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Article

Implementation of the GAA 'healthy clubs project' in Ireland: a qualitative study using the Consolidated Framework for Implementation Research

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Abstract

The sports clubs' role in promoting health has been acknowledged by policy makers and researchers, but there is little evidence on how sports clubs implement health-related interventions. The present article investigates the Gaelic Athletic Association Healthy Club Project (HCP) implementation process (mechanisms, barriers, leverages) over a 10-year timeframe. A case study design helped to produce and compare a data synthesis for five clubs involved since 2013. A qualitative iterative data collection, including document analysis was conducted through 20 focus groups with Healthy Club Officers, coaches, participants and members. The Consolidated Framework for Implementation Research was used in the deductive analysis process, conducted by the first author. Results have shown the success of the HCP in placing health promotion on the agenda of sports clubs leading to informal policy for health promotion, even if activities and recognition are directed toward and coming from the community. This study also underlines the virtuous cycle of the settings-based approach in enhancing membership and volunteer recognition through health promotion actions, and the importance of social good and corporate social activities for sports clubs. Nevertheless, the HCP still relies on limited human resources, is not recognized by competitive oriented adult playing members. and acknowledged as a resource by some coaches, limiting its rootedness in the core business of sports clubs. Future research should empower the HCP community to focus on organizational changes and develop outcomes for individuals, for the club as a whole as well as for the local community.

Keywords: health promotion, sports clubs, CFIR framework, complex intervention

BACKGROUND

Sports clubs, defined as 'private, non-profit organizations formally independent of the public sector, including volunteer members and a democratic structure, having sport provisions as their main aim' (Elmose-Østerlund *et al.*, 2017), have been recognized for their contribution to physical activity (PA) (Kokko *et al.*, 2018), which has numerous health benefits and is recognized as a key factor in mitigating against the rise of noncommunicable diseases (Anderson and Durstine, 2019). Nevertheless, the myth of healthism (Holman *et al.*, 1997) in sport is an important consideration as sports clubs have also been recognized as unhealthy settings in regard to food provision (Pauzé *et al.*, 2020), alcohol consumption (Ireland *et al.*, 2019) and unhealthy sponsorship practices (O'Reilly *et al.*, 2018; Donaldson and Nicholson, 2020). In sum, sports clubs could be labeled as important settings for the promotion of PA, albeit in an unhealthy environment.

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Contribution to Health Promotion

- The application of the settings-based approach to sports clubs poses challenge in terms of policy development and implementation.
- The Gaelic Athletic Association Healthy Club Project has improved the club contribution to society, by linking with community, local partners and by organizing health promoting events.
- The Gaelic Athletic Association Healthy Club Project is not widespread within sports clubs, especially among adult playing members.

To enhance sports clubs engagement toward health promotion (HP), only three interventions have been identified in the literature as being successfully implemented and tested rigorously (McFadyen *et al.*, 2018). In Australia, the Good Sports Program has reduced alcohol consumption and its associated risks through changes in sports clubs policies and practices, such as responsible serving guidelines and access to free water (Rowland *et al.*, 2012, 2014). This potential of sports clubs in playing a societal role in building health and social capital is important considering 13% of the population practice, and 6% volunteer, in sports clubs throughout Europe (European 2022 Sport and PA Eurobarometer). In turn, over the last decade, research has focused on the application of a settings-based approach to HP in sports clubs.

A settings-based approach to HP acknowledges that change is not solely focused on individuals and their health problems, but is generated in organizations and communities to ensure the development of environments that support population-wide changes in health-related behavior (Whitelaw *et al.*, 2001). The application of the settings-based approach has already shown promise in other settings, such as schools (Langford *et al.*, 2014), cities (De Leeuw, 2009) and universities (Dooris *et al.*, 2014). In regard to its application in sports clubs, the Health Promoting Sports Clubs (HPSC) concept or model (Van Hoye *et al.*, 2021), incorporates three different levels: the club as an entity (macro), managers' support of coaches and sport participants (meso) and coaches' activities (micro). At each level, HP investment has been categorized across four determinants: organizational, such as sport club status, sport participants' charter; social, such as motivational climate, sports values, alcohol consumption norms; environmental, such as safe and secure facilities and changing rooms, waste management, pollution; and economic determinants (including commercial determinants; Donaldson and Nicholson, 2020), such as volunteer engagement or sponsorship. The HPSC model is designed to be applicable to any sports clubs with consideration of the nature of the core business of the sports club (type of sport and level of participation), and the specific context of the sports clubs (location, size) (Van Hoye *et al.*, 2021).

