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Development of the HPSC approach: Theory of implementing a complex intervention

Stacey Johnson

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THÈSE DE DOCTORAT

Promouvoir la santé au sein des clubs de sport (PROSCeSS) :

du développement de la théorie à l'intervention

Stacey JOHNSON

Laboratoire Motricité Humaine Expertise Sport Santé – UPR 6312

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Promouvoir la santé au sein des clubs de sport (PROSCeSS) :

du développement de la théorie à l'intervention

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Abstract

For nearly 40 years, public health advocates have been called upon to invest in settings to promote health. Many settings (hospitals, schools, universities) have been researched to understand their capacity to change and develop into 'healthy' settings. Sports clubs have been undergoing similar research and development to increase their health promotion actions. However, the settings-based approach is rarely implemented or properly executed in the sports club context.

Therefore, this thesis undertook an iterative approach to educate sports clubs on the benefits of promoting health and provide guidelines for implementing health promotion actions. The objective is for sports clubs to go beyond promoting one health behavior to one sports club level by incorporating health promotion actions into the club's daily operations and policies. To understand health promotion perceptions of sports club managers, coaches and participants, a multi-level questionnaire was designed (study 1) and psychometrically validated (study 2). Study 3 created the health promoting sports club (HPSC) model with three levels (macro, meso, micro) interacting with 4 health determinants (economic, environmental, organizational, social). Strategies and intervention components were developed from evidence-driven guidelines and categorized into the HPSC model to create an intervention planning framework (study 3). A concept mapping study generated statements directly from sports actors regarding needed support to increase health promotion actions in sports clubs (study 4). Study 5 revised the HPSC model (study 3) to include both internal *and* external levels impacting a sports club's ability to promote health. Stakeholder-generated statements (study 4) were formulated into new intervention components and categorized into a revised HPSC framework. To provide concrete examples, study 6 capitalized on eight exemplar French sports clubs successfully implementing health promotion projects.

The HPSC approach encompasses all sports club actions to improve the mental, social and physical health of stakeholders. From a research perspective, the multi-level design of the HPSC model shows how interconnected internal and external levels are to help impact stakeholder health. Including participation from sports stakeholders improves the acceptability, sustainability and success of health promotion interventions. From a public health perspective, focus has been on increasing physical activity levels. Through informal settings such as sports clubs, wider audiences can be reached to offer physical activity opportunities and general health education. Combined, study results offer sports clubs a rationale to invest in health promotion. The steps laid out in this thesis support sports club during the development and implementation process of interventions, targeted to sports club's needs and goals, grounded in theory and evidence-based.

Keywords: health promotion, intervention framework, intervention mapping, settings-based, sports clubs, sports club model

Résumé

Depuis près de 40 ans, les acteurs de la santé publique sont appelés à investir dans des milieux qui favorisent la santé. De nombreux milieux (hôpitaux, écoles, universités) ont déjà fait l'objet de recherches pour comprendre leur capacité à changer et à devenir des milieux "sains". Les clubs de sport ont fait l'objet de recherches et de développements similaires afin d'accroître leurs actions de promotion de la santé. Cependant, l'approche basée sur les milieux est rarement mise en œuvre ou correctement exécutée dans le contexte des clubs de sport.

Par conséquent, cette thèse a utilisé une approche itérative pour sensibiliser les clubs de sport aux avantages de la promotion de la santé et fournir des recommandations pour la mise en œuvre d'actions de promotion de la santé. L'objectif est que les clubs de sport aillent au-delà de la promotion d'un comportement de santé au niveau d'un club de sport en incorporant des actions de promotion de la santé dans les opérations et les politiques quotidiennes du club. Pour comprendre les perceptions de la promotion de la santé des dirigeants de clubs de sport, des entraîneurs et des pratiquants, un questionnaire à trois niveaux a été créé (étude 1) et une validation psychométrique effectuée (étude 2). L'étude 3 a créé le modèle théorique des clubs de sport promouvant la santé (HPSC) avec trois niveaux (macro, méso, micro) interagissant avec 4 déterminants de la santé (économique, environnemental, organisationnel, social). Des stratégies et des composantes d'intervention (CIs) ont été développées à partir de recommandations basées sur la preuve scientifique et catégorisées dans le modèle HPSC pour créer un cadre de planification des interventions (étude 3). Une étude de cartographie conceptuelle a permis de recueillir auprès des acteurs du sport les besoins de soutien qu'ils nécessitent pour accroître les actions de promotion de la santé dans les clubs de sport (étude 4). L'étude 5 a révisé le modèle HPSC (étude 3) pour inclure les niveaux internes et externes ayant un impact sur la capacité d'un club de sport à promouvoir la santé. Les besoins (étude 4) ont été formulés en nouveaux CIs, et catégorisées dans un cadre HPSC révisé. Pour illustrer HPSC, l'étude 6 s'est appuyée sur huit clubs de sport français qui ont mis en œuvre avec succès des projets de promotion de la santé. L'approche HPSC englobe toutes les actions des clubs de sport visant à améliorer la santé mentale, sociale et physique des parties prenantes. Du point de vue de la recherche, la conception à plusieurs niveaux du modèle HPSC montre à quel point les niveaux internes et externes sont interconnectés pour aider à influencer la santé des parties prenantes. L'inclusion des parties prenantes améliore l'acceptabilité, la durabilité et le succès des projets de promotion de la santé. Du point de vue de la santé publique, l'accent a été mis sur l'augmentation des niveaux d'activité physique et la santé générale. Grâce à des milieux informels tels que les clubs de sport, l'activité physique et l'éducation à la santé sont accessibles à un plus large public. Des deux points de vue,

les résultats de l'étude offrent aux clubs de sport une motivation pour investir dans la promotion de la santé. Les étapes présentées dans cette thèse aident les clubs de sport pendant le processus de développement et de mise en œuvre d'une intervention équilibrée, ciblée sur les besoins et les objectifs du club de sport, fondée sur la théorie et sur des preuves.

Mots clés : cadre d'intervention, cartographie des interventions, clubs de sport, milieux de vies, modèle du club de sport, promotion de la santé

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Thesis linked publications and communications

Publications in international peer reviewed journals (as they appear in this text):

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Van Hoyer, A., **Johnson, S.**, Geidne, S., Donaldson, A., Rostan, F., Lemonnier, F., Vuillemin A. The health promoting sports club model: An intervention planning framework. *Health Promotion International*, 2020; <https://doi.org/10.1093/heapro/daaa093>

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Glossary

In the framework of the PROSCeSS project, many terms were used to ensure consistency throughout the research. Table 1 contains many of the common terms with their definitions found throughout this thesis. Throughout the research, each definition was re-examined by the research team based on new findings and understandings to ensure they were still valid in terms of the research scope.

Table 1. Common terms

Term	Definition	Source
Health	“A resource of daily life and not as the goal of life; it is a positive concept accenting social and personal resources and on physical capacities. The promotion of health is therefore not only a matter for the health sector: it does not merely advocate for the adoption of lifestyles that promote good health; its ambition is the complete well-being of the individual”	(World Health Organization, 1986)
Health determinant	“A range of personal, social, economic and environmental factors that influence health”	(World Health Organization, 2017)
Health promotion	“The process of enabling people to increase control over and thereby improve their health”	(Nutbeam, 1998)
Physical activity	“Any body movement generated by the contraction of skeletal muscles that raises energy expenditure above resting metabolic rate”	(Caspersen et al., 1985)
Physical inactivity	“Non-achievement of physical activity guidelines”	(Thivel et al., 2018)
Salutogenesis	“The origins of health begin with a person’s sense of coherence which provide the basis for resource-based health perspective”	(Mittelmark & Bauer, 2017)

Sedentary behavior	“Waking behaviors characterized by an energy expenditure ≤ 1.5 METs while sitting, reclining or lying down”	(Tremblay et al., 2017)
Setting for health	“A place or social context where people engage in daily activities in which environmental, organizational and personal factors interact to affect health and well-being”	(Nutbeam, 1998)
Settings-based approach	“A place where people live, work, play or go for education or care that helps them to make healthy choices”	(Koski et al., 2017)
Socio-ecological approach	“An approach that takes into account the social and environmental factors that affect health and well-being”	(Booth et al., 2009)
Sports club	“A private, non-profit organization formally independent of the public sector, including volunteer members and a democratic structure, having sport provisions as their main aim”	(Elmose-Østerlund, Ibsen, et al., 2017)
Sports club actor	“Any person working in or for a grassroots sports club including the executive board of directors, managers, administrative staff, volunteers, coaches, athletes”	(Johnson et al., 2019)
Stakeholder	“Any person who impacts or is impacted by the actions and efforts of sports clubs from a national to a local level. This may include government agencies, community members, sports club actors (see above), parents, family and friends of sports participants”	(Van Høye et al., 2020)

Acronyms

Comité National Olympique et Sportif Français (CNOSF)

École des Hautes Études en Santé Publique (EHESP)

European Union (EU)

Health Enhancing Physical Activity (HEPA)

Health Promotion (HP)

Health Promoting Schools (HPS)

Health Promoting Sports Club (HPSC)

Intervention Component (IC)

Instance Régionale d'Éducation et de Promotion de la Santé (IREPS)

Non-communicable Disease (NCD)

Non-governmental Organization (NGO)

Physical Activity (PA)

Promotion of Health within Sports Clubs (PROSCeSS)

Sports Club (SC)

Sports Clubs for Health (SCforH)

World Health Organization (WHO)



GENERAL INTRODUCTION

"The greatest wealth is health"

...Virgil, Roman poet

Health is our most valuable asset. It is a human right with multiple dimensions including “physical, mental, spiritual and social well-being” (World Health Organization, 1946). When combined, these dimensions help individuals and nations reach equality, security and peace therefore, promoting health should be extensive and a prime focus in every country. Unfortunately, human health is deteriorating with life expectancy declining (Ho & Hendi, 2018) and projections showing that the current generation may be the first in history to be outlived by their parents (Daniels, 2006; Wang & Veugelers, 2008). Multiple reasons exist for this decline with one major cause being the global increase of physical inactivity in all age groups, especially in high-income countries since 2001 (Guthold et al., 2018). In fact, in 2015 only 61.3% of adults in Europe achieved moderate to high levels of physical activity (European Commission et al., 2018). Increasing physical activity levels can have a profound effect on decreasing many chronic diseases such as obesity, metabolic syndrome, hypertension, heart disease, diabetes and various types of cancer (Bailey et al., 2015; Durstine et al., 2013). Additionally, physically active populations lead to improved mental health, less anxiety, better ability to handle stress and lower non-communicable disease (NCDs) rates (Bailey et al., 2015). The WHO reports that physical activity levels have not improved since 2001 and launched the Global Action Plan on Physical Activity 2018-2030 which calls for “a whole system response involving all sectors and stakeholders taking action at global, regional and local levels to provide safe and supportive environments and more opportunities to help people increase their levels of physical activity” (World Health Organization, 2018). This ‘pandemic’ of physical inactivity is further exasperated by other unhealthy behaviors such as poor nutrition from quick convenience foods rather than nutritious meals, increased screen-time as a substitute for active leisure practices and convenient transportation methods instead of active transport such as walking or cycling (Thivel et al., 2018). In response to these trends, the Global Strategy on Diet, Physical Activity and Health was launched in 2004 which further recognized the need to establish strategies to increase physical activity levels and improve diets (World Health Organization, 2004). This work can be advanced by recognizing that health is created in settings where “people live, learn, work and play” (World Health Organization, 1986) and through building the capacity of these settings to educate, inform and take action to promote health (Kickbusch, 2019). Social scientists have long known that behaviors can be instilled, reinforced or modified based on where people spend time (Scriven & Garman, 2007) especially, when spending time with others of similar backgrounds, beliefs and interests. Recognizing that health and behaviors are strongly influenced by circumstances including economic and social status, cultural and moral beliefs, environmental and organizational factors (Dooris et al., 2014) can help direct where actions to promote health need to be focused. It may be that to look forward to promoting health and physical activity in

various settings, we need to take a look back. One of the oldest forms of structured physical activity dates back to ancient times with cave painting depicting various forms of *sport* (Crowther, 2007). Lest we not forget the Olympics as a one of the oldest forms of organized, competitive athletic endeavors beginning as early as 776BC. In fact, many of the same sports were practice then as now including, foot racing, wrestling, boxing and discus throwing (Nelson, 2007). The history of sport is enduring and has been long used for a myriad of reasons including mental, social and physical health and well-being (Bailey, 2006; Robertson et al., 2018). This backdrop of sport has implications for development as a setting to include its obvious benefits of providing sport thereby, increasing physical activity levels but additionally, to go beyond just one health behavior and transform sports clubs by providing a broad concept of health in all policies and daily actions. The most recent Eurobarometer shows that in Europe alone, nearly 19 million people from all ages and social circles are associated with a sports club (European Commission et al., 2018). There are over 150 000 sports clubs in Europe making it an ideal setting to promote physical activity and from a broader perspective, health. Sport in general, has been used as a setting for health promotion since the 1990's through sponsorships and advertising predominantly at high level athletic events (Corti et al., 1995; Giles-Corti et al., 2001). Nearly ten years later, work on building sports clubs as a setting to promote health began (Casey et al., 2009; Kokko et al., 2006) with notable success in countries such as Ireland with the Gaelic Athletic Association's Healthy Club Project (Lane et al., 2020) and the Good Sports Program in Australia (Gonzalez et al., 2020). Armed with these promising examples, this thesis seeks to build upon their successes and exploit grassroots sports clubs as a setting to promote a broad vision of health through education, action and policies.



CHAPTER 1: THEORETICAL BACKGROUND

"There's nothing so practical as a good theory"

...Kurt Lewin, German/American social psychologist

1.1 The call for promoting health

To increase global health, combat the growing risk of NCDs and health disparities, public health experts from around the globe have called for local and national government agencies to take action by working on policies, strategies and action plans to promote health. Because health can be influenced through lifestyle and living conditions, targeted public policy can help frame favorable settings for better health (Wilkinson & Marmut, 2003). The first international call for 'health promotion' began in 1986 with the World Health Organization's Ottawa Charter. This poignant document sets the stage for health promotion by describing it as the "process of enabling people to increase control over, and to improve, their health" (World Health Organization, 1986). This call is reminiscent to the salutogenic approach which has been around for over 40 years. Originally introduced by Aaron Antonovsky in 1979, salutogenesis focuses on the individual's ability to control their health based on the relationship between health, stress and coping (Mittelmark & Bauer, 2017). Salutogenesis purports that focus should be placed on factors that support human health rather than those that cause disease. Which has become the basis for salutogenesis in health promotion; giving individuals the capacity for control over their own health and well-being by building their sense of coherence (Mittelmark & Bull, 2013). Health promotion incorporates multiple sciences including environmental: to promote safe built settings, psychological: to educate and empower individuals, social: to decrease inequities and increase the capacity of workplaces, communities and nations, medical: to go beyond treating disease and sports: by encouraging physical activity opportunities, exercise, improving lifestyle choices and decrease injury risk. All of which are progressively incorporating a broader concept of health (McCuaig & Quennerstedt, 2018). Moreover, sport sciences often add the dimensions of physical activity, physical education, nutrition and general wellness. Together, these combine to increase knowledge, solve problematics and give populations the capacity to make positive behavior changes. In this manner, health promotion goes beyond individual psychology by developing the concept of settings such as groups and communities that can positively influence health behaviors (Kickbusch, 2019) through multiple determinants of health such as cultural, economic, environmental and social (Bambra et al., 2010; Wilkinson & Marmut, 2003). Determinants of health characterize how psychological and social influences impact mental and physical health, well-being and lifespan. For example, economic circumstances can affect health through financial resources and employment to afford medical care, education or nutritious food options. It is well known that better health is associated with higher socioeconomic positions in life (Bambra et al., 2010). Social circumstances impact health through the individual and their social circles, people they regularly interact with such as family, friends, colleagues or the community. Cultural

circumstances give individuals a sense of coherence, their orientation to the world through their customs, morals, beliefs and traditions which makes life meaningful and manageable (Antonovsky, 1987). Finally, environmental determinants are the physical spaces in which people spend time (World Health Organization, 2017). Determinants do not 'live' in a vacuum, they interact to support or suppress health. For example, access to good schools from a young age increases opportunities for education which helps to elevate an individual's economic circumstances through better career options. Economic status allows for things such as healthcare improved neighborhoods with greater access to parks, grocery stores, outdoor spaces and lower environmental pollution levels. Better neighborhoods and careers allow for interactions with others in the same social circles. Directing attention to health determinants within health promotion helps to reduce health disparities linked to NCDs (Schulz et al., 2002). Due to the rising levels of NCDs, the declining levels of physical activity and increase in energy dense, nutrient deficient foods, there is an urgent call for promoting health. To further the emphasize the relevance and need of health promotion, the WHO has released many supporting documents most notably, the 1986 Ottawa Charter where nations at multiple levels are called upon to commit to taking action to promote health within all sectors (World Health Organization, 1986). The Ottawa Charter's primary focus is on promoting health beyond just the healthcare/medical setting. The suggestion is multi-faceted with the creation of healthy settings, involving communities, educating and empowering individuals on healthy options (active transportation, physical activity recommendations, nutrition) and orienting health services toward promoting health instead of simply taking care of the sick (World Health Organization, 1986). Soon after the Ottawa Charter, the WHO released the document, 'Healthy Public Policies' in 1988 which calls for countries to include health promotion in all policies (World Health Organization & South Australia, 2010) and the Sundsvall Statement in 1991 encouraging the creating of environments which support health (World Health Organization, 1991). In this way, the importance of health promotion moves beyond just enabling individuals but also focuses on social and physical environments (settings) and encourages framing policies and strategies responsible for promoting health at community and national levels. Beyond these broad documents, many other international and national documents have called for promoting health in more concise ways, such as through physical activity and nutrition. The Global Strategy on Diet, Physical Activity and Health addresses the growing risk of NCD's and recognizes the importance of promoting physical activity and diet to help combat these risks. The main goal of this document is to "promote and protect health by guiding the development of an enabling environment for sustainable actions at individual, community, national and global levels" (World Health Organization, 2004). The document goes into detail about how both diet and physical activity are

key determinants for lessening the risks of NCDs and gives recommendations promoting positive changes through government and partner action and policies. Additionally, it emphasizes that settings are key factor and must be considered when promoting health to the general population. The WHO also drafted a similar document, the Global Action Plan on Physical Activity 2018-2030. This action plan was drafted at the request of member states to update guidance on effective and feasible policies related to promoting physical activity. The document stresses the importance of leadership, coordination and a 'whole-system' response to encouraging and supporting an active lifestyle (World Health Organization, 2018). Similar to the Global Strategy on Diet, Physical Activity and Health, the Toronto Charter calls to create sustainable opportunities for physically active lifestyles (Global Advocacy Council for Physical Activity, 2010) which includes the built environment (setting). Most notable in the field of sports, the European Commission's 2007 White Paper on Sport which has subsequently become the European Union Work Plan for Sport. Included, are sections on sports integrity (i.e. governance, equality, doping, etc.), the economic dimension of sports (i.e. benefits, financing) and sports place within society (i.e. physical activity, education, etc.). This work plan highlights the role that sports should play in the cross-sectoral cooperation for EU's security, economic and social policy agendas and the strategy for smart, sustainable and inclusive growth (European Commission, 2017b). An additional charter connected to the European Week of Sport in 2017, is the Tartu Call for A Healthy Lifestyle which advocates for the promotion of healthy lifestyles through diet, physical activity, education and sports (Hogan et al., 2017). Fifteen joint actions were agreed upon by the commissioners heading the 2017 European Week of Sport. Actions are aimed at promoting healthy lifestyles across multiple sectors such as health, sports, education and food. Specific to sports was a call to increase funding to the Sports chapter of the Erasmus + programme, support for healthy lifestyles through sports clubs and creating cooperation across health and sports networks (European Commission, 2017a). As this thesis was undertaken in France and uses many French experts and stakeholders, one more document worth mentioning is France's National Health Strategy 2018-2022, which prioritizes health including the promotion of healthy eating and regular physical exercise (Ministère des Solidarités et de la Santé, 2018). It his based around four priorities: 1) implementing health-promotion policies in all settings, 2) tacking social and territorial inequalities, 3) guaranteeing quality, safety and appropriate healthcare and 4) ensuring that users are involved and knowledge and experiences from other nations is considered. From a health promotion stand-point, the first priority is again similar to the Global Strategy on Diet, Physical Activity and Health in that it highlights the importance of promoting healthy eating and regular physical exercise, in addition to working on chronic diseases which can be directly treated with nutrition and physical activity.

Although not directly addressed by the second priority, decreasing inequalities to accessing places for physical activity and sport and the economic barriers to participation can help to reach the second priority. The third priority for guaranteeing appropriate healthcare includes promoting appropriate forms of healthcare and training healthcare workers. Often medical staff are undertrained in the use of diet and physical activity to reduce the risks associated with many NCDs (Chung et al., 2014; Levy et al., 2014; Sodjinou et al., 2014), therefore, educating these workers on their benefits can be seen as a necessity in priority three. This thought process is further accentuated in France's 2017 decree 'sport sur ordonnance' (sport on prescription). Finally, the fourth priority focusing on including partners in the healthcare system increases knowledge and sharing of various forms of treatments for NCDs. Not only does this involve sharing innovation across borders but also including patients in their treatment. Many patients may prefer to increase their physical activity levels through sport to counteract NCDs rather than take medical prescriptions. The fourth priority implies this as an option. A common theme of promoting health, physical activity and diet can be seen within all of these documents. Taking this into account a differentiation must be made between 1) promoting physical activity for health, 2) promoting health through physical activity and 3) promoting health within a setting (which is the basis for this thesis). Promoting physical activity for health is based around the notion that increasing levels of physical activity will increase population health (recommended daily exercise intake to make a person healthier). This notion is based around the singular action of physical activity considered a health behavior and is the basis for the European Network for the promotion of Health-Enhancing Physical Activity (HEPA) which is aligned with the WHO's Global Action Plan on Physical Activity 2018-2030 (World Health Organization, 2018). HEPA Europe has as its primary goal to support research on physical activity benefits, advance policies which advocate for increased physical activity access and options and promote favorable conditions for practicing physical activity (Martin et al., 2006). Similar to this, promoting health through physical activity shows the multiple benefits to an individual's health by participating in physical activity such as lowering the risk of obesity or NCDs. Again, a behavioral approach to promoting health. Finally, promoting health within a setting takes into account the individual's surroundings, social context and resources. For example, having access to clean, safe places to practice physical activity. The settings-based approach seeks to work on the individual's behaviors through providing healthy settings for the individual to engage in life. Thus, developing the setting to promote health has beneficial effects on physical, mental and social well-being of all stakeholders who encounter and engage in the setting. To supply the factors that affect individuals linked to the setting a model of the setting provides context

in which to base health promotion interventions (Fernandez, ten Hoor, et al., 2019; Glanz & Bishop, 2010).

1.2 Models for health promotion

Similar to the myriad of documents calling for health promotion, there are numerous theories and models for health promotion depending upon the approach (individual, setting, context specific, deficit, asset, etc.). Many of the models in existence are targeted to create behavior change at the individual level. This may be because individual lifestyle factors are easy to identify and treat (Bambra et al., 2010), such as smoking or recommended daily physical activity. In the past, most models were based on a deficit model whereby the focus was placed on problems (Morgan & Ziglio, 2007), rather building capacity for salutogenesis (Mittelmark & Bull, 2013). Some well-known and studied models used in health psychology include the Health-Belief model, Stages of Change Model, Transtheoretical Model of Behavior Change (TTM), the Health Action Process Approach (HAPA), the Behavior Change Wheel (BCW) and the Precede-Proceed model (PPM). For purposes of this thesis, the two models reviewed for their relevance are the HAPA and the BCW. Although they place the individual at the center, these two models recognize the influence of the setting on health and are not based around one behavior but are more transversal in their approach. The HAPA is a social-cognitive model developed in 1993 by Ralf Schwarzer. This model primarily is based on individual behaviors and perceived self-efficacy. Although social support and resources are taken into account, it is not specifically a settings-based approach but rather how an individual can adopt and maintain healthy behaviors by looking at the outcomes expected and perceived risks. The process is divided into two 'phases' a motivation phase and a volition phase (Schwarzer, 2016) in order for an individual to set goals and then pursue them. Although a good model to aid with individual behavior change, it does not directly consider how the setting can encourage or discourage health nor does it help to transform the setting. These models often apply the unpremeditated psychological processes or planned steps the individual must take in order to make the desired changes and reach their goals. While directly targeting the individual, they often overlook the setting in which people "live, learn, work, and play" (World Health Organization, 1986) which fails to recognize that "change is not solely focused on individuals and their health problems, but are generated in organizations and communities to ensure the development of environments that support population-wide changes in health-related behaviors" (Whitelaw et al., 2001). One of the more widely used models to create behavior change interventions is the Behavior Change Wheel (BCW) from Michie and colleagues (Michie et al., 2011). In fact, it was created though analyzing multiple different framework designs and uses a "capability, opportunity, motivation, behavior" (COM-B) model as the basis. The BCW recognizes

multiple factors that must be changed to maximize effective health promotion interventions. It incorporates a three 'layer' design and takes into account how these layers interact and function. The BCW includes nine intervention functions to choose from based on a need's analysis with seven categories such as guidelines or legislation that can help to develop or communicate an intervention. The outer most layer includes policy categories such as legislation and regulation, the middle is based on the intervention functions such as coercion and enablement and the inner circle includes the sources of behavior such as an individual's capabilities, opportunities and motivations (Michie et al., 2011)(see Figure 1). The 'wheel' format shows how no specific layer is more important than another and all can be intermixed based on needs and objectives. The model is very useful but does not go into specifics on the different 'levels' of an organization to be targeted nor how the levels interact with various health determinants. At the core, the BCW is based around individual change rather than creating and developing organizations for health promotion.

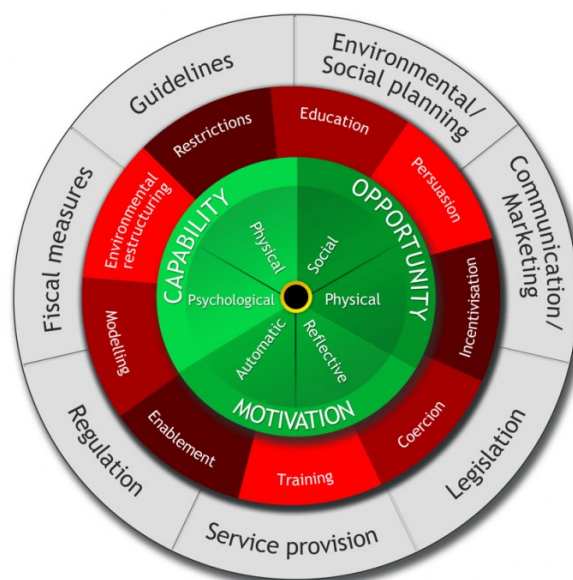


Figure 1. Behavior change wheel (Michie et al., 2011)

Taking the organization into consideration, the 'Precede-Proceed' model (PPM) has been used extensively to plan health interventions. It was developed in the early 70's as a cost-benefit analysis to aid with designing health programs by encouraging intervention managers to analyze

desired outcomes and then work backwards to plan and implement an intervention to achieve their goals. This model has primarily been used to plan interventions in the healthcare field (i.e. dental and nursing care) (Crosby & Noar, 2011). It has additionally been advised to use during intervention mapping when assessing a problem in behavior or environments (Kok et al., 2017). Because many sports clubs do not yet know what outcomes to expect nor have they set goals or definitive 'problems' to diagnose, this model was not as useful as others. In addition, the PPM heavily relies on community participation, which at its core is a good idea, but in reality, is very difficult to achieve. The PROSCeSS project was in the infancy of discovering and developing the concept of health promoting sports clubs therefore, more research was needed before the PPM could have been effectively utilized. In addition, targeting different health determinants were not considered as part of the PPM model which is a key component to many health promotion interventions. Therefore, basing the health promoting sports club on a theoretical model which is more inclusive of factors within the setting that positively affect health was more appropriate.

Socio-ecological models attempt to link individuals with their environments to help improve health. They take into consideration the context influencing health by viewing individuals within a larger model (Golden & Earp, 2012; McLeroy et al., 1988). Additionally, socio-ecological models demonstrate how interactions within multiple levels of a person's environment have strong influence on behavior (Bronfenbrenner, 1977). An influential socio-ecological model of health has been around since the early '90's and later updated in 2007 (Dahlgren & Whitehead, 2007). The model gained notoriety for its inclusion of the main determinants of health with the purpose of aiding interventions to improve health by addressing key policies. This was a layered model showing how individual lifestyle factors can be influenced by their social and community networks and how these networks are also determined by socio-economic, cultural and environmental factors. The primary purpose was for policy makers to be able to draft health policies based on these determinants. In the past 30 plus years, many public health agencies have applied the socio-ecological model to develop policies and interventions in various settings (Bambra et al., 2010). In 2001, Dahlgren and Whitehead's model was adapted to show how different socio-ecological factors influence physical activity and diet (Booth et al., 2009) (see Figure 2). Considering how settings for physical activity can influence health has roots in the socio-ecological model. This model is constructed with a three-layer design including the individual layer being the at the center, followed by the micro-environment with interpersonal factors and government is located on the outer most layer. For example, at the individual layer, a person can be influenced by factors from all three layers. By providing a setting to practice physical activity that gives an individual pleasure and impacts them in a positive psychological manner increases the chances that they will continue

to practice. Interpersonal factors in the micro-environment include recreational opportunities such as parks and recreation centers including sports clubs. Having access to these settings provides favorable circumstances for physical activity practice. Finally, societal factors found in the outer layer include policies and legislation for various industries including sports and leisure. Thereby, bringing the socio-ecological model into specific settings that provide physical activity opportunities such as sports clubs. Relationships between levels do not work in isolation but rather interact from the individual (micro) to social groups (meso) and through to broader societal and political levels (macro), especially those drafting policies directed toward physical activity and diet.

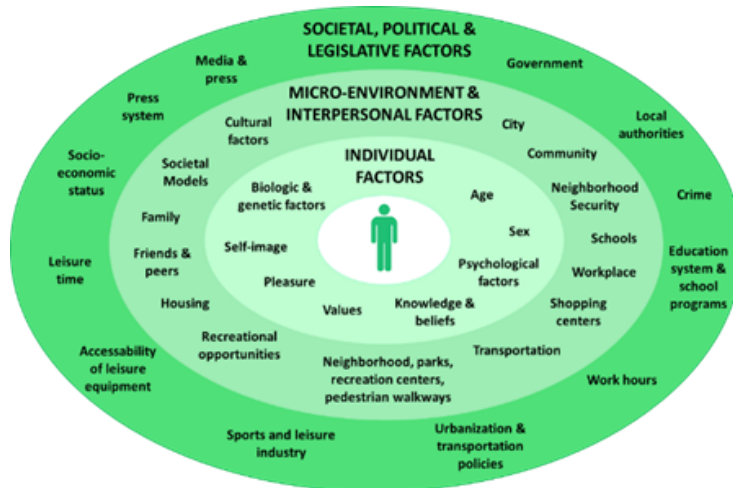


Figure 2. Factors influencing physical activity practice (Booth et al., 2009)

This model clearly depicts how individual, environmental and governmental factors influence behaviors and impact health. These factors can therefore, be considered determinants of health (cultural, economic, environmental, social) (World Health Organization, 2017), integrated to contribute to health and physical activity. Keeping in mind that this model includes multiple levels with a reciprocal cause and effect, the current socio-ecologic approach falls short in several areas when applied in the sports club context:

- The sports club is constructed with multiple levels engaging with each other (i.e. managers, coaches, volunteers, participants); current methods are unable to measure all these levels

and show how their interactions and influences. For example, the coach can interact and impact participants, and participants can likewise affect the coach or other participants.

- Each level includes 4 types of health determinants; it has been difficult to recognize the 'feedback loops' between the different determinants and levels. For example, in many inner cities, economic factors can impact social factors; not having financial resources to provide sufficient equipment can impact the number of members who practice in a certain club.
- The sports club is a complex open, dynamic system (Paton, 2005) making it difficult to study at one point-in-time because of this constant change. From season to season, coaches change and participants move to different teams giving them diverse experiences.
- Standardizing an approach to every sports club is often not the best option because of the vast differences in needs and current health promotion states and knowledge. Sports clubs across countries are diverse in size, organization, sporting culture and type of sport offered to members. In certain countries sports is enjoyed by a larger percentage of the population while in others, very few frequent organized sports clubs. For example, in the Netherlands 27% of the population has a sports club membership while in Romania, only 1% (Breuer et al., 2015). As an example directly from research done within this thesis, one interviewed sports club was narrow in focus with 200 members and only offered one sport to women over the age of 17, while another club offered multiple sports and had over 12 000 members of all ages and sexes. Thus, diversity can be seen both across different nations but within the same country as well. Some sports clubs may already have a health promotion focus and implemented projects while others have never considered promoting health beyond providing their specific sport. In certain countries, sport is built into the civic culture, as is the case in Ireland with the GAA (Lane et al., 2017) while other countries do not have this civic engagement developed. Often, national sporting federations have built their capacity for health policies and practices but this has not translated directly to local sports clubs (Casey et al., 2012a). Therefore, sports club actors need capacity building and training to understand how promoting health can benefit the participants and the sports club.

Booth's model (Booth et al., 2009), as well as the behavior change wheel (Michie et al., 2011), can be useful for individual behavior change but may be made more effective by combining and applying them within a setting. Helping people personally increase control over their health is made more effortless when environments (settings) they frequent reinforce positive healthy behaviors (Scriven & Garman, 2007). Social psychology asserts that individual's behaviors are

largely influenced by their setting. Therefore, considering the layers provided in the BCW (sources of behavior, intervention functions, policy categories) (Michie et al., 2011) and the socio-ecological factors (individual, environmental, governmental) from Booth's model (Booth et al., 2009) better helps to show how developing a settings-based intervention can directly impact stakeholder's health giving reason to build healthy settings.

1.3 Settings-based approach to health promotion

Recently, the WHO updated physical activity recommendations (World Health Organization, 2020), providing guidelines for various age groups. Particularly relevant to this thesis within the update, the WHO points out the importance of building settings which can positively contribute to achieving these recommendations. The settings-based approach was first broadly introduced during the 1986 Ottawa Charter (World Health Organization, 1986) and has since evolved over the past 30+ years. Where initially, promoting health was based solely on the individual, the setting-based approach is defined as “the place or social context in which people engage in daily activities, in which environmental, organizational and personal factors interact to affect health and well-being” (Nutbeam, 1998). This approach provides an ecological perspective (Green et al., 2005) beyond the individual to consider the context of settings and how they can positively impact health. Much of the current research on settings has been done to develop the ‘whole system’ wherein and individual is part of the setting but the setting is built like a system (Whitelaw et al., 2001). Viewing a setting as a system helps to incorporate different levels; promoting health within the setting can begin at any level and requested changes in individual behavior and organizational behavior need to be in harmony with each other (Beer & Huse, 1972). Developing this ‘leveled’ approach requires that a model be applied to the setting. Previous research on common traits for models and frameworks used to implement settings-based interventions helped to create the aforementioned BCW. Among other factors, this ‘wheel’ again highlights the importance of policies and commitment. It also points out capacities of individuals and opportunities to promote health through social and physical interactions (Michie et al., 2011). Thus, the settings-based approach to health promotion was derived from the socio-ecological model of health considering how the environment (setting) strongly influences the health individuals (Golden & Earp, 2012). Thinking about the physical activity model from Booth (Booth et al., 2009) it can be reapplied to settings in the broader sense of health. Combining the BCW with this model gives a broader application to how the setting can influence individual's health. It can, therefore, be concluded that multiple settings are a positive means for promoting health to various populations and are answering the WHO's call. Because people live in multiple settings (i.e. education, work, recreation), work on promoting health in various settings is necessary and should be context specific but contain similar

messages in line with those from various documents such as the Global Strategy on Diet, Physical Activity and Health or France's National Health Strategy. The original socio-ecologic model has been successfully adapted in various settings to develop health promotion interventions. Settings such as hospitals, now dubbed 'health promoting hospitals', show evidence of how this setting underwent organizational change to re-orient by increasing health promotion activities (Johnson & Baum, 2001) both for hospital staff as well as patients. The hospital setting reiterates how commitment to promoting health is at the forefront of organizational change and is a prime example of the transition from a deficit model to an assets model for promoting health (Morgan & Ziglio, 2007). Universities and schools are another area which have implemented settings-based health promotion tactics which focus on healthy behavior changes, identifying needs and providing resources (Dooris et al., 2014). Universities specifically pointed out the need to take culture into consideration while developing the health promoting school approach focuses on the health and well-being of all school users including teachers, administrative staff and students (Turunen et al., 2017). *Health Promoting Schools* include school policies, the physical and social school setting, provisions for promoting health literacy in the curriculum, family and community partners and the school's health services (Schools for Health in Europe, 2014). Another example is the unique setting of prisons. The *Health Promoting Prisons* approach is committed to safe environments with respect for inmate's human rights. Additionally, health-promoting prisons use a systems perspective by considering not only inmates but equally the health of staff members (Baybutt & Chemlal, 2016). On a grander scale, the *Healthy Cities Programme* was launched by the WHO to improve the environment of urban cities and provide a better quality of life for inhabitants. It was the main focus of the Global Conference on Health Promotion in 2016 in Shanghai. The programme helps managing and planning urbanization to control pollution, overcrowding, violence, mental illness, increased access to healthcare and nutritious foods (World Health Organization, 2016). It includes multiple phases with 11 primary tenants: 1) quality of the physical environment, 2) sustainable ecosystem, 3) supportive communities, 4) community participation for decision-making, 5) basic needs of the community members, 6) resource accessibility, 7) thriving economy, 8) cultural connections, 9) structured city to provide all of the aforementioned tenants, 10) strong public-health agencies and 11) low disease rates and high health status (de Leeuw, 2012). To make these settings more effective at promoting health, the actors within the setting need guidelines, step-by-step instructions. Instructions should not only include *how* to implement health promotion actions but *why* they should undertake it. Not only why it is important to improve health but reasons it helps the environment, whether it be in schools for children to help them learn or for better behavior while in classrooms or in prisons for inmates to have control over themselves when

in-face of delinquent behavior which could include teaching them how to live outside the confines of the prison setting and better integrate into society. When healthy behaviors are adhered to, it also makes the environment better for other actors such as teachers or guards. This can have positive consequences such as keeping teaching or prison staff longer (retention benefits also leading to long-term economic benefits), better mental health with lower stress and anxiety. Common themes can be seen between these different settings: 1) they all have a context specific framework to guide research, policy development and implementation which may help improve efficacy (Dooris, 2006), 2) they seek to use a whole system approach recognizing that efforts should focus on the organization as well as all stakeholders involved and 3) they point out that organizational change and commitment is necessary for sustainability of these programs. These types of benefits can also be seen when translating into other settings such as sport which is a low cost, high impact tool to contribute to healthy societies by promoting health.

1.3.1 Current state of health promotion in sports clubs

Hospitals, schools and prisons are three solid cases of settings-based health promotion put into action. These act as examples to set the stage for research on leisure settings such as sports clubs to be addressed. With the many of the documents highlighting the need to direct attention to increasing physical activity and diet, sports clubs are a perfect context to develop as health promoting settings. The 2018 Eurobarometer reported that there are 16 million participants and 3 million volunteers in sports clubs (European Commission et al., 2018). Furthermore, there are over 100 sports federations with more than 700 000 associated sports clubs in Europe making sports clubs an ideal setting to promote health.

To operationalize this setting, previous work has been undertaken to understand how sports clubs are organized. Although based on the individual and related to physical activity, when applied to the setting of sports clubs and thinking in broader health terms, a microcosm of Booth's model (Booth et al., 2009) can be seen. Sports participants are at the center, impacted by their personal characteristics such as their motivation to participate in sport. Surrounding them, but still within the structure of the sports club, includes the sports club staff and fellow members while the policies of the sports club can be viewed as the outer most layer. Supporting this type of 'layered' approach to the sports club setting, work done by Kokko (Kokko, 2014b) used the settings-based approach by building a health promoting sports club (HPSC) concept with three sports club levels (club policies, officials, coaches) and four determinants of health (cultural, economic, environmental, social) (see Figure 3) (Kokko et al., 2014). Rather than applying the socio-ecological approach to a specific behavior such as physical activity and diet, as that of Booth (Booth et al., 2009), this concept applies it to the setting of sports clubs. It was with this initial

research that the PROSCeSS project began to fill in the following short falls: 1) to fully develop the HPSC concept, 2) to redirect the primary focus from youth athletes to all sports club actors (participants, coaches, directors, volunteers, family members, etc.) and 3) to aim attention on broader perspectives of health rather than solely behavior change related to physical activity.

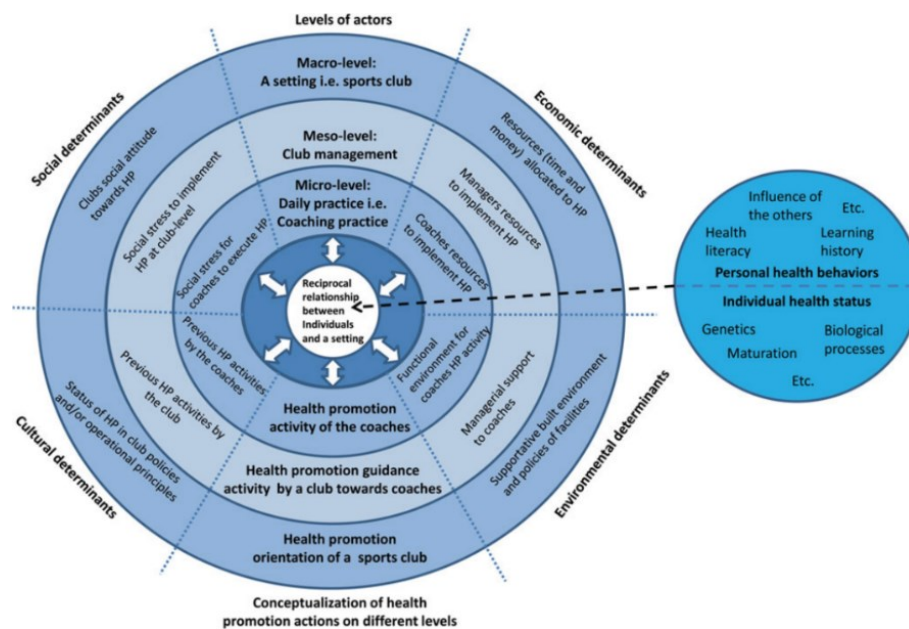


Figure 3. Determinants of settings-based health promotion and reciprocal interaction of setting- and individual-based factors within a sports club setting (Kokko et al., 2014)

Complimentary to Kokko's HPSC concept (Kokko et al., 2014), the Health Enhancing Physical Activity (HEPA) working group, Sports Club for Health (SCforH) has directed attention to building sports clubs as healthy settings by acknowledging multiple health benefits that can come from practicing a particular type of sport (single behavior approach). With this in mind, members of the SCforH working group drafted guiding principles for sports clubs (Koski et al., 2017):

- Promote physical activity benefits for health, based on evidence and proven practices put in place by qualified and competent personnel
- Promote regular practice of sports within the sports club
- Present little to no health and safety risks
- Practice in a healthy environment
- Obtain commitment from the club to promote a responsible, stimulating, engaging and favorable setting

The principles are focused on practicing sport and promoting regular opportunities for physical activity. The SCforH working group also designed an application model for clubs to follow for promoting the practice of sport (Figure 4). Again, this approach offers many benefits but is lacking in several key areas: 1) it does not take into account the levels of sports clubs and how they interact, 2) it is focused on solely sports participants; leaving out other potential factors such as policies and stakeholders, 3) it aims to promote regular physical activity opportunities through sports without considering the sports club as a setting and 4) the attention is toward the physical benefits of a particular sport omitting factors such as mental and social well-being (Bailey et al., 2015; Robertson et al., 2018) which are considered main factors of health and need to be considered when developing a setting (World Health Organization, 1986).

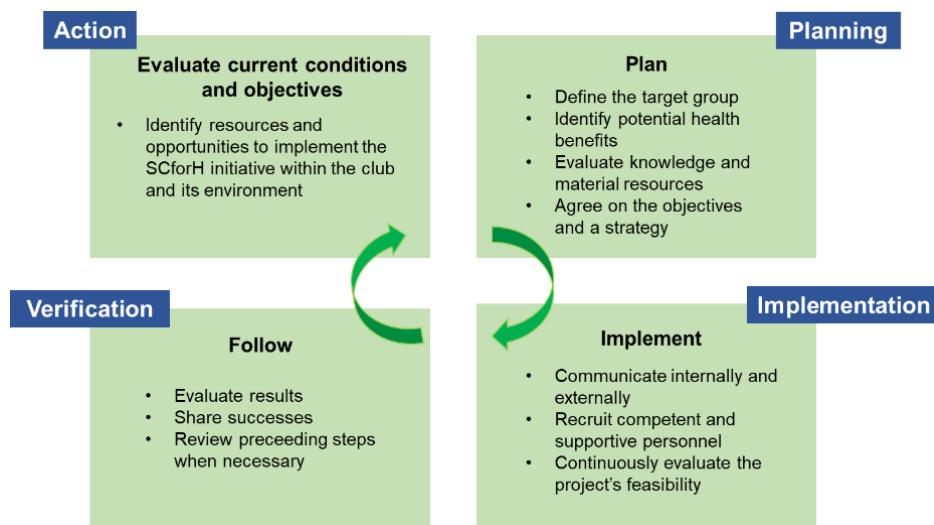


Figure 4. Sports Club for Health application model (Koski et al., 2017)

Rigorous research on developing health promotion within sports clubs really began in the early 2000's. Early work from Finland presented the concept of a health promoting sports club and provided 22 standards based on the Ottawa Charter through a Delphi study (Kokko et al., 2006). The standards ranged from ideology to formal policies with experts agreeing that many of these were difficult to implement without organizational change. Most of this research was done on youth clubs specific to the Finnish sporting system. Studies from Finland also compared perceptions of the health promotion orientation of the sports club between official's, coaches and players as well as the physical activity profiles of youth participating in sport (Kokko et al., 2009, 2011; Kokko, Villberg, et al., 2015). Findings show that officials have higher perceptions than those of the

coaches and players and that sports clubs need work to develop their health promotion policies and practice (Kokko et al., 2009). Physical activity levels were also, on average, higher in youth participating in organized sports compared to those not participating in six European countries (Kokko et al., 2019). More recently, similar research was conducted to determine the effectiveness of strategies used to implement policies and programs in sports organizations (McFadyen et al., 2018). End results revealed little evidence of the effectiveness and lack of the generalizability of the strategies. Additional studies demonstrate that in order to be more effective, interventions need to use multiple strategies which are consistent, well described, well reported and the capacity of the actors who are delivering the intervention strategies and those who the intervention is targeting should be strengthened (Jackson et al., 2006; Proctor et al., 2013). These studies offer proof that a distinct need exists to provide sports clubs with evidence-driven strategies to implement health promotion policies and programs in order to progress toward creating a health promoting setting. Research coming out of Australia also used the Ottawa Charter principles to increase physical activity for communities in sports clubs and ensure the environment is welcoming in turn, this development sought to increase sport participation (Eime et al., 2008). This study partnered the Victorian Health Promotion Foundation with State Sporting Associations to develop healthy and welcoming environments in affiliated sports clubs. The results showed that many community sports clubs need support, guidance and capacity building in order to plan and implement programs. Additional work carried out in Australia looked at creating partnerships for health promotion interventions in the sports club context (Casey, Payne, Brown, et al., 2009). It confirmed the need for capacity building and commitment from all partners involved in health promotion programs with an emphasis on partnerships seen in more recent publications (Misener & Misener, 2016). Another study looked at the ability of national and state sports organizations in Australia to support community sports clubs through available health-related policies. Again, most policies were related to youth sports clubs with the majority of policies focusing on social inclusion (Kelly et al., 2010). More recently, studies have been carried out to discover motives and barriers for sports clubs to become health promoting settings. Some of the primary barriers included lack of expertise and interest by the sports club directors (Meganck et al., 2015). It was found that the priority for youth sports clubs remains to provide the provision of sports and competition. This was also mirrored in a study carried out with International Sports Federations with one top barrier being lack of support and knowledge (Mountjoy et al., 2019). Additionally concerning is the lack of importance International Sports Federations place on the health of the general population choosing to instead focus attention on doping and image (Mountjoy et al., 2018). A more recent international Delphi study discovered that grassroots sport clubs have the impression that their

primary responsibility lies in sports participation, developing safe and inclusive settings and ensuring the economic viability of the sports club. Concluding that sport clubs may not have the immediate capacity promote a broader concept of health (Robertson et al., 2018).

Prior to beginning the work on this thesis, a mapping literature review was conducted to understand how sports clubs have been used as a setting to promote health (Geidne et al., 2019). The review details how sports clubs have applied the settings-based approach with levers and barriers to implementation. This mapping review provided 14 guidelines to help sports clubs implement health promotion interventions. It also identified gaps and weaknesses with current implementation practices of the settings-based approach to health promotion within sports clubs. Some interesting results include the fact that most published studies have been in Europe or Australia and focused primarily on male, youth sports participants. The programs also focused on individual behaviors rather than building the setting. Therefore, the settings-based approach to health promotion was rarely implemented and if done, it was poorly executed. This previous research on sports clubs has shown a gap in the use and implementation of the settings-based approach to health promotion. Although these gaps exist, they were used to further the Health Promoting Sports Club (HPSC) concept.

1.4 The HPSC vision

Used within the context of this thesis, the previous theories, models and examples from other settings (universities, schools, hospitals, prisons) provide a basis for understanding and an explanation of the current state of health promotion within grassroots sports clubs (Casey, Payne, Eime, et al., 2009; Geidne et al., 2019; Glanz & Rimer, 2005; Kokko, 2014b). These models have been used as a conceptual framework to inform the work in this thesis and aid with identifying key constructs to target for developing a more comprehensive health promoting sports club. The vision of an HPSC is broader than what is currently available by going beyond simply promoting the benefits of sport or just one health behavior (i.e. physical activity, tobacco or alcohol control) to participants, which is currently the standard (Geidne et al., 2019; Kokko et al., 2016). This vision rethinks the sports club to come from the perspective that effectively developing this setting can: 1) promote physical, mental and social well-being of all actors involved in the club, 2) support concepts of social justice and equality, 3) provide a safe and nurturing setting, 4) advocate for participation for all, 5) involve partners and community members, 6) integrate health into the daily activities of the club, 7) set goals based on stakeholder needs and expectations and 8) evaluate the health promoting actions in order to make improvements when and where needed. Having this broad vision of what sports clubs can become demands organizational change from sports clubs. This type of ambitious innovation often comes with some avoidance from stakeholders most

affected who are satisfied with the current status quo. Therefore, the foreseen benefits, 'what's in it for me', must be relayed to all those involved in this development. By increasing health promotion actions, clubs have the potential to increase sports participation (Eime et al., 2008), attract new members and volunteers, in addition to increasing the performance and enjoyment of their athletes (Kokko, 2014b). In fact, recent findings have shown that sports club memberships have been declining since the early 2000's, especially among adults looking for health benefits (Eime et al., 2020). They are choosing to exercise and practice physical activity in other spaces. Therefore, considering the wants and needs of stakeholders beyond competition by adding options such as 'light sport' programs, social affiliation (Borgers et al., 2018) and other health promotion actions may lead to a reversal of these dwindling numbers, boosting revenue and reinventing the sports club in relation to health. Another benefit can be seen in the network around the club and by the placement of the sports club within the local community (Kokko et al., 2016). Several successful examples of this can be seen in Ireland with the Gaelic Athletic Association's (GAA) 'Healthy Club Project' (Lane et al., 2017). As the GAA is interwoven into Irish communities they have successfully been able to include health as part of the core business of their sports clubs. A primary point making this project a success was adapting typical health promotion language into a sporting language in order to make health issues more relatable and motivating. For example, rather than 'healthy eating' the term 'recipes for success' and 'mental fitness' replaced 'mental health' (Lane et al., 2020). In Australia, the 'Good Sports Program' has seen similar success with a three level accreditation system for sports clubs. Level one consists of healthy signage, level two involves serving non-alcoholic drinks and healthier food options at sporting events and level three incorporates transportation means around the club. The primary focus of this Australian program is on lowering fast food, tobacco and alcohol sponsorships in junior level sports clubs (Gonzalez et al., 2020). Promoting health within the sports club can reinforce individual behaviors both while at the club, but also while outside the club. It encourages people with similar beliefs and behaviors to congregate together which can encourage or discourage them to return depending on their experiences (welcoming friendly club versus overly competitive). Taking this into account, sports clubs are not only about competition but building comradery between players, coaches (including volunteers) and other staff members. Following these working examples, the vision of HPSC aims to educate and inform grassroots sports clubs of the benefits of promoting health.

1.4.1 Capacity building for organizational change

Rethinking the sports club as a setting to promote health to *all* stakeholders requires capacity building for organizational change. The vision of an HPSC calls for multiple sports club levels and health determinants within both single sports clubs and a network of clubs to be interconnected, integrated, interrelated and interdependent to allow for a whole systems approach to implementing health promotion interventions (Dooris, 2006; Skyttner, 2001). The 'system', in this case the sports club, must reorganize in order to grow, innovate, and stay competitive. Sports clubs need to build a culture and structure internally and externally, which includes affiliated sports federations and expert working groups to move them forward for innovation. This type of systems-thinking takes a holistic viewpoint: the stages of organizational change should be synergistic by looking at the environment in and around the sports club (the whole) and not the sum of the parts (each level independent of the others). The sports club is part of an interrelated system to other similar clubs of the same sport, different sports, federations and the local community. This 'cause and effect' shows how sports clubs can accomplish something bigger with the system that surrounds them compared to what can be done alone. Thus, sports clubs need help and support from a wider system externally and internally. Feedback loops help the sports club make adjustments based on current functioning. Sports clubs can see how they are interconnected with each other and the broader system. Building this new vision of the HPSC is a complex system for clubs to interact and partner with each other, use the culture of the similar clubs and build a sustainable 'community' approach for sports clubs. In this way, all stakeholders can benefit. The HPSC is local-based action which helps to move towards system sustainability. This type of organizational change requires capacity-building strategies to aid sports clubs with developing the wider vision of the HPSC rather than the current sport based focus. Capacity-building within the context of health promotion seeks to increase the ability of the organization to "prolong and multiply health effects representing a value added dimension" (Hawe et al., 1997) to the regular offerings of the organization, in this case, offering the provision of sport. Capacity-building was further identified by the WHO as one of the 5 track themes during the 7th Global Conference on Health Promotion. The WHO regards capacity-building as a necessary process for organizations to institutionalize health promotion and make it part of daily activities and policies. This includes training actors in leadership roles, increasing knowledge, planning resources and creating partnerships (World Health Organization, 2009). Research from Australia has shown that sports clubs can build their capacity to become health promoting settings when guided by a strategic plan to help set goals and objectives for incorporating the health promotion principles of the Ottawa Charter (Casey et al., 2012, 2012a; Casey, Payne, & Eime, 2009). In order to accomplish this, sports clubs need

support to build capacity in several key areas including: organizational development, workforce development, resources allocation, leadership and partnership (Casey, Payne, & Eime, 2009). This requires an understanding of the sports club's readiness to change and including sports club actors in planning goals and objectives of health promotion programs.

1.5 Framing the research questions and primary goals

The PROSCeSS project was framed around the HPSC vision and seeks to create a setting fully embracing health through policies and daily sports club actions. While models of behavior change place the individual at the core, this thesis places attention on developing the setting in order to help the individual. Thus, the end result may be the same, but the focus is on the sports club setting to support the actors to make healthy choices through the club's promotion and reinforcement of healthy behaviors.

The project sought to fill in some of the current gaps and limitations in research for applying the settings-based approach to sports clubs and following the steps suggested in the intervention mapping protocol which has been used as a basis to plan and implement health promotion projects in psychology and social sciences (Kok et al., 2017). The settings-based approach is based on the knowledge that providing members, staff and even the surrounding community with a safe and healthy environment can go far beyond what is typically provided as a sports club's core business. Keeping this in mind, the PROSCeSS project aims to support sports clubs in their efforts to increase health promotion actions. From this perspective, distinct gaps in current research were found:

1. A lack of a validated measurement tool to evaluate the application of the settings-based approach within the sports club context. Current questionnaires focus on interviews or self-report tools (Casey et al., 2011), tool that were used were not qualitative, unvalidated measures (Geidne et al., 2019) or the tools were not culturally universal (Kokko et al., 2009).
2. Although there is a health promoting sports club concept, no theoretical model exists with a coordinating evidence-based framework to provide guidelines for policy development and implementation practice. This is important to achieve successful health promotion interventions (Michie et al., 2011; Peters et al., 2009). When health promotion interventions are implemented in the sports club context, theories to inform their design and evaluation are rarely specified (Rothman, 2004). Furthermore, providing a model of the sports club as a setting, gives intervention planners targets for levels and health determinants. A

model demonstrates how the various levels interact and are interconnected to support each other in increasing health.

3. Multiple published documents and articles stress the importance of framing strategies to promote health (World Health Organization, 1986), implement programs in the sporting context (McFadyen et al., 2018) and build the organizational capacity of sports club actors to promote health (Casey et al., 2012). While guidelines exist, predominantly derived from youth sports club interventions (Geidne et al., 2019), no concrete strategies have been drafted for use in all grassroots sports clubs. Offering specific strategies for the sports club setting can help with developing policies and set health promotion interventions into practice (Dooris et al., 2014).
4. Stakeholder ideas are valuable when developing settings-based health promotion interventions yet, seldom are their expectations or needs considered (Van Hoya et al., 2015). Collaborating with stakeholders by using a participative (bottom-up) approach can help to increase the acceptability and endorsement when framing policies, co-designing interventions and evaluating the outcomes (World Health Organization, 2015). It is an essential part of the intervention mapping process and should be considered throughout the planning, design, creation and evaluation steps (Kok et al., 2017). A lack of collaboration with sports club actors implementing health promotion programs exists in current research (Kokko et al., 2011; Van Hoya et al., 2015). This type of collaboration can help to gain the endorsement of sports club actors and gain and understanding of their expectations for health promotion programs within their club. In this way, adding a bottom-up approach to the currently available research increases the chances of success (Poland et al., 2009).

In order to fill in these gaps and develop the vision of the HPSC, several research questions were formulated to frame this thesis:

1. How can we measure current health promotion perceptions in sports clubs?
2. What strategies can be and already have been used to promote health in sports clubs?
3. How can clubs incorporate health promotion initiatives into their daily actions?
4. What support do sports clubs need to increase health promotion actions?
5. How can an intervention be co-designed with sports club stakeholders?

Ultimately, becoming a health promoting sports club requires organizational readiness and capacity building (Casey et al., 2012) from within the club as well as support from actors outside the club that can influence and impact health promotion policies, planning and implementation. To

accomplish this, the settings-based approach needs to be applied in the sports club context. To apply the setting-based approach, answer the research questions and propose solutions, the PROSCeSS project had three main objectives: 1) measure current perceptions of health promotion actions in sports clubs, 2) develop an intervention planning framework based on a theoretical settings-based model to support and guide sports clubs in their health promotion efforts and 3) capitalize on exemplar sports club experiences to share knowledge and learn from others when implementing health promotion actions within their clubs. This work was accomplished in several stages through multiple studies:

- I. Create and psychometrically validate a self-evaluation tool to measure health promotion perceptions
- II. Develop a theoretical model of sports clubs to include levels and health determinants
- III. Formulate indicators to identify a health promoting sports club
- IV. Draft strategies to implement health promotion interventions specific to the sports club context
- V. Identify sports club actors' needs and expectations when planning interventions
- VI. Explore necessary conditions to implement interventions in sports clubs
- VII. Capitalize on the health promotion experiences of exemplar sports clubs



CHAPTER 2: EXPLORING HEALTH PROMOTION PERCEPTIONS

"Perception is reality"

...Lee Atwater, American political commentator

2.1 Preparing for study 1

The first research question posed was: '*How can we measure current health promotion perceptions in sports clubs?*'. In order to discover what sports club stakeholders perceive as health promotion and how it is being undertaken within their clubs helps us to understand how *and* if managers, coaches and sports participants including their parents understand the concept of health promotion in the context of sports clubs. The first study brought together experts in the fields of sports and public health to become stakeholders in sports clubs and co-create a tool by which a needs assessment can be carried, fulfilling the fourth step of the intervention mapping protocol (Kok et al., 2017). As was made aware through subsequent studies, these stakeholders can have a profound impact on a sports club's ability to promote health. Measurement tools have been created to aid with needs assessments, development of health promotion programs and drafting policies in other settings such as schools. The School Health Index (SHI) is a tool used to self-assess and plan physical activity and nutrition aimed at students from elementary to high school levels (Bryn Austin et al., 2006). The SHI assesses health policies and programs in order to develop an action plan which engages school stakeholders to promote health-enhancing behaviors (Centers for Disease Control and Prevention, 2019). It has also been used to help build collaborations between universities and school districts (Butler et al., 2011). Although a measurement tool such as this is helpful to assess current health promotion programs, the current methods of research make it difficult to measure the settings-based approach to health promotion (Dooris, 2006) due to interactions between multiple levels and health determinants. Therefore, the objective of study 1 was to draft and validate a measurement tool relevant in the sports club setting including multiple interacting levels (macro, meso, micro) to inquire about what current perceptions of health promotion actions undertaken in sports clubs. Perceptions can also give details on how health promotion interventions are implemented and communicated, what areas can be improved upon and the expectations of sports club actors. This can provide an initial 'needs assessment' on which to base a health promotion intervention and is a necessary premier step during the intervention mapping protocol (Kok et al., 2017). There also exists a 'myth of healthism' surrounding sports which can affect how sports club actors view promoting health within this context. The sports club is naturally viewed as a 'healthy' place but, as has been identified in previous studies, the majority of health promotion done within sports clubs is based around physical activity to youth participants (Kokko et al., 2009; Meganck et al., 2015). Apart from providing physical activity opportunities, many sports participants are still at risk for unhealthy behaviors such as alcohol abuse, violence and doping (Holman et al., 1997; Laure, 1997; O'Farrell et al., 2010; Sønderslund et al., 2014). While providing physical activity opportunities is noble and

answers the call of many international documents (Global Advocacy Council for Physical Activity, 2010; World Health Organization, 2004, 2018), sports clubs, as a setting, are underutilized to promote a broader vision of health (Geidne et al., 2019; Kokko et al., 2006). Therefore, analysis of sports club actor's perceptions gives insight into expectations, understanding and capacity to promote health. Applying the settings-based approach to sports clubs, reveals the multiple levels therefore, respondent specific scales need to be designed for the actors within sports clubs: managers, coaches and sports participants. Using components from the previous tools (Casey et al., 2011; Kokko et al., 2009), the difference being an international panel of experts was used to draft and decide upon the items, three separate scales were created to question the health promotion actions at three levels in the sports club (macro, meso, micro) and each item was classified into one of four health determinants (cultural, economic, environmental, social). Creating three unique scales also allows for comparisons between the different sports club actors to see if health promotion is understood differently between managers, coaches and participants. It allows for the examination of how health promotion actions are executed and received. As several other tools exist within the sports club context (Casey et al., 2011; Kokko et al., 2009), the goal was to co-construct a questionnaire with a panel of international experts, to include scales focusing on the three different sports club actors. Creating a tool specific to the setting helps to collect data from all those impacted by the setting and allows items to be asked about the different factors which affect health in the setting, in this case, cultural, economic, environmental and social. Multiple options exist for designing a research questionnaire with the most common being the researcher or an interested team drafts the items to include based the data they wish to collect (Sreejesh et al., 2014). Often, the research team will use currently available questionnaires and customize the items to fit their specific scenario (Hyman et al., 2006). While these may be good methods for specific situations, they lack the ability to combine currently available tools with expert opinion from multiple regions or countries. The Delphi method was developed over 70 years ago in order to allow experts to anonymously pool their ideas and reach consensus (Dalkey & Helmer, 1963). It is based on a system of 'rounds' where each round uses and combines the results from the previous rounds. Participants in a Delphi study can see the results from the various rounds in order to contemplate alternative points of view without bias (Barrett & Heale, 2020). Therefore, the Delphi method was chosen for the first study as it allowed for researchers to expand the knowledge base from available tools in the sports club context and incorporate the ideas and experience from multiple sporting systems in different countries This process ensured the questionnaire would not be culturally specific, as are the current questionnaires (Casey et al., 2011; Kokko et al., 2009). This method has been used in many different contexts including

education (Mensual-Andrés et al., 2016), business (MacCarthy & Atthirawong, 2003) and often in healthcare (Boulkedid et al., 2011). Because the Delphi method was conducted online, it had the benefit of allowing international experts to participate at their convenience without the fear of being overlooked or their ideas being rejected by other respondents (Okoli & Pawlowski, 2004). The working language of study 1 was English in order to include a wide range of expert panelists and ensure the measurement tool would have international applicability. This had the added advantage of ensuring items were not culturally specific and were both relevant and important within the sports club context. In addition to providing sports club level-specific scales, all items needed to be classified into one of four health determinants (cultural, social, environmental, economic) within the three-level design (see Figure 5). The figure displays that the levels are not hierarchical but are interconnected and can impact each other through level and health determinant. This work began with first defining the multiple levels and health determinants within the sports club. The health promoting sports club concept (Kokko, 2014b) was used as a basis to refine the sports club level definitions and health determinants to provide the expert panelists with guidance when classifying items. Once items were agreed upon and classification was complete, the three scales needed to be validated.

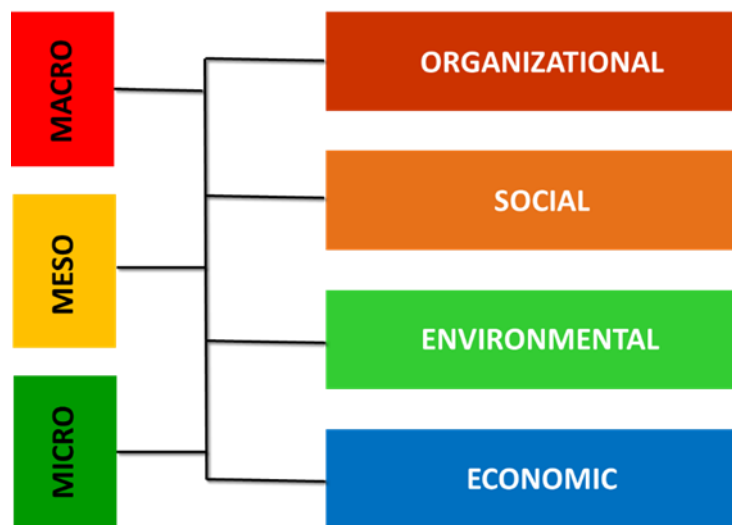





Figure 5. Sports club levels and health determinants


2.2 Study 1: Measuring Health Promotion in Sports Club Settings: A Modified Delphi Study



Article

Measuring Health Promotion in Sports Club Settings: A Modified Delphi Study

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Abstract

Settings-based approaches have become an increasing health promotion focus since the World Health Organization's 1986 Ottawa Charter. While schools, cities and prisons have implemented this approach, its development within sports environments is recent. Sports are a popular leisure-time activity, requiring validated tools to measure health promotion activity. This study's aim was to develop a measurement tool based on international consensus which measures perceptions of health promotion within sports clubs. It is grounded in the settings-based approach and builds on theory from previous works expanding their context and knowledge. An online, 3-round international Delphi study was conducted, inviting experts in sports and health fields to participate in designing the tool. Round one created a collaborative list of items, round two validated items based on relevance, importance and feasibility and the final round classified items into one determinant category: social, cultural, environmental or economic. Panelists (69 experts) from 13 countries participated, creating a final list of 62 items at 3 organizational levels; the sports club

level included 23 items, the officials level retained 20 items and the coaching level contained 19 items. This study provides several innovations; 1- applying the settings-based approach to health promotion within sports clubs, 2- defining each club level (sports club, official, coaching) and determinants (social, cultural, environmental, economic) within 3-levels, 3- creating a tool which measures perceptions of health promotion activities per level and determinant and 4- obtaining expert consensus on included items. These advancements allow further research on promoting health within sports clubs.

Keywords: health determinants, health promotion, modified Delphi study, settings-based approach, socio-ecological approach, sports clubs

Introduction

According to the World Health Organization (WHO), Health Promotion (HP) is “the process of enabling people to increase control over and to improve their health”. To develop this, the Ottawa Charter (World Health Organization, 1986) pointed out the importance of a settings-based approach in health promotion based on the idea that “change is not solely focused on individuals and their health problems, but that changes are 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 objective is to go beyond a behaviorally focused approach and move toward a socio-ecological approach, by working on cultural, social, economic and environmental determinants of health (Glanz & Bishop, 2010). Multiple settings, such as schools (Rees et al., 2006), hospitals (Johnson & Baum, 2001), workplaces (Noblet, 2003) and cities (de Leeuw, 2009) have used this framework when implementing HP programs. While these settings are established, the application of the socio-ecological approach has been limited regarding leisure settings such as sports (Fredriksson et al., 2018).

According to the Eurobarometer, in Europe alone, more than 33% of the population participates in sports (European Commission et al., 2018). Thus, studies have supported the recognition of sport clubs as health promoting settings (Kokko, 2014b). Grounded in the socio-ecological approach, the health promoting sport club includes four determinants of health (cultural, social, environmental, economic) (Golden & Earp, 2012) applied at three club levels: macro- (overall policies and orientations of club activities), meso- (activities of club officials) and the micro-level (coaches’ activities in guiding, altering or supporting actions of club members) (Kokko, 2014b). The application of the settings-based model into sport clubs has received less attention thus, evaluation tools to measure HP in sports clubs are rare and primarily focused on interviews

and self-reported questionnaires (Casey et al., 2011). A recent literature review on health promotion interventions in sports clubs found that most studies used non-validated, qualitative measurement tools (Geidne et al., 2019). Furthermore, those that were validated are culturally specific (Casey et al., 2011; Kokko et al., 2009). To our knowledge, two national Delphi studies were conducted, one identified indicators of health promoting sport clubs and one aimed at policies, practices and capacity. One international Delphi study focused on how health promotion fits in with social responsibilities of sports clubs was also completed.

The first study, based on the Ottawa Charter and the settings-based approach, aimed to identify standards for health promoting sports clubs (Kokko et al., 2006). Consensus on 22 HP standards was reached by 27 Finnish experts. Standards were classified into 4 categories: policy, ideology, practice and environment and tested among a Finnish sample of clubs, officials and coaches, which resulted in the Health Promoting Sports Club Index (HPSC) (Kokko et al., 2009). This measurement tool has been used at the official, coach and youth sports participant level in Finland (Kokko et al., 2011; Kokko, Villberg, et al., 2015) and the official level in Belgium (Meganck et al., 2015). A modified version was tested at the club (macro) level in Ireland (Lane et al., 2017) and the coaches and youth sports participant level in France (Van Hoye et al., 2015; Van Hoye et al., 2018).

The second national Delphi study was conducted in Australia to determine aspects necessary for sports clubs to develop healthy sporting environments for children (Kelly et al., 2014). This study invited 46 experts to rate standards relating to seven health promoting themes: healthy eating, sponsorship and fundraising, alcohol management, smoke-free environment, sun protection and social inclusion. Key HP areas were added from the Finnish Delphi study including; smoking and tobacco use, healthy eating and social inclusion (Kokko et al., 2006). These standards have yet to be directly used or tested among sports clubs.

The third national Delphi study captured sport related policies, practices and organizational capacity across events and sports clubs, by questioning state sport organizations (Casey et al., 2011), rather than sports clubs. Incorporating these responses and some HPSC index items, (Kokko et al., 2009) it produced the Health Promotion in Sport Assessment Tool (HP-SAT). It included a general organizational capacity section and the following dimensions: smoke-free environment, responsible serving of alcohol, sun protection, healthy eating, injury prevention, club management, welcoming and inclusive, violence in sport and other. Validation was done using a test-retest reliability method among 22 sport state organizations in Australia.

The international Delphi study was primarily concerned with the social responsibility of sports clubs and how health promotion fits into this framework (Robertson et al., 2018). It included

a panel of 56 experts (sport management journal academics and national sport organization managers) from 14 countries. Consensus identified 33 items among 7 social responsibility dimensions: human rights, labor practices, economic, governance, community development, fair operating practices and environment. These items have not been tested within sports clubs to validate a measurement tool.

Health priorities vary between countries which can influence individual health behaviors (e.g., sun protection, nutrition factors) thus, indicators relevant to a range of sports cultures and systems are required (Kokko et al., 2016). Furthermore, approaches to health promoting sports clubs vary, including settings-based approaches (Kokko, Villberg, et al., 2015), capacity building (Casey et al., 2012a), social responsibility (Robertson et al., 2018) or specific behaviors (Kelly et al., 2014) which should be considered when building measurement indicators. Several limitations of previous works were identified: 1- mostly non-validated, non-theoretically based tools exist therefore, no instrument rooted in a theory-based framework has been fully validated, 2- only culturally specific tools were found, thus no international consensus exists and 3- current tools do not take into account the many determinants of health (social, cultural, environmental, economic), each classified at the three sports club levels. The aim of this study is to reach an international consensus to create a measurement tool grounded in the settings-based approach at the macro- (club), meso- (official) and micro- (coach) levels of health promotion in sports clubs. It is proposed that this tool will be used by officials, coaches and sports participants to evaluate perceptions of health promotion orientation, guidance and activities within their club.

Method

Study Design

A Modified Delphi method was chosen to elicit expert opinion on items to include at each level of the sports club, for each determinant of health. The Delphi method is a method for structuring group communications, so that the process is effective in allowing a group of experts to reach consensus regarding a complex problem (Okoli & Pawlowski, 2004). This method has the advantage of collecting experts' perspectives without confronting them directly thereby keeping responses anonymous. The Delphi method establishes rounds of questions where each round builds on the previous rounds' responses. A series of 3-rounds was conducted which included stages of item selection, generation, modification and ranking.

Panelists

Sixty-nine experts were contacted via email, having one of three profiles (sport science or public health academics, sport club director/management, regional, national or international sport/health

institution), at least 5 years of experience within their field and a working knowledge of English. Location and profession were taken into account to ensure diversity and international representation. Panelists were chosen from members of the Erasmus + Sports Clubs for Health group (SCforH), the Health Enhancing Physical Activity (HEPA) Europe working group, researcher networking and snowballing. Experts were invited to take part in each round regardless of previous round participation.

Preparation

The research team convened twice to review the existing tools, compile indicators, detect similarities and reformulate items. Initial items were chosen based on a literature review (Geidne et al., 2019), the three previously mentioned Delphi studies (Kelly et al., 2014; Kokko et al., 2006; Robertson et al., 2018) and the two validated measurement tools: the HPSC index (Kokko et al., 2009) and the HP-SAT scale (Casey et al., 2011). Items from the adapted versions of the HPSC index were also included (Kokko et al., 2011; Kokko, Selänne, et al., 2015; Van Hoyer et al., 2016). The research team clarified and refined the definitions of each sports club level (macro, meso, micro) and the determinants within each level (cultural, social, environmental, economic) (see Figure 1) based on the work of Kokko (2014).

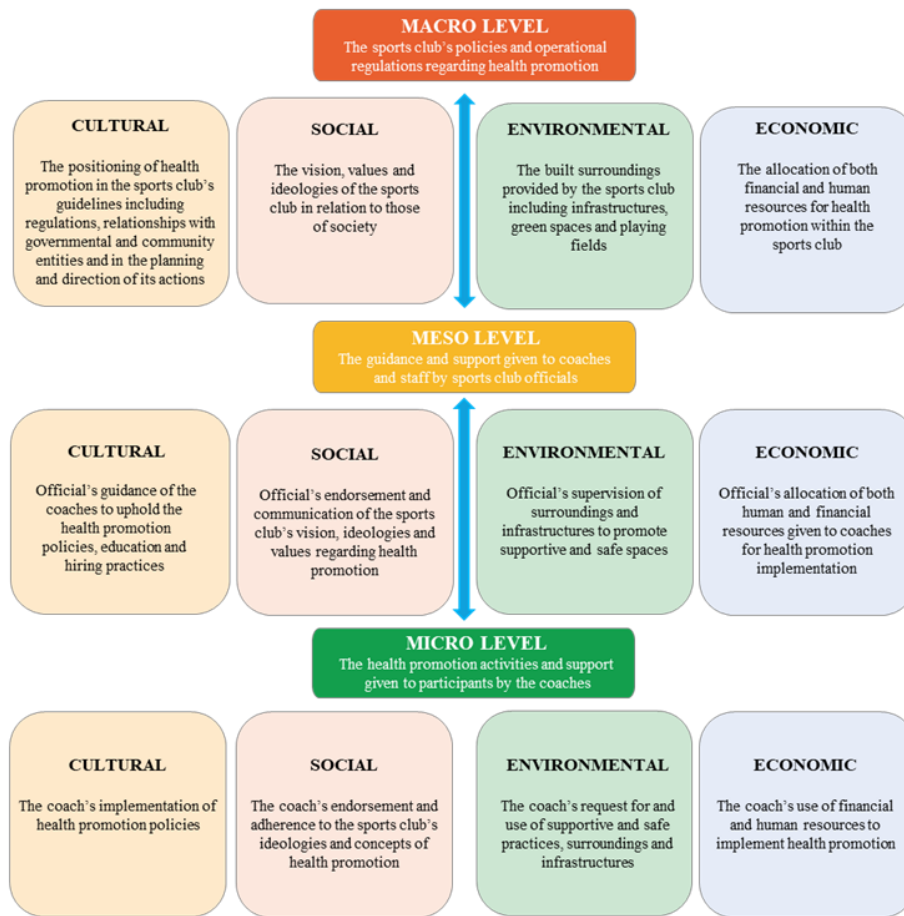


Figure 1. Four determinants at three sports club levels

Round Description and Analysis

Round 1

Item selection. The first round helped to select and propose initial items for each of the three levels (macro, meso, micro). Respondents were given the opportunity to delete and/or reformulate items in order to establish a stable list. Experts were able to duplicate items from one sports club level to another (i.e., macro, meso, micro), to reformulate, modify, clarify and add supplemental information such as explanations. For example, the item 'All youth events are held in an alcohol free environment' can be seen at the macro, meso and micro levels.

Indicator rating. Panelists used three indicators for item selection: HP relevance (how relevant is the item in regard to health promotion in sports clubs?), feasibility (how feasible/doable

is it for sports clubs?) and importance (how important is this item in regard to other priorities?). Items were rated on a 6-point Likert scale (1= Do not agree at all to 6= Totally agree).

Analysis. Consensus was achieved only when $\geq 80\%$ of experts rated the item 4 or above for all of the indicators. Strong consensus was described as any response that received a mean score of ≥ 4 and an interquartile range (IQR) ≤ 1 , moderate consensus to any mean score ≥ 3.75 , or if an IQR ≤ 1.25 (von der Gracht, 2012). Items that fell below 80% for any indicator underwent qualitative analysis by the research team. The research team came to agreement whether to keep the original item, reformulate it or exclude it for the second round.

Round 2

Item selection. The second round included new suggested items and reformulated items from round 1. Experts were asked to validate the proposed items and to delete or add new items if they had suggestions or felt items were problematic, duplicated or complicated.

Indicator rating. In addition to the three indicators from round 1, experts also rated items based on relevance to sports culture in order to ensure items were applicable across multiple countries. Items were again rated on the same 6-point Likert scale from round 1.

Analysis. Analysis was conducted using the same method as round 1 with consensus being achieved when $\geq 80\%$ of the experts rated items 4 or above on the Likert scale for each of the four indicators. Researchers qualitatively analyzed items receiving $< 80\%$ for HP relevance, feasibility and importance indicators but immediately deleted items below 80% agreement on culture relevance.

Round 3

Item ranking. Researchers organized items into a specific determinant of health at each sports club level to propose to experts (Figure 1). Experts were asked to rank each item within the designated determinant per level. Item ranking was based on feasibility, importance and HP relevance. If an item was not considered necessary, they were not required to rank it. The aim was to prioritize between 5 – 10 items per determinant with a minimum of 3 per category.

Analysis. In order to analyze items in round 3, a weighted-point value based on number of items per club level and determinant was used to rank items for each panelist's answer. Depending on the number of items per determinant (e.g. 7), 7 points were awarded for the highest ranked item, 6 points for the second, 5 points for the third item and so forth. Median scores were then calculated per item; only items with the five highest scores within each determinant/level were retained. If there were less than 5 items in a determinant at a particular level, researchers retained all items for the final questionnaire.

Data collection

An email explaining the study's purpose, procedures and a consent clause was sent requesting participation. Surveys were sent in English to all 69 experts in each round regardless of previous round participation via web-based software (limesurvey.com). Rounds were expected to take 45 minutes to complete. Panelists were given 2-3 weeks to complete each round; non-respondents were sent an email reminder after 7 days.

Results

Mean item scores on the Likert scale per indicator including expert agreement percentages for rounds 1 and 2 are displayed in Table 1. A flow chart of the number of panelists participating per country in each round is displayed in Figure 2.

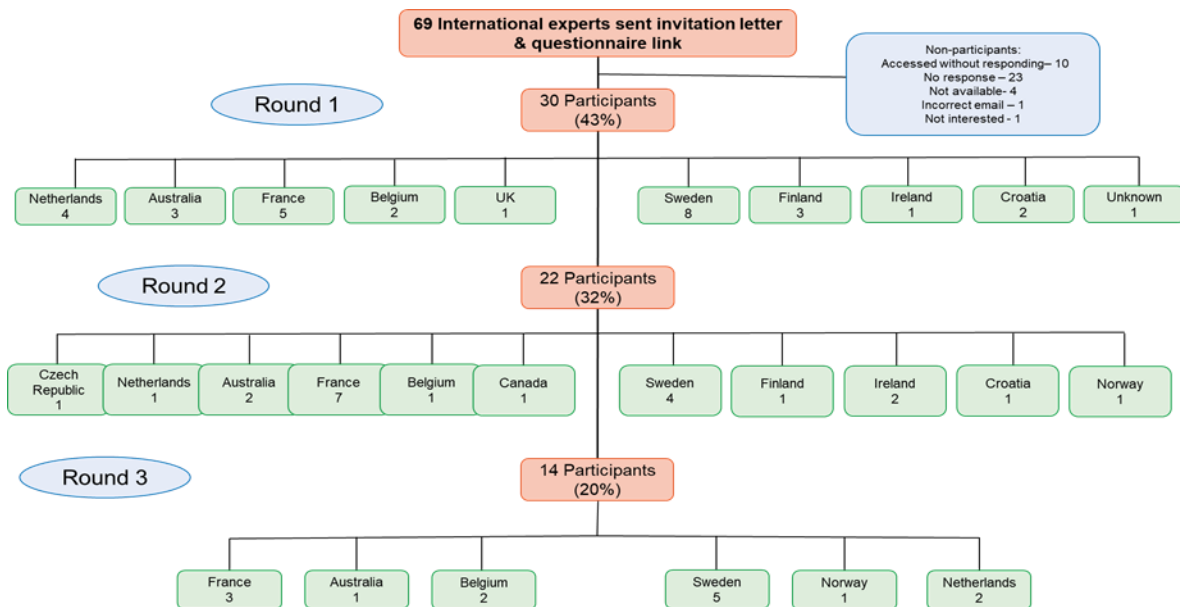


Figure 2. The three-round expert panelist flow chart

In the first round, 30 experts (43%) answered the questionnaire (16 males, 13 females and 1 non-specified gender). Panelists were from 9 different countries across Europe and Australia with a balance of academics ($n = 12$), non-governmental sports organization (NGOs) members ($n = 11$), a governmental sports organization ($n = 1$) and others in sports and health related sectors

(n = 6). The first round included 31 items at the macro, 11 at the meso and 17 at the micro level. All items were considered relevant and important to HP at the meso and micro levels. One item fell below 80% at the meso level and 3 items at the micro level, all of these in the feasibility indicator. More items fell below 80% at the macro level; 7 in relevance, 7 in feasibility and 5 in importance. These items were reformulated for the second round. Panelists added two items at the macro level. Duplicated items included 18 from both the macro to the meso level and from macro to the micro level, 2 items were duplicated from the meso to the macro level and 4 items from the meso to the micro level, as well as 2 from the micro to the meso level and 3 from the micro to the macro level. After duplication and reformulation of items, the second round consisted of 38 items at the macro level, 28 at the meso level and 29 at the micro level.

The second round included twenty-two experts (32%, 14 males, 8 females) from 11 countries across Europe, Australia and Canada. Panelists were comprised of 9 academics, 9 NGO members and 4 others from sports related sectors. Of these panelists, 12 completed the first round and 10 were new to this round. After the second round, 80% consensus was not achieved for several items at each sports club level (10 macro, 10 meso and 13 micro). At the macro level, 6 items were deleted: 5 for a low cultural relevance consensus and 1 for low feasibility. Researchers reformulated 4 items with a low feasibility consensus and experts added 1 extra item. The meso level included deletion of 8 items. Low consensus in cultural relevance resulted in 7 items being deleted and another item was removed due to low consensus on feasibility. Researchers reformulated 2 items with a low feasibility consensus and experts added 3 items. At the micro level, 11 items were deleted due to lack of cultural relevance and 1 due to low feasibility. Two items were reformulated and experts suggested 6 additional items. Going into round 3 expert panelists were proposed 33 items at the macro level, 23 items at the meso level and 23 micro level items. Round 1 and 2 results are available in Table 1.

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Table 1. Round 1 & 2 Indicator Results.

