A Healthy Sports Club Initiative in Action in Ireland

Aoife Lane[a], Niamh Murphy[b], Alex Donohoe[b] and Colin Regan[c]

[a]Department of Sport and Health Science, Athlone Institute of Technology, Athlone, Co Westmeath, Ireland.
[b]Department of Health, Sport and Exercise Science, Waterford Institute of Technology, Ireland.
[c]Gaelic Athletic Association, Dublin, Ireland

Abstract

Objective*:* The Gaelic Athletic Association (GAA) is part of the cultural fabric of Irish society with a club in almost every community nationwide. The aim of this project was to carry out a pilot evaluation of the GAA Healthy Club Project (HCP), which is a unique effort by a national governing body to include health as part of the core business of the organisation at grass roots level.
Design: A pre- post- intervention group only design was used across eighteen clubs recruited to a pilot phase of the project.
Setting: GAA grassroots sports clubs across Ireland.
Methods: Twelve Healthy Club Officers completed a self-evaluation survey of their club at two time points to indicate the health promotion orientation of their club and the extent of health promotion activity in the club.
Results: Data showed improvements in the health promotion orientation of clubs, from moderate to high health promoting overall and particular increases in policy and practice scores. This is likely due to the widespread appointment of Healthy Club Officers and the delivery of health-related initiatives in clubs.
Conclusion: The impact of the project, while not demonstrable as an intervention effect at this stage, was real for the clubs involved. The GAA HCP is a novel way of carrying out health promotion in Ireland, serving as a meeting point between the 'push of health' and 'pull of the sports club.'

Keywords sports clubs, health promotion, community, Ireland

Corresponding author:

Aoife Lane, Department of Sport and Health Science, Athlone Institute of Technology, Athlone, Co Westmeath, Ireland
Email: alane@ait.ie

Introduction

The EU White Paper on Sport (2007) recognised the societal importance of sport, including its role in public health through participation in physical activity (PA) and broader health promotion activities. There are established health benefits of sport; young people who play sport are more active than those who do not play sport (Marques, Ekelund and Sardinah, 2014~~)~~6), and youth sport involvement is associated with significantly lower mortality rates (Andersen et al., 2000), and with lower BMI and higher PA in adulthood (Alfano et al., 2002). In addition, participation in sport is associated with lower consumption of alcohol and smoking rates (Wichstrom and Wichstrom, 2009; Henchoz et al., 2014), and is linked to greater self-worth and enhanced emotional wellbeing (Donaldson and Ronan, 2006; Ruseski et al., 2014; Fujiwara, Kudrna and Dolan, 2014).

The health impact of sport is not always realised, or indeed always positive. Oja et al., (2015) reported at best moderate evidence for the health benefits of adult specific sport while the majority (72-80%) of young people playing sport do not achieve sufficient PA for health benefits (Vella, Cliff and Okley, 2014, Telford et al., 2016). It is also argued that sports involvement moves from being a protective mechanism during childhood to becoming a risk factor for alcohol and cigarette use in older athletes (Kulesza et al., 2014). Finally, sport is often linked with unhealthy sponsorship (Lindsay et al., 2013; Pettigrew et al., 2013) particularly in relation to alcohol and fast food, which can serve to enhance awareness of, and normalise these behaviours (Houghton et al., 2014). Sport must consider its role in providing opportunities for health enhancing PA and positive health behaviours, which supports the emergence of the sports club as an emerging setting for health promotion.

Kokko, Green and Kannas (2013) conceptualised a holistic sports club model, which includes a high-level orientation towards health promotion, support from club management, and action at the coalface of club activity among members. Case studies of sports-based health promotion have highlighted national and sporting governing body positions on 'sport for health' and actions across all levels in clubs albeit with complexities between policy and implementation stages (Kokko et al., 2016). Sport-based interventions have been implemented and evaluated to show a positive impact on health. Schools that ran the FIFA 11 programme experienced an 18% improvement in health knowledge (Fuller et al., 2011) while the Good Sports Program in Australia had a positive impact on drinking behaviours and club membership (Crundall 2012) and the Football Fans in Training (FFIT) initiative led to significant weight loss in participants (Hunt et al., 2014). Lastly, the Healthy Sporting Environment Demonstration Project (HSEDP), a regional and state led initiative in Australia has also shown positive institutional change towards health promotion across sports clubs (Nicholson et al., 2013).