The paucity of evidence on the implementation of HP interventions in sports clubs (McFadyen *et al.*, 2018), as well as the poor application of the settings-based approach to sports clubs (Geidne *et al.*, 2019) suggests a need for further research to better understand both process and effectiveness. A framework that has been widely used to document HP intervention implementation is the Consolidated Framework for Implementation Research (CFIR) (Damschroder *et al.*, 2022), describing five domains: (i) intervention characteristics, (ii) inner setting, (iii) outer setting, (iv) individual characteristics and (v) processes of implementation. Different frameworks exist in terms of intervention implementation, like the Medical Research Council guidance (Skivington *et al.*, 2021), but the CFIR offers a clear, practical application to the HPSC, especially in regard to the use of a settings-based approach in 'real-world' implementation.

The Gaelic Athletic Association (GAA) HCP has shown promising impact on HP practice (Lane *et al.*, 2020), as well as on smoke-free policies (Seitz *et al.*, 2020). As previous studies collected data among Healthy Club Officers (HCOs) (the volunteers appointed to run the HCP at club level) only, the present study investigates the HCP implementation process (including mechanisms, barriers and leverages) over a 10-year timeframe, through engagement with these HCOs, and in addition, club coaches and members around their perceptions of changes in policies and practice.

METHODS

The present work uses a multiple case study design (Stake, 2013), based on qualitative and iterative methods, including different sequential data collection with HCOs, coaches, participants and members. This data triangulation is shaped by context and emergent data, with the aim of exploring a real-life bounded system over time, through the involvement of multiple sources of information (Stake, 2013).

Participants

Each of the 16 initial GAA 'healthy clubs', starting the program in 2013, were invited to participate in the study in October 2021, through an email, and subsequent call with HCOs. The GAA HCP strives to 'make every GAA club in Ireland a hub for health, capable of

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providing their members and communities with programs that support their physical, emotional and social wellbeing' (https://www.gaa.ie/news/gaa-healthy-club-project-transforming-ireland-health/), through the appointment of Healthy Club Officer (HCOs; i.e. volunteer appointments to this role) and the implementation of healthy club statements and plans (Lane *et al.*, 2021). The HCP is generally implemented over seven steps during an 18-month cycle, with HP activities across different priority areas, as set out by the national Community and Health Department within the GAA: PA, Diet and Nutrition, Mental Fitness/Health, Gambling and Substance Use awareness, Diversity and Inclusion, Personal and Community Development and Sustainability. Five clubs (31%) took part in the study, two clubs were situated in county Cork, one in Down, one in Tipperary and one in Meath. Seven clubs did not reply, two clubs replied positively by email, but they did not engage after with a follow up call, and two clubs organized a first meeting with the research team, but could not reach out to other potential participants.

Data collection

Written policy documents (e.g.: club development plan, regulation, member charter) were collected from HCOs, club websites and the GAA HCP reporting portal. In total, 20 focus groups, four in each sports club were carried out by the first author (Table 1). The first focus group was with HCOs, to investigate the implementation of the HCP and were carried out online due to COVID19 regulations to analyze the impact of the HCP initiative on participating sports clubs' policies. Active written consent was obtained by the HCOs for club involvement and individually for each focus group participant. Based on HCO identification and recruitment of participants in their club, three further face to face focus groups were carried out. Selection criteria were: (i) aged over 18 years, involvement in the specific selected category (i.e. coach, senior playing member) since at least the beginning of the current season. No specific knowledge about the HCP was required. In turn, a second focus group was organized with sports club coaches to explore their perceptions about HCP, their behaviors in terms of HP and barriers or facilitators to HCP implementation. A third focus group was undertaken with adult sports participants to investigate their perceptions of HP and their awareness of the HCP. A fourth focus group was carried out with wider club nonplaying members that benefited from one of the HCP activities. Activities included PA programmes for disabled people, and programmes for older inactive males and isolated men, as well as walking groups, and participants were asked about barriers to engagement in activities, changes in policy, as well as the impact of the programme on their experience of, and benefits accrued from sport (see interviews guides in Supplementary Files).