MACRO	Items	Round 1			Round 2			
		HP relevance % (mean)	Feasibility % (mean)	Importance % (mean)	HP relevance % (mean)	Cultural relevance % (mean)	Feasibility % (mean)	Importance % (mean)
*Item 1:	The sports club assures that health education is carried out	75% (4.7)	79% (4.42)	90% (4.85)	100% (5.31)	84.6% (4.69)	92.3% (4.77)	84.6% (4.23)
Item 2:	The sports club collaborates with external actors to promote health	94.4% (5.17)	94.4% (4.83)	94.1% (4.94)	100% (5.08)	100% (4.69)	92.3% (4.92)	100% (4.69)
Item 3:	The sports club clearly defines and understands the roles, responsibilities and expectations when working with other sectors to promote health	94.1% (4.53)	87.5% (4.5)	100% (5)	100% (5.42)	84.6% (4.62)	92.3% (5)	100% (4.62)
Item 4:	The sports club considers that sponsors and sponsorship are made in a health promoting way (banning unhealthy sponsors)	82.8% (4.76)	82.8% (4.71)	82.8% (4.88)	100% (5.46)	92.3% (4.46)	84.6% (5.23)	92.3% (4.23)
Item 5:	The sports club allows financial support to health promotion actions (e.g. communication systems, administrative support, staff time)	100% (5.13)	87.5% (4.5)	87.5% (5.06)	92.3% (5.23)	92.3% (4.54)	92.3% (5.08)	100% (4.08)
Item 6:	The sports club provides incentives to participate in health promotion actions	80% (4.6)	80% (4.53)	80% (4.6)	92.3% (4.92)	77.9% (4.46)	66.7% (4.92)	91.7% (4.25)
*Item 7:	The sports club ensures that health promotion activities are being properly resourced (e.g. staffing, financial summaries, highlights or case study reports)	71.4% (4.64)	64.3% (4.21)	75.7% (4.71)	100% (5.15)	69.2% (4.46)	69.2% (4.85)	84.6% (4.08)
*Item 8:	The sports club has staff with designated responsibilities to address the health of participants (e.g. time allocation to attend meetings)	79.6% (4.5)	71.4% (4.07)	84.7% (4.71)	100% (5.15)	92.3% (4.69)	92.3% (5.15)	100% (4.15)
Item 9:	The sports club ensures that people who are likely to work on sport-related health promotion activities possess sufficient skills	100% (5.5)	85.7% (4.64)	92.9% (5.07)	100% (5.15)	92.3% (4.54)	92.3% (4.92)	100% (4.08)
Item 10:	The sports club's regulations include a written section on well-being and/or health promotion and/or health education and/or healthy lifestyle	76.9% (5.08)	84.6% (4.92)	84.6% (5)	100% (5.23)	92.3% (4.69)	84.6% (5.23)	100% (4.77)
Item 11:	The sports club's regulations include a written section on health behavior (e.g. substance abuse, injury prevention...)	100% (5.38)	100% (5.31)	100% (5.38)	100% (5.08)	100% (4.92)	76.9% (4.92)	92.3% (4.54)
Item 12:	The sports club observes health and well-being viewpoints in the sports club's decision-making process	84.6% (5.08)	92.3% (4.85)	92.3% (5)	100% (5.38)	92.3% (4.77)	84.6% (4.92)	92.3% (4.69)
Item 13:	The sports club's health promotion activities and/or state of well-being are evaluated in the Annual Report	90.9% (5.09)	81.8% (4.64)	81.8% (5.09)	92.3% (5)	92.3% (4.31)	61.5% (5.08)	100% (4.23)
Item 14:	The sports club promotes the 'everyone plays' ideology	75% (5.17)	84.6% (5)	92.3% (4.77)	91.7% (5)	100% (5.08)	84.6% (5.08)	100% (5)
Item 15:	The sports club promotes the 'fair play' ideology	83.3% (5)	100% (5.75)	81.7% (4.92)	92.3% (5)	100% (5.23)	91.7% (5)	100% (5.33)
Item 16:	The sports club explicitly promotes integration and equity through sport	90.9% (5.36)	100% (5.55)	90.9% (5.27)	92.3% (5.08)	92.3% (4.92)	84.6% (5.31)	92.3% (5)
*Item 17:	The sports club cares about ethics	75% (3.92)	83.7% (4.33)	73.7% (3.91)	92.3% (5.15)	100% (5.08)	91.7% (5.42)	100% (5.33)
Item 18:	The sports club assumes its share of responsibility for a safe sports environment (e.g. reviews the sports environment yearly, in co-operation with the proprietor)	90.9% (4.82)	100% (4.91)	90.9% (4.73)	100% (5.38)	84.6% (4.92)	76.9% (4.77)	92.3% (5.42)
Item 19:	The sports club provides equitable access to disadvantaged groups through subsidies, access times, locations...	100% (5)	74.7% (4.45)	90.1% (4.91)	92.3% (5.15)	92.3% (4.77)	84.6% (5.15)	92.3% (5.23)
Item 20:	The sport club is aware that promoting health improves its credibility and enhances sport participants' experience	100% (5.09)	90.1% (4.91)	100% (5)	92.3% (5.23)	92.3% (5)	84.6% (5.15)	92.3% (4.69)
Item 21:	The sports club proposes safe and welcoming infrastructures and changing facilities	90.1% (5.18)	100% (4.73)	90.1% (5.09)	100% (5.38)	92.3% (5.08)	84.6% (5.15)	92.3% (4.69)

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Item 22:	The sports club provides signage for health behavior (e.g., non-smoking, violence prevention, warm-up...)	81.8% (4.64)	90.1% (4.82)	81.8% (4.64)	92.3% (5.31)	84.6% (5)	92.3% (4.46)	92.3% (5.08)
Item 23:	The sport club ensures up to date occupational health and safety standards and procedures	75% (4.83)	83.3% (4.5)	83.3% (4.75)	84.6% (4.92)	84.6% (4.62)	92.3% (4.77)	92.3% (4.62)
*Item 24:	The sports club provides evidence that target group have been included in the decision process of health promotion actions	81.8% (4.64)	64.6% (4)	72.7% (4.45)	92.3% (4.92)	92.3% (4.54)	92.3% (4.85)	100% (4.62)
Item 25:	The sports club ensures the appropriate organizational governance frameworks are in place to effectively identify and manage the organization's health promotion objectives	80% (4.8)	80% (4)	80% (4.7)	92.3% (4.92)	69.2% (4.38)	84.6% (4.92)	84.6% (4.46)
Item 26:	Around the sports club, there is a favorable external environment for promoting health through sport (e.g. the community opinion and policy environment support the promotion of health through sport)	90.9% (5.09)	72.7% (4.09)	90.9% (4.73)	100% (5.08)	92.3% (4.69)	76.9% (5.08)	92.3% (4.38)
Item 27:	The sports club contributes to increasing social capital and community cohesion through community Involvement	90.9% (5.18)	90.9% (4.91)	90.9% (5)	91.7% (5.42)	92.3% (5.08)	92.3% (5.15)	92.3% (4.85)
Item 28:	The sports club disseminates its health promotion actions on the media	81.8% (4.8)	81.8% (4.9)	63.6% (4.7)	92.3% (4.77)	92.3% (4.54)	92.3% (4.62)	84.6% (4.31)
Item 29:	The sports club works actively with youth and participant's involvement in the decision making process.	90% (5)	100% (5.18)	90% (4.91)	100% (5)	92.3% (4.77)	92.3% (4.92)	100% (4.46)
Item 30:	The sports club actively collaborates with parents	90.9% (4.64)	100% (4.36)	90.9% (4.09)	92.3% (5.15)	92.3% (4.77)	92.3% (5.23)	92.3% (4.77)
*Item 31:	The sports club encourages flexible membership options (e.g. pay as you go, social member)	81.8% (4.9)	72.7% (5.3)	63.6% (4.8)	92.3% (4.77)	92.3% (4.77)	92.3% (4.62)	92.3% (5)
Item 32:	My sports club is recognized as a health promoting setting in my community				92.3% (5)	92.3% (4.62)	92.3% (4.85)	100% (4.77)
Item 33:	My sports clubs offer adapted sports for people who are insufficiently active.				92.3% (5.08)	100% (5.08)	92.3% (5.23)	84.6% (4.85)
*Item 34:	My sports club selects and approves coaches who have accredited health promotion qualifications (healthy lifestyle, first aid, violence/injury prevention...)				92.3% (4.77)	92.3% (4.62)	61.5% (4.62)	100% (3.77)
Item 35:	My sports club provides material (kits, packs, tools) to support coaches' health promotion actions				92.3% (4.62)	69.2% (4.31)	83.3% (4.75)	91.7% (4.67)
Item 36:	My sports club ensures the balance between sport activities and participants' other daily activities is considered in coaching practice				84.6% (4.92)	76.9% (4.54)	66.7% (4.91)	90.9% (4.42)
Item 37:	My sports club provides healthy food options during sports club's activities				92.3% (4.92)	84.6% (4.92)	84.6% (5.15)	100% (4.38)
Item 38:	My sports club ensures all juvenile events are held in an alcohol-free and tobacco-free environment				92.3% (5.54)	92.3% (5.08)	92.3% (5.23)	92.3% (5.23)

MESO

Items	Round 1			Round 2			
	HP relevance % (mean)	Feasibility % (mean)	Importance % (mean)	HP relevance % (mean)	Cultural relevance % (mean)	Feasibility % (mean)	Importance % (mean)
Item 1: Officials ensure that coaches apply sports clubs' regulations and policies	80% (4.9)	100% (5.3)	80% (4.8)	100% (5.38)	84.7% (5.21)	92.3% (5.21)	92.9% (4.85)
Item 2: Officials ensure coaches play a role model for their participants	88.9% (5.44)	100% (5.56)	88.9% (5.44)	100% (5.38)	100% (5.07)	100% (5.57)	92.9% (5.08)
Item 3: Officials provide information to coaches and participants on health behaviors	100% (5.3)	90% (4.8)	100% (5.1)	92.3% (5.15)	84.7% (4.79)	100% (5.14)	100% (4.85)
Item 4: Officials disseminate and provide guidance to coaches on health promotion actions	100% (5.3)	80% (4.8)	100% (5.2)	100% (5.38)	92.3% (4.92)	92.3% (5.29)	92.9% (5.69)
*Item 5: Officials select and approve coaches who have accredited health promotion qualifications (first aid, violence/injury prevention, criminal records...)	89.9% (4.89)	89.9% (4.89)	89.9% (4.89)	100% (4.92)	84.7% (4.5)	92.3% (4.86)	92.9% (3.91)
Item 6: Officials encourage coaches to register for health promotion training	90% (5.2)	80% (4.7)	90% (5.3)	100% (5)	71.5% (4.5)	92.3% (4.93)	92.9% (4.31)

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*Item 7:	Officials ensure that coaches-athletes conflicts are monitored	90% (4.7)	90% (4.7)	80% (4.6)	92.3% (5.23)	92.9% (5)	92.3% (4.93)	92.9% (5)
*Item 8:	Officials acknowledge coaches' health promotion actions and disseminate them within and outside the sports clubs	100% (4.9)	90% (4.7)	100% (5)	92.3% (4.92)	92.9% (4.57)	92.3% (4.93)	85.7% (4.46)
Item 9:	Officials care that training pitches are distributed and scheduled fairly across all teams in the sports clubs	90% (4.4)	80% (4.5)	90% (4.6)	100% (5.46)	100% (5)	100% (5)	85.7% (5)
*Item 10:	Officials provide material (kits, packs, tools) to support coaches' health promotion actions	90% (5.2)	77.2% (4.44)	90% (5.1)	100% (5.38)	71.5% (4.64)	92.3% (5.29)	92.9% (4.62)
*Item 11:	Officials care that coaches engage parents in their activities	100% (5)	90% (4.6)	100% (4.9)	100% (5.15)	92.9% (4.93)	92.9% (5.21)	85.7% (4.69)
*Item 12:	Officials of my sports club care about the balance between sport activities and participants' other daily activities				92.3% (4.69)	64.3% (4.43)	76.9% (4.57)	92.9% (4.31)
Item 13:	Officials of my sports club provides healthy food options during sports club's activities				91.7% (5)	92.3% (4.77)	92.3% (5.07)	100% (4.62)
Item 14 :	Officials of my sports club ensures all juvenile events are held in an alcohol-free and tobacco-free environment				100% (5.77)	92.9% (5.29)	100% (5.64)	100% (5.31)
Item 15:	Officials of my sports club ensure that health education (knowledge, information) is carried out in their regular activities				92.3% (5.15)	85.7% (4.64)	92.3% (5.14)	85.7% (4.69)
Item 16:	Officials of my sports club solicit external actors to promote health				100% (4.92)	92.9% (4.71)	72.7% (4.83)	91.7% (4.36)
*Item 17:	Officials of my sports club have designated responsibilities to address health promotion				92.3% (4.92)	64.3% (4.5)	92.3% (5)	78.6% (4.77)
Item 18:	Officials of my sports club possess sufficient sport-related health promotion skills				100% (5.23)	92.9% (4.71)	75% (5.08)	100% (4.25)
*Item 19:	Officials of my sports club provide written plans for coaches' health promotion guidance activities				84.6% (4.92)	78.6% (4.86)	84.6% (5.14)	100% (4.54)
*Item 20:	Officials evaluate their health promotion activities regularly				100% (5.08)	71.5% (4.64)	92.3% (5)	92.9% (4.08)
Item 21:	Officials of my sports club promote the 'everyone plays' ideology				100% (5.17)	92.3% (5.08)	100% (5.08)	92.3% (4.92)
Item 22:	Officials of my sports club promote the 'fair play' ideology				100% (5.08)	100% (5.29)	100% (5.07)	92.9% (5.23)
Item 23:	Officials of my sports club promote integration and equity through sport				92.3% (5.15)	92.9% (5.07)	100% (5.29)	92.9% (5.15)
Item 24:	Officials of my sports club share responsibilities for a safe environment				100% (5.54)	92.3% (5.14)	92.3% (5.29)	92.9% (5.15)
Item 25:	Officials of my sports club ensure attention is paid to disadvantaged groups in their guidance activity				100% (5.15)	92.9% (4.93)	92.3% (5.21)	92.9% (4.77)
*Item 26:	Officials of my sports club are aware that promoting health improves the clubs' credibility and enhances sport participants' experience				100% (5.15)	85.7% (4.64)	92.3% (5)	92.9% (4.62)
Item 27:	Officials include the target group in the decision process of health promotion actions				92.3% (4.92)	92.9% (4.64)	76% (5.07)	92.9% (4.31)
*Item 28:	Officials work actively with youth and participant's involvement in the decision making process				100% (4.77)	78.6% (4.5)	92.3% (5.36)	100% (4.69)

MICRO

Items	Round 1			Round 2			
	HP relevance % (mean)	Feasibility % (mean)	Importance % (mean)	HP relevance % (mean)	Cultural relevance % (mean)	Feasibility % (mean)	Importance % (mean)
Item 1: My coach encourages players to respect sport regulations	90% (5.1)	100% (5.8)	90% (5)	93.7% (4.81)	94.4% (5.28)	100% (4.94)	82.3% (5.75)
*Item 2: My coach organizes lectures or invites external experts on health promotion actions	90% (4.8)	70% (4)	90% (4.6)	100% (5.31)	88.9% (4.72)	56.2% (4.82)	94.1% (4.31)
*Item 3: My coach treats athletes fairly in training and games (e.g. equitable participation, skills)	90% (5.3)	100% (5.5)	90% (5.3)	94.7% (5)	94.4% (5.06)	100% (5.24)	94.1% (5.5)
Item 4: My coach cares about safety issues during training and games	100% (5.7)	100% (5.8)	100% (5.6)	100% (5.38)	94.4% (5.22)	93.7% (5.4)	94.1% (5.31)
*Item 5: My coach deals with participant's failure in a positive way	90% (5.2)	100% (5.3)	90% (5.1)	100% (5.31)	94.4% (5.07)	100% (5.41)	94.1% (5.5)
*Item 6: My coach understands how their own behavior affects the health behavior of their participants, especially youth	90% (5.3)	100% (5.4)	90% (5.3)	100% (5.44)	72.2% (4.72)	93.7% (5.35)	100% (5.19)

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*Item 7:	My coach encourages social interaction between athletes within and outside practice/competition	90% (5.7)	100% (5)	90% (4.8)	94.7% (4.94)	77.7% (4.5)	93.7% (4.59)	88.2% (4.75)
Item 8:	My coach talks about health behavior	90% (4.8)	90% (5.2)	100% (5.6)	100% (5.31)	94.3% (4.89)	93.7% (5.12)	100% (4.94)
Item 9:	My coach considers health promotion also beyond sport performance	90% (5.6)	80% (5)	90% (5.5)	100% (5.38)	83.3% (4.89)	93.7% (5.12)	94.1% (5)
Item 10:	My coach disseminates information about health behavior to sport participants	100% (5.5)	90% (5)	100% (5.4)	100% (5.25)	88.2% (4.59)	87.5% (5)	94.1% (4.69)
*Item 11:	My coach intervenes in case of substance use	100% (5.2)	90% (4.4)	90% (4.9)	100% (5.44)	88.9% (4.94)	87.5% (5.24)	94.1% (4.75)
*Item 12:	My coach cares for and talks about athlete's nutrition	100% (5.7)	80% (5)	100% (5.6)	100% (5.19)	78.4% (4.89)	93.7% (5.12)	88.2% (4.81)
*Item 13:	My coach balances sport activities and participants' other daily activities	90% (5)	100% (4.89)	90% (4.8)	100% (5)	78.8% (4.61)	81.2% (5.12)	94.1% (4.44)
*Item 14:	My coach ensures that training is sensible/fun	90% (5.2)	90% (5.3)	90% (5.1)	100% (5.13)	94.4% (4.94)	93.7% (5.24)	100% (5.19)
*Item 15:	My coach ensures that healthy choices are the easy choices	90% (5.3)	90% (4.8)	90% (5.2)	100% (5.38)	83.3% (4.78)	87.5% (5.53)	100% (4.81)
*Item 16:	Healthy food options are available during sports club's activities	90% (5.2)	70% (4.8)	80% (5.1)	100% (5.19)	83.3% (4.56)	78.7% (5.18)	100% (4.25)
*Item 17:	All youth events are held in an alcohol-free and tobacco-free environment	90% (5.3)	70% (5.1)	90% (5.3)	100% (5.75)	83.3% (5.06)	93.7% (5.65)	100% (5.25)
Item 18:	My coach follows sports club's health promotion regulations and policies				100% (5.44)	94.4% (4.83)	93.7% (5.47)	100% (5)
*Item 19:	My coach has health promotion qualifications				94.7% (4.94)	66.7% (4.17)	87.5% (4.82)	88.2% (4.56)
*Item 20:	My coach participates in health promotion training				100% (4.81)	72.2% (4.28)	87.5% (5.12)	100% (4.5)
*Item 21:	My coach has designated responsibilities to address health promotion				94.7% (4.88)	72.2% (4.33)	75.5% (5.12)	94.1% (4.31)
*Item 22:	My coach evaluates their health promotion activities regularly				87.5% (4.88)	61.1% (4.17)	62.4% (4.25)	94.1% (5.12)
Item 23:	My coach promotes the 'everyone plays' ideology				94.7% (5.25)	88.9% (4.94)	100% (5.06)	100% (5)
Item 24:	My coach promotes the 'fair play' ideology				87.5% (5.13)	100% (5.28)	100% (5.12)	94.1% (5.44)
Item 25:	My coach promotes integration and equity through sport				94.7% (5.25)	88.9% (4.94)	94.1% (5.47)	100% (5)
Item 26:	My coach ensures attention is paid to disadvantaged people				93.3% (5.2)	82.4% (4.76)	81.2% (5.12)	88.1% (4.69)
*Item 27:	My coach is aware that promoting health improves the clubs' credibility and enhances sport participants' experience				100% (5.38)	77.8% (4.67)	100% (5.38)	94.1% (4.81)
*Item 28:	My coach includes the target group in the decision process of health promotion actions				100% (5.13)	70.6% (4.47)	75% (5.12)	94.1% (4.38)
*Item 29:	My coach works actively with youth and participant's involvement in the decision making process				94.7% (5.06)	72.2% (4.56)	93.7% (5.06)	88.2% (4.19)

Note. Items in grey were added to round 2, Items with a (*) were reformulated by the research team

The third round required experts to order and rank the items. At each level, panelists arranged items within the four determinants of health in order of highest priority. The 5 highest ranked items were retained. Whenever less than 5 items were ranked, all items for that particular sports club level and determinant of health were retained. Fourteen (20%) experts responded (8 males and 6 females) from 6 countries across Northern Europe and Australia, comprising 6 academics, 4 NGO employees and 4 others in the sports sector.

At the end of the third round, the macro level contained 23 items: 7 cultural, 6 social, 5 environmental and 5 economic determinants. The meso level included 20 items: 6 cultural, 5 social, 5 environmental and 4 economic determinants. The micro level had 19 items: 6 cultural, 5 social, 4 environmental and 4 economic determinants. The majority of items dropped (10) were at the macro level, most from the cultural and environmental determinants. Due to the lack of

participation from North America, Asia and Africa, an e-mail was sent to 8 experts from these countries requesting their validation on the final list of items. Two North American academics provided validation. The ranked item list, divided by sports club level and categorized into their respective health determinants with the weighted point scores, can be seen in Table 2.

Table 2. Round 3 Attributed Points with Final Item List

Macro level							
Cultural determinants	Points	Social determinants	Points	Environmental determinants	Points	Economic determinants	Points
*Item 1: My sports club ensures that health education (knowledge, information) is carried out in their daily activities	57	Item 1: My sports club avoids collaborations with sponsors that promote unhealthy products	28	*Item 1: My sports club assumes its share of responsibility for a safe sports environment (e.g. reviews the sports environment yearly, in co-operation with the proprietor)	75	*Item 1: My sports club promotes health through collaborations with external actors (e.g., municipality, experts...)	24
*Item 2: My sports club has defined the roles, responsibilities and expectations when working with other sectors (health, transport...) to promote health	62	*Item 2: My sports club promotes the 'everyone plays' ideology	40	*Item 2: My sports club provides safe infrastructures (e.g. locker room, practice field, indoor space...)	70	*Item 2: My sports club allocates resources to health promotion actions (e.g. communication systems, administrative support, staff time)	34
*Item 3: My sports club's regulations include a written section on well-being and/or health promotion and/or health education and/or healthy lifestyle	94	*Item 3: My sports club promotes the 'fair play' ideology	38	*Item 3: My sports club provides welcoming infrastructures (e.g. locker room, practice field, indoor space...)	55	*Item 3: My sports club has staff with designated responsibilities to address the health of its members	26
Item 4: My sports club's regulations include a written section on health behavior in general or with specific health topic (e.g. substance abuse, healthy eating...)	38	*Item 4: My sports club promotes integration and equity through sport	44	*Item 4: My sports club provide clean infrastructures (e.g. locker room, practice field, indoor space...)	48	*Item 4: My sports club ensures that staff possess sufficient sport-related health promotion skills	31
*Item 5: My sports club takes the health and/or well-being of staff and members into account in the sports club's decision-making process	69	*Item 5: My sports club acts ethically and respects moral principles	53	Item 5: My sports club displays posters or signage for health behavior (e.g. non-smoking, violence prevention, warm-up...)	42	*Item 5: My sports club provides equitable access to disadvantaged groups (through subsidies, access times, locations...)	17
*Item 6: My sports club ensures that target groups (e.g. parents, participants...) have been included in the decision process of health promotion actions	62	*Item 6: My sports club is aware of the benefits of promoting health (improving its credibility and/or enhancing sport participants' experiences)	63	*Item 6: My sport club ensures up to date occupational health, safety standards and procedures	51		
*Item 7: My sports club contributes to increasing social capital and/or community cohesion through community involvement	48	Item 7: My sports club has a favorable external environment for promoting health through sport (e.g. community opinion and policy environment supports the promotion of health through sport)	33	*Item 7: My sports club provides healthy food options during sports club's activities	44		

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Item 8: My sports club disseminates its health promotion actions to the media (newspaper, internet, radio)	24	*Item 8: My sports club is recognized as a health promoting setting in my community	45	Item 8: My sports club ensures all events, that youth attend, are held in a tobacco-free environment	29
**Item 9: My sports club offers flexible membership options	37			Item 9: My sports club ensures all events, that youth attend, are held in an alcohol-free environment	27
**Item 10: My sports club offers adapted sports (e.g. for disabled or chronic disease participants...).	32				
**Item 11: My sports club offers sports for people who are inactive or sedentary	49				

Meso level

Cultural determinants	Points	Social determinants	Points	Environmental determinants	Points	Economic determinants	Points
*Item 1: Officials of my sports club ensure that health education (knowledge, information) is carried out in their regular activities	53	*Item 1: Officials of my sports club promote the 'everyone plays' ideology	33	*Item 1: Officials of my sports club take responsibility for a safe environment	34	*Item 1: Officials of my sports club solicit external actors to promote health	17
*Item 2: Officials of my sports club provide guidance to coaches on health promotion actions	75	*Item 2: Officials of my sports club promote the 'fair play' ideology	31	*Item 2: Officials of my sports club care that training infrastructures are distributed and scheduled fairly across all teams in the sports club	22	*Item 2: Officials of my sports club possess sufficient sport-related health promotion skills	15
*Item 3: Officials of my sports club ensure that coaches apply sports clubs' health promotion regulations and policies	59	*Item 3: Officials of my sports club promote integration and equity through sport	48	*Item 3: Officials of my sports club provide healthy food options during sports club activities	14	**Item 3: Officials of my sports club allocate resources to health promotion actions (e.g. communication systems, administrative support, time)	21
*Item 4: Officials include the target group (e.g. parents, participants) in the decision process of health promotion actions	49	Item 4: Officials of my sports club ensure attention is paid to disadvantaged groups in their guidance activity.	26	**Item 4: Officials of my sports club ensures all events, that youth attend, are held in an alcohol-free and tobacco-free environment	16		
Item 5: Officials of my sports club acknowledge coaches' health promotion actions	45	*Item 5: Officials of my sports club are aware of the benefits of promoting health (improving its credibility and/or enhancing sport participants' experiences)	56				

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Item 6: Officials of my sports club disseminate coaches' health promotion actions within and outside the sports clubs	31	Item 6: Officials of my sports club encourage coaches to engage family members in their activities	21
*Item 7: Officials of my sports club prefer to hire coaches with accredited health promotion qualifications (healthy lifestyle, first aid, violence/injury prevention...)	43	*Item 7: Officials of my sports club make coaches understand that they are role models for their participants	56
Item 8: Officials of my sports club ensure that conflicts are monitored and solved	21		
*Item 9: Officials of my sports club provide information to coaches and participants on health behaviors	0		

Micro level

Cultural determinants	Points	Social determinants	Points	Environmental determinants	Points	Economic determinants	Points
*Item 1: My coach talks about health behavior	64	*Item 1: My coach promotes the 'everyone plays' ideology	34	*Item 1: My coach cares about safety issues during training and competition	29	*Item 1: My coach allocates time to health promotion during training and competition	33
*Item 2: My coach follows sports club's health promotion regulations and policies	65	*Item 2: My coach promotes the 'fair play' ideology	40	*Item 2: My coach encourages consumption of healthy food options	31	*Item 2: My coach has material resources (materials, toolkits, signage) available to promote health	21
*Item 3: My coach disseminates information about health behavior to sport participants	51	*Item 3: My coach promotes integration and equity through sport	53	*Item 3: All events, that youth attend, are held in an alcohol-free environment	15	*Item 3: My coach allocates human resources to health promotion actions (e.g. volunteer engagement, time)	22
Item 4: My coach intervenes in case of illicit substance use	31	Item 4: My coach ensures attention is paid to disadvantaged groups	27	*Item 4: All events, that youth attend, are held in a tobacco-free environment	15	*Item 4: My coach mobilizes sports clubs and/or community know how to promote health	22
Item 5: My coach intervenes in case of alcohol abuse	33	Item 5: My coach encourages players to respect sport regulations	20				
*Item 6: My coach ensures that training is sensible	43	*Item 6: My coach deals with participant's failure in a positive way	48				
*Item 7: My coach ensures that training is fun	51	*Item 7: My coach considers health	50				

promotion as more than
just sport performance

*Item 8: My coach ensures that healthy choices are the easy choices 49

Note. Items with an (*) were retained for the final list, Items with an (**) were reformulated and added to the final list

Discussion

A 3- round Delphi method was used to achieve international consensus from 13 countries to create a multi-level tool for measuring the health promotion orientation of sports clubs. The final tool encompassed 62 total items: 23 at the macro, 20 at the meso and 19 at the micro level. During round 1 and 2, ratings were based on feasibility, importance, HP relevance and specific to round 2, cultural relevance. Feasibility was rated in terms of the item's capacity to be accomplished within a sports club setting. Importance was considered in regard to the item being useful enough to be a priority. HP relevance was regarding item applicability to the sports club setting and cultural relevance was regarding the sports culture in the expert's country. Because sports clubs primarily rely on volunteers with limited resources (Casey et al., 2011) and HP is not their core activity, but an 'added value' (Kokko, et al., 2015), including multiple indicators to measure these factors is a major strength of this study. In both these rounds, the feasibility indicator received the lowest consensus. Many panelists felt items were important and relevant for HP but not feasible, especially at the macro and micro levels. In comparison to other settings, such as schools which have curriculums and paid employees, sports clubs are often run by volunteers with limited budgets, viewing their primary objective as sports performance (Geidne et al., 2013b; Kokko et al., 2009; Van Hoye et al., 2016). This reinforces results from a previous literature review showing that the settings-based approach is rarely implemented within sports clubs (Geidne et al., 2019). Another strength of this study lies in the development of a tool with cultural applicability in many sport systems, as broad variations have been noticed in previous works (Casey et al., 2011; Kelly et al., 2014; Kokko et al., 2016) and suggestions have been made for wider diversity in regard to geographical reach (Kokko et al., 2016). Therefore, round 2 specifically incorporated a rating of cultural relevance. Several items fell below the 80% agreement level for this indicator, for example the item: 'My sports club ensures the balance between sport activities and participants' other daily activities is considered in coaching practice' was duplicated in round 2 at all three levels but not found to be culturally relevant at any level. This may demonstrate cultural differences as it was originally in the micro level and an expert suggested duplication into the meso and macro levels. Round 2 consensus indicated low cultural relevance for this item across all three sports club levels.

In addition, one of the lowest agreed upon items for HP relevance was in regard to financing: 'The sports club ensures that health promotion activities are being properly resourced (e.g. staffing, financial summaries, highlights or case study reports)'. Sports clubs are funded in different ways depending on the country therefore, they may consider financing health promotion as the duty of their governing body while the club typically targets increasing participation rates (Eime et al., 2008). Interestingly, one of the lowest ranking items in importance had to do with offering flexible membership options, which is frequently cited as a barrier to sport club participation (Somerset & Hoare, 2018). If flexible membership options were offered in more clubs, this might attract new members.

Current research has centered on the sports club as an entity (macro level) (Kokko et al., 2016), whereas this measurement tool is based on 3-levels (sports club, officials and coaches); offering the ability to compare perceptions of sports participants to those of their coaches and likewise comparisons from coaches to officials. Actions at one level often depend upon policies and guidance of higher levels (Kokko, 2014b) therefore, intervention effectiveness can be altered by considering all involved stakeholders (any person or entity who shares an interest in the sports club). For example, at the macro level, the highest ranked item for importance and relevance was: 'My sports club's regulations include a written section on well-being and/or health promotion and/or health education and/or healthy lifestyle'. This item directly links to a highly ranked item for importance at the micro level, 'My coach(es) follow(s) sports club's health promotion regulations and policies'. Because each level addresses the levels below, (coaches and volunteers answer the macro and meso level) if no written policies exist or are not expressed to the coaches from officials, HP efforts are difficult to realize. The addition of determinants at each level displays the complexity of the relationship between individuals and the sports club environment, as well as the difficulty of the implementation and measurement of settings-based approaches (Dooris, 2006). The classification of items into determinants at each level is grounded in scientific literature, reflecting the importance of rooting measurement tools and interventions into theoretical models (Glanz and Bishop 2010). Moreover, both the socio-ecological approach (Dooris, 2009) and health promotion literature have shown that multiple level actions (Jackson et al., 2006) are more efficient, underlying the need for measurement tools at different levels (setting, professional, participants).

Limitations

This study provides a first step towards an internationally developed measurement tool for assessing health promoting sports clubs, but some limitations must be acknowledged. Although experts from each part of the world were invited to participate in each round, not all countries

responded, meaning this tool might not be globally applicable. A second limitation exists regarding the panelists that chose to participate in the study. Their views may be different from those that declined participation therefore, the final item list may not fully represent experts in both the HP and sports club fields. In order to minimize this limitation, one final email was sent out to the initial 69 experts requesting comments on the final list of items. Only two return emails were received: one from a Canadian academic expert and one from an American academic. Lastly, a limitation exists regarding the final number of items retained. The macro level included more items for panelist to rank within the four health determinants. Because the top 5 ranked items were retained, some items which reached 80% consensus in the previous two rounds could have been dropped for the final item list.

Implications for Practice and Future Research

Many researchers and government agencies have called for innovative settings to promote health (Geidne et al., 2019; Kokko et al., 2016; World Health Organization, 1986). Sports clubs offer an ideal setting, but research is limited. To develop this setting, research is needed to understand orientations of sports clubs toward health promotion. This study offers expert consensus regarding the most important, feasible and relevant items to monitor health promoting sports clubs. Previous research has demonstrated a link between health promotion, positive sport experience and perceived health thus, increased activity to promote health within sports clubs is needed while keeping in mind clubs' primary directives (Van Hoyer et al., 2015; Van Hoyer et al., 2016). By measuring social, cultural, environmental and economic determinants of health at three levels, this is a more comprehensive measurement tool for comparing health promotion perceptions between sports participants, coaches and officials. Several practical implications can be taken from the development of this tool: 1- it allows for comparisons of participants', coaches' and official's perceptions of health promotion done within sports clubs, 2- the tool highlights areas for improvement within each health determinant at each sports club level and 3- it sheds light on the capacity of sports organizations to implement and monitor health promotion policies and practices. The measurement tool has been culturally adapted and translated from English into French and Swedish with a classic double translation procedure. Answers are based on a 6-point Likert scale from '*strongly disagree*' to '*strongly agree*'. A user guide has been drafted in English and French to inform sports clubs on the importance of using the measurement tools and how to score and interpret results. Items on the tools have been tested for content clarity in English and French speaking populations of officials, coaches and participants. Online psychometric testing of the three sports club levels in English and French is in progress. Validation testing includes factorial structure analysis, temporal stability and predictive validity. Now that psychometric validation has

been completed, this measurement tool can be directly used by French sports clubs at one or multiple levels to determine and compare perceptions of health promotion within their club. The work undertaken in the present publication serves as a first step to inform policy-makers about the ideal state of becoming a health promoting sports club. The measurement tool helps to identify and narrow the gap between the ideal and current state of health promotion within their sports club. Results can then be used to build policies at all sports club levels which focus on promoting a natural shift to increase the health and well-being of all club stakeholders.

2.3 Preparing for study 2

Study 2 was undertaken in order to psychometrically validate the work completed in study 1 and provide a systematic means to evaluate the needs of sports clubs in regards to their health promotion actions. This study further demonstrates the use of including stakeholders within the PROSCeSS project and achieves the use of participation from sports participants as well as coaches and managers. Furthermore, it provides one of the key tenants of intervention mapping through its use of the participative approach, in addition to providing a better understanding of how the various sports club actors view the current state of health promotion actions done within their sports club (Bartholomew Eldredge et al., 2016; Kok et al., 2017). Study 2 gave validity to answering the first research question through the online validation of the questionnaire. Although useful to validate in English, study 2 was conducted in French in order to continue the PROSCeSS project. Creating, culturally adapting and psychometrically validating the e-PROSCeSS measurement tool provides a tool to target organizational change at multiple levels through different health determinants. This validation provided first responses to understanding what current perceptions of health promotion are in French sports clubs. In addition to providing perceptions at the three sports club levels, responses can be compared between the various actors (managers, coaches, sports participants) to gain more insight into how the different actors perceive health promotion actions carried out and supported by the club, the managers and the coaches. Once the final list of items was validated by the expert panelists in study 1, cultural adaptation and psychometric validation in French was planned. There are many types of measurement validation available so to ensure that the three scales measure what was intended and the collected data accurately represents the different dimensions being assessed, in this case the four health determinants at the three sports club levels. In social sciences, often subjective constructs are measured such as feelings, emotions or perceptions rather than objective measures such as heart rate or steps taken per day. Therefore, validating a measurement tool used to evaluate subjective constructs helps to collect better quality data with high comparability to measure accuracy and increase the credibility of the data (Kazi & Khalid, 2012). Different types

of questionnaire validation are used in social sciences to make sure that a questionnaire measures what was intended. For example, internal consistency is often used to determine the homogeneity of items included in a questionnaire (Tavakol & Dennick, 2011), while reliability is often undertaken with a test-retest process, whereby the questionnaire is given to the same or similar group of respondents a second time after a few weeks to see if similar results are obtained. Reliability refers to the consistency of a measure for its intended purpose (Walter et al., 1998). Two other basic components of validity are sensitivity and specificity used to determine presence or absence of a condition in the medical field. Sensitivity refers to the test's "ability to identify a true positive result and specificity refers to the test's ability to identify a true negative result (Swift et al., 2020; Trevethan, 2017). Although, behavioral science is using these tests more often with a score based on a continuum (Sheldrick et al., 2015) it is not very helpful in the case of measuring constructs and latent variables. A common basic form of validation is face validity which tests whether the items on a questionnaire measure what was intended, at face value. This is usually accomplished by experts in the field of research. Because the e-PROSCeSS was constructed through expert consensus in study 1, face validity had been previously established through their consensus. Content validity goes deeper to ensure not only does the questionnaire measure what was intended but also that the construct is adequately measured (Polit & Beck, 2006), in the case of the e-PROSCeSS questionnaire: do the items adequately measure perceptions of health promotion actions carried out within the sports club? Construct validity goes deeper into the items to analyze if they accurately measure the underlying (latent) variables, for the e-PROSCeSS questionnaire, the items that were originally categorized into the different health determinants were considered as latent variables. Therefore, construct validity allows researchers to interpret if these items, in fact, do measure the economic, environmental, organizational and social determinants of health (Cronbach & Meehl, 1955). Predictive validity refers to the extent that the constructs correlate with other phenomenon of interest (Sechrest, 2005) (i.e. drop-out rates, quality of life) which can be important in a practical sense for instance, convincing sports club actors that promoting health is beneficial to the club by retaining participants and staff. Predictive validity was of interest for this questionnaire validation to determine if health promotion actions done within sports clubs are detectable by the sports club actors and if those actions can predict related health factors (mental, social, physical well-being) (Mokkink, et al., 2010). To test predictive validity, several additional items from validated measurement tools are added to the questionnaire during the validation process. If no specific validated items are found, they can be created through consensus by the research team or by modifying validated items. This modification process was undertaken in order to assess the drop-out intentions of coaches and managers. Additional items

were created by the research team to assess coaches' and managers' 'job satisfaction' and sports participants perceived sports performance. Internal consistency is another assessment commonly undertaken during the validation process; it is a measure based on the correlation of items which are supposed to measure the same latent variable, for example do all of the items in the economic health determinant correlate with each other (Vaske et al., 2017) or do they cross correlate with items from the other variables. The use of external criterion to evaluate a questionnaire is often used if a similar, validated tool is available. This adds an additional step requiring study participants to respond to a second questionnaire. Depending on the length of the initial questionnaire and the second external tool, survey participants often experience what is referred to as 'respondent fatigue' wherein the quality of the collect data deteriorates with many 'I don't know' responses or survey participants begin to choose the same answer through the remainder of items or choose to not complete the questionnaire leaving missing data (Lavrakas, 2008). Because this questionnaire is the first of its kind to measure three sports club levels and four health determinants, no such scale exists. The HP-SAT is similar but is not an evaluation tool administered to sports club actors but rather, it is designed for State Sporting Organizations (Casey et al., 2011). Additionally, the Health Promotion in Sport Clubs index (Kokko et al., 2009) has yet to be validated and is not based on a theoretical model rendering it not suitable for use as an external criterion. This index is based on the sports club without considering the actions and support given by sports club managers and coaches. Structural Equation Modeling (SEM), is a form of psychometric validation more often used in behavioral and social sciences as a statistical technique to model the relationships between variables. SEM frameworks attempt to 'fit' items (*factor structure*) within a questionnaire to the latent constructs the items measure, thereby providing a model of how each item fits with the latent variable. The latent constructs are often theoretical or abstract concepts that are difficult to directly measure (Bowen & Guo, 2012) therefore, the observed variables (items on a questionnaire) are tested to determine if correlations exist from the scores (Kaplan, 2009). Each item from the questionnaire should correlate to an associated latent variable to provide a theoretical structure to the questionnaire (Kaplan, 2001). The latent variables should then fit with the main construct that is being measured. The e-PROSCeSS questionnaire is measuring the construct of health promotion within sports clubs with four pre-determined latent variables (economic, environmental, organizational, social) therefore, SEM was chosen for the validation method in study 2. Within SEM, the technique of Exploratory Factor Analysis (EFA) displays items having similar response patterns and if they fit together on one latent variable. Using many of the same concepts from EFA, Confirmatory Factor Analysis (CFA) allows the researcher to predetermine the factor structures to see if the data appropriately

conforms (Altman, 1991). CFA is also done within the SEM framework as it tests the factor structure and the quality of fit through statistical analysis. It has the advantage of determining if items found within certain latent constructs are very similar allowing researchers to correlate items and choose those with stronger correlations to the latent variable and delete items with weaker correlations (Bowen & Guo, 2012; Kaplan, 2009) (see Figure 6). This helps to shorten a lengthy questionnaire by choosing to include the strongest items for each latent construct. Therefore, psychometric validation using SEM was chosen for study 2 because the factors (latent variables) had been predetermined within study 1 by the expert panel who helped to design the questionnaire with three separate scales. CFA would then test how strongly the items fit into the predetermined health determinants.

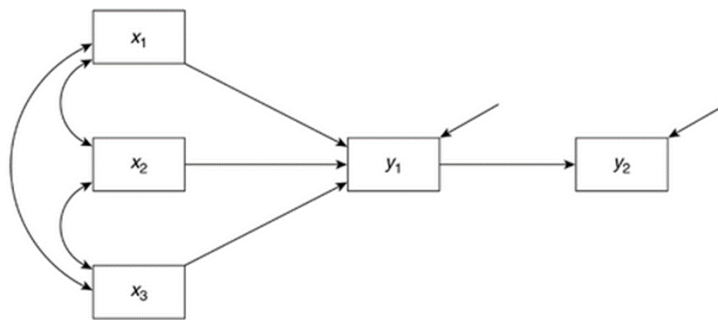


Figure 6. A Prototype Recursive Path Model (Kaplan, 2009)

Study 2 is the first administration and analysis of the e-PROSCeSS questionnaire therefore test-retest has not yet been undertaken to determine reliability. Prior to psychometric validation, the research team translated the health promoting sports club context and all measurement tool items into French. Then, the research team mapped out respondents to each of the three questionnaires and how to best present the information to the respondents. Invited respondents included sports club directors, managers and administrators, coaches and volunteer staff and sports participants. This characterizes the respondent groups within the sports club. To better display the respondents for each of the three questionnaires, a diagram of the club levels and scales is included in Figure 7.

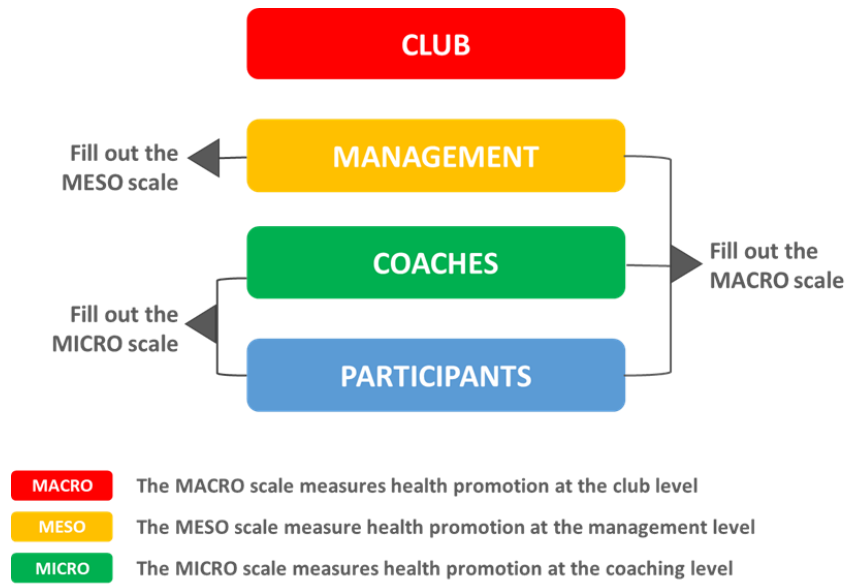


Figure 7. Respondent groups to the three sports club level scales

2.3.1 Study 2: French validation of the e-PROSCeSS questionnaire

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OXFORD

French validation of the e-PROSCeSS questionnaire: stakeholder perceptions of the health-promoting sports club

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Abstract

The health promoting sports club model describes the development of the settings-based approach in sports clubs. Based on this model, a questionnaire was developed to measure health promotion perceptions in sports clubs (e-PROSCeSS). This study's objective was to assess the psychometric properties of the French version of the e-PROSCeSS measurement tool. The questionnaire includes three scales measuring stakeholder's perceptions of the club (macro), management (meso) and coaches' (micro) activities toward promoting health. Five steps were undertaken which included 473 total respondents. First, scales were translated into French. Second, content clarity was tested in three populations (managers, coaches, sports participants). Third, descriptive statistics were presented. Fourth, confirmatory factorial analysis was performed

with 26 of 36 items retained at the macro level, 15 of 25 items retained at the meso level and 15 of 25 items retained at the micro level. Finally, predictive validity found positive relationships between health promotion perceptions and managing/coaching positions and negative relationships with drop-out intentions. Positive relationships were also found between sports participants' perceptions of health promotion and their self-rated performance and quality of life, while negative relationships were detected with drop-out intentions. The French e-PROSCeSS subscales showed good psychometric properties in measuring health determinants at multiple levels (except environmental) but could not measure health promotion as an overarching concept in sports clubs.

Keywords: health promotion perceptions, sports clubs, questionnaire validation, health promoting sports clubs, e-PROSCeSS scales

Introduction

The 2018 Eurobarometer reported that 12% of European Union citizens practice in sports clubs, while 6% volunteer as coaches or to organize events (European Commission et al., 2018). Although sports clubs have been 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, Breuer, et al., 2017), many receive partial financing or support from public sources and members (Scheerder et al., 2011). Through sports participation, populations can benefit from increased physical activity and better mental, social and physical health and well-being (Bouchard et al., 2012; Pelletier et al., 2013). Thus, sports clubs are well-positioned to promote health as an additional aim to their core activities. However, previous studies question the “myth of healthism” (Holman et al., 1997) surrounding sports. In fact, sports participants have elevated risk factors concerning alcohol, steroids and snuff consumption (Holman et al., 1997; Musselman & Rutledge, 2010; Werch et al., 2005) and sport is a primary contributor to injuries among adolescents (Emery, 2003). Therefore, sports clubs are not necessarily health promoting just by offering sports, but need increased investment (Geidne et al., 2013b). The effects of sport participation on health are well studied (Eime et al., 2013b; Kokko et al., 2019; Koorts et al., 2019), but exploring the mechanisms leading to Health Promoting Sports Clubs (HPSC) and their measurement are more recent (Geidne et al., 2019; McFadyen et al., 2018). The HPSC model (Van Hoyer et al., 2020) is rooted in the settings-based approach, which defines a setting as “the place or social context in which people engage in daily activities, in which environmental, organizational and personal factors interact to affect health and well-being” (World Health Organization, 1998). The HPSC model (Johnson et al., 2019; Van Hoyer et al., 2020)

defines levels of sports clubs: the macro level includes health promotion policies and organization of sports clubs; the meso level describes support managers offer coaches and volunteers to promote health; and the micro level describes coaches' health promotion activities targeting participants. Each level includes four health determinants: organizational, social, environmental and economic (Johnson et al., 2019).

A recent literature review highlighted the use of the settings-based approach in sports clubs, with many health promotion interventions directly focusing on sports participants, without taking a multi-level and multi-determinant approach (Geidne et al., 2019). This review found that many interventions were not properly evaluated through validated measurement tools. Although promising, instrument validation of scales assessing health promotion in sport has primarily been conducted at national levels, such as Finland (Kokko, 2014b), Australia (Kelly et al., 2010), Ireland (Lane et al., 2017) and France (Van Hoyer et al., 2015). Several tools exist to capture the perception of HPSC activities, with only two being validated: the Finnish Health Promotion in Sport Clubs index (HPSC) (Kokko et al., 2009) and the Australian Health Promotion in Sport Assessment Tool (HP-SAT) (Casey et al., 2011). Limitations of these scales include: 1) lack of theoretical foundations, 2) measurement at a single level and 3) construction of the scale in one country. Studies also show how complicated generating evidence of effectiveness of the settings-based approach can be partly due to multiple levels, determinants and outcomes and a lack of understanding of the health promotion concept (Dooris, 2006; Whitelaw et al., 2001). To address these shortfalls, a Delphi study invited international experts to create the e-PROSCeSS questionnaire, a three-level, self-evaluation measurement tool based on the HPSC model (Johnson et al., 2019). The current study aimed to assess psychometric properties of this measurement tool in French.

Methods

Study design

The psychometric properties of the e-PROSCeSS questionnaire were tested through a 5-step process (Mokkink et al., 2010). Step 1 translated the questionnaire from English into French using the Evaluative Linguistic Framework and the Dual-focus Approach (Clerehan et al., 2016; Erkut et al., 1999). Step 2 tested item clarity within three populations (managers, coaches, sports participants) using the Translation and Cultural Adaptation working group guidelines (Wild et al., 2005). Step 3 tested item acceptability (Vallerand, 1989) by analyzing 'I do not know' responses, missing data, floor effects and ceiling effects. Step 4 tested theoretical model fit using Confirmatory Factor Analysis (CFA) (Mokkink et al., 2010). Step 5 examined the questionnaire's predictive

validity to investigate if health promotion is a predictor for related health variables (Mokkink et al., 2010). Ethical approval was obtained and registered through CNIL by the Delegate of Data Protection N°2019-054 by the University of Lorraine.

Measurement

The e-PROSCeSS questionnaire includes three scales to assess perceptions of health promotion in sports clubs. Each scale is composed of four health determinants: organizational, social, environmental and economic. The macro scale begins with the stem 'My sports club...' and was developed to be answered by all three populations (managers, coaches, participants). It included 36 items (11 organizational, 11 social, 10 environmental, 4 economic), measuring perceptions of the whole club. The meso scale begins with the stem 'I...' referring to managers' perceptions of their own health promotion activities. It contained 25 items (9 organizational, 8 social, 5 environmental, 3 economic). The micro scale has two stems, 'I...' for coaches' responses and 'My coach...' for sports participants' responses. It contained 25 items (8 organizational, 9 social, 4 environmental, 4 economic).

Participants and procedure

Step 1: A nine-person panel (four academics, two health promotion professionals, one sports coach, one measurement validation specialist and one English translator) was formed. Panelists were native English speakers, native French speakers or had a working knowledge of both languages. Four native French speakers (AVH, AV, FR, FL), and a native English speaker (SJ) forward-translated the Delphi study scales (Johnson et al., 2019) into French to establish consensus on the translations. Scales were then back translated and compared to original versions. Adaptations were made in both languages and harmonized accordingly.

Step 2: Sports club managers, coaches and participants were contacted through researcher networks. Invitation letters were sent, and each participant provided informed consent. Thirty-eight respondents (26 English and 12 French), provided clarity feedback on the scales. Respondents included 25 females (66%) and 13 males (34%). Ages depended upon population: managers ($n = 7$, $M_{age} = 40.86$, $SD = 6.15$), coaches ($n = 11$, $M_{age} = 40.09$, $SD = 10.08$) and participants ($n = 20$, $M_{age} = 33.1$, $SD = 12.18$). Represented sports included: field hockey (10), athletics (4), tennis (4), swimming/diving (3), martial arts (2), gymnastics (2), equestrian (2), multi-sports (2), soccer/football (2), volleyball (1), rugby (1), yoga (1) and wrestling (1). One-hour cognitive interviews were scheduled in-person or via telephone in March and April 2019. Participants were asked to rate the clarity of each item on the relevant scales from 0–100%. Scores <70% were considered ambiguous and participants were encouraged to give feedback or

suggestions to improve clarity (Gray et al., 2016). This step was undertaken a second time with a similar protocol to ensure all scores were $\geq 70\%$ (Shoemaker et al., 2014).

Steps 3, 4 and 5: Data was collected from May 2019 to February 2020 via *limesurvey* with specific links for managers, coaches or sports participants. Respondents were recruited from a sample of clubs linked to French federations including individual, team and multi-sports (e.g. boxing, sport for all, swimming, sport for all, university sport). In total, 435 respondents were recruited (75 managers, 79 coaches, 281 sports participants). Sports club managers responded to the macro and meso level scales ($n = 75$; male = 57, $M_{age} = 57$; $SD = 13.38$). Coaches responded to the macro and micro scales ($n = 79$; male = 48; $M_{age} = 44.49$; $SD = 13.41$). Sports participants responded to the macro and micro scales ($n = 281$; male = 123; $M_{age} = 45.77$; $SD = 15.71$). Respondents provided informed consent and were given instructions, assurance of anonymity and answered demographic questions (age, gender, sport, etc.). Questionnaire responses were based on a 6-point Likert-scale with 1 being 'completely disagree' to 6 being 'completely agree' with a separate 'I don't know' option.

Data analysis

Statistical analysis was conducted in R 3.6.1 using the lavaan package (Rosseel, 2012).

Step 1: The panel analyzed item translations and reconciled inconsistencies. Items which were difficult to directly translate were recorded on an excel spreadsheet and refined for Step 2 preparation.

Step 2: The panel qualitatively analyzed items scoring $< 70\%$ for clarity. Item modification, explanation or rewording suggestions from respondents were considered until consensus was achieved.

Step 3: Item acceptability was tested by the frequency (%) of 'I do not know' and missing data. Floor and ceiling effects were analyzed through the distribution of responses per item. A ceiling effect was detected for items with a response rate $> 15\%$ for 'completely agree' whereas a floor effect was detected for items with a response rate $> 15\%$ for 'completely disagree' (McHorney & Tarlov, 1995). Means and standard deviations (SD) were analyzed to compare managers', coaches' and sports participants' responses and explore differences between the four health determinants.

Step 4: 'I don't know' responses were treated as missing data and replaced using expectation maximum replacement with a robust indicator (MLR) (Van Hoyer et al., 2016), after verification through the Little χ^2 test to determine if data were Missing Completely at Random. Thus, the combined missing data and 'I don't know' responses constituted the replaced data.

Construct validity was tested using confirmatory factor analysis (CFA), with maximum likelihood estimation, as items were previously classified by an international panel into the HPSC model (Johnson et al., 2019). To assess the model fit, multiple indicators were used (Mokkink et al., 2010): the Comparative Fit Index (CFI; values ≥ 0.90), the Tucker-Lewis Index (TLI; ≥ 0.90) and the Root Mean Square Error of Approximation with a 90% confidence interval (CI) (RMSEA 90% CI; values of < 0.06) (Hu & Bentler, 1999). Items with poor fit were examined using modification indices (Bowen & Guo, 2012) with factor loading > 0.40 (Hair et al., 1998). Internal consistency was tested through Cronbach's Alpha (values > 0.70) (Tavakol & Dennick, 2011).

Step 5: Predictive validity was assessed using previously validated measures associated with coaches' and sports participants' perceptions of health promotion: self-perceived satisfaction with coaching (coach/manager) or self-rated performance (participants), drop-out intentions and self-reported quality of life (QoL) (Van Hoyer et al., 2018; Van Hoyer et al., 2016). No validated measurement of managers' or coaches' drop-out intentions was found, therefore, four items were modified from an existing measurement tool with acceptable internal consistency: "I have the intention to quit coaching/managing at the end of the season" (5-point Likert scale from 'Completely Disagree' to 'Completely Agree') (Sarrazin et al., 2002). Sports participants' intentions to drop-out (negative correlation) were validated in a youth sports sample (Quested et al., 2013). Coaching/managing satisfaction was measured using one item: 'Indicate your level of satisfaction with the conditions of managing (or coaching) at your club' (5-point Likert scale from 'Completely satisfied' to 'Completely dissatisfied'). Self-rated participants' performance was measured with one item: 'Indicate your level of satisfaction with your sport performance in the last three weeks (5-point Likert scale from 'Completely satisfied' to 'Completely dissatisfied'). Participant's perceived QoL was assessed on a 10-point scale (Cantril, 1965), 1 being 'their worst' to 10 being their 'best possible life'. This indicator has been used in public health research (Benjamins et al., 2004) and in a youth soccer sample (Wold et al., 2013).

Results

Step 1 ensured a high-quality French version of the questionnaire. The translated questionnaire was developed over four meetings. Panelists discussed translations of items and came to consensus on accurate formulations. The final French translation showed acceptable cross-cultural equivalence with the original English version.

Step 2 ensured understanding of the items using cognitive interviews. Instruction clarity was universally understood. In addition, respondents understood answer choices but requested an 'I do not know' option be included. In general, items were considered clear and understandable. Certain words, (i.e. 'health promotion' changed to 'talking about health') were adjusted to improve

understanding. At the macro level, the lowest English score was 81%, which increased to 97% during the second round of interviews. In French, the lowest macro level score was 77% (*'My sports club respects moral principles'*). Based on feedback, the research team split this question: *'My sports club upholds good values'*, *'My sports club does not allow cheating (doping, betting, match fixing)'* and *'My sports club respects certain principles and values'* (see Table 1). The meso level in both languages was generally well understood with all scores above 78% (see Table 2). In French, the lowest micro level score was 20% (*'My coach ensures that healthy choices are the easy choices'*). Based on comments, the research team clarified the term 'healthy choices' which increased clarity to 50%. Although lower than 70% in French, the item was retained due to the English clarity score (93%). In general, the micro level received lower scores in French than in English (see Table 3).

Step 3 results depended upon respondent type and level. At the macro level, 'I don't know' responses varied: 0–7% for managers, 1–13% for coaches and 7–61% for sports participants. For example, items #4 and #21 had over 50% 'I don't know' responses from sports participants. The percentage of missing data was low for managers ($\leq 5\%$) and coaches ($\leq 8\%$), but higher among participants ($\leq 26\%$). No floor effect ($>15\%$; 'I completely disagree') was detected from any respondent population. A ceiling effect ($>15\%$; 'I completely agree') was seen on all items with 14 items from managers, 11 from coaches and 8 from sports participants having a ceiling effect $>50\%$. Results on the macro level subscales can be seen in Table 1.

At the meso level, managers had a higher frequency of 'I do not know' (1–15%) compared to their macro level responses. Missing data was also higher (10–13%), but no floor effect was detected. A ceiling effect was again detected with six items having ceiling effects $>50\%$. Complete results on the meso level subscales can be seen in Table 2.

At the micro level, coaches had 0–13% 'I do not know' answers with sport participants ranging from 5–63%. Percentages of missing data were 9–12% and 8–26% for coaches and sports participants, respectively. No floor effects were detected for coaches but items #2 and #3 had floor effects from sports participant responses. Ceiling effects were detected on all items except #2 and #3 for coaches (12 items $>50\%$) and 20 items for sports participants (5 items $>50\%$). Complete results on the micro level subscales can be seen in Table 3 below.

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MACRO LEVEL SCALES		Manager Responses							Coach Responses					Sport Participant Responses				
		†EN Median	†FR Median	Mean (SD)	% Ceiling Effect	% Floor Effect	% "I don't know"	% Missing data	Mean (SD)	% Ceiling Effect	% Floor Effect	% "I don't know"	% Missing data	Mean (SD)	% Ceiling Effect	% Floor Effect	% "I don't know"	% Missing data
General Scale	Directions/Consignes	100	100															
Organizational Scale																		
1.	My sports club ensures that health education (knowledge, information) is carried out in their daily activities <i>(Mon club de sport veille à ce qu'on parle régulièrement de la santé)</i>	100	100	4.18 (1.11)	50.00	5.00	1.00	0.00	4.27 (0.86)	48.10	1.00	1.00	0.00	4.23 (1.37)	21.00	4.00	21.00	12.00
2.	My sports club has defined the roles, responsibilities and expectations while working with partners to promote health <i>(Mon club de sport a identifié les rôles et attentes de chacun de ses partenaires pour parler de santé)</i>	100	100	3.76 (1.12)	28.00	6.00	4.00	0.00	3.75 (1.08)	24.00	3.00	6.00	0.00	4.23 (1.37)	16.00	4.00	27.00	9.00
*3.	My sports club has written regulations regarding the promotion of well-being, health, health education and/or a healthy lifestyle <i>(La promotion du bien-être et/ou de la santé et/ou l'éducation pour la santé est inscrite dans le règlement de mon club de sport)</i>	100	100	3.93 (1.30)	44.00	8.00	4.00	0.00	3.68 (1.12)	27.00	3.00	10.00	0.00	4.36 (1.42)	21.00	2.00	48.00	10.00
4.	My sports club has written regulations regarding health behaviors in general or on specific health topics (e.g. alcohol or drug abuse, healthy eating, etc.) <i>(Les comportements en matière de santé général ou sur des sujets de santé spécifiques (alcool, drogue, alimentation saine, etc.) sont inscrits dans le règlement de mon club de sport)</i>	100	100	3.54 (1.33)	29.00	11.00	7.00	0.00	3.48 (1.27)	24.00	5.00	10.00	0.00	4.53 (1.39)	15.00	2.00	61.00	6.00

Level subscale translations, scores and factor loadings

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My sports club takes into account the health and/or well-being of staff and members in its decision-making process <i>Mon club de sport prend en compte la santé et/ou le bien-être de son personnel et ses adhérents dans ses décisions)</i>	100	100	4.19 (1.00)	45.00	4.00	3.00	0.00	4.14 (0.90)	40.00	1.00	1.00	0.00	4.85 (1.17)	29.00	1.00	30.00	17.00	0.68	0.76
My sports club ensures that target groups (e.g. parents, participants, etc.) are involved in the decision-making process regarding actions related to promoting health <i>Mon club de sport s'assure que les groupes cibles (ex: parents, pratiquants, etc.) ont bien été associés au processus de décision)</i>	100	100	3.86 (1.11)	32.00	7.00	3.00	0.00	3.88 (0.92)	24.00	1.00	4.00	0.00	4.64 (1.17)	16.00	0.00	45.00	15.00	0.58	0.64
My sports club helps to enhance the life of the local community <i>Mon club de sport s'implique pour améliorer la vie du quartier ou de la commune)</i>	100	100	4.04 (1.20)	44.00	5.00	5.00	1.00	4.13 (0.89)	39.00	1.00	5.00	0.00	4.99 (1.23)	30.00	2.00	33.00	18.00	0.68	0.58
My sports club shares its actions regarding health with the media (newspaper, internet, radio) <i>Mon club de sport communique sur ses actions liées à la santé auprès des médias (presse, internet, radio)</i>	100	100	3.76 (1.29)	36.00	5.00	7.00	1.00	3.72 (1.20)	30.00	6.00	6.00	1.00	4.36 (1.46)	22.00	5.00	36.00	17.00	x	x
My sports club offers flexible membership options <i>Mon club de sport propose des options d'adhésion à la carte)</i>	100	100	3.44 (1.42)	28.00	15.00	4.00	1.00	3.19 (1.35)	22.00	10.00	11.00	0.00	4.55 (1.58)	33.00	6.00	26.00	14.00	0.41	0.52
My sports club offers adapted sports practices (e.g. persons with disabilities or chronic diseases) <i>Mon club de sport propose une pratique sportive adaptée (ex: pour les personnes en situation de handicap ou atteintes de maladies chroniques, etc.)</i>	100	100	4.04 (1.27)	47.00	9.00	4.00	0.00	3.91 (1.29)	48.00	6.00	5.00	0.00	5.15 (1.22)	46.00	2.00	17.00	17.00	0.59	0.62
My sports club adapts sports practices to inactive or sedentary persons <i>Mon club de sport propose une pratique sportive adaptée aux personnes inactives ou sédentaires)</i>	100	100	4.27 (0.93)	50.00	1.00	3.00	1.00	4.00 (1.25)	46.00	5.00	8.00	1.00	5.05 (1.30)	47.00	2.00	19.00	15.00	x	x
Environmental Scale																			
My sports club assumes its share of responsibility for a safe sporting environment (e.g. reviews the sports environment yearly on and off the field) <i>Mon club de sport assume sa part de responsabilité pour garantir un environnement sportif sûr (ex. en contrôlant les installations chaque année)</i>	100	100	4.23 (1.15)	49.00	7.00	4.00	0.00	4.17 (1.00)	47.00	3.00	4.00	4.00	5.28 (1.01)	40.00	1.00	29.00	16.00	x	α = 0.86
My sports club has safe infrastructures (locker rooms, practice fields, other facilities) <i>Mon club de sport propose des infrastructures sûres (ex: vestiaires, terrains, locaux, etc.)</i>	100	100	4.36 (1.01)	57.00	5.00	1.00	0.00	4.33 (0.88)	51.00	1.00	4.00	1.00	5.39 (0.95)	53.00	1.00	8.00	23.00	x	0.72

Table 1. continued

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My sports club has clean infrastructures (locker rooms, practice fields, other facilities)	100	100	4.35 (1.07)	57.00	5.00	3.00	3.00	4.34 (0.91)	53.00	1.00	3.00	4.00	5.30 (1.02)	48.00	1.00	7.00	26.00	x	0.88
<i>Mon club de sport propose des infrastructures adéquates (ex: vestiaires, terrains, locaux, etc.)</i>																			
My sports club is welcoming (e.g. staff, coaches and volunteers)	100	100	4.62 (0.77)	70.00	3.00	1.00	0.00	4.61 (0.63)	66.00	1.00	1.00	0.00	5.57 (0.86)	63.00	1.00	7.00	20.00	x	0.90
<i>Mon club de sport est accueillant (ex: entraîneurs, bénévoles, etc.)</i>																			
My sports club displays posters or messages about health behaviors (e.g. injury/violence prevention, warm-up, etc.)	100	100	3.48 (1.28)	27.00	9.00	1.00	0.00	3.37 (1.22)	19.00	9.00	5.00	1.00	4.19 (1.52)	21.00	7.00	23.00	18.00	x	0.89
<i>Mon club de sport expose des affiches ou une signalétique concernant les comportements en matière de santé (ex: interdiction de fumer, prévention de la violence, échauffement, etc.)</i>																			
My sports club ensures up to date national health and safety standards and procedures	100	100	3.83 (1.14)	29.00	7.00	5.00	0.00	3.63 (1.06)	23.00	1.00	6.00	1.00	4.92 (1.27)	25.00	1.00	44.00	16.00	x	0.77
<i>Mon club de sport applique des normes et procédures actualisées en matière de santé et de sécurité au travail</i>																			
My sports club offers healthy food options during club activities	100	100	3.43 (1.21)	24.00	9.00	3.00	3.00	3.09 (1.24)	14.00	14.00	6.00	1.00	4.01 (1.66)	18.00	9.00	37.00	9.00	x	0.88
<i>Mon club de sport donne accès à une alimentation saine pendant les activités du club</i>																			
My sports club ensures all youth attended activities are held in a tobacco-free environment	100	100	4.33 (1.08)	60.00	4.00	3.00	0.00	4.39 (0.99)	61.00	4.00	3.00	3.00	5.40 (1.00)	48.00	1.00	28.00	11.00	x	0.88
<i>Mon club de sport veille à ce que toutes les activités auxquelles les jeunes assistent se déroulent dans un environnement sans tabac</i>																			
My sports club ensures all youth attended activities are held in an alcohol-free environment	100	100	4.38 (1.01)	62.00	4.00	3.00	0.00	4.29 (1.02)	57.00	4.00	3.00	1.00	5.40 (1.01)	47.00	1.00	30.00	12.00	x	0.88
<i>Mon club de sport veille à ce que toutes les activités auxquelles les jeunes assistent se déroulent dans un environnement sans alcool</i>																			
My sports club avoids collaborations with sponsors that promote unhealthy products	100	100	4.15 (1.02)	42.00	4.00	5.00	0.00	4.09 (1.01)	39.00	3.00	11.00	1.00	5.16 (1.04)	25.00	0.00	56.00	7.00	x	0.88
<i>Mon club de sport évite les partenariats avec des sponsors qui mettent en avant des produits mauvais pour la santé</i>																			
Overall scale																			α = 0.94
My sports club encourages the "everyone has a role" ideology	100	100	4.57 (0.76)	68.00	1.00	0.00	0.00	4.43 (0.88)	57.00	3.00	3.00	4.00	5.60 (0.82)	59.00	1.00	9.00	20.00	0.88	0.88
<i>Mon club de sport encourage la participation de tous</i>																			
My sports club promotes the "fair play" ideology (respect for others and rules of the game)	100	100	4.55 (0.83)	68.00	3.00	3.00	0.00	4.54 (0.81)	65.00	1.00	5.00	3.00	5.62 (0.76)	59.00	0.00	11.00	19.00	0.90	0.90
<i>Mon club de sport encourage le « fair play »</i>																			
My sports club promotes integration through sport (social inclusion and diversity)	100	100	4.57 (0.92)	73.00	4.00	1.00	0.00	4.56 (0.73)	61.00	1.00	4.00	3.00	5.57 (0.90)	60.00	1.00	13.00	16.00	0.89	0.89
<i>Mon club de sport encourage l'intégration par le sport (inclusion sociale, mixité par le sport)</i>																			
My sports club acts in an ethical manner	100	100	4.44 (0.94)	61.00	4.00	0.00	5.00	4.32 (0.89)	47.00	1.00	3.00	8.00	5.52 (0.90)	49.00	1.00	17.00	20.00	0.77	0.77
<i>Mon club agit de manière éthique</i>																			

Table 1. continued

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26. My sports club is aware of the benefits of promoting health (e.g. improving credibility and/or enhancing participants' experiences) (<i>Mon club de sport connaît les bénéfices qu'il peut tirer de son engagement dans la promotion de la santé (ex: renforcer sa crédibilité et/ou améliorer la satisfaction des pratiquants)</i>)	100	100	4.28 (0.95)	53.00	3.00	1.00	1.00	4.39 (0.84)	53.00	3.00	6.00	1.00	4.98 (1.26)	32.00	1.00	40.00	13.00	0.75
27. My sports club has support from the community and local government to promote health (<i>Mon club de sport dispose du soutien de la commune ou du quartier pour favoriser la santé</i>)	100	100	3.86 (1.15)	36.00	4.00	7.00	1.00	4.01 (0.92)	32.00	8.00	13.00	1.00	4.76 (1.34)	24.00	1.00	44.00	15.00	x
28. My sports club is recognized as a health promoting setting in my community (<i>Mon club de sport est reconnu au niveau local comme un lieu de promotion de la santé</i>)	100	100	4.02 (1.15)	43.00	7.00	4.00	1.00	3.97 (1.01)	37.00	1.00	11.00	1.00	4.91 (1.30)	34.00	2.00	30.00	17.00	x
33. My sports club offers equal access to disadvantaged groups (e.g. subsidies, access hours, spaces, etc.) (<i>Mon club de sport propose un accès équitable aux personnes qui ont des difficultés financières</i>)	100	100	4.23 (0.96)	47.00	3.00	4.00	1.00	4.17 (0.96)	44.00	3.00	5.00	1.00	4.91 (1.26)	22.00	2.00	47.00	13.00	x
34. My sports club upholds good values (<i>Mon club de sport défend de bonnes valeurs</i>)	*	*	4.61 (0.75)	69.00	1.00	3.00	1.00	4.62 (0.67)	66.00	1.00	3.00	1.00	5.58 (0.81)	59.00	1.00	8.00	21.00	0.80
35. My sports club does not allow cheating (betting, doping, match fixing) (<i>Mon club de sport ne triche pas (dopage, pari, transfert...)</i>)	*	*	4.69 (0.71)	75.00	1.00	5.00	1.00	4.73 (0.54)	73.00	0.00	6.00	1.00	5.61 (0.79)	57.00	1.00	23.00	14.00	x
36. My sports club respects definitive values and principles (<i>Mon club de sport respecte certains principes et certaines valeurs</i>)	*	*	4.70 (0.71)	77.00	1.00	1.00	1.00	4.71 (0.63)	75.00	1.00	3.00	3.00	5.63 (0.77)	64.00	1.00	9.00	17.00	x
Economic Scale																		$\alpha = 0.84$
29. My sports club promotes health through collaborations with external actors (e.g. local government, experts, etc.) (<i>Mon club de sport s'engage dans des activités liées à la santé grâce à des partenariats avec des acteurs extérieurs (ex: municipalité, experts, etc.)</i>)	100	100	4.12 (1.14)	52.00	4.00	1.00	1.00	3.97 (1.04)	37.00	1.00	6.00	1.00	4.76 (1.41)	29.00	3.00	37.00	15.00	0.68
30. My sports club allocates resources to promote health (e.g. communications, administrative support, staff time) (<i>Mon club de sport attribue des ressources pour les actions liées à la santé (ex: communication, soutien administratif, temps de personnel)</i>)	100	100	3.75 (1.25)	37.00	7.00	4.00	3.00	3.65 (1.17)	30.00	4.00	11.00	1.00	4.55 (1.43)	19.00	4.00	49.00	12.00	0.90
31. My sports club has staff with designated responsibilities to address the health of its members (<i>Mon club de sport dispose d'un personnel chargé de s'occuper de la santé des adhérents</i>)	100	100	3.47 (1.39)	28.00	13.00	4.00	3.00	3.33 (1.31)	28.00	9.00	4.00	3.00	4.29 (1.60)	20.00	7.00	36.00	14.00	0.73
32. My sports club ensures that staff possess sufficient sport-related health skills (<i>Mon club de sport veille à ce que le personnel possède les compétences suffisantes en matière de santé liées au sport</i>)	100	100	4.24 (0.98)	47.00	3.00	4.00	1.00	4.17 (0.96)	44.00	3.00	1.00	1.00	4.86 (1.41)	36.00	4.00	30.00	14.00	0.73

†All manager, coaches' and sports participant responses were averaged together for the final clarity score

*Items were added based results from final clarity interviews

*Item deleted; α after CFA

Table 1. end

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MESO LEVEL SCALES

Manager Responses

	EN Median	FR Median	Mean (SD)	% Ceiling Effect	% Floor Effect	% "I don't know"	% Missing data	Factor Loadings
General Scale Directions/ <i>Consignes</i>	100	100						
Organizational Scale								$\alpha = 0.89$
1. I ensure that health education (knowledge, information) is carried out in coaches' regular activities <i>Je veille à ce qu'on parle régulièrement de la santé</i>	100	100	4.90 (1.20)	35.00	4.00	11.00	5.00	0.89
2. I provide guidance to coaches for promoting healthy behaviors <i>J'oriente et conseillent les entraîneurs sur les actions liées à la santé</i>	100	100	4.58 (1.40)	28.00	5.00	5.00	11.00	0.87
3. I ensure that coaches apply the club's regulations and policies for talking about health <i>Je veille à ce que les entraîneurs appliquent le règlement et les politiques du club en matière de santé</i>	100	100	4.97 (1.15)	36.00	3.00	4.00	11.00	0.87
4. I include the target group (e.g. parents, participants) in the decision-making process regarding actions related to health <i>J'associe le groupe cible (ex : parents, pratiquants) dans le processus de décision concernant les actions liées à la santé</i>	100	100	4.40 (1.19)	16.00	3.00	11.00	11.00	0.89
5. I acknowledge coaches' actions related to health <i>J'accorde de la reconnaissance aux actions des entraîneurs pour favoriser la santé</i>	100	100	4.98 (1.01)	33.00	1.00	4.00	11.00	0.75
6. I share coaches' actions related to health within and outside the sports club* <i>Je diffuse les actions liées à la santé des entraîneurs au sein du club de sport et à l'extérieur</i>	100	100	4.69 (1.25)	29.00	3.00	9.00	11.00	0.84
7. I prefer to hire coaches with health related qualifications (e.g. healthy lifestyle, disease/injury prevention, etc.) <i>Je privilégie l'embauche d'entraîneurs disposant de qualifications en matière de la santé (mode de vie sain, prévention de la violence/des blessures, etc.)</i>	100	100	4.73 (1.39)	36.00	5.00	11.00	11.00	0.76
8. I ensure that conflicts are identified, managed and resolved <i>Je veille à ce que les conflits soient identifiés, gérés et résolus</i>	100	100	5.15 (1.03)	43.00	3.00	4.00	11.00	x
9. I communicate information about healthy behaviors to coaches and participants <i>J'informe les entraîneurs et les pratiquants sur les comportements en matière de santé</i>	100	100	4.57 (1.36)	28.00	5.00	9.00	11.00	0.81
Social Scale								$\alpha = 0.97$
0. I promote the "everyone plays" ideology <i>J'encourage le sport à tous</i>	100	100	5.40 (1.01)	59.00	0.00	1.00	12.00	0.97
1. I promote the "fair play" ideology (respect for others & rules of the sport) <i>J'encourage le fair-play</i>	100	100	5.53 (0.87)	63.00	1.00	3.00	12.00	0.77
2. I promote inclusion through sport (social inclusion & diversity) <i>Je favorise l'intégration sociale (inclusion sociale, mixité) par le sport</i>	100	100	5.42 (0.87)	55.00	1.00	3.00	12.00	0.75
3. I am open to all coaches and participants <i>Je suis équitable envers tous les entraîneurs et tous les pratiquants</i>	100	100	5.37 (0.98)	52.00	3.00	3.00	11.00	0.93

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offer incentives or aid to financially disadvantaged groups <i>(qu'une attention particulière est accordée aux personnes qui ont des difficultés financières)</i>	100	100	5.05 (1.01)	37.00	1.00	3.00	13.00	0.70
the benefits of promoting health (e.g. improving the sports club's credibility and/or enhancing participants' experiences) <i>(les bénéfices que le club peut tirer de son engagement dans la promotion de la santé pour crédibilité et/ou améliorer la pratique sportive des pratiquants)</i>	100	100	5.16 (1.01)	43.00	1.00	4.00	12.00	x
encourage coaches to include participant's families in their activities <i>(encourager les entraîneurs à associer les familles des pratiquants dans leurs activités)</i>	100	100	4.97 (1.20)	36.00	4.00	11.00	12.00	0.84
make sure coaches understand that they are role models for participants <i>(s'assurer que les entraîneurs comprennent qu'ils sont des modèles pour les pratiquants)</i>	100	100	5.14 (1.14)	47.00	3.00	5.00	13.00	x
Internal Scale								$\alpha = 0.90$
take responsibility for a safe sporting environment <i>(prendre la responsabilité d'un environnement sûr)</i>	100	100	5.17 (1.06)	45.00	3.00	4.00	13.00	0.79
ensure that facility access is distributed equally between the various club groups <i>(s'assurer que l'accès aux installations soit réparti équitablement entre les différents groupes du club)</i>	100	100	5.08 (1.10)	41.00	3.00	9.00	11.00	0.76
provide access to healthy food options during club activities <i>(accéder à une alimentation saine pendant les activités du club)</i>	100	100	4.45 (1.31)	24.00	1.00	13.00	12.00	0.57
ensure that all youth attended activities are held in a tobacco-free environment <i>(s'assurer que toutes les activités auxquelles les jeunes assistent se déroulent dans un environnement sans tabac)</i>	100	100	5.22 (1.21)	52.00	3.00	5.00	11.00	0.90
ensure that all youth attended activities are held in an alcohol-free environment <i>(s'assurer que toutes les activités auxquelles les jeunes assistent se déroulent dans un environnement sans alcool)</i>	100	100	5.31 (1.12)	53.00	3.00	5.00	11.00	0.94
External Scale								$\alpha = 0.88$
rely upon external experts to talk about health (nutritionists, physiologists, sports doctors) <i>(reposer sur des acteurs extérieurs (ex : municipalité, experts, etc.) pour promouvoir la santé)</i>	85	100	4.22 (1.54)	27.00	5.00	15.00	10.00	0.92
possess sufficient sports related health skills <i>(posséder des compétences suffisantes en matière de santé liées au sport)</i>	100	100	4.40 (1.42)	27.00	4.00	8.00	11.00	0.82
provide health resources (e.g. communication, administrative support, time) <i>(fournir les moyens pour favoriser la santé (ex : communication, soutien administratif, temps))</i>	100	100	4.40 (1.39)	27.00	4.00	11.00	11.00	0.82

and; α after CFA

Table 2. end

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CRO LEVEL SCALES		Coach Responses							Sport Participant Responses					
		†EN Median	†FR Median	Mean (SD)	% Ceiling Effect	% Floor Effect	% "I don't know"	% Missing data	Mean (SD)	% Ceiling Effect	% Floor Effect	% "I don't know"	% Missing data	Factor Loading
General Instructions/Consignes	Scale	100	100											
Economic Scale														$\alpha = 0.8$
My coach (I) take(s) time to talk about health during both practices and competitions <i>(Mon entraîneur (Je) prend(s) du temps pour parler de la santé pendant les entraînements et les compétitions)</i>		100	100	5.06 (0.89)	35.00	1.00	6.00	9.00	4.10 (1.52)	24.00	6.00	5.00	20.00	0.67
My coach has (I have) material resources (supplies, fliers, posters, signage) available to promote health <i>(Mon entraîneur a (J'ai) du matériel (plaquettes, affiche, affiches) pour parler de la santé)</i>		100	71	3.54 (1.47)	13.00	8.00	6.00	9.00	2.85 (1.41)	8.00	18.00	16.00	8.00	0.74
My coach (I) provide(s) human resources for health related actions (volunteers, dedicated people) <i>(Mon entraîneur (Je) mobilise des personnes pour les actions santé)</i>		100	100	3.98 (1.42)	13.00	5.00	8.00	9.00	3.05 (1.48)	9.00	16.00	20.00	13.00	0.92
My coach (I) find help within the club to talk about health <i>(Mon entraîneur trouve de l'aide dans le club pour parler de la santé)</i>		100	100	4.22 (1.42)	22.00	4.00	3.00	9.00	3.18 (1.46)	10.00	11.00	29.00	11.00	0.87
Environmental Scale														x
My coach (I) find help within the club to talk about health <i>(Mon entraîneur trouve de l'aide dans le club pour parler de la santé)</i>		100	100	5.42 (0.71)	49.00	1.00	1.00	10.00	5.01 (1.19)	43.00	2.00	7.00	24.00	x
Subscale translations, scores and factor loadings														
My coach (I) encourage healthy options <i>(Mon entraîneur encourage les pratiquants à manger sainement)</i>		100	100	5.30 (0.74)	44.00	0.00	1.00	10.00	4.06 (1.55)	24.00	7.00	11.00	18.00	x

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7. All youth attended activities are held in a tobacco-free environment <i>(Toutes les activités auxquelles les jeunes participent se déroulent dans un environnement sans tabac)</i>	100	100	5.61 (0.72)	63.00	0.00	5.00	10.00	5.43 (1.04)	54.00	2.00	22.00	14.00	x
8. All youth attended activities are held in an alcohol-free environment <i>(Toutes les activités auxquelles les jeunes participent se déroulent dans un environnement sans alcool)</i>	100	100	5.58 (0.74)	61.00	1.00	6.00	10.00	5.44 (1.01)	50.00	1.00	25.00	14.00	x
Social Scale													$\alpha =$
9. My coach (I) promote(s) the "everyone plays" ideology (encourage the participation of all) <i>(Mon entraîneur (J) encourage la participation de chacun)</i>	100	100	5.65 (0.60)	64.00	0.00	1.00	10.00	5.44 (0.94)	52.00	1.00	8.00	26.00	x
10. My coach (I) promote(s) the "fair play" ideology (respect for others & rules of the sport) <i>(Mon entraîneur (J) encourage le « fair play » (respect des règles du sport et des autres)</i>	100	100	5.66 (0.60)	63.00	0.00	4.00	10.00	5.42 (0.96)	49.00	1.00	14.00	25.00	0.89
11. My coach (I) promote(s) integration through sport (social inclusion & diversity) <i>(Mon entraîneur (J) encourage l'intégration sociale (inclusion de tous, mixité)</i>	100	81	5.64 (0.62)	65.00	0.00	3.00	10.00	5.53 (0.85)	54.00	1.00	14.00	22.00	0.88
12. My coach (I) treat(s) all participants fairly <i>(Mon entraîneur est (Je suis) équitable envers tous les pratiquants)</i>	100	100	5.61 (0.67)	65.00	0.00	1.00	10.00	5.38 (1.02)	56.00	1.00	7.00	22.00	0.79
13. My coach is (I am) a role model in terms of health and sport <i>(Mon entraîneur est (Je suis) un exemple en termes de santé et de sport)</i>	100	100	4.93 (1.16)	35.00	3.00	3.00	10.00	5.15 (1.10)	40.00	1.00	14.00	26.00	x
14. My coach (I) ensure(s) that attention is given to financially disadvantaged groups <i>(Mon entraîneur (Je) porte attention aux personnes qui ont des difficultés financières (prêt d'équipement...))</i>	100	75	5.14 (1.03)	43.00	0.00	4.00	11.00	4.79 (1.16)	16.00	1.00	54.00	13.00	0.64
15. My coach (I) encourage(s) players to respect sport regulations <i>(Mon entraîneur (J) incite les pratiquants à respecter le règlement sportif)</i>	100	100	5.70 (0.56)	67.00	0.00	4.00	10.00	5.42 (0.91)	50.00	1.00	10.00	26.00	0.90
16. My coach (I) deal(s) with participant failures in a positive manner <i>(Mon entraîneur (J) gère les échecs des pratiquants de manière positive)</i>	100	100	5.52 (0.71)	57.00	0.00	3.00	10.00	5.16 (1.05)	34.00	1.00	28.00	22.00	0.85
17. My coach (I) consider(s) health actions as more than just sport performance <i>(Mon entraîneur se (Je me) préoccupe de la santé en plus de la performance sportive)</i>	100	75	5.25 (0.88)	46.00	0.00	3.00	10.00	4.89 (1.23)	38.00	1.00	13.00	25.00	x

Table 3. continued

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ational Scale													α = 0.91
coach (I) ensure(s) that healthy choices are the choices	100	50	5.41 (0.86)	57.00	0.00	0.00	10.00	4.74 (1.29)	34.00	2.00	14.00	24.00	x
<i>entraîneur (Je) facilite les comportements « bons santé »)</i>													
coach (I) talk(s) about healthy habits	100	100	5.30 (0.91)	49.00	0.00	1.00	12.00	4.21 (1.56)	24.00	6.00	11.00	20.00	0.90
<i>entraîneur me (Je) conseille en matière de santé)</i>													
coach (I) follow(s) the sports club's regulations policies to promote health	100	100	5.57 (0.67)	58.00	0.00	5.00	10.00	4.71 (1.29)	27.00	1.00	32.00	20.00	0.90
<i>entraîneur (Je) respecte les règles et politiques du matière de promotion de la santé)</i>													
coach (I) share(s) information about healthy habits with sport participants	100	100	5.22 (0.95)	46.00	0.00	3.00	10.00	4.21 (1.53)	23.00	6.00	19.00	19.00	0.91
<i>entraîneur (Je) transmet(s) des informations aux participants sur les comportements en matière de santé)</i>													
coach (I) intervene(s) in cases of prohibited use	100	100	5.14 (1.19)	49.00	1.00	13.00	10.00	4.56 (1.44)	14.00	2.00	63.00	12.00	0.66
<i>entraîneur (J') intervient(s) en cas de consommation de substances interdites)</i>													
coach (I) intervene(s) in cases of alcohol abuse	100	100	5.10 (1.19)	48.00	1.00	10.00	10.00	4.59 (1.37)	14.00	1.00	63.00	10.00	x
<i>entraîneur (J') intervient(s) en cas d'abus d'alcool)</i>													
coach (I) ensure(s) that training is adapted for each	100	100	5.62 (0.69)	63.00	0.00	1.00	10.00	5.34 (1.05)	56.00	1.00	6.00	23.00	0.59
<i>entraîneur (Je) veille à ce que l'entraînement soit adapté à chacun)</i>													
coach (I) ensure(s) that training is enjoyable	100	100	5.74 (0.70)	54.00	0.00	0.00	10.00	5.18 (1.12)	46.00	1.00	6.00	26.00	x
<i>entraîneur (Je) veille à ce que l'entraînement soit agréable)</i>													

athletes' and sports participant responses were averaged together for the final clarity score reported; α after CFA

Table 3. end

The psychometric tests of the scales showed poor fit indices. For example, the Macro level results for managers and coaches: CFI = 0.7, TLI = 0.70, RMSEA = 0.11 (90% CI 0.10, 0.12) (see supplementary file 1). Using modification indices and adding correlations between items did not improve fit enough to achieve an acceptable model. Validation was therefore undertaken on each determinant as a subscale (Organizational, Social, Environmental, Economic), rather than the complete scale (macro, meso, micro).