Progress has also been forthcoming in the development of a standardised tool for assessing the health promotion orientation of sports clubs. Kokko, Kannas and Villberg (2006) used the Delphi method to generate a health promoting sports club index (HPSC) comprising of 22 standards for health promotion across the areas of policy, ideology, practice and the club environment. In brief, *policy* refers to the formal adoption of policies addressing specific health needs into a club's regulations and constitution. *Ideology* is concerned with embracing the ethos of health promotion. *Practice* relates to how a club communicates and educates people around health issues and *Environment* includes both the physical and cultural environment and looks at the provision of a safe sports environment, and an awareness that health promotion goes beyond sports performance and links with the wider community.

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Subsequently, Kokko, Kannas and Villberg (2009) implemented the HPSC in Finnish youth sports clubs and found that clubs scored highest for ideology and environment and lowest for policy and practice. Meganck et al., (2014; 2017) observed a similar trend in youth and adult sports clubs in Flanders as did Van Hoye et al., (20154) in a coach specific assessment of the HPSC tool in France.

The Gaelic Athletic Association (GAA) is Ireland's largest community and sporting organisation with a network of over 2,000 clubs. These sports clubs form an integral part of Irish society reaching deep into communities and, in many cases transcending competitive sport, as a forum for people of all ages to become part of something beneficial for themselves and their community. In turn, GAA clubs often naturally engage in health related initiatives. ~~GAA clubs naturally orient towards health promotion activity and thus~~ The Healthy Club Project (HCP) was developed to ~~harness the current, and~~ support more structured health promotion activity in the GAA club setting. The HCP aimed to provide training and guidance to help clubs to deliver improved health promotion activity and work to embed health in the day to day workings and overall philosophy of the club. Clubs were supported by a leadership team at national and regional level to develop the HCP within their own resources and needs. An initial pilot Phase I ran across 18 clubs from March 2013 to July 2015 before progression to a Phase II rollout to 60 clubs in February 2016 and a stated ambition to ultimately offer the HCP to all clubs. XXXX et al., (2017), in an assessment of the baseline health promotion orientation of clubs participating in the pilot Phase I, confirmed that clubs were positively oriented towards, and engaged in, health promotion. Similar to previous research, scores for policy were the lowest observed with higher scores for ideology, and indicators of practice and environment rated as moderate. The purpose of this paper is to report on the subsequent impact of the first phase of GAA HCP on clubs ~~in this pilot phase.~~

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Methods

Sample and Design

The research used quantitative methods in a pre-post intervention group only design (i) to assess the impact of the HCP on clubs, and (ii) to describe activities undertaken by clubs. Eighteen clubs were recruited in 2013 to a two-year pilot Phase I of the HCP following an open call for applications from clubs and a subsequent objective selection process. In summary, clubs were scored and selected with a view to recruiting clubs from across the four regions in Ireland that reflected a variety of GAA club contexts in relation to size and location, community links and existing health promotion activity (XXXX et al., 2017).

The GAA and Irish Health Service Executive (HSE) used a Delphi technique similar to that adopted by Kokko, Kannas and Villberg, (2006), to develop a model to guide the implementation of the HCP. This Healthy Club Framework, which reflected the World Health Organisation's settings approach to health promotion, consists of four pillars, offering clubs a structure to integrate health promotion into their daily activities.

- Governance: policy and executive support for health promotion in the club.
- Environment: generating a physical, social, coaching, playing, cultural environment that is conducive to health and wellbeing.
- Partnerships: extending the reach and capacity of clubs by engaging with relevant local stakeholders.

- Programmes: developing and providing initiatives designed to tackle health issues, specific to the needs of the community.

Clubs were encouraged to self-select health promotion activity that (i) was specific to the needs of their respective communities, and (ii) reflected all elements of the Healthy Club Framework, which was subsequently evaluated at follow up. No financial assistance was provided, but representatives from all clubs~~all clubs~~ were trained at a central orientation day on the development of action plans oriented around the Healthy Club Framework for proposed activities. Clubs also attended regional group meetings every three months throughout the duration of the project. Finally, all clubs were encouraged to appoint Healthy Club Officers to lead a small volunteer project team, and co-ordinate health promotion activity. The philosophy at this stage was to organise, capture and develop activity that clubs opted to engage in rather than to prescribe health promotion interventions.