Data analysis

After full transcription of each focus group, a deductive data analysis using the CFIR (Damschroder *et al.*, 2022) was carried out using Nvivo software, to rate the 39 implementation indicators across the five domains (see Table 2 for details of rating and quotes for each indicator in each club). Despite the fact that the CFIR has been created for health care settings, it has been recently used to review literature in community settings (Cooper *et al.*, 2021), as well as to analyze PA promotion programmes in German sports clubs, due to its multi-level and multi-strategies approach (Cardona *et al.*, 2023). Based on the definitions presented in the updated CFIR framework, each indicator was rated for each club in accordance with associated rating rules (https://cfirguide.org/wp-content/uploads/2019/08/ratingrules10-29-14.pdf), as presented in previous

Table 1: Interviews and case study design

	County	Healthy Club Officers (HCOs)	Coach	Athletes	Members
Club 1	Cork	4 members	8 coaches from youth and senior team	6 athletes from senior hurling and camogie team	16 participants from walking group
Club 2	Cork	4 members	4 coaches of youth teams	7 athletes from female and male senior hurling/ camogie team	One participant and 4 parents of All Star program
Club 3	Tipperary	1 officer Board of the club	3 coaches of youth team	13 senior camogie players	2 participants from walking group
Club 4	Meath	4 members	5 coaches' children and youth	4 senior athletes (3 hurling; 1 camogie)	15 men on the move; 2 men's shed; 1 Irish teacher;
Club 5	Down	1 member	2 coaches of girls camogie	15 ladies from senior team football	2 participants from walking group

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Table 2: Data collected on each indicator of the CFIR framework

	Main finding	Club 1	Club 2	Club 3	Club 4	Club 5
Innovation domain		**+14**	**+12**	**+8**	**+14**	**+14**
A. Innovation source	Trust in the GAA Community and Health Department, as project fitted with ongoing activities and needs at time	+2	+2	+2	+2	+2
B. Innovation evidence-base	Different scientific evaluation of the project	+1	+1	+1	+1	+1
C. Innovation relative advantage	Reaching beyond club members, better recognition in club, not such program in other sport	+2	+2	+1	+2	+2
D. Innovation adaptability	The innovation has been tailored in each club, with different configurations of HCOs team and activities	+2	+2	+2	+2	+2
E. Innovation trialability	In each clubs, specific activities have been offered and have not sustained, without having negative impact	+2	0	+1	+2	+2
F. Innovation complexity	HCP should be kept simple, small steps, where organizational change is long and complex	+2	+2	X	+1	+2
G. Innovation design	Document and guidance are well covered, on ground support for funding or how to receipt are not found by all clubs	+2	+2	−1	+2	+1
H. Innovation cost	Cost should be reduced to 0 and fundraising/call for funding are targeted in different clubs	+1	+1	+2	+2	+2
Outer setting domain		**+5**	**+4**	**+8**	**+3**	**+9**
A. Critical incidents	COVID-19 has hindered on site activities, but generated community support through Whatsapp group, individual stepping in or out has influenced the implementation process	0	0	+2	+1	+2
B. Local attitudes	HCP increased recognition from local community and included the community (nonplayers) in the GAA activities	+2	+2	+2	+2	+2
C. Local conditions	Not all clubs have mentioned local factors supporting proactively their project, but there is a warm welcome of the different activities offered by the HCP	+1	0	+1	0	+1
D. Partnerships and connections	Different local resources are used to implement HCP activities, coming from NGOs, charities or health organization, like a cancer prevention day, suicide prevention workshops, healthy eating workshops	+2	+1	+2	+1	+2
E. Policies and laws	HCP develop policy document only on GAA request, no mention of local or national policy supporting has been made	0	+1	0	−1	0
F. Financing	Two clubs are particularly answering to many funding calls under HCP project, other work on reducing activities costs or fundraising	0	0	+1	0	+2
G. External pressure	No club mention any external pressure to implement HCP, as they consider HCP as an added value beyond sport offer for GAA club	0	0	0	0	0
Inner setting domain		**+2**	**+4**	**−1**	**0**	**0**
A. Structural characteristics	The HCP officer has different configurations, from a single individual to a team of 6 people. In each case, there is a leader and its team. One people is responsible of the communication, others are responsible of some activities depending on their own interest.	+2	+2	0	+1	−1