Macro level scale

To ensure sufficient power during subscale testing, managers' and coaches' data were compiled (Kline, 2014). The Organization subscale showed acceptable fit after deleting items #3, #8 and #11 and adding a covariance between #5 and #6; $N = 154$, CFI = 0.96, TLI = 0.94, RMSEA = 0.06 (90% CI = 0.02, 0.09). Reliability was good ($\alpha = 0.85$). The Social subscale showed good fit with all items loading above 0.70, after deleting items #27, #28, #33, #35 and #36; $N = 153$, CFI = 0.99, TLI = 0.99, RMSEA = 0.05 (90% CI = 0.00, 0.11). Reliability was good ($\alpha = 0.94$). The Economic subscale showed good fit with all items retained; $N = 151$, CFI = 0.99, TLI = 0.98, RMSEA = 0.06 (90% CI = 0.00, 0.16). Reliability was good ($\alpha = 0.84$). The Environmental subscale did not have acceptable fit. All four subscales had acceptable to good fit for sports participants. The Organizational subscale showed acceptable fit after deleting items #3, #8 and #11 and a covariance added between #5 and #6; $N = 281$, CFI = 0.96, TLI = 0.95, RMSEA = 0.03 (90% CI = 0.00, 0.06). Reliability was good ($\alpha = 0.93$). The Social subscale showed good fit after deleting items #27, #28, #33, #35 and #36 and adding a covariance between item #22 and #23; $N = 259$, CFI = 0.95, TLI = 0.92, RMSEA = 0.08 (90% CI = 0.06, 0.10). Reliability was good ($\alpha = 0.93$). The Economic subscale showed good fit with all items retained; $N = 225$, CFI = 0.99, TLI = 0.97, RMSEA = 0.06 (90% CI = 0.00, 0.13). Reliability was good ($\alpha = 0.94$). The Environmental subscale showed good fit after deleting items #16 and #18 and adding a covariance between items #13 and #14 and between items #19 and #20; $N = 276$, CFI = 0.98, TLI = 0.97, RMSEA = 0.05 (90% CI = 0.02, 0.08). Reliability was good ($\alpha = 0.89$).

Meso level scale

The Organization subscale showed acceptable fit after deleting item #8 and a covariance added between items #2 and #9; $N = 75$, CFI = 0.99, TLI = 0.98, RMSEA = 0.00 (90% CI = 0.00, 0.07). After modifications, reliability was good ($\alpha = 0.95$). The Social subscale showed good fit after deleting items #14, #15 and #17; $N = 75$, CFI = 0.97, TLI = 0.94, RMSEA = 0.13 (90% CI = 0.03, 0.23). After deleting the two items, reliability was good ($\alpha = 0.94$). The Economic subscale showed good fit with all items retained; $N = 75$, CFI > 0.99, TLI > 0.99, RMSEA = 0.00 (90% CI =

0.00, 0.00). Reliability was good ($\alpha = 0.88$). The Environmental subscale did not show acceptable fit.

Micro level scale

Coach and sports participant responses were analyzed together for the micro level subscales. The Organization subscale showed acceptable fit after deleting items #17, #18, 23, #25; $N = 468$, CFI = 0.99, TLI = 0.98, RMSEA = 0.03 (90% CI = 0.00, 0.06). Reliability was good ($\alpha = 0.91$). The Social subscale showed good fit after deleting items #9 and #13; $N = 448$, CFI = 0.99, TLI = 0.98, RMSEA = 0.03 (90% CI = 0.01, 0.05). Reliability was good ($\alpha = 0.94$). The Economic subscale showed adequate fit with all items retained; $N = 474$, CFI = 0.99, TLI = 0.99, RMSEA = 0.04 (90% CI = 0.00, 0.10). Reliability was good ($\alpha = 0.86$). The Environmental subscale did not show acceptable fit.

Predictive validity showed relationships between the different scales with drop-out intentions, coaching/managing and performance satisfaction and QoL. On the macro level scales for managers, multiple regression of the four determinants on managing satisfaction was significant, $R^2 = 0.28$, $F(4,61) = 5.89$, $p < 0.001$, with the social determinant being significantly related to managing satisfaction ($\beta = 0.56$). Due to high correlations between the determinants, simple regressions were also tested and showed relationships of all four determinants with managing satisfaction: organizational, $R^2 = 0.17$, $F(1,64) = 12.91$, $p < 0.01$, ($\beta = 0.41$), social, $R^2 = 0.28$, $F(1,64) = 24.32$, $p < 0.001$, ($\beta = 0.53$), environmental, $R^2 = 0.16$, $F(1,64) = 13.37$, $p < 0.01$, ($\beta = 0.42$), and economic, $R^2 = 0.06$, $F(1,64) = 4.20$, $p < 0.05$, ($\beta = 0.25$). Additionally, multiple regression of the four determinants on drop-out intentions was significant $R^2 = 0.17$, $F(4,62) = 3.21$, $p < 0.05$, but none of the determinants were related to drop-out intentions. Simple regressions showed all four determinants negatively linked to drop-out intentions: organizational, $R^2 = 0.10$, $F(1,65) = 7.44$, $p < 0.01$, ($\beta = -0.31$), social, $R^2 = 0.17$, $F(1,65) = 13.08$, $p < 0.01$, ($\beta = -0.41$), environmental, $R^2 = 0.12$, $F(1,65) = 9.10$, $p < 0.01$, ($\beta = -0.35$) and economic $R^2 = 0.07$, $F(1,65) = 4.95$, $p < 0.05$, ($\beta = -0.27$).

Coaches had similar results compared to managers for coaching satisfaction: multiple regression of the four determinants was significant, $R^2 = 0.15$, $F(4,65) = 4.12$, $p < 0.01$, but no determinant specifically predicted coaching satisfaction. Simple regressions showed relationships with each determinant: organizational, $R^2 = 0.15$, $F(1,68) = 12.24$, $p < 0.01$, ($\beta = 0.39$), social, $R^2 = 0.12$, $F(1,68) = 9.29$, $p < 0.01$, ($\beta = 0.34$), environmental, $R^2 = 0.17$, $F(1,68) = 14.60$, $p < 0.001$, ($\beta = 0.42$) and economic, $R^2 = 0.07$, $F(1,68) = 6.86$, $p < 0.001$, ($\beta = 0.27$). Regarding drop-out intentions, only the single regression linking environmental determinants and drop-out intentions was significant, $R^2 = 0.06$, $F(1,68) = 5.58$, $p < 0.05$, ($\beta = -0.25$).

Multiple regression of the four determinants on the macro scales on sports participants' self-rated performance was significant, $R^2 = 0.08$, $F(4,268) = 5.84$, $p < 0.001$, with only economic determinants being related ($\beta = 0.38$). Simple regression showed significant relationships for two determinants: social, $R^2 = 0.03$, $F(1,271) = 7.26$, $p < 0.01$, ($\beta = -0.16$) and environmental, $R^2 = 0.04$, $F(1,272) = 10.65$, $p < 0.01$, ($\beta = -0.19$). Multiple regression of the four determinants on sports participants' QoL was significant, $R^2 = 0.03$, $F(4,266) = 2.74$, $p < 0.05$ with no determinant specifically predicting QoL. Simple regressions showed relationships with three determinants: organizational, $R^2 = 0.02$, $F(1,269) = 6.00$, $p < 0.05$, ($\beta = -0.15$), social, $R^2 = 0.02$, $F(1,269) = 7.35$, $p < 0.01$, ($\beta = -0.16$) and environmental, $R^2 = 0.04$, $F(1,269) = 10.96$, $p < 0.01$, ($\beta = -0.20$). Multiple regression of the four determinants on sports participants' intention to drop-out was also significant, $R^2 = 0.08$, $F(4,264) = 6.77$, $p < 0.001$, with the organizational determinant being directly linked ($\beta = -0.26$). Simple regression showed relationships negatively linked with all four determinants: organizational, $R^2 = 0.08$, $F(1,267) = 22.77$, $p < 0.001$, ($\beta = -0.28$), social, $R^2 = 0.04$, $F(1,267) = 11.99$, $p < 0.01$, ($\beta = -0.21$), environmental, $R^2 = 0.07$, $F(1,267) = 21.47$, $p < 0.001$, ($\beta = -0.27$) and economic, $R^2 = 0.04$, $F(1,267) = 12.71$, $p < 0.001$, ($\beta = -0.21$). Regarding the micro level scales, while multiple regression was not significant, simple regression showed a relationship between sports participants' self-rated performance with the social determinant, $R^2 = 0.02$, $F(1,271) = 5.68$, $p < 0.05$, ($\beta = -0.14$). Simple regression of the determinants on sports participants' QoL showed a relationship with three determinants: organizational, $R^2 = 0.02$, $F(1,269) = 5.41$, $p < 0.05$, ($\beta = -0.14$), social, $R^2 = 0.02$, $F(1,269) = 5.15$, $p < 0.05$, ($\beta = -0.14$) and economic, $R^2 = 0.01$, $F(1,269) = 4.33$, $p < 0.05$, ($\beta = -0.13$). Finally, multiple regression of the four determinants on sports participants' intention to drop-out was significant, $R^2 = 0.05$, $F(3,265) = 5.35$, $p < 0.01$, with the organizational determinant being directly linked ($\beta = -0.30$). Simple regression showed relationships with three determinants: organizational, $R^2 = 0.05$, $F(1,267) = 15.1$, $p < 0.001$, ($\beta = -0.23$), social, $R^2 = 0.02$, $F(1,267) = 7.44$, $p < 0.01$, ($\beta = -0.16$) and economic, $R^2 = 0.02$, $F(1,267) = 4.42$, $p < 0.05$, ($\beta = -0.13$).

Discussion

This study aimed to assess the psychometric properties of the French version of the e-PROSCeSS questionnaire. Based on a Delphi study (Johnson et al., 2019), the current study translated the questionnaire and assessed its content validity, internal consistency, construct and predictive validity. During CFA analysis, the theoretical model including health promotion as a latent variable showed poor fit, with items cross-loading onto different determinants leading to the decision of analyzing the data by determinant. This maintained consistency with the HPSC model (Van Hoyer et al., 2020). These results have implications for health promotion measurement applied to the

settings-based approach in sports clubs (Dooris, 2006): (1) the health promotion concept is not well understood, (2) sports participants have trouble answering macro-level scale, exhibiting the difficulties in capturing cross-level activities, (3) environmental determinants rarely converged, showing the difficulty in capturing this concept. For example, during Step 2, interviewees had a difficult time understanding the 'health promotion' terminology therefore, it was replaced by the word 'health' in many items, to increase understanding. Moreover, although questions were understood, sports participants could not answer the macro level scales. These findings lead to several interpretations. First, when the settings-based approach is properly implemented, health promotion is embedded in the sports club's daily activities, becoming implicit for sports participants and therefore difficult to evaluate (Speller et al., 2005; Whitelaw et al., 2001). This partially explains the request for an 'I don't know' response during step 2 as well as the high proportion of this response during the validation process. This highlights difficulties with measuring health promotion and begs the question, "if properly applied, should health promotion efforts be detectable or should they be considered second nature?" (Dooris, 2006). Second, the concept of health promotion is complex with physical, social and mental health requiring a broad range of associated concepts such as moral attitudes (Lee et al., 2007) or healthy eating (Kelly et al., 2014) be included, each needing individual scales. In other words, is the concept of health promotion too broad and too inclusive to be measured? (Dooris, 2006). Third, as the HPSC model is relatively new, its refinement through several studies enhanced definitions of health determinants and club levels, leading to necessary adaptations of measurement methods (Johnson et al., 2019; Van Hoyer et al., 2020). Stakeholders may have found it difficult to understand how the levels and health determinants interact and affect each other.

Once subscales were analyzed and CFA provided good fit, macro level subscales were combined from the three respondent groups validating 26 of the original 36 items. The meso level subscales were analyzed using managers' responses with 15 of the original 25 items retained. At the micro level, subscales were analyzed from coach and sports participant responses providing a scale with 15 of the original 25 items. Although determinants are better understood than the concept of health promotion, the Environmental subscale was problematic at the macro level with managers and coaches, the meso level with managers and the micro level with coaches and sports participants. This pattern has been seen in previous studies (Kokko et al., 2006; Van Hoyer et al., 2015) and may be due to respondents struggling to differentiate this determinant, as well as the lack of literature on this particular determinant (Geidne et al., 2019). According to the HPSC model (Van Hoyer et al., 2020), the environment refers only to "the physical surroundings in a

sports club” thus, the physical environment may not be considered ‘actionable’, partly due to the shared responsibility of infrastructures (Van Hoyer et al., 2015, 2016).

Sports participants had the most ‘I do not know’ answers, further illustrating the difficulties in perceiving how sports club’s activities directly impact sports participants. For example, the items *‘My sports club has written regulations in regard to health behaviors in general or on specific health topics’* and *‘My sports club avoids collaborations with sponsors that promote unhealthy products’*, had 61% and 56% ‘I don’t know’ response rates, respectively. This may be explained by sports participants coming to train and not being aware of formal club policies. This has been demonstrated with discrepancies found between managers and coaches when investigating the lack of top-down communication within sports clubs (Van Hoyer et al., 2016) further indicating the need for both top-down and bottom-up approaches to successfully implement policies (Geidne et al., 2013b). Sports participants also used this response for items that may not concern them. For example, *‘My coach intervenes in cases of prohibited substance use’* and *‘My coach intervenes in cases of alcohol abuse’* both had 63% ‘I don’t know’ response rates. In contrast, managers and coaches had much lower rates of this response which may reflect a better understanding of the clubs’ formal policies.

Besides the Environmental subscales, the Social subscales had the most reduction of items at the macro and meso levels. Deleted items were based on community support, offering access to monetarily disadvantaged groups and respect for values, further illustrating difficulties in understanding the concept of health promotion and its application in the sports club context. Therefore, it may be beneficial to include a bottom-up approach to creating items which account for the reciprocal relationship of the individual with their setting (Whitelaw et al., 2001). For example, items incorporating participants’ personal feelings of inclusion or taking their morals and ethics into consideration. Contrasting this, all items for the Economic subscales were retained; perhaps reflecting the small number of items (4) and these items were easily identifiable.

In general, a ceiling effect was seen within all scales at all levels. This could be due to one club, the ASM, having a ‘healthy-sport’ focus, potentially explaining the low floor effects. There was a noticeable increase of both missing data and ‘I don’t know’ responses from sports participants. Between levels communication issues (Van Hoyer et al., 2016) and differences in perceptions (Kokko et al., 2009) have previously been reported without interpretation. Thus, ensuring managers and coaches consciously communicate their health promotion activities to participants is fundamental to increasing participants’ healthy behaviors and understanding their benefits.

These scales provide insight into how promoting health in the sports club context can have positive health effects. Healthy participants perceive better experiences which encourages lifelong participation in sports (Kirk, 2005). Lower drop-out intentions for respondents was also reported which is supported by results in previous studies (Van Hoyer et al., 2015, 2016). In addition, increasing health promotion activities was correlated with increased satisfaction for managing/coaching, providing a positive rationale for sports clubs to include health promotion to support these actors. The objective of sports clubs is often increasing the sports performance of their athletes (Kokko, et al., 2015) therefore, by enhancing health promotion perceptions within clubs, a HPSC supports this primary objective and goes beyond this single expectation.

Some limitations need to be acknowledged regarding the results. First, because this is a self-report questionnaire, there is a potential for social desirability bias which has been seen in similar studies (Kokko et al., 2009). This could account for the high ceiling effects that were found. Additionally, a question of generalizability to youth sports clubs could be raised as well as cultural applicability. The scales were validated in a French population aged 15 and up. One way to circumvent this is for parents to supervise younger athletes when responding to the scales. Finally, one club could have biased the results by providing many respondents: 25% of the managers, 20% of the coaches and 53% of the participants. This particular club has a 'healthy-sports' focus which leads to an elevated average age (30+) and many people belong to the club for general health purposes rather than sports practice or competitions.

Conclusion

The e-PROSCeSS scales show adequate psychometric properties of the social, organizational and economic health determinants at the three levels, but not in regard to the health promotion concept or to the environmental determinant. Identifying areas of strengths and weaknesses by considering health determinants at multiple levels in sports clubs is the first step to creating integrated interventions to employ the full potential of the settings-based approach (Whitelaw et al., 2001). Although behavioral approaches are easier to measure, the objective of the HPSC (Van Hoyer et al., 2020) is to develop sports clubs as a setting by moving toward a socio-ecological approach and incorporating the four health determinants (Glanz & Bishop, 2010). This study exposes difficulties in measuring health promotion because the concept is broad and incorporates multiple levels and determinants. The e-PROSCeSS should be validated in other languages and sporting contexts to increase acceptability.

2.4 Analysis & considerations

The data compiled within these first two studies provides helps to answer the first research question; *'How do we measure current health promotion perceptions in sports clubs?'*. This is the first time a multi-level measurement tool has been developed in the sports club context linking a questionnaire with a theoretical sports club model. The socio-ecological approach was applied to sports clubs through the four health determinants which interact between the multiple sports club levels. By using the e-PROSCeSS questionnaire, sports clubs can go from offering only their main of sport provision (Elmose-Østerlund, et al., 2017) to incorporating all aspects of health promotion including physical, social and mental health benefits (Robertson et al., 2018) within the club's daily routines. The creation of an international measurement tool allows the sports club to identify the current state of health promotion perceptions of the internal sports club actors (managers, coaches, participants). Although future research shows that health promotion policies and actions in sports clubs are impacted by external levels (Casey et al., 2012a; Jackson et al., 2006; Meganck et al., 2016) which are not considered in this questionnaire design. Including items which question the capacity of sports club managers or coaches to call upon external resources for support should be considered.

The Delphi study only examined items from academics, researchers and field experts without representation from sport club participants (bottom-up). The majority of items were already included in the HPSC index (Kokko et al., 2009) at the macro level with changes made to the stem at the meso and micro levels. There may be additional ideas or items from sports players, coaches or managers which are not included on the current questionnaire that can add valuable insights and render the questionnaire more relevant for sports club actors. During validation (study 2), many 'I don't know' responses were given especially by the participants. During clarity interviews, respondents often commented that the item was understandable, but they would not know the answer, especially in relation to sports club policies such as attention to financially disadvantaged groups, intervening in cases of alcohol or drug abuse, or identifying roles of the sports club during partnerships; if the respondent was not directly affected they would not know how these issues were handled. These conclusions provide evidence that including actors from within sports clubs is beneficial when drafting items. Answers to some of the questionnaire items such as this are assumptions leading to many ceiling effects that were found during study 2, leading us to question if the e-PROSCeSS questionnaire exacerbates and prolongs the 'myth of healthism' (Holman et al., 1997).

Settings are difficult to measure and having a purely subjective, self-report tool renders evaluation of health promotion projects in the setting even more difficult. In fact, many actions that

sports clubs have already implemented may not be perceived as health promoting, such as inclusivity signs or ensuring all participants have an opportunity to play, but are considered under umbrella of health promoting actions. This questionnaire is a subjective self-report tool aimed at understanding *perceptions* rather than reality therefore, designing an objective audit tool specifically intended for directors or managers to discover what is *actually* done, may be more useful. Many of the items at the macro level within the organizational determinant (written regulations, membership options, roles of partners) may be better suited to this type of evaluation method. An audit tool would be beneficial to analyze what policies exist, for example, is 'fair play' written into the club's regulations, how are regulations communicated and implemented in reality and then, compare this audit with perceptions from the e-PROSCeSS questionnaire.

Furthermore, the concept of health promotion is not well understood by many sports club actors which led to misunderstandings and a potential reason for many cross-loading of items during SEM. For this reason, every health determinant had to be analyzed independently bringing up the question: did we make the data 'fit' our preconceived theory of how the sports club is organized into only three levels with four health determinants rather than letting the data inform the HPSC model? (Kaplan, 2009). For example, the cultural determinant was replaced by the organizational determinant of health in all three scales. The cultural determinant of health is established by the WHO (Marmot & Wilkinson, 2004) and distinct from the social determinant. At the conclusion of study 1, it was determined that items within the social and cultural determinants were closely aligned and could be combined and the organizational determinant could be created to contain items such as club policies. This could have been another reason for the misunderstandings and cross-loading during validation (study 2). This was noticeable during the clarity interviews and the responses during the psychometric analysis as it was difficult for respondents to make distinctions between the different determinants and connections to impacting their health. For example, in the environmental determinant, respondents did not seem to understand how the environment relates to health. Some items that were categorized into the environmental determinant could have been considered cultural or even social determinants. As an example, *'My sports club is welcoming (e.g. staff, coaches and volunteers)'*, has more to do with the culture and attitudes of those working in the club rather than the built structures as was the intended meaning of the environmental determinant. An item from the micro scale *'My coach cares about safety issues during practices and competitions'*, is very broad and left up to respondent interpretation; it could refer to the built environment such as the building and playing fields or it may refer to the feeling of safety from harassment. Due to this, the environmental determinant is only included with the macro scale on the e-PROSCeSS questionnaire. Without

items on the other two scales (meso and micro), it is currently impossible to evaluate perceptions of all the health determinants and link those perceptions to the internal sports club levels or completely compare the levels. Little research currently exists on the environmental determinant; this is a field that needs additional study to fully explore the determinant and connect it to the settings-based approach and a theoretical model for health promoting sports clubs. It may be beneficial to reconsider the cultural determinant of health to identify if this determinant is better understood by sports club actors and its impact on their health.

Psychometric validation is a long process to obtain an adequate amount of responses. Even then, it is best used as a research tool rather than directly in the field. In the case of the e-PROSCeSS validation, response rate could be based on length of the questionnaire (each respondent filled out two separate scales), interest, the need for immediate plans or preset health promotion projects and goals. The sheer length of this questionnaire calls into question its feasibility as it is more difficult to administer and the concepts may be considered complex (García de Yébenes Prous et al., 2009). Additionally, with current health conditions, the reliability was not analyzed with a test-retest methodology as many sports clubs are temporarily closed due to Covid-19. Although questions regarding the research gaps remain, producing and validating the e-PROSCeSS scales with the first two studies can help sports clubs to take a multi-level approach to health promotion actions. It is important to point out the scales were created in English and the translated version was psychometrically validated in French.

2.4.1 Practical implications

Once the three scales achieved acceptable psychometric validation in French, the research team drafted an e-PROSCeSS users' guide and three separate instruction guides which include the individual scales (macro, meso, micro) with the validated items. This process was undertaken in both French and English and includes forwards from Susanna Geidne, co-responsible for SCforH working group of HEPA Europe network and Geneviève Chêne, the director of Santé publique France, to highlight the importance of health promotion within sports clubs and the usefulness of a tool such as this. The English versions of the user's guide can be seen in supplementary file 2 along with English versions of the macro (supplementary file 3), meso (supplementary file 4) and micro (supplementary file 5) scales. The primary purpose for the users' guide is to assist sports club stakeholders in the analysis of their needs to increase health promotion actions within their sports club. The users' guide includes sections on why stakeholders, such as the sports club directors, managers and/or coaches, would want to use the e-PROSCeSS and how to use the three scales, such as who to mobilize, defining objectives, identifying resources and how to calculate the scores from the different scales. This paves the way for sports clubs who are

interested in increasing their health promotion actions an overview of similarities and differences in stakeholders' perceptions and a starting point for intervention implementation. Analyzing results from the e-PROSCeSS questionnaire aids stakeholders when choosing which sports club levels and health determinants to target when planning health promotion actions. The users' guide and three validated scales can be seen in the supplementary files.



CHAPTER 3: CREATING A MODEL AND FRAMEWORK

“High achievement always takes place in the framework of high expectation”

...Charles Kettering, inventor, engineer, businessman

3.1 Preparing for study 3

The next three studies respond to questions two, three and four. They help to create a standard HPSC model, discover health promotion intervention strategies, formulate intervention components and create a user friendly intervention planning framework. Study 3 responds to the second research question: '*What strategies can be and already have been used to promote health in sports clubs?*'. In addition, it responds to the third question: '*How can clubs incorporate health promotion initiatives in their daily actions?*', by building an initial intervention planning framework. To begin this process, a theoretical model for sports clubs needed to be built. Models are useful to understand how an organization or company is configured and how the configuration impacts the different stakeholders. When interventions are based on theory they are more successful (Peters et al., 2009) and this theory begins with a practical model grounded in the socio-ecological approach to begin the intervention mapping process (Kok et al., 2017). The theoretical model displays how the setting 'fits' together to impact different stakeholders and helps with understanding the context in which an intervention will be implemented (Bartholomew Eldredge et al., 2016). In certain settings, top-down configurations are more dominant; where those at the 'top' (directors, executive officers) give directives without considering the impact on other stakeholders. This type of configuration was originally seen in for-profit businesses, but current business models are moving to a more sustainable approach, collaborating with stakeholders (Stubbs & Cocklin, 2008). Combining the bottom-up approach into a model provides participation from all stakeholders a key component of intervention mapping. This approach has been widely used in NGOs to collaborate with local communities to gain their working knowledge of the issue (Panda, 2007). Thus, the model can show the interactions of the different levels not just from the top-down but also the influence from the bottom-up. As an example in sports clubs, if a coach is experiencing difficulties with a specific sports participant that participant may have an effect on the other players (within level influence) and those players can then exert influence on the coach (bottom-up influence). Furthermore, theoretical models give an indication of the different factors that affect actors in a setting which in-turn, affect partners and other stakeholders. Factors vary among different settings and should therefore be customized accordingly. Building a theoretical, multi-level sports club model was based on the socio-ecological model by including determinants of health and their influence and interaction with sports club actors (Booth et al., 2009; Dahlgren & Whitehead, 2007) within the same level and the other levels. For example, in certain cultures, women are discouraged from playing sports therefore, cultural beliefs can lead to social behaviors. In fact, it was not until the late 1960's that women were allowed to officially register and run the Boston Marathon, breaking gender bias in this sport (Pate & O'Neill, 2007). The environment was

not welcoming to women based on social bias. Another example of cultural influence on unhealthy behavior is obesity in the Caribbean. Being overweight or obese is a sign of health and power in this culture (Bramble et al., 2009). It is difficult to combat poor nutrition and sedentarity when this belief is built into the culture of a people. Therefore, the four health determinants were defined and embedded into the model at each level to demonstrate how this setting can affect these factors and what type of support may be needed. The model was originally created with the internal club levels to correlate with the e-PROSCeSS questionnaire levels. External levels were later added to consider their potential influence on sports clubs with support such as policy development or financial and human resources. Once we had a working theoretical model, evidence-driven guidelines (Geidne et al., 2019) were formulated into strategies. Strategies are broad concepts of initiatives that the different sports club levels can take to implement health promotion actions thus, they were sub-divided into actionable intervention components which are needed to improve implementation programs (McFadyen et al., 2018). Strategy development is needed to co-construct an intervention and give intervention managers 'tools' for intervention implementation (Fernandez, ten Hoor, et al., 2019) during the intervention mapping process. While these were originally formulated in English, each step was subsequently translated into French. A framework was then constructed using the theoretical HPSC model and the formulated intervention components. Sports club actors often lack the capacity to implement health promotion actions (Casey et al., 2012) therefore, providing a settings-based, context-specific framework (Dooris, 2006) offers step-by-step guidelines for implementing health promotion actions which target specific health determinants at the various levels. Simultaneous to creating the HPSC intervention planning framework, study 4 was undertaken. Through a concept mapping approach, it directly asked sports clubs stakeholders to respond to the fourth research question: '*What support do sports clubs need to increase health promotion actions?*'. This study took a bottom-up approach to gain further knowledge from direct experiences of stakeholders working in and directly with sports clubs. Adding the bottom-up approach (participative) is necessary to establish rapport with stakeholders (Panda, 2007), ascertain their capacity for promoting health and their perceived needs to implement health promotion actions. Bottom-up approaches to health promotion can be indispensable when co-constructing a settings-based intervention (Kokko et al., 2016). Study 4 added new insight into the needed support at the different sports club levels. Through this, 9 thematic clusters with 78 generated ideas to analyze and consider as strategies or intervention components. Finally, study 5 defined the new sports club levels and combined stakeholder responses to the second question into the HPSC framework. This provided a bottom-up approach for planning, designing and implementing health promotion actions in sports clubs. Creating the

theoretical HPSC model and framework was an iterative process (Figure 8). During these three studies, the theoretical model underwent several modifications with definitions and additions of several levels. With adding the new levels, the intervention planning framework was expanded and additional intervention components were included by using the participative approach from study 4.

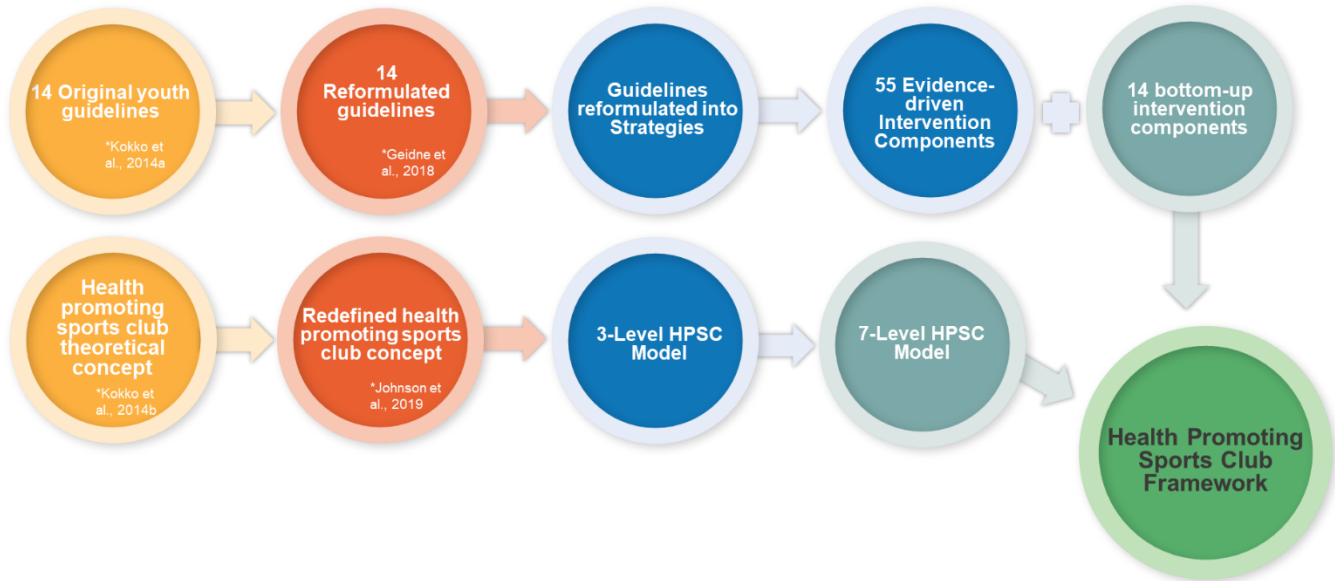


Figure 8. Workflow for the HPSC framework creation

3.2 Study 3: The health promoting sports club model: An intervention planning framework

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Article

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The health promoting sports club model: an intervention planning framework

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Abstract

Researchers and policymakers acknowledge sports clubs (SCs) as health promoting settings. Limited research links the health promoting sports club (HPSC) concept with evidence-driven strategies to provide SCs guidance to develop health promotion interventions. As implementation science insists on theoretically-grounded interventions, the present work's objective was to provide SCs an evidence-driven intervention framework for planning, developing and implementing health promotion (HP) initiatives. Four iteratively sequenced steps were undertaken: 1) investigation of 'health promoting' indicators, 2) adaptation of the HPSC concept to create the HPSC model, 3) formulation of published evidence-driven guidelines into strategies and implementable intervention components (ICs) and 4) merging the HPSC model with the ICs to

create an intervention planning framework for SCs. First, researchers drafted five HPSC indicators. Second, they defined three SC levels (macro, meso and micro) and four health determinants (organizational, environmental, economic and social) to create a HPSC model. Third, researchers used published guidelines to develop 14 strategies with 55 ICs. Fourth, three workshops (one each with French master-level sport students, French sport and health professionals and Swedish sport and health professionals) had participants classify the ICs into the model. The HPSC model and intervention framework are starting points to plan, select and deliver interventions to increase sports club HP. This planning framework is usable in several ways: 1) clubs can apply strategies to achieve specific goals, 2) clubs can target specific levels with corresponding ICs and 3) ICs can be used to address particular health determinants.

Keywords: evidence-based health promotion, intervention framework, sporting club, strategies

Introduction

The settings-based approach to health promotion emerged from the Ottawa Charter, which acknowledged that health operates in context beyond the individual. It explicitly states that “health is created and lived by people within the settings of their everyday life; where they learn, work, play and love” (World Health Organization, 1986). Subsequent WHO publications (World Health Organization, 1991) encouraged this shift from the deficit model of disease to a salutogenic approach focused on factors that increase one’s health such as settings. A ‘setting’ is “the place or social context where people engage in daily activities in which environmental, organizational and personal factors interact to affect health and well-being” (Nutbeam, 1998). This definition views settings as complex open dynamic systems, encompassing inputs, throughputs and outputs (Paton, 2005), characterized by integration, interconnectedness, interrelationship and interdependencies between elements (e.g. top-down and bottom-up approaches) (Dooris, 2006; Skyttner, 2001). To operationalize the settings-based approach in health promotion and build upon the socio-ecological model (Bronfenbrenner, 1977), an application was derived incorporating different health determinants (intrapersonal, interpersonal, institutional, community and policy) (Golden and Earp, 2012) which have subsequently been categorized as cultural, social, economic and environmental life conditions (McQueen, 2007).

The settings-based approach offers opportunities to situate HP practice within social frameworks, optimize interventions for specific contexts and target organizational factors, rather than applying ‘one-size-fits-all’ interventions. Despite 30 years of research on settings-based approaches, evaluation has traditionally been problematic (Dooris, 2004). Specifically, little is

known about effective implementation of a comprehensive, integrated approach to capture the “added value of a whole system approach” (Dooris, 2006). The settings-based approach lacks a clear and coherent framework to provide defined guidelines to steer policy, practice and research (Dooris et al., 2014). Among health promotion interventions, when theories are referenced, there is seldom a precise explanation of how they inform intervention design or how evaluation tests theories (Rothman, 2004).

The settings-based approach has been conceptually applied to sports clubs (Kokko, 2014b) which provides theoretical underpinnings to setting-specific intervention frameworks. The health promoting sports club (HPSC) concept was designed using a Delphi study to develop concept standards (Kokko et al., 2006) and a literature review of characteristics of settings-based approaches in other environments (Kokko et al., 2014). The HPSC concept reflects four health determinants (social, cultural, environmental, economic) active at three levels: the macro- (overall policies and orientation of club activities), meso- (activities of club officials) and the micro-level (coaches’ activities to guide, alter or support club member’s actions) (Kokko, 2014b). While this concept has merit, it lacks clear definitions of health determinants specific to each level, inadequately demonstrates interactions between levels and requires concrete implementation strategies. Working on this gap, a Delphi study redefined the determinants at each level to improve comprehension of the HPSC concept (Johnson et al., 2019). Furthermore, a recent literature review found very few implemented interventions in this setting were theoretically-based and if applied, the socio-ecological approach was poorly understood and employed (Geidne et al., 2019). Implementation science can, therefore, help support practitioner and researcher understanding of the theoretical basis when applying the socio-ecological approach.

Implementation science studies “methods to increase the adoption, implementation and maintenance of evidence-based practices, programs, policies and guidelines” (Fernandez, ten Hoor, et al., 2019). It focuses on mapping implementation strategies to provide a ‘how to’ guide to overcome barriers and increase intervention effectiveness (Proctor et al., 2013). Work on ‘components’ and mechanisms of intervention implementation explains how interactions between context (the setting) and mechanisms (strategies) can produce desired outcomes (increased HP efforts) (Pawson and Tilley, 2010). Although modifying factors were not described within the HPSC concept (Kokko, 2014b), key facilitators and barriers were identified to formulate evidence-driven guidelines to promote health in youth sports clubs (Geidne et al., 2019).

Previous work has underlined that to achieve successful behavior change interventions, a useful intervention framework should be “comprehensive, coherent and include links to an overarching model of behavior” (Michie et al., 2011). With these criteria in mind, the objective of

the present study is to create a context specific HPSC model and an intervention planning framework to guide the development and implementation of health promotion efforts in sports club settings.

Methods

Adapted recommendations of the Medical Research Council's guide for developing and evaluating complex interventions were followed (De Silva et al., 2014). A theoretical HPSC concept (Johnson et al., 2019) was combined with 14 evidence-driven guidelines (Geidne et al., 2019) using practitioner, stakeholder and sport actor's knowledge and experience. The study is grounded in a three-step iteratively sequenced process to: 1) identify the evidence, 2) develop the theory and 3) model the process and outcomes (Blamey and Mackenzie, 2007). The research team comprised two sport and physical activity/health promotion specialists and five academics from the fields of sport sciences, public health and health psychology. All steps were executed in English and translated into French using the Evaluative Linguistic Framework guidelines to retain original meanings and ensure cultural context (Clerehan et al., 2016). Consensus was reached within the team before using translated documents.

Step 1 – Identifying the evidence: HPSC indicators, concept and guidelines

Indicators for sports clubs to be considered health promoting and guidelines to serve as the basis for intervention components were identified through published articles of health promotion initiatives implemented in sports clubs (Geidne et al., 2019; Kokko, 2014a; McFadyen et al., 2018). In addition, a recently published article describing levels of sports clubs and health determinants operating at each level (Johnson et al., 2019) was used to identify a theoretical HPSC concept.

Step 2 – Developing the theory: from concept to model

Researchers reviewed previously published indicators that could be used to assess if a sports club is health promoting in order to provide future guidance to sports clubs for self-assessment and to aid researchers with developing the strategies and intervention components. To construct a model, the HPSC concept from Step 1 was redefined to show how each level and health determinant interact and their connection to health promotion. To develop intervention strategies, researchers revised the published guidelines identified in Step 1 (Geidne et al., 2019). Each strategy was labelled and sub-divided to formulate intervention components (ICs). Researchers confirmed that all strategies and ICs maintained original meanings, were relevant to health promotion, were understandable and could be implemented in sports club settings.

Interactive discussions within the research team finalized the indicators, model, strategies and ICs.

Step 3 – Modeling the process and outcomes: integrating theory with experience

Three multi-disciplinary groups were invited to participate in separate one-day workshops to integrate the HPSC model with the ICs. The aim was to merge these using the experience of stakeholders to produce an intervention planning framework. The first group (FS) consisted of 13 French sport science master-level students (3 females, 10 males) in adapted physical activity, sport management, physical education and geography. The second group (FP) consisted of 15 French sport and/or health sector professionals including: a sport ministry representative, three national health promotion organization representatives, three regional health promotion organizations' representatives, a sport federation representative, two French National Olympic committee representatives, two regional sport representatives and three public health academics. These two workshops were conducted in French. The third group (SB), conducted in English, included six Swedish professionals, three from a university sport sciences department and three from regional sports federations.

To familiarize workshop participants with requested tasks, researchers detailed the HPSC model, explained the strategies and ICs and presented a diagram of the model so ICs could be classified to build an intervention framework. Participants were informed how a theoretical sport club model can aid with planning interventions. Workshop groups were tasked with 1) verifying definitions of sports club levels and health determinants with options to propose changes, 2) validating ICs with the ability to suggest modifications, additions or deletions and 3) classifying each IC into the model. ICs could target multiple health determinants within each sports club level; therefore, groups could classify them multiple times within the model. On the contrary, if groups did not agree upon classification, they were not required to classify the IC. A majority participant consensus per group was required for each task.

Data analysis

Moderators recorded results via extensive note taking and photographs of the final decisions from each workshop for comparison. Workshop classification of ICs into the HPSC model was retained if at least two groups classified the IC into the same determinant at the same level. Final classifications were verified during a 1-day research team seminar. Each IC not classified by the minimum requirement (two groups) was also analyzed. Researchers compared workshop classifications of these ICs to evaluate best fit. Decisions to delete, retain or re-categorize these ICs was by unanimous consensus.

Results

Step 1- Identify the evidence: HPSC indicators, concept and guidelines

For context clarity and to ensure comprehensive application of the settings-based model into sports clubs, the research team analyzed published articles based on health promotion interventions within this setting. Based on published guidelines, researchers identified common indicators for a sports club to be considered a health promoting setting (Geidne et al., 2019; Kokko, 2014a; McFadyen et al., 2018). Informed by these indicators, the HPSC concept (Johnson et al., 2019) was chosen as it provided an appropriate settings-based context to develop into a theoretical model. Each level and corresponding determinant was redefined using sports and health promotion terminology.

To identify guidelines, two literature reviews and three trials which analyzed HP interventions in sports clubs were evaluated. A literature review (McFadyen et al., 2018) following Cochrane recommendations analyzed studies with parallel control groups targeting diet, physical activity, obesity, alcohol or tobacco use. A mapping review (Geidne et al., 2019) identified and updated 14 evidence-driven guidelines used by youth sports clubs to promote health (Kokko, 2014a). These were broadly defined making them difficult to categorize into a theoretic model. Among the identified trials (Kingsland et al., 2015; Naylor et al., 2015; Wolfenden et al., 2015), strategies were briefly described but insufficiently detailed making them difficult to categorize and limiting their adaptability into this context.

Step 2 – Developing the theory: from concept to model

Researchers drafted five indicators for a HPSC: 1) an approach embracing all club actions extending beyond promoting one health behavior, topic or issue, 2) involve all levels of the club (participants, parents, coaches, management, volunteers) in HP actions and decision-making, 3) involve external partners and the community in HP actions and decision-making, 4) be conscious that promoting health within the sports club is a continuous iterative process and 5) base actions on needs, acknowledging the limitations of a “one size-fits-all” approach. Definitions and terms of the HPSC concept (Johnson et al., 2019) were redefined for understanding and to reflect these five indicators to create a HPSC model. Two terms were modified to precisely describe sports club levels and health determinants. The term ‘officials’, used at the meso-level in sports clubs, usually refers to umpires, referees or competition judges in English. The intended meaning in the HPSC model is club ‘director/management’ so the term was modified. Determinant labels were reviewed and the term ‘cultural’ did not properly reflect the definition which refers to the notion of sports club policies therefore, the term was modified ‘organizational’. The HPSC model was constructed (see

Figure 1) using arrows to demonstrate interactions between levels and determinants and how all levels are independent of and dependent upon the others.

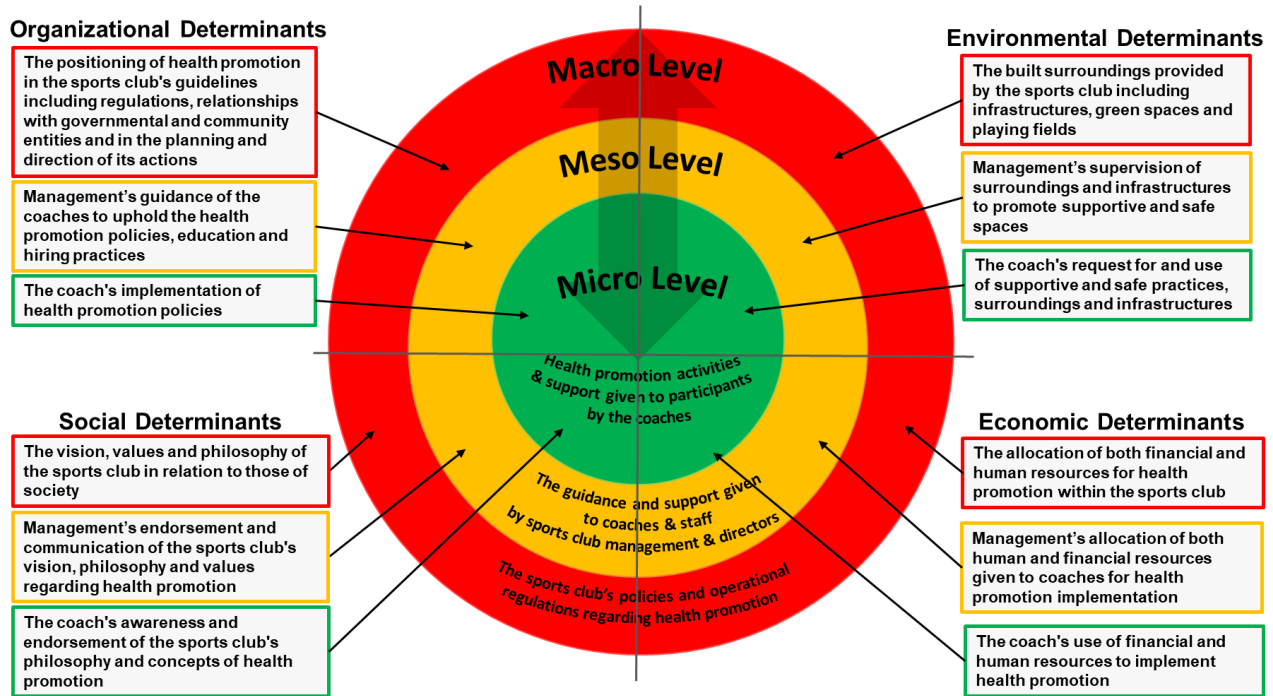


Figure 1. Health Promoting Sports Club Model

To create strategies and ICs, researchers analyzed each evidence-driven guideline (Geidne et al., 2019) to ensure relevance with the HPSC model. Through majority consensus, all 14 guidelines were retained, formulated into strategies and assigned labels to specify main concepts. Labels include: communication, dynamics, education, experience, feasibility, goals, mobilization, monitoring, motivation, participative approach, partners, planning, policies and resources. Several labels changed to better reflect the concept of each strategy. 'Recognition' was changed to 'Participative approach' to refer to stakeholders' participation in health promotion efforts. 'Objectives' was changed to 'goals' to indicate the long-term, continuous nature of health promotion. 'Image' was changed to 'Mobilization' to emphasize identifying and using internal and external actors to assist with promoting health. The term 'Training' in this setting is often associated with participating in sports, therefore, this term was modified to 'Education' to represent educating stakeholders. During analysis, definitions for 'Feasibility' and 'Monitoring' were changed

to make clear distinctions between them. 'Feasibility' refers to a club's capacity to achieve overall HP goals, whereas 'Monitoring' now refers to reviewing HP practices and effects. Once formulated, each strategy was sub-divided into detailed intervention components. This was informed by the work of McFadyen (McFadyen et al., 2018) to ensure each IC was relevant, replicable and implementable in the sports club context. Each strategy contains between two to six ICs (see Table 1).

Table 1. 14 Labeled strategies and 55 intervention components alphabetized and categorized

Labels	Strategies	Intervention Components
Communication (COM)	Develop and implement communication to raise awareness of the actions taken to promote health within the sports club	1-Develop a communication plan 2-Communicate with one message, a slogan (clear, explicit and visible) 3-Ensure internal club communication 4-Ensure the club communicates with the external community 5-Ensure the club communicates with partners
Dynamic (DYN)	Create strategies to improve all stakeholders' sense of belonging to the club and take into account the individual and their environment (socio-ecological approach) in order to define the most relevant health promotion goals	1-Take the feeling of belonging to the club into account when defining the goals 2-Take into account interactions between the individual and their environment, while defining health promotion goals
Education (EDU)	Support coaches by varying the type of education they receive, using active engagement which specifically focuses on the sports participants they coach	1-Support coaches to actively engage in gaining knowledge and skills to promote health 2-Tailor the support to the coach individually in relation to the sports participants they coach (mentoring, courses, online tools) 3-Encourage coaches to support each other to promote health
Experience (EXP)	Identify past club experiences, organizational readiness and the reasons and quality of the club's commitment to promote health	1-Identify previous club experiences to promote health 2-Identify the organizational readiness to promote health

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		<p>3-Identify reasons for commitment to promote health</p> <p>4-Identify the quality of commitment to promote health</p>
Feasibility (FEAS)	Regularly review the capacity of the sports club to achieve its health promotion goals	<p>1-Regularly review the financial resources being used</p> <p>2-Regularly review the financial resources being used</p> <p>3-Regularly review the club's capacity to undertake the actions required to achieve the goals</p> <p>4-Regularly review the time dedicated to achieving the goals</p>
Goals (GLS)	Write down the sports club's health promotion goals, using positive messages, adapted to sports language, culture and the placement of health promotion within the club, taking into account the social inequalities of health	<p>*1-Define the goals of health promotion</p> <p>2-Health promotion goals are formally written and documented</p> <p>3-Write goals in a positive sporting language based on the club's culture</p> <p>4-Take into account inclusivity (i.e. how people experience health differently) when defining the goals</p>
Mobilization (MOB)	Mobilize people to manage the development of health promotion	<p>1-Mobilize champions for your cause</p> <p>2-Mobilize experts in health promotion</p> <p>*3-Identify and mobilize one or several internal health promotion representatives</p>
Monitoring (MON)	Monitor health promotion activities in daily practice using a 'small steps' philosophy and review any changes	<p>1-Review small improvements towards achieving health promotion goals</p> <p>2-Review all the health promotion activities undertaken in the club</p> <p>3-Review the short term effects of the actions (changes within 1 sports season)</p> <p>4-Review the long term effects of the actions (changes beyond 1 sports season)</p> <p>5-Review the health promotion policies of the sport clubs</p>
Motivation (MOT)	Understand what motivates coaches to implement health promotion and empower them in this undertaking	<p>1-Foster positive interpersonal stakeholder relationships</p> <p>2-Take coaches' skills to manage situations into account</p> <p>*3-Take coaches' motivation for coaching and their</p>

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future expectations into account
 4-Strengthen coaches' autonomy to promote health
 5-Strengthen coaches' sense of ownership of the club

Participative Approach (PAP)	Value a 'participative approach' to promote health throughout the club and beyond	1-Recognize participants' actions 2-Recognize coaches' actions 3-Recognize management actions 4-Call attention to every health promotion action 5-Highlight how health promotion activities can benefit the club 6-Include the managers, coaches and participants in the decision making process
Partners (PART)	Partner with other organizations to create a common culture and collaborative process to promote health	1-Identify partners for health promotion (clubs, agencies, health professionals) 2-Define how to collaborate with existing and future partners (define roles, share experiences, contract terms, evaluation of results, equal partner power) 3-Create a common culture with existing and future partners (trust, recognition, shared time)
Planning (PLAN)	Create an implementation plan to achieve the written health promotion goals	1-Include the core goals in the plan 2-Include the target population in the implementation plan 3-Include the funding sources in the implementation plan 4-Include the responsible persons in the implementation plan 5-Include key steps in the implementation plan 6-Consider the sustainability of the health promotion actions
Policies (POL)	Integrate evaluation into health promotion policies to refine planning and future policies	1-Create future policies based on the evaluation of current actions 2-Plan future actions based on the evaluation of current actions

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Resources (RES)	Review financial, human and capacity building resources available to invest in health promotion	1-Review available financial resources (subsidies, sponsors) to invest in health promotion 2-Review available human resources (dedicated volunteer time, staff turnover) to invest in health promotion 3-Review current skills and knowledge available to promote health
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Step 3 – Modeling the process and outcomes: integrating theory with experience

To provide clubs with the 'how to' component of intervention development and implementation, workshop participants validated formulations of ICs and categorized each IC into the HPSC model based on health determinants at each club level. Neither the FS nor the SP participants added new ICs, whereas the FP participants suggested adding an IC to the 'Mobilization' strategy (MOB3), one to the 'Motivation' strategy (MOT3) and one to the 'Goals' strategy (GLS1) (see additions in Table 1). Researchers validated suggestions and included them in the ICs. Workshop participants also amended several ICs for clarification. For example, the SP group suggested changing the word 'evaluate' to 'review' within descriptions. To establish final classifications into the HPSC model, ICs had to be classified in the same position (i.e. the same level and same determinant) during at least two workshops. ICs within each strategy were categorized into the model: communication (4), dynamics (4), education (4), experience (10), feasibility (21), goals (6), mobilization (6), monitoring (14), motivation (17), participative approach (49), partners (19), planning (45), policies (13), resources (7). Table 2 compares the three workshop classifications of each IC.

Table 2. Comparison of the 3 workshop intervention component classifications

		<u>Focus Groups</u>									
Club		French Students			French Professionals			Swedish Professionals			
Levels	Determinants	French Students			French Professionals			Swedish Professionals			
MACRO	Social	COM1 , GLS3, PAP2, PAP3, PAP4 , PAP5	EXP2, GLS4, MOB1, FEAS3, PAP4 , PAP5	EXP3, MOB1, FEAS3, PART1, PART2, PART2, PART3, PLAN1, PLAN2, PLAN5, PLAN6	COM1 , GLS3, MOT5, PAP1, GLS4, MOB1, MOT5, PAP1, PAP6, PART1, PAP2, PAP3, PAP4 , PAP5 , PART2, PART3, PLAN1, PAP6, PART1, PART2, PLAN2, PLAN3, PLAN4, PART3, PLAN1, PLAN2, PLAN5, PLAN6	EXP2, EXP3, EXP4, GLS4, MOB1, MOT5, PAP1, PART1, PART2, PLAN1, PAP6, PART1, PART2, PLAN2, PLAN3, PLAN4, PART3, PLAN1, PLAN2, PLAN5, PLAN6	COM1 , GLS4, MOB1, MOT5, PAP1, PART1, PART2, PLAN1, PAP6, PART1, PART2, PLAN2, PLAN3, PLAN4, PART3, PLAN1, PLAN2, PLAN5, PLAN6	EXP4, GLS4, MOB1, MOT5, PAP1, PART1, PART2, PLAN1, PAP6, PART1, PART2, PLAN2, PLAN3, PLAN4, PART3, PLAN1, PLAN2, PLAN5, PLAN6	FEAS3, GLS4, MOB1, MOT5, PAP1, PART1, PART2, PLAN1, PAP6, PART1, PART2, PLAN2, PLAN3, PLAN4, PART3, PLAN1, PLAN2, PLAN5, PLAN6	FEAS3, GLS4, MOB1, MOT5, PAP1, PART1, PART2, PLAN1, PAP6, PART1, PART2, PLAN2, PLAN3, PLAN4, PART3, PLAN1, PLAN2, PLAN5, PLAN6	
	Organizational	EXP1, GLS3, PAP2, PAP3 , PAP5 , PAP6, PART2	EXP2 , MON1, MON2 , PAP3 , PAP4 , PAP5 , PAP6, PART2	GLS2, EXP1, EXP2 , MON3, MON4, MOT2, MOT4, MON3, PAP3 , PAP4 , PAP5 , PART2, MOT4, PAP2, PAP3 , PAP4 ,	EXP1, EXP2 , FEAS1, FEAS2, EXP2 , GLS2, GLS3, MON2 , FEAS3, MON1, MON2 , MON3, MON4, MOT2, MOT4, MON3, MON4, MOT2, PAP3 , PAP4 , PAP5 , PART2, MOT4, PAP2, PAP3 , PAP4 ,	FEAS1, FEAS2, EXP2 , GLS2, GLS3, MON2 , FEAS3, MON1, MON2 , MON3, MON4, MOT2, MOT4, MON3, MON4, MOT2, PAP3 , PAP4 , PAP5 , PART2, MOT4, PAP2, PAP3 , PAP4 ,	FEAS1, FEAS2, EXP2 , GLS2, GLS3, MON2 , FEAS3, MON1, MON2 , MON3, MON4, MOT2, MOT4, MON3, MON4, MOT2, PAP3 , PAP4 , PAP5 , PART2, MOT4, PAP2, PAP3 , PAP4 ,	FEAS1, FEAS2, EXP2 , GLS2, GLS3, MON2 , FEAS3, MON1, MON2 , MON3, MON4, MOT2, MOT4, MON3, MON4, MOT2, PAP3 , PAP4 , PAP5 , PART2, MOT4, PAP2, PAP3 , PAP4 ,	FEAS1, FEAS2, EXP2 , GLS2, GLS3, MON2 , FEAS3, MON1, MON2 , MON3, MON4, MOT2, MOT4, MON3, MON4, MOT2, PAP3 , PAP4 , PAP5 , PART2, MOT4, PAP2, PAP3 , PAP4 ,	FEAS1, FEAS2, EXP2 , GLS2, GLS3, MON2 , FEAS3, MON1, MON2 , MON3, MON4, MOT2, MOT4, MON3, MON4, MOT2, PAP3 , PAP4 , PAP5 , PART2, MOT4, PAP2, PAP3 , PAP4 ,	
	Environmental	PAP2, PAP3, PAP4 , POL2, FEAS3, PAP4 , PAP5, PART3, FEAS3, PAP2, PAP3, PAP4 , PAP5, PART3, PLAN6	PAP2, PAP3, PAP4 , POL2, FEAS3, PAP4 , PAP5, PART3, FEAS3, PAP2, PAP3, PAP4 , PAP5, PART3, PLAN6	POL2, FEAS3, PAP4 , PAP5, PART3, FEAS3, PAP2, PAP3, PAP4 , PAP5, PART3, PLAN6	FEAS3, PAP4 , PAP5, PART3, FEAS3, PAP2, PAP3, PAP4 , PAP5, PART3, PLAN6	FEAS3, PAP4 , PAP5, PART3, FEAS3, PAP2, PAP3, PAP4 , PAP5, PART3, PLAN6	FEAS3, PAP4 , PAP5, PART3, FEAS3, PAP2, PAP3, PAP4 , PAP5, PART3, PLAN6	FEAS3, PAP4 , PAP5, PART3, FEAS3, PAP2, PAP3, PAP4 , PAP5, PART3, PLAN6	FEAS3, PAP4 , PAP5, PART3, FEAS3, PAP2, PAP3, PAP4 , PAP5, PART3, PLAN6	FEAS3, PAP4 , PAP5, PART3, FEAS3, PAP2, PAP3, PAP4 , PAP5, PART3, PLAN6	FEAS3, PAP4 , PAP5, PART3, FEAS3, PAP2, PAP3, PAP4 , PAP5, PART3, PLAN6
	Economic	FEAS1 , PAP2, PAP3, PAP4 , PAP5 , RES1, RES2	MOB1, MOB2, FEAS1 , MOT4, PAP4 , PAP5 , PART1, MOB1, MOB2, MOT4, PAP5 , RES1, RES2	MOB2, FEAS1 , MOT4, PAP4 , PAP5 , PART1, MOB1, MOB2, MOT4, PAP5 , RES1, RES2	FEAS2, FEAS3, FEAS1 , FEAS2, FEAS3, PART1, MOB1, MOB2, MOT4, PAP5 , RES1, RES2	FEAS2, FEAS3, FEAS1 , FEAS2, FEAS3, PART1, MOB1, MOB2, MOT4, PAP5 , RES1, RES2	FEAS2, FEAS3, FEAS1 , FEAS2, FEAS3, PART1, MOB1, MOB2, MOT4, PAP5 , RES1, RES2	FEAS2, FEAS3, FEAS1 , FEAS2, FEAS3, PART1, MOB1, MOB2, MOT4, PAP5 , RES1, RES2	FEAS2, FEAS3, FEAS1 , FEAS2, FEAS3, PART1, MOB1, MOB2, MOT4, PAP5 , RES1, RES2	FEAS2, FEAS3, FEAS1 , FEAS2, FEAS3, PART1, MOB1, MOB2, MOT4, PAP5 , RES1, RES2	FEAS2, FEAS3, FEAS1 , FEAS2, FEAS3, PART1, MOB1, MOB2, MOT4, PAP5 , RES1, RES2
Social	COM1, DYN1, EXP3, DYN1, EXP3, EXP4, FEAS3, COM1, EXP4, FEAS3, MOB1, MOT2, MOT5 , PAP2 , PAP3	DYN1, EXP3, DYN1, EXP3, EXP4, FEAS3, COM1, EXP4, FEAS3, MOB1, MOT2, MOT5 , PAP2 , PAP3	EXP3, DYN1, EXP3, EXP4, FEAS3, COM1, EXP4, FEAS3, MOB1, MOT2, MOT5 , PAP2 , PAP3	COM1, EXP4, FEAS3, MOB1, MOT2, MOT5 , PAP2 , PAP3 , PAP4, PAP6, PAP1, PAP2 , PAP3 , PAP4, PART3, PLAN1, PLAN2, PAP6, PART3, PLAN1, PLAN3, PLAN4, PLAN5, PLAN2, PLAN3, PLAN4, PLAN6	COM1, EXP4, FEAS3, MOB1, MOT2, MOT5 , PAP2 , PAP3 , PAP4, PAP6, PAP1, PAP2 , PAP3 , PAP4, PART3, PLAN1, PLAN2, PAP6, PART3, PLAN1, PLAN3, PLAN4, PLAN5, PLAN2, PLAN3, PLAN4, PLAN6	COM1, EXP4, FEAS3, MOB1, MOT2, MOT5 , PAP2 , PAP3 , PAP4, PAP6, PAP1, PAP2 , PAP3 , PAP4, PART3, PLAN1, PLAN2, PAP6, PART3, PLAN1, PLAN3, PLAN4, PLAN5, PLAN2, PLAN3, PLAN4, PLAN6	COM1, EXP4, FEAS3, MOB1, MOT2, MOT5 , PAP2 , PAP3 , PAP4, PAP6, PAP1, PAP2 , PAP3 , PAP4, PART3, PLAN1, PLAN2, PAP6, PART3, PLAN1, PLAN3, PLAN4, PLAN5, PLAN2, PLAN3, PLAN4, PLAN6	COM1, EXP4, FEAS3, MOB1, MOT2, MOT5 , PAP2 , PAP3 , PAP4, PAP6, PAP1, PAP2 , PAP3 , PAP4, PART3, PLAN1, PLAN2, PAP6, PART3, PLAN1, PLAN3, PLAN4, PLAN5, PLAN2, PLAN3, PLAN4, PLAN6	COM1, EXP4, FEAS3, MOB1, MOT2, MOT5 , PAP2 , PAP3 , PAP4, PAP6, PAP1, PAP2 , PAP3 , PAP4, PART3, PLAN1, PLAN2, PAP6, PART3, PLAN1, PLAN3, PLAN4, PLAN5, PLAN2, PLAN3, PLAN4, PLAN6	COM1, EXP4, FEAS3, MOB1, MOT2, MOT5 , PAP2 , PAP3 , PAP4, PAP6, PAP1, PAP2 , PAP3 , PAP4, PART3, PLAN1, PLAN2, PAP6, PART3, PLAN1, PLAN3, PLAN4, PLAN5, PLAN2, PLAN3, PLAN4, PLAN6	

MESO	Organizational	COM1, DYN1, FEAS3, MOT2, MOT4, PAP2, PLAN1, POL1	EDU1, COM1, DYN1, MON4, FEAS2, FEAS3, MOT5, MON2, MON3, MON4, MOT2, MON2, MON3, MON4, MOT4, PAP2, PAP3, PART3, PLAN6, PART3, PLAN1, PLAN2, PAP2, PAP3, PAP4, PAP5, MOT2, MOT4, MOT5, PLAN6, PART3, PLAN1, POL1	EDU1, FEAS1, COM1, DYN1, FEAS1, GLS2, MOB1, FEAS2, FEAS3, GLS2, MOB1, FEAS2, FEAS3, GLS2, MOT5, MON2, MON3, MON4, MOT2, MON2, MON3, MON4, MOT4, MOT5, PLAN6, PART3, PLAN1, PLAN2, PAP2, PAP3, PAP4, PAP5, MOT2, MOT4, MOT5, PLAN6, PART3, PLAN1, POL1
	Environmental	MON4, PART3	MON4, PAP5, PART3	PAP5
	Economic	FEAS1, FEAS2, PAP2, PART1, PART2, PART3, POL1, RES1, RES2	EDU2, FEAS3, PAP4, PAP5, PART1, PART2, PART3, PLAN3, PLAN3, PLAN6, PLAN4, PLAN5, POL1, RES1, RES2	EDU2, FEAS1, FEAS2, PAP3, PAP4, PAP5, PART1, PART2, PART3, PLAN1, PLAN3, FEAS3, PAP2, PAP3, PAP4, PLAN6, POL1, RES1, RES2

MICRO	Social	DYN1, MOT1, PAP2, PAP3	EXP3, PAP1	DYN1, EXP3, EXP4, FEAS3, MOT1, PAP1, PAP2, PAP3	PAP4, PAP5, PART3, PLAN1, PLAN6	EXP4, FEAS3, MOT1, PAP1, PAP2, PAP3	PAP4, PAP5, PART3, PLAN1, PLAN6
	Organizational	MON3, PLAN1, PLAN4, POL1	MON4, PLAN2, PLAN5	COM2, FEAS3, MON3, MON4, MOT2, MOT4, PAP4, PAP5, PLAN1, PLAN2, PLAN4, PLAN5, PLAN6, POL1, POL2		COM2, FEAS3, MOT2, MOT4, PAP4, PAP5, PLAN6, POL1, POL2	
	Environmental	PAP1, PAP2, PAP3, PLAN2, PLAN4, PLAN5	PLAN4	FEAS3, PAP4, PAP5, PART3, PLAN4, PLAN5, PLAN6		FEAS3, PAP1, PAP2, PAP3, PAP4, PAP5, PART3, PLAN6	
	Economic	MON3, PAP3, POL1, RES2	PAP2	FEAS3, MON3, PAP4, PAP5, PART3, PLAN6, POL1		FEAS3, PAP2, PAP3, PAP4, PAP5, PART3, PLAN6, RES2	
OTHER	Individual	EXP3		EXP3			
	Sports Federations			EDU1, EDU2, MOB1, MOT3, MOT4, PAP1, PAP3, PAP4, PAP5, PART1, PLAN6, POL1, POL2, RES3		EDU1, EDU2, MOB1, MOT3, MOT4, PAP1, PAP3, PAP4, PAP5, PART1, PLAN6, POL1, POL2, RES3	
	2nd Line Actors			DYN2, FEAS3, GLS4, MON3, MON4, MOT3, PAP1, PAP3, PAP4, PAP5, PART1, PLAN6, POL1, POL2, RES3		DYN2, FEAS3, GLS4, MON3, MON4, MOT3, PAP1, PAP3, PAP4, PAP5, PART1, PLAN6, POL1, POL2, RES3	

Strategies are displayed label and intervention component (IC) name and number

*Bold font indicates 3 group agreement

At the macro level, ICs were classified 78 times: organizational n=27, social n=23, economic n=21, environmental n=7. At the meso level, ICs were classified n=64 times: organizational n=24, social n=18, economic n=19, environmental n=3. The micro level had ICs classified 49 times: organizational n=15, social n=13, economic n=10, environmental n=11.

The most frequently classified ICs were in the 'participative approach' (PAP) and 'planning' (PLAN) strategies. PAP ICs were classified 49 times (macro n=19, meso n=14, micro n=16) and ICs in PLAN were classified 45 times (macro n=19, meso n=14, micro n=12). Several ICs were deleted. Three 'participative approach' ICs were deleted which concerned rewarding actions. Both professional groups thought rewarding was not harmonious with HP instead, focus should be on recognizing, sharing and disseminating actions. Two ICs were deleted from the 'feasibility' strategy because they were duplicated in other strategies. One final IC was deleted from the 'planning' strategy as it simply restated the strategy. Workshop participants found it difficult to classify ICs in the environmental determinant at any level because *"the environment is the setting"* (SP), *"changing built environments of sport clubs is very expensive"* (FS) and it is *"not the responsibility of sports club actors"* (FS). Seven ICs did not meet the minimum 2 group agreement: four original ICs (DYN2, EDU3, FEAS4, RES3) and three created by the French professionals (GLS1, MOB3, MOT3). During the researcher seminar, these ICs were discussed. Although not classified into the HPSC model by workshop participants, researchers decided to retain them for several reasons: 1) the FS group was the first workshop so they were not presented with ICs created by other groups, limiting the opportunity for categorization, 2) new ICs could increase the effectiveness of intervention implementation and 3) these ICs can enhance clubs' abilities to adopt HP.

Workshop participants suggested several other 'levels' were active when implementing interventions: individuals, sports federations and second line services (e.g. government, public health departments). All 3 groups agreed these additional levels could affect sports clubs' health promotion efforts therefore, researchers allowed IC classification into them. Two groups agreed upon 1 IC at the individual level, 15 ICs at the sports federation level and 15 ICs at the second line service level. Health determinants categories were not considered during these classifications. Figure 2 shows the HPSC intervention planning framework with ICs incorporated into the model.

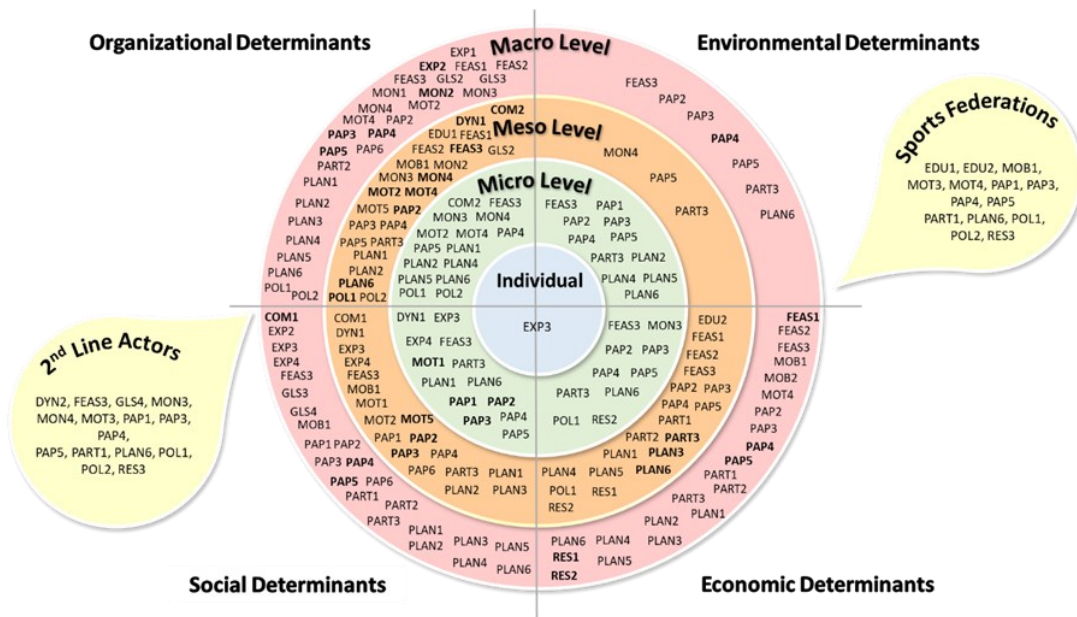


Figure 2. Health Promoting Sports Club intervention planning framework

The underdeveloped use of the settings-based approach in sports clubs (Geidne et al., 2019) supports the need for an intervention framework rooted in a theoretical concept. Beginning with the HPSC concept (Kokko, 2014a) and evidence-driven guidelines (Geidne et al., 2019), researchers, aided by sports club and health professionals in France and Sweden, created the HPSC model and designed an intervention framework to support planning and implementation in this setting. An imperative first step was determining indicators to serve as the minimum criteria for sports clubs to become health promoting and then creating the HPSC model, through redefining the definitions of health determinants at each sports club level. One challenge was acknowledging the complexity of the settings-based approach (Dooris, 2006; Dooris et al., 2014) and applying this understanding to sports clubs. Considering the need to capture mechanisms that are involved in health promotion in sport clubs, both internal (within each level) and external (surrounding the sports clubs), as well as the usefulness of the framework (Michie et al., 2011), guidelines (Geidne et al., 2019) were developed into strategies and divided into ICs. This allowed workshop participants to classify each IC into the theoretical HPSC model. This increases stakeholder understanding of how theory informs an intervention. During the framework building process, the two professional groups agreed upon classification more often compared to the FS group. One reason the FS group may not have classified as similarly could be less experience. Master level students are newer to the field thus, may not be able to relate health promotion to

sports clubs as effectively as the professional groups. The student group was also more reserved when classifying ICs multiple times. Lastly, both professional groups included health promotion experts while the student group did not.

The importance of including participation from stakeholders at multiple levels was emphasized as 'participative approach' ICs were categorized more often than others. This strategy encourages clubs to include all actors in health promotion decision-making, embracing both top-down and bottom-up approaches. Alternatively, the least categorized strategies included: 'communication' (4), 'dynamics' (3) and 'education' (2). These may be lower priorities since there is less effect on increasing revenue or sports performance which has been found as sports clubs' core business (Van Hoyer et al., 2016). In addition, educating coaches and management is difficult when these positions are frequently filled by volunteers (Casey et al., 2012a).

Few ICs were classified into the environmental determinant at any sports club level. This is interesting because this determinant was found to be highly important by coaches and managers in previous studies (Kokko et al., 2009; Van Hoyer et al., 2015). Few ICs are oriented towards facilities and buildings, thus there is a lack of research based on safe, sustainable and welcoming environments. In addition, facilities are often not owned by sports clubs, but typically rented or provided by the municipality or other organizations giving sports clubs little ability to improve infrastructures (Van Hoyer et al., 2015; Van Hoyer et al., 2016). More research is needed on the environmental determinant for intervention purposes to understand sports clubs' perceptions and abilities to leverage or modify this determinant.

The project team focused on keeping strategies and ICs clear and distinct therefore, several ICs were deleted in the 'feasibility', 'participative approach' and 'planning' strategies. These decisions were made primarily due to workshop participants stating that ideas were either irrelevant (e.g. rewarding actions) or duplicated in other strategies (e.g. evaluating goals was in both 'feasibility' and 'policies').

This study demonstrates the importance of grounding ICs into a theoretical model (Glanz and Bishop, 2010) which provides a scientific basis for sports clubs to begin the settings-based approach to health promotion. By creating an intervention planning framework, including implementable ICs at specific club levels, clubs have an opportunity add value for their stakeholders and develop their organization.

Table 3. Terminology Chart

Term	Meanings and relationship to other terms	Where the item was derived
Indicators	<p>Five indicators</p> <ol style="list-style-type: none"> 1. An approach embracing all club actions extending beyond promoting one health behavior, topic or issue 2. Involve all levels of the club (participants, parents, coaches, management, volunteers) in HP actions and decision making 3. Involve external partners and the community in HP actions and decision making 4. Be conscious that promoting health within the sports club is a continuous and iterative process 5. Base actions on needs, acknowledging the limitations of a one-size-fits-all approach 	Indicators for sports clubs to be considered health promoting and guidelines to serve as the basis for intervention components were identified through published articles of health promotion interventions implemented in sports clubs (Geidne et al., 2019; Kokko, 2014a; McFadyen et al., 2018) and then formulated into indicators by the research team
Sports club levels	Macro, meso, micro are based on the HPSC concept, and describe the different levels of leverage within sports clubs	A recently published article defining levels of sports clubs and health determinants operating at each level (Johnson et al., 2019)
Health determinants	Organizational, Environmental, Economic, Social	A recently published article describing levels of sports clubs and health determinants operating at each level (Johnson et al., 2019), which was based on a previous publication describing the socio-ecological approach (Golden & Earp, 2012)
HPSC Concept	Theoretical concept combining the three sport club levels with the four health determinants.	The HPSC concept is informed by the work of Kokko et al. (2013), describing the application of the settings-based approach to sport clubs. The concept was transformed into a model by Johnson et al., 2019

HPSC model	The three sport club levels combined with the health determinants (See Figure 1)	The HPSC model has drawn further from the HPSC concept in a previous publication on the measurement of health promotion in sports clubs (Johnson et al., 2019)
Guidelines	14 previously published guidelines (Geidne et al., 2019)	Guidelines come from a mapping review of 58 studies focusing on health promotion intervention in sports clubs (Geidne et al., 2019)
Strategies	The researchers developed 14 strategies from the guidelines (Geidne et al., 2019)	Reformulation of the guidelines identified by Geidne et al. (2019)
Intervention components (ICs)	The researchers sub-divided the 14 strategies into 55 ICs	ICs are the key mechanisms involved in implementing health promotion within sports clubs based on the 14 developed strategies (See Table 1)
Intervention planning framework	The result of merging the HPSC model with the 55 ICs components	See Figure 2

Strengths and Limitations

One strength is that this study used published research in the sports club setting as its basis. The HPSC concept (Johnson et al., 2019) and implemented interventions (Geidne et al., 2019) were used to develop indicators, a model, strategies and ICs. Another strength is the use of three workshops from two countries with a range of sports club stakeholders. This allows the theoretical model to be better rooted into the daily activities of sports clubs and a clear understanding of the strategies and ICs using sports oriented language.

Several limitations must be mentioned. Although three workshops were held, none were with native English speaking groups. Therefore, cultural differences could be concerning. To overcome this, each strategy and IC was translated into French with attention given to retain original meanings and capture the sports and health culture in France. During the Swedish workshop, two members from the project team both fluent in English and one fluent in Swedish conducted the meeting using English materials. These results were confirmed by five international experts fluent in English. Lastly, because each workshop was an opt-in, day long meeting, the possibility of selection bias exists. All participants have an interest in promoting health within sports clubs therefore, therefore dedicated time to the study. This could lead to participants viewing each strategy and IC as important whereas some actors directly working in sports clubs may not share

this perspective. To reduce this bias, actors at all levels within sports clubs were invited to participate.

Conclusion and Future Research

Informed by implementation science and grounded in the settings-based approach to health promotion, the present study created a HPSC model and offers a practical intervention planning framework for developing, implementing and evaluating sports club health promotion activities. The HPSC model was developed using a broad definition of sports clubs as “organizations having in common the provision of opportunities for competition and sports practice, including those who can also be considered social organizations, promoting social welfare and health” (Donaldson & Finch, 2012). Because this approach embraces a large diversity of sports clubs, it can be carried out in all types of clubs. Offering a framework such as this to sports club actors can help guide planning for health promotion practices from both bottom-up and top-down approaches. Strategies and ICs can be incorporated into sports clubs in several ways: 1) clubs can use the e-PROSCeSS questionnaire (Johnson et al., 2019) to target specific club levels and employ corresponding ICs to address priority areas, 2) clubs can use the strategies and ICs directly based on their key objectives, 3) strategies and ICs can be selected as a guide to adopt, implement, sustain or increase HP efforts, 4) strategies can be a practical tool to act as a starting point for planning, selecting and delivering interventions or 5) ICs can be used at multiple club levels to influence specific health determinants. Future steps include determining if strategies and/or ICs should be chronologically ordered into long-term, mid-term or short-term actions based on sporting seasons. Then, piloting the framework within a group of sports clubs to evaluate acceptability and effectiveness to make any necessary modifications. By incorporating HP into daily activities, clubs can realize the five indicators of a HPSC with a long-term focus.

3.3 Preparing for study 4

The HPSC intervention planning framework was designed to provide sports clubs with strategies from a top-down approach to plan health promotion actions. The tool is useful for sports clubs but lacks the knowledge and needs from sport club actors such as managers, coaches and directors. Adding the bottom-up approach (participative approach) to the framework incorporates ideas from those working directly in the sports club resulting in a more participative, harmonious intervention. In fact, participative approaches to health promotion have been recognized for over 40 years as potentially being one of the most effective methods for promoting health in communities and settings (Findlay & Palmer, 1994). This aids with co-constructing an intervention with those who manage the intervention and those who will be impacted as has been suggested in intervention

science (Fernandez, ten Hoor, et al., 2019). Therefore, study 4 directly asked these actors what support they think sports need to increase their health promotion actions. By providing their knowledge and experience from working in field these actors can potentially add missing ideas to the evidence-driven data already collected in order to enhance the HPSC framework. Collecting their ideas can conceivably give additional insight into needed strategies, they would be from a bottom-up (participative) approach. Currently, strategies were formulated from evidence-driven guidelines primarily provided to youth sports clubs (Geidne et al., 2019; Kokko, 2014a; McFadyen et al., 2018) without considering their capacity, commitment, expectations (Van Hoye et al., 2015) or needs. Study 4 allows us to investigate these aspects, identify missing strategies by comparing them to those included in the HPSC framework, and build a more comprehensive framework (Poland et al., 2009). Including the bottom-up approach can be indispensable when co-constructing an intervention with sports club stakeholders to increase their motivation and acceptance for promoting health (Kelly et al., 2007; Poland et al., 2000; World Health Organization, 2015). Study 4 directly answered research question number 4: '*What support do sports clubs need to increase health promotion actions?*', through an online concept mapping approach. This study offered a unique approach to obtain input from sports club actors and allowed the project to move forward. This study allowed researchers to compare concepts previously embedded in the HPSC framework and ensure that the most important and feasible ones were captured within the strategies from study 3 (see Figure 9). Study 4 was conducted in French; all generated ideas and cluster themes were translated into English to ensure broad cultural applicability.

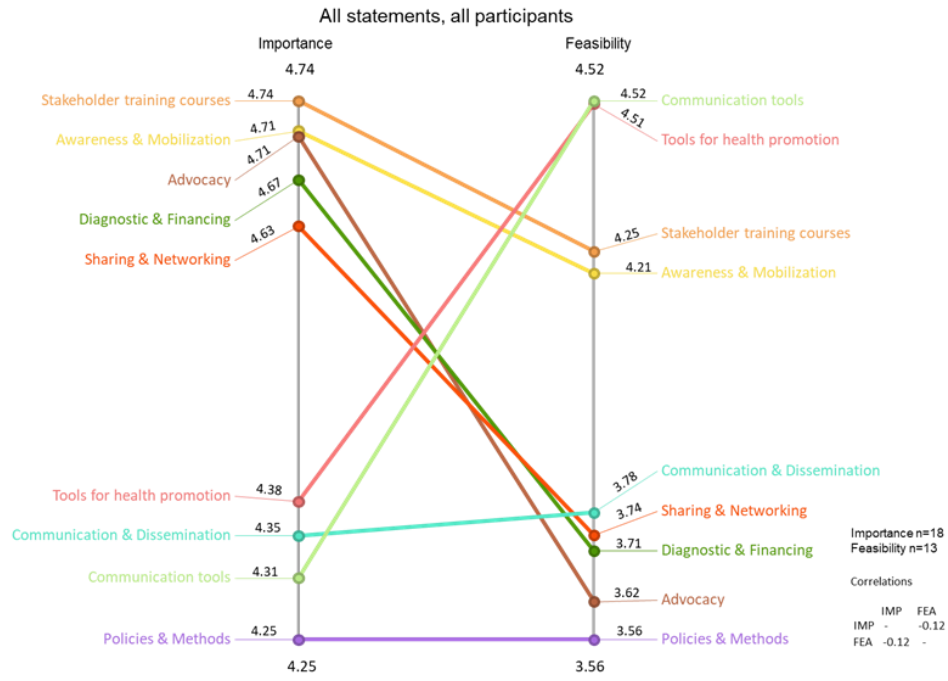


Figure 9. Cluster comparisons

3.3.1 Study 4: Building health promoting sports clubs: A participative concept mapping approach

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Original Research

Building health-promoting sports clubs: a participative concept mapping approach

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Abstract

Objectives

The potential of sports clubs to promote health beyond physical activity has been acknowledged by researchers and policy-makers. This study aimed to gather stakeholder ideas on support sports clubs need to increase health promotion efforts and prioritize them based on importance and feasibility.

Study design

Mixed-methods concept mapping approach.

Methods

French sports and public health stakeholders (n=45) were invited to participate. Steps included: 1) formulating a focus prompt, 2) brainstorming statements in response to the focus prompt, 3) sorting statements into themed piles and 4) rating statements based on indicators. Multi-dimensional scaling and hierarchical cluster analysis were used to produce visual cluster maps

and descriptive statistics generated Go-Zone graphs based on mean importance and feasible ratings.

Results

Participants generated 62 statements from the focus prompt: *'What assistance would benefit sports clubs to become a health-promoting setting?'*. Final sorting produced 9 clusters: *Tools for health promotion, Communication tools, Stakeholder training courses, Diagnostic and Financing, Awareness and Mobilization, Advocacy, Policies and Methods, Sharing and Networking and Communication and Dissemination*. Participant ratings produced 34 statements within the Go-Zone graphs.

Conclusion

Understanding stakeholders' needs to increase health promotion activities in sports clubs is crucial to planning and implementing sustainable health promotion policies and practice. Priority areas include increasing awareness of health promotion benefits, mobilizing actors, advocating for support and educating sports club actors.

Keywords: concept mapping, health promotion, intervention, settings-based approach, sports clubs

Introduction

Public health authorities call for strategies to create healthy settings that extend beyond the individual to include social and physical places where people live, work and play (World Health Organization, 1986). The settings-based approach to health promotion has been developed in multiple settings including hospitals (Johnson & Baum, 2001) and health services (Whitelaw et al., 2001), schools (Rees et al., 2006) including universities (Dooris et al., 2014), prisons (Woodall & Dixey, 2017) and, more recently, sports clubs. These developments emphasize the importance of taking a "whole systems approach" and recognizing the challenge that often settings are "dynamic open systems"(Dooris, 2006). Sports clubs are in a unique position to provide physical activity opportunities and offer broader health promoting activities (e.g. social cohesion, nutritional behaviors) (Geidne et al., 2019; Kokko, 2014b; Robertson et al., 2018). Nevertheless, viewing clubs as this 'dynamic, whole system' has yet to be explored. Several studies have linked perceived coaches' health promotion activities with positive sport experience and perceived health by sports club stakeholders (Van Hoyer et al., 2015; Van Hoyer et al., 2016). However, it is unknown what support coaches and sports clubs need to increase such activities and from where support should originate. For sports clubs, the goal is to go beyond increasing athletic performance and

take a settings-based approach (Johnson et al., 2019) to health within their facilities and daily activities. This transformation begins with understanding multiple view points from various actors involved in sports clubs and including strategies based on their participation, which was expressed by the work of Poland and colleagues when creating a framework to guide intervention design and implementation (Poland et al., 2009). Previous studies explored barriers to implementing injury prevention programs (Donaldson et al., 2018) and strategies to lower youth sports drop-out rates (Vissek et al., 2015). Additionally, several studies have quantitatively measured perceptions, barriers and motives around health promotion (Meganck et al., 2015) or qualitatively explored sustainability and capacity building strategies for health promotion programs (Casey, Payne, & Eime, 2009; Casey et al., 2009). However, researchers rarely collaborate with sports club stakeholders at multiple levels to define acceptable health promotion strategies in this setting. To answer such context-specific questions, participatory approaches can garner positive results by increasing stakeholder endorsement and clarifying expectations for successful health promotion practices (Kokko et al., 2011; Van Hoyer et al., 2015; World Health Organization, 2015). Participatory approaches require stakeholders to disclose their perspectives, including experiences and opinions, allowing the identification of new elements to consider while preparing policy, planning interventions and evaluating outcomes (Bergold & Thomas, 2012). For purposes of diversity, a broad definition of 'sports clubs' was applied to the present study; "organizations having in common the provision of opportunities for competition and sports practice, including those who can also be considered social organizations, promoting social welfare and health" (Donaldson & Finch, 2012). Obtained results can therefore be applicable in a variety of sports organizations without limitations to type or level of sport.

