the program has benefitted you?
   -How has it benefitted the club?

4. Were you happy with the program content?
   -You got to choose the activities?

5. Does the program being men only make it easier to engage with?
   -What are the advantages of this?

6. Are there any challenges you see to taking part?
   -What would you change about the program?
   -If there was a fee would that make you reconsider participating?

7. Would/Will you participate again?
   -Encourage other to participate?
   -Do you feel this has a place in a GAA club and works well in this setting?

Appendix 6b

PA Initiative Club Executive Interview Topic Guide

This interview is being carried out by the WIT evaluation team on the GAA's Healthy Club project. This is an interview focusing on experiences, attitudes and reflections of your involvement in the project thus far and in particular the development and subsequent implementation of a physical activity program. 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 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 interview at any point.

1. Opening Question
   In your opinion, how can health promotion benefit a GAA club?
   On and off the pitch

2. Support
   Was the executive involved/supportive of the club engaging in the HCP?
   Supportive of the PA / MoM program?
   Is the HCP discussed regularly at committee meetings, on the AGM agenda?
   Do you see it as a way to improve peoples' health or a way to increase revenue and members?

3. Is there a good working relationship between the executive and the H&W committee?
   Does anyone sit on both committees?
   Have exec. Members attended H&W events/PA events?

4. Partners
   Have you noticed the club working with a range of partners due to the engagement in the HCP/MoM program?

5. Policy
   Has your club developed new policies as a result of your engagement in the HCP?
   Healthy eating, PA, smoking etc.

6. Progress
   Has your perception of the HCP changed over time?
   How, Why?
   Have you experienced positive changes in the club due to the HCP?

Is health promotion now seen as a core business of the club?

7. Barriers
   What barriers have you encountered, if any, in supporting your H&W committee?

8. Future
   Do you feel it is sustainable for your club to continue engaging in these programs / the HCP?
   Do you think the HCP / MoM has raised your clubs profile in the community?
   Would you encourage other clubs to engage in the HCP?

Appendix 6c

PA Initiative Healthy Club Officer Interview Topic Guide

This interview is being carried out by the WIT evaluation team on the GAA's Healthy Club project. This is an interview focusing on experiences, attitudes and reflections of your involvement in the project thus far and in particular the development and subsequent implementation of a physical activity program. 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 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 interview at any point.

1. Opening Question
   How many people are on your H&W committee?
   Do you have other roles in the club besides H&W officer?

2. Background
   Was the club involved in promoting physical activity programs previous to the Healthy Clubs project? (apart from promoting core Gaelic games activity)

3. Physical activity promotion
   Can you describe what your club did to promote physical activity/Men on the move?
   Did you advertise these events to the community / club members?

4. Club
   Do you feel the club has benefitted from engaging in the Men on the move program?
   Have players/coaches benefitted?
   Has the wider community benefitted?

5. Policy
   Has your club developed physical activity guidelines?
   How did you go about developing this resource?
   Do you think people are aware of these guidelines in the club?

6. Partnerships
   You partnered with the LSP. Any other partners engaged?
   Did you find it easy/difficult to engage with the appropriate partners?

7. Support
   Did the executive committee buy into the idea of Men on the move in the club?
   Did you receive appropriate support from the Croke Park project team?

Support from county H&W officer?

8. Challenges
   Did you face any challenges in delivering the program?
   Participants, venue, resources

9. Sustainability
   Do you feel this is a sustainable program and something that will benefit the club and community long term?
   Do you plan to engage in the program again?
   Is there anything you would change about it?

Appendix 6d

PA Initiative GAA Community and Health Team Member Interview

This interview is being carried out by the WIT evaluation team on the GAA's Healthy Club project. This is an interview focusing on experiences, attitudes and reflections of your involvement in the project thus far and in particular the development and subsequent implementation of a physical activity program. 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 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 interview at any point.

1. Introduction
   What was your own involvement in the initiative?

2. Communication
   How was the communication between you and the partners involved?
   How was the communication between you and the clubs involved?

3. Impact
   What impact did you feel the initiative had on clubs and participants?
   How did the initiative go relative to your expectations?

4. Challenges or changes
   Did you encounter any challenges?
   What changes would you make?
   Would you do anything differently?
   Any other key learnings?

5. Future
   How sustainable is this initiative?
   Has there been interest from other clubs?

6. Further comments?

Appendix 6e

PA Initiative Participant Questionnaires

Consent Form for Intervention Group

This has to be completed at the FIRST TIME POINT of data collection with each participant.

Participant Name: _____ [PLEASE PRINT]

Contact Details: Mobile _____ [PLEASE PRINT]

Email _____ [PLEASE PRINT]

To be Completed by Research Team:

Code Assigned: County Code; B;26P;52P

Participant Code: _____

IF AN ADMINISTRATOR IS PRESENT – Protocol for Administrator:

1. Read the instructions below to the participant prior to administering the questionnaire. In particular insure that the participant gives their consent to participating in this phase of the study.
2. When necessary, use block capitals when documenting evidence, otherwise clearly mark the answer given.
3. Ensure that the participant can see the questions at all times and that he can clearly see how you are responding on his behalf.

Informed Consent:

1. We would appreciate it if you could take the time to participate in this study as part of the Men on the Move programme. Participating in this study involves having your height, weight, waist circumference and time to complete one mile recorded as well as completing a questionnaire at the beginning of the programme, at the end of the programme and again next February and next August. You will also be invited to participate in a focus group with other men who participated in the Men on the Move programme or a one-to-one interview.