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Table 2: Continued

	Main finding	Club 1	Club 2	Club 3	Club 4	Club 5
B. Relational connections	The HCP is not known by senior players, and only acknowledge by coaches in some clubs, as it is described by members as activities to reach out to the community, not directed towards players. (delivering AROUND the club, not IN the club)	−1	−2	−1	−2	−1
C. Communications	Social networks are used to share HCP activities and Whatsapp internal to club also, communication is a key to success	+2	+2	+1	+2	+2
D. Culture	In some clubs, the healthy club is seen as an attempt to a one club culture, even if members do not mention opportunities to mix up with other categories or members	−1	0	+1	−1	−1
E. Tension for change	The HCP answer to members request, but no urgent tension or critical incidents have been reported for change	−2	−2	−2	−2	−2
F. Compatibility	HCP has developed process as report to General Assembly, communication, event organization, but are not linked to decision-making process in each club	0	0	−1	−1	+1
G. Relative priority	HCP is seen as going beyond the sport performance remit of sports clubs and provide added value. (coaches do coaching, not health promotion)	+1	+2	0	+1	0
H. Incentive systems	HCP brings new volunteers, social goods and recognition to the club	+1	+2	+1	+2	+2
I. Mission alignment	HCP is about reaching out to community, not taking care of actual members, as perceived by coaches and sport participants, but is seen as one of club mission from HCP officer	X	X	X	X	X
J. Available resources	HCP is running at low costs, in club infrastructures or outdoor and based on volunteer. Activities are adapted and based on resources	X	X	X	X	X
Individuals domain		**+11**	**+11**	**+7**	**+10**	**+9**
A. High-level leaders	HCP is run by HCP officer, with a strong leader, who is in charge, and helpers, who are responsible of some activities and supporting. No recurrent pattern has been observed on leaders' profile, except they were asked to play this role and saw an interest	+2	+2	+2	+2	+2
B. Mid-level leaders	HCP MANAGER members are often in charge of a specific activities (e.g. walking club, fruits for kids training), one is in charge of communication,	+2	+2	+1	+2	0
C. Opinion leaders	HCP officer is often seen as a very involved person having big achievements on HCP, no specific other leaders have been described	+1	+1	+1	+1	+1
D. Implementation facilitators	HCP call for internal or external experts to run their activities (yoga teacher, walker…)	+1	+1	0	+1	+2
E. Implementation leads	The project is implemented by HCP officer, having club executive approval or commitment	+2	+2	+2	+2	+2
F. Implementation team members	The team meets on average every month to every 2 months, they plan for quarters and discuss about their ideas	+2	+2	0	+1	0

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Table 2: Continued

	Main finding	Club 1	Club 2	Club 3	Club 4	Club 5
G. Other implementation support	Volunteers are asked to support the delivery based on their own interest	+1	+1	+1	+1	+2
H. Innovation deliverers	This depends on activities delivered, no specific person appointed	0	0	0	0	0
I. Innovation recipients	This depends on activities, but most activities are targeting nonplaying members or youth, not targeting players directly and are directed towards a specific age group or category	X	X	X	X	X
Implementation process domain		**+6**	**+6**	**0**	**+5**	**+4**
A. Teaming	The HCP officer is working together based on meeting every 2 months and on allocated tasks for each officer. A specific role (communication, representation on executive board is allowed to one individual).	+2	+2	0	+1	0
B. Assessing needs	A need assessment has been done as mandatory task when launching GAA HCP, but has not been renewed. Informal needs assessment is ongoing, based on request or discussion	+2	+1	0	+1	+1
C. Assessing context	The club executive is supportive and the events are based on opportunities or request. The HCP officer is not recognized as existing by every club member	X	X	X	X	X
D. Planning	The planning is done on a single season, and per quarter. Only one club has an official plan, other discuss activities and put them in place in the next 3 months	+1	+1	0	+1	+2
E. Tailoring strategies	The criteria for putting an activity in place are: low cost, 6–8 weeks program, already designed, having an interested person available to deliver	−1	−1	−1	−1	−1
F. Engaging	Engaging the target population is done through social media and communication in the community	+1	+2	+1	+2	+2
G. Doing	Beyond mandated policies (critical incident plan and smoke-free policy), no policy has been designed by HCP MANAGER, and if a policy document exists, it's not shared within the club	−1	−1	−1	−1	−1
H. Reflecting and evaluating	The activities are not evaluated, but reconducted if sufficient numbers of participants have been reached.	0	0	0	0	0
I. Adapting	Depending on the number of members in HCP officer and on their availability, the HCP officer is more or less active through the years, but is always maintain and valued as important	+2	+2	+1	+2	+1

studies (Damschroder and Lowery, 2013). The rating was done in two steps, by the first author, with verification from the last author and club by club: (i) identification of quotes related to each indicator, (ii) quantification of the direction of influence for the indicator. The latter relates to the valence (positive (+) or negative (−)) influence or not appropriate (X) and the strength weak (i) or strong (ii) of the indicator on implementation. A second coding of quotes of each club were also used for a general synthesis presentation of commonalities.