Attention has been given to integrating health promotion and sport (Misener & Misener, 2016) with recent research conducted on how sports organizations can influence the health of spectators (Hunt et al., 2020), yet limited evidence exists regarding the effectiveness of health promotion policies or practices within sports clubs themselves (McFadyen et al., 2018). When interventions have been implemented, comprehensive descriptions and mechanisms of the intervention process have rarely been described (Geidne et al., 2019) or do not target stakeholder expectations (Van Hoyer et al., 2015). For example, health promotion training and education is needed to increase the acceptability and implementation of programs (Eime et al., 2008; Kokko et al., 2014), but previous studies report that coaches believe these actions should target sport club management and do not expect this support for themselves (Van Hoyer et al., 2015; Wiersma & Sherman, 2005). Thus, a coordinated effort between researchers, public health professionals and sports club actors is needed to enhance program acceptability and feasibility, as well as guide

implementation and long-term adoption (Geidne et al., 2013; Van Hoyer et al., 2015; Wiersma & Sherman, 2005).

Therefore, the purpose of this study was to gather stakeholder ideas on the types of support sports clubs need to increase health promotion efforts and to prioritize the support needed based on importance and feasibility.

Methods

Study Design:

This study used the participative concept mapping (CM) (Kane & Trochim, 2007) approach to include the expertise of stakeholders at multiple sporting and health promotion levels and locations (Burke et al., 2005) throughout France. CM offers a structured framework to explore stakeholder ideas regarding a key question allowing them to become part of the answer (Trochim, 1989). This multi-step process: 1) displays results using statistical analysis, 2) implements multi-dimensional scaling and hierarchical cluster analysis, 3) uses qualitative and quantitative methods and 4) encourages sharing, learning, creativity and adaptation (Kane & Trochim, 2007). CM was previously used to explore challenges to implementing sports injury protocols (Donaldson et al., 2018), rejecting unhealthy sponsorships (Donaldson et al., 2019) in community sports clubs and increasing community physical activity (Kelly et al., 2007; Lebel et al., 2011). This study involved six steps: idea generation, statement sorting, rating, analysis, interpretation and planning (Burke et al., 2005). The study was carried out from April to October of 2019 with French sports and public health stakeholders. All data was gathered, stored and analyzed using the Concept System® groupwisdom™ build 2019.24.01, cloud-based platform. Once completed, two native English speakers translated French generated data into English using the Evaluative Linguistic Framework (Clerehan et al., 2016).

Preparation:

The research team formulated the following focus prompt to elicit participant ideas (Kane & Trochim, 2007).

- *“What assistance would benefit sports clubs to become a health-promoting setting?” (Comment accompagner un club sportif à devenir un milieu de vie promoteur de santé?).*

The focus prompt was tested and refined with two professionals from Santé publique France before commencing the study. The research team chose two indicators, importance and feasibility (Donaldson et al., 2018), for rating statements.

Participants:

The research team, in collaboration with the French Ministry of Sports, Santé publique France and the French National Olympic and Sport Committee recruited two groups of French sports and public health stakeholders (n=45). Group 1 consisted of 22 experts from French sports federations, academia and public health fields. Group 2 consisted of 23 stakeholders at the French sports club level (coaches, managers, directors). Stakeholders were invited by email to contribute to the study. They received an explanation letter, an opt-out clause and participation instructions. The email included a *groupwisdom*TM platform link enabling participants to anonymously register and create a unique password, give informed consent and contribute data. Upon log-in, mandatory demographic questions were prompted (i.e. age, organization position, etc.). Participants were invited to complete each step regardless of previous step participation. Each step took 4 to 6 weeks, with participation reminders sent regularly. All steps were completed online via the web-based software.

Idea Generation

Participants generated 2–5 statements each in response to the focus prompt. Participants could anonymously view the statements made by others, to avoid duplicating ideas. The brainstorming process encouraged ideas to flow freely without fear of bias or censorship (Hanson et al., 2013). The research team edited the statements to remove duplicates, synthesize similar ideas, separate compound statements and delete irrelevant statements; this ensures uniqueness, clarity, grammar and comprehension (Kane & Trochim, 2007).

Statement Sorting

Next, participants sorted statements into themed piles with similar concepts, which aids in understanding how participants view associations between statements. Participants were presented with the list of all generated statements and then instructed to sort each one into piles that made sense to them. Instructions included: (1) each statement could only go into one unique pile, (2) no statement could be in a pile alone and (3) all statements could not go into one large single pile. Once sorted, participants labeled each pile they created by main topic (e.g. policy, funding, training).

Statement Rating

This step allowed participants to prioritize statements based on perceived value (Kane & Trochim, 2007). Participants were encouraged to use the full Likert-scale spectrum (1: not at all – 6: very) to rate importance and feasibility. The goal was to discover what stakeholders think is important

for sports clubs to implement and compare this with what is believed feasible, which aids with acceptability and implementation.

Interpretation and Planning

Initial results from the statement sorting and rating activities informed an interpretation and planning meeting with invited members from both participant groups to identify areas of consensus and outline future implementation strategies. Statements in the Go-Zone graphs, those which participants collectively rated above the means for both importance and feasibility, provided input for health promotion intervention strategy development based on the two rating indicators. The data interpretation allowed the research team to understand concepts and ideas that were considered valuable to stakeholders.

Data Analysis

Sorting and rating data were statistically analyzed using the Concept Systems Global Max™ *groupwisdom*® web platform to produce a series of visual representations (maps, ladders and graphs). The software uses multi-dimensional scaling to plot statements on a two-dimensional x-y point map (Trochim & McLinden, 2017), closer statements represent those more often grouped together. Then, hierarchical cluster analysis was used to merge statements into clusters to visualize their interrelationships (Kane & Trochim, 2007; Rosas & Kane, 2012). Cluster scenario parameters were based on the minimum and maximum number (4–9) of piles created by participants during sorting (Burke et al., 2005). The final cluster map provided the most logical statement grouping. To analyze ratings, data was aggregated by the rating given per participant for every statement. Average values for statements were calculated separately for importance and feasibility. To visualize statement ratings of important and feasible, Go-Zone graphs were generated for all-statements and within-cluster statements. Go-Zones plot statements into quadrants by mean ratings of importance and feasibility. The upper right quadrant (Q4) includes statements above both means. Statements in the upper left quadrant (Q3) are above the mean for feasibility but below the mean for importance. The lower right quadrant (Q2) contains statements above the mean for importance but below the mean for feasibility. Statements that fall into the lower left quadrant (Q1) are below both means.

Results

Participants

Twenty-eight participants contributed to the collected data: 17 brainstormed statements, 15 sorted statements into piles, 18 rated statement importance and 13 rated feasibility. Participant characteristics per step are detailed in Table 1.

Table 1. Participant characteristics by activity

	Idea Generation (n=17)	Sorting (n=15)	Importance rating (n=18)	Feasibility rating (n=13)
Sex				
Female	10	8	8	6
Male	7	7	10	7
Age range				
18–34	8	7	8	5
35–44	7	7	9	7
55+	2	1	1	1
Education level				
Bachelor's degree	0	1	1	2
Master's degree	12	11	13	9
PhD	5	3	3	2
no response	0	0	1	0
Current position				
Health promotion professional	6	6	11	5
Sports sector (not at club level)	4	2	2	3
Club manager	1	1	1	1
Coach	3	2	1	1
Other	3	4	3	3
Years in position				
Mean (SD)	5.24 (4.59)	6.05 (5.97)	6.75 (7.24)	6.81 (7.4)
Range	1–20 years	1–20 years	1–26 years	1–26 years
Personal sports practice				
Yes	12	8	7	6
No	5	6	10	7
Other	0	1	1	0

Idea generation

Seventeen participants (group 1 (71%) and group 2 (29%)) brainstormed 62 statements. The research team, which consisted of 4 native French speakers and 3 native English speakers, edited the statements. The team came to consensus during a half-day meeting by charting similar ideas, words and meanings and proceeded to delete redundant ideas (n=19), separate compound statements (statements with multiple ideas) (n=14) and clarify ideas (n=14). After synthesis and editing 78 statements were available for participants to sort and rate (see Table 2).

Table 2. Statements by cluster and Go-Zone quadrant

Cluster	Statement	Mean rating (1-6)*		Go-Zone Quadrant	
		Importance (m=4.52)	Feasibility (m=4.00)	All-statement	Within cluster
Cluster 1: Tools for health promotion		4.38	4.52		
		(sd=0.37)	(sd=0.48)		
1	Offer educational opportunities that enable clubs to carry out health promotion activities for children	4.33	4.83	3	3
8	Create tools which allow sports clubs to integrate axes from the Ottawa Charter while writing the club's HP policies	3.94	3.50	1	1
10	Create tools to allow the clubs to propose adapting the sports discipline to allow everyone to participate, in any condition	4.65	3.82	2	2
12	Provide educational health promotion materials (posters, training kits, online communication, etc.)	4.21	5.31	3	3
17	Propose a variety of ways to raise awareness to promote health to the clubs	4.78	4.44	4	2
29	Create tools so that clubs can integrate health-related content for each age group. For example, dress codes, respect for the rules, hydration, understanding rules, healthy living, prophylaxis, etc.	4.29	4.75	3	3
39	Create an activity card for setting up an 'edutainment' workshop within clubs to raise awareness of health promotion issues and possible actions	3.82	4.33	3	1
48	Create tools so that clubs can integrate health into their health promotion project	5.31	4.50	4	2
60	Provide the club with tools to formalize current health promotion practices, points of success and areas for improvement	4.35	4.83	3	3
63	Create tools to help sports clubs to develop health promotion actions for 10–15 year olds while involving their parents	4.50	4.42	3	2
74†	Rely on existing proven tools for health promotion	4.43	5.00	3	4
76	Create tools to allow clubs to define realistic and shared objectives, visualizing an evolution that everyone feels is necessary	4.13	4.08	3	1
77	Prepare a methodological guide including concepts in health promotion, the intervention framework, project methodology, etc. for the actors	4.14	4.90	3	3
Cluster 2: Communication tools		4.31	4.53		
		(sd=0.20)	(sd=0.23)		

46	Provide communication tools so clubs can share their health promotion actions in order to involve all stakeholders	3.94	4.17	3	1
53	Provide communication tools to the club so they can share their health promotion actions with the local decision makers	4.47	4.70	3	4
61	Provide the club with tools to disseminate current health promotion practices, points of success and areas for improvement	4.53	4.40	4	2
69	Create tools to communicate the benefits of health promotion with sports clubs to attract new audiences into the clubs	4.33	4.60	3	4
71	Create tools to communicate the benefits of physical activity on health to attract new audiences into the clubs	4.29	4.80	3	3
Cluster 3: Stakeholder training courses		4.75	4.25		
		(sd=0.32)	(sd=0.40)		
14	Establish a training program for health promotion within sports clubs	4.94	3.73	2	2
15	Direct education towards actors in a position to lead a training-action course on health promotion in sports environments	4.69	4.50	4	3
18	Train coaches and management of the same club together to promote health	4.67	4.09	4	1
19	Provide training programs/modules for coaches from the same club on health promotion	4.75	4.27	4	4
20	Provide training programs/modules to the managers of the same club on health promotion	4.11	4.45	3	3
33	Systematically integrate training designed for managers on how the club can influence health individually, collectively and in relation to the environment	5.11	3.67	2	2
34	Systematically integrate training designed for coaches on how the club can influence health individually, collectively and in relation to the environment	5.00	4.50	4	4
35	Systematically integrate training designed for volunteers on how the club can influence health individually, collectively and in relation to the environment	4.88	3.92	2	2
40	Offer the actors from the sports world (federations, CDOS, CROS) content on health promotion to integrate into their training courses	5.13	5.08	4	4
41	Provide training programs/modules for educators in sports-health (take into account persons with pathologies and/or risk factors)	4.73	4.54	4	3
56	Identify and train a person in charge of health promotion within sports clubs	4.82	3.83	2	2
67	Provide training programs/modules for educators on medical sports prescriptions	4.11	4.36	3	3
Cluster 4: Diagnostic and Financing		4.67	3.69		
		(sd=0.30)	(sd=0.40)		
2	Specify funding dedicated to purchasing specific equipment for developing health promotion	4.33	3.58	1	1
22	Influence sports federations to allocate funding to hire someone to develop health promotion within sports clubs	4.94	3.18	2	2
31	Run a diagnostic to evaluate the needs and expectations, motivations, strong and weak points, opportunities and barriers of the sports club to involve itself in health promotion	4.63	4.00	2	3

42	Allow the clubs to project several years of funding without changing regional/national guidelines on health 'priorities' (ex. disability, females, sports-health)	5.13	3.42	2	2
49	Run a diagnosis (by qualitative survey or questionnaire) to evaluate the needs and expectations regarding health promotion within the sports club	4.29	3.56	1	1
50	Rely on a diagnostic evaluation of needs and expectations to implement health promotion actions	4.71	4.38	4	4
Cluster 5: Awareness and Mobilization		4.71 (sd=0.19)	4.21 (sd=0.35)		
25	Mobilize health promotion professionals to raise awareness among managers	4.53	4.46	3	4
26	Mobilize health promotion professionals to raise awareness among coaches	4.71	4.44	4	3
27	Mobilize health promotion professionals to raise awareness among managers and coaches together	4.73	4.15	4	2
51	Evaluate the perception of health promotion within the club by the managers, coaches and sports participants	4.53	3.55	2	1
57	Offer management and coaches a discovery day of health promotion giving keys to success to encourage them to implement it for their members	5.06	4.45	4	4
Cluster 6: Advocacy		4.71 (sd=0.40)	3.63 (sd=0.59)		
21	Influence local authorities to allocate funding to hire a person to develop health promotion within sports clubs	4.86	2.82	2	2
23	Advocate for support from the local political environment for health promotion within the clubs	5.24	3.67	2	4
24	Advocate for support from federations for health promotion within the clubs	4.89	4.55	4	4
32	Encourage clubs to explore partner possibilities around health promotion	4.83	4.08	4	4
47	Encourage sports clubs to create a club project with a health focus	3.94	2.92	1	1
52	Encourage managers to share the club's health promotion actions with the local decision makers	5.00	4.10	4	4
72	Encourage the development of a common framework for intervention between all stakeholders (internal and external to the club) around health promotion	4.18	3.08	1	1
78	Encourage the clubs to construct public policies which promote Sports for Health activities in the clubs, especially through specific and targeted financing	4.73	3.85	2	4
Cluster 7: Policies and Methods		4.26 (sd=0.33)	3.55 (sd=0.42)		
3	Encourage stakeholders to participate in the reflection, animation and development of activities and trainings by setting up a system of a minimum number of members that must be mobilized	3.89	2.50	1	1
7	Encourage sports clubs to integrate the Ottawa Charter axes while writing the club's health promotion policies	3.88	3.57	1	3
13	Help clubs make links between their activities, their operations, their territorial registration and the way in which these can influence the health of their members, volunteers, professionals, partners and their community	4.38	3.55	1	4
16	Encourage sports club managers to organize regular meetings with intervention experts	3.82	4.00	1	3

28	Encourage the clubs to integrate health-related content for each age group. For example, dress codes, respect for the rules, hydration, understanding rules, healthy living, prophylaxis, etc.	4.33	4.00	1	4
30	Involve people who have had positive experiences within their clubs by sharing how these health promotion projects can benefit all club members	4.88	3.62	2	4
36	Propose a health promotion program which involves all stakeholders from the sports club	4.47	3.08	1	2
37 [†]	Offer nutritional support to sports clubs, including access to "healthy snacks" to encourage a healthy and balanced diet	4.38	3.92	1	4
38	Encourage the implementation of an 'edutainment' workshop within clubs to raise awareness of health promotion issues and possible actions	3.93	3.75	1	3
58	Encourage the clubs to formalize current health promotion practices, points of success and areas for improvement	4.67	3.46	2	2
62	Encourage sports clubs to develop health promotion actions for 10-15 year olds and involve their parents	4.00	3.27	1	1
75	Encourage sports clubs to define realistic and shared objectives, visualizing an evolution that everyone thinks is necessary	4.50	3.83	1	4
		4.64	3.83		
Cluster 8: Sharing and Networking		(sd=0.50)	(sd=0.69)		
4	Encourage clubs to set up locations to share their thoughts about the proposed activities with managers & stakeholders	3.94	3.00	1	1
5	Encourage clubs to create spaces for managers & stakeholders to share their thoughts about the proposed activities	3.94	3.17	1	1
11	Create a network of sports clubs and associations where stakeholders can go without differentiating sport licenses	3.94	2.92	1	1
43	Create synergies between all stakeholders interested in health promotion at the local level (managers, coaches, institutions, associated actors, organizations, academia)	5.19	3.38	2	2
44	Favor an interactive approach (from the field) of health promotion actions between motivated actors (managers, participants, coaches, institutions, associations, academia, organizations)	4.94	3.82	2	2
54	Set up a national resource site to promote health within sports clubs	5.07	4.88	4	4
55	Set up a national reference advisor to promote health within sports clubs	4.53	4.11	4	3
64	Host a national network of health promotion advisors within clubs (share expertise)	4.71	3.75	2	2
65	Host a regional network of health promotion advisors within sports clubs (share expertise)	4.87	4.50	4	4
73	Rely on experiences from other sports clubs to implement health promotion actions	5.29	4.82	4	4
		4.35	3.80		
Cluster 9: Communication and Dissemination		(sd=0.36)	(sd=0.41)		
6	Encourage clubs to set up communication tools for managers & stakeholders to share their thoughts about proposed activities	3.59	3.00	1	1
9	Encourage the clubs to propose an adaptation of the sports discipline to allow everyone to practice, in any condition	4.56	3.67	2	2
45	Encourage the clubs to share their implemented health promotion actions in order to involve all stakeholders	4.29	3.54	1	1

59	Encourage the clubs to disseminate current health promotion practices, points of success and areas for improvement	4.61	3.90	2	4
66	Host a local network of health promotion advisors within sports clubs (share expertise)	4.75	4.25	4	4
68	Encourage clubs to communicate the benefits of promoting health within sports clubs to attract a new public into the clubs	4.50	4.00	1	4
70	Encourage the clubs to communicate the benefits of physical activity on health to attract new audiences into the clubs	4.13	4.27	3	3

*1 = not at all important or not at all feasible; 6 = very important

†Statements moved from original clusters (Statement 74 moved from Cluster 2 to Cluster 1 & Statement 37 moved from Cluster 2 to Cluster 7)

Quadrant 1 statements are below the mean for importance and feasibility

Quadrant 2 statements are above the mean for importance and below the mean for feasibility

Quadrant 3 statements are below the mean for importance and above the mean for feasibility

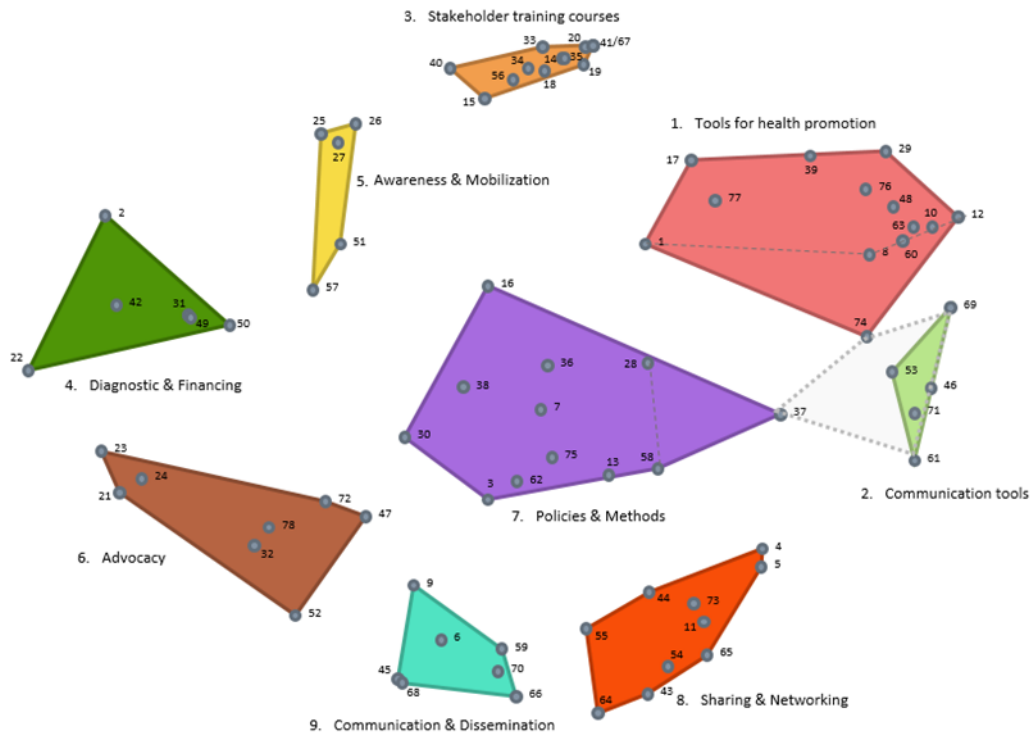
Quadrant 4 statements are above the mean for importance and above the mean for feasibility

Sorting

Sixteen participants sorted statements into themed clusters then labeled each cluster. One participant's sorting data was excluded from analysis as only 27 of the 78 statements were sorted. *Groupwisdom*TM guidelines require at least 75% of the data must be sorted for analysis.

Clusters

Participants created between 4–9 piles by sorting the 78 statements. After hierarchical cluster analysis, researchers chose a 9-cluster option. The 9-cluster stress value is 0.295 where the average is 0.285; lower stress values indicate well represented data (Kane & Trochim, 2007). Once the 9-cluster map was chosen, researchers moved two statements into adjacent clusters as these statements were more aligned with neighboring cluster themes. Statement #74 was moved from Cluster 2 to Cluster 1 and statement #37 was moved from Cluster 2 to Cluster 7. To finalize the map, researchers considered the labels generated by the *groupwisdom*TM software (based on labels given by participants during sorting) and agreed on the best label for each cluster's theme (see Figure 1).



*Dotted lines represent the original clusters prior to statement

Figure 1. Cluster map of health promoting sports club support

Rating

For data analysis inclusion, participants were required to rate 50% or more of the statements per indicator for comparison purposes and to create a balanced ‘Go-Zone’ graph. Eighteen participants’ data was included in the analysis of importance. Fifteen participants’ data was included in the analysis of feasibility.

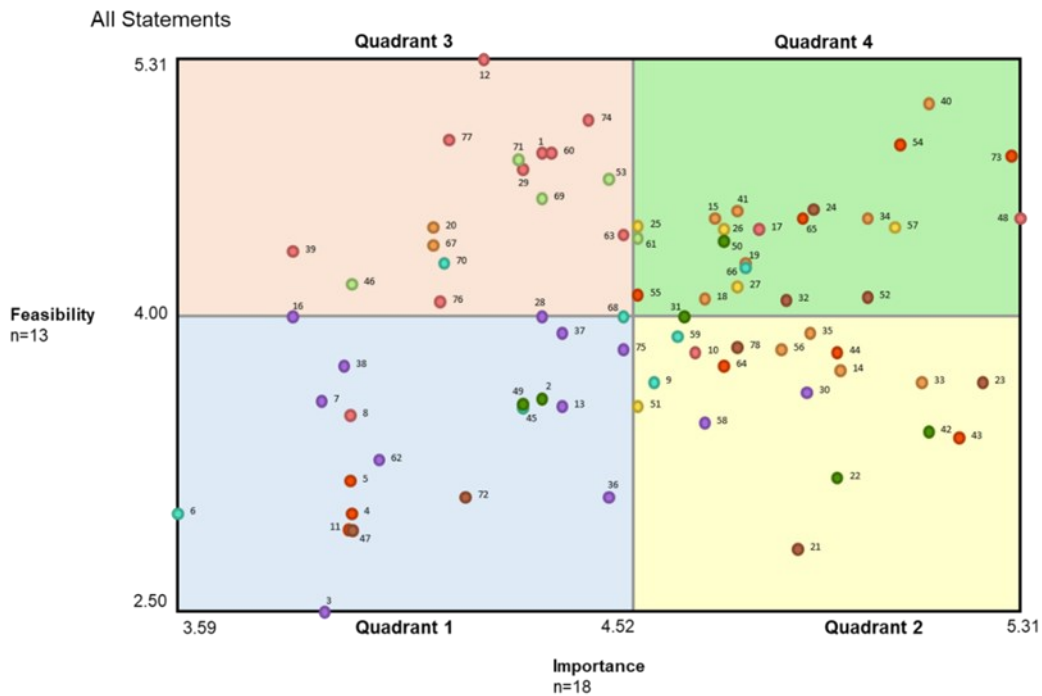
Statement #48 in Cluster 1, ‘Tools for health promotion’, had the highest importance rating (5.31) and statement #12 in the same cluster had the highest feasibility rating (5.31). Statement #40 from Cluster 3 ‘Stakeholder training courses’, received the highest average rating for the two indicators (5.11). Statement #6 in Cluster 9 ‘Communication & Dissemination’ had the lowest importance rating (3.59) and statement #3 in Cluster 7, ‘Policies & Methods’, had the lowest feasibility rating (2.50) as well as the lowest average rating (3.20).

Cluster 3, ‘Stakeholder training courses’, had the highest mean importance score (4.75) and Cluster 2, ‘Communication tools’, had the highest mean feasibility score (4.53). Conversely,

Cluster 7, 'Policies & Methods', had the lowest mean scores for importance (4.26) and feasibility (3.55).

Go-Zone

A Go-Zone graph was generated for all 78 statements (Figure 2). It is separated into 4-quadrants by the mean importance (4.52) and feasibility (4.00) for all statements. Thirty-four statements were rated above the mean for both indicators and appear in the all-statement Go-Zone Q4. All clusters, except Cluster 7, had at least one statement in the all-statement Go-Zone. Eight of the nine clusters had statements in both Go-Zone variations (all-statement and within-cluster). When viewed by statements, three clusters (Stakeholder training courses, Advocacy, Policies & Methods) each had five Go-Zone statements. On the contrary, one cluster (Diagnostic & Financing) only had one Go-Zone statement. Table 2 displays which Go-Zone quadrant statements are found in for both Go-Zone variations.



- Quadrant 1 statements are below the mean for importance and feasibility
- Quadrant 2 statements are above the mean for importance and below the mean for feasibility
- Quadrant 3 statements are below the mean for importance and above the mean for feasibility
- Quadrant 4 statements are above the mean for importance and above the mean for feasibility

Figure 2. All-statement Go-Zone for health promoting sports clubs

Discussion

This study identifies three elements mentioned by Poland and colleagues (Poland et al., 2000) when designing settings-based health promotion interventions: 1) understand the setting and stakeholder interests, 2) understand the capacity and engagement of the setting and stakeholders and 3) develop and translate knowledge to stakeholders. The current mixed-methods study answers to these elements by directly asking key stakeholders in the sports club domain their ideas on what types of support are needed when developing health promotion activities in this context. In this way, interventions can combine research and practice to develop and deliver more sustainable programs (Hawe, 2015; Miller & Shinn, 2005; MacPhail & Lawson, 2020). Using this approach empowers sports club actors by allowing researchers to take advantage of their skills, knowledge and strengths thereby linking their experiences with research (Donaldson et al., 2018; Vella et al., 2019). This novel research highlights the importance of balancing bottom-up with top-down approaches when creating health promotion initiatives, thereby developing cooperation and increasing the knowledge base to plan effective interventions (Geidne et al., 2013a). This study produced 78 statements, classified into 9 themed clusters: *Tools for health promotion; Communication tools; Stakeholder training courses; Diagnostic and Financing; Awareness and Mobilization; Advocacy, Policies and Methods; Sharing and Networking; and Communication and Dissemination*. These clusters offer statements which can be translated into unique strategies for inclusion in a framework to guide intervention design (Poland et al., 2009). Participants rated 34 statements above the means for importance and feasibility: recognizing the need for tool development, specific training, advocacy, policy framing and networking. Statements cover a wide range of educational support beyond training (Eime et al., 2008; Kokko et al., 2014) and embrace the need for a multi-level and multi-strategic approach to health promotion in sports clubs (Geidne et al., 2019; Jackson et al., 2006). ‘Stakeholder training courses’ was the highest rated cluster for importance, followed by ‘Awareness and Mobilization’ and ‘Advocacy’. Clusters related to tool development (communication *and* health promotion) were rated as most feasible (but considered less important). The relative importance given to advocacy (mean importance rating = 4.71), the professional support requirement and encouragement for sports clubs to embrace health promotion aligns with the European Commission’s 2007 White Paper on Sport and with research questioning the role of sport clubs in public health (Mansfield et al., 2018; Misener & Misener, 2016). Across multiple clusters, such as ‘Advocacy’ and ‘Sharing and Networking’, participants expressed the need for partnership development which can be undertaken by sports clubs and by other stakeholders (e.g. sports federations, government and public health actors) (Casey et al., 2012a). Participants described the need for resource sites and locations to share experience as

well as the asking for aid from federations or local authorities to support health promotion efforts. Previous studies have similar findings stressing the need to create supportive networks (Geidne et al., 2013a). The lowest rated cluster for feasibility and importance was Policies & Methods. This is likely because most clubs have no formal health promotion policy and consider themselves 'health promoting' by the nature of their business (Kokko et al., 2015; Van Hoya et al., 2016). This is supported in a study by Eime and colleagues, which suggests health promotion may best be introduced to some sports clubs in stages instead of taking a grand approach (Eime et al., 2008). Sports clubs may have informal health promotion activities, but organizational change takes time and acceptance by stakeholders and requires support for developing policies (Dobbinson, 2006). Many clusters align with a previous mapping review identifying evidence-driven guidelines that sports clubs used to promote health (Geidne et al., 2019). For example, underlining the importance of collaboration is seen both in the guidelines as well in Cluster 6 which includes the need for advocating for support and partnerships with other stakeholders. The guidelines highlight communication which is strongly related to Cluster 2, 'Communication tools', which encourages clubs to communicate their health promotion actions. Educating coaches can be found in both the guidelines as well as Cluster 3, 'Stakeholder training courses', and finally, Cluster 7, 'Policies and Methods', can be seen in two guidelines regarding creating policies and written health promotion goals. Within the all-statement Go-Zone, the three highest rated statements were #40, recommending the development of content for health promotion training directed towards actors in the sports world, #54 creating a resource site for sports clubs to access health promotion materials and ideas and #73 sharing experiences between clubs on how to implement health promotion actions. These statements further demonstrate the need for collaboration and connections between sports clubs and key actors in the sporting community, as was previously reported in other physical activity-related CM studies (Bergeron & Lévesque, 2014; Fitzpatrick & Zizzi, 2014; Geidne et al., 2013a). The differences in cluster and statement ratings highlights the difficulties between what statements participants perceived as important versus feasible, but they show the variety of ways sports clubs require support. Clubs can focus on Q4 statements which are both feasible and important for potentially high impact and easy implementation. By contrast, they can decide to focus on statements in Q2 which are considered important but less feasible which may require more work and potentially external support. Additionally, clubs could look at the statements in Q3 that are considered very feasible but less important as it is probable they currently have the capacity for implementation.

Limitations

Participants were from the French sporting system thus, translation into other cultures could be questionable. To address this, during editing, statements were revised to broaden cultural relevance while maintaining original meanings. Additionally, this study used a small convenience sample of French sports club stakeholders from multiple areas of France, therefore, it is unclear how well the findings represent those of all French stakeholders and how well findings can be generalized to an international sports club context. Regrettably, few club level stakeholders participated, possibly because they perceived CM as a time consuming process. To combat this, deadlines for steps were extended and email reminders were periodically sent. Finally, two online platform issues were encountered. First, *groupwisdom*[™] is in English while participants were native French speakers. This issue prevailed only during sign-in as instructions and activities were in French. Secondly, the study started in Concept Systems Global-Max© for brainstorming and migrated to their new platform, *groupwisdom*[™] for sorting and rating. To mitigate confusion, researchers transferred participant information to *groupwisdom*[™], set up user accounts and sent individual links to participants with access codes for anonymity. Any other issues were addressed with researchers being available for participant support.

Conclusion

Understanding the support stakeholders need in the sports club context is paramount to planning and implementing sustainable health promotion policies and practices in this relatively underutilized setting. Incorporating stakeholder expectations and perceptions when developing interventions may increase acceptance within sports clubs. Using the participatory approach of CM, this research highlights several areas of focus: educating sports club actors, increasing awareness of health promotion benefits, mobilizing actors to assist and advocating for support at multiple levels. This study adds to the current body of evidence-driven research on health promoting sports clubs (Geidne et al., 2019). Basing statements and clusters on importance and feasibility ratings, the strategies developed from this study can be added to findings from previous studies (Geidne et al., 2019) to integrate more robust data into current or emerging club health promotion policies and practice. By generating and organizing ideas from stakeholders, researchers gain insight into perceptions of implementing the settings-based approach to health promotion within sports clubs. Triangulating perspectives stakeholders have on health promotion activities undertaken in sports clubs (Johnson et al., 2019), guidelines previously used to promote health in this setting (Geidne et al., 2019; Kokko, 2014a; McFadyen et al., 2018) and what support stakeholders need to increase these activities will help to advance this area of research. This process should be guided by an intervention planning framework (Poland et al., 2009) in order to

identify priority areas and use evidence-driven strategies best suited to target key health promotion objectives set by the sports club (Van Hoye et al., 2020). Although this study included stakeholders who influence sports clubs, future research should explore participant expectations regarding health promotion activities provided by their club.

3.4 Preparing for study 5

The original HPSC intervention planning framework created in study 3, took a predominantly top-down approach to provide sports clubs with strategies and ICs. The strategies were formulated through evidence-driven guidelines (Geidne et al., 2019) and the ICs were derived by sports and public health academics and experts. Classification to create the first HPSC framework was done by expert focus group consensus. Study 4 took a bottom-up (participative) approach to discover sports club actors' views on needed support to increase health promotion actions. In order to provide a more robust and more inclusive framework, these two studies were combined in study 5. Intervention mapping requires the use of stakeholders throughout the intervention process, thus by adding the stakeholder-driven statements to the framework, an additional step in the protocol for intervention mapping was met (Kok et al., 2017). Therefore, the next objective in the PROSCeSS project was to strengthen the HPSC framework by incorporating the top-down approach from study 3 with the bottom-up approach from study 4. Incorporating these two approaches helps to better understand the setting and the capacity for organizational change needed for sports clubs to transform into an HPSC. In this way, study 5 strengthened the response to research question 5: *'How can an intervention be co-designed with sports club stakeholders?'*. Study 5 used two previous studies (Johnson et al., 2020; Van Hoye et al., 2020a), one conducted in multiple languages and the other in French. To combine these two studies, particular attention was given to cultural applicability of the research conducted in French during study 3 and 4. For example, when formulating ICs from participant generated ideas, references specific to the French sports system were excluded or generalized.

3.4.1 Study 5: A health promoting sports club framework: connecting participation with evidence

Submitted: *Global Health Promotion*



A health promoting sports club framework: connecting participation with evidence

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Abstract

The World Health Organization has focused on a settings-based approach to health promotion since the 1986 Ottawa Charter (World Health Organization, 1986). Sports clubs are prime settings to include daily health promotion actions. A robust framework for intervention planning is required incorporating top-down and bottom-up approaches to increase the efficiency, success and sustainability of interventions. The present work integrated stakeholder needs, knowledge and experience into an evidence-driven intervention planning framework. We undertook a three-step process to: 1) define newly identified sports club levels and health determinants, 2) formulate evidence-driven intervention strategies and intervention components (ICs) from previously

generated stakeholder driven statements about needed support for health promotion actions and 3) categorize ICs into the revised health promoting sports club (HPSC) model to update the HPSC intervention planning framework. Researchers first defined the Individual, Sports Federation, Public Health Actor and Government Authority levels along with their corresponding health determinants (social, organizational, environmental, economic). Second, published stakeholder statements were used to formulate new or modify existing strategies and ICs. Two existing strategies and nine ICs were modified, and fourteen additional ICs were created. Finally, a workshop with French sports stakeholders classified ICs into the HPSC model. The revised HPSC intervention planning framework offers 13 strategies and 69 ICs targeting seven sports club levels. This framework can be used to guide health promotion actions based on sports club's goals.

Key words: health promoting sports clubs, intervention framework, settings-based health promotion, sports clubs

Introduction

Public health authorities and academics have advocated for settings-based health promotion for decades (Kickbusch, 2019; World Health Organization, 1986). The World Health Organization (WHO) calls for increasing health promotion (HP) actions in various settings (World Health Organization, 1986). A setting is a “place or social context where people engage in daily activities in which environmental, organizational and personal factors interact to affect health and well-being” (Nutbeam, 1998). Including health promotion actions within settings where “people live, learn, work and play” (World Health Organization, 1986), improves conditions for physical, social and mental health and well-being. Numerous settings, such as schools (Rees et al., 2006), hospitals (Johnson & Baum, 2001) and universities (Dooris et al., 2014; Suárez-Reyes & Van den Broucke, 2016) have implemented HP interventions. Although some setting-based frameworks exist (Suárez-Reyes & Van den Broucke, 2016) to guide research, policy development and good practice, a context specific framework (Dooris, 2006) can improve effective implementation. Sports clubs emerged as a setting for health promotion in the early 2000's (Casey, Payne, Eime, et al., 2009; Kokko et al., 2006) but require guidance to plan, implement and structure health promotion interventions (Kokko, 2014b; Van Hoya et al., 2020). Although single health promotion interventions — injury prevention (Donaldson et al., 2018), capacity building (Casey, Payne, & Eime, 2009) and physical activity (Kokko et al., 2019) — have been implemented within sports clubs, strategies targeting multiple levels within organizations to guide concrete intervention implementation is in its infancy and sports clubs have not embraced organizational change to fully operationalize a settings-based approach. A review concluded that sports club health promotion

interventions are rarely based on theory and a settings-based approach was either lacking or poorly implemented (Geidne et al., 2019). A settings-based approach has been applied within sports clubs (Kokko, 2014b) and the definition of health promoting sports clubs (HPSC) has been refined to create a health promotion measurement tool (Johnson et al., 2019). To progress sports clubs as a relevant setting to promote health and provide clubs with a framework to plan health promotion interventions, a model of an HPSC was developed along with indicators to determine if a sports club is health promoting (Van Hoyer et al., 2020). The HPSC model identifies multiple sports club levels (second line actors, sports federations, club, managers, coaches, individuals) and determinants of health (organizational, social, economic, environmental) which act interdependently to reinforce the health of all stakeholders (Van Hoyer et al., 2020). In addition, previously published guidelines (Geidne et al., 2019; Kokko, 2014a) have been reformulated into 14 strategies along with 55 intervention components (ICs). Once formulated, the IC were categorized into the model by level and health determinant to produce an evidence-driven intervention planning framework (Van Hoyer et al., 2020). The HPSC is a newer approach to incorporating health promotion interventions into daily activities of a sports club. It goes beyond promoting one health behavior or targeting one sports club level as is current practice (Geidne et al., 2019; Johnson et al., 2019). Because sports clubs are diverse in offerings and operations, a general definition has been used to describe clubs 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, Ibsen, et al., 2017), but recognizing that many benefit from public support including funding (Scheerder et al., 2011). Considering this, the settings-based approach to health promotion helps sports clubs to embed themselves within their community and reach a wide audience across the lifecycle. Yet, clubs cannot achieve the ideal of the HPSC without external support (Geidne et al., 2013; Lane et al., 2020; Van Hoyer et al., 2020). The HPSC intervention framework is based on the “added value of a whole system approach” (Dooris, 2006) and offers sports clubs the option to choose a variety of broad strategies and targeted ICs which best suit their needs (Van Hoyer et al., 2020), when planning and implementing health promotion interventions. Each strategy is divided into multiple ICs allowing sports clubs to target multiple levels and health determinants for health promotion action.

A concept mapping study was conducted to ask sports club stakeholders (coaches, managers, public health and sports experts) what support they needed to incorporate HP actions into daily sports club activities (Johnson et al., 2020). This study produced statements from sports club stakeholders which were rated as the most feasible and important for sports clubs to be able to plan and implement HP policies and practices. Among the statements, several areas of focus

were highlighted, notably ensuring that sports club actors are educated on and cognizant of the benefits of promoting health, and collaborating with stakeholders and advocating for their support to promote health actions within their sports club (Johnson et al., 2020). This study offered a bottom-up approach to health promotion within sports clubs which can increase stakeholder acceptance and understanding of how interventions are informed by theory. These previous studies have set the groundwork to plan health promotion interventions in sports clubs, but several gaps remain: 1- although the internal sports club levels and health determinants were defined, those working externally (second line actors (government, public health) and sports federations) as well as the individual level were not, 2- many statements from the concept mapping study are pertinent from a bottom-up approach and should be formulated into strategies or ICs and 3- these ICs can be added to the intervention planning framework to strengthen the options available to sports clubs when planning their health promotion interventions. Therefore, the purpose of this study was to incorporate a bottom-up approach with a top-down approach to provide sports clubs with a robust intervention framework to plan and implement health promotion interventions.

Methods

The Medical Research Council's guidelines to develop and evaluate complex interventions were followed (De Silva et al., 2014). A three-step process was carried out to combine the HPSC intervention planning framework (Van Hoyer et al., 2020) with stakeholder-driven statement for needed support (Johnson et al., 2020): 1- define the new HPSC model levels and health determinants, 2- formulate strategies and intervention components (ICs) from stakeholder-driven statements and 3- categorize the intervention components into the newly defined HPSC model.

The international research team included two physical activity and sport health promotion specialists and five sports science and public health academics. Each step was undertaken in English and translated into French following guidelines from the Evaluative Linguistic Framework (Clerehan et al., 2016). This was part of a larger study registered with CNIL (Commission Nationale de l'Informatique et des Libertés) in February 2020 (N°2020-093). Ethical standards were maintained throughout and all working group participants provided informed consent for inclusion in all parts of the study.

Step 1 – Defining new HPSC levels & health determinants

Based on a previously published article (Van Hoyer et al., 2020), four newly identified levels were defined using similar sports language as the original three levels. Definitions took into account the five HPSC indicators (Van Hoyer et al., 2020) to consider sports clubs and their surrounding levels which could be considered health promoting (Geidne et al., 2019; Kokko, 2014a; McFadyen et al.,

2018). Researchers formulated definitions with the intention to maintain consistency with the HPSC model (Van Hoyer et al., 2020).

Step 2 – Formulating strategies and intervention components

A previously published concept mapping study (Johnson et al., 2020) and the published HPSC strategies and ICs (Van Hoyer et al., 2020), provided the basis for new strategies and ICs. The research team participated in a half day workshop to review the previously published strategies, ICs (Van Hoyer et al., 2020) and statements (Johnson et al., 2020) that rated at or above the mean for importance and feasibility by study participants to ensure applicability and eliminate redundancy. Through team consensus, statements were classified into strategies, ICs or actions. Actions were considered examples for sports clubs to achieve a strategy or IC thus, they were not retained. Statements were then analyzed to ensure they were not covered in a pre-existing strategy or IC. If a statement was included in a pre-existing strategy or IC, the original strategy or IC was analyzed to determine if there was a need for modifications to include any further details. If the statement was not in a pre-existing strategy or IC, it was formulated to maintain similar terminology, care was taken to use the 'language of sports' in order to ensure each new strategy and IC was relevant to sports club stakeholders (Kokko et al., 2016). Researchers then gave suggestions on which strategy or IC the reformulated statement corresponded with, to determine if a new strategy would be practical or if it was applicable to a current strategy and a new IC needed to be created.

Step 3 - Categorizing ICs into the HPSC model

A second half-day workshop was organized to integrate the ICs into the theoretical HPSC model. One workshop analogous to those used to create the original HPSC intervention planning framework (Van Hoyer et al., 2020) was conducted with a French working group consisting of 11 participants (4 academics, 2 public health professionals, 2 ministry of sport professionals, 1 professional from French Olympic federation and 2 actors within French sports organizations). Workshop participants were presented with the updated HPSC model from Step 1 and asked to reclassify 30 original ICs which were previously only classified into '2nd line actors'(15), 'Sports Federations'(14) or 'Individuals'(1) (Van Hoyer et al., 2020). Original ICs were merely classified into levels as the health determinants were yet to be defined because levels were suggested by participants during the study's three workshops. Participants were asked to verify classifications of any original IC that had been modified during Step 2. Then, participants were requested to classify the newly created ICs from Step 2 into any of the updated HPSC model levels and health determinants. Guidelines for classification included: 1- ICs could be classified into multiple levels

and multiple health determinants, 2- if an IC was not considered to correspond to any level or determinant, it was not required to be classified and 3- consensus had to be reached by group majority to retain classification.

Data analysis

Comments, reformulations and suggestions from Step 1 & 2 were recorded onto an excel spreadsheet for comparison and extensively discussed during the first workshop. Final decisions were discussed with all modifications being recorded and validated by group consensus. Classifications of ICs into the new HPSC theoretical model during the second workshop were recorded via comprehensive note taking and follow-up verification by all workshop participants. In order to retain final results for new sports club level definitions, strategies, IC formulation and HPSC model classification, group consensus was reached during both workshops.

Results

Step 1: Defining new HPSC levels & health determinants

Newly identified levels included 'Government authorities', 'Public health actors', 'Sports federations' and 'Individuals'. In order to differentiate and specify the '2nd line actors' level, it was separated into two distinct categories: 'Government authorities' and 'Public health actors'. Thus, giving the updated HPSC model a total of 7 levels working within and outside the sports club. Once the four new levels were defined, the corresponding health determinants were formulated again, using consistent, sports language (see Table 1 for definitions of new levels and corresponding health determinants).

Table 1. New HPSC level and health determinant definitions

Individual

Participants' (e.g. athletes, parents, etc.) personal characteristics and behaviors in terms of physical, mental and social health	
Social	Participants' (e.g. athletes, parents) sense of belonging to and engagement with the sport club and the way in which they know about, adopt and act according to the club's philosophies and concepts of health
Organizational	The way in which participants' (e.g. athletes, parents) know about, adopt and act according to the sports club's health promotion policies provided by their coach
Environmental	The way in which participants' (e.g. athletes, parents) feel supported and safe in their club's surroundings and infrastructures
Economic	The way in which participants' (e.g. athletes, parents) benefit from human resources and financial support of their sports club

Sports Federations

The sports federation's policies, regulations and support given to affiliated sports clubs to implement health promotion	
Social	The vision, values and philosophy of the federation in relation to those of society
Organizational	The federation's guidelines including policies, rules and regulations provided to affiliated sports clubs
Environmental	Sports federations' support for safe, supportive and sustainable infrastructures green spaces and playing fields provided to affiliated sports club
Economic	The financial and human resources provided by federations to affiliated sports clubs

Public Health Actors

Public health actors' guidance and support for the development of health promotion within sports clubs	
Social	Public health actors' vision, values, and philosophies in relation to those of society
Organizational	Public health guidelines including policies, rules and regulations which support health promotion in sports clubs
Environmental	Public health actors' guidance and support to create sustainable, safe and supportive infrastructures, green spaces and playing fields
Economic	The financial and human resources provided by public health actors to sports federations and sports clubs to promote health

Government Authorities

Government led support at the national through to the local levels to invest in health promotion within sports clubs	
Social	Government's values, vision and philosophies in relation to those of society
Organizational	Government guidelines including policies, rules and regulations which support health promotion in sports clubs
Environmental	Government's guidance and support to provide sports clubs with sustainable, safe and supportive infrastructures, green spaces and playing fields
Economic	The financial and human resources provided by government authorities for sports clubs to promote health

Each level includes 4 health determinants: organizational, social, environmental and economic; they were formulated following the same structure as the previously defined health determinants for the original sports club levels. The updated HPSC model illustrating interactions between levels and health determinants within and outside the sports club can be seen in Figure 1.



Figure 1. The HPSC 7-level model

Step 2: Formulating strategies and intervention components

Researchers first reviewed the 14 original strategies (Van Hoyer et al., 2020) and combined two ('Policies' was merged with 'Planning'). The primary focus of ICs within the Policies strategy dealt with policy planning rather than framing. Therefore, to avoid misunderstanding between planning for policies or planning for intervention actions, this strategy was removed and combined with the Planning strategy. Due to this change, original ICs under the 'Policies' strategy changed from POL1 to PLAN7 and POL2 to PLAN8. These changes were then reflected within IC classification in the HPSC intervention planning framework. Then, researchers evaluated statements from the second study (Johnson et al., 2020) and retained the 35 statements considered at or above the mean rating for both importance and feasibility. To transform retained statements into either strategies or ICs, each one was analyzed and compared with the previously published strategies and ICs (Van Hoyer et al., 2020) to avoid duplication and ensure applicability. Incorporation included modification of two original strategies (Education and Resources), modification of 8 original ICs (EDU1, EDU2, EDU3, EXP4, MOB1, PART1, PLAN7, PLAN8 (originally POL1 and POL2, respectively) and one final IC was modified and moved from the 'Participative Approach' strategy to the 'Communication' strategy as it was more adapted to this theme. Thus, PAP5

became COM6; this modification was also reflected in all HPSC intervention planning framework classifications. While no new strategies were created, 14 new ICs were formulated and added to existing strategies (Education: EDU4, EDU5, Experience: EXP5, EXP6, EXP7, Mobilization: MOB4, MOB5, MOB6, Participative Approach: PAP6, Resources: RES4, RES5, RES6, RES7, RES8). Additional minor modifications included several statements being combined together to modify existing strategies (Education and Resources) or ICs (EDU1, EDU2, EDU3, PART1). For example, original statements separated education for sports club managers and coaches into two statements; when reformulated into a strategy they were combined: *‘Support the sports club, managers and coaches by varying the type of education they receive, taking into account the types of sports club participants they coach’*. Ultimately, 7 of the 35 statements were not retained as they were considered actions, culturally specific or limited for health promotion within the general sports club context. For example, the statement *‘Provide training programs for educators in sports-health (take into account persons with pathologies and/or risk factors)’* targets only stakeholders with pathologies or high risk factors and assumes most sports clubs have a sports-health educator. With modifications and additions, 13 strategies with the new and modified ICs can be seen in Table 2.

Table 2. 13 Strategies with new and modified intervention components

13 Strategies	New & Modified Intervention Components (ICs)	Original statement (Johnson, et al., 2020)	Notes
COMMUNICATION: Develop and implement communication to raise awareness of the actions taken to promote health within the sports club	*†COM6: <i>Communicate the benefits</i> of health promotion activities	Encourage managers to share the club's health promotion actions with the local decision makers	IC moved from PAP5 and modified
DYNAMIC: Create strategies to improve all stakeholders' sense of belonging to the club and take into account the individual and their environment (socio-ecological approach) in order to define the most relevant health promotion goals			No changes to strategy or ICs

<p>EDUCATION: Support the <i>sports club, management</i> and coaches by varying the type of education they receive and take into account <i>differences in</i> the sports participants they coach</p>	<p>EDU1: Support <i>the managers and</i> coaches to actively engage in gaining knowledge and skills to promote health</p>	<p>Strategy and EDU1, EDU2 & EDU3 modified to add 'the sports club, managers or management'</p>
	<p>EDU2: Tailor the support to the <i>managers and</i> coaches individually in relation to the sports participants they coach (mentoring, courses, online tools)</p>	
	<p>EDU3: Encourage the <i>managers and</i> coaches to support each other to promote health</p>	
	<p>*EDU4: Propose a variety of ways for the sports clubs to raise awareness about health promotion</p>	<p>Propose a variety of ways to raise awareness to promote health to the clubs</p>
	<p>*EDU5: Create tools and training courses to support health promotion in sports clubs</p>	<p>Provide training programs/modules for coaches from the same club on health promotion</p>
<p>EXPERIENCE: Identify past club experiences, organizational readiness and the reasons and quality of the club's commitment to promote health</p>	<p>EXP4: Identify the <i>degree of</i> commitment to promote health</p>	<p>Run a diagnostic to evaluate the needs and expectations, motivations, strong and weak points, opportunities and barriers of the sports club to involve itself in health promotion</p> <p>IC modified to reflect the degree of commitment sports clubs have for health promotion actions</p>
	<p>*EXP5: Rely on existing, evidence-based health promotion tools</p>	<p>Rely on existing proven tools for health promotion</p>
	<p>*EXP6: Rely on a diagnosis to assess needs and expectations in order to</p>	<p>Rely on a diagnostic evaluation of needs and</p>

Chapter 3: Creating a Model and Framework

implement health promotion actions expectations to implement health promotion actions

***EXP7:** Rely on other clubs' experiences when developing health promotion actions Rely on experiences from other sports clubs to implement health promotion actions

FEASIBILITY: Regularly review the capacity of the sports club to achieve its health promotion goals		No changes to strategy or ICs
GOALS: Write down the sports club's health promotion goals, using positive messages, adapted to sports language, culture and the placement of health promotion within the club, taking into account the social inequalities of health		No changes to strategy or ICs
MOBILIZATION: Mobilize people to manage the development of health promotion	MOB1: Mobilize <i>sports champions to support the development of health promotion within your club</i>	Advocate for support from federations for health promotion within the clubs IC reflects that sports champions are found through Sports Federations requiring their support
	*MOB4: Mobilize parents (and other family members) to support health promotion actions	Create tools to help sports clubs to develop health promotion actions for 10–15 year olds while involving their parents IC formulated to mobilize parents; no age constraint
	*MOB5: Mobilize local decision-makers and elected officials to promote health within the sports club	Advocate for support from the local political environment for health promotion within the clubs Reinforces the Government Authorities & Public health actor levels

	<p>*MOB6: Advocate with sports federations to support the clubs on health promotion actions</p>	<p>Advocate for support from federations for health promotion within the clubs</p>	<p>Reinforces the Sports Federation level</p>
<p>MONITORING: Monitor health promotion activities in daily practice using a 'small steps' philosophy and review any changes</p>			<p>No changes to strategy or ICs</p>
<p>MOTIVATION: Understand what motivates coaches to implement health promotion and empower them in this undertaking</p>			<p>No changes to strategy or ICs</p>
<p>PARTICIPATIVE APPROACH: Value a 'participative approach' to promote health throughout the club and beyond</p>	<p>*PAP6: Involve parents (and other family members and friends) in health promotion efforts</p>	<p>Create tools to help sports clubs to develop health promotion actions for 10–15 year olds while involving their parents</p>	<p>IC formulated to include parents in HP actions; deleted age specifics</p>
<p>PARTNERS: Partner with other organizations to create a common culture and collaborative process to promote health</p>	<p>PART1: Identify partners for health promotion (clubs, agencies, <i>regional authorities</i>, health professionals)</p>	<p>Direct education towards actors in a position to lead a training-action course on health promotion in sports environments</p>	<p>IC modified to include partners who lead trainings</p>
<p>PLANNING: Create an implementation plan to achieve the written health promotion goals</p>	<p>†PLAN7: <i>Base future plans and policies on current health promotion actions</i></p> <p>†PLAN8: Plan future actions based on the evaluation of current actions</p>		<p>IC moved from Policies; modified to harmonize with Planning</p> <p>IC moved from Policies; modified to harmonize with Planning</p>
<p>RESOURCES: Identify, <i>develop or review</i> financial, human, <i>material</i> and capacity building resources available to invest in health promotion</p>			<p>Strategy updated: add development & reviewing of resources; material</p>

*RES4: Identify and mobilize tools for health promotion development within sports clubs	Create tools so that clubs can integrate health into their health promotion project
*RES5: Identify the funding that can be used for health promotion actions	Encourage the clubs to construct public policies which promote Sports for Health activities in the clubs, especially through specific and targeted financing
*RES6: Establish a national resource site for health promotion within sports clubs	Set up a national resource site to promote health within sports clubs
*RES7: Establish a national spokesperson for health promotion within sports clubs	Set up a national reference advisor to promote health within sports clubs
*RES8: Create and host a regional and local network of health promotion mentors within sports clubs (share practices)	Host a local network of health promotion advisors within sports clubs (share expertise)

Italics represents changes to original strategies or ICs

*represents new ICs

†displays ICs which were moved from one strategy to another and renamed

Previously published strategies and ICs can be seen in Van Hoye et al., 2020

Step 3: Categorizing ICs into the HPSC model

To update the HPSC intervention planning framework, workshop participants categorized original and newly formulated ICs into the updated HPSC model by health determinant per sports club level. Unanimous participant consensus was required in order to retain IC classification into the HPSC model. Original ICs including any modifications which occurred during Step 2 were only required to be classed into the newly defined determinants at the Individual, Sports Federations, Public Health Actors and Government Authorities' levels. Participants were presented with 1 IC at the Individual level, 14 at the Sports Federation level and 15 at the Public Health Actors level and the same 15 at the Government Authorities' level (2nd line actors level was split into two separate levels during Step 1). Because this level had been split, participants could choose to classify ICs at one or both levels within the various health determinants. At the Individual level, the IC EXP3

was classified into all four health determinants. At the Sports Federation level, 6 original and 7 new ICs were classified into the social determinant, 10 original and 11 new ICs into the organizational determinant, 4 original and no new ICs into the environmental determinant and 10 original and 6 new ICs into the economic determinant. At the Public Health Actors' level, 5 original and 10 new ICs were classified into the social determinant, 8 original and 13 new ICs into the organizational determinant, only 1 original IC into the environmental determinant and 9 original and 7 new ICs into the economic determinant. At the Government Authorities' level, 2 original and 6 new ICs were classified into the social determinant, 7 original and 10 new ICs into the organizational determinant, 1 new IC into the environmental determinant and 5 original and 7 new ICs into the economic determinant. Table 3 displays IC classifications into the various levels and coordinating health determinants.

Table 3. Intervention component classification

Sports Club Level	Determinants	Concept Mapping IC classification	Original IC classification
MACRO	Social	COM6, EXP6, EXP7, MOB4, MOB5, PAP6	
	Organizational	COM6, EXP5, EXP6, EXP7, MOB4, MOB5, PAP6, RES4, RES5	
	Environmental	COM6, EXP6	
	Economic	COM6, EXP5, EXP6, EXP7, MOB4, MOB5, PAP6, RES5	
MESO	Social	COM6, EXP7, MOB4, MOB5	
	Organizational	COM6, EXP7, MOB4, MOB5, PAP6, RES5	
	Environmental	COM6	
	Economic	COM6, EXP7, MOB4, MOB5, PAP6, RES5	

MICRO	Social	COM6, MOB4, MOB5, PAP6	
	Organizational	COM6, MOB4, MOB5, PAP6	
	Environmental	COM6	
	Economic	COM6, MOB4, MOB5, PAP6	
Individual	Social		EXP3
	Organizational		EXP3
	Environmental		EXP3
	Economic		EXP3
Sports Federations	Social	COM6, EXP7, MOB5, RES5, RES6, RES7, RES8	MOB1, MOT3, MOT4, PAP1, PAP3, PAP4
	Organizational	COM6, EDU4, EDU5, EXP5, EXP7, MOB3, MOB5, RES4, RES5, RES6, RES7, RES8	EDU1, EDU2, MOB1, MOT3, MOT4, PAP3, PAP4, PART1, PLAN6, PLAN8
	Environmental		MOT3, MOT4, PAP3, PAP4
	Economic	EDU4, EDU5, EXP5, EXP7, MOB3, MOB5, RES4	EDU1, EDU2, MOB1, MOT3, MOT4, PAP3, PAP4, PLAN6, PLAN8, RES3
	Social	COM6, EXP7, MOB4, MOB5, MOB6, PAP6, RES5, RES6, RES7, RES8	DYN2, GLS4, PAP1, PAP3, PAP4
Public Health Actors	Organizational	COM6, EDU4, EDU5, EXP5, EXP7, MOB3, MOB4, MOB5, MOB6, PAP6, RES4, RES5, RES6, RES7 RES8	DYN2, FEAS3, MON3, MON4, PART1, PLAN6, PLAN7, PLAN8
	Environmental		DYN2

Government Authorities	Economic	EDU4, EDU5, EXP5, EXP7, MOB5, MOB3, MOB6, RES4	FEAS3, MON3, MON4, PAP3, PAP4, PLAN6, PLAN7, PLAN8, RES3
	Social	COM6, EXP7, MOB6, RES6, RES7, RES8	PAP3, PAP4
	Organizational	COM6, EDU4, EDU5, EXP5, EXP7, MOB3, MOB6, RES4, RES6, RES7, RES8	MON3, MON4, PAP3, PAP4, PART1, PLAN6, RES3
	Environmental	COM6	
	Economic	COM6, EDU4, EDU5, EXP5, EXP7, MOB3, MOB6, RES4	MON3, MON4, PAP3, PAP4, PLAN6

Strategies are labeled; intervention components (IC) are labeled by abbreviation and number

The environmental determinant at all levels had the fewest ICs classified at any sports club level (new ICs n=5; original ICs n=6), while the Individual level had the fewest ICs classified into any determinant. The Public Health Actors level had the highest number of new ICs classified (n=30) while the Sports Federation level had the highest number of original ICs classified (n=30). The organizational determinant had the highest number of ICs classified (new IC n=53; original ICs n=26). From the newly formed ICs, COM6 was classified most often (n=20) while EXP6 was classified least often (n=4). Although original ICs were only classified into the determinants at the new levels, PAP3 and PAP4 had the highest number of classification (n=9) with the ability to be classified into the health determinants at the Sports Federation, Public Health Actors and Government Authorities levels. The GLS4 IC was only classified once and was presented for classification in both the Public Health Actor’s and Government Authorities’ health determinants. Figure 2 shows the revised HPSC framework including the new and original ICs classified into the updated HPSC model.

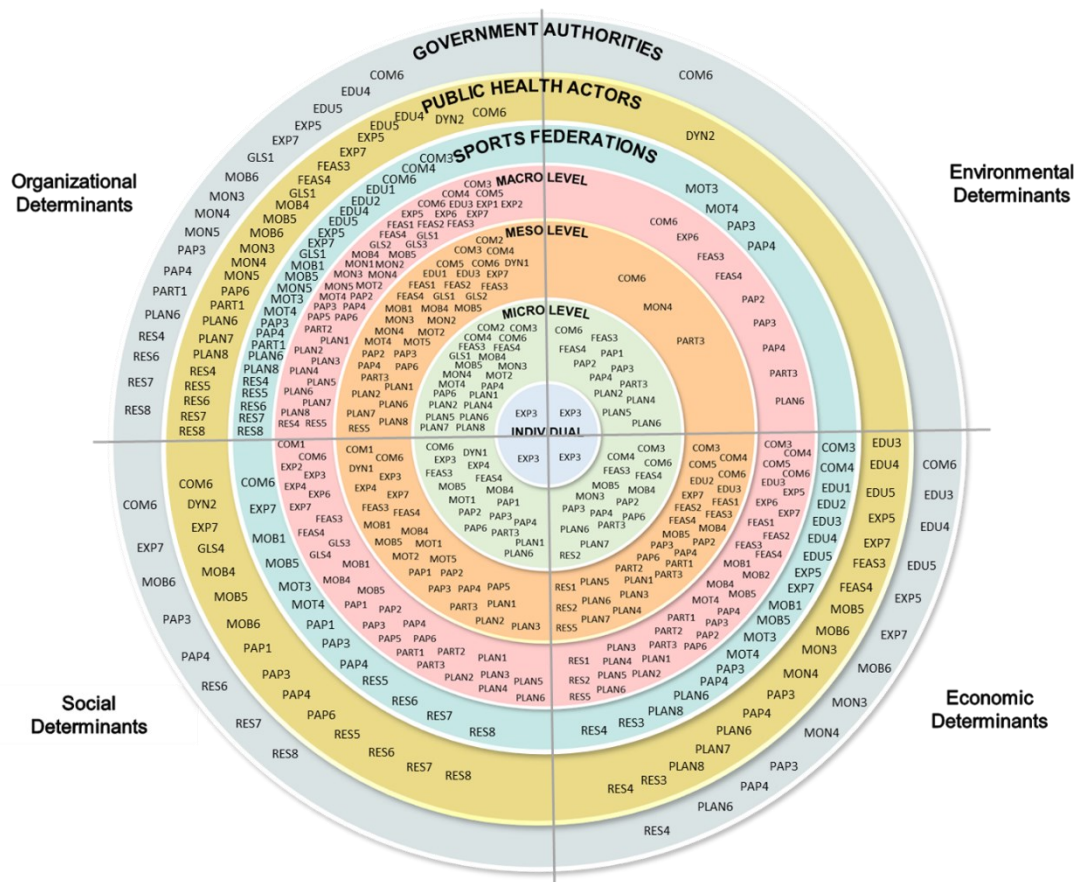


Figure 2. The HPSC framework

Discussion

Although less developed compared to other settings such as hospitals (Johnson & Baum, 2001) and schools (Rees et al., 2006), the settings-based approach to health promotion is gaining traction in sports clubs (Johnson et al., 2019; Kokko, 2014b; Van Hoye et al., 2016). The current study was grounded in this approach with the purpose of incorporating the outcomes of a participative approach into an HPSC framework. The HPSC model was expanded to include three levels acting outside sports clubs and one level within the club. Previous studies suggest that other stakeholders can act as support networks around sports clubs: individuals, sports federations, second line actors or the local community (Kokko et al., 2016; Van Hoye et al., 2020). Incorporating these stakeholders as new levels (Government Authorities, Public Health Actors, Sports Federations, Individuals) into the existing HPSC model (Van Hoye et al., 2020), required defining them and identifying the corresponding health determinants (organizational, social, economic, environmental). These levels provide support and direction when developing and implementing

components of a complex intervention (Craig et al., 2008) to increase effectiveness (Pawson & Tilley, 2010). The new external levels may provide national or regional level policies and resources for implementing health promotion actions. As individual's are often the primary target for health promotion action, they may provide direction as to what type of actions are needed or expected from the sports club.

To add the bottom-up approach to intervention design, new ICs were developed using stakeholder driven statements. In addition, multiple strategies and ICs were modified, formulated and classified to provide an updated version of the HPSC intervention framework with 13 strategies and 69 ICs. This provides a robust framework for sports clubs when planning health promotion interventions by combining stakeholder needs and experiences with published research (Donaldson et al., 2018; Vella et al., 2019). Research suggests that settings benefit from a planning framework (Suárez-Reyes & Van den Broucke, 2016) which includes internal and external mechanisms (Michie et al., 2011) as well as clear strategies to aid with policies and practice (Dooris et al., 2014).

As has been seen previously (Van Hoyer et al., 2020), the environmental health determinant had the fewest ICs to be classified even though studies suggest this is an important determinant for stakeholder health (Kokko et al., 2009; Van Hoyer et al., 2015). This could be due to a gap in research on this specific determinant and how it affects stakeholders. Interestingly, statements oriented toward educating and training managers and coaches were seen by stakeholders as the most important and feasible group of statements (Johnson et al., 2020) yet ICs focusing on this subject were rarely classified (Van Hoyer et al., 2020) nor were the two newly formulated ICs classified in the current study. This may be due in part because education and training is difficult within the sports club context when many of those involved are volunteers (Casey et al., 2012a). More research is needed to identify the types of education desired and how best to provide it.

Due to the addition of the four new sports club levels, workshop participants were also able to classify three previously unclassified ICs into the health determinants in the new levels (DYN2, MOT3, RES3) (Van Hoyer et al., 2020). These additions offer sports clubs more options for outside support when planning and developing health promotion interventions. Sports clubs often have little internal support for health promotion actions making it important to access guidance and encouragement from outside sources when undertaking health promotion interventions (European Commission & Directorate-General for Education and Culture, 2007; Misener & Misener, 2016). This study provides suggestions on how outside sources such as government actors, public health actors and sports federations can offer needed support (Jackson et al., 2006). This was emphasized with multiple statements regarding advocating for external support (Johnson et al.,

2020) and reinforces the necessity of these additional levels into the HPSC model. As Casey and colleagues (Casey et al., 2012a) discovered during the Partnership for Health scheme, when sports clubs were supported by their state sporting organization, their organizational capacity for health promotion increased. Studies have also shown a link between health promotion perceptions and membership with sports federations, which can in-turn provide additional resources (Meganck et al., 2016). Although multiple ICs in nine different strategies were categorized into the Sports Federation level including education and resources, research has shown that many International Sports Federations give a low priority to the health of the general population and rather focus their resources on high level athletes and educate athletes and coaches on sport-specific issues such as doping and injury prevention (Mountjoy et al., 2018). The new level Public Health Actors, had the most ICs with 11 of the 13 strategies such as education, resources and planning, classified into the new HPSC framework. Support and guidance from this level can be seen in countries such as Ireland with the Healthy Club Project (Lane et al., 2020) and in Australia through VicHealth (Casey, Payne, & Eime, 2009) which provide resources including funding, policy planning and education to support practitioners. At the highest level, the Government Authorities had 8 strategies classified into the HPSC model including mobilization and resources. This may include government authorities from local to national levels. Health ministries acknowledge the role governments play in creating healthy communities (Habkirk, 2013) and government investment in sport leads to increased participation and community cohesiveness (Grix & Carmichael, 2012). Although many governments invest in elite sports, the 'trickle-down' effect to the general population can often been seen, especially after large sporting events (Weed, 2014). Thus, investment in sports clubs at any level can help to promote health within local sports clubs. In addition to the external levels, the updated HPSC model defines how individuals are part of the sports club and affected by their health promotion actions. Individuals can be impacted by the sports club in general and notably by the coaches they directly interact with (Kokko, Selänne, et al., 2015; Van Hoya et al., 2016), giving more validity to the HPSC intervention planning framework.

The current study is based on two previously published studies integrating bottom-up and top-down approaches. The benefit of mixing the two approaches gives strength and applicability when planning and implementing health promotion interventions in the sports club context. This adds to the credibility of the HPSC framework yet, several limitations occurred during the updating process. Researchers used statements from a previous study which rated at or above the mean for importance and feasibility. In so doing, some key stakeholder ideas for intervention planning may have been missed. The intervention planning framework is a tool for intervention managers

to plan and develop health promotion actions within their club therefore, the most feasible and important ICs were chosen to allow for a manageable starting point. This study only conducted one workshop to classify the ICs. Although it was previously seen that conducting multiple workshops did not yield significant differences in classifications. In addition, because several of the original ICs were modified it may have been beneficial to offer these during the workshop for participants to re-classify if necessary. During the IC formulation, researchers unanimously validated original classifications. Finally, the workshop was conducted with a French speaking group bringing up the question of transferability into other national sports systems. Albeit, the new HPSC model levels and ICs were formulated by an international research team giving credibility to the new definitions and additions.

Conclusion and future research

Grounded in the settings-based approach to health promotion, this study offers an updated version of the HPSC model and framework for intervention planning. The organization of sports clubs varies across many countries (Elmose-Østerlund et al., 2017) with some supported through public sources (Scheerder et al., 2011). This variety and support confirms the need to include public sources into the HPSC model and demonstrate how they can influence local sports club's HP interventions through the planning framework. Including multiple stakeholders in the design and implementation process of an intervention signals a component of a complex intervention (Craig et al., 2008). This update can be used by sports clubs and outside stakeholders when planning and implementing health promotion interventions. Sports clubs now have the option to use strategies and ICs to target multiple levels within and outside the sports club. They can use the updated intervention planning framework to request support from within and outside the club when targeting different health determinants. Future research should focus on the acceptability and feasibility of using the updated HPSC intervention planning framework through a pilot study. In addition, research should be undertaken to provide the outside levels with a top-down approach to the health promoting sports club. Analysis is needed to discover what types of policies, strategies and action plans are currently being used from national levels to support sports clubs in their pursuit to incorporate health promotion actions in daily activities.

3.5 Analysis & considerations

In social sciences, it is said that there is "nothing as practical as a good theory" (Axelrad, 1951). Theory is the basis to test evidence and begin the learning process by giving us a proper understanding of what is being studied (Pawson, 2003) and the context in which it is being studied. Theory allows for the review of current evidence as a basis for a new intervention and projects

based on theory have shown to be more effective compared to non-theoretically based interventions (Peters et al., 2009). Intervention science asserts the advantages of rooting interventions in a theoretical settings-based model (Fernandez, ten Hoor, et al., 2019; Glanz & Bishop, 2010). In order to understand the setting, we need to understand how it is organized and how it can be impacted. Therefore, a multi-level HPSC model was created and defined. The model includes interactions between levels and how those interactions affect the health determinants. With this in mind, data compiled through studies 3 and 5 helped to build the theoretical HPSC model. This new model of how a sports club is organized was built upon the original concept (Kokko et al., 2014) to show that interactions are not one-way; they flow from the top-down *and* from the bottom-up. For example, within the sports club, the managers support the coaches' and volunteer's actions which in turn supports the health of their sports participants. By including the individual level in the theoretical model, it helps intervention managers consider their needs and expectations when planning and implementing health promotion actions that directly affect sports club athletes, participants, their family and friends. The original concept only included internal sports club levels with brief definitions (Kokko et al., 2014). Through multiple iterations and a committee approach, the new model improves upon this by giving richer definitions of each level and health determinant. For example, the definition for the meso level was "health promotion guidance activity by a club towards coaches" (Kokko et al., 2014), whereas the new definition reads: the guidance and support given to coaches and staff (including volunteers) by sports club management and directors. The model was also amended by replacing the 'cultural' determinant with 'organizational' to improve upon the concept of the setting and how the policies related to health promotion can impact the different levels if carried out. This change was made because it was decided that 'culture' was already considered in the social determinant. By replacing this health determinant, there may be some important factors that have been left out as this is a standard determinant of health used by the WHO (World Health Organization, 2017). Within the university setting, the cultural context played an important role in success as well as ensuring stakeholders were involved in planning and implementing interventions (Suárez-Reyes & Van den Broucke, 2016). Therefore, it may be beneficial to reconsider this health determinant within the sports club context. In addition to the changes made to the internal sports club levels, a major innovation to the HPSC model was to include external levels which were not present in the original concept. External levels demonstrate how the sports club can benefit from the support of sports federations, public health actors and government authorities. Applying the setting-based approach to a theoretical sports club model demonstrates the reciprocal interactions of the multiple levels and health determinants and how they can interact to influence each other.

The theoretical HPSC model gives us a structure in which to base the planning framework. From an intervention mapping standpoint, a theoretical model of the setting needed to be formulated in order to identify the various actors and understand how the setting can support their needs (Kok et al., 2017). Through participant categorization of the intervention components into the HPSC model we now have a framework for practical intervention design, planning and implementation. The original intervention components from study 3 were formulated with the help of multiple sports experts, academics and public health expert without direct input from sports club actors. Through the use of study 4, additional intervention components were formulated and added to the framework. This was a bottom-up approach but the vast majority of respondents were from regional sports federations with only a small minority coming directly from the sports club in the form of managers or coaches and no sports participants were solicited to take part in any of these three studies. This may be an untapped source to acquire additional data to enrich the HPSC framework. For example, by including this group, they may give more insight into why the environmental determinant is not well understood and how it can be better represented not just as items on the e-PROSCeSS questionnaire, but as a health determinate to be targeted through the framework. Recalling the difficulty study participants had when validating the environment as a sub-scale in study 2, participants also had a difficult time classifying intervention components into the environmental health determinant during studies 3 and 5.

Similar to other settings (Dooris, 2006; Dooris et al., 2014), these three studies demonstrate just how complex the sports club is in regard to the settings-based approach. In all of these settings, the results stress the need to include partners in all phases of the intervention from planning to implementation to evaluation (Bartholomew et al., 1998; Kok et al., 2017). Theoretical constructs, such as sports club levels, strategies and ICs, have been targeted in order to select the different components to include when designing flexible interventions based on a sports club's needs and goals. Together these constructs provide a framework with defined guidelines and indicators which help direct policies, practice and future research (Dooris et al., 2014). Providing a framework can lead to progress but without communication, dissemination and support including political commitment, sports clubs will have a difficult time making the organizational change needed to be considered an HPSC. The identified strategies must be implemented across multiple sectors. These studies exhibit how sports clubs are complex, multi-faceted organizations with levels both internally and externally. All of these levels and health determinants must work together in order to build an ecological framework for an HPSC.

3.5.1 Practical implications

Based on studies 3 and 4, two separate flyers were produced to give sports clubs examples they can use in an easy to understand 'sporting' language. From study 3, the flyer describes the 5 HPSC indicators for sports clubs to be considered health promoting and from study 4 the flyer shares the 5 highest ranked cluster with the 10 highest ranked stakeholder-driven statements for the support needed to increase health promotion actions (see supplementary file 6). Another flyer was created to share the 13 evidence-driven strategies finalized before beginning study 5 (see supplementary file 7). Both these flyers have been created in French with English versions to come.



CHAPTER 4: CAPITALIZING ON EXPERIENCE

"The only source of knowledge is experience"

...Albert Einstein, German theoretical physicist

4.1 Preparing for study 6

To gain knowledge from the field (Hohmann & Shear, 2002), the research team set out to learn directly from sports club intervention managers and capitalize on their experiences. Clubs are often more likely to implement interventions that have been field tested and successful with their peers therefore, collecting and circulating these experiences was the main objective of study 6. Conducting study 6 also allows for increased participation from sports club stakeholders working directly in the club setting which is a main component of the intervention mapping protocol (Bartholomew et al., 1998; Kok et al., 2017). This study also provided an opportunity to discover how the HPSC intervention planning framework was used in the field and the possibility to gain more strategies that had not yet been formulated. Through the capitalization process, we were able to interview French intervention manager to gain knowledge on the club's experiences with health promotion projects and gather additional information for research question 2; '*What strategies can be and already have been used to promote health in sports clubs?*'. Additionally, it helps to gain more knowledge on the current capacity of sports clubs to promote health and how to better co-construct an intervention (research question 5). This study was conducted in French and all relevant quotes were translated into English.

4.2 Study 6: Capitalization of health promotion initiatives within French Sports Clubs



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Article

Capitalization of Health Promotion Initiatives within French Sports Clubs

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Abstract

The settings-based approach to health promotion within sports clubs is a growing field of research. Evidence of health promotion intervention effectiveness in scientific literature is scarce, and little is known about their implementation mechanisms. The present study explores how promising health promotion interventions in 8 French sports clubs are developed, and how the health promoting sports club's intervention planning framework is applied. A method to collect

Experiential Knowledge in health promotion was used, based on 2 iterative interviews to analyze intervention mechanisms and completed with document analysis. A deductive analysis using the health promoting sports club intervention planning framework was then undertaken. Among the 14 evidence-driven strategies, 13 were implemented in sports clubs (min = 9; max = 13). Policies were not targeted by any of the interventions. Key competencies of the managers of these health promotion interventions were identified: (1) having a deep understanding of the public and environment, (2) acquiring a high capacity to mobilize internal and external human resources, (3) possessing communication skills and (4) having an ability to write grant applications. By using evidence-driven strategies and intervention components, sports professionals can use this experiential knowledge to create successful and sustainable interventions.

Keywords: capitalization; complex interventions; health promotion; settings-based; sports clubs

1. Introduction

Beyond the benefits of sport practice (Eime et al., 2013), research has shown that health promotion (HP) activities implemented by sports coaches decreased drop-out intentions, increased enjoyment in sport, as well as self-reported quality of life, among youth and adults (Van Hoya et al., 2016; Van Hoya et al., 2020). According to the World Health Organization (WHO), HP designates “the process of enabling people to increase control over and to improve their health” (World Health Organization, 1986). To develop this process, the Ottawa Charter (World Health Organization, 1986) pointed out the importance of a settings-based approach (Whitelaw et al., 2001) in HP, defined as “the place or social context in which people engage in daily activities, in which environmental, organizational and personal factors interact to affect health and well-being” (Nutbeam, 1998). As researchers have called for multi-level and multi-strategy approaches to health problems (Jackson et al., 2006), the settings-based approach highlights the importance of the whole system in a setting (Kokko, 2014b), as well as the important potential that sports clubs have to promote health, but it won’t happen in itself (Geidne et al., 2013b). Sports clubs have been 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, Ibsen, et al., 2017). Although admittedly, many sports clubs receive partial financing or support from public sources (Scheerder et al., 2011). Sport clubs are interesting settings from a public health perspective, for several reasons: (1) they welcome a diverse population, across socio-economic status and lifespan (Eime et al., 2013), (2) the voluntary nature

of sport participation provides an opportunity for health education, (3) previous studies have highlighted the benefits of health promotion, such as increased membership or improved sport participants' health (Van Hoya et al., 2018). Nevertheless, recent results have shown that traditional sports clubs are no longer a favorite setting for adults to exercise for health benefits (Eime et al., 2020). Thus, working on health promotion could help sports clubs to reinvent themselves in relation to health. In sports clubs, the settings-based approach has been adapted to include determinants (social, organizational, environmental, economic) active at three levels: the macro- (overall policies and orientations of activities of a club), meso- (activities of club management) and the micro level (coaches' activities in guiding, altering or supporting actions of club members) (Johnson et al., 2019). In other words, within a single sports club, macro and meso levels set out HP preconditions and aims for the micro level (Kokko, 2014b). Cross-sectional studies using self-reported measurements to evaluate sports club's HP initiatives have underlined the development of environmental and social determinants, but less on organizational and economic determinants (Kokko et al., 2009; Meganck et al., 2015; Van Hoya et al., 2016). A recent literature review (Geidne et al., 2019) selected 58 articles encompassing 33 unique interventions of HP within sports clubs. The 33 analyzed interventions mainly focused on a single behavior targeting a single group (male sports participants), limiting the understanding of the application of the settings-based approach (e.g. alcohol policies) (Geidne et al., 2013a). The development of the settings-based approach in sports clubs is relatively recent (Kokko et al., 2014) and its empirical application is still questioned in peer-reviewed articles (Geidne et al., 2019). Complementarily, previous work has shown that there is limited knowledge on how organizational changes can be implemented to transform sports clubs into health-promoting settings (Casey, Harvey, et al., 2012; Kokko et al., 2016). Considering these findings and previous case studies of HP within sports clubs (Kokko et al., 2016), authors have suggested that evidence could potentially be found in grey literature and not only in peer-published articles (Priest et al., 2008a, 2008b). Nevertheless, few qualitative studies have focused on the mechanisms at play when implementing HP activities. Previous work (Van Hoya et al., 2016) has shown that (1) sports clubs rarely have written policies, but rather informal oral communication of guidance from management to coaches to sports participants (Geidne et al., 2013a), (2) coaches are not aware of the many partnerships managers negotiate to enhance sports clubs' resources and (3) manager guidance is often oriented towards sport performance rather than health matters (Kokko et al., 2011). For example, it is more typical for sports clubs to organize sporting events rather than having specific HP interventions. As most of the studies on HP in sports clubs are cross-sectional, previous literature reviews have identified only three effective interventions tested rigorously, worldwide (McFadyen et al., 2018), as well as

underlined the poor application of settings-based approaches in sports clubs (Geidne et al., 2019), more knowledge is needed specifically on how sports clubs implement HP. In 2020, the health promoting sports club framework was created (Van Hoyer et al., 2020b), describing 14 strategies with 55 interventions components, formulated from published evidence-driven guidelines (Geidne et al., 2019). This framework offers a novel opportunity to understand the health promoting sports club approach with practical implementation guidance. To document organizational changes, the present study analyzes French sports clubs' HP initiatives to: (1) question how sports clubs develop HP interventions, (2) analyze how the health promoting sports club intervention planning framework, particularly the 14 strategies and 55 interventions components (Van Hoyer et al., 2020b), is applied within sports clubs and (3) document elements of transferability from one HP intervention in a sports club into another sports club.

2. Materials and Methods

This is a practice-based research study, on how interventions work in real life (Hohmann & Shear, 2002), in this case grassroots French sports clubs (Green, 2008; Green, 2006). The method has been developed by a national health promotion working group, called Experiential Knowledge in HP (CEKHP) (Laurent et al., 2020), in order to capitalize, collect and circulate knowledge gained from the experience of actors running interventions and to share this within the French health promotion community. CEKHP includes a framework for reporting key mechanisms that influence health promotion intervention outcomes: context, partnership, key steps, barriers and levers, ethics, theoretical foundations and transferability (Laurent et al., 2020). The present work uses a multiple case study design (Stake, 2006), based on qualitative and iterative methods with four steps: (1) document and website analysis, (2) semi-structured interviews with intervention managers, (3) expert analysis of interventions and (4) validation by intervention managers. Case study research is intended to capture the complexity of the object of study (Stake, 2006), here HP interventions within sports clubs. The multiple data collection is shaped by context and emergent data, with the aim of exploring a real-life, contemporary bounded system over time, through detailed, in-depth data collection involving multiple sources of information (Stake, 2006). The document and website analysis served as a basis to question the intervention mechanisms and strategies during the interview, helping the interviewer to have a basic understanding of the intervention to support the subsequent in-depth analysis.

2.1. Research Settings

Eleven French grassroots sports clubs were identified through researcher networks, multiple foundations (French National Olympic and Sports Committee, Agence pour l'éducation par le sport, Fondation du football) and sports federations. Sports clubs were selected, because they specifically implemented HP interventions using a setting-based approach, with minimum criteria being to: (1) implicate more than two partners, (2) work on a multi-level strategy (managers, coaches, participants) and target different health determinants (social, organizational, environmental, economic), as well as (3) have at least one year of implementation (Van Hoyer et al., 2020b). Interventions are defined in a wider sense as, "to disturb the 'natural' order of things or a foreseeable sequence of events" (Hawe & Potvin, 2009). In addition to the above criteria, sports clubs had to be affiliated to the French National Olympic and Sports Committee and officiate at grassroots levels. From the 11 originally selected clubs, eight completed the three-step data collection process (Table 1) while the other three only participated in initial interviews. Among these three, one withdrew before the second interview due to lack of time and two were rejected as they did not meet study inclusion criteria (one not yet having a full year of implementation and the other was not affiliated with the French Olympic Committee).