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Data Collection

A Healthy Club Questionnaire (HCQ) was administered online in September 2013 and July 2015 at the start and end of the pilot Phase I, with two reminders over a four-week period. The HCQ, to be completed by the Healthy Club Officer, collated descriptive data on clubs such as membership (both playing and non-playing members such as coaches, officials, supporters) and playing codes and facilities. The HCQ was also used to record each activity undertaken by clubs, across the four aspects of the Healthy Club Framework and incorporated a 34 item modified version of the HPSC index (Kokko, Kannas and Villberg, 2006), to assess the baseline and follow up health promotion orientation of participating clubs. Modifications included the addition of a juvenile (U-18) environment section, as GAA clubs are responsible for sports promotion among youth and adults. This addition focused on the operation of 'everybody plays' and 'fair play' policies and the recruitment of suitable and qualified underage coaches. Also, the ideology section was altered to reflect the promotion of two individual GAA principles: the Go Games initiative and the Respect initiative, which promote participation and fair play.

Data Analysis

Each item on the HCQ was scored between (0-1; 0 indicates that the factor does not describe the club at all and 1 indicates it describes the club very well) so the overall range of scores on the index was between 0 and 34. A score was generated for each component (policy, ideology etc.) of the index and clubs were categorised as low, moderate or high health promoting in each, and overall using a classification system similar to that used by Kokko et al., (2009). Higher scores reflected a greater orientation towards health promotion, with scores of 23 plus deemed high health promoting. Scores between 17 and 22.99 were classed as moderate while clubs who scored less than 16.99 were deemed low health promoting. Scores for each of the sub-indices were also categorised into low, moderate and high. For policy, scores higher than six and lower than 3.99 were deemed high and low health promoting respectively. Scores >1.72 and >4.50 were required for a high health promotion score for ideology and practice respectively, while cut points for high and low health promotion were >5.30 and <3.49 for the environment and >8.25 and <5.49 for the juvenile environment. Descriptive

statistics and paired sample t-tests were used to present data and assess differences between baseline and follow up; p-values were set at 0.05 and all analysis was carried out in SPSS 21.0.

An impact rating scale of high impact, medium impact and low impact was also developed by the evaluation team to assess the initiatives in the context of the four elements of the Healthy Club Framework. Clubs described each initiative they carried out detailing if there was a policy or broader plan for the specified health topic in the club (Governance), providing information on how the activity was visibly impacting on the physical, social, coaching, playing or cultural environment in the club, if it included some element of partnership with local entities, and/or entailed a programme to address a health issue among individual or groups of participants. Clubs scored 1 for each element they included with a maximum score of 4 for each activity carried out. Clubs earned a rating of high impact if their initiative encompassed all four elements of the framework in its implementation. Medium impact was given for initiatives that comprised of at least three elements of the framework. Finally, a low impact rating was given when initiatives included two or less elements of the Healthy Club Framework.

Results

Description of Participating Clubs

Eighteen clubs of varying size were recruited at baseline, four from each of the four regions across Ireland, and two additional clubs who had demonstrated higher amounts of health promotion activity, and thus deemed mentoring clubs. Sixteen clubs (89% response rate) submitted the HCQ at baseline. Characteristics of these 16 clubs at baseline are presented in Table 1. There was an average of 408 youth and adult members across clubs and all had playing fields and access to at least two changing rooms. The most common sports provided were football and codes that were male-oriented and while there were many coaches with basic (Foundation) certification, lower proportions had progressed up the coaching pathway. Twelve clubs completed the HCQ at both time points, representing a 67% response rate for this element of the analysis.

[Table 1: Characteristics of Participating Clubs (n=16) at Baseline]

Effect of the HCP

Health Promotion Orientation

The overall health promotion (HP) score for clubs at follow up was 23.85±3.34, increasing from 19.88 at baseline ($p<0.05$) with higher scores indicating a higher health promotion orientation (*Table 2*). There were significant increases in the policy and practice domains ($p<0.05$) with improvements also noted for both environment sections; these were not significant. There was a marginal decrease in the ideology score, which was not meaningful in a statistical context. Clubs moved from low to moderate for the policy index, decreased into the moderate category from high for ideology, and overall increased from medium to high in relation to health promotion orientation.