2. All information will be held in the strictest of confidence. All data will be stored securely and only the primary researchers will have access to the data. THE INFORMATION COLLECTED HERE WILL BE SEALED IN ENVELOPES THIS EVENING AND SENT VIA REGISTERED MAIL TO RESEARCHERS AT WIT. NO SERVICE PROVIDER HERE THIS EVENING WILL GO THROUGH THE INFORMATION IN

DETAIL; THEY WILL SIMPLY CHECK THAT ALL OF THE INFORMATION IS RECORDED. The findings from this study may be disseminated via a variety of media; however, at no point will personal details be included in any report or paper published. Data will be stored for 5 years post publishing and will be destroyed thereafter (in accordance with WITs Data Protection Policy).

3. While there are no physical risks from participating in this project, you will be asked some personal questions. However, as stated above, all data will be documented with the utmost respect and sensitivity and will be held in the strictest of confidence and stored anonymously.

4. You are free to refrain from answering any question you choose to and/or to withdraw from this study at any time without consequence.

5. **If you consent to participate in this research study please tick the box** ☐

6. Consent Form for Comparison Group

This has to be completed at the FIRST TIME POINT of data collection with each participant.

Participant Name: _____ [PLEASE PRINT]

Contact Details: Mobile _____ [PLEASE PRINT]

Email _____ [PLEASE PRINT]

To be Completed by Research Team:

Code Assigned: County Code; B;26P;52P

Participant Code: _____

IF AN ADMINISTRATOR IS PRESENT – Protocol for Administrator:

1. Read the instructions below to the participant prior to administering the questionnaire. In particular insure that the participant gives their consent to participating in this phase of the study.
2. When necessary, use block capitals when documenting evidence, otherwise clearly mark the answer given.
3. Ensure that the participant can see the questions at all times and that he can clearly see how you are responding on his behalf.

Informed Consent:

1. We would appreciate it if you could take the time to participate in this study as part of the Men on the Move programme. Participating in this study involves having your height, weight, waist circumference and time to complete one mile recorded as well as completing a questionnaire in Sept and December 2015 and again in February and August 2016. We will also contact you 1 week and 12 weeks after your health check in September to ask you about your experience of the health check.

2. All information will be held in the strictest of confidence. All data will be stored securely and only the primary researchers will have access to the data. THE INFORMATION COLLECTED HERE WILL BE SEALED IN ENVELOPES THIS EVENING AND SENT VIA REGISTERED MAIL TO RESEARCHERS AT WIT. NO SERVICE PROVIDER HERE THIS EVENING WILL GO THROUGH THE INFORMATION IN DETAIL; THEY WILL SIMPLY CHECK THAT ALL OF THE INFORMATION IS RECORDED. The findings from this study may be disseminated via a variety of media; however, at no point will personal details be included in any report or paper published. Data

will be stored for 5 years post publishing and will be destroyed thereafter (in accordance with WITs Data Protection Policy).

3. While there are no physical risks from participating in this project, you will be asked some personal questions. However, as stated above, all data will be documented with the utmost respect and sensitivity and will be held in the strictest of confidence and stored anonymously.

4. You are free to refrain from answering any question you choose to and/or to withdraw from this study at any time without consequence.

5. **If you consent to participate in this research study please tick the box** ☐

7. Baseline Questionnaire

A. RECORDED MEASUREMENTS

Height (m) _____

Weight (kg) _____

Waist Circumference (cm) _____

Body Mass Index _____

Time to complete 1 mile _____ **mins** _____ **secs**

[NOT AVAILABLE AT REGISTRATION EVENING FOR INTERVENTION GROUP]

NB: This data is to be replicated in the participant's wallet card.

<u>For Comparison Group only:</u>

Blood Pressure (mmHg) _____

Cholesterol (mM) _____

Have you been referred to your GP? Yes □ No □

How would you like to be contacted by the WIT researcher? Phone □ Email □

B. ABOUT YOURSELF

1. Please state your date of birth _____[day/month/year]

2. Which of the following best describes your ethnic background?

(Please tick **one** box only)

White (Irish, Irish Traveller, Any other white background) □

Black or Black Irish (African or Any other black background) □

Asian or Asian Irish (Chinese or Any other Asian background) □

Other (including mixed background) □

If 'other', please specify _____

3. Which of the following best describes your level of education?
Please tick **one** box only)

Primary education only □
Some or completed secondary education □
Some or completed third level education □

4. Which of the following best describes you? (Please tick **one** box only)

Married / cohabiting □ Widowed □ In a relationship □
Separated /divorced □ Single □

5. Which of the following best describes you? (Please tick **one** box only)

I live alone □ I live with family/wife/partner □ I live with friends □

6. Which of the following best describes you? (Please tick **one** box only)

Employed (full time)	□	Employed (part time)	□
Self-employed	□	Unemployed and looking for work	□
Looking after home/family	□	Retired from paid work	□
Student	□	Volunteer	□
Unable to work due to long term illness/disability	□		

7. If you are in paid employment, please tell us whether in the last 12 WEEKS you have had:

Time off work Yes □ No □ If yes, how many days?

(not including holidays)

_____

8. Which of the following best describes how you found out about this project?
(Please tick **one** box only)

Word of Mouth	□	Newspaper/Media/Social Media	□		
Referred	□	Sports Partnership	□	Local service/club	□
Family	□	Health Professional	□	Other	□

If 'other', please specify _____

C. ABOUT YOUR HEALTH

9. I would say my health is: (Please tick **one** box only)

Excellent	□	Very good	□	Good	□
Average	□	Poor	□		

D. ABOUT YOUR PHYSICAL ACTIVITY

10. **In the past week, on how many days have you done a total of 30 minutes or more of physical activity, which was enough to raise your breathing rate? This may include sport, exercise and brisk walking or cycling for recreation or to get to or from places, but should not include household work or physical activity that may be part of your job.**

(Please tick **one** box only)

Never	**1 Day**	**2 Days**	**3 Days**	**4 Days**	**5 Days**	**6 Days**	**7 Days**
□	□	□	□	□	□	□	□