Table 1. Main characteristics of the selected sports clubs

Club	Sport offered	# of members	Location	Intervention manager position	HP action	HP paid staff	Gender & age (years)	Funding source
1	Multisport	7000	Clermont-Ferrand	Responsible for youth education	After school homework	3	All (≥ 6)	Private partners, city
2	Track & field	1000	Nice	Responsible for the sport and health section	Elderly sports practice	1	All (≥ 5)	Health Insurance
3	Soccer	310	La Montagne	Responsible for youth education	Youth health behavior and social health	0	All (≥ 5)	City, private partners
4	Soccer	324	Biot	Main coach	Injury prevention	0	Males (≥ 5)	None
5	Soccer	500	Epinal	Sport club employee	Citizenship	1	All (≥ 5)	City, department, private partners
6	Soccer	950	Serris	Responsible for female football practice	Youth healthy eating	0	All (≥ 5)	None
7	Cycling	200	Lille	Director	Integration through sport	0	Females (≥ 18)	City
8	Multisport	12000	Marseille	Responsible for the sport and health section	Sport and health services	1.5	All (≥ 5)	City, Department, Region, national center for sport development, private partners

2.2. Procedure

The study was registered with the CNIL (Commission Nationale de l'Informatique et des Libertés). Ethical standards were maintained throughout the study, written consent was secured from sports club directors and key informants. All participants were identified with a code number to protect their identity. No individual data on intervention managers was collected, except their position within the club and employment. Different steps were undertaken: (1) an initial interview to describe the intervention, (2) document analysis, (3) intervention mechanisms and stakes analysis. Step 1: After an initial contact email to the sports club's intervention manager, a short phone interview (conducted by AVH, FL or FR and LC) helped to (1) document the intervention and ensure fit with inclusion criteria, (2) collect documents and the club's website address for intervention comprehension and (3) transmit all ethical documents, including informed consent and an intervention information letter. Step 2: Analysis of documents and the intervention was undertaken by the interviewer, to gain knowledge about the intervention and its mechanisms, as well as prepare the second interview. Step 3: a second in-depth interview took place, lasting from 1 to 3 hours, to collect more information on the intervention mechanisms and stakes. After the

transcription and coding process, the transcribed interview and analyzed data were validated individually by each intervention manager, through email exchanges.

2.3. Measurement

Based on the interview guide created by the CEKHP method (Laurent et al., 2020), two semi-structured interview guides were developed by the research team: the club identity card, including the context of the HP action, partnerships and stakeholder implications and evaluation (step 1) and an extended interview guide for an in-person interview, including the in-depth description of the intervention (theory, guidelines, strategies, key moments or experiences, etc.), evaluation, transferability, key mechanisms and required competencies (step 3) (supplementary file 8).

2.4 Data analysis

Qualitative data from all interviews were digitally recorded, fully transcribed and analyzed using a paper and pencil approach, to accomplish the organization and coding process. Each sports club's transcription and collected documents, including information gathered from their website, were read twice to underline key ideas. Then, the Health Promoting Sports Club (HPSC) intervention planning framework (Van Hoyer et al., 2020b) was used to analyze interviews and accompanying documents (sports clubs' regulations, educative project, submitted funding application). The deductive coding approach (Raskind et al., 2019; Stuckey, 2015) was applied to identify which of the 14 strategies and underlying 55 intervention components from the HPSC intervention planning framework (Van Hoyer et al., 2020b) were cited and how they were implemented, by categorizing the quotes into a strategy and linking it with an intervention component. To complement the qualitative analysis, AVH recorded if each intervention component was implemented or not in the sports clubs. This allowed for quantitative data comparison across the eight sports clubs regarding which strategies and intervention components were implemented. Identity cards were individually coded by AVH with a second researcher, SJ, verifying the categorization of each coded intervention component. Then, each full transcription, identity card and intervention component results were sent to the respective intervention manager for verification and validation.

3. Results

Among the 14 evidence-driven strategies (Van Hoyer et al., 2020b), 13 were implemented in sports clubs, with low variability (minimum of 9; maximum of 13). Policies were not targeted by any of the interventions. Results are presented for each of the 13 evidence-driven strategies. Of the 55 total intervention components (ICs) (Van Hoyer et al., 2020b), only 8 were not used by the sports clubs. One from motivation, 3 from participative approach, 2 from planning and 2 from policies. Although one of the smaller clubs (324 members) with no paid HP staff, Club 4 implemented 13 of the

strategies and used 31 ICs within their project. While Club 1, with the second largest membership and 3 paid HP staff, implemented 12 strategies but used the highest number of ICs (32). Club 8 had the highest membership base (12000) and some paid HP staff (1.5), yet implemented the least number of strategies (9) and ICs (14). Both these clubs are multisport. Club 5 & 6 also implemented 12 strategies and used almost half of the total ICs (12 & 24, respectively). Both of these are soccer clubs with less than 1000 members and only Club 5 has a paid HP staff member. Club 7 implemented 11 strategies with 24 ICs, this was the smallest club with only 200 members and no paid staff to implement the health promotion project. Finally, Clubs 2 & 3 both implemented 10 strategies and 18 ICs. While Club 2 has 1000 members and 1 paid HP staff, Club 3 only has 310 with no staff specifically paid for HP. See Table 2 for categorization of intervention components used by each club. See Table 2 for categorization of intervention components used by each club.

Table 2. Summary of implemented strategies and intervention components among sports clubs

Club	COM	DYN	EDU	EXP	FEAS	GLS	MOB	MON	MOT	PAP	PART	PLAN	RES	PO L
1	COM	DYN	EDU	EXP	FEAS	GLS	MOB	MON		PAP	PART	PLAN	RES	
	1		1	1	1	1	3	1		4	1	6	1	
	COM		EDU	EXP	FEAS	GLS		MON			PART		RES	
	2		2	2	2	2		2			2		2	
	COM		EDU	EXP	FEAS	GLS		MON			PART		RES	
3			3	3	4	4		3			3		3	
4	COM							MON						
5	COM							MON						
2	COM	DYN	EDU	EXP	FEAS	GLS	MOB	MON	MOT		PART			
	1	2	3	1	1	1	1	1	1		2			
	COM			EXP	FEAS		MOB	MON	MOT					
4			2	2		3	3	2						
5	COM				FEAS									
3		DYN	EDU	EXP	FEAS	GLS	MOB	MON	MOT	PAP	PART			
		2	1	4	3	1	2	2	3	4	2			
			EDU			GLS	MOB	MON	MOT	PAP				
			2			2	3	3	4	6				
			EDU			GLS								
			3			4								
4	COM	DYN	EDU	EXP	FEAS	GLS	MOB	MON	MOT	PAP	PART	PLAN	RES	
	3	2	2	2	2	1	2	1	1	4	1	1	1	
	COM		EDU	EXP	FEAS	GLS	MOB	MON	MOT	PAP	PART	PLAN	RES	
4		3	3	3	4	3	2	2	5	2	2	2		
				FEAS				MON	MOT			PLAN		
				4				3	3			5		
								MON	MOT					
								4	4					

5	COM	DYN	EDU	EXP		GLS	MOB	MON	MOT	PAP	PART	PLAN	RES
	2	2	1	1		1	2	1	1	4	1	5	2
	COM		EDU			GLS	MOB	MON	MOT	PAP	PART	PLAN	
	4		2			2	3	2	2	5	2	6	
						GLS					PART		
						4					3		
6	COM	DYN	EDU	EXP	FEAS	GLS	MOB	MON	MOT	PAP	PART		RES
	3	2	2	1	2	1	1	1	1	4	1		2
	COM		EDU	EXP		GLS	MOB		MOT	PAP	PART		RES
	4		3	2		3	2		2	6	2		3
							MOB		MOT				
							3		3				
									MOT				
									4				
7	COM	DYN	EDU	EXP	FEAS	GLS	MOB	MON		PAP	PART		RES
	2	1	3	1	3	1	4	1		5	1		2
	COM	DYN		EXP	FEAS		MOB	MON		PAP	PART		
	3	2		2	4		6	3		6	2		
	COM			EXP				MON			PART		
	4			3				4			3		
	COM												
	5												
8	COM		EDU	EXP	FEAS	GLS	MOB			PAP	PART		RES
	3		3	1	2	1	3			4	1		1
	COM			EXP							PART		RES
	4			2							2		2
											PART		
											3		

COM-Communication; DYN-Dynamics; EDU-Education; EXP-Experience; FEAS-Feasibility; GLS-Goals; MOB-Mobility; MON-Monitoring; MOT-Motivation; PAP-Participative Approach; PART-Partners; PLAN-Planning; RES-Resources; POL-Policies (Van Hoye, Johnson, Geidne, Donaldson, et al., 2020).

3.1. Communication (COM)

In the communication strategy, only 2 sports clubs developed a communication plan (COM1), three created a single message, a slogan (COM2) for the intervention such as “Your safety, our priority” (Club 5), five communicate within the sports club on HP (COM3), seven communicate with the external community on HP (COM4) and three ensured communications with partners (COM5). For example, one intervention manager explained: “But it’s true, we don’t do a 4 by 3 campaign, we communicate through our website, on social networks and through doctor’s offices” (Club 2). Another stated that the first objective was to: “popularize the project within the club in a very, very local way, so well, I’m lucky enough to be able to create video or visual content quite easily, because of my professional activity, so I highlight that a little bit via the club’s Facebook and their website, we made the digital version of our handbook available for free of course, so that allowed us to communicate with the community, parents and other groups, who talked a little bit about all this, it made a little buzz internally” (Club 6). Moreover, communication is the strategy where intervention managers estimated having learned the most, because it is not part of their sport management degree: “The fact of managing the department from A to Z, yes in terms of communication, I discovered a lot of things that we don’t have in our Adapted Physical Activity (APA) training, there is no communication, marketing, partnership, there is some financial

management but, I learned about it in more detail although we had concepts” (Club 8). Only Club 1 targeted all five communication intervention components while Club 3 did not target any of these intervention components.

3.2. Dynamic (DYN)

In the dynamic strategy, one sports club worked specifically on the feeling of belonging in the club (DYN1), where seven clubs considered how the targeted public related to their social and physical environment and the community (DYN2). For example, an intervention manager explained: “it has to do with the sedentary lifestyle of these isolated or geographically segregated women, so I think that’s the number one issue, the condition, the distance they travel per day in their immediate environment, speaking of health. After that, there are all the axes added to this, the psychological, physical, mental health” (Club 7). A second intervention manager explained: “With this project, we feel useful and we give back a little bit to the community in which we work, it is a way for us to participate in a collective life” (Club 1). While Club 7 targeted both intervention components, Club 8 used none.

3.3. Education (EDU)

Among the education strategy, three sports clubs considered support for coaches to actively engage in acquiring HP skills (EDU1). Five sports clubs tailored the support they provide on HP to their coaches (EDU2). Seven sports clubs provided resources for coaches to support each other to promote health (EDU3). One intervention manager explained: “In this case, in fact, we have done more internal training, whether by sociologists, sports psychologists or sports doctors, to try to understand how a child develops and the impact that diet or lack of sleep can have” (Club 3). Three sports clubs implemented all three education intervention components.

3.4 Experience (EXP)

Six sports clubs based their interventions on the identification of previous experiences in HP (EXP1), six considered organizational readiness (EXP2), three incorporated the reasons for commitment towards HP (EXP3) and one focused on the quality of commitment (EXP4). For example, one sports club started with a health commission before launching the intervention: *“There was already a desire to bring the health side to the club, there was already a sports health commission that was created by the current general secretary and the president who are very conscious of health, because the general secretary is the former director of a rehabilitation center so he has always worked in health and the president was the vice-dean of the faculty of sport; he is now vice-president of the university. So, in fact, they already had a network by word-of-mouth, they created a commission of doctors with the idea of proposing prevention activities for the*

members" (Club 8). Another sports club based their actions on observations from the main coach: *"I've been taking care of the senior team for seven or eight years. In fact, we noticed that in our daily practice, many, many injuries could have been avoided if, in fact, there had been a message passed on beforehand, hence the idea of carrying out preventive actions to be able to pass on this message and stop having small pathologies of the sportsman on a daily basis which requires sports interruptions and penalize the teams concerned"* (Club 4). No sports club implemented all four intervention components.

3.5 Feasibility (FEAS)

Two clubs regularly reviewed financial resources used (FEAS1) and five sports clubs regularly reviewed the human resources being used (FEAS2). Four sports clubs reviewed the sports club's capacity to undertake the actions required to achieve their goals (FEAS3) and three sports clubs reviewed the time dedicated to achieving the goals (FEAS4). For example, an intervention manager explained: "We saved time, because we already made a financial commitment for 2020 - 2021, it was recorded, which was not the case last year, so the actual problem is how long we'll be able to keep two schools, if it's done in other schools, other services will be required" (Club 1). No sports club implemented all four feasibility intervention components.

3.6 Goals (GLS)

All sports clubs defined the goals of their HP intervention (GLS1), but only three were formally written (GLS2), one wrote the goals in a positive sporting language based on the sports club's culture (GLS3) and only four clubs took inclusivity into account while defining the goals (GLS4). For example, one sports club integrated the following statement into their regulations: "The purpose of the association is to contribute to the physical and cultural development of its members through the practice of football (soccer) and to create bonds of friendship and solidarity among them through the educational and social nature of this sporting activity. To initiate and/or carry out any action in favor of social integration through sport as well as in favor of the development of citizenship, civic morality, the fight against violence, respect for the environment, the fight against discrimination, incivility, health education and solidarity" (Club 5). No sports club implemented all four intervention components.

3.7. Mobilization (MOB)

Two sports clubs mobilized 'champions' for their HP interventions (MOB1). One sports club asked a professional player to give her 'tricks'; the intervention manager explained: "It's nice to say what you want, if it's not legitimized and validated by the testimony of a prominent person, a figure, personality, professional player, it will have less weight than if it's confirmed by someone who

knows what they're talking about" (Club 6). Four clubs mobilized experts in HP (MOB2) and seven identified a responsible party within the sports club (MOB3). No sports club implemented all three intervention components.

3.8. Monitoring (MON)

Six sports clubs reviewed small improvements achieving HP goals (MON1), four reviewed all HP activities undertaken by the sports club (MON2). Five clubs reviewed the short-term effects (MON3) and three reviewed the long-term effects (MON4) of the HP actions. For example, an intervention manager explained: "It's been a year since we've designated a player as a health referent, we haven't done it, and I have players who are today 17 years old and who I had when they were 13 or 14 years old, they've kept that reflex of leading the warm-ups, pre-game stretches, post-game stretches and remind the team to hydrate, so that's a great victory" (Club 4). One sports club reviewed its HP policies (MON5). One sports club implemented all five monitoring intervention component and one did not implement any. Intervention managers have difficulties finding time and may not have the competency to evaluate their intervention effectiveness, outcomes and mechanisms: "And that's something do because it's true that at the end of the season, it's always a race and I've moved on (from the project) and so we didn't capitalize too much on that, and again, I didn't want it to be like an evaluation, like it's going to be graded" (Club 6).

3.9. Motivation (MOT)

Four sports clubs fostered positive interpersonal stakeholder relationships (MOT1) to improve HP. Four clubs took coaches' skills to manage situations into account (MOT2). For example, in one sports club, the intervention manager explained that there is a specific profile to coach their players: "It's already part of the management skills. It's not so much a technical skill, since these exercises are the equivalent of what we can do with children that we will transpose to adults, but it's really the capacity for guidance and observation. To say to oneself: "Okay, I'm going to give a coordination exercise. John Doe does it well. Jane Doe can't do it, why?" And quickly think, "how do I modify the exercise?" (Club 2). Three sports clubs took coaches' motivation for coaching and future expectations into account (MOT3). Two sports clubs strengthened coaches' autonomy to promote health (MOT4). For example, an intervention manager explained: "At the beginning of the season, the first workshop was dedicated to educators, to teach them the right skills (whether on warm-ups, stretching, recovery, nutrition, physical preparation), before the age of 16, so that they, themselves, can be the relay in the field on a daily basis with the children" (Club 4). No sports club implemented all five motivation intervention components and no sports club worked on strengthening coaches' sense of ownership of the sports club (MOT5).

3.10. Participative Approach (PAP)

Although six sports clubs called attention to all HP actions when interventions were launched (PAP4) none of the clubs recognized specific actions during the intervention (PAP1-3). Three clubs highlighted how HP activities could benefit their sports club (PAP5), such as transmitting information to parents: “If you send your children to us, they will not only have a technical and tactical approach to soccer, they will also have a civic education in health and sport” (Club 4). Three clubs included managers, coaches and participants in the decision-making process (PAP6). No sports club implemented all six participative approach intervention components and one sport club did not target any of these intervention components (Club 2).

3.11. Partners (PART)

Six sports clubs identified partners for HP (PART1), starting with the question: “We want to do this, how can we get to the end of the project and what are the relative problems we might encounter? Who are the people we could ask to help us?” (Club 1). All of the clubs defined how to collaborate with existing and future partners (PART2) and four sports clubs created a common culture with their partners (PART3). Four sports clubs implemented all three intervention components in this strategy.

3.12. Planning (PLAN)

Club 4 included the core goals in its plan (PLAN1), as well as the target population (PLAN2). Two clubs included key steps in implementation plans (PLAN5) and one considered the sustainability of the HP actions (PLAN6). No sports club implemented all six planning intervention components and five did not implemented any of these intervention components. In fact, none of the clubs implemented PLAN3 to include funding sources or PLAN4 to include responsible persons in the implementation process. One intervention manager stated, that two years after the launch: “We're in the process of writing something that can be replicated, in any case, we're working on a project called ‘Fight Anti-discrimination’, in which projects like this will have an emphasis on spreading and multiplying” (Club 7).

3.13. Policies (POL)

None of the sports clubs targeted the policy strategy. In different clubs, despite the implementation of actions, policy writing and planning is still lacking. The intervention manager from Club 8 stated: “No, the statutes have not been changed, but the club's development is very health-oriented, it's very much linked to health and social issues, because the president takes this approach. And the members hear a lot about sport and health”.

3.14. Resources (RES)

Three sports clubs reviewed available financial resources (RES1) and six clubs reviewed their human resources (RES2) to invest in HP. For example, an intervention manager explained: “We are in the process of developing a financial partnership because until now, we have limited ourselves to private partnerships such as cash donations, but they are not official partners they are simply sponsors who are interested in where they invest money” (Club 3). Another explained that the life cycle of the intervention is often based on voluntary human resources: “You can see it in the balance sheets, I think there was six months or a year of hesitation, and the projects are starting up again, it's also starting up again because it's up to people, like a lot of projects. We are aware that this also raises questions about the sustainability of the project, if we both leave [the two project managers], it will be very complicated” (Club 7). Two clubs reviewed current skills and knowledge available to promote health (RES3). Club 1 implemented all three resource intervention components while two clubs did not implement any. Another intervention manager stated: “No, I don't see how it can stop, even with little means, we can do it, even if only the manual. At the end of the day, if you don't have the means, neither human nor financial, you can always involve the educators who say: You continue to develop the Federal Educational Plan” (Club 5).

4. Discussion

The diversity of sports clubs in regard to size, paid staff to undertake HP projects and type of sport (see Table I for details) has shown that implementing HP in sports clubs is feasible (Geidne et al., 2019). The present study questioned eight promising HP interventions of various sports clubs in France to understand how key strategies and intervention components of the HPSC intervention planning framework (Van Hoyer et al., 2020b) were implemented. By implementing at least 9 of the 14 evidence-driven strategies from the HPSC intervention framework (Geidne et al., 2019; Van Hoyer et al., 2020a), these sports clubs have reinforced the call of many authors highlighting that evidence of settings-based approaches within sports clubs can be found in the grey literature (Kokko, Selänne, et al., 2015). In other words, the experiential knowledge collected in the present study has filled a gap providing proof for the feasibility of the health promoting sports club approach.

In regard to sports club characteristics, a previous literature review identified limitations regarding the target population, where male team sport participants were the primary target and interventions were only implemented at the sports participant level (Geidne et al., 2019). The present work has shown a broad diversity of targeted populations (from youth to vulnerable to elderly) and implicated different levels (managers, coaches, participants), as well as including at least two partners in their interventions. These findings reinforce the hypothesis of the applicability

of the settings-based approach to sports clubs, as its key characteristics encompass multi-level and multi-strategy interventions in sports clubs (Geidne et al., 2019; Jackson et al., 2006; Van Hoyer et al., 2020b). These findings also raise question about the paucity of published studies on HPSC interventions, which could potentially be explained by the issue of a lack of measurement of health promoting sports clubs, as the impact and implementation of multi-level and multi-strategy interventions is complex to evaluate (Johnson et al., 2019). The inclusion of 4 soccer clubs among the 8 was explained by the support provided by the soccer federation and directives through the federal education project, providing guidelines for HP, as well as a specific foundation (Fondation du football) to promote sports clubs which develop social responsibility actions. This shows that having guidelines and regulations from sports federations seems to support sports clubs' engagement in HP (Meganck et al., 2015, 2016).

As interventions have demonstrated many are effective at targeting a single behavior (McFadyen et al., 2018), but the settings-based approach encourages a broader 'umbrella' approach. An encouraging result in the present work was that every sports club prioritized a specific thematic (e.g., citizenship, education) or a particular behavior (e.g. healthy eating), yet kept in mind that the HP activity was their first step to a more comprehensive, holistic and participative approach to health (Casey et al., 2009). These findings are interesting in regard to the generalization and transferability of the behavioral approach to HP in sports clubs, where focusing on a single behavior could be considered a preliminary step for the settings-based approach (Whitelaw et al., 2001). Intervention managers also expressed that their motivation was based on the idea that sports clubs have an important role to play within their communities (Misener & Misener, 2016), which aligns with the community health perspective of the settings-based model to create a social context favorable to health.

The CEKPH method was developed to collect and disseminate experiential knowledge about health promotion interventions by creating unique tools such as interview or user guides (Laurent et al., 2020). The use of the HPSC intervention framework (Van Hoyer et al., 2020b) to analyze the collected data, which aligned with the tool created by CEKPH has shown that this framework can serve as a theoretical basis for intervention mapping (Bartholomew et al., 1998) and settings-based intervention development in sports clubs, with club managers validating the classification after the interview process.

Interestingly, deepening previous findings (Van Hoyer et al., 2016b), many necessary strategies, such as education and goals, implicating written policies, implementation planning (including funding, target population, etc.), as well as evaluation are still lacking in sports clubs, but this does not refrain the actions from taking place. By considering the implemented intervention

components, the barriers previously described in the literature, such as lack of policies (Van Hoye et al., 2016b), as well as the classical sequence of project implementation in health promotion (Fertman & Allensworth, 2010) does not seem to be necessary in order to implement HPSC interventions in sports clubs. Nevertheless, longitudinal analysis on the project development and long-term effects are needed to solidify these findings.

Two key competences of intervention managers were identified as (1) being able to observe and adapt the interventions to the sports club and its targeted population (by using sports games, specific language, knowing individual life stories, understanding the institutional context of their sports club and surroundings) and (2) being able to find resources (by inviting already known voluntary expertise or by finding specific funding options or partners). Learned competencies during the individual club interventions included: communication (both internal and external), to be able to disseminate the intervention's specifics, being recognized by other sports clubs and partners and intervention application writing (to increase funding and recognition). Competences that intervention managers wanted to acquire included evaluation, to be able to produce "more objective" evaluations about their interventions, rather than informal discussions. Interestingly, and in opposition to intervention management in HP (Kokko, 2014a), sports clubs started their interventions in very different ways, some by finding a partner to provide resources, others by identifying a health problem in their sports club, while others used opportunities to offer new services. Depending on the position of intervention manager, some received only passive recognition by the board on the intervention while others were fully supported with the intervention being written into regulations and integrated into the sports club's activities. This adds to the findings of a previous study regarding manager's need for support for HP (Kokko et al., 2011). In regard to the sustainability of interventions, almost half depended on the intervention manager's involvement and availability, where the other half could be sustained with human resource changes. This is an important point because HP changes are more visible after 3 sporting seasons (Lane et al., 2020), and are a step-by-step long lasting effort for sports clubs, with human and financial resources needing to be reviewed regularly (Casey, Payne, et al., 2012). In the present work, when scheduled, each intervention manager only planned their activities for one sporting season and reproduced and/or enhanced from one season to the next (Kokko et al., 2016). Although the interviews were undertaken with intervention managers, other sports club actors could give insight into the planning and implementation process. While the present study embraces the diversity of sports clubs, it was not possible to allocate the difference in strategy implementation to sports clubs' characteristics, such as size, type of sport or other contextual variables; future quantitative research is needed for this aim.

5. Conclusions

The present work highlighted the usability of the HPSC intervention framework (Van Hoyer et al., 2020b) to document strategies and intervention components of promising HP interventions in French sports clubs. Among the 14 evidence-driven strategies, 13 were implemented in sports clubs (min = 9; max = 12). Policies were not targeted by any of the interventions. An important take-away from this study is that sports clubs varied their use and order of implementing chosen strategies, some intervention managers even reversed the order and finished with writing the project objectives and planning after having implemented it and having found and consulted partners. Some projects did not even include written objectives or prior planning. Key competencies of HP intervention managers have been identified as: (1) a deep understanding of the public and environment, (2) a high capacity to mobilize internal and external human resources, (3) communication skills and (4) grant writing application skills. This research takes a bottom-up approach by learning from HP activities already implemented in sports clubs to expand knowledge on evidence-driven strategies applied within the HPSC intervention planning framework (Van Hoyer et al., 2020b). Practical implications include (1) the applicability of the strategies and intervention components by sports clubs, in the order they find suitable to their needs to develop a HPSC, (2) the support or training sport or health actors can provide on key competencies or the attention given during recruitment of managers in regard to these competencies and (3) the provision of full CEKHP reports (Laurent et al., 2020) from sports clubs on request.

4.3 Analysis & considerations

The bottom-up approach can add many advantages throughout the intervention process as it enriches the intervention with novel ideas, multiple perspectives and helps to avoid past mistakes and pitfalls. In fact, intervention mapping pushes the idea of including as many participants along the different steps (designing, planning, delivery, evaluation) as possible (Bartholomew Eldredge et al., 2016; Kok et al., 2017). Additionally, receiving stakeholder feedback helps with the success (Poland et al., 2009) of a project by obtaining their acceptance and active participation. Therefore, researchers are becoming more inclined to co-construct health promotion interventions with stakeholders rather than designing and delivering an intervention without their input (Fernandez, ten Hoor, et al., 2019; Kok et al., 2017; Peters et al., 2009; Rousseau et al., 2019). Health promotion interventions have been developed and successfully implemented into other settings such as universities (Dooris et al., 2014) by ensuring stakeholders were involved in the planning and implementation steps (Suárez-Reyes & Van den Broucke, 2016).

Through the capitalization study, several key take-aways were discovered: 1) without guidance, intervention managers in sports clubs are often inept at designing interventions, 2) they

rarely set goals or objectives for their interventions, 3) they have little experience planning health promotion projects 4) intervention managers rarely evaluate the process of implementing the project or the outcomes and 5) they lack understanding of how the various parts of an intervention work together. For example, the intervention managers in study 6 did not consider how the project affects the multiple levels of the sports club or the health determinants, but they rather focused on how the project affects the behaviors of the participants. As has been previously noted, many sports club interventions focus on one health behavior (Giles-Corti et al., 2001; Fuller et al., 2011; Geidne et al., 2013a) or one target audience and rarely implement the setting-based approach with a theoretical model or framework (Geidne et al., 2019). Using a theoretical model could help them target specific levels and set objectives for their project. Because intervention managers are typically someone from within the sports club, they lack training to go through the various steps of intervention implementation (Fernandez, ten Hoor, et al., 2019). They often had an idea that “something should be done” or have seen a project carried out in another club and decided to mimic the project. The planning and implementation were carried out without a proper understanding of the organization of their sports club (levels) or the needs and expectations of the club’s members or staff. Rather than using a framework, most clubs just came up with an idea and started the project and “found partners along the way” without a needs assessment or guidance. Several managers explained that it was a project they implemented previously in another club or a successful project they ‘borrowed’ from an affiliated club. In rare instances, the intervention manager recognized a need they saw in their players. But again, this was based on their assumption without player collaboration or considering how the project could affect other levels of the sports club. In addition, evaluation is rarely carried out in this setting to see if the project made any changes to the organization or individual behaviors; partly because they are not trained on evaluation methods.

Another eye-opening finding was that none of the interviewed clubs have formal written policies related to promoting health. Policies are a core principle in health promotion (Priest et al., 2008a) yet both this study and study 4 demonstrate a lack of understanding as to their importance. Which brings into question the results from responses to the e-PROSCeSS questionnaire validation (study 2) regarding health promotion policies within sports clubs. When prompted by this question, most respondents said ‘yes’ their sport club has policies, rules and regulations for promoting health and their coach ‘follows these policies’. These findings further showing the need for better implementation of communication strategies, so stakeholders are aware of the actual club policies. Respondents could be assuming that the sports club has health promotion policies

based on their 'myth of healthism' that: if it is a sports club, it would only make sense that they have policies to promote health.

The data compiled from study 6 shows how sports clubs have already operationalized most of the evidence-driven strategies when planning and implementing health promotion actions without an evidence-driven framework or including stakeholders in the process. With this in mind, Study 6 offers more answers to research question two: '*What strategies can and already have been used to promote health in sports clubs?*'. This offers clubs experience-based knowledge (Hohmann & Shear, 2002; Laurent et al., 2020).

To add strength to this study, capitalizing on the experiences from sports clubs outside of France could add additional perspectives. Learning from some of the successful programs already implemented, such as the 'Healthy Club Project' in Ireland (Lane et al., 2017) and the 'Good Sports Program' in Australia (Gonzalez et al., 2020) would broaden the knowledge base for other sports clubs to use as positive examples to link the theory created by the HPSC approach with practice (Poland et al., 2000). Additionally, the gap of policies and planning discovered during interviews with intervention managers needs to be explored to discover if the sports club has the capacity to draft their own policies or if most policies come from the top-down such as through sports federations or government sports ministries.

4.4 Practical implications

The capitalization interview guide was originally created in French and has been translated into English (see supplementary file 8). Once the interviews were transcribed and validated by the intervention managers, identity cards were created for all 8 sports clubs as examples for other sports clubs (see supplementary file 9). Because the capitalized clubs were all French, the identity cards have currently been designed in French only. They include useful information such as the sports club's theme linked to health promotion along with the objectives of the project. To give other sports clubs a working example, each identity card also discusses the target audience, financial and partner resources, strategies used to implement the project, where the project was undertaken (in the club, school, partner associations, etc.), actions used, limitations and the methods of evaluation. Identity cards also take into consideration how the projects address the Ottawa Charter (World Health Organization, 1986) and more specific to this thesis, how the project fits in with the HPSC approach by applying the theoretical model with the 13 strategies.



CHAPTER 5: DISCUSSION AND CONCLUSIONS

"Enough research will tend to support your conclusions"

...Arthur Bloch, American author

5.1 General discussion

The concept of health is multi-faceted and influenced by a multitude of factors which are individually and socially driven often interacting with each other (Dooris et al., 2014; Scriven & Garman, 2007) to strengthen or weaken health. Likewise, health issues can be brought on by decisions people make such as poor food choices, lack of physical activity and negative personal habits (alcohol abuse, tobacco) to name a few (Bailey et al., 2015). Often, these are the easy options such as using personal vehicles rather than active transportation, taking an elevator rather than climbing stairs or eating prepackaged foods instead of taking the time to prepare meals, all of these potentially leading to decreases in physical, social and mental health (Booth et al., 2009). Therefore, giving people the capacity to increase control over their own health has been a push by health promotion advocates since the 1986 Ottawa Charter (World Health Organization, 1986). One notable way this can be accomplished is by working on the various settings in which people spend their time. As was established throughout this thesis, organized sports clubs can be an excellent setting to support the health and well-being of sports participants and extends beyond to all stakeholders (managers, coaches, volunteers, family, etc.). Although work has previously been carried out on sports clubs (Geidne et al., 2013b; Kokko, 2014b), the whole setting had yet to be fully developed. As noted, many sports club interventions focus on one health behavior or one target audience and rarely implement the setting-based approach with a theoretical model or framework (Geidne et al., 2019) which helps to guide the planning, implementation and evaluation of projects. To develop the sports club as a viable setting, the research gaps were first identified: 1) no internationally validated measurement tool, 2) no model in which to build an intervention framework, 3) no concrete strategies to guide sports clubs when planning or implementing health promotion projects and) no direct collaboration with sports club actors. With this in mind, this thesis took an iterative approach with the vision of developing sports clubs as settings to promote health guided by the intervention mapping process. Using the intervention mapping protocol requires a complete understating of the issue and context (Bartholomew Eldredge et al., 2016; Rousseau et al., 2019). In the case of this thesis, we needed to 1) understand the setting, 2) be abreast of the current state of research done within sports clubs, 3) establish the present condition of health promotion within this setting, 4) identify the stakeholders, 5) determine the needs of the setting and stakeholders, 6) discover the expectations and capacity of the stakeholders, 7) fill the gaps in research and knowledge and 8) brainstorm potential solutions. In order fill the gaps and progress the HPSC vision, the studies in this thesis filled these gaps by: 1) creating and validating the e-PROSCeSS questionnaire, 2) developing the HPSC model, 3) formulating strategies to create the HPSC intervention planning framework, 4) partnering with various sports club stakeholders to take

into account their needs and expectations and 5) providing examples to sports clubs looking to implement the HPSC approach. Each of the six studies conducted during the PROSCeSS project added to the qualitative and quantitative data collected through the participation from researchers, academics, field experts and sports club actors. These stakeholders were called upon at various times during the studies to add to the quality and knowledge base of the research. The collection of studies compiled to build the HPSC approach and the process sports clubs take to become an HPSC can be viewed from the stance of intervention mapping to provide a practical application tool for more impactful research, development and ultimately, intervention adoption and success (Fernandez, ten Hoor, et al., 2019).

5.1.1 The HPSC approach through the lens of intervention mapping

Intervention mapping has been used in health promotion intervention planning for more than 20 years. It is widely used in psychological and social sciences such as strategy development for implementation (Fernandez, ten Hoor, et al., 2019), intervention development in the health education field (Bartholomew et al., 1998) and psychological therapy programs (Haeyen et al., 2018). Although the predominant use has been with project development leaving out many of the other steps in the protocol for intervention mapping. The protocol provides the ‘how-to’ component for stakeholders, giving them a road-map for including participation, assessing needs, designing an intervention, implementing the intervention, communicating the action plan and evaluating every step along the way. Realistic strategies are used to enhance “adoption, implementation and sustainability” of health promotion projects which helps with overcoming barriers (Michie et al., 2011; Proctor et al., 2013) to planning and implementation. While it is usually used to elicit individual behavior change, many elements translate to the settings-based approach. Intervention mapping supports the socio-ecological approach wherein behavior is both a function of the individual and the physical, social and organizational setting where people live (Marmot, 2000). Intervention science asserts that advantages of rooting interventions in a theoretical settings-based model (Fernandez, ten Hoor, et al., 2019; Glanz & Bishop, 2010). In their 2017 article, Kok and colleagues propose that intervention mapping has three characteristics: 1) it is based on the socio-ecological approach, 2) it combines theory with evidence and practical knowledge and 3) it encourages the participative approach (Kok et al., 2017) to ensure relevance, acceptability, contextual and cultural appropriateness to facilitate the implementation process. Although the intervention mapping protocol was not carried out sequentially within the PROSCeSS project, it is clear how each step built upon the previous in order to provide sports clubs with the ability to implement the protocol within their club. This thesis embodies these primary characteristics: 1) the HPSC model is based on the socio-ecological approach linking individuals with their

environment (Booth et al., 2000; Dahlgren & Whitehead, 2007), 2) the model and framework were theoretically designed based on previous evidence from the field (Geidne et al., 2019) and learned knowledge from the studies and 3) participation from sports club stakeholders was paramount in all of the stages. Although previous work has been done on sports clubs (Geidne et al., 2013b; Kokko, 2014b), the whole setting had yet to be fully developed. Intervention mapping calls for an iterative approach rather than linear (Bartholomew Eldredge et al., 2016; Heaney, 1998), the work completed in this thesis embodies this sentiment by repeatedly revisiting and refining steps and considering alternative methods to broaden the knowledge base. Rather than a linear approach, the same process should be taken when a sports club uses the HPSC approach to develop and implement regular health promotion actions. The HPSC approach is a vision of how sports clubs can innovate to include health promotion actions within all their policies and daily actions rather than simply considering an intervention as a one-time occurrence. Although the goal of this thesis was not to design and pilot a specific intervention, but rather to provide the theoretical processes and evidence-base behind an intervention to render it more effective (Peters et al., 2009). Superimposing the six-step process that intervention mapping recommends onto the PROSCeSS project, gives an idea of how critical it is to revisit and revise during intervention planning, design and implementation rather than taking a straightforward approach. Prime examples throughout this thesis include: 1) the HPSC model definitions were redefined based on increased knowledge to operationalize it in the field, 2) evidence-driven strategies and intervention components were revised several times to improve formulation and add data provided by sports club actors (coaches and managers), rendering the framework more useful by end-users, 3) items from the Delphi study (study1) were refined during the cognitive interviews during the e-PROSCeSS validation based on suggestions from respondents. These are not only examples of the iterative approach taken, but also demonstrate how participation from different actors in the sporting world helped to mold the HPSC approach. Intervention mapping weighs heavily on the participation from stakeholders at every step in an intervention, not only the planning and implementation, but also in how the intervention is developed and evaluated (Kok et al., 2017). Thus, at each stage in building the HPSC approach, to take a step forward, the research team looked back to ensure the knowledge and needs were regularly updated.

The first step in the intervention mapping protocol calls for a participant group to assess a problem and set goals to address this issue (Kok et al., 2017). The original recommendation is to use the PRECEDE-PROCEDE model (Bartholomew et al., 1998; Green et al., 2005). As was mentioned in the theoretical background, this model is not as useful when applying it to the settings-based approach as it does not take into consideration the interactions of different levels

and health determinants (Dooris, 2006; Skyttner, 2001) and the dynamic, open system (Paton, 2005) that characterize sports clubs. Developing a settings-based approach is not simply about defining a problem but involves stakeholders from within and outside the sports club to identify their current state of health promotion and assess the capacity of the club to innovate in order to incorporate health promotion in their policies and daily actions. The first tenant of intervention mapping calls for rooting the intervention in the socio-ecological approach (Kok et al., 2017). Therefore, a multi-level theoretical HPSC model was created with the input from multiple sports club stakeholders, academics, sport science students and members from research committees (CNOSF, EHESP, IREPS), which formed the 'participant group'. The HPSC approach is based on a theoretical sports club model first developed from the concept used in study 1, then defining definitions of the internal levels and health determinants in study 3 and finally redefining internal and adding the external levels and health determinants in study 5. Through the participative approach, the HPSC model went through multiple iterations based on their feedback. Many stakeholders were identified (those who can make the decisions) at different levels (coaches, managers, government, etc.) by their input, but less emphasis was placed on the individual and their immediate interpersonal surroundings (parents, partners, etc.). Identifying stakeholders was much broader than originally planned. For example, during the focus groups, participants added their knowledge by highlighting how external levels can be considered stakeholders and impact sports clubs, leading to the addition of 3 new external levels (sports federations, public health actors, government authorities) defined in study 5. Keeping in line with the socio-ecological model of health (Booth et al., 2009), the individual level was added. From the intervention mapping process, after the model is decided upon, the first step a sports club would take is deciding to become an HPSC. Then a project team is assembled with internal sports club members (managers, coaches, volunteers, parents) and external stakeholders (community members, club affiliates, public health advocates) who have a shared interest in implementing the HPSC vision (Lane et al., 2020; Leventon et al., 2016). For example, the project team went through multiple iterations of the HPSC model to define the levels and health determinants including the addition of several new levels based on their feedback. The final definitions of each level and corresponding health determinants can be seen in Table 2.

Table 2. Internal & external sports club levels and health determinants

Internal sports club levels		
Individual	Participants' (e.g. athletes, parents) personal characteristics and behaviors in terms of physical, mental and social health	First identified in study 3 and defined in 5
Economic	The way in which participants' (e.g. athletes, parents) benefit from human and material resources and financial support of their sports club	Defined in study 5
Environmental	The way in which participants' (e.g. athletes, parents) feel supported and safe in their club's surroundings and infrastructures	Defined in study 5
Organizational	The way in which participants' (e.g. athletes, parents) know about, adopt and act according to the sports club's health promotion policies provided by their coach	Defined in study 5
Social	Participants' (e.g. athletes, parents) sense of belonging to and engagement with the sport club and the way in which they know about, adopt and act according to the club's philosophies and concepts of health	Defined in study 5
Macro level	The sports club's policies and operational regulations regarding health promotion	First defined in study 1, redefined in study 3 and 5
Economic	The allocation of human, material and financial resources for health promotion within sports the sports club	First defined in study 1, redefined in study 3 and 5
Environmental	The built surroundings provided by the sports club infrastructures, green spaces and playing fields	First defined in study 1, redefined in study 3 and 5
Organizational	The position of health promotion in the sports club's guidelines, rules, organization (including partners) and planning	First defined as 'cultural' in study 1, redefined in study 3 and 5

Social	to the vision, values and philosophy of the sports club in relation to those of society	First defined in study 1, redefined in study 3 and 5
Meso level	The guidance and support given to coaches and staff (including volunteers) by sports club management and directors	First defined in study 1, redefined in study 3 and 5
Economic	Management's allocation of human, material and financial resources given to coaches for health promotion implementation	First defined in study 1, redefined in study 3 and 5
Environmental	Management's supervision of surroundings and infrastructures to promote supportive and safe spaces	First defined in study 1, redefined in study 3 and 5
Organizational	Management's guidance of the coaches and staff to uphold the health promotion policies, education and hiring practices	First defined in study 1 as 'cultural', redefined in study 3 and 5
Social	Management's endorsement and communication of the club's vision, philosophy and values regarding health promotion	First defined in study 1, redefined in study 3 and 5
Micro level	The health promotion activities and support given to participants by the coaches	First defined in study 1, redefined in study 3 and 5
Economic	The coaches' use of human, material and financial resources to implement health promotion actions	First defined in study 1, redefined in study 3 and 5
Environmental	The coaches' request for and use of supportive and safe practices, surroundings and infrastructures	First defined in study 1, redefined in study 3 and 5
Organizational	The coaches' implementation of health promotion policies	First defined as 'cultural' in study 1, redefined in study 3 and 5
Social	The coaches' awareness and endorsement to the club's philosophies and concepts of health promotion	First defined in study 1, redefined in study 3 and 5

External sports club levels		
Sports Federations	The sports federation's policies, regulations and support given to affiliated sports clubs to implement health promotion	First identified in study 3 and defined in study 5
Economic	The financial, material and human resources provided by federations to affiliated sports clubs	Defined in study 5
Environmental	Sports federations' support for safe, supportive and sustainable infrastructures green spaces and playing fields provided to affiliated sports club	Defined in study 5
Organizational	The federation's guidelines including policies, rules and regulations provided to affiliated sports clubs	Defined in study 5
Social	The vision, values and philosophy of the federation in relation to those of society	Defined in study 5
Public Health Actors	Public health actors' guidance and support for the development of health promotion within sports clubs	Identified as '2 nd line actors' in study 3 and separated into 2 levels and defined in study 5
Economic	The financial, material and human resources provided by public health actors to sports federations and sports clubs to promote health	Defined in study 5
Environmental	Public health actors' guidance and support to create sustainable, safe and supportive infrastructures, green spaces and playing fields	Defined in study 5
Organizational	Public health guidelines including policies, rules and regulations which support health promotion in sports clubs	Defined in study 5
Social	Public health actors' vision, values, and philosophies in relation to those of society	Defined in study 5

Government Authorities	Government led support at the national through to the local levels to invest in health promotion within sports clubs	Identified as '2 nd line actors' in study 3 and separated into 2 levels and defined in study 5
Economic	The financial, material and human resources provided by government authorities for sports clubs to promote health	Defined in study 5
Environmental	Government's guidance and support to provide sports clubs with sustainable, safe and supportive infrastructures, green spaces and playing fields	Defined in study 5
Organizational	Government guidelines including policies, rules and regulations which support health promotion in sports clubs	Defined in study 5
Social	Government's values, vision and philosophies in relation to those of society	Defined in study 5

The second step in the intervention mapping protocol employs a logic model to identify objectives and outcomes; it is essentially a description of the planning and implementation process with an impact assessment (Kok et al., 2017). A logic model was created based on the HPSC approach with inputs needed, activities to complete and outputs produced to help sports clubs with the intervention process (see Figure 11, Chapter 5.1.3). Step two begins with a needs assessment to help guide the sports club to set objectives. As was discovered during the capitalization interviews (study 6) most sports clubs rarely undertake this step choosing to implement a project based on an intervention manager's idea, previous success from within their club or project success from an affiliated club. Applying this intervention mapping step to the PROSCeSS project, provided sports clubs with a tool to identify needs based on sports club actors' perceptions of health promotion actions within their club. This intervention mapping step supported the objectives of the first two studies. While study 1 developed the premier version of the e-PROSCeSS questionnaire through expert participation; through the validation process, study 2 brought the knowledge that many sports club stakeholders do not understand the concept of 'health promotion' or how the 'environment', as a determinant, contributes to their health. Similar

results have been shown in previous studies (Kokko et al., 2006; Van Hoye et al., 2015) therefore, the research team discussed the need to explore this specific health determinant in more detail. Through the participative approach, the questionnaire was adapted at each level to render it more understandable, which brings up the notion that a second Delphi study might be warranted in order to add items from a bottom-up approach. This study also suggested that health promotion may be implicit within this setting making it difficult to measure which was further confirmed by the high ceiling effects from the questionnaire respondents. When applying the intervention mapping steps to sports clubs, a needs assessment can be done by an initial administration of the validated e-PROSCeSS questionnaire (study 2) in order to target specific sports club levels and health determinants. Although not mandatory, the results can be analyzed to provide the club with feedback of sports club actors' perceptions to give pre-project data to be used for later evaluation. The logic model includes assumptions and external factors. Careful attention should be given to these such as new national or regional policies, which can affect the intervention at multiple stages. The final component of the logic model includes an impact assessment which should include short, intermediate and long-term objectives with a project evaluation. In order to assess the success of a health promotion project, both outcomes and processes need to be evaluated (Nutbeam, 1998a). In terms of the PROSCeSS project, each of the developed theories need to be tested and evaluated in grass-roots sports clubs. An evaluation method has yet to be developed for testing the theoretical processes used to create a HPSC. In relation to sports club's use of the HPSC approach, when designing a project, stakeholders need to decide upon evaluation methods which remains a current gap in research. Although we have the e-PROSCeSS questionnaire, it is purely subjective. There is the question of using a purely subjective tool to measure objective changes in the organizational capacity to innovate and promote health in a broader sense. An objective way to measure the health outcomes of stakeholders due to the health promotion actions of the sports club needs to be designed to demonstrate success. Additionally, a proper evaluation of the change in the organizational development of the sports club should be developed, for example, has there been a significant difference in applying the health determinants within the setting (is the environment notably safer, more welcoming; have more financial resources been spent on promoting health; are all participants included during practices and competitions, etc.?). By the end of this step, there should be a shared understanding of the objectives, development, delivery and evaluation process by the stakeholders (Rousseau et al., 2019). To date, this logic model has not been externally validated or tested in the sports club setting.

Step three calls for an intervention to be designed by matching the behavior change methods to certain determinants (Kok et al., 2017). Often this step is the most difficult and poses

the most challenges (Rousseau et al., 2019), especially when intervention planning is new. Comparing this to the HPSC framework (studies 3 & 5), each intervention component, derived from the strategies, is matched to certain health determinants and then linked to the various sports club levels. This gives intervention managers a wide array of options but also helps with targeting their goals. Kok also insists on participation from stakeholders at every step in an intervention (Kok et al., 2017) especially during the design and implementation process. By including stakeholders the pool of knowledge, skills and experience is increased (Bartholomew Eldredge et al., 2016), not only in the planning and creation but also in development, implementation and evaluation. When creating the HPSC intervention planning framework (study 3), the PROSCeSS project has relied upon participation from sports actors, focus groups, academics and public health experts. The framework is based on theoretical constructs, such as sports club levels, strategies and ICs. The levels have been used to select the different components to include when designing flexible interventions based on a sports club's needs and goals from step 2. Together these constructs provide a framework with defined guidelines and indicators which help direct policies, practice and future research (Dooris et al., 2014).

Step four in the intervention planning protocol is the actual production of the intervention or project. The health promotion intervention should be produced based on the needs assessment from step 2 and participation from all stakeholders involved. The PROSCeSS project provided the means for sports clubs to produce a customized intervention. Choosing strategies to structure the intervention should include participation from those who are partnering with the sports club to deliver resources, those who are delivering the intervention and those who the intervention will impact. The identified strategies must be implemented across multiple sectors as was demonstrated during studies 3, 4 and 5. This again calls for the participative approach which may be most important in this step to get acceptance and adherence (Kelly et al., 2007; Poland et al., 2000; World Health Organization, 2015). The individual level is a vital group to include in the final intervention creation. Including people from all these areas gives a broader picture of the influencers favoring a more valuable context for interventions (Bartholomew et al., 1998). Applying the HPSC framework gives sports club actors strategies to enhance “adoption, implementation and sustainability” to help with overcoming barriers (Michie et al., 2011; Proctor et al., 2013) such as lack of training or resources.

Step five could be termed the ‘action’ or ‘communication’ plan. Once the intervention strategies have been decided upon, an action plan needs to be developed and communicated to all stakeholders. Included in the HPSC framework is a specific strategy regarding communication. This strategy specifically stresses the importance of communicating health promotion actions to

those who are impacted within the sports club. Communication was reiterated again during study 4 with the discovery that realization that most sports clubs lack formal planning methods and policies, and therefore need communication to organize and facilitate a successful project. Providing a framework can lead to progress but without communication, dissemination and support including political commitment, sports clubs will have a difficult time making the organizational change needed to be considered an HPSC. Although not considered previously, social marketing can be used as an approach to communicate ideas which lead to “positive behavior change and socially desirable goals” (Kotler & Zaltman, 1971). This type of communication ‘marketing’ can be done in terms of targeting sports club stakeholders, communicating the intervention plan, promoting multiple healthy behaviors (i.e. doping prevention, social inclusion, health nutrition, injury prevention) and ensuring messages are relevant and motivating (Donovan, 2011).

The final step is an evaluation plan based on varied methods (Kok et al., 2017) to analyze the effectiveness of the intervention. Although, planning evaluation methods should start during the needs assessment (iterative approach) and continue through the entire planning and implementation phases of the health promotion intervention. The current methods of research makes it difficult to measure the settings-based approach to health promotion (Dooris, 2006). Throughout our research, both qualitative and quantitative data collection and evaluation methods were applied (Steckler et al., 1992) through questionnaire design (study 1) and validation (study 2), focus groups (studies 3 & 5), online brainstorming (study 4) interviews (studies 2 & 6), and planning and follow-up committee meetings (all 6 studies). For example, the validation process (study 2) used qualitative methods during cognitive clarity interviews and quantitative data analysis for SEM, concept mapping (study 4) required qualitative data collection during on-line brainstorming sessions and quantitative analysis to importance and feasibility rating, while building the HPSC framework (studies 3 and 5) primarily relied on focus groups and committee meetings to validate formulations and classifications of intervention components applying a purely qualitative approach. Similar processes are undertaken when designing questionnaires often employing focus groups or Delphi methods to formulate items and quantifying the items through analytical methods such as Likert-scale ratings for importance (Lehmann et al., 2014). These processes were employed throughout the different studies leading to a better understanding and evaluation of the findings. In order to understand the impact, the intervention has on the club’s stakeholders and the wider community, evaluating the process (planning, design, implementation) and outcomes (short, intermediate, long-term) is necessary. Evaluation includes assessing the

strategies which have been adopted by club, the social impact in which the intervention had on the stakeholders and the sustainability and replicability of the intervention for the future.

Combined, these six studies closely follow the intervention mapping protocol (Kok et al., 2017) both during the PROSCeSS project as well as when sports clubs undertake the HPSC approach. The studies map health promotion interventions by providing the 'how-to' component for sports club stakeholders. Figure 10 shows how research, experiences and planning amalgamate to contribute to the collected data in this thesis and how a sports club can use this information to become an HPSC. Simply put, an intervention manager would first administer and use responses from the e-PROSCeSS questionnaire to determine current perceptions of health promotion actions within their sports club. Then, based on their health promotion objectives and responses to the questionnaire, the intervention manager would target specific sports club levels and or health determinants depending on goals and needs. The intervention manager can choose to target one or multiple levels and determinants. The intervention planning framework will guide them as to which strategies and ICs are best suited to target their reported needs in order to create a health promotion project. They can also refer to the capitalization identity cards for real-world examples of how to deploy their chosen strategies. The proposed health promotion intervention needs to be communicated to all stakeholders via an action plan. Once they have undertaken this process, the intervention should be regularly evaluated on a short-term, intermediate and long-term basis. During the premier evaluation, the intervention manager should refer to the 5 indicators (study 3) to becoming an HPSC to ensure they are on track and adjust where needed.

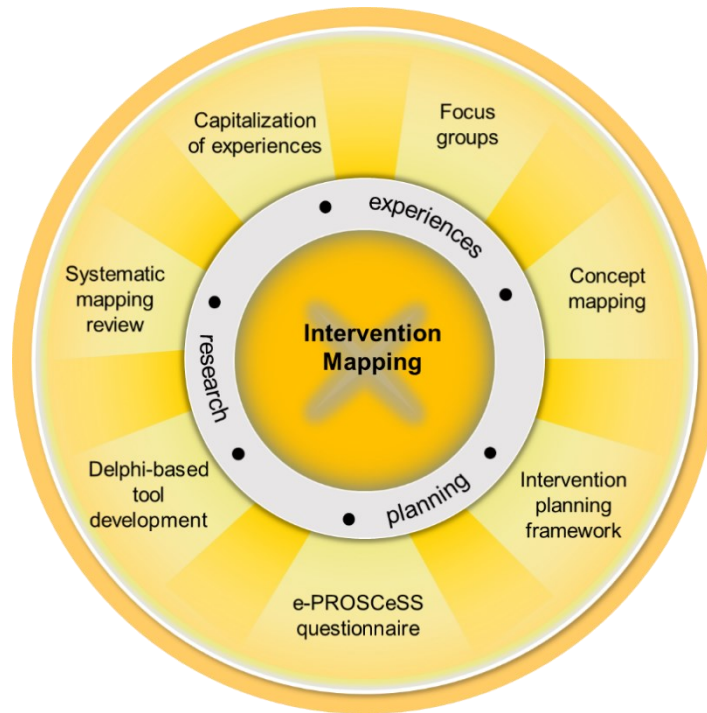


Figure 10. Intervention mapping

5.1.2 5-stage approach

Currently, there is a divergent thought process on exactly what it means to be an HPSC, with many focused on increasing physical activity. The newer vision rethinks the HPSC to provide a much broader focus than those currently being undertaken, such as HEPA or SCforH. It requires a sports club to embed health promotion actions into the setting and sustain these actions (Poland et al., 2000). The various types of health promotion focusing on sports clubs could be considered as stages, with the HPSC approach being the capstone. It requires a sports club to build capacity and make organizational change in order to properly implement the approach. A distinctive characteristic of the HPSC approach is that when applied, sports clubs consider physical, social and mental health when drafting and implementing their policies but also promote health in all their daily actions. This focus on “health in all policies, which calls for leaders in all sectors to improve health” by including policies which put health at the forefront of an organization and their stakeholders, has been around for over 10 years (World Health Organization & South Australia, 2010). Including policies on health in the sports club context, establishes sports clubs as a setting

for health promotion in-line with the Ottawa Charter directives (World Health Organization, 1986). The HPSC goes further than just writing policies, it also highlights the importance of including health factors in the daily actions of the sports club. While many interventions focus on one type of health behavior (Donaldson et al., 2018) or direct health promotion actions toward sports participants (Geidne et al., 2019; Kokko, 2014a), the HPSC takes a broader view, focusing on all stakeholders and partners potentially impacted by the sports club and includes four health determinants. Including health promotion within the sports club can be viewed in 'stages' from the simplest, physical activity opportunities (HEPA), to the more complex (HPSC), requiring organizational change. For example, just before the final stage, sports club-based health promotion is an avenue through which clubs can fully embrace the HPSC approach and increase their relevance in communities by developing a relationship between the club and the health of the club's stakeholders (Misener & Misener, 2016). The HPSC approach is the most inclusive of all 5 types of health promotion actions within sports clubs (see Table 3). This approach is similar to that of Whitelaw and colleagues in 2001 which begins with a more "passive model" placing solutions to health at an individual level, through to a "comprehensive/structural model" which views the setting as the viable solution to health (Whitelaw et al., 2001).

Table 3. 5-stage approach to HPSC

Stage	Types	Characteristics	Basis
1	Health-enhancing physical activity (HEPA)	Develop physical activity for all and enhance the core business of clubs to create more physical activity opportunities	Based on increasing physical activity
2	Sports clubs for health (SCforH)	Acknowledge all the benefits of sports practice (diversity of sport, diversity of outcomes, etc.)	Based on the benefits of practicing a particular sport
3	Health promotion in sports clubs	Sporadic sports club-based health promotion activities (e.g. healthy eating, conferences, charitable events)	Based on a one-time health promotion activity (may reoccur every year)
4	Sports club-based health promotion	Programs or activities developed by sports clubs to promote health and make the setting more health oriented	Based on a single permanent program or activity developed within the sports club
5	Health promoting sports clubs (HPSC)	Multiple health topics are incorporated into all sports club activities and written into all policies	Based on organizational change to incorporate health promotion into daily sports club actions

5.1.3 The HPSC Logic Model

Health promoting sports clubs evolve over time. This evolution is structured into several phases according to an understandable, iterative Logic Model (Peterson et al., 2013). This process begins with deciding upon the **objectives** of the sports clubs. Objectives should take into account several elements: 1) the needs and expectations of the club's stakeholders, 2) the current situation of club, 3) the capacity and readiness of the sports club, 4) the club's priorities and 5) the vision and values of the sports club related to promoting health. Once these are decided upon, **inputs** must be determined; what must be invested for the project realization such as time, human and material

resources. The **activities** (what is done) are then directly linked to the **outputs** (who is reached). The overarching **impact** can be assessed through the **outcomes** on a short-term (one sporting season), mid-term (between 1-3 years) and long-term basis (+3 years). To verify that the process is on track, **evaluation** measures should be continuous and present during each step. This allows the sports club to make any needed adjustments along the way to ensure proper implementation and expected/desired results. During each phase of the health promotion project, it should be noted that various influences can affect the phases such as environmental factors, structural/organizational changes or governmental reforms, hence why evaluation is an on-going process. Evaluating periodically also allows for adjustments in unforeseen circumstances.

When properly implemented, all of the above elements lead to a positive impact towards developing and increasing health promotion activities within the various levels of sports clubs. The logic model is structured to enable the sports club's health promotion liaison to monitor all aspects of the project. It is framed with the knowledge that sports clubs vary across countries and regions. Thus, this logic model (Figure 11) was constructed to be clear and cognizant of those differences.

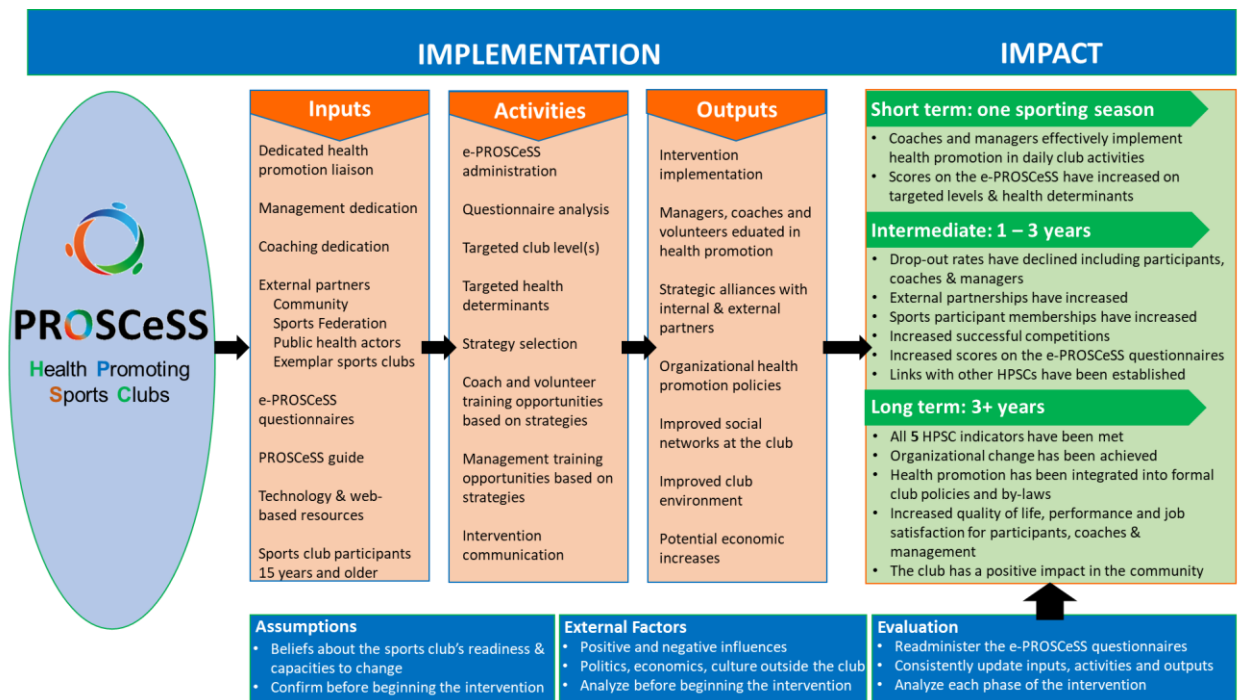


Figure 11. The HPSC Logic Model

5.2 Development of the HPSC approach compared to HPS

Because people live in multiple settings, all aspects of the settings they frequent can impact their health and well-being. Recently, there has been a push for intersectoral collaboration for health promotion policies such as partnerships between schools and sports clubs. Many sports clubs have the same benefactors as schools being situated in the same community therefore, the two settings can and should complement each other with their health promotion actions and messages (Turunen et al., 2017). From this perspective, it makes sense to compare the work done on HPSC with the established Health Promoting Schools (HPS) conceptual framework (Bada et al., 2019) to see the complementary nature of the setting-based approach within sports clubs and schools. Correlations are numerous with a similar pattern of logic between the development of HPS and HPSC. They are both based on the 1986 Ottawa Charter for Health Promotion (World Health Organization, 1986) and recognize the importance of creating a supportive network, including the partners and taking a whole-systems approach toward promoting health in their respective setting. The HPS asserts that “healthy students learn better and healthy teachers work better” (Schools for Health in Europe, 2014) which supports the idea that health promotion within an organization has benefits at multiple levels, drawing correlations between students and sports participants and teachers with sports coaches. Additionally, benefits can be seen with other administrative staff at schools similar to volunteers, managers and other actors within the sports club.

HPS primarily focus on the social and environmental determinants (Turunen et al., 2017) but also stress the importance of including health promotion policies and impacting the wider community. They include five core values: equity, sustainability, inclusion, empowerment and democracy. These core values are supported by five pillars: a whole-school approach, school quality, evidence-based, involvement of a network of schools and partnering with the surrounding community (Turunen et al., 2017). The values and pillars align closely with the 5 HPSC indicators. The European Health Promoting Schools includes 8 standards broken down into implementation components (Samdal & Rowling, 2011) similar to the 13 strategies and 69 intervention components which guide HPSCs. The standards correspond to different stages of HPS policies, strategy planning, implementation and evaluation which are further accompanied by indicators specific to each standard (Bada et al., 2019). These indicators provide schools a systematic way to rate their efforts for improving the health and well-being of stakeholders. An additional evaluation form was created called the HPS Monitoring Questionnaire which targets students. The goal is to understand students’ perceptions about their school in relation to the school’s health promotion activities (Struthers et al., 2016). Although similar to the e-PROSCeSS questionnaire created for sports clubs, the HPS Monitoring Questionnaire only measures perceptions at one

level (students) rather than getting a broad sense of all actors impacted by health promotion actions within the setting (principals, teachers, administrative staff, etc.). Research done on HPS acknowledges that teacher's commitment to health promotion is enhanced by taking their perspectives and needs into account when asking them to consider health promotion actions (Jourdan et al., 2011). This is similar to the methods advocated for while building HPSCs. Incorporating a bottom-up approach into many of the conducted studies (3,4,5,6) was considered paramount to success during this thesis. Partnerships and networking are two areas already developed in HPS similar to the call for participative approach in HPSC. Participation from stakeholders is highly encouraged during all stages of planning, development, implementation and evaluation. In fact, the participative approach is one of the 13 strategies which guide sports clubs for targeted intervention planning. This type of collaboration with multiple stakeholders from international to local levels helps to increase sustainability of health promotion interventions and adds ideas from external partners, internal actors and community members (Turunen et al., 2017; World Health Organization, 2015).

The HPSC approach takes into consideration the diversity of sports clubs across different countries, cultures and sports systems. Attention is even given to how sports clubs within the same country can operate differently due to size, sport offered or club organization (Breuer et al., 2015). Similar aims were noted during the development of HPS with differences in school systems and cultures (Turunen et al., 2017). The underlying principles of HPS are in line with those of HPSCs: consistently strengthening capacity as a health promoting setting through policy development, providing safe environments, building stakeholder competencies, creating community links and social development. Many factors have been shown to work in schools such as participation, partnerships, sense of stakeholder ownership, using diverse strategies, time resources dedicated to health promotion, focusing on issues that matter to actors in the setting, strategies based on the whole organization, capacity-building opportunities for staff, positive social environments, consistency of the approach, development of clear goals and objectives, providing evidence-based resources as tools to those who administer health promotion actions and finally creating expectations for those who are targeted by the health promotion actions (Schools for Health in Europe, 2014). When compared to the sports club setting, these same factors can be seen in the work conducted throughout this thesis, especially in the HPSC model and final intervention planning framework. They equate with many of the strategies, ICs and HPSC indicators used to guide sports clubs in the HPSC approach.

5.3 Research perspectives

The work completed in the framework of this thesis offers several new scientific research perspectives on the settings-based approach to health promotion applied to the sports club context. The vision of the HPSC is broad compared to the current health promotion aims of sports clubs typically targeting one health behavior intended for sports participants (Geidne et al., 2013b) without taking into consideration how all sports club actors can benefit from promoting health. The theoretical model for HPSC (study5) was created to be generalized to sports clubs in many countries rather than specific to one sporting culture (Kokko, 2014a). Furthermore, it could be modified or used as an example for other settings when developing similar approaches. The true innovation of the model comes in the form of the multi-level design which includes both internal and external levels interconnected, showing how they work together to impact all sports club stakeholders. Furthermore, this is the first model with specific definitions of the levels and the four health determinants making it more coherent.

Another novelty is the development of a framework using targeted strategies and ICs to guide sports clubs when planning and implementing health promotion interventions. When supplemented by first administering the e-PROSCeSS questionnaire, sports clubs now have a step-by-step plan to guide them in the HPSC approach. They are able to design, plan and implement a health promotion intervention based on needs and expectations of the different levels of the sports club. Additionally, the sports club is able to call upon outside resources for support when developing health promotion policies and actions. This work was continuously aided by the perspectives, knowledge, experience and ideas from multiple sports club stakeholders. Therefore, the HPSC approach has the distinction of being created through a top-down *and* a bottom-up approach. By including participation along every step in the PROSCeSS project, the HPSC vision was expanded and enhanced. That is to say, not only is participation encouraged when planning and developing health promotion interventions within sports clubs *but* participation was used when developing the settings-based approach to health promotion within the sports club.

5.3.1 Public health perspectives

The work done in the thesis offers public health perspectives not only for the promotion of physical activity but from broader health perspectives such as sustainable development, social integration, multiple health competencies and inclusivity. Public health agencies are concerned with increasing the general health of society through policies and actions at multiple levels (Tulchinsky & Varavikova, 2015). The sports club can act as a microcosm of a 'society' which may even include the local community. Therefore, targeting sports club levels through specific policies and health

promotion actions can potentially increase sports club actors' health. Study 1 displays the interactions of different sports club actors such as managers, coaches and sports participants.

Building settings, such as sports clubs, to promote health has been a directive of the WHO since its first mention in the Ottawa Charter (World Health Organization, 1986). Promoting health in various settings involves policies and actions to increase the health and well-being of individuals and communities. Actions can be directly implemented into the setting as demonstrated in study 3 but can also include policies from national to local levels. As has been demonstrated in study 5, public health actors can serve as a resource and support mechanism for sports clubs to become settings for health promotion. In fact, many committee members from the studies conducted throughout this thesis were public health actors coming from academia and regional or local level public health agencies. It is necessary to advocate for health promotion within the sports club setting from public health actors.

From both a public health standpoint and a sports club standpoint, developing sports clubs as a viable setting to promote health makes common sense. Health promotion in sports clubs extends sports clubs from providing only physical activity opportunities to targeting other behaviors such as alcohol and tobacco use, diet and social inclusion (Kelly et al., 2010; Lane et al., 2020). Additional reasons to build the sports club as a health promotion setting include: 1) research has shown that by promoting health in this setting, membership numbers increase (thereby reaching more people) and the health of participants improves (Van Hoye et al., 2018), 2) participation in sports clubs can be an agent providing opportunities for informal health education as has been noted in the sustainable development goals (Lemke, 2015) and 3) sports clubs offer a large and diverse audience spanning many demographics and socioeconomic status (Breuer et al., 2015; Eime et al., 2013a). The value of sport has also been implicated in various other sustainable development goals through its role in promoting well-being, inclusivity, gender equality and improving QoL (Bácsné-Bába et al., 2021; Lindsey & Chapman, 2017).

5.4 Implications for future research

Many questions arose throughout this research and need to be tested in real world situations. Several important questions need to be considered: Are we asking too much of a sports club, an institution that has been around for hundreds of years? Is the organization able to develop and progress to promote health in a broader sense or is this setting more suited for specific risk factors such as low physical activity levels? The capacity of sports clubs to reconsider their objectives and make necessary organizational changes through a whole-systems approach (Dooris, 2006) needs to be further tested. Many grassroots sports clubs are currently limited by their core business of providing sport and consider anything beyond this as an 'added-value' (Kokko,

Selänne, et al., 2015). Examining how closely this core business aligns with the ambitious HPSC vision of promoting health in a broader sense needs to be explored.

5.4.1 Pilot study

As of now, implementing settings-based approach in the sports club context has been limited due to sports club actors' lack of knowledge and their required support from board members, affiliated sports federations and government ministries which oversee sports (Casey, Payne, Brown, et al., 2009; Casey, Payne, et al., 2012). Many sports clubs rely heavily upon volunteers, adding health promotion tasks to unpaid positions places additional requirements and capacity building of these actors (Casey et al., 2011). Furthermore, if volunteers do not perceive health promotion actions as part of core business of their sports club implementing new policies and actions will be difficult (Casey, Payne, et al., 2012). If sports clubs only focus on one health behavior such as increasing physical activity of their members, to what extent does this single behavior change bring about increased holistic health (mental, social, physical well-being) to multiple sports club actors? To begin answering these questions, results from this thesis, need to be tested and confirmed in grass-roots sports clubs through a pilot study. This includes empirically testing and evaluating the theoretical HPSC model and intervention framework. Sports club actors need to be educated on best practices for using the framework for their goals, guided on the benefits of a multi-level approach and advised on which strategies are best suited for their current capacities and health promotion objectives. To properly pilot the HPSC approach, evaluation should be considered both proximal (the immediate impact) and distal (long term achievements) as was shown in the HPSC logic model which remains to be externally validated. Evaluations should consider if sports clubs have been transformed by adopting new health promotion policies and embedding health promotion into daily actions (organizational change). Because this type of organizational change takes time, evaluations may need to occur in the long-term with follow-up surveys and re-administration of the e-PROSCeSS questionnaires several years after the initial launch. In addition to evaluating the project, each strategy should be evaluated to determine the impact it has on the setting to support the health of sports club actors. The pilot study should ensure that all stakeholders are involved from the beginning of planning the intervention through the evaluation steps (Minkler, 2005; Wallerstein & Duran, 2006) to help assure that the intervention strategies chosen reflect the need's assessment and the expectations of all the sports club's stakeholders. Including them also helps to get different perspectives on the 'problems' that need to be addressed and practical solutions (Steckler et al., 1992).

5.4.2 Assessing the health determinants

Based on the validated e-PROSCeSS questionnaire (study 2), the four health determinants (economic, environmental, organizational, social) need to be assessed to identify how they interact, affect stakeholder health and their sustainability. Specifically, the environmental health determinant needs more research, development and must be well-defined. During several of the studies (2,3,5), it was discovered that many stakeholders did not understand how the environment interplays with health promotion in this context. For example, the safety of infrastructures (e.g. locker rooms, playing fields, equipment) is well regulated in some countries by the government (Harichaux, 2005) while in other countries, it is left up to the individual sports club. This makes it difficult for sports club actors to recognize who this responsibility falls on (Van Hoyer et al., 2015). To make matters more confusing, how coaches deal with bullying and nutritional considerations are also incorporated into this determinant. Nutritional offerings from canteens or food distributors can be considered structural, but coaches educating sports participants about proper nutrition is more capacity building (Kelly et al., 2010). Although linked through topic, these two ideas are different in relation to health determinants. This was apparent during study 2 when validating the questionnaire items in this sub-scale and during studies 3 and 5 when focus group participants had a difficult time classifying intervention components into this determinant. At all levels within the HPSC model, ICs were rarely categorized into the environmental determinant. Furthermore, without items on the e-PROSCeSS questionnaire targeting the environmental determinant at the meso and micro levels is left up to the judgement of the intervention managers to choose ICs which coincide with this determinant at these two levels. Once interventions are implemented, it will not be possible to evaluate if the perception of health promotion targeting the environment has improved. These issues lead to the conclusion that items in the environmental determinant need to be clearly differentiated from the other three (economic, organizational, social) to demonstrate how the environment can be an 'actionable' determinant.

5.4.3 Evaluation methods

Along the same lines as the questionnaire, when designing a project, evaluation methods need to be decided upon. In order to assess the success of a health promotion project, both outcomes and processes need to be evaluated (Nutbeam, 1998a). This remains a current gap in research. Although the e-PROSCeSS questionnaire was produced, it is purely subjective. An objective way to measure the health outcomes of stakeholders needs to be designed to evaluate success. Additionally, a proper method to evaluate the change in the organizational development of the sports club should be developed, for example, has there been a significant difference in improving the health determinants within the setting (is the environment notably safer, more welcoming; have

more financial resources been spent on promoting health; are all participants included during practices and competitions, etc.?). In other words, are there more objective measures that can be analyzed such as injury reports, doctor visits, performance scores (i.e. competitive team wins, body composition changes), retention numbers (participants, coaches, volunteers, management), percentage of budget spent on health promotion actions, increase in amount of signage or alternative communication avenues.

5.4.4 Focus groups

Although this work took a top-down and bottom-up approach to creating the HPSC intervention framework, sports participants in particular, were not widely incorporated. Our studies have strongly considered the needs of the sports club, but there is a lack of consideration for the needs and expectations of the sports participants. We have assumed they would be complacent in any organizational changes made within the sports club. Sports club participants were an integral part of the validation process but were not included during the design of the e-PROSCeSS questionnaire, which became apparent during the cognitive interviews conducted in study 2. Many sports participants did not understand the general concept of health promotion within the sports club context exhibiting the myth of 'healthism' (Holman et al., 1997) among this group. In essence, they perceive that sports clubs are inherently health promoting by nature of the business they provide. Future work may necessitate revising the e-PROSCeSS questionnaire to include items generated from the perspective of sports participants to better understand their perceptions of health promotion. Directly asking sports club participants of their wants and expectations would not only help to improve the questionnaire but could lead to refinements in the HPSC framework by incorporating their ideas into future intervention components to help design an intervention and explore their capacity for behavior changes. A sports participant driven study commenced with the completion of only 5 of the 10 planned focus groups with this specific aim. Due to the Covid 19 pandemic, this study had to be postponed until sports clubs were able to reopen and in-person focus groups could be conducted. To give power to this study, a minimum of 5 additional focus groups need to be conducted for the data to be analyzed.

5.4.5 MOOC

Responding to suggestions from both study 4 and 6, educating sports club stakeholders (managers and coaches) and building their capacity to promote health, especially directors and coaches, should begin with creating a basic training course. Education and capacity building were key intervention components during study 3 and study 4, which are key elements to successful health promotion interventions (Poland et al., 2000). During study 4, many respondents mirrored

this suggestion with 12 statements regarding training and this cluster being the highest rated for importance. Most of the intervention managers interviewed during study 6 reiterated the point that they had not formal training; the health promotion project was just an idea they had so they decided to implement it. To begin stakeholder training, a Massive Open Online Course (MOOC) will be constructed to: 1) educate stakeholders about the benefits of health promotion within their sports club, 2) how these benefits correspond with the socio-ecological approach and settings-based approach to health, 3) the direct application of the Ottawa Charter to sports clubs and 4) how to implement the HPSC approach through the various steps researched in this thesis. Figure 12 shows the benefits of a health promoting sports club. Creating and offering a MOOC helps to diffuse the HPSC approach and make it more widely available. Diffusion can aid the acceptability through support from government ministries by sharing the information via websites and tutorials and including dedicated space on sports federation and public health websites.



Figure 12. Benefits of a health promoting sports club

5.4.6 HPSC-NAT

The value of having assistance from levels acting outside the sports club was demonstrated during studies 3 and 4. Although identified and implicated, less work has been done to develop these levels. Currently, it is not known what different countries do at the national level (governmental authorities) to encourage and support sports clubs in this approach. It is recommended to partner with a large organization to discover this current state of support including national policies, communication methods, implementation strategies and evaluation techniques. Creating a health promotion sports club national audit tool (HPSC-NAT) to disseminate at a national level will give public health advocates and national ministries perspective on the present state of health promotion policies and support given to local sports clubs. This audit tool can also help to identify what stage of development sports clubs are in within a country and highlight the benefits of the HPSC approach to national ministries. This work has started with a partnership between the WHO, the Université Côte d'Azur and the University of Lorraine.

5.4.7 Sports Federation development

Studies 3 and 4 stressed the importance of the sports federation level. Particularly, how national, regional and local federations could provide direct leadership and coordination for the promotion of health within affiliated grassroots sports clubs. Recent research on International Olympic Sports Federations showed that very little attention was paid to the health of the general population (Mountjoy et al., 2019) including those who practice sports at a local, non-competitive level. Similar to study 3, indicators specific to sports federations to be considered health promotion need to be researched. Strategies, based on the predefined health determinants at this level, need to be researched through both current evidence, taking a top-down approach, and by directly questioning sports federation actors, taking a bottom-up approach for successful application (Geidne et al., 2013b). Once strategies are identified, guidelines can be developed to provide sports federations a concrete method to support their affiliates.

5.4.8 Capitalizing on international projects

Finally, gaining more knowledge from successful health promotion interventions through additional capitalization interviews should be conducted. Semi-structured interviews are planned with intervention managers and academics from both Ireland and Australia. This will aid in understanding how to increase chances of success and open the health promoting opportunities of the sports club to a wider community audience. Understanding and learning from the steps the 'Healthy Club Project' (Lane et al., 2017) and the 'Good Sports Program' (Gonzalez et al., 2020) underwent, will help future researchers overcome barriers and build on their successes.

5.5 Conclusion

Applying the research conducted in this thesis, sports clubs can begin the process of incorporating health promotion actions into their daily activities and within all their policies. The collected research from this thesis is a roadmap to specify the theoretical processes and empirical findings to aid researchers and sports clubs with planning and developing health promotion policies and actions (Fernandez, Ruiter, et al., 2019) by considering the components and mechanisms of a whole-systems approach. This approach has been used for organizational development in multiple settings for nearly fifty years (Beer & Huse, 1972). The thesis is thus grounded in proven techniques by showing how sports clubs are interconnected, integrated, interrelated and interdependent (Dooris, 2006; Skyttner, 2001). Working closely with sports club stakeholders, academics and research committees, helped to modify the way in which the HPSC approach is viewed. Incorporating the participative approach helped us understand what sports clubs need to create a final intervention plan and thus allowed us to include their suggestions throughout the various steps in the project. Each study added specific details to create a framework for HPSCs by responding to specific questions or by adding further participant- and evidence-driven data to strengthen collected data.

Applying the steps researched during this thesis supports sports clubs to initiate the process of organizational change needed to become a setting for health promotion. Sports clubs need to be supported and guided to make the decision to implement health promotion actions in all policies and daily operations. To limit barriers, intervention managers should first auto-evaluate through the e-PROSCeSS questionnaire at the various levels to provide current perceptions of health promotion actions done within their club. This gives intervention managers a starting place to target their efforts based on their specific needs and objectives. Then, the results can be used to target the sport club levels and health determinants which need improvement. Applying this step-by-step approach aids sports club stakeholders with developing and implementing a well-planned intervention grounded in theory and based on evidence.



“The end is only the beginning of an even longer story”

...Zadie Smith, English novelist



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**SUPPLEMENTARY
MATERIALS**



**SUPPLEMENTARY
FILE 1**

Psychometric validation poor fit indices

Poor Fit Indices				
	N	CFI	TLI	RMSEA (90% CI)
Macro Level Scales				
Managers & Coaches	154	0.73	0.71	0.11 (0.10, 0.12)
Sports Participants	289	0.54	0.51	0.14 (0.14, 0.15)
Meso Level Scale				
Managers	67	0.72	0.69	0.17 (0.16, 0.18)
Micro Level Scales				
Coaches	72	0.65	0.61	0.16 (0.15, 0.18)
Sports Participants	426	0.75	0.72	0.11 (0.11, 0.12)
Macro Level Environmental Scale				
*Managers & Coaches				
Meso Level Environmental Scale				
Managers	64	0.90	0.79	0.26 (0.15, 0.37)
Micro Level Environmental Scales				
*Coaches				
*Sports Participants				

*Model does not converge



**SUPPLEMENTARY
FILE 2**

e-PROSCeSS

HPSC – Health Promoting Sports Clubs evaluation tool

User guide for measuring perceptions of
health promotion within sports clubs



PROSCeSS
PRoMotion de la Santé dans les ClubS Sportifs





The e-PROSCeSS tool consists of several documents:

1. The e-PROSCeSS evaluation users guide
2. The evaluation tools (for management, coaches and sports participants)
3. An excel spreadsheet which allows clubs to analyze results

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FOREWARD

You have, in your hands, the first tool to measure the promotion of health within sports clubs. This tool was developed through a collaboration between Santé publique France, The Université Côte d'Azur and the Université of Lorraine. It is founded in the theoretical model of the Health Promoting Sports Club and by the scientific working group Sport Clubs for Health (SCforH) of the HEPA Europe network.

This new approach thinks of the sports club as a health-promoting environment and uses the vision of health promotion to develop the sports club's daily goals and actions. Initiated about twenty years ago in Australia and further developed in Finland in the early 2000's, France is now joining this innovative movement.

One of the key factors to develop a complete project is knowledge. Nevertheless, this knowledge must be relevant, produced and used at the local level to have value for the target audience. This tool was developed to enable amateur clubs to gain knowledge about their organizations, which allows them to evolve. Using the PROSCeSS tool will provide a snapshot of your club's health promotion activities and offers ideas to managers, coaches and sports participants to take action.

The user's guide allows managers, researchers, coaches, sports educators and sports participants to be guided in the evaluation of health promotion within their sports club with the aid of the e-PROSCeSS measurement tool. This tool and the accompanying guide are designed for actors within the sports club but, also, for external partners who wish to support an initiative of one or more sports clubs.

Becoming a health promoting sports club requires a collective, participative and dynamic long-term investment. It is a process, which does not end and can always be improved, but where every little bit of progress counts, making it possible to be an even more health-promoting club every day.

Susanna Geidne, PhD, Senior Lecturer, Örebro University, Sweden

Co-head of the working group SCforH of the Health Enhancing Physical Activity Europe network

FOREWARD

The first four axes of the French national health strategy 2018-2022 are to put in place a health promotion policy (including prevention) in all environments for living. Santé publique France, the national health agency, is part of this strategy to address the major issues when implementing these objectives. Knowledge, actions and evaluation must be included when considering the impact of environments on health.

Complementing schools, the sports world is of major interest in reaching the population, especially youth. There are more than one hundred sports federations in France, representing more than 150,000 clubs. They bring together around 16 million people (6 million females and 10.1 million males), half of whom are younger than 20 years old.

It is for this reason that Santé publique France has engaged in a research project aimed to develop and support sports clubs to become health-promoting environments.

The PROSCeSS project – Health Promotion in Sports Clubs – is the outcome of a partnership with the Université Côte d’Azur and the Université of Lorraine, which is very exciting. It is based on knowledge gained from scientific literature and the World Health Organization’s ‘Health Promoting Schools’ conceptual framework, adapted to sports clubs.

The objective is to reach multiple populations to protect and improve their health and to work with all partners in the field to do so:

This self-assessment questionnaire for health promotion in your organization is the first step in a project that aims to produce a tool to accompany sports clubs in the development of health promotion, a questionnaire co-constructed with you, on the basis of a validated theoretical model.

Geneviève Chêne

Director, Santé publique France

INTRODUCTION

Health promotion is the process of empowering people to increase control over and improve their own health⁶. It integrates actions which aim to act on environments and to develop social and individual resources, as well as each person's capacities.

Sports clubs are settings in which these actions can find a place. Additionally, sports clubs complement the school and family environment offering children and youth the potential for supplementary development. In this space, youth can acquire new skills, develop autonomy, experience new forms of socialization and interactions with peers and adults.

A health promoting sports club (see Annex 1) involves not only the educational team (coaches, trainers), but also management, volunteers, participants⁶ and their parents.

Management ensures that the environment within and around the club is well organized which includes providing essential resources to the staff and volunteers who welcome sports participants and their families.

In order to implement health promotion actions⁶, it is necessary to act on several elements offered to different actors¹ :

- Educational strategies,
- Training and working conditions of the team,
- Arrangement of equipment and premises in a way that is safe and suitable for the population being served,
- Reception, communication and hospitality,
- Implementation of specific actions that are aimed at acquiring and developing health knowledge and psychosocial competence⁶ (problem solving, stress management, decision making, effective communication, creative and critical thinking, skillful interpersonal relations, self-awareness and empathy)

Thus, sports clubs can become 'health promoting'², that is to say, not only addressing health issues related to sports performance, but also offering an eco-responsible, welcoming and healthy environment.

⁶ Definition found in the Glossary at the end of the guide

¹ Management, coaches, participants and their family

² Note : The health promoting sports club is distinct from the healthy-sports club, by the fact that they promote physical, mental and social health, beyond the offer of adapted physical activity for sedentary persons or specific populations (disabilities, chronic illness, obesity). The distinction can be more subtle → actions with the public and also the environment ; the club engages in healthy-sport but also promotes health, some healthy-sport clubs or clubs with healthy-sport activities also work on mental health and the environment as determinants of adapted physical activity.

Why undertake the development of health promotion?