[Table 2: Health Promotion Orientation of Participating Clubs (n=12) at Baseline and Follow up]

At baseline, scores for the policy domain were among the lowest for all indicators of health promotion in the clubs. At follow up, scores for each item in the policy domain improved and significantly so ($p<0.05$) in two instances; club regulations including a written section on health (.21-.42) and health promotion activity being addressed in Annual Reports (.35-.84), while the distribution of schedules and training pitches was high at both time points (.82-.82). While the inclusion of health promotion in the regulations and constitution of the club improved, it remained low at follow up (.28-.41). Ideology scores in relation to maximising participation and promoting respect were high at both baseline and follow up (-85-.88). For the practice component, there were significant ($p<0.05$) increases in indicators relating to the discussion of regulations with parents and coaches (.46-.63) and paying attention to coaches interaction skills (.50-.73). Across the environment index, there were significant ($p<0.05$) improvements in managing conflict such as bullying (.70-.91) and providing healthy food options (.33-.52), yet this scored low overall. Despite no significant change, at both time points issues in relation to respect for referees (.69-.77), maintenance of a safe sports environment (.73-.77), and good demonstration of behaviour from coaches and officials (.77-.85) all scored well. In relation to the juvenile environment, significant improvements were noted for recruitment of coaches (.50-.73) and not tolerating bad language (.65-.79). No significant change but high scores were observed for maintaining alcohol free environments for juvenile events (.83-.88), and promoting maximum participation for young players (.70-.84). Also, although not significant, low scores, in this case a positive, were recorded at both time points in the juvenile (U18) coaching environment for the club measuring underage success by winning (.31-.32), or for success only being achieved by having the best players on the pitch at all times (.30-.31).

[Table 3: Individual Component Analysis Baseline and Follow-up (n=12)]

Membership

Clubs submitted their membership numbers at both time points (Figure 1). Total membership increased by 34.8%, playing membership rose by 16.4%, while non-playing membership grew by 65%; increases were not significant ($p>0.05$).

[Figure 1 Membership at Baseline and Follow Up (n=12)]

Health Promotion Activity

At the end of the pilot phase, 83% of clubs had appointed a Healthy Club Officer. In the follow up HCQ, clubs were also asked to indicate areas of health promotion that they had targeted during the HCP. In total, clubs reported 100 initiatives; an average of seven initiatives per club across the topic areas presented in *Table 4*. Emotional wellbeing, diet and nutrition, and alcohol/smoking and drug awareness related initiatives were most common with activity also described for physical activity and social inclusion. The majority (90%) of these initiatives were community oriented in that they involved engagement with the broader community rather than the alternative where initiatives were delivered only to club members.

The impact rating analysis revealed that few initiatives were deemed high impact. Those that were embraced the development of a policy in the roll out of their initiative, and therefore included all aspects of the Healthy Club Framework. One such initiative addressed smoking in the club facility. It involved the development of an anti-smoking policy, the

erection of no smoking signage in clubs, publicity across club membership, in an overall effort that was supported by Healthy Ireland (Ireland's National Framework for Health and Wellbeing). A second initiative involved the delivery of a 12-week physical activity programme to club members and non-members from across the community in partnership with local fitness and health professionals. The programme was run in club facilities and culminated in a 5k charity community fun run.

[Table 4: HCP Health Promotion Activity (n=12)]

Discussion

This study profiled the health promotion status of Irish GAA clubs and identified the impact of health promotion activity in the sports club setting on the club. At follow up, data showed a progression in clubs from being moderate to high health promoting. Clubs improved their scores across the policy, practice, environment and juvenile (u18) coaching environment sub-components contained within the HCQ. Policy scored lowest at baseline but significant improvements were noted in policy indicators and in the practice domain over time. Overall, the 12 clubs planned 100 initiatives across seven areas of health over a two-year period. These were mainly delivered to the community rather than targeting club members only and the impact of initiatives were projected to be mainly low to moderate based on a partial engagement with the Healthy Club Framework.

Geidne et al. (2013) have noted that given the popularity of sport, there is the potential for societal intervention on the broader concept of health. In this study, non-playing members made up 30% of the total membership of a club, hence a significant reach in terms of community based health promotion. Previously, XXXX et al., (2017) demonstrated that the GAA sports club is a relevant setting for health promotion, both due to an existing tendency towards this work and a perceived sense of responsibility by the club to engage more broadly with members and the community, beyond the core business of sports promotion. The subsequent roll out of the HCP led to an enhanced health promotion orientation of clubs over a two-year period. Jackson et al., (2005) suggested that the potential of a sports club was vast if a culture of health enhancing behaviour could be generated and sustained and results from this analysis offer strong support for continued investment in GAA clubs to support an existing and growing culture for community engagement in the area of health promotion offsetting the sometimes negative impact of sport.