RESULTS

The details of participants included are presented in Table 1. The results are presented using the CFIR in a two-step process: (i) a club comparison of the ratings and (ii) presentation of qualitative data in each

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domain (see Figure 1 for an integrative presentation of results).

Club comparison based on the CFIR rating

Table 2 summarizes the ratings of the CFIR framework per club, where strengths can be identified in terms of the quality of the HCP in terms of innovation (perceived as both flexible and adaptable, even complex), the outer setting domain where partnerships and local attitudes are generated through the HCP, and on individual domains, where strong leaders bring on board mid-level and opinion leaders. Results are more mixed for the implementation process, where steps like reflecting and evaluating are missing and more negative for the inner setting, where there is a lack of recognition and evidence of a whole club approach, even if there is support from club executive or management. The two clubs who report having a standalone HCO score lower in different dimensions, where other characteristics of the HCO or the level of participation, size of club or location (rural versus urban) do not seems to play a role in HCP implementation.

Presentation of qualitative findings in each CFIR domain

The innovation domain

In the CFIR framework, the innovation domain refers to the 'thing' being implemented (Damschroder *et al.*, 2022). In this case, the present section discusses perceptions of the HCP by the different stakeholders.

HCOs did trust the GAA Community and Health Department, and appreciated the human (one dedicated manager) and material (training, templates, signages) support allocated, even if they focus principally on reducing costs in intervention delivery.

One HCO describes the program as *'we try to be something for everybody in the club. It's not just about people who play the games or people who coach and mentor. No, this is for all those and the rest, ourselves being the rest. I mean, people who no longer coach or who no longer play and maybe their kids…So we're trying to keep people within the club really'* (Club 1; HCO).

The interviewed clubs already had initiatives in place. *'There was a group of people at work who were trying to create a healthy workplace. And*

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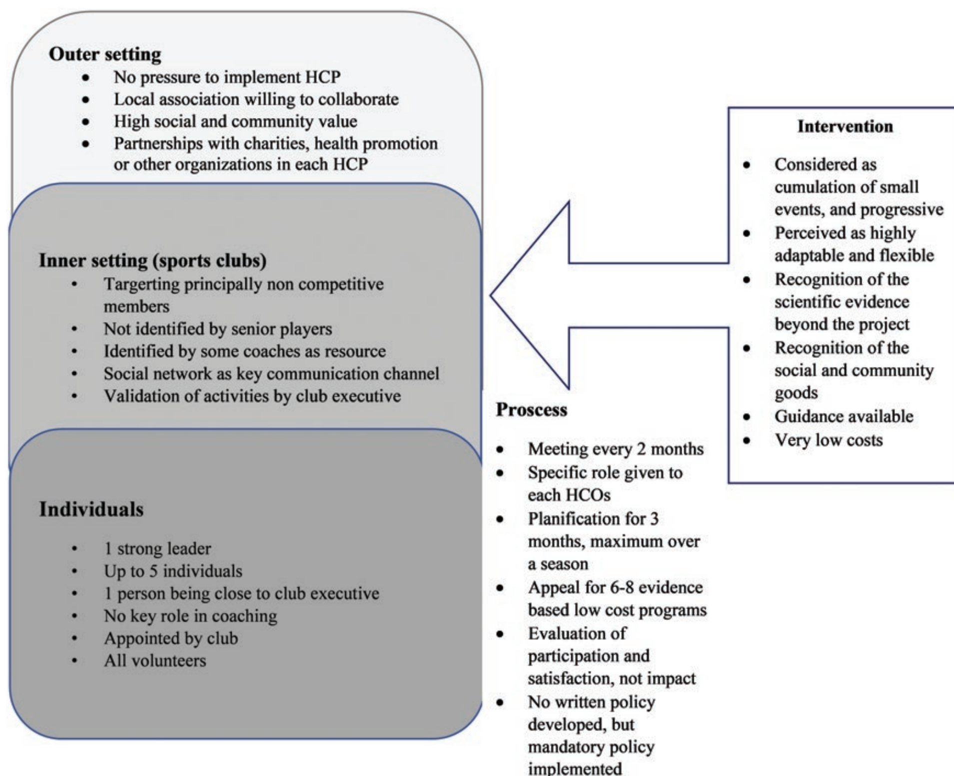

Fig. 1: Summary of the findings using the CFIR.