Several studies^{3,4} have highlighted the benefits of implementing a health promotion policy for sports clubs (see Figure 1):

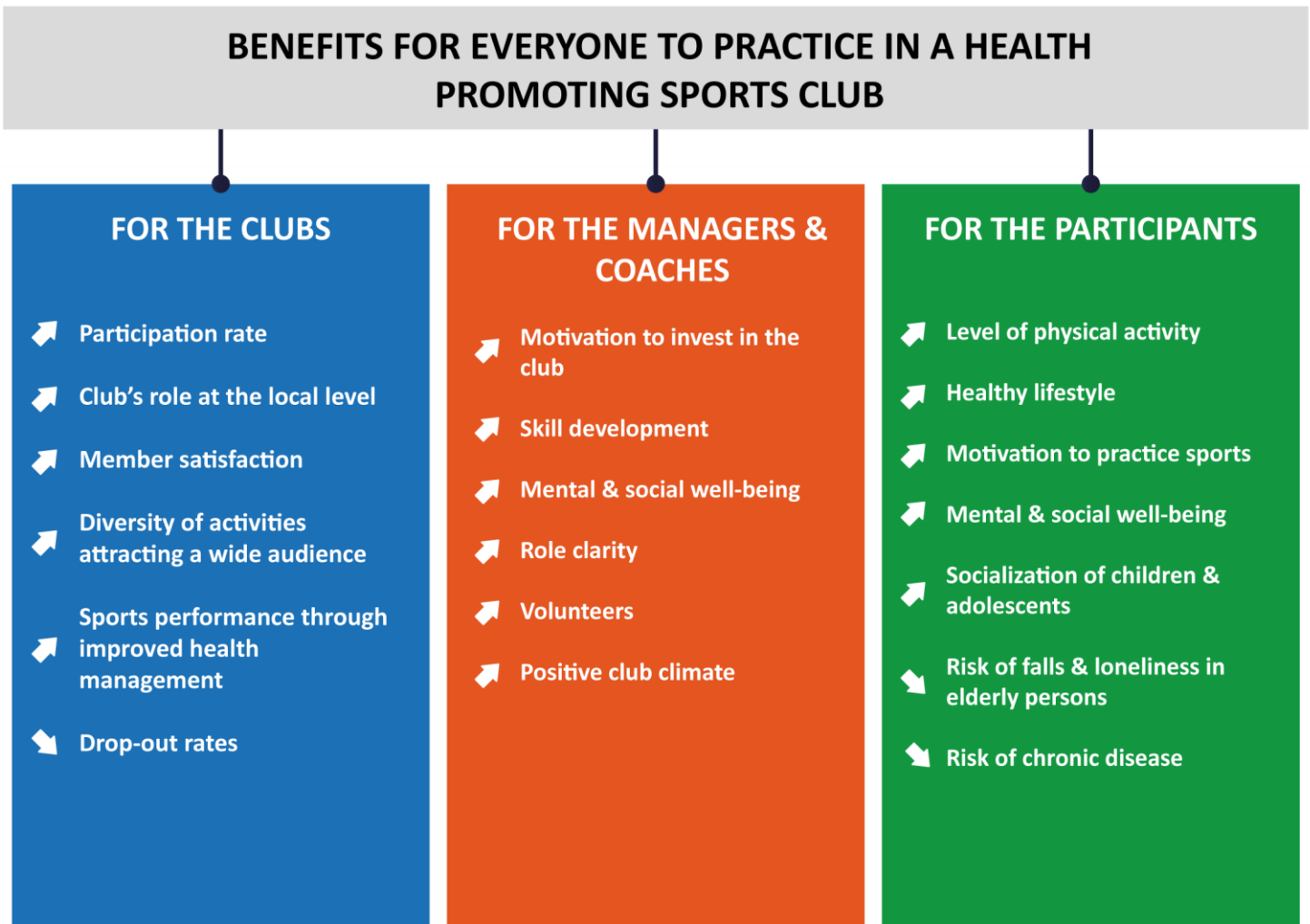


Figure 1: Diagram of the benefits of the health promoting sports club approach adapted from the SCforH guide

³ Casey et al. The influence of a Healthy Welcoming Environment on participation in club sport by adolescent girls: a longitudinal study. *BMC Sports Science, Medicine and Rehabilitation* (2017) 9:12

⁴ Koski, P., Matarma, T., Pedišić, Z., Kokko, S., Lane, A., Hartmann, H., Geidne, S., Hämäläinen, T., Nykänen, U., Rakovac, M., Livson, M. & Savola, J. (2017). *Sports Club for Health (SCforH) – Mise à jour des recommandations concernant les activités sportives bénéfiques pour la santé et pratiquées en club*. Helsinki, FI: Comité olympique finlandais.

What is the 'health promoting sports club approach'?

The health promoting sports club is designed for all sports clubs regardless of location, size or sports level and can be used as a philosophy integrated into the daily club activities.

It is based on a socio-ecological approach⁶ to health, which explains that individual behaviors are **influenced by and interact with their environment**.

An example of good practice: when renovating a gym, washing machines could be installed in order to clean youth jerseys. This helps save working parents time and avoids the marginalization of some children who might otherwise come to practice or games with dirty uniforms.

Factors which influence physical activity practice, according to Booth⁶

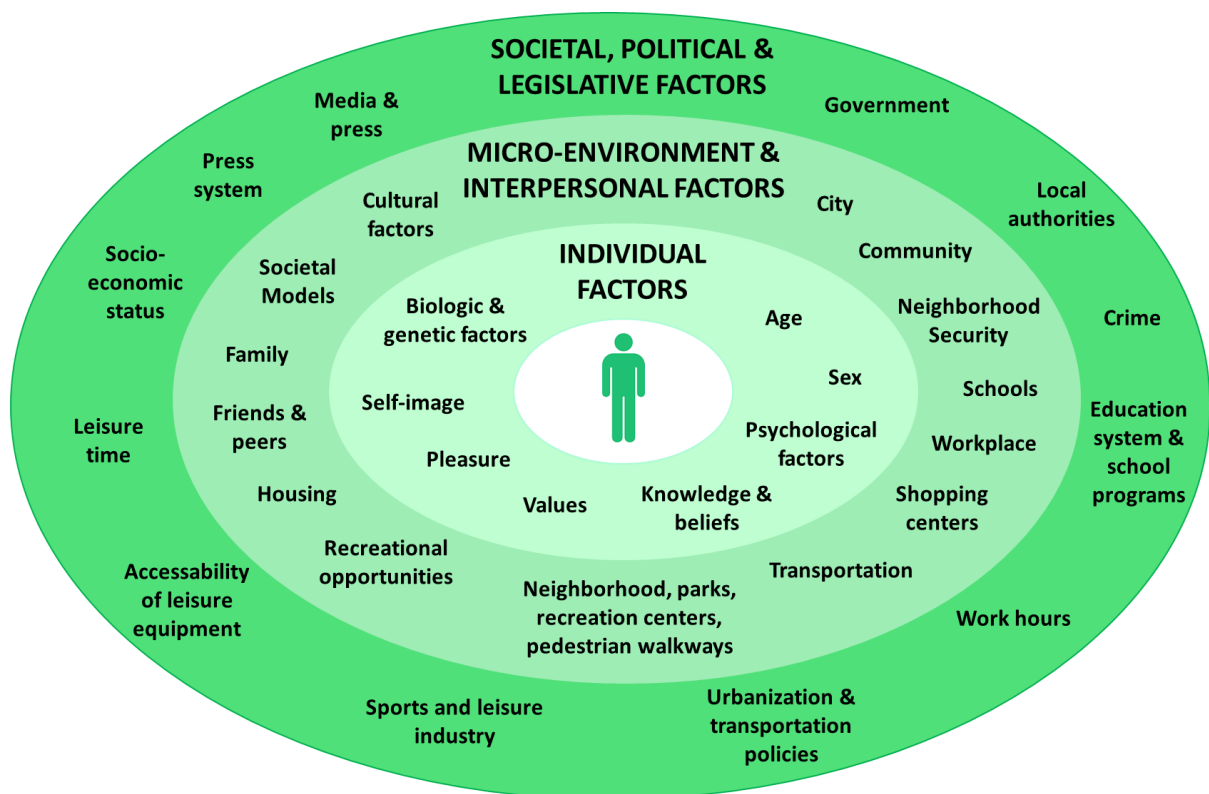


Figure 2 : Presentation of the socio-ecological approach to physical activity⁵

⁵ Oppert J.-M., Simon C., Rivière D., Guezennec C.-Y. Activité physique et santé. Arguments scientifiques, pistes pratiques. Ministère de la Santé, coll. " Les synthèses du PNNS ", 2006 : 58 p.

⁶ Booth, Sallis, Ritenbaugh et al. (2001). Environmental and societal factors affect food choice and physical activity: rationale, influences, and leverage point. Nutrition review, 59(3).

What is the 'health promoting sports club approach'?

Becoming a health promoting sports club requires a long-term collective and participative commitment. It also requires coordinated policies from each sector of the sports club and from every age group to place the health of the participants, coaches^G and managers^G within the center of the club's values and objectives.

A health promoting sports club:

- promotes the health and physical, social and mental well-being of its participants;
- addresses issues relating to the health and well-being of everyone involved in the sports club (employees, volunteers, participants);
- integrates health into the daily activities;
- supports the concepts of social inclusion and equality;
- provides a welcoming and safe environment;
- involves the participants;
- involves parents, the neighborhood and the local community;
- sets realistic objectives in accordance with the aims of the club;
- seeks to improve its actions through continuous evaluation.

This collective and participative mobilization is based on an ecological approach also known as the settings-based approach and relies on the capacity of the club to implement strategies at different levels (the club as an entity, managers, coaches, participants) and on aspects related to the organization of the sports club (regulations, charters, rules, decision-making processes), economic aspects (financial, human and social resources), social (values, norms, support systems) and environmental (infrastructure, equipment).

The five key indicators of the investment of a sports club in health promotion (see Annex 1):

- Implement an approach which include all club actions contributing to health, not just those centered on one behavior or theme
 - Involve all levels of the sports club (participants, parents, coaches, managers, volunteers) in the actions and decision making linked to health promotion
 - Involve external partners and local actors in the actions and decision processes linked to health promotion
 - Be conscious that promoting health is a continuous and cumulative process
 - Base actions on the needs of the sports club and its actors, according to the context of the club and local actors
-

The e-PROSCeSS tool

Who is the e-PROSCeSS designed for?

Sports actors who wish to develop the promotion of health:

→ Sports federations, managers, technical directors and/or sports club employees, coaches, volunteers

Health promotion actors who would like to support sports clubs in this approach

All others who would like to encourage sports clubs to participate in the promotion of health.

What is the purpose of the e-PROSCeSS?

It can help sports clubs to integrate more health actions into their daily routines.

Using this tool allows a snapshot of the perception of the sports club's health promotion activities taken from three perspectives: managers, coaches and participants. It also allows the managers and coaches to self-evaluate their involvement in the promotion of health and identify areas and paths for improvement.

When to use the e-PROSCeSS and the results of the approach?

Anytime that seems appropriate for the club:

- At the beginning or end of a sporting season to make an evaluation or assessment
- When changing directors or management of the sports club
- When requesting financing
- When change is needed, wanted or required

The e-PROSCeSS tool

Why use the e-PROSCeSS tool?

The tool can be used to:

1. Measure participants' perceptions of their club's commitment (management, coaches) to promote health.
2. Investigate stakeholders' perception of the sports club health promotion (diagnose or assess) to be able to set progressive objectives.
3. Measure coaches' perceptions of the commitment of the club and its managers to promote health.
4. Evaluate the contribution of the sports club to the health of each sports club stakeholder, in partner with other organizations (community, local health contracts, city health services).
5. Give visibility to the sports club's health promotion activities.

What is the e-PROSCeSS tool and its components?

This tool is composed of three questionnaires which measure the perception of health promotion at three levels (see Annex 2): the club as a whole (**club level**), management practices (**management level**) and coaches' practices (**coaching level**). It can be used in total (all 3 levels) or partially (1 level), according to the objectives of the sports club.

Table 1. Completion of the questionnaires by the different respondents

	Sports Participants	Coaches	Managers
Club Level	X	X	X
Management Level			X
Coaching Level	X	X	

Thus, sports participants complete two questionnaires: the club level and coaching level, coaches complete two questionnaires: the club level and coaching level and managers complete two questionnaires: the club level and management level.

The e-PROSCeSS tool

The e-PROSCeSS tool has four types of determinants of health⁶ (factors which influence health (see Annex 2)):

- **Organizational determinants**⁶ represent the positioning of health promotion in the sports club's guidelines. This includes rules and regulations, relationships with governmental and community entities and in the organization and direction of the club's actions.
- **Social determinants** include the vision, values and philosophy of the sports club in relation to those of society.
- **Environmental determinants** describe the built surroundings provided by the sports club including infrastructures, green spaces and playing fields.
- **Economic determinants** correspond to the allocation of financial, human and material resources for health promotion within the sports club.

Table 2. Number of questions by level and determinant

	Organizational Determinants	Social Determinants	Environmental Determinants	Economic Determinants
Club Level	8 questions	6 questions	8 questions	4 questions
Management Level	8 questions	6 questions	-	3 questions
Coaching Level	5 questions	6 questions	-	4 questions

The e-PROSCeSS tool

How to use the e-PROSCeSS tool

Using the e-PROSCeSS is done in several steps which allows for the preparation, collection of data and analysis of the results:

Table 3. Stages of use for the e-PROSCeSS

BEFORE	DURING	AFTER
1 – DEFINE THE TARGET OBJECTIVE	3 – IDENTIFY PEOPLE TO BE POLLED	6 – COMMUNICATE THE RESULTS AND SHARE THE CONCLUSIONS
2 – IDENTIFY THE CLUB RESOURCES TO MOBILIZE TO IMPLEMENT THE E-PROSCeSS TOOL	4 – COLLECT THE INFORMATION	7 – ADJUST THE SPORTS CLUB'S ACTIVITIES
	5 – ANALYZE THE INFORMATION	

Before using the
e-PROSCeSS

1. Define the objectives to be targeted with this tool

Depending on the characteristics of the sports club, take into account the resources needed to implement the e-PROSCeSS. Prior to beginning, it is important to understand the aim of the goals for this tool, for example:

The e-PROSCeSS tool

- Compare the perceptions of health promotion development in your club between actors (managers, coaches, participants)
- Evaluate participant's perceptions of their club's commitment to health promotion
- Identify health promotion indicators at each level
- Identify strengths, weaknesses and areas for improvement related to one or all of the above objectives
- Raise awareness of health promotion to all of the club's actors and members
- Explain the collective vision of the health promoting sports club
- Involve all the club's actors and members in assessing needs to develop a health promotion project

Before completing any scale, it is important to mention the objectives of the information collection, how will the responses be used (who has access and how; where the responses are stored) and ask for informed consent (consent forms are included). In order to obtain honest responses, it is important to guarantee anonymity and confidentiality of the collected data.

2. Identify resources to mobilize for e-PROSCeSS implementation

Resources to mobilize are both human (people for information collection, analysis, communication) and material (paper documents, computers, etc.).

To use the tool, it is important to mobilize different people to support of the undertaking and to relay the information within the sports club:

- a. Contact the sports club's management and office for support and resource allocation. In addition, involve them in the analysis and follow-up of the results.
- b. Identify key people (coaches or some 'prominent' sports participants) and key moments (general assembly, meetings for start or end of sporting seasons) to promote and distribute the questionnaires to participants, coaches and managers.
- c. If the questionnaires are completed online, a page of each respondent's score can be retrieved. In addition, the scores of each determinant within levels can be calculated. If the questionnaires are completed on paper, it will require entering the data into an excel file to calculate these scores.

The e-PROSCeSS tool

While using the e-PROSCeSS

3. Identify people to fill-out the questionnaires: Who? Why? How many?

The questionnaire was designed for all types of clubs (amateur volunteer clubs to high level professional). However, due to its complexity and number of questions, the e-PROSCeSS tool should be reserved for persons 15 years and older.

Several options are possible:

- 1) You would like to know the perceptions of participants regarding the activities of coaches to promote health: **at least 10 participants with the same coach should answer the 'Coaching Level' questionnaire.**
- 2) You would like to know the coaches' perceptions of their own engagement in health promotion: **at least 6 coaches should answer the 'Coaching Level' questionnaire.**
- 3) You would like to know management's perceptions of their engagement in health promotion: **at least 4 managers should answer the 'Management Level' questionnaire.**
- 4) To know the perception of health promotion within your club: **at least 10 people⁷ per level should respond to the 'Club Level' questionnaire.**
- 5) You wish to have a global vision of health promotion or compare the perceptions of management, coaches and participants: **administer the questionnaire to at least 10 people per level⁸.**

The number of persons given above is an indication which can be adapted according to the club size, number of coaches and managers, as well as the number of licensees. If you wish to have a multi-perspective view and allow for a triangulation of perceptions of health promotion within your club, about 10 responses per level is recommended.

⁷ Participants, coaches, managers

⁸ See Annex 2. Participants respond to 2 questionnaires : 'Club Level' and 'Coaching Level' ; coaches respond to 2 questionnaires : 'Club Level' and 'Coaching Level' ; managers respond to 2 questionnaires : 'Club Level' and 'Management Level'.

The e-PROSCeSS tool

4. Calculate the scores

Several uses of this tool are possible according to the objective sought by the club.

Based on this, scores may be calculated per level or for all levels for each of the determinants.

In other words:

- Participant responses to the 'Coaching Level' indicate what they think their coach is doing in regards to promoting health (e.g. "My coach addresses health behaviors").
- Coaches responses to the 'Coaching Level' explain what they think they are doing to promote health (e.g. "I address health behaviors").
- Management responses to the 'Management Level' explain what they think about their contribution to promoting health (e.g. "I ensure that coaches apply the club's health rules and policies").
- All three actors' responses to the 'Club Level' indicate what they think about the club's commitment to promoting health (e.g. "My sports club has policies pertaining to health").

From the online responses, a score is automatically calculated or can be calculated using the provided excel file to assess the perceptions of health promotion at these three levels. The calculation is done by determinant type (organizational, social, environmental, economic) and by club level (Club, Management, Coaching). This score is calculated for each respondent and an average of the respondents' scores gives an overall perception of health promotion within the sports club (Annex 3).

5. Analyze the collected information

Once the scores have been calculated, either for respondents per level or for the club in general, you can identify the determinants you would like to focus on.

The determinants which the club is already achieving can be identified by scores at or above 7 and those where it can improve include scores below 7. Strengths can be identified by the three questions with the highest scores and area needing improvement are shown through the questions with the three lowest scores.

If you want to compare responses between what is perceived by the participants and implemented by the coaches, compare the scores of the participants at the 'Coaching Level' with the scores of the coaches at the 'Coaching Level'. This allows you to see whether or not the participants perceive what coaches believe they implement.

If you want to compare how health promotion is perceived at each level, you can compare the scores of sports participants, coaches and managers on the 'Club Level' questionnaire.

The 'I don't know' responses stress the inability of respondents to give opinions on questions. Analyzing the reasons why these questions have received this response (above 30%) is advantageous for the club to understand how to improve health promotion in these areas including communication.

The e-PROSCeSS tool

The online version offers the advantage of comparing your club's scores to other clubs of the same sport, clubs in the same region and/or clubs globally. It is not a ranking, but rather a way to compare your club with the health promotion development of other sports clubs.

After using the e-PROSCeSS

6. Communicate the results and share the conclusions

It is important to take time to discuss and analyze the results in relation to the initial objectives. It is essential to offer feedback to those who responded to the questionnaires.

This communication can have several objectives:

1. Present the approach within the sports club
2. Complete and amend the information collected from the questionnaires
3. Initiate or reinforce a dynamic within the sports club to promote health

Comment: The presence of an external speaker during feedback, such as a health promotion professional, to conduct or take part in the meeting can be helpful. This person has no stake in the sports club and can easily bring out different opinions, synthesize or help clarify a point of view. They can also intervene to provide further analysis, recommendations and explanations to begin initiation of a short, medium or long-term action plan based on the e-PROSCeSS approach.

This communication can take place at a general meeting within the club without needing to be specifically dedicated to this project (technical meeting, general assembly, etc.).

It is important to provide results and share the conclusions both internally and externally to club partners and the community as well as elected directors, administrators and other sports associations. This could be an occasion to share the role that the sports club can play in participant's health, complimentary to offering sports. This can be done through the sports club's website, a flyer outlining the results of the club or any other well-known distribution channels.

The e-PROSCeSS tool

7. Adjust the sports club's activities and discuss the barriers and facilitators

The results allow an exchange regarding the barriers, facilitators and resources to mobilize in order to adjust the activities of the club. This helps to implement and reinforce the health promoting sports club approach. The club can also call upon actors in the field of health promotion.

In addition, the PROSCeSS project team has developed a comprehensive guide to help sports clubs become health promoting.



ADDITIONAL INFORMATION

If you wish to go further

A guide to promote health within your club

This guide, developed in the context of the Erasmus+ project 'Sport Clubs for Health', provides information on the benefits of sport for participants' health, but also offers courses of action and project management focused on the promotion of health within sports clubs.

Link to the guide : https://www.scforh.info/content/uploads/2017/03/ranska_verkko.pdf

A guide to evaluate the quality of your actions to promote health

This guide, on how to improve the quality of health promotion projects, was made by and for organizations involved in health promotion. The objective is to provide step-by-step benchmarks to guide an organization in its appraisal in order to engage in a progressive approach of quality improvement. Therefore, it is usable at different actionable moments and invites the organization to go beyond the analysis phase.

Link to the guide : <http://inpes.santepubliquefrance.fr/guide-autoevaluation-qualite/pdf/Guide-qualite-version-integrale-Anglais.pdf>

A guide to the Health Promotion Strategic Framework Model

The health promotion strategic framework model (HPSF) is an Irish model which shows the main elements of health promotion for several settings including schools, hospitals and communities. It is rooted in the settings-based approach and recognizes social determinants of health and the impact that inequality can have on the health of populations.

Link to the guide : http://www.healthpromotion.ie/hp-files/docs/HPSF_HSE.pdf

ACRONYMS

ARS: Agence régionale de santé (Regional agency of health)

HPSC: Health Promoting Sports Club

IREPS: Instance Régionale d'Éducation et de Promotion de la Santé (Regional Authority of Education and Health Promotion)

SCforH: Sports Clubs for Health

WHO: World Health Organization

GLOSSARY

Coach: Anyone supervising the practice of sport activity within a sports club including volunteers

Determinants of health: These refer to factors that have significant influence on health. Four distinct determinants of health are found within the sports club context. Each of these determinants, organizational, social, environmental and economic, have the potential to impact health at the club, management and coaching levels. In turn, this influences participants and potentially to family members. Determinants interact with each other at all sports club levels including a top-down and bottom-up dynamic.

Health: “Health is perceived as a resource of daily life and not as the goal of life; it is a positive concept accenting social and personal resources and on physical capacities. The promotion of health is therefore not only a matter for the health sector: it does not merely advocate for the adoption of lifestyles that promote good health; its ambition is the complete well-being of the individual” (Ottawa Charter, 1986)⁹.

Health promotion: The process of enabling people to increase control over, and improve, their health⁹. This includes the process of improving the health of an individual, group or population by acting on factors which influence health. These may be policies (urban planning, employment, housing, leisure, etc.), environmental or living conditions. They also concern social relationships and community participation. Factors can be found in the healthcare system and its adaptation to the needs of individuals and populations. Health promotion also includes health education. By acting on these factors and empowering individuals and populations to act for themselves, health promotion seeks to reduce social inequalities of health.

Health promotion actions: The actions of health promotion are intended to give populations and individuals “equal opportunities and resources to achieve their fullest health potential”⁹

Managers/directors: Volunteers or paid employees with managerial responsibilities in the sports club including those on the board of directors

Participant: Individuals practicing within a sports club

Psychosocial competence: These are ten essential skills, presented in pairs, which have been established by the WHO. They are defined as “the ability of an individual to respond effectively to the demands and challenges of daily life and to maintain a state of subjective well-being which enables him or her to behave appropriately and positively during interactions with others, culture and environment” (WHO, 1994)¹⁰. They are recognized as key determinants of health and well-being that can be effectively addressed.

Socio-ecological approach to health: This approach takes into account various influential factors of health (individual, social, environmental, political)

Questionnaire: Three different questionnaires to be directed towards specific respondents at various levels in the sports club (Club Level, Management Level, Coaching Level)

⁹ World Health Organization. (1986). WHO / The Ottawa Charter for Health Promotion. WHO. <http://www.who.int/healthpromotion/conferences/previous/ottawa/en/>

¹⁰ World Health Organization. Division of Mental Health. (1994). Life skills education for children and adolescents in schools. Pt. 1, Introduction to life skills for psychosocial competence. Pt. 2, Guidelines to facilitate the development and implementation of like skills programmes, 2nd rev. World Health Organization. <https://apps.who.int/iris/handle/10665/63552>

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ANNEX 1

MORE INFORMATION

What is a health promoting sports club?

A health promoting sports club is founded on the principles of the 1986 Ottawa Charter for the promotion of health from the World Health Organization.

The health promoting sports club has five essential components:

- **Policies for sports clubs to promote health**

These have been clearly defined by the clubs or their stakeholders in documents (associated projects, educational projects) or by well-established and accepted practices to promote health and well-being. Many national and federal policies (policies to combat disrespect, violence and discrimination in sport) can help to promote health and well-being in sports clubs.

- **The physical environment of the club**

The notion of the physical environment refers to equipment, buildings, grounds and playing fields both in and around the sports club. The following are included: the design and location of equipment, facilities for safe practice, sanitary spaces (toilets, showers), lockers rooms, reception and shared spaces (club house, etc.), facilities conducive to sustainable development (bicycle parking to encourage active mobility, water source to clean equipment, etc.). The physical environment also refers to the maintenance of facilities and hygiene practices that prevent the transmission of diseases; safe drinking water and all environmental, biological or chemical contaminants that can harm health.

- **The social environment of the club**

The social environment of the club is a combination of the quality of relationships between the staff and management (employees and volunteers) as well as between staff and participants. It is influenced by the relationships with parents and the community at large (other sports clubs, schools, etc.).

- **Individual health skills and the ability to act**

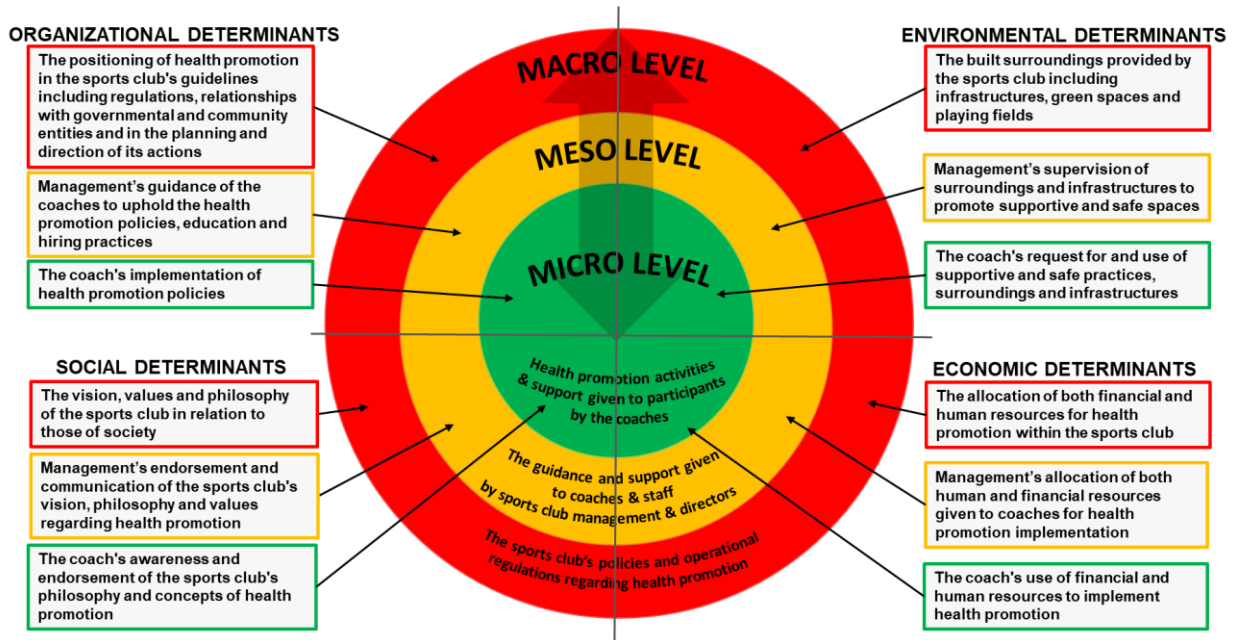
This refers to all the skills and health literacy knowledge participants acquire, according to their age, education and experience which allow them to develop know-how and undertake actions with the goal of improving their health and well-being. This can include actions for themselves and other members of their community. These actions are likely to improve their sporting practice as well.

- **Community links**

The community links are relationships between the club and the families of youth participants, as well as those between the club and key groups and individuals at the local level. A real partnership with the various stakeholders provides participants and staff context and support for their health promotion actions.

ANNEX 2

DEFINITION OF THE DETERMINANTS AT EACH LEVEL



ANNEX 3

EXPLANATION OF THE AUTOMATIC CALCULATION OF THE QUESTIONNAIRE SCORING AND ALGORITHM

When a respondent completes a questionnaire in the excel file, formulas are used to calculate the score automatically out of 10. Therefore, the algorithm assigns a score according to the checked box: 1 for 'Strongly disagree', 2 for 'Disagree', 3 for 'Slightly disagree', 4 for 'Slightly agree', 5 for 'Agree' and 6 for 'Strongly agree'. When having answered, the scores are transformed to a 10 point scales (by dividing the answer by six and multiplying by 10). The response will not be counted in the calculation if the respondent did not answer a question, if they checked more than one box or if the 'I don't know' response was chosen. The algorithm can provide the percentage of 'I don't know' responses for each question. In addition, an automatic calculation puts respondents' scores on a scale of 0 – 10 for greater clarity.

Once the scores have been calculated for each respondent, the algorithm sums the scores divided by the number of people who have responded. This is done for each question and for all questions of each determinant at each level. In this way, the club can identify the types of determinants it is already employing (for which the scores are at least 7) and those which it can improve (scores below 7). Analysis can also look at the three questions with the highest scores to identify strengths and the three questions with the lowest scores to identify areas which require the largest need for improvement.



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The e-PROSCeSS tool was developed by Santé publique France, the University Côte d’Azur and the University of Lorraine. It is based on an international Delphi study and the work of the research team. The project team is composed of Fabienne Lemonnier, Florence Rostan, Anne Vuillemin, Stacey Johnson and Aurélie Van Hoyer.

The tool was reviewed and amended by the PROSCeSS project monitoring committee, composed of: The Agency for Education through Sport - Patricia Guibert, French National Olympic and Sports Committee - Benoit Chanal, Regional Direction of Youth, Sports and Social Cohesion, Auvergne Rhône-Alpes – Maud Ottavy, Ecole des Hautes Etudes en Santé Publique Laboratory ARENES (EHESP) - Marie-Renée Guevel, French Sports for All Federation - Frederic Lecren & Julien Grignon, National Federation of Education and Health (FNES) - Christine Ferron, Fondation du Football - Guillaume Naslin, Ministry of Sports, Direction of Sports - Gilles Einsargueix & Nadia Mimoun and The Ministry of Solidarity and Health, Direction General of Health - Simona Tausan.

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**SUPPLEMENTARY
FILE 3**

e-PROSCeSS

Measurement of the perceptions of health promotion within sports clubs

Sports Manager's

Policies and operational rules of the sports club concerning health promotion

Managers activities to support coaches' health promotion activities



PROSCeSS

PROmotion de la Santé dans les Clubs Sportifs





INSTRUCTIONS

This questionnaire focuses on your perceptions on how health is promoted in your sport club.

There are no good or bad responses, merely indicate your degree of agreement with each statement by checking the corresponding box. Only check one box per line.

Please respond as sincerely as possible.

THANK YOU FOR YOUR RESPONSES.



Produced by Santé Publique France, the University Côte d’Azur and the University of Lorraine. It is based on an international Delphi study and the work of the project team. It has been validated among 621 participants, 110 coaches and 95 managers of French sports clubs.





**SUPPLEMENTARY
FILE 4**

e-PROSCeSS

Measurement of the perceptions of health promotion within sports clubs

Coaches Questionnaire

Policies and operational rules of the sports club concerning health promotion

Coaches activities to promote health





INSTRUCTIONS

This questionnaire focuses on your perceptions on how health is promoted in your sport club.

There are no good or bad responses, merely indicate your degree of agreement with each statement by checking the corresponding box. Only check one box per line.

Please respond as sincerely as possible.

THANK YOU FOR YOUR RESPONSES.



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**SUPPLEMENTARY
FILE 5**

e-PROSCeSS

Measurement of the perceptions of health promotion within sports clubs

Participant Questionnaire

Policies and operational rules of the sports club concerning health promotion

The health promotion activities and support given to participants by the coaches





INSTRUCTIONS

This questionnaire focuses on your perceptions on how health is promoted in your sport club.

There are no good or bad responses, merely indicate your degree of agreement with each statement by checking the corresponding box. Only check one box per line.

Please respond as sincerely as possible.

THANK YOU FOR YOUR RESPONSES.



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**SUPPLEMENTARY
FILE 6**



Indicateurs de la Promotion de la santé au sein des clubs sportif :



Mettre en place une approche qui regroupe toutes les actions du club, contribuant à la santé pas seulement celles centrées sur un comportement ou une thématique de santé



Impliquer tous les niveaux du club de sport (participants, parents, entraîneurs, dirigeants, volontaires) dans les actions et processus de décisions liés à la promotion de la santé



Impliquer des partenaires extérieurs et les acteurs locaux dans les actions et processus de décisions liés à la promotion de la santé



Être conscient que promouvoir la santé est un processus continu et cumulatif



Fonder ses actions sur les besoins propres au club de sport et à ses acteurs, en fonction du contexte du club de sport et des acteurs locaux

Les résultats sont issus d'une étude de cartographie conceptuelle incluant les réponses de 28 acteurs français du sport et de la santé. La génération et l'organisation de leurs idées donnent un aperçu des perceptions de ce dont les clubs sportifs ont besoin pour développer et mettre en œuvre des interventions de promotion de la santé.



Pour plus d'informations, contactez :

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10 stratégies plébiscitées par les acteurs

Formation des acteurs

- Fournir des programmes / modules de formation les éducateurs en sport-santé (prise en charge des publics présentant des pathologies et/ou des facteurs de risques)

- Intégrer de manière systématique dans les formations à destination des entraîneurs, une réflexion autour de la manière dont le club de sport peut influencer la santé tant au niveau individuel, collectif que vis-à-vis de son environnement

- Proposer aux acteurs du monde sportif un contenu sur la promotion de la santé à intégrer dans leur formations

Sensibilisation & Mobilisation

- Proposer une journée découverte de la promotion de la santé au sein des clubs de sport, aux dirigeants et éducateurs du club de sport pour leur donner envie de la mettre en place pour leurs adhérents avec des clés pour réussir

Plaidoyer

- Faire du plaidoyer auprès des fédérations pour un soutien aux clubs de sport sur la promotion de la santé

Partage et mise en réseau

- Mettre en place un site national de ressources pour la promotion de la santé au sein des clubs sportifs

- Animer un réseau régional de référents en promotion de la santé au sein des clubs (partage de pratiques)

- S'appuyer sur les expériences prometteuses d'autres clubs sportifs pour mettre en place les actions de promotion de la santé

Outils de promotion de la santé

- Créer des outils pour que les clubs puissent intégrer la santé dans leur projet de club

- S'appuyer sur des outils probants existants en promotion de la santé





**SUPPLEMENTARY
FILE 7**

Les 13 stratégies fondées sur des preuves scientifiques



APPROCHE PARTICIPATIVE

Valoriser une approche participative pour promouvoir la santé à travers le club de sport au-delà



COMMUNICATION

Développer et mettre en place une communication pour attirer l'attention sur les actions entreprises pour promouvoir la santé au sein de club de sport



DYNAMIQUE

Créer des stratégies d'amélioration du sentiment d'appartenance au club de sport en tenant compte des individus et de leur environnement (approche socio-écologique) pour définir les objectifs de promotion de la santé les plus pertinents



EDUCATION

Soutenir les clubs de sport, les dirigeants et les entraîneurs, en variant le type d'éducation qu'ils reçoivent, en tenant compte des spécificités des pratiquants qu'ils encadrent



FAISABILITÉ

Evaluer régulièrement la capacité du club de sport à atteindre ses objectifs de promotion de la santé



EXPÉRIENCE

Identifier les expériences antérieures, la volonté organisationnelle, les raisons et la qualité d'un engagement du club de sport en faveur de la promotion de la santé



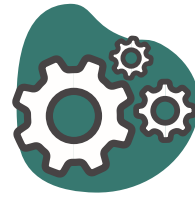
MOBILISATION

Mobiliser des personnes pour soutenir le développement de la promotion de la santé



MONITORING

Faire le suivi des activités de promotion de la santé au quotidien, en appliquant une philosophie, « chaque petit progrès est important » et analyser chaque changement



MOTIVATION

Comprendre ce qui motive les entraîneurs à mettre en place des actions de promotion de la santé et leur donner les capacités d'agir



OBJECTIFS

Ecrire les objectifs de promotion de la santé du club de sport, en utilisant des messages positifs, adaptés au langage du club, à la culture et à la place de la promotion de la santé dans le club, en tenant compte des inégalités sociales de santé



PARTENARIATS

Lier des partenariats avec d'autres organisations pour créer une culture commune et des processus collaboratifs pour promouvoir la santé



PLANIFICATION

Créer un plan de mise en œuvre pour atteindre les objectifs de promotion de la santé fixés



RESSOURCES

Identifier, développer ou évaluer les ressources financières, matérielles, humaines et de pouvoir d'agir disponibles pour investir en/dans la promotion de la santé



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**SUPPLEMENTARY
FILE 8**

Capitalization Interview Guide

Identity card headings

- Themes
- Objectives
- Targeted population
- Strategies used
- Implemented activities
- Funding
- Territory/location of action implementation (rural, urban, suburban)
- Involved partners
- Evaluation indicators

Explored elements

Elements of the context of action (There is no consensus on the notion of 'context') – there is no single model to describe the context which allows all dimensions to be described.

- **Nature of the environment: rural/urban/ suburban (collect more detail compared to the ID card)**
- **Starting points/emergence of the action: why choose this action at this point in time?**
- **Description of the general issue of the project in context**
- **Context-related barriers and levers:**
 - o At the national level (text- call for project proposals- new legislation- programs- plans)
 - o At the regional level (PRS priority- call for project proposals, etc.)
 - o At the local level
 - o At the organizational level
 - Inclusion of the action/project in the organization: stakeholder involvement- inclusion in a global project- existence of related actions, etc.

Partners

- **Nature of formed partnerships**
- **Mobilized skills/skills to be strengthened/missing skills**
- **Distribution and, when needed, development of the roles of the partners involved**
- **Barriers and levers to partnerships and counter strategies**

The action

- **Emergence of the action:** actions developed elsewhere, reference readings, specific demands, etc.
- **Action references:** underlying theories, guides to good practice and methods, etc.
- **Stakeholder involvement procedures**
 - o mobilization and level of partner involvement
 - o mobilization and level of implicated users/citizens
- **Choice of strategies**
- **Analysis of key moments of action**
 - o identification of key moments
 - o analysis of 3 key moments
- **Success factors**
 - o perception of what was successful in the action
 - o elements/factors which fostered these successes: identify 3 elements
- **Barriers**
 - o perception of failed elements in the action
 - o elements/factors which caused these failures: identify 3 elements

Evaluation of the action

- **Method and evaluation tools**
- **Principal results of the evaluation (in terms of results and processes)**

Reproducibility/transferability

- **Perception of the reproducibility in the same or different context**
- **Perception of the conditions of reproducibility/transferability (place, public, moments)**

Project / introduction to the interview:

Within the framework of a research and development project regarding health promotion in sports clubs (PROSCeSS), we would like to identify encouraging experiences of health promotion interventions (actions, initiatives) developed within sports clubs. This project, which we are working on throughout France, is the subject of a partnership between the University of Lorraine, Université Côte d'Azur and Santé publique France.

We have adapted a method and a guide for capitalizing on the data from the experience, built collectively by a national group led by the National Federation for Education and Health Promotion – FNES and the French Public Health Society – SFSP¹. The aim is to collect as much detailed information as possible on the actions carried out in the field, in

order to analyze, edit and share the information in order to enrich practices with the lessons learned from other's experiences, and to strengthen the skills of actors involved.

This information primarily concerns the strategies used in the actions and their key moments. We have already established, with your club, the identity card of the actions taken. The interview will be both voice recorded and notes will be taken. It will take about 2 hours to fully understand and document the actions taken within your club.

The text of this interview will be transcribed and analyzed to sort and organize all the information.

The product of this analysis will be sent to you for validation.

The section on data ownership will be integrated here (charter of the SFSP-FNES practical guide)

¹ Fédération nationale d'éducation et de promotion de la santé et Société française de santé publique

Objective: respond to the question: How does the club integrate health into its daily dynamic?

Variables	Question(s)	Follow-up Questions
CONTEXT OF THE ACTION		
Issue of the action	Which health problem(s) does your action/project address? Within your environment how does your project address the problem(s)?	Explore the elements for clarification: - diagnostic or existing data - perception through experience/knowledge of the field (provide examples)
Starting point/Emergence of the action	Can you tell me how this project was conceived? <i>(this question is not to explore content, but rather context, initiators, opportunities)</i>	Why have you engaged in this action at this time? What events/opportunities triggered considering this action? - Opportunities at the national level - Opportunities at the regional level

		<ul style="list-style-type: none"> - Opportunities at the local level or within your organization? - An observation / needs / problems within your organization? <p>In what way did you feel the context was favorable when you initiated this action?</p> <p>Were there any obstacles linked to the context, any resistance in the action's environment that made its implementation difficult?</p>
Position of the action within the organization	How is this action integrated within the daily life of your organization?	<p>Is it part of the club's community project?</p> <p>With which goals?</p> <p>Is it an extension of another project, and if so, which one?</p> <p>Does your club dedicate human and / or financial resources to this type of project?</p>
Funding the action	How is this specific action funded?	Did your club allocate a budget? Human resources? Have your partners contributed to the funding? Have you received a grant?
THE ACTION		
Partners	What partners were involved in your project/action?	<p>What were the specific skills or competencies of each of them?</p> <p>What was the role of each partner?</p>
	Have the roles of the partners changed over the course of the project?	Why, in what manner?
	According to you, which partners/types of partners were missing during the course of this action/project?	Today, for example, if you had to replicate this action, what new skills would you mobilize?

	How would you like the partnership to work?	Possible obstacles to the successful functioning of the partnership? How did you manage the obstacles? Levers for successful operation
Elaboration of the action	On which theoretical and practical elements did you base your action? <i>(This question is to explore the theoretical and practical frame of reference not the context)</i>	What examples of similar actions inspired you? What practical guides or references have helped you? Could you recommend one or two relevant documents?
Developed strategies	How have you defined your target population? What was done to mobilize them?	Detailed description of the relays and supports Why this choice?
	How did you define public participation in your action?	Describe the modalities to associate the different phases of the action
	What action strategies have you used?	Why have you chosen these? What hypothesis have you made? Describe the strategy, the modalities to implement these tools
Communication around the action / development	Was a communication/value added strategy carried out?	Describe the strategy, implementation procedures and tools (with whom, how and when).
Perception of the action	Please identify 3 key moments of the action. These are the moments when you felt that something happened either to promote the dynamic or to slow it down. These can be moments that you identify as positive or difficult.	Why or what do you think made this moment crucial? How did you overcome the more difficult moments? Explore several dimensions related to the environment, skills, public, choice of strategies, partnerships, etc.
	Please tell me why you consider this action a success?	Identify three success factors

	Have you seen any unanticipated positive effects?	Did this action produce benefits that were not included in your original objectives, for example increased member loyalty?
	What have you learned from this action in your professional practice? What competencies have you personally developed?	If you reproduce this action what would you keep, what would you change?
EVALUATION		
Evaluation method	How have you evaluated the action?	Which method and which evaluation indicators did you choose? Who is in charge of evaluation? Was an evaluation document produced? How was it shared and in what format?
Results	What do you think are the principle results of the action?	What changes did this action produce? Explore changes in the public as well as in practices and dynamics around the club
	According to you, how has this action contributed to integrate health into the daily dynamic of the club?	Did a manager or beneficiaries question the club's commitment to the project? Does this type of project meet an objective of a community project? If no, is it foreseen to introduce an objective relating to health in this project?
Reproducibility/transferability	What conditions are necessary to reproduce this action elsewhere? What type of support would you have liked to have when you began this project?	If you had to advise an intervention manager working in a similar context, what advice would you give them to carry out the same action? What are the essential 'ingredients' for good results? What may have made it easier for you when you started the project, what might be helpful

		to another club interested in carrying out the same type of project?
Records/documents	Do you have any documents or writings produced or used in connection with this action that you could provide?	Does an educational project exist? A charter? regulations? press articles? educational support materials?



**SUPPLEMENTARY
FILE 9**

LA CARTE D'IDENTITÉ DU PROJET

L'école Jaune et Bleu

ASM (Association Sportive Montferrandaise) Omnisports
Clermont-Ferrand – Pôle Sport Avenir Jeunesse

Thématique(s)

L'école Jaune et Bleu cible les thématiques liées à la nutrition (APS et alimentation), à la citoyenneté, et à la réussite scolaire.

Objectifs

L'ASM Omnisport de Clermont Ferrand se fixe plusieurs objectifs dans le cadre de ce projet :

- > Donner une appétence à la pratique sportive, individuelle et collective
- > Se servir du sport comme levier éducatif
- > Faciliter les apprentissages (scolaires, sportifs, de savoir être)
- > Éduquer à la santé avec le concours du pôle vitalité





Public(s) concernés

Enfants de 8-10 ans, 2 groupes de 30, issus de deux écoles en QPV (Quartiers prioritaires de la Politique de la Ville)



Stratégies d'action déployées

Plusieurs stratégies sont mises en œuvre pour atteindre ces objectifs :

- l'utilisation du sport comme un levier éducatif
- l'éducation pour la santé
- l'éducation à la citoyenneté
- le développement de compétences comme le savoir être



Activités déployées

L'école Jaune et Bleu est une des actions parmi la quarantaine menées à l'année dans le cadre du pôle éducatif du club. Ce projet se déroule deux fois par semaine, de 16h à 18h pour chacune des deux écoles du quartier de la Gauthière, en partenariat avec l'association de quartier « L'ouverture » et deux Etaps (Educateur territorial des activités physiques et sportives) de la ville, avec plusieurs activités :

- Formation des éducateurs sportifs à playdagogie, (active et participative qui utilise le jeu sportif pour faciliter les apprentissages) par Play International
- Atelier aide aux devoirs par groupe de 15
- Atelier APS multi activités, multisports (changement de sport tous les trimestres)
- Goûter en commun, temps d'éducation à l'alimentation (collation, équilibre alimentaire, ...)
- Après le goûter, inversion des groupes APS et Aide aux devoirs
- 3 à 4 fois/an, atelier APS en intergénérationnel avec des adhérents ASM – pôle Vitalité qui pratiquent de l'APA



Financements

Le financement de ce projet est de 21 000 € par école par an.

Les financements viennent de plusieurs sources : de l'ASM directement, de la Ville de Clermont, de l'Ouverture, de l'association Apels (prix Fais-nous rêver), de Techpro (entreprise).



Territoire/lieu de déroulement de l'action

Deux écoles du quartier de la Gauthière à Clermont-Ferrand, l'équipement de la section tennis de l'ASM pour l'aide aux devoirs.



Partenaires impliqués

Différents partenaires sont mobilisés dans le projet, avec en interne, le pôle Vitalité et le cabinet médico-sportif de l'ASM et à l'externe, l'Éducation nationale (équipes éducatives des deux écoles + rectorat), la ville de Clermont-Ferrand, l'association « l'Ouverture » et des bénévoles.



Indicateurs d'évaluation

L'ASM Omnisport évalue principalement la perception et l'adhésion au dispositif, le sentiment d'appartenance, la volonté de pratiquer, l'adhésion et la fidélisation à l'ASM.

L'école Jaune et Bleu

ASM Omnisports Clermont-Ferrand – Pôle Sport Avenir Jeunesse

L'action en quelques mots

L'école Jaune et Bleu souhaite utiliser le sport comme moyen de développement des compétences physiques, sociales et mentales des jeunes, dans une approche globale et ludique, pour une réussite scolaire et une éducation permanente.

Le club souhaite jouer un rôle actif dans la communauté locale, notamment au sein du quartier où il est implanté. Ce rôle a toujours été plébiscité par les fondateurs du club avec une vision de sport pour tous et d'intégration par le sport.

L'école Jaune et Bleu est un dispositif de soutien scolaire et de partenariat avec les écoles pour les jeunes d'écoles proches du club de sport. Les jeunes bénéficient d'un goûter et d'une sensibilisation à l'alimentation saine, sont accompagnés par un soutien aux devoirs et des activités sportives à la sortie de l'école, pendant deux heures (de 16 à 18h), deux jours par semaine.

Le contexte

L'ASM Omnisport est un club adhérent à la Fédération Française des Clubs Omnisports. Il est composé de 15 sections sportives, complétées par un pôle « sport avenir jeunesse » travaillant à l'intégration des jeunes par le sport et au dynamisme de la communauté locale), un pôle « ASM vitalité » (sport en entreprise, en station thermale, en local, à la maison, bilan de santé) et une « pépinière de Haut Niveau Rugby ». Le club a été fondé en 1911 pour promouvoir une politique sportive ouverte au plus grand nombre, en proposant d'une part une participation aux compétitions nationales et internationales au plus haut niveau et en encourageant la pratique à tous les âges de la vie, par l'entreprise Michelin. Le club possède un budget annuel de 10,6 millions d'euros, pour l'accueil de 7000 adhérents, 172 salariés (80 ETP), 400 bénévoles. Il est situé dans un quartier prioritaire de la politique de la ville. Les infrastructures du club incluent un espace restauration (7j/7 avec 300 repas par service), un cabinet médical intégré (médecins, kiné, diététiciens) réalisant 12 000 actes médicaux par an, des infrastructures à la Gauthière (6 hectares), aux Gravances (2 hectares) et à la salle Diderot. L'ASM souhaite travailler autour de parcours de vie avec quatre thématiques : sports pour la santé, sports pour tous, sports pour s'intégrer et sports pour devenir. La section ASM Sport Avenir Jeunesse a un budget de 266 000 euros pour financer une trentaine d'actions, mises en place par deux salariés (un temps plein et demi), les prestations des entraîneurs et la logistique. L'école Jaune et Bleu coûte 42 000 euros par an.

Le dispositif touche 60 enfants de CM1 et de CM2 des écoles Jean de La Fontaine et Charles Perrault, ainsi que leurs familles. Le choix de ces écoles a été réalisé pour éviter les problématiques de transports, et le choix des enfants a été posé selon trois critères : des jeunes en difficulté scolaires, et/ou en difficulté sociale et/ou qui n'ont pas de pratique sportive dans le milieu associatif.

Le constat

Au départ, le club souhaitait faire plus pour le quartier au sein duquel il déploie ses activités que proposer du sport-spectacle ou une pratique sportive « classique ».

Un second constat a été fait sur les blessures des jeunes lors des activités sportives (encadrées ou non), et donc un besoin de réagir par rapport à des problématiques que les jeunes et leurs familles font remonter. Les projets portés par l'ASM sont construits au sein d'un écosystème, avec les partenaires (conventionnés ou non) et avec le public cible, pour définir les activités.

L'opportunité

La genèse du projet vient du groupe professionnel Michelin, de son manager, qui a changé de mission il y a quatre ans, puisque c'est la troisième année que l'école Jaune et Bleu existe. Dans sa mission première, il avait l'innovation, la formation et le lien avec Clermont. Il a lancé des réflexions sur l'impact du sport spectacle, sur l'implication du sport féminin et souhaite lancer une action au cœur de Clermont pour soutenir les enfants du quartier. Il a été rejoint dans son projet par l'ancien inspecteur de l'académie, impliqué dans la section rugby amateur, qui travaillait en lien avec les écoles primaires. C'est de là que sont parties les idées de l'école Jaune et Bleu. Le projet a débuté avec une école (Jean Fontaine), par la construction du programme et le recherche de partenariats pour pouvoir proposer deux heures d'activités par jour, quatre jours par semaine.

Le dispositif de l'Ecole Jaune et Bleu s'inscrit « dans le cadre des actions politiques de la ville, donc avec l'accompagnement des acteurs de la politique de la ville, à savoir la mairie, la métropole, le département et l'État, au travers CGT, FIPD... ».

Les principes d'action de l'action

> Être à l'écoute des jeunes, dans une approche participative : « ce projet-là se construit indirectement avec eux [les jeunes] donc dans les cycles, alors il y a des choses que l'on peut faire et des choses que l'on ne peut pas faire, pour X raisons, infrastructures, moyens, mais on essaye de regarder, d'être regardant sur ça. Pour que ça marche bien, c'est bien de partir de leurs envies même si, je vous le disais, on ne fait pas ça à 100 %, voilà. »

> Adopter une posture professionnelle, pour que les enfants s'adressent à nous de manière respectueuse et qu'ils nous donnent du crédit dans nos paroles et actions.

> Favoriser la mixité des âges et des cultures, où notamment les jeunes côtoient les pratiquants de tennis adultes, les anciens du dispositif, d'autres jeunes pour créer un climat d'échange intergénérationnel et interculturel positif.

Les objectifs du projet

L'ASM Omnisport de Clermont Ferrand se fixe plusieurs objectifs dans le cadre de ce projet :

- > Donner une appétence à la pratique sportive, individuelle et collective ; se servir du sport comme levier éducatif,
- > Faciliter les apprentissages (scolaires, sportifs, de savoir-être)



Le contenu de l'action

L'accompagnement des jeunes se fait à partir de plusieurs activités :

- En début d'année scolaire, ce sont les enseignants des écoles qui ont identifié les enfants en difficulté et leur ont proposé l'activité. Les jeunes ont tout de suite adhéré et sont venus participer aux séances (« on a fait septembre, octobre, novembre et il n'y avait pas un absent. »). Même si les jeunes n'allaient pas à l'école, ils venaient aux activités, notamment pour le goûter proposé.
- Aux enfants en difficultés, des activités de 16 à 18h sont proposées, avec un goûter (bouteille d'eau, fruit, Grany), un soutien aux devoirs et des activités sportives ludiques et variées, deux fois par semaine (allant de vacances à vacances).
- Les enfants qui ne bénéficient pas du dispositif, car ils sont plus en réussite scolairement ou plus sportifs, sont également invités à certains moments.
- Les activités sportives proposées sont variées (pas de pratique mono-sportive), il n'y a pas de notion de compétitions, et une préoccupation de ludo-sportif.
- Après la Toussaint, une fois que le dispositif est mis en place et stabilisé avec les jeunes, il y a quelques activités de plus grande ampleur (visiter Michelin, visiter le Puy de Dôme, faire un tournoi de hand). Les jeunes bénéficient également de maillots à l'effigie du dispositif, pour améliorer le sentiment d'appartenance.
- Il y a une action commune entre les anciens du dispositif et les nouveaux, pour que les enfants puissent se retrouver et travailler la transition avec le collègue. Il y a une volonté de garder un contact avec les enfants jusqu'à la 3ème, pour connaître leur suivi scolaire.
- Des outils ont été créés pour favoriser la concentration et l'attention, comme l'explique un des responsables de l'action : « on a détourné des jeux éducatifs, des jeux que l'on va retrouver à Toy's R Us, à E. Leclerc, etc. où vous voulez, et à chaque jeu correspond la notion de concentration, d'attention, de mémorisation, etc. on achète ces jeux-là, les enfants font des jeux et indirectement on les fait travailler sur l'attention – concentration. ». D'autres outils pour sensibiliser à l'alimentation saine : « j'avais récupéré toutes les dinettes, etc., et après des produits non périssables. On fait des groupes et on met tous les produits sur la table et on disait « voilà, c'est quoi ton petit-déjeuner préféré ? », alors ils viennent, ils prennent les gâteaux, ils prennent, etc., et après on allait dans la réflexion en disant « tu crois que c'est bien pour la santé ? », donc on leur explique, mais sous forme de jeu, et donc ils construisent, alors ils ont des petits plateaux comme à la cantine, etc. ils mettent dans les plateaux donc on essaye de faire des choses un petit peu sympa avec eux. La seule réflexion que j'avais eu la première fois, j'ai eu « monsieur, il n'y a pas de kebab ».
- Les encadrants, notamment de la partie sur l'école de devoirs, ont été formés pour travailler avec les jeunes sur l'attention, sur la concentration, pas uniquement sur le fait de faire les devoirs.

Les partenaires du projet/ de l'action

- > Un partenariat a été lié avec la municipalité de Clermont Ferrand, notamment sur la collaboration avec des entraîneurs pour animer les activités (huit heures par semaine).
- > L'association Ouverture, qui participe pour l'aide aux devoirs.
- > L'académie de Clermont Ferrand soutient le déploiement du dispositif dans deux de ses écoles
- > La fondation Play International (Play Pédagogie) qui participe à l'organisation de débats sur les problématiques de mixité, de violence etc.
- > L'entreprise Techpro qui est une entreprise auvergnate qui fabrique des portails et souhaite soutenir les initiatives de responsabilité sociétale et citoyennes de l'ASM Omnisport, à hauteur de 7000 euros par an.

- > Le Commissariat Général pour l'Égalité des Territoires
- > L'école supérieure de commerce travaille avec les responsables du dispositif sur la question de l'évaluation et du marketing.
- > Un partenariat avec la filière Education et Motricité de l'UFR Staps de Clermont permet de monter une plateforme et son cahier des charges pour suivre les jeunes passés par le dispositif à long terme, sur le plan scolaire et sur le plan sportif. Il permet également de solliciter des stagiaires pour construire des séances pédagogiques pour les jeunes.
- > Le club est financé pour plus de la moitié par la Fondation d'entreprise Michelin (approximativement 6 millions d'euros) et est propriétaire de ses infrastructures. Une convention est signée chaque année, avec des objectifs sociétaux qui vont au-delà de la pratique sportive. La Mairie, la Métropole, le Département, la Région et l'Etat subsidient le club à hauteur de huit cent - neuf cent milles euros. Les adhérents participent également au modèle économique.

L'évaluation

Un bilan est effectué sur les activités proposées avec les jeunes : « on les sollicite, on fait un bilan avec eux aussi pour savoir les activités qu'ils ont aimées, celles qu'ils ont moins aimées, et celles qu'ils aimeraient faire. » Le critère principal de l'évaluation est la réussite scolaire au niveau de l'Éducation nationale. Le critère secondaire est l'inscription dans une pratique sportive et plus largement, l'adoption d'un comportement physiquement actif. Il y a un suivi à long terme, en sixième, en cinquième et en quatrième, pour savoir si les jeunes poursuivent l'activité.

L'ancrage dans un modèle théorique ou des données scientifiques

Le programme a été inspiré d'une action qui était déjà mise en place au sein du Paris Saint Germain, c'est l'idée qui a été reprise, tout le reste a été construit par les porteurs de l'action.

Les limites du projet/ de l'action

Une des difficultés liées au projet est la logistique (organisation des plannings, réservation de salle, programmation des séances, courses) et le coût (48€/semaines, plus les goûters pour chaque enfant), qui nécessitent de trouver des ressources humaines et financières.

Une des limites à l'élargissement et à la pérennisation du projet repose sur les infrastructures et la réservation des installations pour les années futures. Une salle dédiée au dispositif, notamment pour l'aide aux devoirs, où il est possible de refaire la décoration et de l'adapter au dispositif serait un plus, car à l'heure actuelle, ces activités sont faites dans la salle de réunion. Par ailleurs, une salle de musculation dédiée à tous les âges, où une salle d'activités pour enfants et adultes avec différents espaces de loisirs (avec des modules de psychomotricité, etc.) serait l'idéal.

L'avenir du dispositif et de l'ASM de manière plus générale est lié aux décisions de l'entreprise Michelin, qui finance le club de manière importante. Le jour où cette entreprise déménage ou arrête de soutenir l'ASM Omnisport, l'école Jaune et Bleu s'arrêtera également. Par ailleurs, le fait que Michelin finance fortement le club renvoie l'image d'une structure qui n'a pas besoin de soutien financier et les responsables des projets doivent se battre pour obtenir des financements publics ou privés.

A l'avenir, le dispositif pourrait être transféré dans d'autres clubs, et également mis en place sur Clermont Sud, mais ce travail nécessite la mise à l'écrit et la formalisation par un cahier des charges des actions entreprises.

Dans l'idéal, l'engagement d'un doctorant en thèse pour évaluer le projet et les effets du dispositif permettrait d'aller plus loin, avec des compétences que l'équipe n'a pas actuellement.



Les moments clés du projet

Un premier moment clé de l'action est le lancement, les enfants ont pris l'habitude de serrer la main des entraîneurs, mais également des autres jeunes et des enseignants. C'est une habitude qui illustre bien la dynamique de l'action et le responsable cite un enfant : « parce qu'ici ça veut dire que l'on est respectueux et que l'on est accepté donc il faut faire pareil ».

Un second moment clé de l'action est l'entrée dans l'activité des jeunes, notamment au tennis, qui est un sport considéré comme dédié à une certaine classe sociale, où les enfants ont eu peur d'entrer sur le cours, ainsi que leurs parents, ils étaient sur la défensive. Cela casse l'image et les enfants voient les installations de chez eux et s'identifient, font le lien ainsi avec les activités proposées.

Si c'était à refaire

Au départ, les activités démarraient à 16h pile, ce qui demandait aux enfants de quitter la classe un peu plus tôt et créait un conflit temporel sur la fin des activités scolaires. Les activités commencent à 16h10 maintenant.

Un des points de réussite est que les jeunes qui ont suivi le dispositif s'inscrivent dans le milieu associatif sportif ou au sport scolaire (45% pratiquent en club).

Un second point de réussite est la diminution des dégradations des installations, notamment au tennis, où l'école Jaune et Bleu a animé des activités avec les jeunes. Il n'y a plus de soirées, de saccages ou d'insultes, parce que ce sont les frères ou sœurs aînées des jeunes qui viennent dans le cadre du dispositif.

Les conditions pour reproduire l'action

Plusieurs éléments contextuels ont permis à l'action de se développer :

- Un des responsables du projet a pris le temps d'installer un climat de confiance, notamment par des déplacements auprès des partenaires, un suivi, la création de relations privilégiées et en face à face, notamment lors du démarchage de partenaires, pour « qu'ils accrochent » à la démarche. Il accorde de l'importance au développement et à l'entretien des relations avec les partenaires.
- Une attention particulière est portée tout au long du projet à réfléchir à sa pérennité et à son amélioration, pour consolider ce qui est fait, mais aussi pour élargir et faire grandir le dispositif. L'objectif premier n'est pas d'élargir, mais de conserver ce qui est mis en place, notamment le tournoi de handball.
- L'ASM Omnisport travaille avec trois agences de communication et a préparé pour le projet un dossier de presse, des vidéos et des supports. Des actions de marketing social ont été réalisées pour pouvoir solliciter des partenaires publics et privés. Cette action est diffusée en interne au club, comme les autres activités du club, sur les réseaux sociaux, lors de l'assemblée générale notamment.

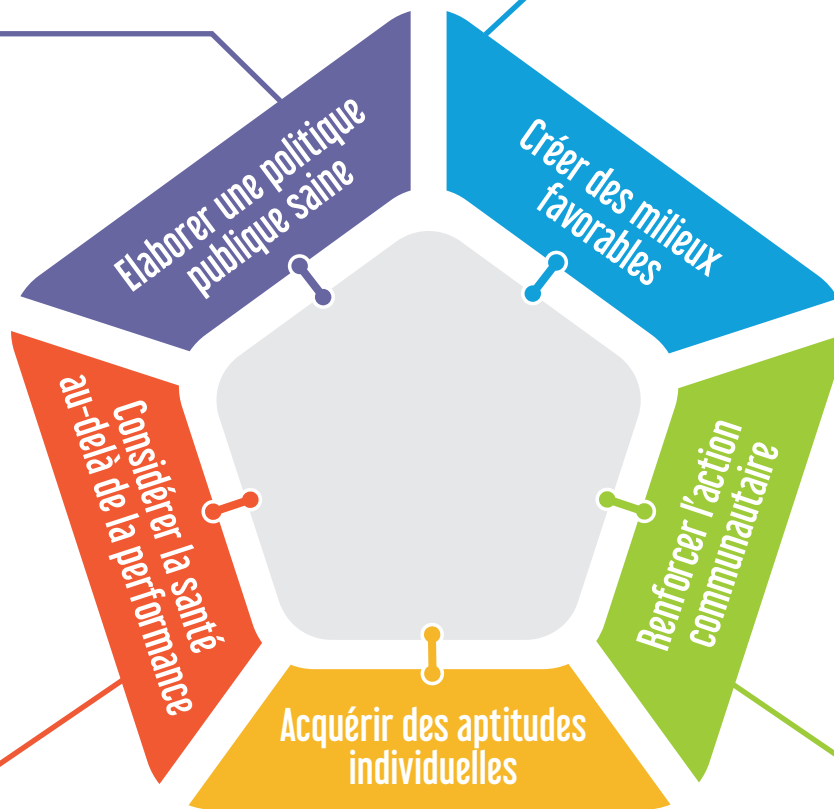
Plusieurs compétences ont été acquises par les responsables de projet :

- La première compétence est la construction d'un discours sur l'action en fonction de l'interlocuteur, ce qui a forcé une structuration de la pensée, une synthétisation pour un accès à différents niveaux et pour pouvoir répondre aux appels à projets : « Sur cette action précise, moi c'était de voir comment on pouvait la bétonner et quel discours on pouvait en avoir suivant l'endroit où on était. L'école Jaune et Bleu je ne l'explique pas pareil aux enfants qui la pratiquent que comme je peux l'expliquer à vous. »
- La seconde compétence développée repose sur le positionnement et l'accompagnement de l'équipe d'entraîneurs, pour répondre à leurs attentes, mais aussi à celles du public. C'est un aspect de coordination et de référence qui m'a poussé à prendre une posture éducative avec les différents encadrants impliqués dans l'action.

Éléments clés au regard de la Charte d'Ottawa

- > La création de l'ASM Omnisport avait déjà en 1911, une vocation à proposer du sport pour tous
- > Le club travaille avec son écosystème pour développer de l'éducation permanente, du sport-santé, du sport pour tous
- > L'école Jaune et Bleu entre dans les dispositifs nationaux des Quartiers Politiques de la Ville

- > L'école Jaune et Bleu offre la possibilité à l'ASM Omnisport de travailler l'éducation permanente et d'utiliser le sport à des fins éducatives scolaires et pour la santé
- > Par l'école Jaune et Bleu, la mixité sociale et culturelle est favorisée au sein du club

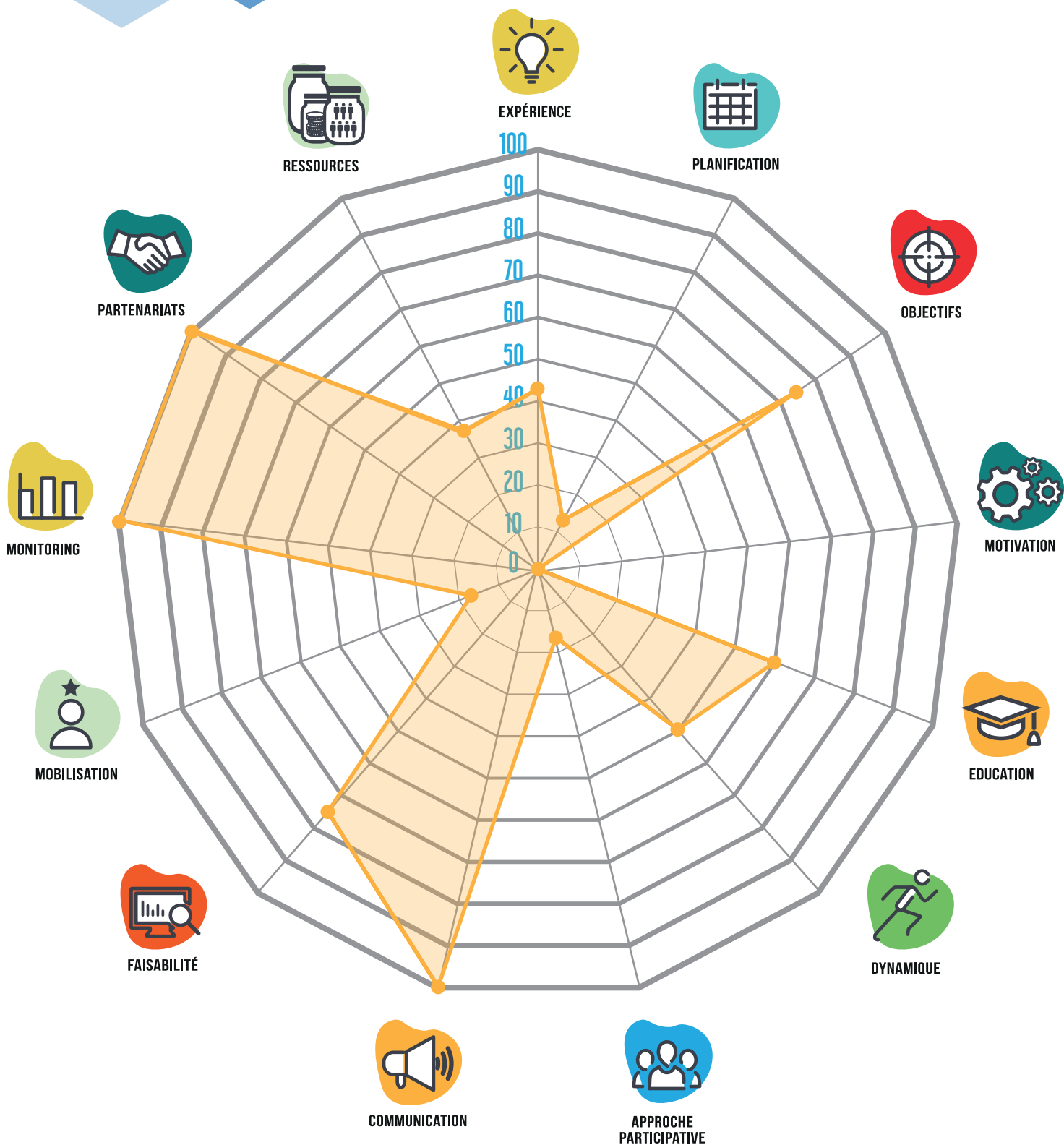


- > L'AMS Omnisport souhaite fortement jouer un rôle actif dans le développement et la réussite scolaire des jeunes du QPV où il est implanté, pas seulement développer de jeunes sportifs performants ou de loisirs.

- > L'ASM Omnisport joue un rôle très actif au sein du QPV où elle est implantée, que ce soit pour du sport de haut-niveau, du quartier prioritaire de la ville, du sport pour tous, ou de l'intégration par le sport
- > De nombreux partenaires, publics et privés collaborent pour soutenir l'école Jaune et Bleu
- > Le lien avec les écoles du quartier et le dispositif de collaboration proche entre le sport et l'école permet une prise en charge globale des jeunes

- > Par les activités proposées, les jeunes adaptent leurs comportements de santé (alimentation), travaillent leur concentration-attention, leurs compétences psycho-sociales et développent un goût pour une pratique sportive

Éléments clés au regard du modèle du club de sport promoteur de santé



Éléments clés au regard du modèle du club sportifs promoteur de santé

Communication

Créer un plan de communication (COM1) : Les agences de communication de l'ASM Omnisport ont développé des supports et outils de marketing pour diffuser le dispositif de l'école Jaune et Bleu.

Communiquer avec 1 seul message, un slogan (clair, explicite et compréhensible) (COM2) : Le nom de l'école Jaune et Bleu, ainsi que les messages clés ont été travaillés par le club pour avoir un discours adapté aux interlocuteurs.

Assurer la communication interne au club de sport (COM3) : le dispositif est diffusé en interne au club, comme les autres activités du club, sur les réseaux sociaux, lors de l'AG.

Assurer la communication externe du club de sport (COM4) : le dispositif est diffusé à l'externe, notamment grâce au plan de communication établi.

S'assurer que le club de sport communique avec tous les partenaires (COM5) : Une attention spécifique est portée à l'établissement de relations durables avec les partenaires, par une disponibilité importante et des échanges en face à face.

Dynamique

Tenir compte des interactions entre l'individu et son environnement, lors de la définition des objectifs de promotion de la santé (DYN2) : Tous les niveaux de l'ASM Omnisport (du bureau aux parents, en passant par les dirigeants, entraîneurs et partenaires) ont été sollicités dans la construction de l'action par diverses consultations.

Education

Soutenir les dirigeants et les entraîneurs à s'engager activement dans l'acquisition de connaissances et de compétences pour promouvoir la santé (EDU1) : Les entraîneurs de l'école Jaune et Bleu, et également des autres dispositifs sont accompagnés par le club, dans une réflexion générale, mais aussi dans la prise en charge spécifique de leur groupe pour promouvoir la santé.

Adapter individuellement le soutien aux dirigeants et aux entraîneurs en fonction du public qu'ils encadrent (tutorat, cours, e-learning) (EDU2) : La responsable de l'action a veillé à accompagner individuellement chaque entraîneur participant à l'école Jaune et Bleu, pour les sensibiliser aux spécificités du public.

Encourager les dirigeants et les entraîneurs à se soutenir mutuellement pour promouvoir la santé (EDU3) : C'est toute une équipe, au niveau du pôle avenir jeunesse, mais également au niveau du club, qui se préoccupe du rôle citoyen que le club peut jouer au sein de la société et plus précisément du QPV au sein duquel il est implanté.

Créer des outils et des formations pour soutenir la promotion de la santé au sein des clubs de sport (EDU5) : Des outils pour sensibiliser les jeunes, mais également accompagner les responsables des sections investis dans les activités proposées aux jeunes ont été développés dans la mise en place de l'action.



Expérience

Identifier les expériences antérieures du club de sport en matière de promotion de la santé (EXP1) : L'ASM Omnisport se base sur plus de 100 ans d'expérience pour proposer différentes pratiques sportives et actions de promotion de la santé. L'École Jaune et Bleu est dans la lignée d'autres actions antérieures.

Identifier la volonté organisationnelle en faveur de la promotion de la santé (EXP2) et identifier les raisons de l'engagement en faveur de la promotion de la santé (EXP3) : L'ASM Omnisport a une volonté forte de développer la promotion de la santé dans toutes ses actions, pour jouer un rôle actif dans le quartier au sein duquel il est implanté.

S'appuyer sur un diagnostic évaluant les besoins et attentes pour mettre en place les actions de promotion de la santé (EXP6) : Une consultation de l'écosystème du club est mise en place, notamment avant de lancer une action comme l'école Jaune et Bleu.

S'appuyer sur des expériences d'autres clubs de sport dans le développement de la promotion de la santé (EXP7) : L'idée de cette action vient du PSG.



Faisabilité

Évaluer régulièrement les ressources financières mobilisées (FAIS1) et évaluer régulièrement les ressources humaines mobilisées (FAIS2) : Les ressources financières sont évaluées toutes les années et chiffrées de manière très précises par les responsables du projet. Il en va de même pour les ressources humaines.

Évaluer régulièrement le temps dédié à l'atteinte des objectifs (FAIS4) : Le temps dédié par le club à la logistique, la mise en place des activités de l'école Jaune et Bleu sont identifiés et chiffrés par le club. Le temps de démarchage de partenaires et de création d'outils est moins chiffré, mais fait partie du développement du programme.



Objectifs

Définir des objectifs de la promotion de la santé (OBJ1) et rédiger et documenter formellement les objectifs de promotion de la santé (OBJ2) : Les objectifs du dispositif ont été définis et rédigés dans divers supports, notamment dans des dossiers d'appel à projets, dans des clips vidéos ou dans le projet éducatif du club.

Prendre en compte la manière dont les personnes appréhendent leur santé lors de la définition des objectifs de promotion de la santé (OBJ4) : les objectifs ont été définis après une consultation de l'écosystème de l'ASM Omnisport.



Mobilisation

Identifier et mobiliser un ou plusieurs représentants en interne en promotion de la santé au club de sport (MOB3) : Les responsables du dispositif sont bien identifiés au sein de l'ASM Omnisport, par les dirigeants, les entraîneurs, les partenaires et le public ciblé.

Mobiliser les décideurs et élus locaux pour promouvoir la santé au sein des clubs de sport (MOB5) : En s'insérant dans le dispositif QPV, le programme sollicite le soutien des élus locaux à nationaux.



Monitoring

Collecter ou répertorier les petites améliorations en vue d'atteindre les objectifs de promotion de la santé (MON1) : un suivi proche des jeunes, mais également de l'investissement des partenaires et de la logistique de l'activité, pour une adaptation en fonction des besoins du public est réalisé par le responsable du dispositif.

Suivre toutes les activités de promotion de la santé entreprises dans le club de sport (MON2) : Les activités, ainsi que les sorties sont répertoriées et suivies par le responsable du dispositif.

Suivre les effets des actions à court terme (changements sur 1 saison sportive) (MON3) et suivre les effets des actions à long terme (changements au-delà d'une saison sportive) (MON4) : Les effets du programme sont suivis du CM2 à la quatrième, notamment sur la réussite scolaire et l'investissement dans une pratique sportive associative ou scolaire.

Suivre les politiques de promotion de la santé du club de sport (MON5) : Ce dispositif reflète l'application des principes généraux du club et de sa politique sportive et citoyenne.



Approche participative

Identifier et valoriser chaque action de promotion de la santé (APP4) : les actions mises en place au sein du dispositif sont identifiées et valorisées en interne et externe à l'ASM Omnisport.



Partenariats

Identifier des partenaires pour mettre en œuvre des actions de promotion de la santé (clubs de sport, agences, collectivités territoriales, professionnels de santé...) (PART1) : un travail important de recensement de nouveaux partenaires est réalisé en continu, en fonction des opportunités.

Définir les modes de collaboration avec les partenaires existants et à venir (définir les rôles, partager les expériences, les termes du contrat, l'évaluation des résultats, le pouvoir égal des partenaires...) (PART2) : Les modes de collaboration et d'investissement des différents partenaires, ainsi que leur rôle dans le dispositif est bien défini avec le responsable du dispositif.

Construire une culture commune avec les partenaires existants et à venir (confiance, reconnaissance, temps partagé...) (PART3) : Une attention particulière est portée aux échanges et à la confiance avec les partenaires du dispositif.



Planification

Tenir compte de la durabilité des actions de promotion de la santé (PLAN6) : La pérennité des actions est considérée dans la mise en place du dispositif.



Ressources

Evaluer les ressources financières disponibles (subventions, sponsors) pour investir dans la promotion de la santé (RES1) et évaluer les ressources humaines disponibles (temps consacré au bénévolat, turnover du personnel) à investir dans la promotion de la santé (RES2) : Les ressources disponibles pour l'école Jaune et Bleu sont évaluées de manière régulière.

Evaluer les compétences et les connaissances actuelles dans le club de sport disponibles pour promouvoir la santé (RES3) : Le club est conscient des compétences mobilisables (pour créer les outils et organiser l'action) et à mobiliser, notamment sur l'évaluation, pour promouvoir la santé.

Identifier les financements mobilisables pour la promotion de la santé (RES5) : Le club sollicite les collectivités territoriales pour financer l'école Jaune et Bleu.



PROSCeSS

PRoMotion de la Santé dans les Clubs Sportifs

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LA CARTE D'IDENTITÉ DU PROJET

Mon corps, j'apprends à le connaître
FC la Montagne

Thématique(s)

Bien-être physique et mental, nutrition, sommeil, activité physique, citoyenneté, développement des compétences psychosociales, promotion de la santé par le sport.

Objectifs

- > Favoriser les relations fondées sur le respect mutuel, la coopération, l'entraide, les règles de vie, les décisions collectives et l'autonomie de l'individu.
- > Favoriser toute mixité confondue, et permettre à tout enfant de pratiquer une activité physique de son choix. Le développement et la réflexion, notamment autour du handicap, doit être un objectif de l'équipe encadrante, dans les valeurs de l'Education Populaire : « une activité pour tous, réfléchis par tous ! »
- > Favoriser la mixité sociale, et être vigilant face à la fragilité de familles en difficulté, pouvant entraîner isolement et/ou exclusion.
- > Sensibiliser les enfants sur des situations de sociétés, et favoriser leur participation dans des activités de solidarité, de lutte contre les discriminations.
- > Favoriser la prise de conscience de la nécessité d'acquérir des connaissances dans la pratique de gestes de premiers secours, et leur proposer des activités d'initiation.
- > Favoriser l'expression, la prise de parole, la prise de position sur un sujet, quel qu'il soit, en posant des moments d'échanges, de réflexion, de débat, à l'intérieur du groupe à des moments choisis.
- > Permettre aux enfants de s'ouvrir à des activités culturelles, sociale, sportives, autres que celles exercées habituellement, afin d'aiguiser leur curiosité et de s'adapter à un environnement inconnu ou peu connu.
- > Permettre aux enfants de comprendre et de respecter les règles essentielles d'hygiène et de santé dans la pratique du sport (équilibre alimentaire, sommeil, hygiène corporelle, ...).
- > Faciliter l'implication des familles dans la vie du club.
- > Proposer des activités, des stages, autour du foot, qui soient financièrement accessibles à tous.





Public(s) concernés

Enfants de 5 à 15 ans, familles, bénévoles



Financements

- > Collectivité territoriale
- > Forte implication bénévole



Stratégies d'action déployées

Education populaire - Education pour la santé



Territoire/lieu de déroulement de l'action

Football club La Montagne – commune située à 15 kms de Nantes



Activités déployées

- > Diagnostic/état des lieux
- > Ateliers par petits groupes (10 enfants)
- > Formation des intervenants, entraîneurs sportifs, responsables techniques.
- > Création d'un outil d'autoévaluation de l'alimentation et du sommeil
- > Dialogue avec les parents



Partenaires impliqués

Bénévoles de l'association, psychologue du sport, sociologue, ESAT (Etablissement et service d'aide par le travail), municipalité



Indicateurs d'évaluation

- > Adhésion, participation des enfants et des familles
- > Adhésion des bénévoles à la démarche
- > Adaptation de l'outil au public

Mon corps j'apprends à le connaître

Football club de la Montagne

L'action en quelques mots

La thématique de l'action est centrée sur le développement de l'enfant grâce au sport, avec un axe sportif sur la maîtrise des gestes du football et un axe social, reprenant le développement de la santé physique, mentale et sociale, par une sensibilisation sur les comportements de santé, les compétences psycho-sociales.

L'intérêt avancé par le Football Club de la Montagne s'appuie sur le fait que le club de foot occupe une place privilégiée dans la vie des enfants et que les entraîneurs sportifs contribuent au même titre que les parents, l'école... à leur éducation et à la transmission de valeurs.

Le projet s'appuie sur un projet éducatif qui intègre un axe sportif et un axe social, pour que les enfants comprennent mieux leur corps et soient en capacité de faire des liens entre leurs performances sportives, leur hygiène de vie, leur santé physique et psychique.

Le contexte

Le club de foot de la Montagne accueille des enfants de 5 à 15 ans. Il est situé dans la petite couronne Nantaise, à 15 kms de Nantes. La population a évolué au cours des dix dernières années. Plutôt ouvrière il y a quelques années, elle se caractérise aujourd'hui par une plus grande diversité culturelle et des difficultés sociales. La question de l'exclusion se pose de manière différente pour le club.

Le public concerné comprend les pratiquants de 5 à 15 ans, les membres et leur entourage du club de football La Montagne.

L'action est intégrée dans le projet du club, comme le souligne la responsable de l'action : « Il faut qu'il y ait un projet associatif qui aille vers la transmission de valeurs, la transmission dans l'accompagnement de son public qui ne soit pas que sur de la consommation de sport et de la compétence sportive »

Le constat

Le projet Mon corps j'apprends à le connaître est né du constat par les personnes qui les encadrent d'une fluctuation de la forme physique et de l'attention des enfants au cours des entraînements et des matchs. Le projet s'est alors construit pour que les enfants comprennent mieux leur corps et soient en capacité de mieux contrôler leur santé. La réflexion au sein du club a permis de mettre à jour notamment le fait que de nombreux enfants, en garde partagée vivaient des rythmes différents chez leurs deux parents avec une incidence sur leur forme physique. Par ailleurs les profils, les conditions de vie et les habitudes des enfants sont très différentes d'une famille à l'autre et l'objectif du club était alors « de ne pas donner une règle générale, une grande ligne que conduit tout le monde... mais que cela puisse répondre à chacun »

Après un questionnaire envoyé aux familles et des entretiens auprès des enfants, l'intérêt se porte sur la nutrition et le rythme de vie (sommeil notamment).

L'opportunité

L'opportunité saisie par le Football Club de la Montagne s'appuie sur le fait que le club de foot occupe une place privilégiée dans la vie des enfants et que les entraîneurs sportifs contribuent au même titre que les parents, l'école... à leur éducation et à la transmission de valeurs.

La mise en place du projet éducatif fédéral a constitué une opportunité pour les clubs de football de s'engager dans une réflexion sur la dimension éducative. Il a permis au FC La Montagne d'intégrer la question de la santé à travers la nutrition notamment et de penser la notion de référent de façon différente. La dimension éducative qui ne rentrait pas dans les cases s'inscrit aujourd'hui dans un cadre au niveau national.

Le projet été créé il y a 8 ans, par la mise en place un projet pédagogique construit autour de 2 axes : un axe sportif (acquisition des gestes technique de la pratique du football) sous la responsabilité d'un référent « vie sportive » et un axe social (sous la responsabilité d'un référent « vie sociale » (intégration des valeurs du vivre ensemble et développement de l'enfant, notamment la nutrition et le sommeil).

Les principes d'action de l'action

Le principe fondamental du projet est « l'accompagnement de la personne dans sa construction de tous les jours ». Plusieurs autres principes d'action complète ce principe fondamental :

> S'appuyer sur les principes de l'éducation populaire. Faire en sorte que les enfants deviennent « acteurs de leur vie » et qu'ils apprennent à se connaître « pour savoir de quelle façon il fallait qu'ils vivent et qu'ils grandissent pour être le moins fatigués possible

> Un principe de non jugement, de non culpabilisation et de respect des singularités et des conditions de vie des familles « comment on leur donne des bases à chacun un outil des références et avec ça comment on l'adapte à son mode de vie » « que les familles ne se sentent pas dirigées par le foot »

> Faire évoluer le projet en fonction des besoins : « ce sont des thématiques qu'on observe, de problématiques qu'on peut observer et on s'interroge sur ce que l'on peut essayer autour de ça, c'est plutôt de l'observation, des propositions des uns et des autres, des questionnements qui nous amèneraient à essayer des choses à mettre des projets en place »

> La conscientisation : « les enfants il fallait qu'on leur fasse conscientiser le fait qu'effectivement mon rythme de vie peut avoir un impact sur mon bien-être et ma santé »

> L'interculturalité

Les objectifs du projet

Plusieurs objectifs ont été identifiés par la responsable du projet :

> Contribuer à l'amélioration du bien-être physique et mental des enfants dans un contexte de pratique sportive

> Permettre aux enfants de comprendre et de respecter les règles essentielles d'hygiène et de santé dans la pratique du sport (équilibre alimentaire, sommeil, hygiène corporelle, ...).