At the outset of the HCP, it was encouraging that clubs had an existing moderate orientation towards health promotion moving to a higher health promoting focus at follow up. Kokko, Kannas and Villberg (2009) in their baseline analysis of the health promotion status of Finnish youth sports clubs likewise found clubs were on average moderately health promoting. Meganck et al. (2014) found that three in five sports clubs in Belgium were categorised as low health promoting. In relation to the different sub-indices of health promotion, GAA clubs scored strongest for ideology and lowest for policy, similar to Kokko et al. (2009), Meganck et al., (2014; 2017) and Van Hoye et al., (20154).

Priest et al., (2008) and Dobbinson, Hayman and Livingston (2006) noted policy to integrate health promotion into the constitution and regulations for clubs is not yet consistent in sport. Of note in the HCP is that policy scores increased significantly over time, linked likely to the appointment of Healthy Club Officers, who sit within the Club Executive structure, which is now mandated across the entire community of GAA clubs. This is an important

development; in order to capitalise on the HCP, volunteers must be supported by management and a strong governance structure (Nicholson et al., 2013). In their experience with workplace health promotion initiatives Jorgensen et al. (2013) refer to the support of senior management as being an essential factor in the success of health promotion projects from both a pragmatic and a symbolic perspective. Similarly, in this instance, leaders need to embrace change and view the HCP as a whole club project rather than just an offshoot taken on by a small subset of members. The Healthy Club Officer and their place on the Executive ensures health promotion is on the club agenda. This is reflected in positive changes to the inclusion of health in club regulations, reporting of health promotion in Annual Reports and practice scores in relation to appointing coaches and communication with coaches and parents. In addition, it was notable that initiatives in the area of alcohol/smoking and drugs received the highest impact scores mainly due to an existing policy (GAA Alcohol and Substance Abuse Policy) adopted by the Healthy Club Officer suggesting an awareness of, and readiness to embrace policy development. The overall volume of initiatives delivered in the HCP helps to explain the significant improvement in the practice domain while although not significant, improvements were also noted in the environment and juvenile environment indices. Progress in relation to bullying is likely linked to a GAA tackle bullying initiative that started in 2003 while positive scoring in relation to youth players reflects the commitment to the ideology indicators of respect and Go Games, which promotes the ethos of maximum participation.

To further emphasise the value of health promotion in a sports club, it is important to link this activity to the core business of a sports club, i.e. recruiting members and promoting lifelong participation in sport. At the end of the HCP, total membership increased by 34% primarily due an increase in non-playing membership (65% increase). The lack of a controlled comparison limits the attribution of enhanced membership to the HCP but is supportive of observations from the majority (97.2%) of Executive Officers for Australian State Sporting Assemblies who felt the creation of a supportive environment would facilitate increased membership alongside the traditional lure of sports competition (Eime and Payne, 2007). Similarly, Crundall (2012) and Kingsland et al. (2015~~)~~3 demonstrated that improved management strategies in relation to health can lead to benefits beyond positive behaviour change such as improved perceptions of the club and can ultimately lead to increased club sustainability through increased membership and overall involvement. In relation to promoting physical activity through sport, the HCP did not appear to prioritise strategies to promote sports or physical activity participation among club members but rather oriented activity around broader aspects of health promotion and the wider community. There were no coach specific programmes to enhance the physical activity contribution of sport or to prevent drop out, which are both core functions of all sports clubs. Inchley, Muldoon and Currie (2006) viewed the integration of initiatives into the on-going life of a setting as crucial in the sustainability of a health promotion programme, so it is important moving forward that activity is embedded into the core business of the GAA sports club, (i.e.) sports and physical activity promotion to supplement the current successful efforts that positively impact the influence of the club on the wider community.