E. ABOUT YOUR LIFESTYLE

11. **How many portions of fruit and/or vegetables (including pulses, salad, vegetables, fruit juices and fresh, dried and canned fruit) did you eat yesterday?** (Please tick **one** box only)

None	**1**	**2**	**3**	**4**	**5**	**6**	**7+**
□	□	□	□	□	□	□	□

12. **Do you currently smoke cigarettes, cigars, a pipe or use chewing tobacco?**

(Please tick **one** box only)

Never Smoked □

Former Smoker □

Current Smoker □

13. **If you are a current smoker, how many per day on average do you 'smoke'?** _____

14. **Do you drink alcohol?** Yes □ No □

15. **If yes, how much alcohol do you consume on an average drinking occasion?**

(Put the number in each of the spaces provided)

Pints of larger, or beer or stout _____

Small glasses of wine (about 175 mls) _____

Large glasses of wine (about 250 mls) _____

Shots of spirits _____

16. In an average week, how many days do you do you drink alcohol? _____

F. ABOUT YOUR WELL-BEING

17. Below are some statements about feelings and thoughts. Please tick the box that best describes your experience of each over the last 2 WEEKS.

Statements	None of the time	Rarely	Some of the time	Often	All of the time
I've been feeling optimistic about the future	1	2	3	4	5
I've been feeling useful	1	2	3	4	5
I've been feeling relaxed	1	2	3	4	5

I've been feeling interested in other people	1	2	3	4	5
I've had energy to spare	1	2	3	4	5
I've been dealing with problems well	1	2	3	4	5
I've been thinking clearly	1	2	3	4	5
I've been feeling good about myself	1	2	3	4	5
I've been feeling close to other people	1	2	3	4	5
I've been feeling confident	1	2	3	4	5
I've been able to make up my own mind about things	1	2	3	4	5
I've been feeling loved	1	2	3	4	5
I've been interested in new things	1	2	3	4	5
I've been feeling cheerful	1	2	3	4	5

G. ABOUT YOUR SOCIAL WELL-BEING

18. The following questions asks about your social support. Please read the following questions and tick one box only that most closely describes your <u>current</u> situation.

	None	1 or 2	3 to 5	6 to 9	10 or more	Unknown
How many *close friends* do you have, people that you feel at ease with, can talk to about private matters?						

How many *relatives* do you have, people that you feel at ease with, can talk to about private matters?

19. Do you participate in any groups, such as an active retirement group, social or work group, religious-connected group, self-help group, or charity, public service, or community group? (Please tick one box only)

Yes □ No □ Unknown □

20. About how often do you go to religious meetings or services?

Never or almost never □ Once or twice a month □ Unknown □

Once or twice a year □ Once a week □

Every few months □ More than once a week □

THANK YOU FOR YOUR TIME

8. Physical Activity Readiness - Questionnaire [PAR-Q]

The Physical Activity Readiness – Questionnaire [PAR-Q] is a sensible first step to take if you are planning to increase the amount of physical activity in your life.

For most people, phsical activity should not pose any problem or hazard. PAR-Q has been designed to identify the small number of adults for whom physical activity might be inappropriate or for those who seek advice concerning the type of activity most suitable for them.

Common sense is your best guide to answering these few questions. **Please read them carefully and check the YES or NO opposite the question if it applies to you.**

	YES	NO
1. Has your doctor ever said that you have a heart condition and recommended only medically approved physical activity?	□	□
2. Do you have chest pain brought on by physical activity?	□	□
3. Have you developed chest pain at rest in the past month?	□	□
4. Do you lose consciousness or lose balance as a result of dizziness?	□	□
5. Do you have a bone or joint problem that could be aggravated by the proposed physical activity?	□	□
6. Is your doctor currently prescribing medication for your blood pressure or heart condition (diuretics of water pills)?	□	□
7. Are you aware, through your own experience or a doctor's advice, of any other reason against your exercising without medical approval?	□	□

If you answer yes to one or more of the above questions your should consult your doctor before undertaking physical activity. It is your responsibility to do so.

Participation in physical activity as part of the Men on the Move Programme is done entirely at your own risk.

	YES	**NO**
I have read, understood and completed this questionnaire	□	□

Name: _____ **Date:** _____/_____/_____

9. Time to Complete 1 mile: Intervention Group at Week 1

Participant Name: _____ [PLEASE PRINT]

Contact Details: Mobile _____ [PLEASE PRINT]

Email _____ [PLEASE PRINT]

To be Completed by Research Team:

Code Assigned: County Code; B;26P;52P

Participant Code: _____

A. RECORDED MEASUREMENTS

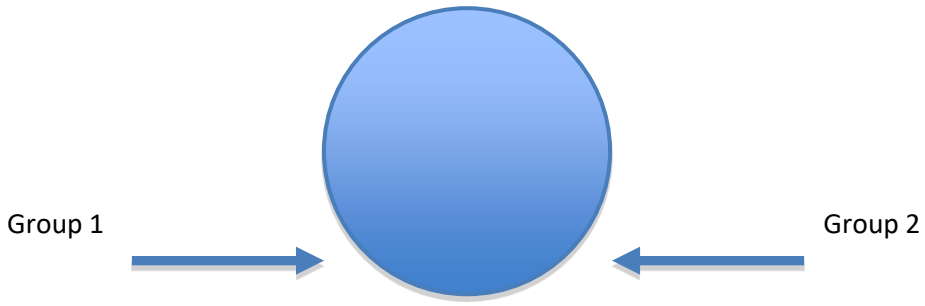
Time to complete 1 mile _____ **mins** _____ **secs**

NB: This data is to be replicated in the participant's wallet card.

All forms are to be checked for completion and placed into the addressed envelopes provided and sealed before leaving. All envelopes to be sent by registered post to WIT the next day [please!].