> Donner aux enfants et à leur famille les outils pour faire des choix favorables à leur santé

> Accompagner les enfants dans leur construction et leur épanouissement

Le contenu de l'action

Différentes actions sont réalisées vers différents publics :

- La première action réalisée a été un questionnaire distribué aux familles sur les habitudes de vies, ainsi que des entretiens avec les plus jeunes et des discussions avec les plus grands. 75% des questionnaires ont été récupérés par le club et les entretiens ont été faits sous forme d'atelier où les joueurs tournent sur des activités physiques pratiques et des ateliers individuels d'échange et de compréhension ou d'apports théoriques (15 minutes par atelier). Cet apport de connaissances théoriques porte sur la nutrition et le lien avec la forme physique. L'image utilisée est celle d'une voiture qui doit fonctionner et la mise en parallèle du corps et de la voiture
- Pour structurer le projet, un thème est choisi chaque année, puis décliné tout au long de l'année avec l'organisation en fin d'année d'un stage de 3 jours. En 2017, le thème « j'apprends à reconnaître et j'apprends à aider les autres » a intégré une initiation aux gestes de premiers secours, une réflexion sur la nutrition et la santé mentale individuelle ou au sein d'un groupe.
- Pour prolonger les ateliers, un outil supporte la réflexion individuelle : « l'équipe éducative a construit un outil d'autoévaluation des prises alimentaires »; chaque enfant renseigne l'outil le jour précédent le match et le jour du match. Les items sont simples : légumineuses, féculents, viande blanche ou poisson, fruits, yaourts, nombre de verres d'eau. Les données sur l'alimentation sont complétées par des éléments sur le nombre d'heures de sommeil et sur la perception des enfants de leur bien-être. Une note de 0 à 5 leur permet de se situer par rapport à la manière dont il s'est senti pendant le match : comment je me suis senti, j'étais fatigué, j'ai réussi à suivre les consignes, j'ai réussi à écouter les conseils, j'ai réussi à mettre des choses en place... Un temps est consacré à cette évaluation à la fin de chaque match. Cet outil est la propriété de l'enfant. Au bout de 5 renseignements, le point est fait collectivement pour analyser les situations, discuter, trouver des stratégies d'amélioration de la situation ou de contournement des obstacles rencontrés.
- L'outil est utilisé conjointement avec un accompagnement permanent des enfants et des familles. Le projet s'articule aussi autour d'échanges informels avec les parents et les enfants. Aucune intervention n'est faite auprès des parents concernant des conseils nutritionnels sans l'aval des enfants. Petit à petit les échanges s'organisent pour faire un point sur la situation, informer d'un événement particulier ... « on ne veut pas imposer aux parents donc c'est comment les enfants communiquent avec les parents, pour leur dire sous quelle forme ils peuvent manger des féculents la veille... » « Si les enfants nous autorisent on peut demander à papa et maman ce qu'ils peuvent faire mais c'est l'enfant qui reste acteur ».
- Pour soutenir les moments d'apports théoriques et l'accompagnement des jeunes et de leurs familles, des formations des intervenants, pour que chaque éducateur soit responsable du suivi de son groupe, est réalisée sur la connaissance de l'enfant, sur les liens entre la santé, les performances et l'hygiène de vie
- Le club propose également un accès aux ordinateurs du club pour les enfants n'ayant pas accès à l'informatique et un accompagnement social d'enfants déscolarisés vers des formations et une intégration dans le milieu sportif;

Les partenaires du projet/ de l'action

Plusieurs partenaires ont été identifiés :

- > Un psychologue du sport accompagne le projet dans son ensemble, il intervient auprès des éducateurs et des jeunes
- > Une nutritionniste du CHU de Nantes intervient sur les contenus de formation sur la nutrition et sur la construction de l'outil
- > L'ESAT à proximité du club fournit les repas pendant les stages. Le personnel de l'ESAT constitue une ressource pour le projet et des échanges sont organisés avec les personnes en situation de handicap autour de la nutrition permettant ainsi de développer le projet éducatif du club.

- > La municipalité finance à 80% le projet
- > Les sponsors contribuent financièrement pour soutenir la mise en place du projet.
- > Les bénévoles du club exercent pour nombre d'entre eux des professions dans le domaine social ou médical. Ils peuvent être sollicités dans le cadre du projet et interviennent à titre gracieux.
- > Un sociologue intervient en formation auprès des éducateurs

L'évaluation

L'évaluation d'impact sur la santé des enfants n'a pas encore été réalisée. Les éléments disponibles portent sur la participation, le niveau d'implication. Par ailleurs, les parents viennent demander des conseils, ils peuvent verbaliser des demandes.

Des chiffres clefs ont été recensés :

- > 50% de l'équipe éducative adhère au projet. Ce qui reste à transmettre est la dimension sociale du projet. Avec les techniciens, il y a le côté compétition et performance, c'est un levier quand ils comprennent qu'il y a une corrélation avec la forme physique. L'intérêt du projet est aussi la montée en compétence des éducateurs et des acquis sur la connaissance de l'enfant.
- > 86% des enfants participent aux stages socio-éducatif et ils adhèrent à l'utilisation de l'outil, le remplissent, demandent des conseils ... Ils s'évaluent de façon très cohérente et sincère. L'étape de conscientisation et de compréhension est achevée maintenant on amorce une transformation de leurs habitudes.

L'ancrage dans un modèle théorique ou des données scientifiques

Il n'y a pas de références à un modèle théorique ou des données scientifiques. La construction des contenus s'est réalisée dans les échanges avec les différents acteurs impliqués dans le projet et avec les enfants et les familles.

Les limites du projet/ de l'action

- > Les thématiques abordées au sein de l'action ne permettent pas toujours de trouver les réponses aux situations des pratiquants, où les solutions sont ailleurs, ainsi la responsable de l'action pose le problème suivant : « comment l'accompagner qu'est-ce qu'on va pouvoir proposer derrière en fait ? »
- > L'action repose sur une action spécifiquement développée pour les catégories d'âge visées et qui ne répond pas aux besoins des plus âgées (notamment 15 ans et plus) et qui pose la question du développement de contenu adaptés à cet âge.
- > Une seconde difficulté repose sur l'utilisation de l'outil, qui appartient à l'enfant mais dont la gestion peut être compliquée quand il change de lieu de résidence (oubli...). L'idée de la laisser au stade a été envisagée. La création d'un outil numérique n'est pas possible compte tenu des caractéristiques de la population. La fracture numérique est une réalité pour les familles accueillies.
- > Le manque de financement. Ainsi, toutes les actions sont réalisées par des bénévoles du club ou grâce au soutien des acteurs locaux, gratuitement.
- > Le manque de communication, notamment externe, pour faire connaître nos actions et notre outil.

Les moments clés du projet

Un moment clé pour le projet est le moment où le bilan de l'action a été présenté en assemblée générale et remis aux parents, « C'est un tableau où les parents peuvent trouver ce qui a été fait, ce qui en est sorti et est-ce que c'est un projet qu'on va continuer sous quelle forme ? ».

Pour les pratiquants sportifs, un moment clé est le moment lié à l'apport théorique qui amorce la réflexion des enfants et donne sens au projet.

Si c'était à refaire

Le projet a été construit à travers des interventions par petits groupes, ce qui a limité la visibilité d'ensemble du projet et la compréhension de la temporalité pour les enfants (toutes les tranches d'âge) : « ils n'ont pas pu prendre conscience qu'on avait du temps pour changer ». Pour pallier à cet écueil, une présentation du projet à tous les enfants en même temps leur permettrait d'intégrer cette donnée et de comprendre que le lien entre la nutrition, les performances dure tout au long de la vie et permet ainsi de prendre le temps d'évoluer, de faire des choix différents ...

Un des freins cités était la culpabilité des enfants et la non-imposition aux parents, les responsables du projet ont travaillé avec un psychologue pour présenter un discours de non-culpabilisation en rapport avec les comportements de santé abordés. Par exemple : « la veille au soir tt le monde des pâtes et du jambon, tout le monde a pas la possibilité, si je mange une pizza est-ce qu'il y a du jambon dedans, qu'est ce qui possible. Ne pas être dans quelque chose qui pouvait paraître très fermé et ne pas se sentir en défaut par rapport au reste du groupe. »

Les conditions pour reproduire l'action

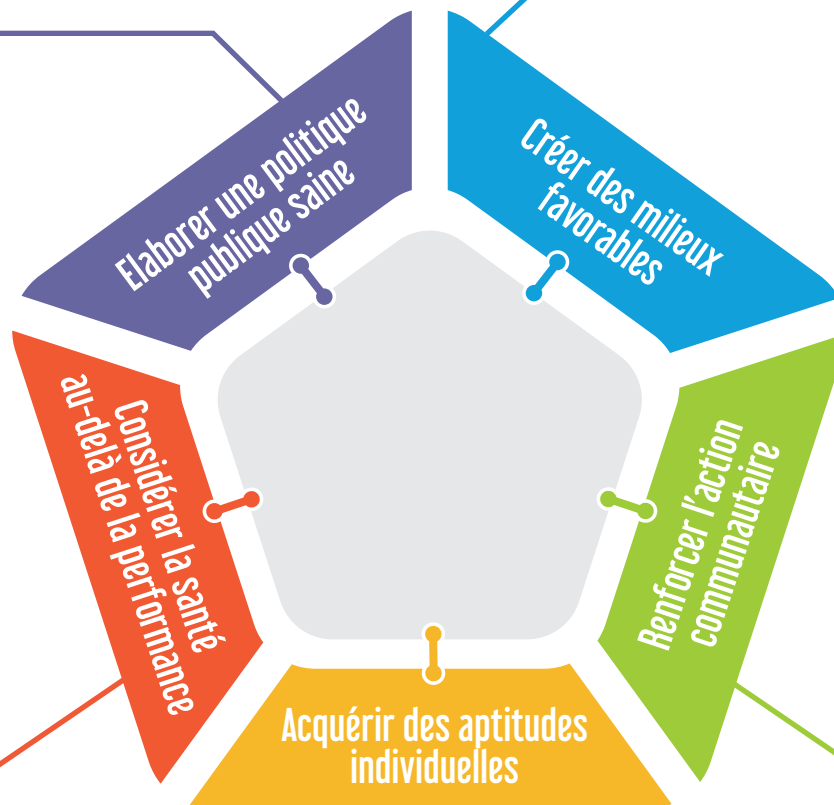
Plusieurs éléments ont été identifiés comme nécessaires pour reproduire l'action :

- L'écriture d'un projet de club qui intègre la dimension sociale et prend en compte la dimension globale de l'enfant.
- La création d'un outil adaptable à tous les contextes parce qu'il est simple, comprend des illustrations.
- La construction d'un réseau de partenaires adapté aux intervenants du club. La nécessité de démarcher et d'être en capacité d'aller défendre un projet. Enrichir son réseau de nouvelles compétences.
- La réalisation d'un état des lieux et connaître la population pour pouvoir repérer les difficultés

Éléments clés au regard de la Charte d'Ottawa

- > L'action a permis de modifier le projet éducatif du club pour intégrer un axe social en plus de l'axe sportif
- > Cette action s'inscrit dans la création des projets éducatifs fédéraux de la Fédération Française de Football

- > Par cette action, le FC La Montagne souhaite créer un milieu où les normes sociales liées aux comportements de santé sont intégrées de manière non culpabilisante
- > Cette action renforce le rôle social de club au delà de la pratique du football
- > Cette action permet une dynamique participative des joueurs et des parents, en collaboration avec les acteurs et partenaires du club, dans une dynamique participative

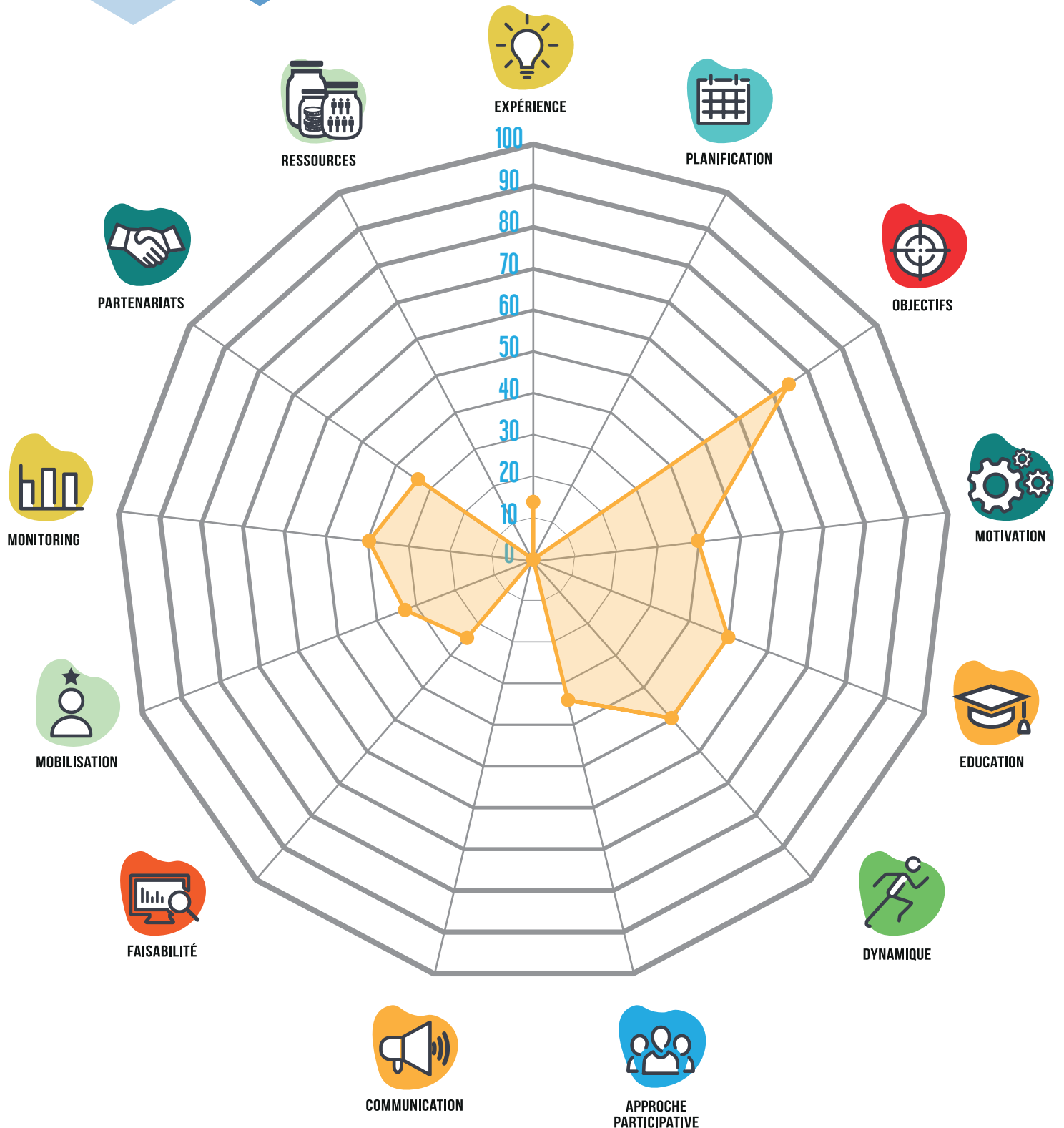


- > Le club dépasse la dimension sportive pour endosser un rôle d'éducation populaire et d'intégration sociale, de manière non-culpabilisante et interculturelle

- > Le club soutient la communauté locale, notamment par un travail sur la fracture numérique, sur l'accueil de jeunes en abandon scolaire, sur le partenariat avec l'ESAT et les autorités locales pour soutenir le développement des jeunes

- > Les jeunes footballeurs, leurs parents et familles, ainsi que les entraîneurs et dirigeants sportifs acquièrent des compétences sociales et sur la gestion de leurs comportements de santé

Éléments clés au regard du modèle du club de sport promoteur de santé



Éléments clés au regard du modèle du club de sport promoteur de santé



Dynamique

Tenir compte des interactions entre l'individu et son environnement, lors de la définition des objectifs de promotion de la santé (DYN2) : La responsable de l'action a réussi à mobiliser tous les acteurs autour de son projet : 1/les joueurs et leurs parents dans l'expression des besoins et la participation aux activités, 2/les éducateurs et les dirigeants dans le suivi de leurs groupes et l'accompagnement des enfants, 3/ les partenaires et bénévoles qui ont apporté leurs savoir-être et savoir-faire à ce projet.



Education

Soutenir les dirigeants et les entraîneurs à s'engager activement dans l'acquisition de connaissances et de compétences pour promouvoir la santé (EDU1) et Adapter individuellement le soutien aux dirigeants et les entraîneurs en fonction du public qu'ils encadrent (tutorat, cours, e-learning) (EDU2): les dirigeants et entraîneurs ont été formés à la promotion de la santé, avec une adaptation des contenus en fonction des catégories d'âge et des interventions venant de partenaires ou bénévoles spécialistes du club.

Encourager les dirigeants et les entraîneurs à se soutenir mutuellement pour promouvoir la santé(EDU3) : Ce projet implique les dirigeants qui ont impulsent et coordonne le projet, avec un suivi rapproché de chaque éducateur par rapport à son groupe. Les conditions environnementales et partenariales sont mises en œuvre pour créer une dynamique favorable au projet.

Créer des outils et des formations pour soutenir la promotion de la santé au sein des clubs de sport (EDU5) : un outil de suivi des comportements de santé des joueurs a été créé pour faire le lien avec la famille et le club de sport.



Expérience

Identifier le degré d'engagement en faveur de la promotion de la santé (EXP4) : Cette action est partie d'un constat des bénévoles dans l'accompagnement des enfants qui souhaitait trouver une solution à un problème récurrent.

S'appuyer sur un diagnostic évaluant les besoins et attentes pour mettre en place les actions de promotion de la santé (EXP6) : Pour lancer cette action, un questionnaire et des échanges avec les parents ont été réalisés pour connaître leurs besoins.



Faisabilité

Évaluer régulièrement la faisabilité de l'atteinte des objectifs (FAIS3) : La responsable du projet est capable d'identifier les limites au projet (communication, financement, partenariats) et fixe des objectifs qui sont adaptés à chaque joueur et sa famille, ainsi qu'aux capacités des acteurs de l'action.



Partenariats

Définir les modes de collaboration avec les partenaires existants et à venir (définir les rôles, partager les expériences, les termes du contrat, l'évaluation des résultats, le pouvoir égal des partenaires...) (PART2) : Les compétences professionnelles des bénévoles du club ont été mis à contribution pour monter cette action au sein du club.

Objectifs

Définir des objectifs de la promotion de la santé (OBJ1) et Rédiger et documenter formellement les objectifs de promotion de la santé (OBJ2) : les objectifs de cette action ont été écrits dans le projet éducatif du club, avec un axe social en plus de l'axe sportif.

Prendre en compte la manière dont les personnes appréhendent leur santé lors de la définition des objectifs de promotion de la santé (OBJ4) : Pour définir les objectifs de l'action, ainsi que les modalités d'accompagnement, un diagnostic a été effectué avec les joueurs et leurs familles, ainsi qu'avec l'encadrement.

Mobilisation

Mobiliser des experts en promotion de la santé (MOB2) : Les compétences des bénévoles du club, également professionnels de santé (sociologue, psychologue, infirmier) ont été mis au service de cette action au sein du club.

Identifier et mobiliser un ou plusieurs représentants en interne en promotion de la santé au club de sport (MOB3) : Le responsable du projet est une éducatrice responsable d'un groupe de jeunes pratiquants, qui est maintenant référente au club pour cette action.

Mobiliser les parents (et l'entourage) pour soutenir les démarches de promotion de la santé (MOB4) : Grâce à l'outil et à des discussions informelles, les parents sont partis prenantes de la démarche et de l'accompagnement de leurs enfants.

Mobiliser les décideurs et élus locaux pour promouvoir la santé au sein des clubs de sport (MOB5) : Le club dispose du soutien de la Commune pour mettre en place les activités. Il joue un rôle actif dans l'insertion des jeunes par le sport.

Faire du plaidoyer auprès des fédérations sportives pour un soutien aux clubs sur la promotion de la santé (MOB6) : Ce projet est bien identifié au niveau régional et national par la Fédération Française de Football, ce qui permet de diffuser ses principes et de mobiliser la fédération sur ces thématiques.

Monitoring

Suivre toutes les activités de promotion de la santé entreprises dans le club de sport (MON2) : un recensement des activités mises en place au sein du projet est réalisé.

Suivre les effets des actions à court terme (changements sur 1 saison sportive) (MON3) : Une évaluation du projet par les joueurs est prévue, mais n'a pas encore été réalisée.

Motivation

Tenir compte de la motivation des entraîneurs et de leurs attentes futures (MOT3) : La responsable de l'action a réussi à mobiliser la moitié des éducateurs du club sur ce projet, mais a des difficultés à mobiliser les éducateurs attachés à la performance sportive.

Renforcer l'autonomie des entraîneurs à promouvoir la santé (MOT4) : par la formation des dirigeants et entraîneurs, ils sont désormais capables de suivre leurs jeunes et leur groupe sur les thématiques abordées par l'action.

Approche participative

Identifier et valoriser chaque action de promotion de la santé (APP4) : Le bilan de l'action a été réalisé en fin de saison sportive et partagé lors de l'assemblée générale et avec les parents.

Impliquer les parents (et l'entourage) dans les démarches de la promotion de la santé (APP6) : les parents sont partie prenante de l'action et soutiennent leurs enfants dans la démarche. Des échanges continus avec ces derniers permettent d'ajuster individuellement les activités.



PROSCeSS

PRoMotion de la Santé dans les Clubs Sportifs

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LA CARTE D'IDENTITÉ DU PROJET

Programme Fit'séniors
NCAA (Nice Côte d'Azur Athlétisme)

Thématique(s)

La thématique ciblée par le NCAA est la santé sociale et la santé physique.

Objectifs

Le club a un objectif prioritaire : réaliser des performances.

> Accompagner et former les athlètes à la compétition

Et secondairement : il souhaite développer le sport-santé.

> Accompagner les gens à un mode de vie plus autonome et plus actif.





Public(s) concernés

Adultes et séniors



Stratégies d'action déployées

- Programme As du cœur
- Programme Fit'séniors



Activités déployées

Le club met en place des séances spécifiques. Les 2 programmes fonctionnent de la même manière avec 2 séances par semaine, une séance de renforcement musculaire et une séance de marche nordique. Le club a recours de manière ponctuelle à des compétences extérieures (ex. diététiciens).



Partenaires impliqués

Différents partenaires permettent l'implémentation des deux programmes : Azur Sport Santé se charge de la coordination et la promotion. L'AG2R finance le programme Fit'séniors et établit les contacts avec les pratiquants. L'ARS PACA finance le programme As du cœur, ainsi que les établissements de santé au sein desquels se déroule le programme As du cœur (Hôpital des Sources et Maison du mineur).



Financements

Pour le programme As du cœur : le club est actuellement en recherche de financement mais auparavant il bénéficiait d'un financement de 50 000€ répartis à environ 50/50 entre Malakoff Médéric et ARS PACA.

Pour le programme Fit'séniors : c'est l'AG2R qui finance.



Territoire/lieu de déroulement de l'action

Nice est (site Vauban), ouest (site Charles Ehrmann), nord. Les bureaux du club sont à Nice ouest.



Indicateurs d'évaluation

Le club évalue différents comportements via deux niveaux : « pour les pratiquants et pour les financeurs. En ce qui concerne les indicateurs évaluant les comportements individuels, ce sont des indicateurs physiques et de la douleur, est-ce que c'est plus ou moins simple ?, comment je me sens ?. Je ne sais pas si on peut mettre ça sous le couvert de la motivation, mais plus côté psycho on va dire. Et à la fin, nous réalisons vraiment un bilan de condition physique : le 6' marche je le fais en combien de temps, le nombre d'assis-debout j'en fais combien et plus un côté bien-être on pourrait dire. Comment est-ce que je me sens : est-ce que je suis plus fatigué, est-ce que je suis moins fatigué, ce genre de choses-là, ce genre d'indicateurs.

Côté financeurs, nous évaluons plutôt des taux de participation : je leur mets également ces tests des personnes, qu'il y a eu une amélioration de la condition physique des personnes qui ont intégré le programme mais après pour les financeurs on est plus sûr de l'évaluation à quoi sert notre financement. Ils n'imposent pas d'indicateurs c'est nous qui les mettons. Je pourrais les ressortir. »

Le programme Fit séniors du NCAA

L'action en quelques mots

Le programme Fit'séniors cible principalement l'entretien des capacités musculaires et cardiovasculaires, pour favoriser la santé mentale, sociale et physique des séniors, en proposant une activité physique visant l'autonomisation de la personne par un maintien de sa condition physique et le développement du lien social entre les pratiquants.

Le programme Fit'séniors rencontre trois intérêts majeurs pour le club : 1/développer le sport-santé et accueillir des populations séniors, 2/ renforcer le modèle économique du club, où le sport-santé (notamment le programme Fit'séniors) permet de financer les coûts du sport de Haut Niveau (10% du budget vient des programmes Sport-Santé et ne sont pas dépensés uniquement par cette section), 3/ Accroître la reconnaissance du club en tant qu'acteur du sport-santé (par des partenariats et des communications en colloque).

Le programme Fit'séniors est un partenariat avec AG2R qui finance la prise en charge de ces affiliés séniors (65 ans et plus) par le NCAA.

Le contexte

Le NCAA est un club d'athlétisme Niçois, qui accueille différents types de pratiquants sportifs : des athlètes de haut-niveau, une école d'athlétisme, des personnes vulnérables (grâce notamment au programme As du Cœur), des pratiques loisirs (Fit' Athlé), des séniors (Programme Fit'séniors). Le club a un budget de 596 863 euros en 2019 et emploie 7 salariés, dont un dédié uniquement au développement du sport-santé. Le club est porté notamment par Odile et Stéphane Diagana, qui sous-traitent le programme As du Cœur qu'ils ont créé pour une mise en place à l'échelle du club. Au-delà du site principal de pratique, il inclut deux sections locales à Valbonne et à Antibes. Le club est classé 8ème club français.

Le programme se déploie sur la ville de Nice, principalement Nice Ouest, Nice Est et Nice Nord. Les sessions se déroulent soit au Parc des sports Charles Ehrmann, soit à l'Hôpital des Sources ou à la Maison du Mineur à Vence, qui sont des services de soins de suite et de réadaptation. Les personnes qui participent sont en ambulatoire et non hospitalisés.

En ce qui concerne le programme Fit'séniors, il n'apparaît pas en tant que tel dans le plan de développement du club, mais le programme 'As du Cœur' dont il est dérivé apparaît. Néanmoins, une convention existe entre le NCAA et AG2R qui régit la collaboration, avec l'aide de juristes sur les points stratégiques. Le responsable sport-santé fait un bilan lors de certaines réunions d'équipe sur la fréquentation et le déroulement, mais communique peu sur le programme. Les pratiquants de ces dispositifs ne croisent pas les autres pratiquants du club, sauf exceptionnellement à l'assemblée générale ou lors d'un événement. Chaque créneau est un groupe à part entière, qui entretient des liens au sein du groupe. Il n'y a pas de charte ou de règlement particulier pour cette action. L'absence d'offre de sport-santé sur le territoire niçois a amené le club, il y a cinq ans, à lancer le programme As du Cœur. Ce programme visait une prise en charge de personnes présentant des pathologies par la pratique d'activité physique adaptée, avec un contenu de séances spécifique.

Le club a perçu la demande de la population concernant le développement du sport-santé, l'absence de solutions pour les politiques dans le soin développement il y a cinq ans et l'opportunité de proposer à un de ses entraîneurs la formation coach-athlé-santé.

L'opportunité

Historiquement, le partenariat qui a lancé le programme As du Cœur était un partenariat avec l'assurance santé Malakoff Médéric. Ensuite, ce premier partenariat s'est arrêté, ce qui a ouvert la porte à un partenariat avec AG2R, grâce à un contact du responsable sport-santé avec une personne au sein d'AG2R, qui cherchait des événements pour mettre en avant l'entreprise et ses partenaires.

En ce qui concerne As du Cœur, le programme qui a inspiré Fit'séniors, il est né en 2015, grâce à une collaboration avec l'Université Côte d'Azur, sur la base d'une première étude scientifique et soutenue par Stéphane et Odile Diagana, très présents dans les structures dirigeantes du club. Ce programme est la propriété de « Diagana Sport Santé », qui délègue au NCAA le programme pour sa mise en place, promotion, etc. C'est toujours le même socle d'actions, qui est déléguée à une association ou entreprise pour être mise en place. Le programme Fit'séniors est en place depuis deux saisons sportives.

Les principes d'action de l'action

Les principes d'action sont :

- > Une prise en charge par un enseignant APAs ou entraîneur formé au vieillissement pour une pratique d'activité physique adaptée et personnalisée
- > Un accès financier et de mobilité favorisé pour les pratiquants, puisque la cotisation est de 25 euros par an et les lieux sont desservis par les transports en commun
- > Un travail d'intégration sociale et de connexion sociale, notamment par la proximité entre les pratiquants et avec le responsable du programme. Comme l'illustre la citation : « Moi, c'est ce que je dis après aux encadrants des autres créneaux, on apporte du social, on apporte du lien social, on apporte de la discussion. Après il faut pas faire chier les gens avec il fallait faire 10 squats, on n'en a fait que 8. Si la personne, elle veut papoter, elle papote, en fait. Il y a 2 poids, 2 mesures, et moi, en fait je tourne beaucoup à la rigolade. C'est-à-dire que je le vois, quand ils se mettent à côté, je leur demande de faire un exercice : « Ah ouais, donc machin... » « Vous faites quoi là ? » « On travaille, on travaille. » « D'accord. » (Rires). Ça ne fait pas rire tout le monde, mais après c'est un besoin qu'ils ont aussi. Il y a des gens qui vivent seuls, c'est peut-être le seul moment où ils voient d'autres personnes, autant les laisser tranquilles. C'est un outil, en fait, on fait du social et l'outil qu'on a c'est le sport. Ce n'est pas plus que ça. »

Les objectifs du projet

Le programme Fit'séniors vise à entretenir les capacités musculaires et cardiovasculaires, pour favoriser la santé mentale, sociale et physique des séniors, en proposant une activité physique visant l'autonomisation de la personne par un maintien de sa condition physique et le développement du lien social entre les pratiquants.

Les objectifs poursuivis actuellement sont de maintenir le programme (qui est au maximum de sa capacité d'accueil) et le partenariat dans les années futures. Veillant à garantir l'exclusivité à AG2R et ayant d'autres programmes comme As du Cœur ou Fit Athlé, le club ne vise pas une augmentation du nombre de personnes prises en charge. Le responsable du programme explique : « si l'année prochaine, si c'est encore une fois reconduit, là, à ce moment-là on pourra dire : « Bon, ben, est-ce qu'on voit plus grand ? Est-ce qu'on reste sur ça ? » Le souci c'est que là, on va commencer à accumuler des gens. Ça, on a un souci sur ces 2 créneaux-là principalement, c'est l'accumulation de personnes. Des gens qui devraient potentiellement partir et qui restent, donc forcément à un moment donné si j'ai 15 places qui sont prises par 15 anciens, je n'en prends pas 15 nouveaux. »

Le contenu de l'action

L'action réalisée est une prise en charge collective (par groupe de 12 à 15 personnes) de deux séances par semaine, complétée par de la marche nordique, en saison sportive (entre mars et décembre, l'été tout s'arrête de fin juin à septembre), avec un coût d'inscription de 25 euros, pour les séniors (60 ans et +) d'AG2R, ayant une pathologie ou non. Le public ciblé comprend 2600 personnes âgées affiliées à l'AG2R sur le territoire niçois. L'année dernière 9000 courriers ont été envoyés, pour 300 contacts téléphoniques et 70 places disponibles. Le public touché est approximativement de 80 personnes par an, équilibré en termes de genre et de personnes présentant une pathologie ou non.

Les pratiquants de Fit'séniors ne rentrent pas dans les dispositifs sur prescription médicales, puisqu'ils sont envoyés par AG2R, qui ne communique pas les données personnelles de ses adhérents, le NCAA fait donc un bilan à l'arrivée des personnes et demande un certificat de non contre-indications à la pratique et une fiche type, pour mieux connaître les pratiquants, leurs limitations fonctionnelles et leurs besoins : « C'est vraiment à la discrétion des gens de dire à l'encadrant : « Ah ben moi, j'ai mal au genou, j'ai des problèmes de cœur ou autres. » Moi, c'est le seul bémol que je trouve à ce programme-là, personnellement, mais comme AG2R ne peut pas divulguer des informations confidentielles sur des prises de médicaments ou autres, on est parti là-dessus. »

Une séance type a été décrite lors de l'entretien : « Une séance de renforcement musculaire, par exemple, les personnes arrivent, elles se changent, elles se mettent à l'aise, on va dire. On a un petit échauffement. Donc, moi, personnellement, je vais faire un peu d'endurance, les personnes vont faire un ou 2 tours de marche, ça dépend des distances, un petit échauffement articulaire, toujours un peu basé sur l'athlé, au final. Moi, typiquement, à l'Hôpital des Sources ils vont faire un tour en montée de genoux, un tour en talon-fesse, un tour avec des tours de bras, ce genre de choses. Derrière, sur le renforcement, moi, j'installe tout le circuit training de base, donc 5-6 ateliers que je dédouble ou pas en fonction du nombre de personnes. Et après, moi, je pars du principe que les personnes, elles doivent faire tout le circuit, dans l'ordre qu'elles veulent, on s'en fout, mais voilà, elles doivent faire les 5 ou 6 ateliers. Donc, je leur explique les 5 ou 6 ateliers, une fois que s'est fait, on fait une mini pause, le temps de boire un coup, et elles partent sur l'atelier. Après, l'atelier, c'est souvent du fractionné : une minute d'effort, 15-30 secondes le temps de changer d'atelier. Et en fait ça tourne comme ça, et moi, je time le truc. Et ça me permet, en fait, de tourner sur les ateliers, d'aller voir les gens. Soit de discuter avec eux, soit de les corriger parce qu'il y a besoin de faire une correction. Donc ça, on arrive à faire à peu près, en fonction du nombre qu'ils sont et en fonction de la dynamique du moment, si ça discute pas mal ou quoi, on peut faire entre 2 et 4 tours. Et un peu à la fin de chaque tour, on fait une pause, on boit un coup, 2-3 minutes, ce n'est pas précis, précis, mais on voit ensemble. Après, on voit au visage des gens s'ils peuvent y retourner ou pas. Donc, ça, c'est la séance et après, petit retour au calme, étirements, et terminé. Et quand on fait la marche, c'est assez équivalent, sauf qu'on va remplacer le renforcement par la marche. »

Les encadrants ont une formation spécifique soit grâce à leur diplôme, soit grâce à un accompagnement du responsable de la section sport-santé : « je les ai formés ou je les ai fait former soit par la Fédé, soit par d'autres organismes aux séniors. Pas forcément sur une pathologie, mais à l'activité physique senior. Après, moi, je suis coach-athlé-santé pour la FFA, j'ai un Master en STAPS et ma collègue qui est aussi salariée, elle a une licence APAS, donc à tous les 2 on a pu quand même leur donner pas mal de contenus. Et ça fait 5 ans qu'on intervient sur le programme As du Cœur, donc on est quand même assez rodé au vieillissement, on va dire pour pas qu'ils partent sans rien ».

Les partenaires du projet/ de l'action

Plusieurs partenaires ont été identifiés :

- > Diagana Sport Santé, qui a conçu le programme, délègue son implémentation et sa diffusion au NCAA.
- > Le SSR de l'hôpital des Sources accueille des créneaux, c'est un partenariat qui date du lancement d'As du Cœur, cela permet à l'hôpital d'avoir une continuité dans la prise en charge de ses patients, notamment ayant des pathologies cardiovasculaires et cela facilite le recrutement des pratiquants.

- > AG2R qui financent à hauteur de 30 000 euros pour la mise en place du programme. Une convention de partenariat régule cette collaboration. AG2R contacte ses adhérents par un courrier qui envoie les personnes intéressées vers le responsable du programme. L'inscription se fait par ordre chronologique d'appel (premier qui appelle, premier servi). AG2R demande annuellement un rapport sur les noms des pratiquants sportifs, les présences, les résultats des tests (avant, pendant, après), pour défendre le renouvellement du financement chaque année. Des échanges informels entre les deux parties ont lieu en cas de besoins ou de demande.
- > L'ARS finance également le programme As du Cœur (à hauteur de 20 000 euros), qui était le programme initial.
- > Pour le programme As du Cœur, le dispositif Nice Santé, de sport sur ordonnance envoie des pratiquants dans le programme As du Cœur, et il y a une collaboration avec des médecins au niveau local pour diriger des patients vers le programme également.
- > Pour le programme As du Cœur, un partenariat avec le LAHMESS (Laboratoire Motricité Humaine Expertise Sport Santé) de l'Université de Nice a permis de publier et de tester le programme scientifiquement, mais également de présenter la démarche lors de congrès.
- > Un partenariat avec la Fédération Française de Cardiologie permet de récupérer et distribuer des goodies auprès des pratiquants (pour le programme As du Cœur)

L'évaluation

Des tests sont effectués à l'entrée dans le programme (mars), avant l'été (juin) et en fin de programme (décembre), pour suivre l'évolution des pratiquants, notamment sur un test de marche et d'autres tests de condition physique. L'évaluation sert à plusieurs fins : le bilan initial permet d'adapter le suivi pour le pratiquant, les bilans en milieu et fin de programme permettent de suivre l'évolution des pratiquants, mais ne sont pas un indicateur principal dans l'évaluation-sanction du financeur, les taux de participations sont le critère principal pour AG2R. Le bilan est composé d'un test de 6 minutes, de tests physiques et de questions sur le bien-être.

L'ancrage dans un modèle théorique ou des données scientifiques

Le programme As du Cœur a fait l'objet de publications scientifiques dans différentes revues :

> Fournier, M., Radel, R., Bailly, L., Pradier, C., Fabre, R., Fuch, A., ... & d'Arripe-Longueville, F. (2018). "As du Cœur" study: a randomized controlled trial on physical activity maintenance in cardiovascular patients. *BMC cardiovascular disorders*, 18(1), 77.

> Bailly, L., Mossé, P., Diagana, S., Fournier, M., d'Arripe-Longueville, F., Diagana, O., ... & Radel, R. (2018). "As du Cœur" study: a randomized controlled trial on quality of life impact and cost effectiveness of a physical activity program in patients with cardiovascular disease. *BMC cardiovascular disorders*, 18(1), 225.

Son déploiement au niveau national est actuellement à l'étude.

Les limites du projet/ de l'action

La limite majeure est l'exclusivité du partenariat avec AG2R, qui ne permet pas d'ouvrir à des non-adhérents et réduit l'accessibilité à tous. Les créneaux étant complets et les personnes souhaitant poursuivre les séances au-delà d'une année, le dispositif permet peu d'entrées de nouveaux pratiquants sportifs. Une autre limite repose sur la disponibilité des encadrants, si une augmentation des créneaux était envisagée.

Le programme « As du Cœur » proposait un suivi nutrition, un accompagnement avec de la sophrologie (selon un partenariat et un tarif préférentiel avec un sophrologue) et d'autres activités de sensibilisation à la santé au départ, qui ont été abandonnées, puisque les pratiquants restent dans le dispositif et ne sont plus demandeurs à long terme.

Le programme Fit'séniors s'arrêterait si le partenariat avec AG2R et l'ARS PACA s'arrête et qu'il n'y a pas nouveau financeur.

Les barrières à la mise en place ont été : 1/ le fait de trouver un lieu pour pratiquer et de le conserver au fil du temps, 2/ le type de pratique proposé, parce qu'une formule cyclisme a été proposée, sans succès auprès des pratiquants, 3/le fait de trouver des encadrants pour ce créneau de pratique.

Les moments clés du projet

Le premier moment clé est le lancement du programme As du Cœur par Diagana Sport Santé, qui a permis au programme d'exister et d'être testé scientifiquement.

Le second moment clé est la fin de la convention avec Malakoff Médéric, qui a permis de nouer un nouveau partenariat avec AG2R. Malakoff Médéric a financé pendant quelques années, en estimant encourager un programme innovant, puis a décidé d'arrêter de financer car le programme n'était plus innovant au vu de sa durée de mise en place.

Le troisième moment clé a été l'engagement du responsable Sport-Santé, en CDI directement pour créer un poste pérenne pour gérer la pratique de loisirs et de sport-santé.

Le quatrième moment clé a été la reconduction du programme Fit'séniors, avec des réajustements sur l'âge des pratiquants.

Si c'était à refaire

Il y a eu peu d'écueils par rapport à la mise en place du programme de manière générale, plutôt l'idée de bien suivre et s'en tenir au cadre de la convention passée avec AG2R. Un obstacle a été au départ la constitution de dossiers très lourds pour les pratiquants pour collecter des informations sur les indications et non-contre-indications à la pratique sportive, mais une transition entre un document de 15 pages à un document de 3 pages a permis de surmonter ce problème. Il y a plusieurs éléments clés qui ont été réunis pour pouvoir mettre en place le programme et une adaptation constante par le responsable du programme, notamment pour suivre les pratiquants sportifs, pour proposer des pratiques ludiques, pour prendre soin du groupe.

Plusieurs points de réussite sont à noter :

- > Le programme proposé par Diagana Sport-Santé est validé scientifiquement et reconnu nationalement
- > Fit'séniors tourne à plein régime et les créneaux sont remplis, la demande est supérieure à l'offre
- > Ce programme rapporte de l'argent au club pour proposer d'autres activités et représente avec d'autres programmes sport santé 10% du budget du club
- > Ce programme permet à des personnes de pratiquer pour 25 euros par an, ce qui est dérisoire et offre un accès à une pratique d'activité physique
- > Les pratiquants sont déçus quand ils ne peuvent pas venir aux séances, ils sont solidaires dans les tragédies de la vie quotidienne, développent une seconde « famille »

Les conditions pour reproduire l'action

Plusieurs éléments contextuels ont permis au programme de se développer :

- Le soutien de « modèle » en termes de sport-santé (Stéphane et Odile Diagana), qui avec leur appui et leur réseau ont permis le développement du programme et le lien avec les dispositifs nationaux et locaux
- Le contact privilégié avec AG2R existant entre le responsable du programme et une de ses connaissances
- L'essor du sport santé de la part de la fédération française d'athlétisme, notamment avec les programmes coach athlé santé
- La création d'un poste en CDI pour un responsable sport-santé au sein du NCAA
- La valorisation du programme « As du Cœur » par des publications scientifiques et des présentations en congrès
- Le fait de pouvoir proposer des créneaux le matin, car c'est la plage préférée des séniors pour ce type d'activité

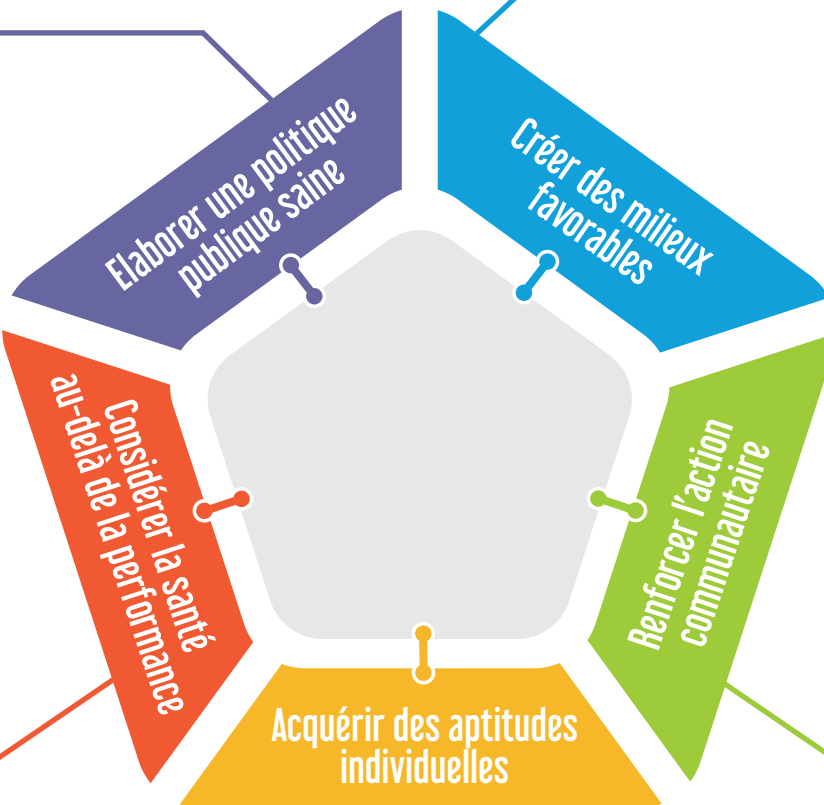
Les compétences spécifiques nécessaires pour la mise en place du projet :

- L'encadrement des personnes qui doit se faire par un entraîneur formé au sport-santé (principalement vieillissement) ou un enseignant en APAs pour proposer des programmes personnalisés
- Une grande disponibilité et une grande écoute de la part du responsable du programme, qui accompagne chaque patient, notamment en début de programme, pour identifier les trajets de bus, transmettre les horaires, échanger par SMS pour tout problème, se rendre disponible pour les pratiquants
- Une capacité à revoir à la baisse les attentes « sportives » et à adapter le contenu en fonction de l'état des personnes et de leur envie, à laisser les pratiquants discuter et bouger, dans le cadre établi, sans pression sur la « performance »
- Une plus grande souplesse administrative dans la mise en place du dispositif, en allégeant les dossiers à remplir
- Des compétences en communication qui ont été développées au fur et à mesure des projets, car il n'y a pas de chargé de communication au sein du club.

Éléments clés au regard de la Charte d'Ottawa

- > Une convention a été signée entre AG2R et le NCAA
- > Ce programme s'insère dans la stratégie nationale sport-santé
- > Le NCAA est soutenu par l'ARS pour ses autres programmes Sport-Santé
- > Le programme As du Coeur, fondement de l'approche, est déployé actuellement au niveau national

- > Offrir une pratique d'activité physique adaptée à des séniors d'AG2R
- > Permettre au club de sport d'accueillir des séniors dans le cadre de la pratique d'activité physique adaptée

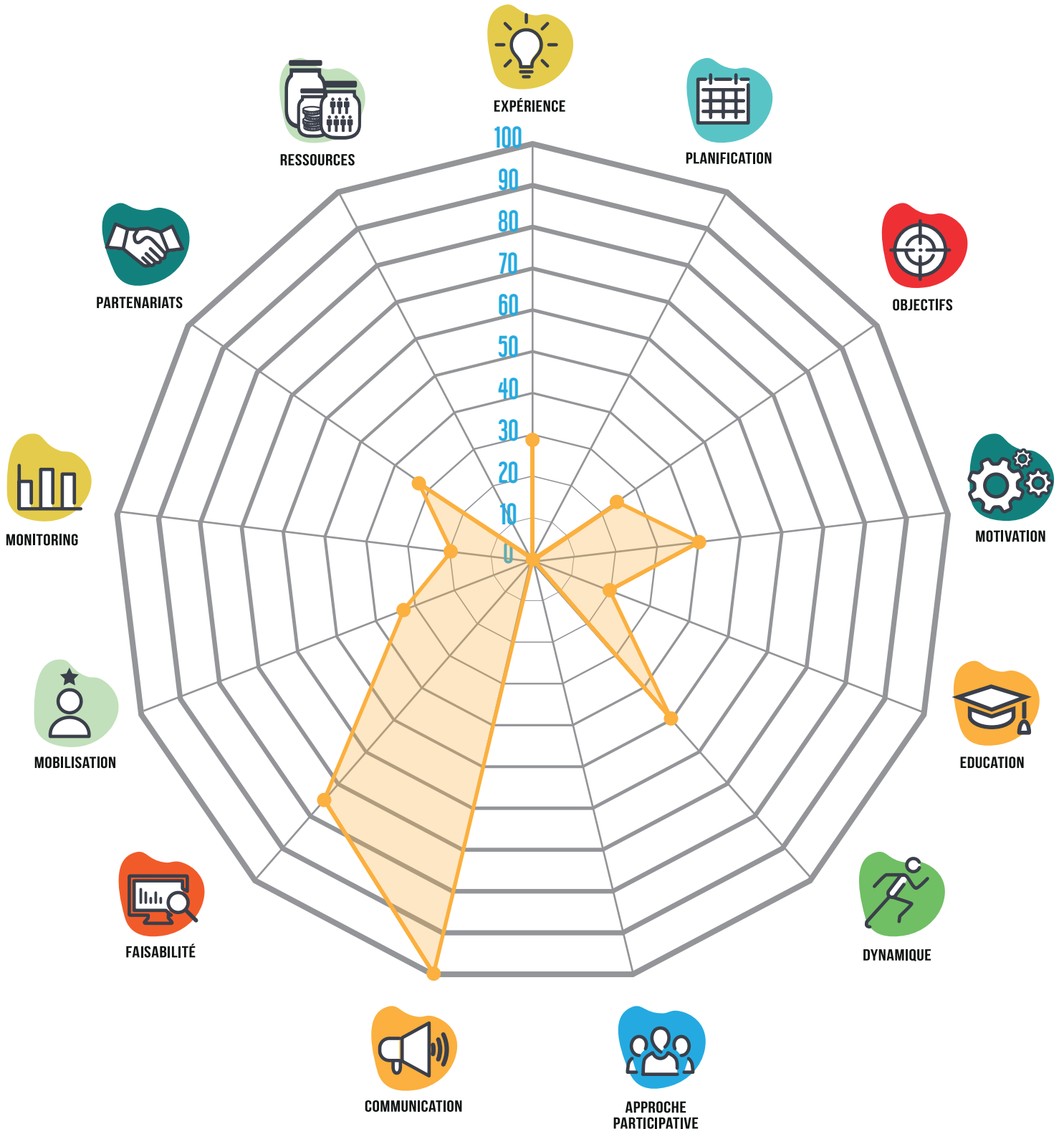


- > Par cette approche, le potentiel du club de sport à offrir des bénéfices pour la santé des séniors inscrits dans ce programme par la pratique d'activité physique est mobilisé.

- > Le programme s'insère dans des soins de suite et de réadaptation et permet de faire le lien entre hopital et club de sport

- > Le programme permet le maintien de la condition physique, qui favorise l'autonomie et la qualité de vie des séniors, ainsi que leur santé sociale

Éléments clés au regard du modèle du club de sport promoteur de santé



Éléments clés au regard du modèle du club de sport promoteur de santé

Communication

Créer un plan de communication (COM1) : Un plan de communication, avec le rôle d'AG2R dans la diffusion du programme et le relais pris par le club pour les inscriptions a été développé.

Assurer la communication externe du club de sport (COM4) : Des communications lors de colloques au niveau régional et national sont assurées pour promouvoir le programme et les actions sport-santé du NCAA.

S'assurer que le club communique avec tous les partenaires (COM5) : Des communications informelles avec AG2R sont régulières et un bilan est fait chaque année avec la publication d'un rapport.

Dynamique

Tenir compte des interactions entre l'individu et son environnement, lors de la définition des objectifs de promotion de la santé (DYN2) : le programme a été proposé pour coller aux demandes des séniors et à l'emploi du temps, dans les horaires, dans l'accompagnement quotidien sur les aspects pratiques et dans l'adaptation des séances.

Education

Adapter individuellement le soutien aux dirigeants et entraîneurs en fonction du public qu'ils encadrent (tutorat, cours, e-learning) (EDU3) : Le responsable sport-santé a proposé des formations ou a accompagné les entraîneurs sportifs pour leur permettre l'encadrement spécifique de ce public.

Expérience

Identifier les expériences antérieures du club de sport en matière de promotion de la santé (EXP1) : le club s'est fondé sur son expérience As du Cœur pour proposer le programme Fit'séniors.

Identifier la volonté organisationnelle en faveur de la promotion de la santé (EXP2) : Les dirigeants, notamment Odile et Stéphane Diagana ont poussé l'engagement du club dans la dynamique sport-santé. Le recrutement d'un salarié à temps plein sur ce poste est un signe fort.

S'appuyer sur des outils probants existants en promotion de la santé (EXP5) : le club s'est fondé sur son expérience As du Cœur, testé scientifiquement, pour proposer le programme Fit'séniors.

Faisabilité

Evaluer régulièrement les ressources financières mobilisées (FAIS1) : la convention est annuelle et donc un état des lieux est fait annuellement sur les financements sport-santé.

Evaluer régulièrement les ressources humaines mobilisées (FAIS2) : les capacités d'encadrement du créneau sont évaluées régulièrement et des adaptations ont lieu en fonction des disponibilités des encadrants.

Evaluer régulièrement la faisabilité de l'atteinte des objectifs (FAIS3) : L'évolution des patients est mesurée trois fois par an. L'atteinte des objectifs est mesurée une fois par an, lors du rapport annuel.

Objectifs

Définir des objectifs de la promotion de la santé (OBJ1) : les objectifs du programme Fit'séniors ont été écrits dans la convention.

Mobilisation

Mobiliser des icônes sportives pour votre cause (MOB1) : Odile et Stéphane Diagana ont porté le lancement du programme.

Identifier et mobiliser un ou plusieurs représentants en interne en promotion de la santé au club de sport (MOB3) : Un temps plein a été alloué par le club à la gestion du sport-santé et sport loisir.

Mobiliser les décideurs et élus locaux pour promouvoir la santé au sein des clubs sportifs (MOB5) : Le club a le soutien de l'ARS, est inscrit dans les dispositifs locaux de sport sur ordonnance, est en lien avec l'Université et la Fédération française de Cardiologie pour promouvoir ses programmes sport-santé.

Monitoring

Collecter ou répertorier les petites améliorations en vue d'atteindre les objectifs de promotion de la santé (MON1) : Le responsable de Fit'séniors adapte au quotidien et apprend continuellement de l'expérience pour améliorer le dispositif, même si ces adaptations ne sont pas consignées par écrit.

Suivre les effets des actions à court terme (changements sur 1 saison sportive) (MON3) : Le bilan d'entrée, à mi-programme et en fin de programme permet de suivre l'évolution des pratiquants.

Motivation

Favoriser des relations interpersonnelles positives entre les parties prenantes (MOT1) : la relation entre le responsable et les pratiquants est un échange d'écoute et de partage important pour les deux parties.

Tenir compte des compétences des entraîneurs à gérer les situations (MOT2) : le responsable de Fit'séniors est très regardant sur la qualité et le profil des encadrants dans ce dispositif, pour qu'ils soient à même d'accompagner au mieux les pratiquants.

Partenariats

Définir les modes de collaboration avec les partenaires existants et à venir (définir les rôles, partager les expériences, les termes du contrat, l'évaluation des résultats, le pouvoir égal des partenaires...) (PART2) : le club a mis en place une convention avec AG2R pour financer et permettre la mise en place de ce programme.



PROSCeSS

PRoMotion de la Santé dans les Clubs Sportifs

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LA CARTE D'IDENTITÉ DU PROJET

Passer'Elles – « En S'Elles »

Thématique(s)

Les thématiques visées par le projet « En S'Elles » est l'inclusion et diversité par la pratique du vélo.

Objectifs

Les objectifs du programme sont les suivants :

- > Créer des passerelles inclusives entre différents publics
- > Lutter contre les discriminations
- > Rendre possible la pratique du vélo et du yoga pour toutes les femmes les plus éloignées de la pratique





Public(s) concernés

Le programme touche principalement 25 femmes des quartiers lillois.



Stratégies d'action déployées

Les stratégies reposent sur les principes de l'éducation populaire :

- L'action se déroule au cœur des quartiers prioritaires, il est co-porté avec l'association Lille Sud Insertion (LSI) qui est régie de quartier et a pour objet d'accompagner les personnes les plus éloignées de l'emploi
- le lieu de pratique est également au cœur de quartier de Lille sud, il s'agit d'un « tiers lieu » animé par des associations diverses (centres sociaux, association de femmes, resto du coeur ...) ce qui permet aux intervenants d'être en contact direct avec le public
- le travail en réseau pluridisciplinaires mené par Passer'Elles et LSI permet de mettre les femmes en contact avec une multitude d'acteurs en fonction de leurs besoins
- enfin la convivialité et la solidarité sont les 2 piliers des actions, les ateliers sont un espace de paroles où les femmes peuvent parler de leurs difficultés, comment elles les surmontent
- Foyers et associations de proximité
- Soutien des salariés ou des cadres au travers de la pratique physique. Ce point concerne plus généralement l'association



Activités déployées

Les activités déployées sont multiples au cours des séances :

- l'apprentissage de la bicyclette,
- des séances de yoga en fonction de l'état des personnes,
- un projet de création de petits déjeuners santé avec des professionnels de santé
- Temps de convivialité et d'espace de paroles : activité physique, santé sexuelle, violences faites aux femmes,
- Participation à un voyage longue distance



Financements

Ce projet repose sur un financement de contrat de ville et de la Fondation de France (depuis l'été 2020)



Territoire/lieu de déroulement de l'action

Lille sud et un voyage prévu au Pays Bas.



Partenaires impliqués

Les partenaires impliqués sont l'association Lille Sud Insertion, la fabrique du sud et la mairie de Lille sud.



Indicateurs d'évaluation

L'évaluation repose sur l'enregistrement de la participation aux 32 ateliers de 2H30 (yoga & vélo), de laquelle dépend une remise de diplôme à la fin. Une évaluation qualitative est également réalisée afin de recueillir la parole des participantes via la méthode du focus group.

Projet « En S'Elles »

Passer'elles

L'action en quelques mots

Le projet « En S'elles » vise l'apprentissage du vélo en non mixité choisie (uniquement des pratiquantes) comme support d'éducation à la santé et de développement communautaire.

Le contexte

Le projet est porté par l'association Passer'Elles, constituée de dix membres bénévoles et 200 femmes licenciées à ce club de la Fédération française d'éducation physique et de gymnastique volontaire (FFEPGV), qui vise l'accessibilité à la pratique physique aux plus démunis, aux plus fragiles. Cette association est itinérante et exerce dans plusieurs salles et lieux de pratique dans différents quartiers lillois. L'objectif de l'association est de créer du lien, de retrouver de la confiance en soi et d'organiser des actions solidaires. Cette association organise différentes activités avec trois objectifs : profiter des bienfaits du sport-santé, créer des points intergénérationnels et partager, échanger, s'enrichir au contact de toutes. Les activités proposées sont la zumba, la marche nordique, le bodyzen, le cross-training et le renforcement musculaire HIIT, notamment. Le projet est co-porté par Lille Sud Insertion. Ce projet se déroule dans un quartier prioritaire de la ville, qui fait l'objet d'une rénovation urbaine profonde. « Même s'il y a eu des grands projets urbains, des salles de spectacles, là ils sont en train de construire aussi un grand centre commercial, mais qui ne correspond pas forcément aux besoins des habitants, c'est aussi un quartier où il y a beaucoup de solidarité, comme dans tous les quartiers populaires, mais il y a aussi, malheureusement, beaucoup de trafic de drogue. Ce n'est pas un quartier où on se sent forcément en sécurité et puis c'est un quartier qui est enclavé puisqu'il est séparé euh... du centre-ville par périphérique, avec très peu euh... de transports en commun, les stations de métro sont à chaque bout du quartier, et c'est aussi le plus grand quartier de la ville, Lille Sud c'est le quartier le plus grand en termes de superficie et en termes de population, voilà, donc ce n'est pas un quartier très simple. ». Ce projet a été primé par l'Agence de l'Education par le Sport, au concours « Fais-Nous rêver ».

Le constat

Le projet part d'un constat : les inégalités de genre liées à la pratique d'activité physique. Les porteuses du projet citent : « c'est la sédentarité de ces femmes isolées ou ghettoïsées, donc je pense que c'est la question numéro un, la condition, le nombre de kilomètres qu'elles font par jour dans leur environnement proche, en parlant de santé. Après, il y a tous les axes qui s'ajoutent à cette... la santé psychique, physique, mentale. ». C'est parti d'une demande de pratique physique régulière, de « bouger dans le quartier », ou de médecins qui envoient ces femmes vers la pratique d'activité physique. C'est aussi une demande d'avoir un espace pour se retrouver, un moment de convivialité, où l'on peut parler de santé sexuelle, de violence, d'empowerement, pas uniquement de « manger, bouger ». Par ailleurs, le projet part d'un constat « de besoin de diversité qui est vraiment essentiel aujourd'hui, et l'activité elle peut promouvoir en tout cas cette accessibilité et tous ces droits, dont la culture. »

L'opportunité

Le projet est né, il y a deux ans. Suite à la création de l'association Passer'elles, qui proposait des cours d'activité physique en non-mixité choisie, pour répondre aux besoins des femmes qui vivaient dans le terrain de Lille sud. A partir de là, le projet « En S'elles » s'est construit. La volonté de mettre en place le projet vient de la rencontre par la coordinatrice de projet de Lille Sud Insertion lors d'ateliers parents-enfants et lors de groupes de femmes dans les écoles. Le financement de l'action de groupes de femmes dans les écoles s'est arrêté et il y avait une demande autour du vélo, donc « En S'Elles » a été lancé. « Et puis, par ailleurs, Lille Sud Insertion a sept chantiers d'insertion, et notamment un atelier de réparation de vélos donc ça s'y prêtait plutôt bien parce qu'on a quand même cette problématique : pour apprendre du vélo, c'est bien d'avoir une bicyclette sous la main. ». Quand le projet a été lancé «on faisait des cours à 90 personnes du quartier, ce qui est pas du tout génial parce que ça limite la qualité de l'activité, mais je n'avais qu'un créneau par semaine donc du coup c'était cette option et oui, elle venait dans les cours. Du coup c'est vraiment, j'insiste, sur le cercle vertueux du travail de terrain d'une coordinatrice sociale sur des projets... »

Les principes d'action de l'action

Un principe majeur de l'action est de travailler sur l'accessibilité à la pratique de vélo pour les femmes défavorisées et isolées, par l'empowerment et la non-mixité choisie. Le projet a comme objectif de faire se rencontrer les femmes du quartier, mais également qui viennent d'ailleurs. L'objectif est de créer des passerelles entre les pratiquantes.

Un des principes de l'action est l'apprentissage par les pairs, où les participantes sont là pour s'encourager, se soutenir, parler d'autres sujets problématiques de leurs vies, élaborer ensemble des stratégies.

Les objectifs du projet

Le projet cible principalement « l'empowerment des femmes, les droits des femmes, la santé sexuelle même, voilà lutter contre les violences et travailler sur l'employabilité. »

Pour l'action « En S'Elles », l'objectif est d'avoir des animations et un atelier vélo auto-porté par les femmes qui participent actuellement, grâce à l'autonomisation et l'éducation par les pairs de ces dernières.

Un des objectifs à long termes du projet est de créer une école de vélo, non-mixte dans le quartier, qui devienne autonome, au-delà de l'action « En S'Elles ».

Le contenu de l'action

Plusieurs activités ont été mises en place pour les 25 femmes qui participent au projet chaque année (avec 5 à 10 femmes à chacune des séances, en fonction de niveaux d'apprentissages) :

- 1) Un group WhatsApp, où les participantes communiquent quotidiennement et gardent le lien en permanence. Les porteuses du projet envoient des textos pour rappeler les séances et appellent si elles perdent le contact avec les pratiquantes depuis trop longtemps.
- 2) Des séances de pratique et d'apprentissage du vélo, suivies par des moments de convivialité, tous les vendredis matins, accessibles gratuitement. Ces séances démarrent par un temps de pratique de la zumba, du yoga ou de renforcement musculaire, avant de monter à vélo.
- 3) Un voyage annuel à l'étranger, la dernière fois au Pays-Bas.

Le projet ne bénéficie pas de financements particuliers à l'époque de l'entretien (un petit financement contrat ville depuis, nous avons obtenu un financement de la fondation de France), mais d'investissements en ressources humaines, par les deux porteuses, sur du temps de travail dans leurs structures, mais également bénévolement.



Les partenaires du projet/ de l'action

Un partenariat a été créé avec l'espace santé, qui repère des actions et organise des médiations autour des collègues du quartier et qui envoie des pratiquantes à l'association.

Le projet est co-porté par les 2 associations Passer'Elles et Lille Sud Insertion, le projet est soutenu financièrement dans le cadre du Contrat Ville.

Une demande de financement vient d'être déposée à la Fondation de France.

Le projet fait l'objet de publications dans la presse et attirent des étudiants qui viennent voir comment l'activité est mise en place. L'action a été primée par le réseau Alliance.

L'UFOLEP est partenaire de l'action, notamment sur l'envoi de participantes qui ont été initiées au vélo par l'UFOLEP dans le cadre du programme « Ca va rouler » du Ministère des Sports.

Un lien existe avec l'association Droit AU Vélo, et surtout l'école du Vélo de Montreuil que nous avons visitée en novembre avec qui nous avons pu faire des échanges de pratiques.

Il y a des partenariats dans le quartier, avec Sois femmes, la F.A.M. E (Femmes Agissant pour un Mieux Etre), Médecins du Monde, Vaï ma Poule, Centre de Santé de Lille Sud et les Restos du Coeur qui soutiennent l'action et en sont des relais.

La Mairie de quartier met à disposition des lieux de pratique et apporte son soutien politique au projet.

Un lien a été établi avec S.O.L.F.A. (SOLidarité Femmes Accueil) un CHRS (Centre d'Hébergement et de Réinsertion sociale) qui accompagne les femmes victimes de violence et qui fait le lien avec des femmes qui souhaitent bénéficier de l'activité.

Un relai important pour les porteuses du projet sont les médiateurs sociaux et les éducateurs de rue, qui permettent un travail en transversalité et l'utilisation du sport comme outil dans la lutte anti-discrimination et l'accessibilité aux publics dits « invisibles ».

L'évaluation

Sur l'évaluation, elle est en pleine modification et adaptation, comme le décrit la porteuse du projet : « On s'est rendu compte qu'il fallait évaluer d'une manière un peu plus régulière, avant on avait des petits enregistrements audio, à la fin des séances, euh... au fur et à mesure, on est plutôt passés à des moments conviviaux, et quand il y a des moments conviviaux, c'est un peu « chiant » d'enregistrer ce qu'elles racontent. On a enregistré une petite grille, on vient de la refaire cette petite grille, c'est une grille d'ailleurs inspirée du planning familial. Sur euh... comment ça fonctionne chez elles, qu'est-ce qu'elles ont besoin, comment est-ce qu'on peut rajouter des choses et que ce soit co-construit. On va se professionnaliser un peu, et donc là on est... on part sur la méthode du Focus group, euh, avec une grille, voilà, deux animatrices, une qui prend des notes, et on enregistrera, sur l'évaluation. Et puis évidemment, on a des feuilles d'émargement, on est plus dans le quanti que dans le quali. »

Des exemples de réussites sont cités tout au long de l'entretien, notamment : « Les nanas elles arrivent à la fin du cours, tout au début, elles sont timides, elles ont peur de rentrer, au fur et à mesure elles dépassent le premier rang, le deuxième rang, le troisième rang, le quatrième rang, après elles sont sur le podium, ensuite elles deviennent même actrices de ce qu'elles proposent, c'est vraiment un cercle vertueux depuis dix ans. ». Les porteuses du projet reviennent sur les progrès personnels et l'autonomisation et la prise de pouvoir sur son corps et la capacitation, qui permet l'émancipation des pratiquantes, qui sont des bénéfices non attendus du projet.

L'ancrage dans un modèle théorique ou des données scientifiques

Les porteuses du projet ont enrichi leur projet grâce à une visite et des échanges avec l'association l'Ecole du Vélo de Montreuil notamment sur les projets développés à Saint-Denis et à Montreuil.

Les limites du projet/ de l'action

Plusieurs freins ont été identifiés par les porteuses du projet :

- 1) La légitimité et la complexité de l'acceptation de la non-mixité de genre (un projet qui est ciblé sur les femmes uniquement) choisie dans la pratique sportive, qui a entraîné un travail sans financement pendant un moment, puisque les porteuses de projet expliquent que ce type de projet n'est pas reconnu en France actuellement.
- 2) Les lieux de pratique sont également un frein, certains lieux n'ont pas ouvert leurs portes à notre association au vu du public ciblé. Un lieu fermé et protégé est nécessaire pour permettre la pratique et ouvert à la population accueillie.
- 3) Le portage du projet par des femmes et la légitimité des femmes auprès des financeurs, notamment les directeurs des centres sociaux.
- 4) Une des difficultés est le partage des financements entre les associations ; d'autres associations ont voulu s'associer au projet, en proposant de mettre à disposition un parc à vélo mais ayant peu d'argent pour financer les activités, le partage n'est pas possible.
- 5) Une autre difficulté repose sur la qualité de l'encadrement d'un parc à vélo, où des actions sont mises en place, notamment par les centres sociaux, mais où l'encadrement n'est pas effectué par une personne formée
- 6) Pour que le projet survive aux porteuses, elles expliquent qu'il faut « qu'on écrive parce que, de toute façon, c'est ce qu'on expliquait euh..., il faut que le projet nous survive donc si on veut faire du tuilage après, c'est à nous de tenir. »
- 7) Il y a des demandes de reproduction de l'activité ailleurs et sur d'autres créneaux, mais cela n'est pas possible actuellement faute de temps et de moyens.

Les moments clés du projet

Un des moments clé du projet est une action menée, un voyage qui a été organisé au Pays-Bas. Au départ, c'était un projet pour les femmes du quartier, puis petit à petit, différents arguments ont été avancés (manque d'assurances, frilosité des participantes), du coup, le voyage a été organisé avec d'autres femmes, sur un itinéraire de 200km. Un diplôme était remis à la fin et un petit déjeuner a été organisé avec les femmes du quartier. C'était de beaux échanges, qui ont permis, l'année suivante d'avoir d'autres femmes qui souhaitent partir et venir à ce voyage.

Un autre moment clé repose sur les prix qui ont été gagnés par le projet, qui lui donnent une légitimité, pas de gros moyens financiers, mais une reconnaissance qui nous permet de nous investir sur le projet et d'avoir le soutien de nos supérieurs.

Si c'était à refaire

Les porteuses de projet identifient peu de changements à apporter si c'était à refaire. Le fait d'avoir lancé le projet sans financement spécifique a permis de ne pas avoir à rendre de compte et de monter le projet comme les porteuses le souhaitait, et cela n'aurait pas eu l'impact que le projet a eu jusque-là, notamment parce que le public cible ne rentre pas dans les cases des appels à projet.



Les conditions pour reproduire l'action

Le projet est parti d'une analyse des besoins et de soutien, notamment du réseau et des relations de la coordinatrice sociale sur les projets de Lille Sud Insertion.

Les porteuses du projet étaient cyclistes et avaient l'habitude de se déplacer à vélo. Elles avaient la volonté de transmettre leurs habitudes de vie.

Le projet a pu démarrer parce qu'il y avait des personnes qui se sentaient concernées par l'action, qui la vivait et l'alimentait, puis il y a eu un relais pendant six mois, avec une absence de ressources humaines, avant que le projet renaisse avec l'arrivée d'une des porteuses du projet, qui a amené ses compétences (dans son engagement auprès de femmes, son militantisme, sa technicité sur les thématiques et sa pratique cycliste).

Une compétence nécessaire à la mise en place du projet est la capacité à être à l'aise avec le public. Une des compétences développées au fil du projet, est la capacité d'écoute et d'observation.

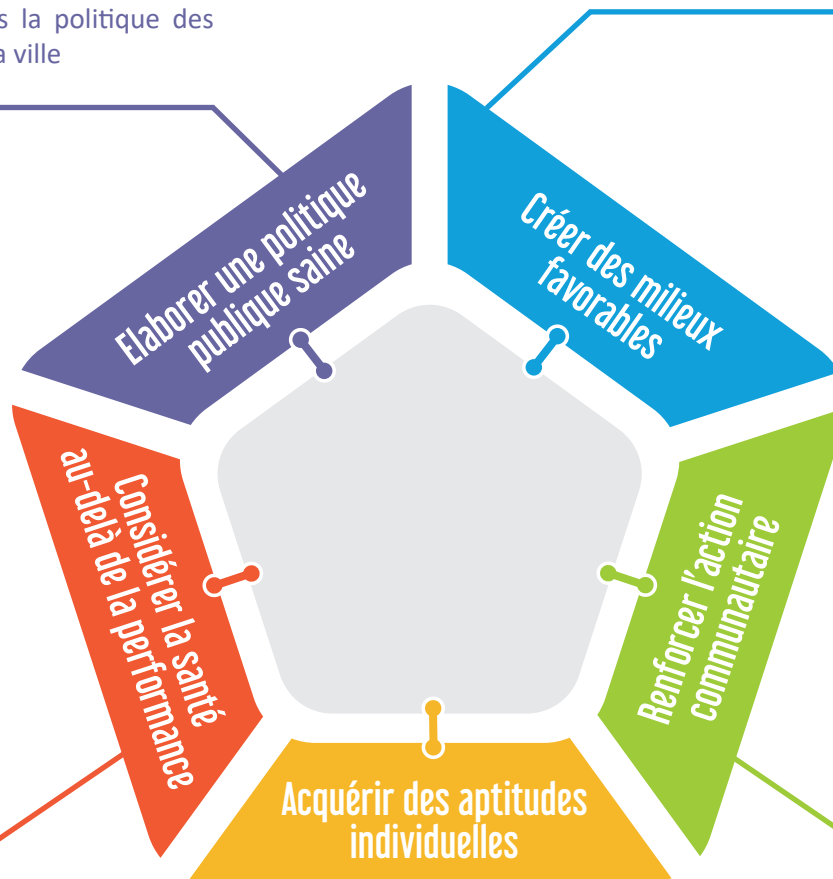
A l'heure actuelle, le projet tient grâce à l'investissement des deux porteuses principales, si elles s'en allaient, le projet serait en grande difficulté. Il y a un besoin de mobiliser d'autres personnes.

A l'heure actuelle, les porteuses du projet travaillent sur la communication, le développement d'un logo, d'un instagram spécifique, pour mieux communiquer sur l'action. Un film sur une des participantes est en cours de tournage également.

Éléments clés au regard de la Charte d'Ottawa

> Le projet s'inscrit dans la politique des quartiers prioritaires de la ville

> L'objectif est de créer un lieu de pratique en non-mixité choisie pour permettre les passerelles et les échanges entre femmes, au delà de la pratique sportive



> L'association Passer'Elles considère l'activité physique comme un support à une action transversale, de lien social, d'émancipation, de prise de pouvoir sur son corps et sa santé

> Par le projet « En S'Elles », l'association crée des ponts avec les médiateurs sociaux, avec d'autres associations

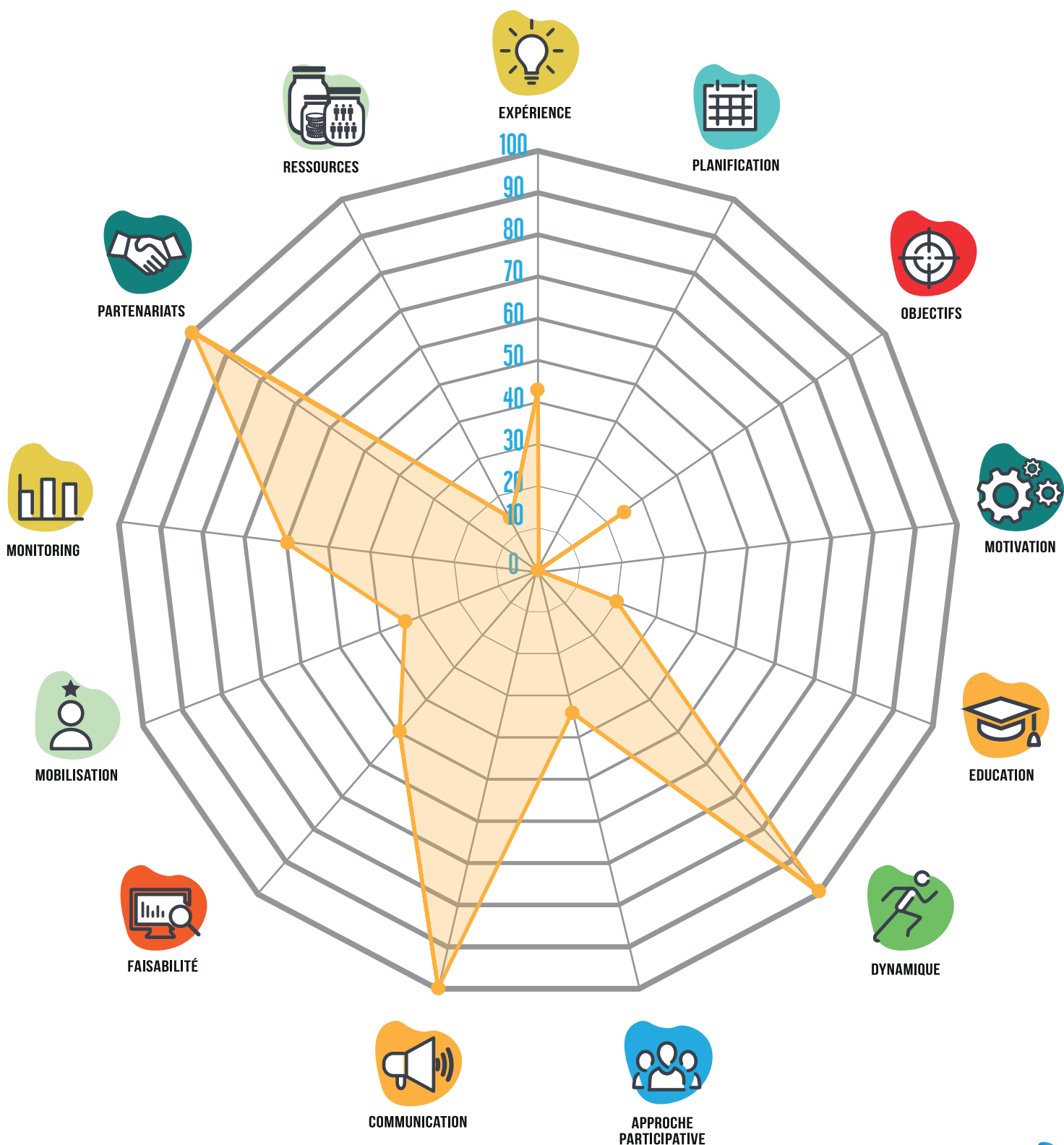
> Des ponts sont créés entre les pratiquantes (du quartier ou non), pour des échanges de pratiques, de conseils

> Les pratiquantes (ré)-apprennent à rouler à vélo, mais également à maîtriser leur corps

> L'activité est utilisée de manière informelle pour échanger sur des thèmes de santé (sexuelle, sociale, physique...)

> L'objectif est que les femmes soient autonomes dans leur pratique à l'issue de leur participation

Éléments clés au regard du modèle du club de sport promoteur de santé



Éléments clés au regard du modèle du club de sport promoteur de santé



Communication

Les porteuses du projet prévoient de communiquer plus autour de l'action en externe notamment (COM5), même si l'association a déjà un site internet, un logo, etc. (COM4). Il y a une volonté de créer un message clair, un slogan autour du projet (COM2). La communication interne est assurée par un groupe WhatsApp vers les pratiquantes (COM3).



Dynamique

Le projet tient compte de l'environnement dans lequel il évolue, avec l'idée de proposer des activités dans différents lieux, de bien connaître le public, de définir des objectifs qui sont atteignables et centrés sur l'empowerment des individus (DYN2). Par ailleurs, dans la définition des objectifs, le sentiment d'appartenance à l'association, comme son identité ont été considérées, par le choix de pratique en non mixité (DYN1).



Education

Les porteuses de projet se soutiennent mutuellement pour mettre en place le projet et échanger leurs compétences (EDU3).



Expérience

Le projet est basé sur d'autres expériences antérieures des porteuses de projet (EXP1), sur une volonté organisationnelle et des raisons d'engagement fortes et militantes (EXP2, EXP3). Le projet s'appuie sur une évaluation des besoins lors d'échanges avec les femmes du quartier (EXP6) et sur des expériences d'autres clubs (DAV Montreuil ; EXP7).



Faisabilité

Le projet évolue au fur et à mesure de la disponibilité des porteuses de projet, avec une évaluation régulière des ressources humaines (FAIS2) et de la faisabilité et du temps dédié au projet (FAIS3 et FAIS4), où les porteuses de projet pourraient ouvrir plus de créneaux, au vu de la demande, mais la nature bénévole de leur travail ne leur en donne pas la possibilité.



Objectifs

Les objectifs de l'association ont été décrits et sont présentés sur le site internet (OBJ1). Les objectifs précis du projet ne sont pas formalisés, excepté dans une demande de financement.



Mobilisation

Le projet mobilise actuellement les pratiquantes et leur entourage pour pratiquer et échanger, mais également sensibiliser par les pairs (MOB4). Les décideurs et élus locaux sont également mobilisés (MOB5) et le projet sert de plaidoyer, notamment auprès de la FFEPGV ou de l'APPELS (MOB6).



Monitoring

Un suivi informel des activités et des améliorations à apporter au projet est fait régulièrement (MON1), par des discussions après les activités. Par ailleurs, les résultats à court terme (MON3) et à long terme (MON4) sont suivis, et récompensés notamment par un diplôme pour les pratiquantes. Néanmoins, les porteuses de projet souhaitent mettre en place une évaluation plus importante, notamment par une grille en fin de séance.



Approche participative

Les actions des pratiquantes sportives sont valorisées et reconnues (APP5). Les participantes font partie du processus de décision et sensibilisent leurs pairs, mais également leur entourage (APP5 et APP6).



Partenariats

Des partenaires ont été identifiés, mais également des menaces en termes de partenariats (PART1), avec des rôles de diffusion de l'activité, des rôles de relais, de soutien politique, qui sont clairement définis (PART2). Ces partenariats permettent au fil du temps de construire une culture commune et une reconnaissance et une légitimité au projet (PART3).



Planification

La planification du projet est très succincte à l'heure actuelle, malgré la récurrence des créneaux. Elle est peu formalisée et dépend des opportunités identifiées par les porteuses du projet.



Ressources

Les ressources pour le projet reposent sur le temps bénévole des deux porteuses du projet et du bureau de l'association (RES2), qui influence la mise en place de l'activité. Néanmoins, un repérage des financements mobilisables (RES5), des compétences disponibles par et pour les pratiquantes (RES4) est effectué, pour créer cette dynamique d'émancipation.



PROSCeSS

PRoMotion de la Santé dans les Clubs Sportifs

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LA CARTE D'IDENTITÉ DU PROJET

Projet « Votre sécurité est notre priorité »
SAS Epinal

Thématique(s)

La thématique ciblée par le SAS Epinal est le Sport et citoyenneté. Il travaille autour de la sécurité routière, des gestes de premier secours, de la prévention, des risques de baignades, de la sensibilisation au feu et des jeunes sapeurs-pompiers.

Objectifs

Plusieurs objectifs sont poursuivis par le SAS Epinal :

- > Relayer au mieux les messages mis en place par les pouvoirs publics concernant la citoyenneté
- > Répondre aux besoins du quotidien dans la prévention des risques qui touche la population juvénile
- > Promouvoir la citoyenneté





Public(s) concernés

200 jeunes de 8 à 17 ans, pratiquants ou non le football au SAS Epinal



Stratégies d'action déployées

Différentes stratégies d'action sont déployées :

- Le renforcement des connaissances liées à la prévention des risques
- Une approche participative
- Le renforcement des compétences psychosociales, principalement en lien avec le respect
- Une inscription dans les statuts du club



Activités déployées

Le tableau ci-dessous résume les activités principales du SAS Epinal sur ce projet :

Sécurité routière	Gestes de premiers secours	Village prévention	Risques liés à la baignade	Sensibilisation feu	Volontariat ISP	Volontariat pompiers
Comment éviter un accident de la route ? Comment bien réagir en cas d'accident de la route ? Prévention sur les accidents et les suraccidents, sur la signalisation et simulateur d'accidents de voiture et de scooter	Comment bien réagir en présence d'une personne inconsciente, en convulsion ou en hémorragie ? Formation aux gestes de premiers secours vitaux et simples à réaliser	Mise en place d'une maison sur le stade synthétique comprenant tous les risques domestiques présents dans une maison avec toutes les explications nécessaires à leur bonne compréhension	Quelles sont les règles à respecter lorsqu'on se baigne ? Comment réagir en cas de noyade ? Explication des risques de la baignade sans la présence d'un nageur-sauveteur et mise en situation d'une noyade avec un mannequin	Condition réelle d'un feu, sensibilisation sur les risques du feu. Les pompiers disposent d'une maison à feu à Uxegney pour leur entraînement, l'objectif est de montrer la vitesse de propagation du feu et comment le maîtriser	Explication du rôle des jeunes sapeurs-pompiers et de leur formation. Première explication des jeunes sapeurs-pompiers aux enfants et sensibilisation de l'importance de leur rôle au quotidien	Explication du rôle des pompiers volontaires aux jeunes. Explication de l'importance du volontariat par diverses actions



Partenaires impliqués

Les partenaires impliqués sont détaillés dans la figure ci-après :



Financements

Les financements viennent de plusieurs sources : de la Ville d'Epinal (subvention en réponse à l'appel à projets et mise à disposition des installations), grâce aux Trophées Citoyens de la ville d'Epinal (2000 euros), de la Fédération Française de Football par la bourse au projet LGEF (2500 euros), de sponsors privés (1000 euros) et d'autofinancement par le club SAS Epinal (4500 euros)



Territoire/lieu de déroulement de l'action

- Au sein du club SAS Epinal, mais aussi au sein de la Ville d'Epinal
- Dans les centres sociaux
- Au sein de l'Association Vosgienne pour la Sauvegarde de l'Enfance, de l'Adolescence et des Adultes

Projet « Votre sécurité est notre priorité »

SAS Epinal

L'action en quelques mots

La thématique de santé abordée est la citoyenneté sous toutes ses formes, incluant la sensibilisation à l'alimentation, à la prévention de la consommation de substances, à l'intégration sociale, à la gestion des risques, au développement durable.

Les objectifs de l'action sont de sensibiliser les jeunes à la citoyenneté au sens large : prévention des risques, gestion des consommations, hydratation, développement durable.

L'action se compose de l'organisation de 3 à 4 demi-journées par trimestre, de stages ou d'évènements où des partenaires du club viennent sensibiliser les jeunes à la citoyenneté, sous forme d'ateliers ludiques intégrés à la pratique footballistique.

Le contexte

Le SAS Football Epinal est un club de National 2 de Football, comprenant 500 licenciés, situé dans la Commune d'Epinal. C'est un club sous le statut d'association 1901. Il accueille une école de football pour les jeunes, des équipes de pratique de compétition et de pratique de loisirs. Il sollicite une trentaine d'entraîneurs sportifs, plus trois quatre services civiques ou étudiants en stage.

Le projet se déroule au SAS Epinal et touche de manière plus large la population de la Communauté d'agglomération d'Epinal. Il n'y a pas de volonté du club de proposer des actions au-delà du bassin spinalien, mais il répond à des appels à projet nationaux.

La citoyenneté fait partie des statuts du club, avec un chapitre à part entière : « « L'association a pour objet de contribuer à l'épanouissement physique et culturel de ses membres par la pratique du football et de créer entre eux des liens d'amitié, de solidarité à travers le caractère éducatif et social de cette activité sportive. D'initier et/ou de mener toute action en faveur de l'insertion sociale par le sport ainsi qu'en faveur du développement de la citoyenneté, de la morale civique, la lutte contre la violence, le respect de l'environnement, la lutte contre les discriminations, l'incivilité, l'éducation à la santé et la solidarité. ». Ce projet fait partie du programme citoyen annuel du club.