I stole the idea, basically. I thought we can be a Healthy Club and see what we can do to make…' (Club 5; HCO).

Different strategies for implementation were adopted, all planned on a single season, mostly for the next 3 months, followed by a review period across clubs. In some clubs, the activities are thought-based on rather informal collaboration at local level, to foster the municipality and community dynamic: *'The tactic we took was to adopt a charity every year that we could work with…we've tried to get one who we can work with, not just collect money for a good cause'* (Club 5; HCO). The idea is to offer a diversity of small events for different topics, as well as different population groups *'we had started a number of initiatives doing exercise classes, and we were doing fruits and things like that. Small initiatives or small projects…'* (Club 1; HCO).

The outer setting domain

In the CFIR framework, the outer setting is defined as the setting in which the inner setting exists (Damschroder *et al.*, 2022). In this case, the outer setting is the community or the local level, including community-based associations, schools, housing estates, workplaces… *'at the time that there was somebody from the Health Service Executive through connections… was interested'* (Club 1; HCO).

The HCOs do not feel an external pressure from society or a specific mandate, rather operating opportunistically to build partnership or access expertise, especially with non-governmental or health organizations, and charities, to run programs that are often relatively short term; *'So it's kind of using the opportunities of people's experience, workwise, but bringing those in… So how we organize it, is kind of organically'* (Club 2; HCO). Some HCOs submit to calls for funding, and no systematic search of partnerships are undertaken, but HCOs do seek opportunities at local level, through community information sharing and identification of skilled individuals.

The inner setting domain

In the CFIR framework, the inner setting is common across clubs is described as the setting in which the innovation is implemented (Damschroder *et al.*, 2022), meaning the GAA club, including its different teams or groups and related committees.

HCOs are often structured as a team with a strong leader, and up to five people. In two clubs, the HCP leader has been in position since 2013, with some variation in membership of teams apparent in most clubs. The HCP leader is not involved in club governance, and get support or at least commitment from club executive. '*It's a written document that goes to the committee before, and they adopt it. Like a lot of things, the committee will adopt something without looking at it, they'll take it, you'll have work away, so long as it doesn't require them to do anything in particular'* (Club 5; HCO).

The HCP is recognized by club members as a project or activities that is delivering around the club rather than in the club, suggesting activities are dedicated to nonmembers of the club and not to playing sports participants. *'I think it's great that it's not something that's geared towards players. I don't mean it excludes players, but there's people going for walks and stuff. It's kind of opening up the network a bit'* (Club 1; Coach).

Coach led HP is perceived as being beyond coaches' remit, as their priorities are around participation and retention, building this through fun, respect and teamwork, especially for children and youth. Among adult teams, coaches advise on performance-oriented factors (sleep, injury, healthy eating) and athletes consider game preparation and health behaviors as their own responsibility, not expecting their coach to interfere with it.

'I suppose taking part, feeling part of a team, and getting fit, keeping fit, which sometimes I find people, children especially, they don't like… You have to make it fun. Get them fit without them realizing they're getting fit, when using the ball or doing a game, not telling them to do…' (Club 4; Coach). *'Okay. Yeah. So advice on healthy eating. Yeah. I see that you have a bottle of water with you, some of you'* (Club 3; Player).

The individuals domain

In the CFIR framework, the individuals domain represent the role and characteristics of the people delivering the innovation (Damschroder *et al.*, 2022).

The number of HCOs varies from a single individual to six members, and is often task dependent for different activities run under the HCP banner.

> *The team changes and has changed over the years and people come and go and that's fine because everyone is volunteering and it's their own time. And, we help each other, but there is some kind of areas that naturally fall within people's areas of interest.* (Club 1; HCO)

The HCOs underline the virtuous cycle created by HCP through the uptake of activities and the feedback from participants, and they enjoy being involved and part of it, contributing something meaningful for the club and community.

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> *We try to get new members every year across all the different levels. And when people see the positivity, and see the good work that's going into it, like there's no one on our committee who doesn't feel that the work that's being done under the Healthy Club banner isn't a positive thing.* (Club 4; HCO)

The HCOs do not deliver activities, but plan and coordinate events, while also trying to recruit support from other members based on their own interest and capabilities.