10. 'Time to Complete 1-mile' Protocol

- Each group will move outside to do the fitness test together and it may be necessary to do two groups at the same time. If this is the case, give them two different starting points e.g.



- Stagger the start time of each man in the group by 10 seconds. This will reduce/eliminate the 'group effect' i.e. men within the group walking at someone else's pace rather than their own.
- Record the participants' name in the table below and calculate the time it takes them to complete 1 mile by accounting for their start time [see Table].
- Before the men begin the test, give the following input:
  - Clearly state that the objective should be for them to finish i.e. to complete the distance and in the quickest time that they can do it in. However, the primary objective should be that they complete the mile and let the time be secondary.
  - It's better for them if they can keep moving as opposed to having to stop for a break.
  - Therefore, don't start out too fast and be forced to stop. Move at a pace that is right for them – one that they can sustain for the 1 mile and will ensure that they complete the distance.
  - So this isn't a race against anyone else, or the clock.
  - Acknowledge that it may have been a while since some of them completed 1 mile – so this is all about them achieving that simple objective of finishing this distance.

Group Colour

Name	Start Time	Finish Time	Finish time – Start time	Time to Complete 1 mile
	0		**Finish time – 0 secs**	
	+10 secs		**Finish time – 10 secs**	
	+20 secs		**Finish time – 20 secs**	
	+30 secs		**Finish time – 30 secs**	
	+40 secs		**Finish time – 40 secs**	
	+50 secs		**Finish time – 50 secs**	
	+60 secs		**Finish time – 60 secs**	
	+70 secs		**Finish time – 70 secs**	
	+80 secs		**Finish time – 80 secs**	

Note: Include this sheet with the questionnaires so that the research team can double check and secure this information along with the rest at WIT.

11. Questionnaire at Weeks 12, 26 and 52

Participant Name: _____ [PLEASE PRINT]

Contact Details: Mobile _____ [PLEASE PRINT]

Email _____ [PLEASE PRINT]

To be Completed by Research Team:

Code Assigned: County Code; B;26P;52P

Participant Code: _____

IF AN ADMINISTRATOR IS PRESENT – Protocol for Administrator:

1. When necessary, use block capitals when documenting evidence, otherwise clearly mark the answer given.
2. Ensure that the participant can see the questions at all times and that he can clearly see how you are responding on his behalf.

A. RECORDED MEASUREMENTS

Height (m) _____

Weight (kg) _____

Waist Circumference (cm) _____

Body Mass Index _____

Time to complete 1 mile _____ **mins** _____ **secs**

Nb: This data is to be replicated in the participant's wallet card.

C. ABOUT YOUR HEALTH

1. I would say my health is: (Please tick **one** box only)

Excellent	□	Very good	□	Good	□
Average	□	Poor	□		

D. ABOUT YOUR PHYSICAL ACTIVITY

2. In the past week, on how many days have you done a total of 30 minutes or more of physical activity, which was enough to raise your breathing rate? This may include sport, exercise and brisk walking or cycling for recreation or to get to or from places, but should not include household work or physical activity that may be part of your job.

(Please tick **one** box only)

Never	**1 Day**	**2 Days**	**3 Days**	**4 Days**	**5 Days**	**6 Days**	**7 Days**
□	□	□	□	□	□	□	□

E. ABOUT YOUR LIFESTYLE

3. How many portions of fruit and/or vegetables (including pulses, salad, vegetables, fruit juices and fresh, dried and canned fruit) did you eat yesterday? (Please tick **one** box only)

None	**1**	**2**	**3**	**4**	**5**	**6**	**7+**
□	□	□	□	□	□	□	□

4. Do you currently smoke cigarettes, cigars, a pipe or use chewing tobacco?

(Please tick **one** box only)

Never Smoked	□
Former Smoker	□
Current Smoker	□

5. If you are a current smoker, how many per day on average do you 'smoke'? _____

6. Do you drink alcohol? Yes □ No □

7. If yes, how much alcohol do you consume on an average drinking occasion?

(Put the number in each of the spaces provided)

Pints of larger, or beer or stout _____

Small glasses of wine (about 175 mls) _____

Large glasses of wine (about 250 mls) _____

Shots of spirits _____

8. In an average week, how many days do you do you drink alcohol? _____

F. ABOUT YOUR WELL-BEING

9. Below are some statements about feelings and thoughts. Please tick the box that best describes your experience of each over the last 2 WEEKS.

Statements	None of the time	Rarely	Some of the time	Often	All of the time
I've been feeling optimistic about the future	1	2	3	4	5
I've been feeling useful	1	2	3	4	5
I've been feeling relaxed	1	2	3	4	5
I've been feeling interested in other people	1	2	3	4	5
I've had energy to spare	1	2	3	4	5
I've been dealing with problems well	1	2	3	4	5

I've been thinking clearly	1	2	3	4	5
I've been feeling good about myself	1	2	3	4	5
I've been feeling close to other people	1	2	3	4	5
I've been feeling confident	1	2	3	4	5
I've been able to make up my own mind about things	1	2	3	4	5
I've been feeling loved	1	2	3	4	5
I've been interested in new things	1	2	3	4	5
I've been feeling cheerful	1	2	3	4	5

G. ABOUT YOUR SOCIAL WELL-BEING

10. The following questions asks about your social support. Please read the following questions and tick one box only that most closely describes your <u>current</u> situation.

	None	1 or 2	3 to 5	6 to 9	10 or more	Unknown
How many *close friends* do you have, people that you feel at ease with, can talk to about private matters?						
How many *relatives* do you have, people that you feel at ease with, can talk to about private matters?						