The concept of setting is fundamental to health promotion (Kokko, Green and Kannas, 2013), and the HCP represents an important contribution to the understanding of the sports club as a setting for health, which remains a novel concept. Evidence at this early stage is still tentative but there are many similarities between it and other well established and well-studied settings. For example, one of the features of settings based health promotion is the

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focus on environmental factors and organisation change. The HCP focused not just on the individual but rather on making the whole sports club conducive to encouraging healthy behaviours supported by club management and directed at a national level. The Healthy Club Framework emphasises the environment and governance along with partnerships and programmes and did lead to positive changes in the health promotion orientation of clubs and extensive club activity. In a similar move to provide direct support for clubs in Australia, the Healthy Sporting Environments Demonstration Project (HSEDP), supported by VicHealth, led to positive steps in relation to institutional change and actual delivery of health promotion despite no changes in behaviour although it was noted these may take longer to manifest (Nicholson et al., 2013). Similarly, the level of organisational change and health promotion activity in the HCP is very much desirable but the latter was not always very impactful in terms of design and implementation, not uncommon for sports club interventions (Geidne et al., 2019). Evaluation was limited to an overall club assessment; behaviour change was not measured so at this stage there is no evidence to determine if improvements in orientation of GAA clubs towards health have led to changes in behaviours among its membership or community.

Practical implications from the HCP include the development of a support and operational structure for health promotion in a sporting body from national level to grassroots clubs. The GAA has moved to appoint a Healthy Club Officer in every GAA club throughout Ireland, supported by a regional committee and full time staff at national level. Through incorporating health promotion into the governance structure of the club, and supporting this at all layers of the organisation, there is great potential to reach the entire membership and wider community served by that club. Building relationships, capacity building and working for the benefit of the community have all been evidenced in the HCP and it is this potential for community engagement that is another learning for sports clubs. Finally, placing sport on the health agenda is another important consideration reinforced by the partnership of the national HSE with the GAA HCP.

This pilot analysis was limited to 12 clubs who self-selected to take part in the HCP and self-reported on their own club. In addition, no comparison clubs were recruited and therefore, implications of this research must be considered in the context of limitations in study design. Observed changes in health promotion orientation could be linked to existing health campaigns, such as the Healthy Ireland initiative. Another phase of the HCP is planned that will include a controlled comparison and a larger sample size.

Conclusion

~~An evaluation of the health promotion activities of any Irish sports club is unique with no prior frame of reference established.~~ The unique position of the GAA in Irish society and its associated ideals of community, inclusion and volunteerism make the organisation well placed to contribute to the development of communities where everyone has a chance to be healthier. This research represents the first effort to capture the health promotion potential of sport in this context. It is apparent that t~~T~~he GAA HCP represents a novel way of carrying out health promotion in Ireland, and strikes a natural balance between the health agenda of the public health system and the core business of the GAA club. It reflects a meeting point between the 'push of health' and 'pull of the club' (Wyke et al., 2015). This pilot evaluation has provided support for this type of initiative in terms of the positive impact on the health orientation and practice of participating clubs.

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Ethical Approval

Ethical approval for this project was granted by the WIT Research Ethics Committee.

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Table 1: Characteristics of Participating Clubs (n=16) at Baseline

		Average (Min-Max)
Membership	Playing Members	408 (124-1012)
	Non-Playing Members	146 (45-322)
	Total Membership	544 (189-1285)
Facilities	No. of Pitches	2.2 (1-4)
	Dressing Rooms	4.7 (2-12)
Coaches	Foundation	29.3 (10-46)
(Level of Certification)	Level 1	12.3 (1-25)
	Level 2	2.3 (1-3)
	Level 3	2 (1-3)
		% of Clubs
Playing Codes	Male Football	93.8
	Male Hurling	68.8
	Female Football	62.5
	Female Hurling	43.8

Table 2: Health Promotion Orientation of Participating Clubs (n=12) at Baseline and Follow up

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

*p<0.05 (Baseline v Follow Up)

Table 3: Individual Component Analysis Baseline and Follow-up (n=12)

34 standards	**Baseline Average (0-1)**	**Follow Up Average (0-1)**
Policy index		
The clubs regulations include a written section on well being and / or health promotion / health education / healthy lifestyle	.21	.42*
The clubs regulations include a written policy on substance misuse (ASAP policy)	.50	.71
Health and well being ideals are written in the clubs constitution and regulations	.28	.41
The club health promotion activities are evaluated in the Annual Report	.35	.84*
The club collaborates with other sports clubs and / or health professionals on health issues	.52	.75
The club assures that its sub committees have agreed regulations and practices	.52	.73
Health promotion is part of the coaching practice	.60	.75
Training pitches and schedules are distributed fairly across all teams in the club	.82	.82
Ideology index		
The club promotes the 'Go Games' principles	.88	.85
The club promotes the 'Respect Initiative'	.88	.85
Practice index		
The clubs Executive Committee discusses its regulations with coaches and parents at regular intervals	.46	.63*
The club pays particular attention to coaches/instructors interaction skills	.50	.73*
The club provides education on health issues or makes provisions for its members to receive such education	.35	.58