> *If you have a member who is passionate about a particular topic, they can sort of come through the Healthy Club and say, I'd love to do that. And as with most of the things in an amateur voluntary organization, if you have someone who will take the ball and run with it.* (Club 2; HCO)

The implementation domain

In the CFIR framework, the implementation domain is described as the activities and strategies used to implement the innovation (Damschroder *et al.*, 2022).

Different strategies for implementation are adopted, but all are planned on a single season, mostly for the next 3 months and reevaluated at that time. In some clubs, the idea is to offer a diversity of small events for different categories, where some of those activities are thought-based on partnership. HCOs meet every 3 months and use a mobile communication channel to discuss specific topics and organize activities.

At the outset of phase 1 the HCP, sports clubs evaluated members need before starting HP activities. Subsequently, the HCP team do not repeat a formal needs assessment, but rather responds to specific requests from members; '*We might have one idea, but, I suppose really, we'd look at, as if instance that there, we look at what we have. What our needs are…what we need to invest… I suppose really our plans really are membership based really. What do our members want?*' (Club 2; HCO).

Moreover, the HCOs are focused on acting or doing rather than 'policing'. No policy has been created by the HCOs themselves, but clubs have adopted the two mandatory policies required to get the HCP accreditation (substance use and smoke-free policy and critical incident plan, which outlines appropriate responses to emergency situations). HCOs explained that when the latter the critical incident policy is in place, it is not shared with members as document, but used to inform the club's response if an incident occurs.

> *Yeah. We do have a policy written here somewhere. Yeah, we do have. But, we don't give it to them when they register. No, I'd say it's on our website and it's display outside…It's something we should be doing code of conduct and all that, but it's up there. We should probably inform people.* (Club 3; HCO)

In general, activities are not evaluated in terms of impact, and indicators of success are principally attendance and money raised, as well as participant and community feedback.

> *It's hard to know, hard to say. I mean, I can't give an outsider's perspective because I'm not. And we haven't sort of surveyed it or anything. It would be a lot of effort for a reward to try to do something like that.* (Club 5; HCO)

DISCUSSION

The present case study has shown that HCP is organized in sports clubs by a rather independent HCP team, supported by club executive, comprised of one to six persons, whose purpose is to deliver health-related activities, mostly dedicated to new members across the local community. Results reflect those observed by a previous quantitative evaluation of the project, showing improvement on HP promotion in sports clubs, but highlighting barriers on structural changes at the coaching and among all levels of the sports club (Lane *et al.*, 2021) and prompt consideration of the position of the HCP between the fourth stage of the application of the settings-based approach to sports clubs (Whitelaw *et al.*, 2001), called sport-club based HP (principally focusing on delivering different programs) and the last stage, called HPSC (having a health in all policy, decision-making process and health embedded in sports clubs activities [Geidne and Van Hoye, 2021]). In other words, health is not fully embedded in sports club's decision-making process and policy, even if HCP has support from the executive, and HP programs and activities are delivered.

Results also question the application of the settings-based approach to sports clubs (Whitelaw *et al.*, 2001), where HCP seems to be considered by sports participants as promoting sport 'around' and not in the sports clubs, while the settings-based approach recommends to embed HP in the core business of clubs, which is sport provision (Kokko, 2014). Nevertheless, the most implemented activities are walking clubs or PA for recreation rather than competition, especially targeting vulnerable or sedentary groups, thereby enlarging sports clubs reach and contribution of the sport sector to PA (Eime *et al.*, 2013; Kokko *et al.*, 2019). The number of activities and volume of HCOs

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have not increased over 10 years, but as some activities are repeated within the club, HCOs have opportunities to also focus on new ones. This process highlights the long temporal timeline to the implementation of the settings-based approach (Dooris, 2009; Dooris *et al.*, 2014).