11. Do you participate in any groups, such as an active retirement group, social or work group, religious-connected group, self-help group, or charity, public service, or community group? (Please tick one box only)

Yes □ No □ Unknown □

12. About how often do you go to religious meetings or services?

Never or almost never	□	Once or twice a month	□	Unknown □
Once or twice a year	□	Once a week	□	
Every few months	□	More than once a week	□	

THANK YOU FOR YOUR TIME

Appendix 7a

Healthy Eating Initiative Participant Focus Group Topic Guide

This focus group is being carried out by the WIT evaluation team on the GAA's Healthy Club project. This is an interview focusing on experiences, attitudes and reflections of your involvement in the project thus far and in particular the development and subsequent implementation of a healthy eating program. 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. Are you all members of the club?
   -Have you friends or family that are club members?

2. How did you hear about the program?
   -Social Media, newspaper, word of mouth, coach

3. How do you feel the program has benefitted you?
   -How has it benefitted the club?

4. Were you happy with the program content?

5. Are there any challenges you see to taking part?
   -What would you change about the program?

6. Would/Will you participate again?
   -Encourage other to participate?
   -Do you feel this has a place in a GAA club and works well in this setting?

Appendix 7b

Healthy Eating Initiative Club Executive Interview Topic Guide

This interview is being carried out by the WIT evaluation team on the GAA's Healthy Club project. This is an interview focusing on experiences, attitudes and reflections of your involvement in the project thus far and in particular the development and subsequent implementation of a healthy eating program. 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 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 interview at any point.

1. Opening Question
   In your opinion, how can health promotion benefit a GAA club?
   On and off the pitch

2. Support
   Was the executive involved/supportive of the club engaging in the HCP?
   Supportive of the healthy eating initiative?
   Is the HCP discussed regularly at committee meetings, on the AGM agenda?
   Do you see it as a way to improve peoples' health or a way to increase revenue and members?

3. Is there a good working relationship between the executive and the H&W committee?
   Does anyone sit on both committees?
   Have exec. Members attended H&W events/healthy eating events?

4. Partners
   Have you noticed the club working with a range of partners due to the engagement in the HCP/healthy eating initiative?

5. Policy
   Has your club developed new policies as a result of your engagement in the HCP?
   Healthy eating, PA, smoking etc.

6. Progress
   Has your perception of the HCP changed over time?
   How, Why?
   Have you experienced positive changes in the club due to the HCP?
   Is health promotion now seen as a core business of the club?

7. Barriers
   What barriers have you encountered, if any, in supporting your H&W committee?

8. Future
   Do you feel it is sustainable for your club to continue engaging in these programs / the HCP?
   Do you think the HCP / healthy eating initiative has raised your clubs profile in the community?
   Would you encourage other clubs to engage in the HCP?

Appendix 7c

Healthy Eating Initiative Healthy Club Officer Interview Topic Guide

This interview is being carried out by the WIT evaluation team on the GAA's Healthy Club project. This is an interview focusing on experiences, attitudes and reflections of your involvement in the project thus far and in particular the development and subsequent implementation of a healthy eating program. 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 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 interview at any point.

1. Opening Question
   How many people are on your H&W committee?
   Do you have other roles in the club besides H&W officer?

2. Background
   Was the club involved in promoting healthy eating initiatives previous to the Healthy Clubs project? (apart from promoting core Gaelic games activity)

3. Healthy eating promotion
   Can you describe what your club did to promote healthy eating/Recipes for Success?
   Did you advertise these events to the community / club members?

4. Club
   Do you feel the club has benefitted from engaging in the Recipes for Success programme?
   Have players/coaches benefitted?
   Has the wider community benefitted?

5. Policy
   Has your club developed healthy eating guidelines?
   How did you go about developing this resource?
   Do you think people are aware of these guidelines in the club?

6. Partnerships

You partnered with the local school. Any other partners engaged?
Did you find it easy/difficult to engage with the appropriate partners?

7. Support
   Did the executive committee buy into the idea of healthy eating in the club?
   Did you receive appropriate support from the Croke Park project team?
   Support from county H&W officer?

8. Challenges
   Did you face any challenges in delivering the program?
   Participants, venue, resources

9. Sustainability
   Do you feel this is a sustainable program and something that will benefit the club and community long term?
   Do you plan to engage in the program again?
   Is there anything you would change about it?

Appendix 7d

Healthy Eating Initiative GAA Community and Health Department Member Interview Topic Guide

This interview is being carried out by the WIT evaluation team on the GAA's Healthy Club project. This is an interview focusing on experiences, attitudes and reflections of your involvement in the project thus far and in particular the development and subsequent implementation of a healthy eating program. 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 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 interview at any point.

1. Introduction
   What was your own involvement in the initiative?

2. Communication
   How was the communication between you and the partners involved?
   How was the communication between you and the clubs involved?

3. Impact
   What impact did you feel the initiative had on clubs and participants?
   How did the initiative go relative to your expectations?

4. Challenges or changes
   Did you encounter any challenges?
   What changes would you make?
   Would you do anything differently?
   Any other key learnings?

5. Future
   How sustainable is this initiative?
   Has there been interest from other clubs?

6. Further comments?

St. Angela's College, Sligo
Coláiste San Aingeal, Sligeach
A College of NUI Galway

Appendix 7e

Healthy Eating Initiative Participant Questionnaire

Recipes for Success Questionnaire

GAA Club: _____

Date: _____

Male ☐ **Female** ☐

Age _____

At what level do you play? County ☐ Club ☐ Both ☐

What team/grade you belong to: e.g. Senior/U21/Minor _____

Did you study Home Economics at school? Yes ☐ No ☐
If yes, to what level? (Tick all that apply) Junior Cert ☐ TY ☐ Leaving Cert ☐

Q1: Are you responsible for preparing your own:

Breakfast	Always ☐	Sometimes ☐	Never ☐
Lunch	Always ☐	Sometimes ☐	Never ☐
Dinner	Always ☐	Sometimes ☐	Never ☐
Snacks	Always ☐	Sometimes ☐	Never ☐

If not then, who is? _____

Q2: Where did you learn your cooking skills from? (Please tick as many as relevant)

Mother ☐ Father ☐ Cookery Websites ☐
Secondary School (Home Ec. class) ☐ Primary School ☐ Cookery books ☐
Cookery Programmes (e.g. television) ☐ Self -taught ☐ Family ☐
Cookery lessons other than in school ☐ Friends ☐
Trial and error ☐

Other (Please specify): _____

Q3: How do you feel about....?