The club promotes individual growth and development	.63	.75
Sports injuries are comprehensively dealt with (including the psychological effect of injury)	.63	.73
The club reviews and communicates treatment policies in the case of a sports injury	.56	.65
Environment Index		
The club assumes its fair share of responsibility for a safe sports environment (eg: reviews the sports environment yearly)	.73	.77
The club provides a sports environment that is smoke free during juvenile activities	.67	.71
Coaches and other officials give a good example through their own behaviour	.77	.85
Respect for the referee is evident at all levels in the club (players, coaches, administrators)	.69	.77
Possible conflicts (eg bullying) are monitored and dealt with	.70	.91*
In coaching, there is a health promoting element beyond sports performance	.42	.58
Healthy food options are made available following sports activities	.33	.52*
Juvenile (U18) Coaching Environment index		
All juvenile events are held in an alcohol free environment	.83	.88
The club promotes maximum participation adopting an 'every child gets a game' policy	.70	.84
The implentation of 'everybody plays' policy is dependant on the importance of the competition	.38	.32
The implementation of 'everybody plays' policy is hindered by parents expectations of success by winning	.33	.30

The implementation of 'everybody plays' policy is hindered by other clubs reluctance to adopt a similar approach	.54	.30
The club measurement of success is winning underage tournaments	.31	.32
The club perceives that success can only be achieved by having the best players on the pitch at all times	.30	.31
The club selects and approves coaches who have accredited coaching qualifications	.50	.73*
The club specifically identifies suitable and qualified coaches for juvenile coaching positions	.63	.71
The club does not tolerate the use of bad language	.65	.79*
The club enforces a fair play policy	.77	.83

*p<0.05 (Baseline v Follow Up)

Table 4: HCP Health Promotion Activity

	Total Number of Initiatives % (n)	**High Impact % (n)**	**Medium Impact % (n)**	**Low Impact % (n)**
Emotional Wellbeing	22 (22)	0	100	0
Diet and Nutrition	18 (18)	0	60	40
Alcohol/Smoking/Drugs	18 (18)	28.6	28.6	42.9
Screening/First Aid	15 (15)	0	69.2	30.8
Physical Activity	13 (13)	0	31.8	68.2
Social Inclusion	9 (9)	0	100	0
Anti Bullying	5 (5)	16.7	50	33.3

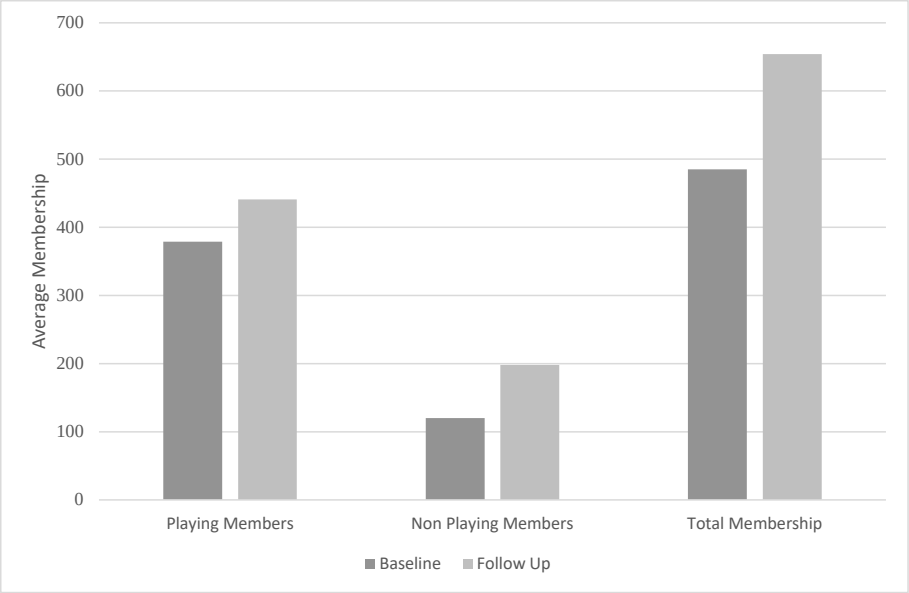

Figure 1 Membership at Baseline and Follow Up