While the social and organizational determinants of health (Van Hoye *et al.*, 2021) are tackled within the HCP, the policy writing and planning process has not yet been undertaken, which is also similar to previous Australian and Finnish work (Casey *et al.*, 2009, 2012a; Kokko *et al.*, 2011) and reflects the general paucity of policies supporting HPSC in Ireland. The HCP changed the club organization, not through policy but through the allocation of human and material resources, and informal planning and implementation, which is in line with previous research confirms that sports club volunteers do not have the capacity to actually promote health (Kelly *et al.*, 2014). Moreover, policies adopted were mandatory to the HCP, albeit suggesting that policy can be enforced by national sports federation to support sports clubs. It appears that while emphasis on policy formalization in sports clubs has been underlined, both for HP (Casey *et al.*, 2012b) and more generally (Doherty *et al.*, 2014), sports clubs function through a reactive manner than having developmental objectives (Harris *et al.*, 2009). These findings align with a previous study showing that sports clubs were confronted by a paradox in terms of feasibility of the safety policy implementation, where stakeholders stated this policy was essential to ensure safe practice, but the cost to the club to adopt this policy would affect their ability to survive (Donaldson *et al.*, 2012). Collectively, these findings raise a major issue in terms of evaluation of policy implementation and accountability, if no written documents are produced (Lobczowska *et al.*, 2022).

Strategies of program implementation at different levels of the sports clubs could be enriched, based on the HPSC logic model (Van Hoye *et al.*, 2023a). At the macro level, executive board and sports clubs still do not have a written policy for HCP, even if organizational change (officer appointment, resources dedication) occurs, which is consistent with a previous French study (Van Hoye *et al.*, 2016). At a manager's level, the HCO and its team develop resources based on community resources through partnerships, charity events, or outreach to other specific settings likes school or parish, thereby overcoming the challenge of partnership for HP in sports clubs (Donaldson *et al.*, 2021). Nevertheless, support and education directly to coaches seems to be missing in some clubs, as well as support in implementing HCP policies (strategic plan, document for coaches or participants), which creates a communication gap, already identified in previous French work (Van Hoye *et al.*, 2016). Coaches activities toward HP seems to be only indirectly impacted by the HCP, through side activities beyond coaching, where coaches place an emphasis on risk limitation (injuries, harassment) and on fun through participation, rather than adopting a global and positive HP approach.

The key message sent by the HCP to external stakeholders, especially the national sports federation, is that development of programs could serve as basis for HP in clubs. Important criteria for programs are the following: not costly, lasting 6–8 weeks, with content already prepared and an identified volunteer or external partner to run it. These types of programs have been recurrently identified in the literature as evidence based (Richardson *et al.*, 2017), but still lack the ability to tackle behavior change, where timeline for behavior maintenance is more than 6 months (Prochaska and DiClemente, 1986).

This study has several strengths, including the triangulation of data (Johnson *et al.*, 2022a) within sports clubs and the use of a structured framework for the analysis (Damschroder *et al.*, 2022). The study presents also some limitation: the limited number of clubs having participated in the full study (5/16), the self-selection bias of focus group participants by the HCP officer, and potential omission of key documents. Moreover, the recall bias over the 10-year period could play a role in the accuracy of data reported, as well as the coding process from a single author.

CONCLUSIONS

The present study emphasizes the success of the HCP in placing HP on the agenda of sports clubs and designing an informal policy for HP in sports clubs, even if HP activities and recognition are directed toward and come from the community rather than sports club members. The HCP relies on limited human resources, is not fully recognized by sports clubs' participants and only acknowledged by some coaches as a resource, limiting embedment in sports clubs core business. Practical implications include: (i) creation of template and accountability system for HP policy in sports clubs by national sports federations, as well as evaluation of implementation, and (ii) availability of 6–8 weeks, low cost and one volunteer dependent, behavior change interventions from external actors to enhance sports clubs' capacity to promote health at an individual level. Further implications of the present work has shown the need to enhance the support from settings and local level to national level, by working at a system level on HP in

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sports clubs (Van Hoye *et al.*, 2023a), as only 26% of European countries have a sport for health policies (Whiting *et al.*, 2021), in order to support sport movement involvement in HP (Johnson *et al.*, 2022b), but also HP contribution to well-being in societies (Van Hoye *et al.*, 2023b). Future research should consider how HCP organizational changes and activities can deliver behavior change at individual and community levels.

SUPPLEMENTARY MATERIAL

Supplementary material is available at *Health Promotion International* online.

AUTHOR CONTRIBUTIONS

A.V.H. contributed to all roles, A.L. and A.V. participated to conceptualization, review and editing, C.R. participated to methodology, data collection support, review and editing, C.W. contributed to funding acquisition, methodology, formal analysis, project administration and review and edit.

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ETHICAL APPROVAL

Ethical approval has been granted by the first author Faculty Ethical Committee of the University.

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