How confident do you feel about being able to cook from basic ingredients ?

Extremely Confident	1	2	3	4	5	6	7 Not at all Confident

How confident do you feel about following a simple recipe ?

Extremely Confident	1	2	3	4	5	6	7 Not at all Confident

How adequate do you feel your diet is at meeting your needs as a GAA player?

Extremely adequate	1	2	3	4	5	6	7 Not at all adequate

How would you describe your interest in nutrition?

Extremely interested	1	2	3	4	5	6	7 Not at all interested

How would you rate your own knowledge of nutrition?

Extremely strong	1	2	3	4	5	6	7 Not at all strong

Appendix 8a

Community Development Initiative Participant Focus Group Topic Guide

This focus group is being carried out by the WIT evaluation team on the GAA's Healthy Club project. This is an interview focusing on experiences, attitudes and reflections of your involvement in the project thus far and in particular the development and subsequent implementation of a healthy eating program. 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 Q
   Can you describe what the program involves?
   Can you describe your role in the program?
   Are you members of the club, past members?
   How did the club become involved in this?
   Have the club been involved in anything like this before?

2. Partnership
   Are you working with any partners due to this initiative?
   How have the partnerships worked during this program?
   What are the lines of communication like between partners?
   Mutually beneficial partnerships?

3. Policy
   Have the club developed a policy in relation to community development?
   Plan to develop one?

4. Impact
   How has the program impacted the club?
   How has the program impacted the community?

5. Challenges
   Have you encountered any challenges in running the program?
   How did you address these?

6. Expectations

If you look back to the start of the program, how has it gone relative to your expectations of it?
How satisfied are you with how it has gone?

7. Future

   How sustainable is this program?
   Is there a cost involved?
   What are the plans for the future?
   Is there anything you would do differently?
   What advice would you give to other clubs embarking on a similar project?

Appendix 8b

Community Development Initiative Healthy Club Officer Interview Topic Guide

This interview is being carried out by the WIT evaluation team on the GAA's Healthy Club project. This is an interview focusing on experiences, attitudes and reflections of your involvement in the project thus far and in particular the development and subsequent implementation of a community development program. 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 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 interview at any point.

1. Opening Question
   How many people are on your H&W committee?
   Do you have other roles in the club besides H&W officer?

2. Background
   Was the club involved in promoting community development initiatives previous to the Healthy Clubs project? (apart from promoting core Gaelic games activity)

3. Community development promotion
   Can you describe what your club did to promote community development?
   Did you advertise these events to the community / club members?

4. Club
   Do you feel the club has benefitted from engaging in the community development programme?
   Have players/coaches benefitted?
   Has the wider community benefitted?

5. Policy
   Has your club developed a community development policy?
   How did you go about developing this resource?
   Do you think people are aware of these guidelines in the club?

6. Partnerships

What partners have been engaged?
Did you find it easy/difficult to engage with the appropriate partners?

7. Support
   Did the executive committee buy into the idea of community development in the club?
   Did you receive appropriate support from the Croke Park project team?
   Support from county H&W officer?

8. Challenges
   Did you face any challenges in delivering the initiative?
   Participants, venue, resources

9. Sustainability
   Do you feel this is a sustainable initiative and something that will benefit the club and community long term?
   Do you plan to engage in the initiative again?
   Is there anything you would change about it?

Appendix 9a

Key Partner Interview Topic Guide Local Sports Partnership

This interview is being carried out by the WIT evaluation team on the GAA's Healthy Club project. This is an interview focusing on experiences, attitudes and reflections of your involvement in the project thus far and in particular the development and subsequent implementation of a physical activity program. 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 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 interview at any point.

1. Introduction
   How did you become involved with the MoM program in the GAA club?
   What was your role throughout the program?

2. Program Impact
   Are you happy with the way the program was run?
   Would you say it was a success?

3. Communication
   How was the communication between you and the club/ Croke Park/ county health and well-being officer?

4. Future
   How sustainable is this model / partnership?
   Is it mutually beneficial?
   Challenges / barriers to this type of partnership?
   What should change / how could it improve?

5. Advice for others
   Do you feel it is easy for clubs to engage with LSPs like this?
   What advice would you give regarding clubs engaging with LSPs?

Appendix 9b

Key Partner Interview Topic Guide St. Angela's College

This interview is being carried out by the WIT evaluation team on the GAA's Healthy Club project. This is an interview focusing on experiences, attitudes and reflections of your involvement in the project thus far and in particular the development and subsequent implementation of a healthy eating program. 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 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 interview at any point.

1. Opening
   Can you briefly outline your role?
   Briefly outline the Recipes for success program run in clubs.

2. Partnership
   How did the partnership between GAA and St. Angela's come about?
   What has been your experience of this partnership? Mutually beneficial?

3. Communication
   What was your experience of the lines of communication between you and the GAA / and clubs?

4. Clubs
   How do you think clubs can be affected by a program like Recipes for success?
   What has the feedback from clubs been?
   How appropriate do you think a GAA club as a setting is for this program?

5. Challenges
   Have there been any challenges from an operational point of view?
   What issues have clubs had if any?

6. Sustainability
   How sustainable do you feel this partnership is?
   How sustainable is this program for GAA clubs to engage in?

7. Future
   Is there anything you see that could improve the program / partnership?

Appendix 10

Other FGDs and Interview details

Organisation	Nature	Length	Date
Healthy Eating Initiative			
GAA C&H Department	Interview	13:27	07/06/17
St. Angela's College	Interview	05:40	17/07/17
Aghamore, Mayo	Executive Officer Interview	21:54	27/02/17
	Participant FGD	05:08	07/03/17
	Healthy Club Officer Interview	21:41	07/03/17
Clonad, Laois	Executive Officer Interview	16:10	19/05/17
	Participant FGD	10:49	19/05/17
	Healthy Club Officer Interview	32:59	23/05/17
JK Brackens, Tipperary	Participant FGD	09:58	06/06/17
	Healthy Club Officer Interview	12:37	15/05/17
Physical Activity Initiative			
GAA C&H Department	Interview	14:00	10/11/17
Aghamore, Mayo	Executive Officer Interview	08:36	30/06/17
	Participant FGD	09:11	09/06/17
	Healthy Club Officer Interview	08:40	03/07/17
Mayo LSP	Interview	08:01	09/06/17
Ballinderreen, Galway	Participant FGD	13:01	07/06/17
	Healthy Club Officer Interview	12:08	25/07/17
Galway LSP	Interview	08:01	29/06/17
Mungret St. Paul, Limerick	Executive Officer Interview	10:25	04/07/17
	Participant FGD	14:28	30/05/17
	Healthy Club Officer Interview	17:04	06/06/17
Limerick LSP	Interview	41:14	30/05/17
Community Development Case Studies			
Ballinderreen, Galway	Participant FGD	18:13	07/06/17
Tubber, Offaly	Participant FGD	20:45	06/07/17
Derrygonnelly Harps	Healthy Club Officer Interview	20:42	27/10/17
S. Mary's Rasharkin	Healthy Club Officer Interview	23:50	25/07/17

Appendix 11

Consent Form

Informed Consent Form

Study Background

The GAA Healthy Club Project 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 David Callaghan 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

Appendix 12

Sub Components of Health Promotion Characteristics for Phase 2 and control clubs

	Phase II Average (0-1)		*Control Average (0-1)*	
	Baseline	*Follow Up*	*Baseline*	*Follow Up*
The clubs regulations include a written section on well being and / or health promotion / health education / healthy lifestyle	.28	.74*	.38	.43
The clubs regulations include a written policy on substance misuse (ASAP policy)	.49	.74*	.38	.43
Health and well being ideals are written in the clubs constitution and regulations	.21	.68*	.25	.25
The club health promotion activities are evaluated in the Annual Report	.27	.77*	.20	.28
The club collaborates with other sports clubs and / or health professionals on health issues	.40	.75*	.63	.50
The club assures that its sub committees have agreed regulations and practices	.49	.73*	.53	.53
Health promotion is part of the coaching practice	.49	.82	.72	.69
Training pitches and schedules are distributed fairly across all teams in the club	.78	.91*	.90	.83
The club promotes the 'Go Games' principles	.78	.97*	.98	.95
The club promotes the 'Respect Initiative'	.71	.92*	.90	.93
The clubs Executive Committee discusses its regulations with coaches and parents at regular intervals	.46	.71*	.43	.63
The club pays particular attention to coaches/instructors interaction skills	.52	.76*	.65	.75
The club provides education on health issues or makes provisions for its members to receive such education	.36	.78*	.60	.65
The club promotes individual growth and development	.42	.73*	.73	.78
Sports injuries are comprehensively dealt with (including the psychological effect of injury)	.49	.71*	.63	.80
The club reviews and communicates treatment policies in the case of a sports	.46	.67*	.63	.63

injury				
The club assumes its fair share of responsibility for a safe sports environment (eg: reviews the sports environment yearly)	.73	.85*	.85	.78
The club provides a sports environment that is smoke free during juvenile activities	.52	.84*	.78	.85
Coaches and other officials give a good example through their own behaviour	.67	.88*	.88	.83
Respect for the referee is evident at all levels in the club (players, coaches, administrators)	.57	.82*	.83	.80
Possible conflicts (eg bullying) are monitored and dealt with	.58	.85*	.80	.85
In coaching, there is a health promoting element beyond sports performance	.52	.85*	.73	.80
Healthy food options are made available following sports activities	.34	.71*	.55	.53
All juvenile events are held in an alcohol free environment	.84	.90	.85	.88
The club promotes maximum participation adopting an 'every child gets a game' policy	.64	.85*	.88	.83
The implentation of 'everybody plays' policy is dependant on the importance of the competition	.34	.33	.30	.33
The implementation of 'everybody plays' policy is hindered by parents expectations of success by winning	.34	.51*	.60	.38
The implementation of 'everybody plays' policy is hindered by other clubs reluctance to adopt a similar approach	.26	.41*	.45	.40
The club measurement of success is winning underage tournaments	.60	.60	.50	.65
The club perceives that success can only be achieved by having the best players on the pitch at all times	.58	.65	.78	.63
The club selects and approves coaches who have accredited coaching qualifications	.64	.78*	.75	.68
The club specifically identifies suitable and qualified coaches for juvenile coaching positions	.65	.75	.78	.63
The club does not tolerate the use of bad language	.57	.75*	.70	.68

The club enforces a fair play policy	.62	.83*	.83	.83

*p<.05 Phase II v Control Clubs

Appendix 13

Health Promotion Classification Matrix

	Low Health Promoting	Moderately Health Promoting	High Health Promoting
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

Table: Facilities Available in Participating Clubs (n=82)

		Healthy Clubs (n=55) *Average (Min-Max)*	*Control (n=27)* *Average (Min-Max)*
Facilities	No. of Pitches	2.2 (1-4)	2.2 (1-6)
	Dressing Rooms	4.2 (2-8)	3.4 (2-4)

Appendix 15

Table: Number of Foundation Coaches in Participating Clubs

	Healthy Clubs (n=51) Mean (Min-Max)	Control Clubs (n=10) Mean (Min-Max)
Football and Hurling (Child 0-11yrs)	9.4 (3-12+)	9.2 (0-12+)
Football and Hurling (Youth 12-17yrs)	8.3 (0-12+)	9.1 (0-12+)
Football and Hurling (Adult 18+yrs)	4.5(0-12+)	4.7 (0-12+)
Ladies Football	4.4 (0-12+)	2.9 (0-12+)
Camogie	4.1 (0-12+)	0 (0-0)
Handball	0.3 (0-4)	0 (0-0)

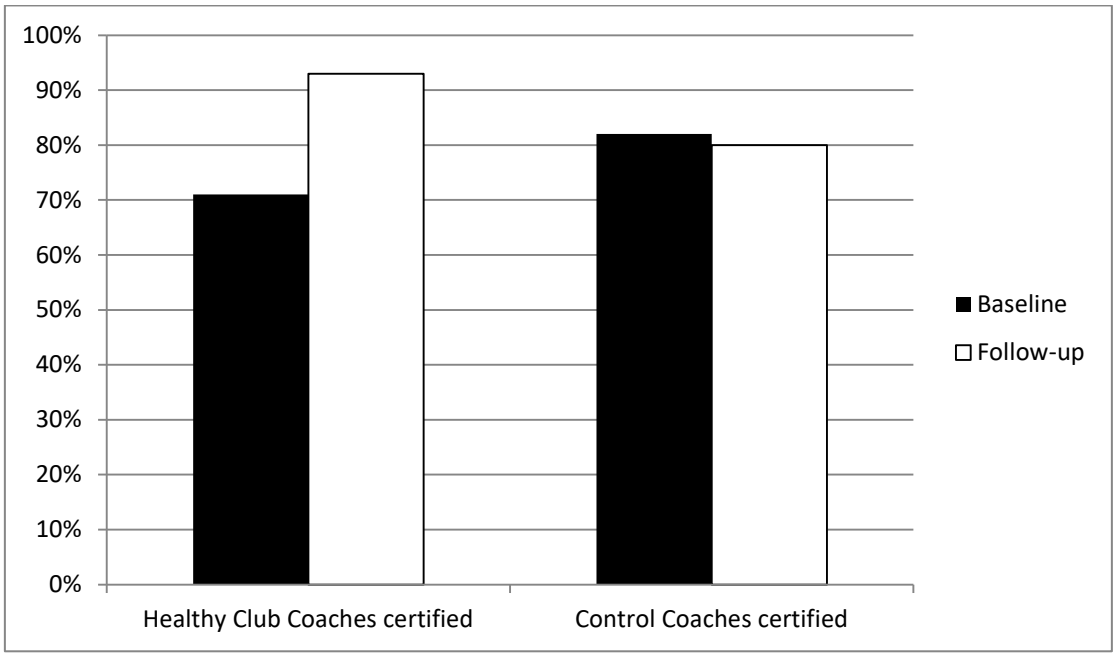
Appendix 16

Table 4.12 Partner Engagement during the HCP by Healthy Clubs

Area of Engagement (n)	Partner (n)	Target Audience (n)
Physical Activity (30)	Primary school (22) Qualified gym/fitness instructor (22) LSP / Sport NI (15) County H&W committee (13) Local Council (12) Park Run (9)	Wider Community (27) Parents (25) Club members (24) Families (20)
Healthy Eating (28)	Local Supermarket (12) County H&W committee (11) Local business (10) Primary/Secondary school (9)	Members (21) Parents (20) Families (18) Children (16)
Mental Health (23)	Mental Health Agency (15) HSE / PHA (12) County H&W committee (8)	Wider Community (19) Members (19) Parents (16)
Anti-smoking (17)	County H&W committee (9) HSE / PHA (9) Healthcare organisation (6)	Members (17) Community (17) Parents, Families (13)
Gambling, Alcohol, Drug Education (11)	County H&W committee (4) Healthcare organisation (4) Primary / Secondary school (3)	Community (7) Parents (7) Coaches / Managers (7)
Anti-Bullying (7)	Primary / Secondary school (4) County H&W committee (2)	Coaches / Managers (7) Parents (5)
Community Development (18)	Doctor (5) Nursing Home (4) Get Ireland Walking (3) Men's Shed (2) Rural Link (1)	Community (15) Members (15) Families (11) Club Officers (11)

Training and Personal Development (23)	LSP / Sport NI (11) County H&W committee (8) Emergency Services (4)	Coaches / Managers (21) Members (19) Club Officers (16)

Appendix 17



Coach Certification at Baseline and Follow Up

Appendix 18

Table 4.20 Barriers Experienced by Clubs

	Healthy Clubs (n=55)	*Healthy Clubs (n=30)*	*Control (n=27)*	*Control (n=10)*
	Baseline % Agree (n)	*Follow Up % Agree (n)*	*Baseline % Agree (n)*	*Follow Up % Agree (n)*
Lack of interest among members	24 (13)	40 (12)	38 (10)	40 (4)

Lack of interest among Executive members in club	6 (3)	10 (3)	34 (9)	10 (1)
Health promotion not a priority	15 (8)	10 (3)	22 (6)	0
Inadequate support from society	24 (13)	43 (13)	37 (10)	40 (4)
Inadequate support from GAA at national level	21 (11)	7 (2)	34 (9)	30 (3)
Lack of knowledge and expertise	37 (20)	17 (22)	37 (10)	30 (3)
Lack of money	59 (32)	60 (18)	52 (14)	40 (4)
Lack of time	46 (27)	60 (18)	59 (41)	70 (7)