Par ailleurs, les joueurs, entraîneurs et dirigeants signent une charte de citoyenneté en entrant au club, qui cible leurs comportements citoyens.

Le constat

Le club a souhaité se lancer pour « faire plus que du football » et rencontrer des missions d'inclusion sociale, jouer un rôle dans la communauté.

L'opportunité

Le projet a été lancé en 2008-2009 sous l'impulsion de l'ancien président du club, qui était député et souhaitait faire de l'insertion sociale son cheval de bataille. Il a lancé le slogan « faire plus que du football au club » et a commencé la mise en place des actions.

La première récompense date d'il y a quelques années, grâce à une récompense de la Fondation du foot, pour une action « un médecin dans le vestiaire », qui était un suivi sur la catégorie U17, portant sur les repas, l'alimentation, le sommeil, l'hydratation, l'hygiène du sportif, la préparation des matchs, la sensibilisation aux stupéfiants, aux addictions, des mises en garde contre le tabagisme, l'alcool, les drogues. Il y avait un médecin qui venait régulièrement, le club faisait des interventions deux fois par mois. On avait créé un support power point (propriété du club). De notre point de vue, c'était le précurseur des fiches du Projet Educatif Fédéral (PEF), suite auquel les fiches pour les différentes catégories ont suivi. Du coup, on a gardé ce support-là, on utilise juste les fiches du PEF pour les petites catégories.

Les principes d'action de l'action

Un des principes de l'action est de créer des temps forts dans le club, c'est-à-dire des actions éducatives comportant un temps fort d'une après-midi tous les 15 jours. Un second principe est de créer des jeux ludiques, avec une dynamique d'échanges actifs et des réponses concrètes.

Un troisième principe de l'action est de créer des synergies, en accueillant des publics qui ne sont pas licenciés au club (issus des CCAS, des centres aérés), en proposant des animations par des acteurs locaux sur des thèmes de santé (recyclage, eau, premiers secours, risques) et des événements.

Un quatrième principe repose sur l'investissement à tous les niveaux du club : des responsables du projet, des entraîneurs et des approches participatives avec les parents et les jeunes.

Les objectifs du projet sont 1/ de sensibiliser les jeunes à être les citoyens de demain, 2/ de dynamiser l'image du club au sein de la communauté d'agglomération d'Epinal (notamment pour recueillir des financements), 3/d'accroître la reconnaissance du club par la Fédération Française de Football et d'autres autorités.

Le contenu de l'action

L'action principale repose sur l'organisation d'après-midi ludiques pour plusieurs catégories d'âge en même temps, par la mise en place de divers jeux ou ateliers, avec deux ou trois rotations, c'est à dire deux temps de foot et un temps de citoyenneté (car les jeunes viennent pour faire du foot principalement) et on fait tourner les groupes. C'est souvent un intervenant extérieur, une association (sur l'eau, sur le papier, sur les premiers gestes, sur le rôle des pompiers) qui vient faire une présentation de ses activités ou sensibiliser les jeunes gratuitement.

Plusieurs autres activités complètent cette action :

- Au-delà des après-midi de sensibilisation pendant les entraînements, le club s'engage également sur des stages mêlant football et citoyenneté, il participe au téléthon et à d'autres événements citoyens.

- « Donc, sur les tous petits, ça va être les risques domestiques. Les 13-15, ça doit être les risques liés à la baignade, 17-19 c'est les accidents de scooter, comment réagir. La prévention de feu pour les plus âgés et tout le monde passe aux gestes aux premiers secours. Et donc là, on essaye d'avoir des thématiques qui sont ciblées par rapport au public. Après, on va faire... on fait la soirée Téléthon dans 15 jours, donc c'est en lien avec la citoyenneté. On fait notre stage au mois de février où là, il y aura des interventions spécifiques liées à la citoyenneté. Donc on essaye, maintenant, de faire des actions qui sont plus ponctuelles, qui sont peut-être un peu plus ciblées, et on n'essaye plus de faire des plus gros projets, et qui peuvent durer sur toute une saison, en fait. Parce qu'on a un petit peu moins de moyens humains aussi »

- La fréquence est 3-4 dates par trimestre, en fonction des rendez-vous des équipes, comme le souligne le responsable du projet : « Généralement, en début de saison, on demande... on fait un petit rétro planning c'est-à-dire qu'on demande aux éducateurs quelles sont, par rapport à leur calendrier sportif, les disponibilités qu'ils auraient en semaine pour pouvoir accorder du temps à la citoyenneté. En fonction de ça, nous, on a 3-4 dates, on va dire, par trimestre, et puis par catégorie. Et puis, à ce moment-là, nous, on sollicite les intervenants extérieurs, et puis pendant une période sportive un peu plus calme c'est-à-dire quand il n'y a pas de gros match à préparer, notamment pour les catégories... plus elles vieillissent, plus des fois le calendrier peut être compliqué pour les jeunes, les tous petits c'est pas un souci, mais voilà. Et puis, on s'adapte par rapport à ça de façon à avoir un calendrier citoyen et sportif qui permette de jongler selon les priorités. »

- Les personnes touchées sont les jeunes du club du SAS Epinal (action pendant les entraînements), les jeunes des écoles d'Epinal (utilisation du foot pour développer la citoyenneté dans les écoles), les jeunes habitants à proximité (pour les stages), les parents des jeunes (indirectement touchés).

- Les actions viennent également de problèmes rencontrés au club (pas d'arbitre pour les matchs du samedi) ou de préoccupations d'entraîneurs, où lors d'échanges informels ou de réunions avec les entraîneurs, des besoins sont identifiés auxquels le club essaie de répondre.

- Une action également est la signature de la charte avec comme modèle les valeurs du club : « respect, citoyenneté et convivialité », qui a été définie en réunion entre entraîneurs sportifs et avec les dirigeants, mais également pratiquants sous forme d'approche participative (proposition de trois valeurs par les entraîneurs et mise en commun) et par la création de commission spécifiques.

- Un responsable (membre du CA) a été nommé responsable d'une manifestation qu'il souhaitait organiser avec le club, par ce biais, ont été réalisés : l'arbre de Noël, une soirée choucroute, un loto, les tournois des stages. Il y a toute une liste de manifestations.

- Le responsable citoyenneté du club est la cheville ouvrière du projet, les entraîneurs du club acceptent et soutiennent le projet, mais ne s'impliquent pas activement dans le projet, ils sont plutôt accompagnants de la démarche. Néanmoins, lors du recrutement des entraîneurs, une attention est portée à la citoyenneté sur le recrutement. Les dirigeants du club cautionnent le projet. Les partenaires viennent sensibiliser au sein du club.

Les partenaires du projet/ de l'action

> La plateforme de la Ville d'Epinal est un partenaire. Le club essaie de répondre présent à toutes les sollicitations de la ville (ex : stand école des champions). Le club sert de laboratoire pour permettre à la ville de développer des projets citoyens et pour tester des actions, qu'elle développe après dans d'autres clubs (notamment le projet sur les valeurs de la République).

> Avec la Communauté d'agglomération d'Epinal, une convention a été signée sur la clause d'insertion par le bénévolat, où le club accueille des personnes pour une réinsertion professionnelle par le biais du bénévolat au club.

> Des partenaires venant sensibiliser : les pompiers, la police, Keolis, la Banque de France, Sicoval (gestion déchets), usine de papier, station d'épuration.

- > Cette action est ouverte au CCAS, aux centres aérés, aux centres sociaux pour accueillir ces publics sur les actions proposées.
- > Le département des Vosges offre une subvention au club pour son caractère citoyen, avec le souhait de signer une convention sur trois ans, pour poursuivre le développement du projet.
- > La clinique d'Epinal, des entreprises, la Ligne Bleu sont également des sponsors qui ont financé le club pour ses actions citoyennes.
- > Le club a été primé dans le cadre du programme « faire plus que » de la Ville d'Epinal.

L'évaluation

L'évaluation des actions est très succincte et se rapporte plutôt au volume des actions : « Il y a un petit bilan des actions qui sont faites, surtout un recensement du nombre d'actions qui sont faites en lien avec le PEF. »

L'indicateur principal de l'évaluation pour les responsables de l'action est le résultat aux appels à projets, pour décrocher des financements, le classement du club sur ces appels à projets.

L'ancrage dans un modèle théorique ou des données scientifiques

Il n'y a pas de modèle théorique sur lequel l'action s'est appuyée.

Les limites du projet/ de l'action

La proposition des fiches par le PEF, qui guide les éducateurs dans la promotion de la santé, est intéressante, mais est considérée par les porteurs du projet comme limitative dans son utilisation, car très répétitive (mêmes contenus d'une catégorie à l'autre) et son utilisation (5-10 minutes par entraînement) ne permet pas d'aller au bout de l'échange. Le fait que la fédération propose ce modèle à suivre est entré en concurrence avec le dispositif que le club avait mis en place.

La lourdeur des démarches administratives pour contacter les partenaires pour intervenir, organiser et coordonner les interventions est un frein (appel, décision de date, coordination avec les entraîneurs...).

Un autre frein important est le manque de ressources humaines qui ne permet plus à l'heure actuelle de monter des gros projets : « Parce que les projets, le projet qui était monté, on était tous les 2 dessus, mais c'est un étudiant d'une école de Lyon qui a passé plusieurs semaines chez nous, et en fait, c'est sur cette base-là que le projet, il a pu naître parce que ça rentrait dans son projet. Il a pu formaliser, nous, on lui a donné les idées, on l'a aiguillé, et puis, au final, on se rend compte que tout le monde est gagnant. Parce que lui, ça lui a fait une belle expérience, nous, on a signé une convention avec les pompiers, on a répondu aux trophées, on a été récompensé, et maintenant c'est nos licenciés qui vont pouvoir en bénéficier. »

Un frein souligné est la demande d'évolution et de projets novateurs par les fondations ou les appels à projet, qui nécessite un renouvellement continu des projets et ne permet pas de capitaliser toujours les actions proposées (jeux et matériel créé). Ce qui est compliqué également, c'est d'identifier et de cibler les appels à projets.

Une des difficultés est l'évolution des relations et des partenariats, où certaines actions sont possibles à un moment grâce à une synergie ou un partenariat, mais pas pérennes et reconductibles. La recherche de partenaires est un travail continu.



Le projet s'arrêterait ou serait largement revu à la baisse si « la citoyenneté ne rapportait plus », si cela ne permettait pas au club d'avoir des financements supplémentaires.

Les moments clés du projet

Les porteurs de l'action ne citent pas de moments clés, mais plutôt une dynamique de 10 ans, avec des actions et des partenaires qui ont rejoint, puis quitté l'action ou sont restés, qui ont permis de réaliser certaines composantes spécifiques de l'action. Il n'y a pas eu de rupture dans l'action depuis 10 ans, mais une dynamique globale mise en place et déclinée.

Si c'était à refaire

Un écueil important à éviter est l'absence de valorisation : « Justement, en parlant de valorisation, il y a aussi après tout ce qui est constitution d'appel à projets. Forcément, nous, on fait beaucoup de choses, on a le savoir-faire, mais après il faut faire savoir aussi. Donc après il faut valoriser ce qu'on veut aussi, c'est important. Donc que ce soit pour, je dirais, le bassin spinalien qui sache un petit peu ce qu'on est amené à faire, mais aussi par rapport aux appels à candidatures qu'il peut y avoir de diverses fondations ou d'organismes institutionnels où là, comme dit Aurélien, c'est une marque de fabrique. »

Les points de réussite sont 1/ les financements des appels à projet qui ont été décrochés, à la Fondation du Football, à la Ville d'Epinal, ainsi que la capacité à mettre en place des actions pour les personnes. 2/la reconnaissance et les sollicitations pour participer à des actions des décideurs politiques ou des partenaires

Les conditions pour reproduire l'action

Plusieurs éléments contextuels ont été identifiés par le responsable de l'action :

- Un responsable citoyenneté est employé à mi-temps au sein du club pour le développement et le soutien du projet, qui est la cheville ouvrière et qui a une vision d'ensemble du projet, pour répondre aux appels à projets notamment. Par ailleurs, ce responsable doit être capable d'analyser la structure, de connaître tout ce qui s'y passe, ses besoins par rapport à son identité, ses publics, et les niveaux d'intervention à proposer.
- L'engagement de services civiques ou d'étudiants en stage qui apportent des ressources humaines qui permettent d'organiser les projets.
- Un comportement proactif de gestion des conflits entre parents, entraîneurs, dirigeants et joueurs est mis en place par le responsable de projet, à l'écoute des différentes difficultés, qui s'appuie sur l'avocat du club au besoin, ce qui permet par le dialogue, de désamorcer les situations, « de calmer le jeu »
- Une des clés à la participation et à la multiplication des événements du club est la planification sur la saison, avec une approche participative : « Et en fait, on a refait un rétro planning sur la saison complète avec des commissions. Il y avait un responsable de commission qui devait choisir ses membres, trouver des membres pour l'aider à chaque... et en fait, on a un responsable par manifestation, et donc là, on va faire l'arbre de Noël, on va faire la soirée choucroute, un loto, les tournois, les stages. En fait, en l'espace de 2 réunions, on a recréé toute une liste de manifestations, et voilà c'est intéressant. »
- Il y a un accompagnement fort des éducateurs et un soutien à la formation du recrutement à la mise en place des actions : « on a créé un projet sportif il y a quelques années avec des fiches animateurs, et des fiches techniques en disant : « Voilà comment... voilà ce que nous, on attend de l'entraîneur en fonction de la catégorie ou de l'équipe entraînée, les prérequis, les attentes, l'investissement et ainsi de suite. » Et avec une fiche technique qui l'aide par rapport à son public. Donc, on a défini les caractéristiques de son public, comment il doit se comporter, comment il doit être avec eux, qu'est-ce qu'il doit lui apporter. Donc ça, c'est des documents avec la charte qu'on leur remet. On leur a remis une clé USB en début d'année avec tous les éléments et c'est comme ça qu'on les accompagne. Après il y a les réunions techniques, il y a le plan de formation... »

- La mise en place de toutes les actions ne serait pas possible sans le soutien et le partenariat fort avec la Ville d'Épinal et le soutien des dirigeants politiques.
- Pour tout ce qui est communication, il y a un chargé de communication au sein du club qui s'occupe de la page facebook et du site internet, il y a un partenariat avec Vosges Matin et Vosges FM, qui communiquent sur les évènements et les actions du club. Les responsables du projet les sollicitent régulièrement.

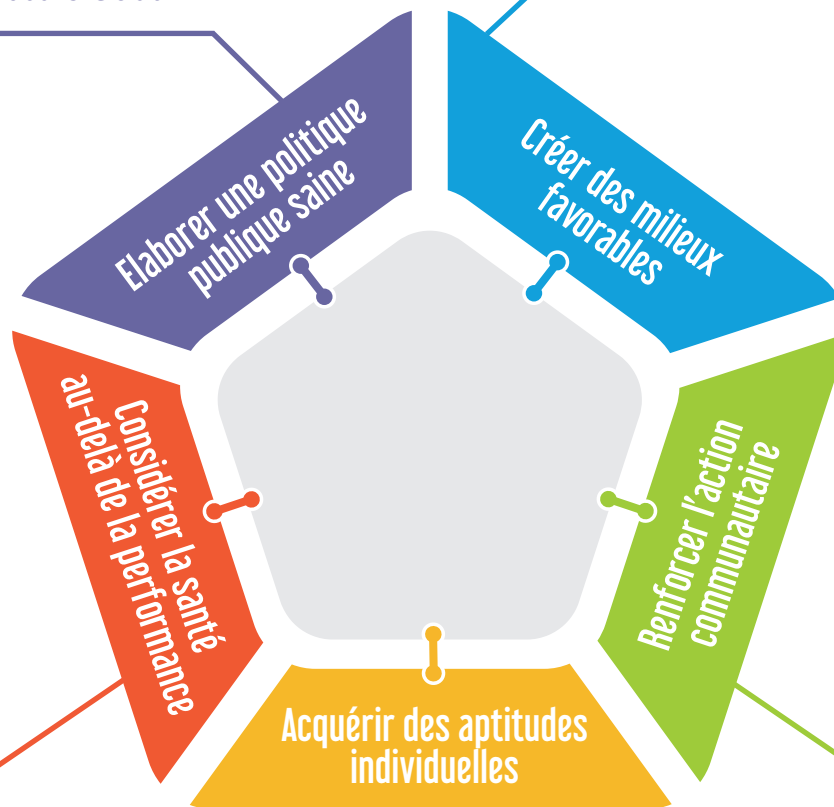
Plusieurs compétences ont été développées au travers du projet :

- Les responsables du projet ont appris à valoriser les actions qu'ils font, notamment au niveau local et ils ont vu la portée de cette valorisation, car le partenariat permet aussi de récupérer des financements, soit par la réponse à des appels à projets, soit par les sponsors, qui sont de plus en plus compliqués à trouver, s'il n'y a pas une vitrine.
- La construction des actions a été modifiée, car le club proposait plein de petites actions ancrées dans l'activité quotidienne du club, mais les fondations et les financeurs demandent un renouvellement des actions et des projets, donc pour continuer à bénéficier des financements, il a fallu renouveler les actions et viser plus grand.
- La capacité des responsables à répondre aux appels à projet et à rédiger les dossiers, qui peuvent être composés d'une centaine de pages.
- Il y a une dynamique qui s'est créée au club, qui incite les responsables du projet à relancer chaque saison des actions : « Aujourd'hui, on ne se voit pas redémarrer une saison sans un projet citoyen, par exemple. Ça fait partie du truc. Ce n'est pas une obligation, mais ça fait partie du projet du Club. C'est forcément la Ville et la campagne, et on a des ressources financières aussi, donc si on ne fait pas, on sait qu'il y a des ressources financières qui vont disparaître et on en a besoin aussi. »

Éléments clés au regard de la Charte d'Ottawa

- > La citoyenneté est présente dans les status du club de sport
- > Les actions proposées vont au delà de l'utilisation des fiches du PEF proposé par la Fédération Française de Football, avec une politique portée par le SAS Epinal
- > Une charte est proposée avec les valeurs du club et signée par les entraîneurs et les joueurs à leur engagement dans le club

- > Faire plus que du football et créer une dynamique de promotion de la citoyenneté au delà de la pratique
- > Permettre au club d'accueillir une grande diversité de personnes grâce à ces partenariats

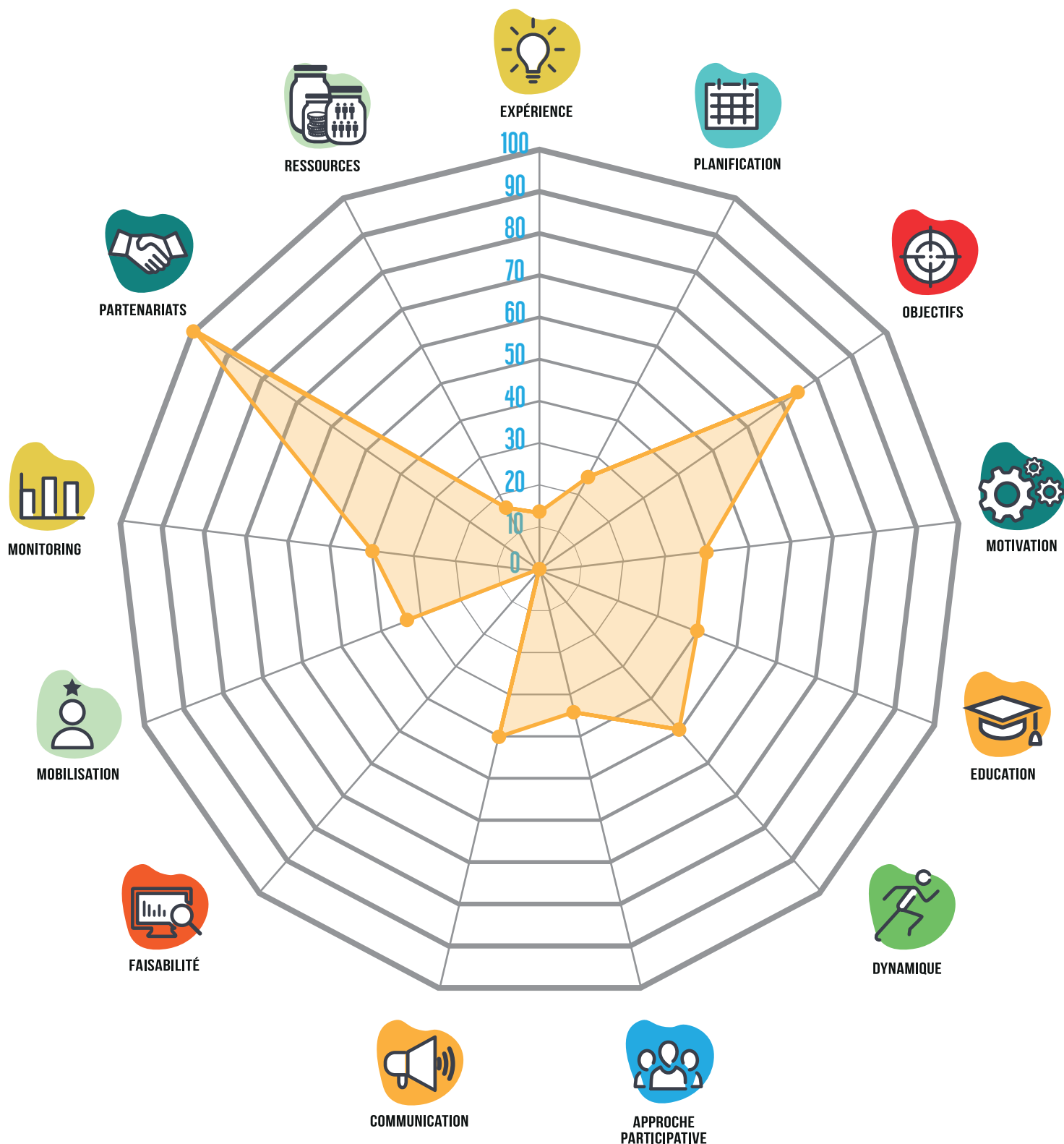


- > Le club considère les joueurs et les entraîneurs dans une approche globale (principalement sociale) et pas uniquement footballistique

- > Le programme permet le développement de compétences psycho-sociales des jeunes, des encadrants et de leurs parents

- > Intégration forte dans la Communauté d'Agglomération d'Epinal et collaboration forte avec la Ville d'Epinal
- > Partenariats très nombreux avec des associations ou structures pour la promotion de la citoyenneté
- > Coordination avec l'enseignement, les services sociaux, les centres aérés pour un accueil de publics variés
- > Favorisation de l'insertion professionnelle de demandeurs d'emploi et de jeunes

Éléments clés au regard du modèle du club de sport promoteur de santé



Éléments clés au regard du modèle du club de sport promoteur de santé

Communication

Communiquer avec 1 seul message, un slogan (clair, explicite et compréhensible) (COM2) : Le club a créé plusieurs slogans pour communiquer sur le projet « Votre sécurité, notre priorité », ainsi que trois valeurs clés qui sont affichées dans les documents du club

Assurer la communication externe du club de sport (COM4) : Le club collabore avec une radio et un journal pour mettre en vitrine les actions faites.

Dynamique

Tenir compte des interactions entre l'individu et son environnement, lors de la définition des objectifs de promotion de la santé (DYN2) : dans la définition des trois valeurs du club, tous les niveaux du club ont été sollicités (dirigeants, entraîneurs, pratiquants).

Education

Soutenir les dirigeants et les entraîneurs à s'engager activement dans l'acquisition de connaissances et de compétences pour promouvoir la santé (EDU1) : Les responsables du club poussent les entraîneurs à se former, par un plan de formation.

Adapter individuellement le soutien aux dirigeants et les entraîneurs en fonction du public qu'ils encadrent (tutorat, cours, e-learning) (EDU2) : les dirigeants du club ont créé des fiches pour chaque catégorie d'âge et soutiennent les entraîneurs dans l'évolution de leurs compétences.

Expérience

Identifier les expériences antérieures du club de sport en matière de promotion de la santé (EXP1) : les responsables du projet se basent sur les actions déjà réalisées depuis 10 ans, pour poursuivre le projet et relancer des actions

Faisabilité

Évaluer régulièrement les ressources financières mobilisées (FAIS1) et évaluer régulièrement les ressources humaines mobilisées (FAIS2) : Les ressources financières sont évaluées toutes les années et chiffrées de manière très précise par les responsables du projet. Il en va de même pour les ressources humaines.

Évaluer régulièrement le temps dédié à l'atteinte des objectifs (FAIS4) : Le temps dédié par le club à la logistique, la mise en place des activités de l'école Jaune et Bleu sont identifiés et chiffrés par le club. Le temps de démarchage de partenaires et de création d'outils est moins chiffré, mais fait partie du développement du programme.

Objectifs

Définir des objectifs de la promotion de la santé (OBJ1) et Rédiger et documenter formellement les objectifs de promotion de la santé (OBJ2) : les objectifs de promotion de la santé sont inscrits dans les statuts du SAS Epinal

Prendre en compte la manière dont les personnes appréhendent leur santé lors de la définition des objectifs de promotion de la santé (OBJ4) : Pour définir les valeurs que le club défend en termes de citoyenneté, le club a mis en place une approche participative avec les entraîneurs, les dirigeants, les pratiquants sportifs.

Mobilisation

Mobiliser des experts en promotion de la santé (MOB2) : le club mobilise des partenaires ayant une expertise spécifique sur une thématique de santé : gestion des risques, premiers secours, recyclage...

Identifier et mobiliser un ou plusieurs représentants en interne en promotion de la santé au club de sport (MOB3) : Le dirigeant porteur du projet est identifié au sein du club et autour du club comme étant la personne ressource sur le projet citoyenneté.

Mobiliser les parents (et l'entourage) pour soutenir les démarches de promotion de la santé (MOB4) : Les responsables mobilisent les parents pour l'organisation de manifestations et le soutien aux actions mises en place par le club.

Mobiliser les décideurs et élus locaux pour promouvoir la santé au sein des clubs de sport (MOB5) : Une collaboration très proche avec la Ville d'Epinal permet au club de pouvoir mettre en place le projet « Votre sécurité, notre priorité » et d'accueillir une diversité de publics.

Faire du plaidoyer auprès des fédérations sportives pour un soutien aux clubs sur la promotion de la santé (MOB6) : Le club a proposé des outils de promotion de la santé qui ont été utilisés par le département et qui servent comme outils pour d'autres clubs.

Monitoring

Collecter ou répertorier les petites améliorations en vue d'atteindre les objectifs de promotion de la santé (MON1) : Le responsable du projet est très présent auprès des parents, des joueurs et des entraîneurs pour modifier les activités, faire des retours et le lien entre les personnes.

Suivre toutes les activités de promotion de la santé entreprises dans le club de sport (MON2) : Le volume d'activité mis en place par le club est monitoré.

Motivation

Favoriser des relations interpersonnelles positives entre les parties prenantes (MOT1) : Le responsable de l'action anticipe et gère les conflits entre les joueurs et les entraîneurs ou entre d'autres membres du club.

Tenir compte des compétences des entraîneurs à gérer les situations (MOT2) : Un suivi personnalisé de chaque entraîneur, de l'embauche à la fin de la saison est réalisé par les responsables de l'action.

Approche participative

Identifier et valoriser chaque action de promotion de la santé (APP4) : Le club communique et met en avant les actions de promotion de la santé, en interne sur facebook et le site internet et en externe dans les médias.

Impliquer les dirigeants, entraîneurs, pratiquants dans le processus de décision (APP5) : une démarche participative a été mise en place pour définir les trois valeurs principales du club.



Partenariats

Identifier des partenaires pour mettre en œuvre des actions de promotion de la santé (clubs de sport, agences, collectivités territoriales, professionnels de santé...) (PART1) : Le club essaie de renouveler continuellement les partenaires avec lesquels il sensibilise les membres du club à la citoyenneté.

Définir les modes de collaboration avec les partenaires existants et à venir (définir les rôles, partager les expériences, les termes du contrat, l'évaluation des résultats, le pouvoir égal des partenaires...) (PART2) : Les conventions avec les partenaires, les modalités d'interventions sont définies avec le responsable de l'action.

Construire une culture commune avec les partenaires existants et à venir (confiance, reconnaissance, temps partagé...) (PART3) : Le partenariat avec la ville d'Epinal permet un appel du club de sport pour des manifestations et des actions. Le club est identifié comme laboratoire pour mettre en place des projets liés à la citoyenneté.



Planification

Inclure les étapes clés dans le plan de mise en œuvre (PLAN5) : Un rétro-planning est mis en place en début de saison pour les actions à faire.

Tenir compte de la durabilité des actions de promotion de la santé (PLAN6) : Le club cherche sans cesse à se renouveler, pour pouvoir proposer des actions innovantes à soumettre aux appels à projets.

Créer des politiques futures fondées sur l'évaluation des actions en cours (PLAN7) : A partir de l'expérience du club dans la promotion de la citoyenneté, de nouveaux projets, avec un plan d'action et des objectifs, sont proposés au sein du club.



Ressources

Evaluer les ressources humaines disponibles (temps consacré au bénévolat, turnover du personnel) à investir dans la promotion de la santé (RES2) : Le club se fonde sur les forces disponibles, notamment l'embauche de stagiaires, pour proposer des actions de promotion de la citoyenneté.

Identifier les financements mobilisables pour la promotion de la santé (RES5) : Le responsable de l'action identifie les appels à projets (six à sept par saison) auxquels répondre pour décrocher des financements.



PROSCeSS

PRoMotion de la Santé dans les Clubs Sportifs

UNIVERSITÉ
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DE LORRAINE



LA CARTE D'IDENTITÉ DU PROJET

Pôle Sport-Santé Bien-Être

Stade Marseillais Université Club (SMUC) Marseille

Thématique(s)

La thématique ciblée par le SMUC Marseille est la prise en charge biopsychosociale des individus par l'activité physique. Comme le souligne sa responsable : « Le Pôle Sport-Santé Bien-Être travaille sur la santé globale de ses adhérents en proposant une activité physique adaptée aux capacités et envies des personnes ».

Objectifs

Plusieurs objectifs sont poursuivis par le SMUC Marseille :

- > Favoriser l'accessibilité aux offres d'activités physiques pour tous publics,
- > Offrir une prise en charge en Activité Physique Adaptée coordonnée et complète
- > Promouvoir les bienfaits d'une activité physique régulière et pérenne
- > Favoriser un mode de vie actif

Un Objectif spécifique concerne le pôle :

- > Proposer de nouvelles activités, notamment aquatiques





Public(s) concernés

Dans tous les cours, sont présentes à la fois des personnes ayant des pathologies ou autre et des personnes qui n'ont pas de problèmes spécifiques, qui ont envie de se maintenir en forme. Il n'y a pas que des personnes malades.



Territoire/lieu de déroulement de l'action

Les pratiquants sportifs viennent principalement de Marseille, du quartier autour du club, mais certains cours et activités touchent tout le département : Carnoux-en-Provence, Aix-en-Provence.



Stratégies d'action déployées

Les stratégies déployées sont les suivantes :

- Création d'un Pôle Sport-Santé Bien-Être,
- > pour offrir des séances sport-santé à tous,
- > dans le club et au sein d'organisation médico-sociales,
- > pour toucher le grand public par l'évènementiel
- > et pour sensibiliser les autres sections du SMUC Marseille au sport-santé



Activités déployées

Le planning hebdomadaire est composé de 30 activités différentes : « on a un peu de tout, pour pouvoir répondre au besoin de chacun, des APA-s le matin et des activités dites de fitness, le soir, qui sont adaptées également, en fonction des personnes et de leurs envies. » Une des activités est de sensibiliser et développer le sport santé dans les 17 autres sections sportives compétitives du SMUC Marseille.

Le Pôle Sport-Santé Bien-Être promeut l'activité physique dans d'autres structures, au plus près des pratiquants sportifs : IME (institut médico-éducatif), hôpital, entreprise. Il organise deux événements à destination du grand public pour sensibiliser la population : MARSeille BLEU et la journée « Proman IntégraSports ». Il propose également des stages aux pratiquants sportifs.



Financements

Le Pôle Sport & Santé du SMUC présente plusieurs types de financement : les adhésions, les prestations, les subventions, les partenariats et l'évènementiel. Son budget annuel est de 150 000 euros.



Indicateurs d'évaluation

Un point est fait avec les pratiquants sportifs et avec les entraîneurs en fin de saison, ainsi qu'un suivi tout au long de la saison.

« Avec les entraîneurs, je fais des réunions plusieurs fois dans l'année, pour faire le point, je vais les voir dans leurs cours, je les recrute, on fait un petit entretien, je fais en fonction de leur expérience ou de leur diplôme. Je leur propose des formations (notamment les services hospitaliers). Je leur communique ce type d'informations. J'avais plusieurs demandes pour mettre en place du step. Il y a toujours une question sur la qualité de l'encadrement. On fait un bilan avec chaque entraîneur pour réajuster. »

« En fin de saison, pour préparer la saison, on fait un sondage sur internet, on envoie par mail le questionnaire, on le distribue et on prend les retours. »

Pôle Sport-Santé Bien-Être

SMUC Marseille

L'action en quelques mots

Le Pôle Sport-Santé Bien-Être aborde principalement la prise en charge des individus présentant des pathologies ou des limitations fonctionnelles, en utilisant l'activité physique comme déterminant de la santé physique, mentale et sociale.

Développer le sport-santé était important pour diversifier les activités du club.

Le Pôle Sport-Santé Bien-Être propose des activités physique santé : 1/ au sein du SMUC Marseille : pilates santé, qi gong santé, marche nordique santé, pour une prise en charge de personnes qui sont orientées par les hôpitaux ou d'autres structures, sur prescription médicale ; 2/ des créneaux de sport-santé au sein des entreprises du territoire de Marseille ; 3/des évènements de sensibilisation à la pratique sport-santé ; 4/ du sport-santé au sein des hôpitaux, des maisons de retraite, d'IME (institut médico-éducatif), d'ESAT (établissement et service d'aide par le travail) et des collectivités Marseillaises ; 5/des bilans médico-sportifs personnalisés.

Le contexte

Le SMUC est un club affilié à la fédération de sport universitaire, qui comprend 18 sections (Athlétisme, Badminton, Basket, Boules, Boxe Anglaise, Escalade, Floorball, Football, Golf, Gymnastique Rythmique, Handball, Judo, Kick-Boxing/Free-Fight, Kendo, Rugby, Tennis, Volley, VTT) et accueille 12 000 membres, dont 380 personnes qui accèdent à l'offre sport-santé. Le club emploie 25 salariés et 500 bénévoles pour organiser les activités. Une chargée de développement s'occupe actuellement à temps plein du Pôle Sport-Santé Bien-Être. Le pôle fait intervenir des autoentrepreneurs : trois enseignants en activité physique adaptée-santé et 8 entraîneurs ayant un BJEPS APT, ainsi qu'une sophrologue. Il est accompagné par la commission médicale du SMUC, composée de 4 chirurgiens, 5 médecins du sport, 1 endocrinologue, 1 médecin généraliste, 1 hématologue et 1 professeur d'université. Le pôle est financé par des subventions de l'échelle locale à nationale, des partenariats privés et génère des ressources par l'organisation d'évènements et les adhésions des pratiquants sportifs.

L'action du Pôle Sport-Santé Bien-Être s'inscrit sur le territoire du département, car il y a des interventions qui se déroulent dans des structures à Aubagne ou Carnoux. La majorité des demandes reste sur le territoire marseillais, dans les locaux du SMUC ou des partenaires.

Le pôle est une partie du club à part entière et reconnue comme telle, à côté des sections sportives, du SMUC Loisirs, du SMUC Entreprise. Le Pôle Sport-Santé Bien-Être ne figure pas dans les statuts du club, mais est présent dans le développement du club, avec un soutien très fort du bureau pour les actions du Pôle Sport-Santé Bien-Être. Le lien est fait avec le bureau par la directrice générale, qui fait remonter les informations de manière hebdomadaire. Le pôle est très libre sur le choix de développement de projets, et sollicite la validation par le bureau pour de gros projets ou pour un engagement financier du club.

Le constat

La création de la section a démarré avec l'envie du président et du secrétaire général que « le SMUC ça devienne un club qui accueille tout type de public, qu'on puisse proposer des activités pour les parents, les grands-parents c'était vraiment l'idée intergénérationnel et apporter le côté santé ». Au départ, il y avait 40 pratiquants sportifs au sein du Pôle Sport-Santé Bien-Être.

L'opportunité

L'engagement d'une responsable du pôle date de 2015, suite à l'envie d'élargir les actions de la commission sport-santé, créée par le secrétaire général (également directeur d'un centre de rééducation) et le président (également vice-doyen de la Faculté des Sciences du sport à l'époque), et qui était composée de médecins. Ensuite au fil des années, le pôle a grandi et augmenté le nombre d'activités proposées, ainsi que diversifié ses activités.

Les principes d'action de l'action

Un des principes d'action est l'accueil de personnes qui sont orientées vers le club, sur prescription médicale, venant d'un hôpital ou d'une structure de santé.

Un second principe est la possibilité de s'inscrire à l'année ou de prendre une carte de 5 ou de 10 séances. Une vingtaine de personnes sur les 300 membres de la section bénéficient de ce système actuellement.

Les objectifs du projet

L'objectif premier pour ce projet est de gagner en qualité sur les prestations de sport-santé et de développer des prestations de sport-santé extérieures aux locaux du SMUC Marseille, mais aussi de diversifier les prestations en intégrant le bien-être : sophrologie, massage...

Le second objectif est de pouvoir proposer une meilleure prise en charge médicale, de santé, pour les adhérents du club, en partenariats avec les hôpitaux, pour des consultations médicales avec des médecins du sport, les centres de rééducation, les chirurgiens, plus rapidement qu'un circuit classique. Une première étape serait de pouvoir faire un suivi des pratiquants sportifs, pas juste un entretien court en début de saison, mais un suivi deux trois fois par année, avec des évaluations et une réorientation au besoin. Une seconde étape serait d'être labellisé maison sport-santé, en lien avec des médecins et des mutuelles.

Le troisième objectif est de pouvoir mieux évaluer l'offre proposée pour diffuser des informations sur l'intérêt de la pratique et faire de la prévention, peu importe les sections du SMUC.

Le quatrième objectif est de pouvoir proposer des actions de prévention et de sport-santé au sein des différentes sections du SMUC, au-delà du basket et du rugby qui ont lancé le mouvement, accompagné par le Pôle Sport-Santé Bien-Être.

Le contenu de l'action

Différentes activités sont mises en place par le Pôle Sport-Santé Bien-Être :

- Le Pôle Sport-Santé Bien-Être propose différents créneaux d'activité physique adaptée, selon le planning suivant (créé par la responsable de section), après une orientation en fonction des capacités fonctionnelles et des préférences de la personne par la responsable de section et selon la disponibilité des autoentrepreneurs délivrant les séances :

SPORT & SANTÉ 2019-2020  **SPECIALISTE DE LA SANTÉ PAR LE SPORT**

	LUNDI	MARDI	MERCREDI	JEUDI	VENREDI	SAMEDI
9h00			MARCHE NORDIQUE 2H Paris, France - Niveau 1	CHI QONG TAIJS Niveau 1	MARCHE NORDIQUE 2H Paris, France - Niveau 2	PILATES Niveau 1
9h30	HATHA YOGA Niveau 1	CHI QONG TAIJS Niveau 1			PILATES Niveau 1	PILATES Niveau 1
10h00					PILATES SANTÉ Niveau 1	PILATES Niveau 1
10h15				CHI QONG SANTÉ TAIJS Niveau 1		
10h45		THAI CHI TAIJS Niveau 1				
11h00	HATHA YOGA Niveau 1					CARPIO BOXING Niveau 1
11h15					GYM POULCE Niveau 1	
12h15	SOPHROLOGIE Niveau 1	CARPIO RENFO Niveau 1		CARSE ARPOS FESSIERS Niveau 1	STRONG Niveau 1	
13h30		MARCHE NORDIQUE 2H Paris, France - Niveau 1			MARCHE NORDIQUE 2H Paris, France - Niveau 2	
14h00				CIRCUIT TRAINING 1H30 Niveau 1		
15h30		MARCHE NORDIQUE 2H Paris, France - Niveau 1			MARCHE NORDIQUE 2H Paris, France - Niveau 2	
17h30	PILATES Niveau 1	SWISSBALL Niveau 1			ZUMBSA Niveau 1	
18h30	PILATES Niveau 2	SWISSBALL Niveau 2	CARPIO RENFO Niveau 1	LEERS TRAINING Niveau 1	PILATES Niveau 1	SWISSBALL Niveau 1
19h30	ZUMBSA Niveau 1	HATHA YOGA Niveau 1	ZUMBSA Niveau 1	PILATES Niveau 1	ZUMBSA Niveau 1	ZUMBSA Niveau 1
20h30	ZUMBSA Niveau 2					

►►► 1 séance/semaine = 240 € // Séances illimitées = 350 € // Cartes de 5 séances = 55 € // Cartes de 10 séances = 95 €
(Séance d'essai offerte - paiement en plusieurs fois)

RENSEIGNEMENTS ET INSCRIPTIONS SUR LE SITE DU SMUC
En contactant Isabelle au 04 91 76 30 70 touche 3 isabelle.petit@smuc.fr ou directement au secrétariat du SMUC.
65, avenue Clot Bey 13008 Marseille (parking disponible). Depuis le métro Rond-Point du Prado, bus ligne 44, arrêt Clot Bey Paul-Jean Douin.

Réservation obligatoire pour chaque cours. Certificat médical obligatoire.
Rendez-vous sur smuc.fr

- Chaque année, le Pôle Sport-Santé Bien-Être organise deux événements phare à destination de ses membres et de la communauté : 1/MARSeille BLEU (course pour le dépistage du cancer colorectal), en collaboration avec le service d'Oncologie Digestive de l'Hôpital de la Timone et l'association ARCADES. Cet événement comprend des courses, ainsi que des stands de découverte sportive pour un public familial. 2/ Intégra' Sports : tournoi sportif pour des personnes en situation de handicap mental, moteur et sensoriel, accompagné par de jeunes adultes, collégiens et lycéens.
- Les programmes du Pôle Sport-Santé Bien-Être font l'objet d'études scientifiques en partenariat avec le département STAPS de l'Université d'Aix-Marseille, notamment à l'heure actuelle pour démontrer l'efficacité de deux programmes (marche nordique, circuit training classique et « feel light » qui sont des ronds lumineux à poser au sol ou sur les murs pour les exercices) de prise en charge d'un public sénior sur leur santé cognitive et physique. Les pratiquants sportifs sont recrutés grâce à une publication dans le journal (article dans la Provence). Plus de la moitié de ces personnes poursuivent la pratique au SMUC après l'étude, grâce au tarif préférentiel offert par le club et à l'offre spécifique due au programme testé.
- Le Pôle Sport-Santé Bien-Être propose un accompagnement des patients au sein des structures partenaires (hopitaux, IME, SSR, EHPAD) avec une prestation d'intervenants du SMUC auprès des patients pour augmenter leur activité physique. Ainsi, le pôle sport & santé est par exemple, impliqué dans la mise en place d'une prise en charge d'éducation thérapeutique du patient pour des enfants épileptiques. L'objectif de ces prestations est de recruter des pratiquants sportifs qui s'inscrivent à la sortie du traitement au SMUC Marseille, sur les créneaux sport-santé.
- Il est également impliqué dans une action en collaboration avec un cabinet d'avocats, pour un accompagnement des personnes dans la reprise d'une vie sociale et active grâce à l'activité physique après le jugement au tribunal.
- Le Pôle Sport-Santé Bien-Être participe à plusieurs salons pour présenter ses activités, comme le festival sport-santé organisé par la ville de Marseille, où il est présent avec un stand. Il participe également à Coaching Marseille, qui propose dans les parcs de Marseille une séance à 2 euros pendant le mois d'avril.
- Deux personnes sont actuellement salariées du Pôle Sport-Santé Bien-Être. Le pôle fait intervenir une dizaine d'entraîneurs autoentrepreneurs, ayant soit un BPJEPS APT (Brevet professionnel de la jeunesse, de l'éducation populaire et du sport - Activités physiques pour tous) ou des enseignants en APAs. Les intervenants sont recrutés par l'intermédiaire de la Faculté ou par bouche à oreille.

Les partenaires du projet/ de l'action

- > Le Pôle Sport-Santé Bien-Être est financé par cinq partenaires pour la mise en place d'actions : la ville de Marseille, le département des Bouches-du-Rhône et de la région Provence-Alpes-Côte d'Azur, l'Agence Régionale de Santé et le Centre national pour le développement du sport.
- > Les partenaires privés (MGEN...) génèrent également des ressources financières, notamment par des propositions de financement en échange d'une diminution du prix de la cotisation pour les membres ou une valorisation de l'image du partenaire lors des événements organisés (Proman, Krys, service traiteur...)

L'évaluation

Au-delà des études scientifiques mises en place et du bilan d'orientation à l'entrée de la saison, il n'y a pas d'évaluation à proprement parler. La responsable du pôle est en lien avec les entraîneurs très souvent de manière informelle (avant ou après les cours), les réunit au moins deux fois par an pour échanger et discuter des ajustements nécessaires. Plusieurs indicateurs sont collectés annuellement : le nombre d'adhérents, le nombre d'activités proposées (créneaux, bilans, interventions auprès des partenaires). Un questionnaire de satisfaction est utilisé auprès des adhérents du Pôle Sport-Santé Bien-Être.

L'ancrage dans un modèle théorique ou des données scientifiques

Certains programmes mis en place font ou ont fait l'objet d'études scientifiques en partenariat avec l'Université d'Aix-Marseille, mais pas tous les créneaux.

Les limites du projet/ de l'action

Un des freins majeurs à la création du Pôle Sport-Santé Bien-Être a été la méconnaissance du sport-santé par le milieu médical et l'absence de formations pour sensibiliser les intervenants au sport-santé.

La saison dernière, le nombre de pratiquants sportifs par créneau de la section n'était pas limité, ce qui diminuait la qualité de la pratique proposée. Dès lors, cette saison, une limite à 20 pratiquants sportifs a été imposée, ce qui fait que les créneaux sont remplis et que la capacité d'accueil de nouveaux pratiquants sportifs est limitée à l'heure actuelle. Le nombre de places par cours varie en fonction de l'activité.

Une autre limite est la taille des installations, qui restreint le nombre de créneaux sport-santé qui peuvent être mis en place au sein du club directement.

Les moments clés du projet

Un premier moment clé pour le projet est la réussite de l'étude scientifique qui a lancé le Pôle Sport-Santé Bien-Être : « Alors je pense que la plus belle réussite a été la première étude, parce que c'est quand même une grosse organisation et comme on dit étude scientifique c'est beaucoup de rigueur, ce n'est pas évident de recruter, c'était une belle aventure, une de nos plus belles réussites. »

Un des moments le plus compliqué a été la réorganisation des créneaux en début d'année, avec un nouveau fonctionnement (limitant le nombre de pratiquants sportifs par créneau).

Un deuxième moment clé est l'arrivée de ma collègue au sein du pôle, car j'arrivais à saturation et ne pouvait plus tout gérer, cela a permis de développer encore plus d'activité au niveau du pôle et de mieux cadrer notre activité pour gagner en qualité. Cet engagement a été possible grâce à la bonne santé financière du Pôle Sport-Santé Bien-Être.

Si c'était à refaire

La responsable du Pôle Sport-Santé Bien-Être donne les conseils suivant à un club qui souhaite se lancer dans le sport-santé : « Bon courage (Rire). Je leur dirais de bien s'entourer et d'être sûr d'avoir vraiment les moyens que ce soit humains, matériels et d'essayer de partir sur une idée au départ, parce que moi je suis partie sur plein de choses et c'est aussi pour ça que je me suis un peu fatiguée, mais peut-être partir d'abord sur qu'un type de public, ou quelques activités, prendre un peu la température en interne dans le club, voir si ça intéresse, parce que moi ça a été impulsé par les présidents. C'est sûr que c'est un des objectifs du club, est-ce que c'est dans l'état d'esprit du club, etc. Et peut-être partir d'abord sur un projet ou deux et développer après, essayer de cibler un peu plus. »

Un premier point de réussite de l'action est que le pôle est régulièrement sollicité (et donc potentiellement reconnu) pour participer à des événements ou proposer des accompagnements grâce à l'activité physique sur le territoire marseillais : « on a été aussi sollicité pour participer à un événement de sensibilisation pour les cardiopathies chez les enfants, par exemple, ce serait la première édition à Marseille ». Un second point de réussite est l'intérêt d'autres sections en interne, qui s'intéressent au sport-santé et veulent développer cette pratique.

Les conditions pour reproduire l'action

Plusieurs éléments contextuels ont été identifiés :

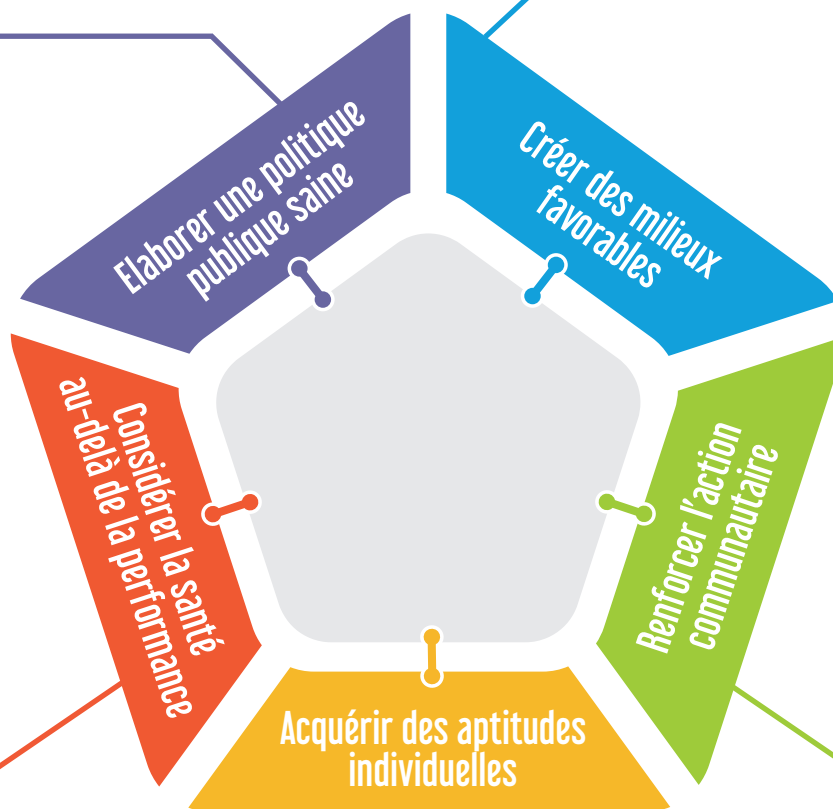
- La responsable du Pôle Sport-Santé Bien-Être regarde régulièrement les appels à projets pour identifier de nouvelles formes de financement
- Le Pôle Sport-Santé Bien-Être essaie d'être présent sur de nombreux salons et événements organisés par les collectivités territoriales, des laboratoires pharmaceutiques ou d'autres partenaires avec un stand ou des activités, pour démarcher de nouveaux partenaires et faire connaître son offre.
- La communication des actions se fait par la newsletter du SMUC, avec une partie sport-santé, grâce au journal La Provence, dans lequel le SMUC a un encadré tous les mardis, les réseaux sociaux et un site internet. Par ailleurs, le pôle est sollicité régulièrement pour intervenir dans des colloques médicaux ou de santé, pour présenter le rôle de l'activité physique dans les pathologies chroniques.

La responsable du pôle a appris beaucoup de choses depuis le début de l'action : « en termes de communication, j'ai découvert plein de choses qu'on n'a pas dans notre formation APA, il n'y a pas de communication, marketing, partenariat, tout ce qui est gestion financière j'ai appris plus en détail même si on avait des notions. Alors partenariat, communication, ce sont les choses que j'ai beaucoup apprises ».

Éléments clés au regard de la Charte d'Ottawa

> La création du Pôle Sport-Santé Bien-Être au delà de la commission médicale permet au club de développer les activités de sport sur ordonnance

> Le pôle sensibilise les autres sections du club au développement du sport-santé
> La création du Pôle Sport-Santé Bien-Être a permis l'accueil de 380 personnes présentant des limitations fonctionnelles



> Le club souhaite renforcer sa capacité à proposer un suivi santé centré sur une synergie entre le monde médical et le monde sportif.

> Le club joue un rôle de passerelle et de continuité dans le parcours de patients des différents hopitaux, structures de soins et de santé sur le territoire Marseillais
> Le club est très présent sur les évènements sport-santé du département des Bouches-du-Rhone
> Le club a de nombreuses subventions à différents niveaux (local, départemental, régional) et de partenariats privés

> Les activités proposées par le Pôle Sport-Santé Bien-Être utilisent l'activité physique comme déterminant de santé des pratiquants sportifs

Éléments clés au regard du modèle du club de sport promoteur de santé



Éléments clés au regard du modèle du club de sport promoteur de santé

Communication

Assurer la communication interne au club de sport (COM3) : grâce à la newsletter et au site internet, le Pôle Sport-Santé Bien-Être communique vers les pratiquants sportifs sur les actions réalisées.

Assurer la communication externe du club de sport (COM4) : Grâce au site internet, à un encadré dans un journal, le SMUC communique sur ses activités de manière hebdomadaire.

Communiquer sur les bénéfices de la mise en place des activités de promotion de la santé (COM6) : Le Pôle Sport-Santé Bien-Être communique lors de diverses manifestations sur les bienfaits du sport sur ordonnance, soit à l'aide de témoignages, d'exemples de pratiques ou d'autres formes d'échanges.

Education

Encourager les dirigeants et les entraîneurs à se soutenir mutuellement pour promouvoir la santé (EDU3) : des échanges informels et des réunions plusieurs fois dans l'année permettent d'échanger sur le sport sur ordonnance et les actions à mettre en place.

Expérience

Identifier les expériences antérieures du club de sport en matière de promotion de la santé (EXP1) : Le Pôle Sport-Santé Bien-Être existe depuis 5 ans et est en continuelle progression, tant sur le nombre de pratiquants sportifs que sur le nombre d'actions réalisées.

Identifier la volonté organisationnelle en faveur de la promotion de la santé (EXP2) : Le Pôle Sport-Santé Bien-Être a un grand soutien de la part du bureau et une liberté dans le choix des projets à développer à l'avenir.

S'appuyer sur un diagnostic évaluant les besoins et attentes pour mettre en place les actions de promotion de la santé (EXP6) : La responsable du Pôle Sport-Santé Bien-Être questionne régulièrement la possibilité de développement, au regard de la qualité du service proposé, mais également des perspectives de développement.

Faisabilité

Évaluer régulièrement les ressources humaines mobilisées (FAIS2) : La responsable du Pôle Sport-Santé Bien-Être fait appel à des autoentrepreneurs pour mettre en place les activités et échange régulièrement de manière informelle avec eux. Elle choisit qui elle sollicite en fonction des actions proposées.

Objectifs

Définir des objectifs de la promotion de la santé (OBJ1) : Même s'ils ne sont pas écrits ou consignés, les objectifs du pôle sont bien définis par la responsable, tant à court qu'à moyen et long terme.

Mobilisation

Identifier et mobiliser un ou plusieurs représentants en interne en promotion de la santé au club de sport (MOB3) : Le Pôle Sport-Santé Bien-Être joue un rôle de catalyseur et de dynamiseur envers les sections sportives qui souhaiteraient développer du sport-santé.

Mobiliser les décideurs et élus locaux pour promouvoir la santé au sein des clubs de sport (MOB5) : Le club est soutenu par les élus du niveau local au niveau régional pour le développement du sport-santé.

Approche participative

Identifier et valoriser chaque action de promotion de la santé (APP4) : les activités mises en place au sein du Pôle Sport-Santé Bien-Être sont valorisées par différents moyens : étude scientifique, newsletter, mise en avant dans des événements, diffusion au sein du bureau et des dirigeants.

Partenariats

Identifier des partenaires pour mettre en œuvre des actions de promotion de la santé (clubs de sport, agences, collectivités territoriales, professionnels de santé...) (PART1) : le Pôle Sport-Santé Bien-Être est continuellement à la recherche de nouveaux partenariats pour proposer des dispositifs passerelles entre des structures ou pour développer et financer ses activités.

Définir les modes de collaboration avec les partenaires existants et à venir (définir les rôles, partager les expériences, les termes du contrat, l'évaluation des résultats, le pouvoir égal des partenaires...)(PART2) : lors des partenariats, le rôle de chacune des parties est bien défini avec la responsable du Pôle Sport-Santé Bien-Être, qui définit le cahier des charges de la prestation proposée aux partenaires.

Construire une culture commune avec les partenaires existants et à venir (confiance, reconnaissance, temps partagé...) (PART3) : Le Pôle Sport-Santé Bien-Être est de plus en plus sollicité par ses partenaires et leurs réseaux pour proposer des activités sport-santé ou sport sur ordonnance.

Planification

Fonder la planification des actions futures sur l'évaluation des actions en cours (PLAN8) : même s'il n'y a pas d'évaluation formelle, les objectifs futurs du Pôle Sport-Santé Bien-Être tiennent compte des actions actuelles, de leur qualité et des capacités d'évolution du SMUC Marseille.

Ressources

Evaluer les ressources financières disponibles (subventions, sponsors) pour investir dans la promotion de la santé (RES1) et Evaluer les ressources humaines disponibles (temps consacré au bénévolat, turnover du personnel) à investir dans la promotion de la santé (RES2): pour chacune des activités, notamment les prestations extérieures, une évaluation des ressources financières et humaines disponibles est réalisée avant l'engagement du Pôle Sport-Santé Bien-Être. Le bilan du pôle est fait de manière annuelle.

Identifier les financements mobilisables pour la promotion de la santé (RES5) : un monitoring des appels à projets ou des forums et salons qui permettent d'identifier de nouveaux financeurs ou partenariats est réalisé de manière active.



PROSCeSS

PRoMOTION de la Santé dans les Clubs Sportifs

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LA CARTE D'IDENTITÉ DU PROJET

US Biot Foot

Thématique(s)

Les thématiques visées par l'US Biot Foot porte sur : l'équipement (la tenue et les protections), l'hydratation, l'alimentation, l'échauffement et les étirements (pour la récupération).

Objectifs

Le projet de l'US Biot Foot vise plusieurs objectifs :

- > Agir en amont pour prévenir les blessures
- > Diminuer les blessures et les différents types blessures

Pour les catégories U6-U11 :

- > à titre éducatif, pour avoir les bons réflexes et qu'ils prennent l'habitude d'aller boire, de se doucher, de s'étirer

Pour les catégories U12-seniors :

- > à visée préventive de la pathologie sportive.





Public(s) concernés

Trois différentes catégories de public sont concernées : les catégories de pratiquants U6 à seniors, les entraîneurs sportifs et les licenciés et parents (conférence sport santé jeunesse)



Financements

L'US Biot Foot fait appel principalement aux ressources propres du club, principalement une forte implication bénévole



Stratégies d'action déployées

Pour atteindre ses objectifs, l'US Biot Foot déploie plusieurs stratégies :

- la formation,
- l'animation
- la communication



Territoire/lieu de déroulement de l'action

Biot : dans l'enceinte du club et dans une salle de conférence de la ville.

Au sein du cabinet de kinésithérapie à proximité du club, pour les soirées récupération pour les seniors.



Activités déployées

Plusieurs actions opérationnalisent ces stratégies :

- la formation de joueurs «réfèrent santé»
- la diffusion d'une Lettre santé, ainsi que via le site internet et une mailing list
- l'affichage dans les vestiaires
- l'utilisation de jeux (matériel, alimentation)
- l'organisation de la conférence sport santé jeunesse
- l'achat de livres pour les entraîneurs



Partenaires impliqués

Plusieurs types de partenaires sont impliqués :

- Un confrère d'un cabinet de kinésithérapie (soirées récupération)
- La mairie (prêt d'une salle pour conférence)
- Une marque de céréales (pour 1 matinée sur 1 action)



Indicateurs d'évaluation

Plusieurs indicateurs sont utilisés pour l'évaluation, comme l'observation et ressentis de la part de certains entraîneurs et des kinés mais pas ces indicateurs sont peu définis et ne font pas l'objet de suivi, par faute de temps.

Projet santé

US Biot Foot

L'action en quelques mots

Le porteur de projet, à l'époque kinésithérapeute de l'équipe première et exerçant la profession de kinésithérapeute, a souhaité mobiliser le club, des catégories jeunes (à partir de six ans) aux adultes, pour les impliquer sur des activités de prévention, grâce à quatre type d'action : la modification des entraînements, la nomination de référents santé dans les équipes, l'organisation d'ateliers et l'organisation d'une conférence grand public chaque saison.

Le contexte

L'US Biot est un club de football amateur, né en 1949 et qui évolue actuellement en promotion première division. Il comptait 324 salariés en 2015. Il emploie un salarié à temps plein et sollicite 16 entraîneurs. Ce club a fait partie des clubs pilotes dans la mise en place du Projet Educatif Fédéral et a été primé par le Fondation du football.

Le constat

Le constat posé par l'entraîneur de l'équipe première du club, qui est également kiné du sport, était qu'il y avait trop de blessures par des pratiques de mauvaise qualité, qui pouvaient être évitées par un échauffement : « m'occupant de l'équipe senior depuis sept, huit ans. On a remarqué que dans notre prise en charge quotidienne au sein de notre cabinet, beaucoup de blessures auraient pu être évitées si il y avait eu un message passé en amont, d'où l'idée, de mener des actions de prévention, pour pouvoir passer ce message et arrêter d'avoir des, j'ai envie de dire des petites pathologies du sportif au quotidien, qui nécessitent des arrêts sportifs et qui pénalisent de ce fait les équipes concernées. »

L'opportunité

Le projet a été lancé il y a quatre ans pour l'équipe sénior. Le porteur du projet a d'abord mis en place des actions lors des entraînements, « En menant des actions de prévention pour, pour pouvoir en fait passer ce message et arrêter d'avoir des, j'ai envie de dire des petites pathologies du sportif au quotidien qui, qui nécessitent des arrêts sportifs et qui pénalisent en fait les équipes ». Et ensuite, l'idée lui est venue de ne pas s'arrêter à l'équipe séniors, mais de toucher les jeunes également, et d' « en faire de bons sportifs, mais d'un point de vue santé et prévention ».

Par ailleurs, la fédération française de football a mis en place ce qu'on appelle le projet éducatif fédéral, qui contenait un module santé et à l'époque, le club n'était pas très attractif pour avoir des joueurs d'excellence. Le club s'est réinventé dans le volet technique du football et dans l'apprentissage à la jeunesse. L'idée était de pouvoir proposer aux parents non seulement une approche footballistique, technique et tactique, mais également une éducation citoyenne et à la santé et au sport. Cela a fait de nous le seul club de la Région à partir sur le volet santé plutôt que fair-play ou autre. Le projet a dès lors été inscrit dans le projet associatif du club et un volet santé figure sur le site internet.

Les principes d'action de l'action

Les principes d'action reposent sur la mise en place d'action de prévention avant les efforts. Principalement centré sur la prévention des blessures par l'apprentissage des échauffements, des étirements,... , l'alimentation, l'hydratation, le projet s'étend également aux valeurs et au rôle citoyen du sportif, à tout âge de la vie. Ils sont illustrés dans la citation suivante : « Notamment l'argument principal dans les catégories plus grandes, c'est en fait, plus vous faites du préventif en termes de santé, plus vous aurez vos joueurs compétents, à disponibilité et du coup vous aurez votre équipe type sûrement plus disponible que, que si on ne mettait pas ça en place, quoi. Voilà. »

Les objectifs du projet

L'objectif est de sensibiliser dès le plus jeune âge, jusqu'aux équipes séniors, les joueurs à la prévention, en insistant sur la qualité de l'échauffement, des étirements et des clés pour prévenir les blessures.

Le contenu de l'action

L'action est structurée sur quatre champs principaux, répartis sur une saison sportive :

- En début de saison, un premier atelier était dédié aux entraîneurs, « pour leur enseigner la bonne conduite (que ce soit sur les échauffements, les étirements, la récupération, l'alimentation, la préparation physique aussi d'avant 16 ans, pour que eux, eux, puissent être le relais sur le terrain au quotidien avec les enfants.) »
- Ensuite, la désignation de deux « joueurs référents santé » par équipe à partir des U11, pour prendre en charge les échauffements, les étirements et la récupération ; Ces joueurs étaient réunis le samedi matin pour leur apprendre à mener ces actions. A l'issue de la matinée, ils recevaient un diplôme et cela les responsabilisaient vis-à-vis de leurs pairs.
- Le troisième champ d'action était une journée alimentation, hydratation, sous forme de jeux ludiques, animée en partenariat avec une marque de céréales pour sensibiliser à l'alimentation, l'hydratation, le sommeil, etc.
- Le quatrième champ d'action était l'organisation en février d'une conférence pour 300 personnes sur le sport santé prévention, invitant joueurs, entraîneurs, parents et d'autre association de Biot, pour traiter des thèmes abordés dans le Projet Educatif Fédéral.

En outre, d'autres actions complètent les quatre champs :

- des interventions sur le terrain, pendant les entraînements, pour limiter les blessures en sensibilisant à l'échauffement, aux étirements pour toutes les catégories d'âge (à partir de six ans)
- Une newsletter trimestrielle, disponible sur le site internet du club, dans un volet santé, qui explique les principes de l'action et l'illustre par des photos.
- La prise en charge coordonnée avec le médecin et le cabinet de kiné, avec un retour fait aux joueurs, mais aussi à l'entraîneur, sur la gravité, l'indisponibilité, le feu vert de reprise.

Le kiné du sport investi au sein du club et le salarié, entraîneur général, sont les deux seuls personnes à travailler sur le projet. Un kinésithérapeute est aujourd'hui dédié aux équipes séniors et un second aux catégories de jeunes.

Les partenaires du projet/ de l'action

Le porteur de l'action au sein du club possède également son cabinet de kinésithérapie, il y a donc une relation forte entre ses activités au club et ses activités professionnelles. L'objectif du projet était de diminuer le nombre de consultations par les joueurs, pour ne pas être débordé.

Il y a des relations qui se sont tissées avec le médecin du sport, voisin du cabinet du kinésithérapeute, et qui est intervenu au cours de conférences.

La mairie met à disposition la salle de conférence ou les terrains quand le club en a besoin pour faire des animations de sensibilisation.

Un partenariat a été mis en place avec une marque de céréales, grâce à une connaissance du club qui y travaille, pour proposer une journée de sensibilisation à l'alimentation saine et à l'hydratation.

Le club n'a pas demandé de subventions pour le projet.

L'évaluation

Le porteur du projet explique : « ça fait un an qu'on l'a n'a pas désigné de joueur référent santé, on ne l'a pas fait, et j'ai des joueurs qui aujourd'hui ont 17 ans et que j'avais eus quand ils avaient 14 ans ou 13 ans, ils ont gardé ce réflexe de mener les échauffements, les étirements de l'avant-match, les étirements d'après match et le rappel de l'hydratation de leur équipe donc ça, c'est une belle victoire. »

En ce qui concerne l'évaluation, il confirme ses propos précédents, sans se fonder sur des indicateurs précis : « pour avoir un beau feed-back de ce qu'on avait fait, en général au printemps je prenais un peu de temps libre pour aller voir un petit peu toutes les équipes, des U6 jusqu'aux seniors, pour voir ce qui avait été mis en place notamment dans les échauffements ou les étirements, et à notre grande surprise, ça avait été complètement intégré dans le programme d'entraînement. » Par ailleurs, la communication via le site internet a permis aux parents d'être plus vigilants sur l'implication de leurs enfants lors des ateliers.

En outre, le porteur de projet confirme la diminution du nombre de blessures « bêtes » et de sollicitations de son cabinet. Il constate que la prise en charge est beaucoup plus rapide et que les pratiquants connaissent la procédure. Il constate aussi que les enfants se sont réinscrits plus facilement au club et que cela a diminué le turnover des entraîneurs, qui restent au club depuis un moment et qui ont vécu le projet, ont acquis des compétences et sont maintenant capables de transmettre.

Enfin, le porteur de projet souligne que « par ce projet, on se sent utile, et on rend un petit peu à la commune dans laquelle on travaille, voilà, c'est une manière de participer à la vie collective.. »

Sur la question de l'évaluation, c'est le manque de compétences informatiques qui a freiné la mise en place d'un questionnaire pour les joueurs : « Ça, ça aurait été intéressant de créer un questionnaire, un questionnaire sur une plateforme à laquelle les enfants, les joueurs du moins, auraient eu accès, par leur numéro de licence, et juste pour avoir en fait un retour, un retour avec des analyses pour savoir qu'est-ce qui a été compris, pas compris, quel message a été compris, et sur quoi il fallait s'améliorer. »

L'ancrage dans un modèle théorique ou des données scientifiques

Le porteur du projet a monté le contenu lui-même, grâce à sa formation de kiné et au plan éducatif fédéral. Il a créé les documents supports, notamment à destination des entraîneurs.

Les limites du projet/ de l'action

Pour le porteur du projet, il y a un nombre important de partenaires qui manquent : acteurs médicaux et paramédicaux, comme nutritionnistes, préparateurs physiques, etc. qui auraient pu intervenir sur des ateliers spécifiques.

Il y a plusieurs freins au projet :

- 1) L'intervention du porteur du projet est réalisée sur un temps de bénévole, ce qui limite le temps qu'il est capable d'investir pour ce projet et qui explique que le projet s'essouffle au vu du manque de temps et de soutien
- 2) Le manque de soutien de l'équipe dirigeante actuelle est un frein majeur, puisqu'aucun budget n'est alloué par le club pour cette action. Le porteur de projet l'exprime comme tel : « la nouvelle direction n'a pas compris l'utilité du projet ».
- 3) Le manque de communication autour de la conférence sport santé, qui limite la participation
- 4) La difficulté de mobiliser les pratiquants et les membres du club autour du projet

Les moments clés du projet

Le porteur de projet identifie deux moments clés : 1) à la fin de la première saison, lorsque le responsable du projet a vérifié les acquis dans les équipes et qu'il a remarqué que tout le monde « avait joué le jeu », que les référents santé s'étaient impliqués et 2) en février, la participation de 200 personnes à la conférence sport santé jeunesse organisée, malgré une communication difficile.

Le capitaliseur identifie un moment clé supplémentaire, qui est le changement de direction du club, il y a deux ans, direction qui n'a pas considéré le projet comme une priorité et n'y alloue pas de moyens.

Si c'était à refaire

Plusieurs points auraient été modifiés par le porteur si c'était à refaire :

- 1) Monter un groupe plus important, plus étoffé, avec les confrères du cabinet de kiné
- 2) De demander au club d'allouer un petit budget pour faire la communication (approximativement 1000 euros)

Les conditions pour reproduire l'action

Deux compétences majeures ont été acquises par le porteur de projet :

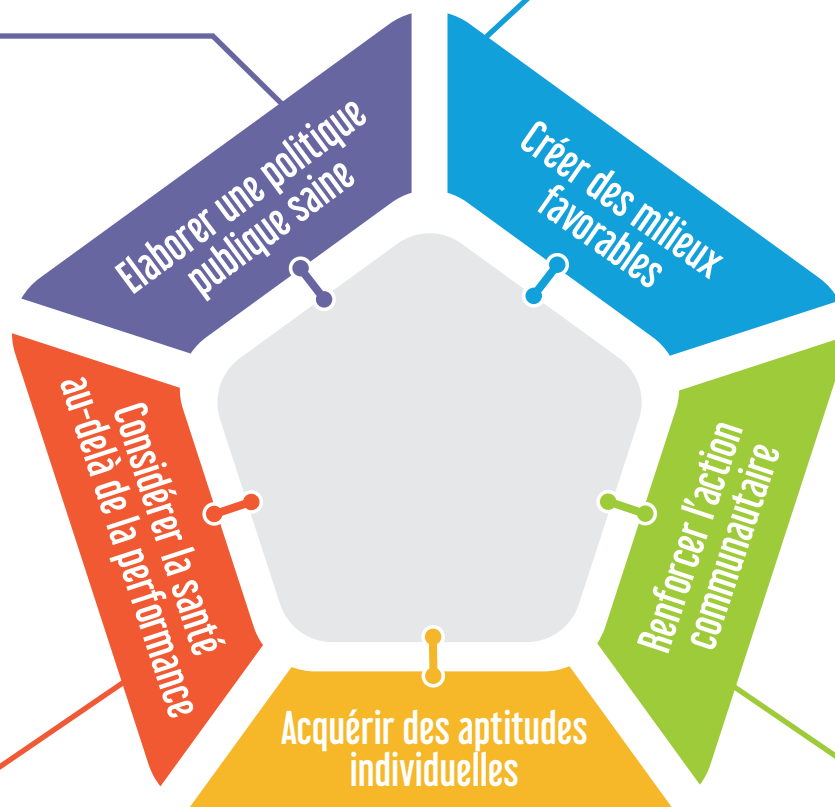
- 1) Une compétence en communication, par la création de poster, d'affiches, de newsletters
- 2) Une compétence pédagogique, par l'intervention lors des conférences devant un grand nombre de personnes

Une compétence en informatique et en création et traitement de questionnaire pour faire l'évaluation aurait été nécessaire pour pouvoir réaliser une vraie évaluation de l'action.

Éléments clés au regard de la Charte d'Ottawa

- > Le projet a été intégré au projet sportif du club
- > Un document socle a été distribué aux entraîneurs et un document d'information aux parents

- > Par ce projet, une responsabilisation des pratiquants, en les nommant référent santé, permet de développer leurs compétences liées à la santé et au sport

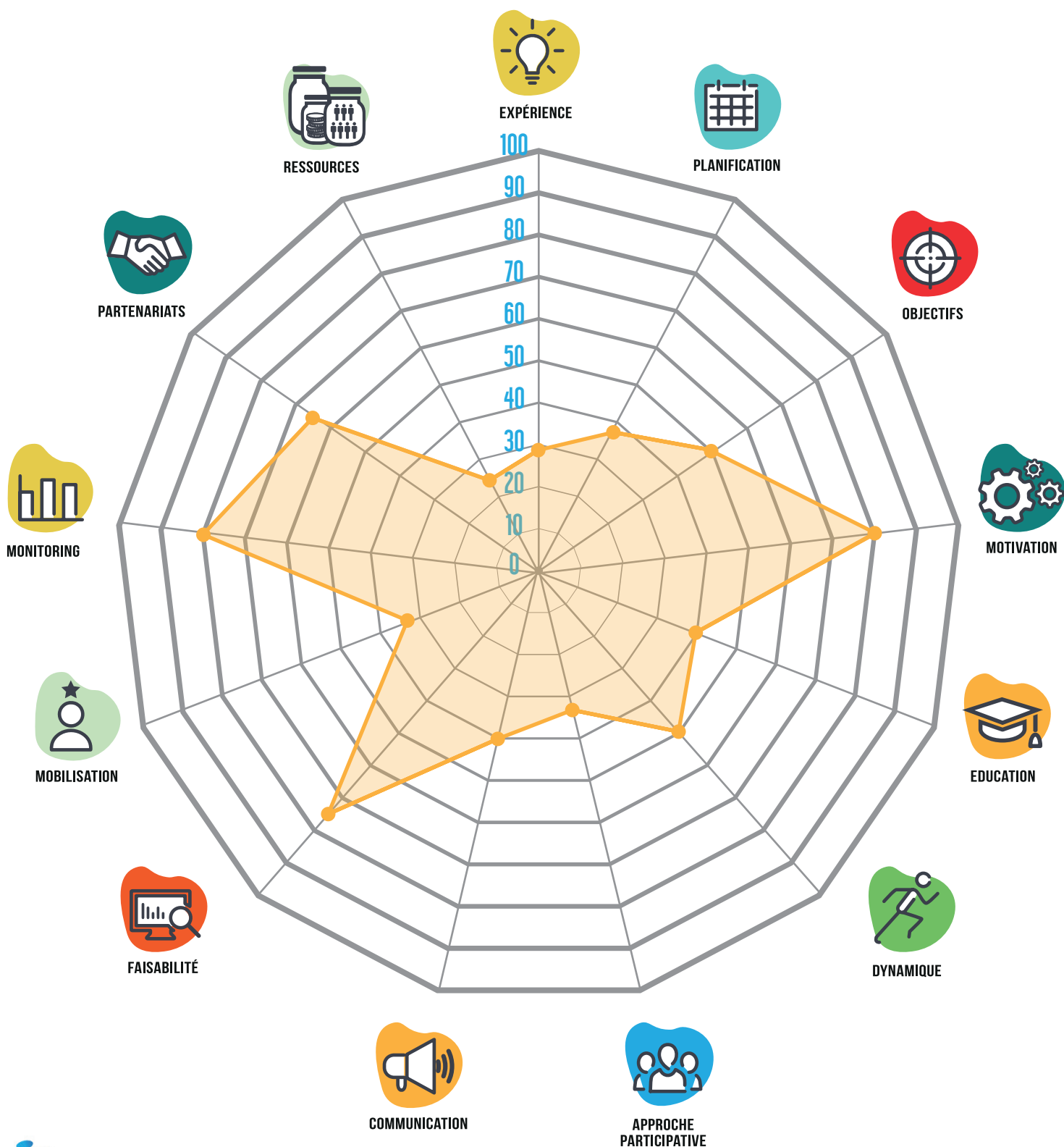


- > Le porteur du projet insiste sur le rôle de l'US Biot pour former des joueurs compétents (capable de prendre en charge leur corps, de prévenir leurs blessures) et citoyens
- > Le porteur du projet insiste sur le service rendu à la communauté par le projet (via les ateliers et les conférences, via la diffusion des newsletters)

- > Le projet est centré sur une double casquette entraîneur/kiné du porteur du projet, qui fait le lien avec le milieu médical et paramédical
- > Le club propose de dynamiser la communauté, par l'éducation de ses pratiquants, mais aussi l'organisation d'une conférence chaque année

- > Par la participation au projet, les pratiquants et les entraîneurs ont changé leurs habitudes de vie (échauffement, étirements, hydratation...)
- > Par l'organisation d'ateliers et de conférences, des informations sur la prévention au sein du sport ont été transmises à la population

Éléments clés au regard du modèle du club de sport promoteur de santé



Éléments clés au regard du modèle du club de sport promoteur de santé

Communication

L'US Biot a mis en place plusieurs stratégies de communication. Par la création d'un document à destination des entraîneurs et d'une plaquette à destination des pratiquants (lors de l'inscription), le porteur de projet a assuré la communication interne au club (COM3). Par la diffusion des actions, des Newsletters sur le site internet et l'organisation de la conférence sport santé jeunesse, il a assuré la communication externe également (COM4), sur le contenu de l'action, ainsi que sur ses bénéfiques (COM6).

Dynamique

La création du projet a permis, même avec un impact présenté modestement par le porteur de projet, de meilleures relations entre les pratiquants et d'améliorer le sentiment d'appartenance au club, même si ces points ne sont pas définis comme tels dans le projet de club (DYN2).

Education

Par les différents champs d'activités cités au sein du projet, différents composants d'interventions liés à l'éducation sont ciblés. Premièrement, le projet permet aux dirigeants et entraîneurs de s'engager activement dans l'acquisition de compétences pour promouvoir la santé. Deuxièmement ce soutien a été adapté aux différentes catégories d'âge et aux profils de leurs entraîneurs (EDU2), il a permis également un soutien mutuel entre les dirigeants et les entraîneurs (EDU3), par la mise en place d'activités variées (ateliers, conférences, newsletter...EDU4) et la création d'outils spécifiques (Module référent santé ; newsletter ; EDU5).

Expérience

Sans le soutien du club, le kiné qui a souhaité lancer le projet a identifié ses compétences et sa volonté comme moyen de mener ce projet (EXP2 et EXP3), en s'appuyant sur le projet éducatif fédéral (EXP5) et sur son constat d'un trop grand nombre de blessures « bêtes » (EXP6).

« Voilà, si le club à la volonté, et si le club met des moyens à disposition hein, c'est-à-dire des moyens humains, bénévoles, des moyens d'aide pour réserver les salles. Ce que j'avais au début, hein, ce que j'avais au début, hein, avec... donc ça, ça roule quoi, ça roule. Et de pas non plus, l'idée c'est de pas non plus... c'est de pas aller... de pas trop en faire. C'est-à-dire cibler les actions. C'est-à-dire ne pas partir sur dix mille thèmes à la fois, quoi. »

Faisabilité

Le porteur du projet a ciblé la première année certaines thématiques, et a commencé le projet avec uniquement l'équipe seniors, avant d'élargir aux autres catégories d'âge, en tenant compte de son temps et de l'investissement que cela peut représenter. En outre, il s'entoure d'autres personnes puisqu'il a moins de temps actuellement et que le projet s'essouffle sans moyens du club (FAIS2 ; FAIS3 ; FAIS4).

Objectifs

Les objectifs du projet ont été écrits dans le projet associatif de l'US Biot (OBJ1). Au sein des objectifs et dans les actions, le porteur de projet est sensible à la manière dont les pratiquants appréhendent leur santé (OBJ4).

Mobilisation

Au sein du projet, en interne, le porteur de projet a identifié et mobilisé des référents santé dans chaque équipe (MOB3), ainsi que des collègues kinés et médecins (MOB2) pour développer le projet.

Monitoring

Tout au long du projet, les activités ont été suivies et répertoriées, par un reportage photo, par un retour sur le terrain et par des discussions informelles avec les pratiquants et les entraîneurs (MON1 ; MON2). Ces retours oraux ont été collectés à court terme (MON3) et à plus long terme (sur plusieurs saisons ; MON4).

Approche participative

Les activités proposées ont été valorisées par des reportages photos, au sein de newsletters, par des affiches et de la communication sur la conférence (APP4). Des dirigeants et entraîneurs ont été impliqués dans le processus de décision et d'organisation de l'activité (APP5).

Partenariats

Des partenaires ont été identifiés comme porteurs pour le projet (kiné, médecin, nutritionnistes, préparateurs physiques, PART1) et certains d'entre eux ont collaboré au projet sur du long terme (PART2).

Planification

Un plan de mise en œuvre a été organisé sur une saison, améliorable et reproductible chaque saison, avec les objectifs, la population et les étapes clés (PLAN1 ; PLAN2 ; PLAN5).

Ressources

Au niveau des ressources, ce sont principalement les ressources humaines (RES2), mais également financières qui ont été évaluées par le porteur de projet (RES1), même si ces dernières n'ont pas fait l'objet d'une demande de financement.

Motivation

Le porteur de projet a été attentif à favoriser les relations interpersonnelles entre les parties prenantes (dirigeants, entraîneurs, pratiquants ; MOT1). Il a également tenu compte des compétences et de la motivation des entraîneurs pour la promotion de la santé (MOT2 et MOT3). Enfin, il a, par cette action renforcé le sentiment d'autonomie des entraîneurs pour prendre en charge seuls un échauffement, étirements, etc. (MOT4). Un extrait de l'entretien en témoigne : « si vous voulez, seul, je ne peux, on ne peut rien faire, mais, mais les entraîneurs, ce sont... c'est pour ça qu'ils ont, ils ont un rôle prépondérant dans ces actions parce que c'est eux qui sont, c'est eux qui sont au cœur du, au cœur de l'action par les messages qu'ils vont transmettre à leurs, à leurs enfants, aux enfants, au même titre que la politesse, le fair-play, voilà. »



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LA CARTE D'IDENTITÉ DU PROJET

« Mission Nutrition » - Val d'Europe FC

Thématique(s)

Nutrition, diététique du sportif, performance, bien-être, estime de soi

Objectifs

Plusieurs objectifs ont été identifiés par le porteur du projet :

- > Agir en amont pour prévenir les blessures
- > Eveiller à l'importance de l'alimentation par rapport au fonctionnement du corps
- > Optimiser les repas pour favoriser la pratique du sport,
- > Développer l'esprit critique et apprendre à choisir parmi différents aliments
- > Transmettre les bases nécessaires à la création d'habitudes alimentaires plus saines
- > Développer l'autonomie des filles sur ce sujet





Public(s) concernés

60 filles de 5 à 13 ans sont concernées, ainsi que leurs familles et entourage proche



Stratégies d'action déployées

Pour atteindre ses objectifs, le Val D'Europe FC déploie plusieurs stratégies :

- Des séances de sensibilisation via des ateliers ludiques
- Des exercices spécifiques inclus dans les entraînements et les matchs
- L'implication de parents, un sponsor (imprimeur), une illustratrice, une joueuse de foot professionnelle et de dirigeants



Activités déployées

Plusieurs actions opérationnalisent ces stratégies :

- La création d'un livret (conseils, recettes, astuces)
- Une intervention théorique
- Des animations d'ateliers sous forme de jeux
- Des ateliers techniques thématiques de foot
- Un rappel sur groupe whatsapp des parents la veille des tournois
- Des questions au moment des échauffements



Financements

Le porteur du projet a identifié l'investissement du Val D'Europe FC à 500 euros pour la conception du livret, illustration et son édition.

Les animations coutent entre 15 à 20 € d'aliments/animation. Le club a également un forfait pour les collations d'après match.



Territoire/lieu de déroulement de l'action

les stades de Serris et Bailly-Romainvilliers (Seine et Marne) et touche les jeunes joueuses et leurs familles.



Partenaires impliqués

Plusieurs types de partenaires sont impliqués :

- Un imprimeur et une illustratrice ont participé à la création du livret
- Une joueuse professionnelle a ajouté un témoignage au livret
- Une maman diététicienne, une maman pâtissière, une maman garde d'enfants et une autre maman



Indicateurs d'évaluation

Plusieurs indicateurs illustrent le déploiement du projet : une bonne réception des livrets, la prescription des enfants auprès des parents lors des courses, la prescription des joueuses plus âgées auprès des plus jeunes, l'impact sur la fin de saison dernière : adaptation des pique-niques, collations d'après matchs (composition qui a évolué). L'implication sur les résultats sportifs du club n'a pas été étudiée.

« Mission Nutrition »

Val d'Europe FC

Le contexte

Le Val d'Europe Football Club est né en 2012, de la fusion de deux clubs voisins, le FC Bailly et le RC Serris. Il comporte actuellement 950 adhérents, répartis en 38 équipes, allant d'U6 à vétérans. Il est situé en Seine-et-Marne. Le club oriente sa politique sur la formation et la progression des joueurs et joueuses dans toutes les catégories. Le bureau est composé de 15 membres. Ce club a été primé pour l'action « Mission Nutrition » aux Trophée Philippe Seguin du FondAction du Football en 2020.

Le constat

En observant les joueurs séniors du club, le porteur du projet s'est rendu compte que de nombreuses jeunes filles avaient des habitudes alimentaires qui avaient des conséquences négatives sur leur forme physique et leurs performances. Ensuite, le porteur du projet a pris la responsabilité de l'école de football de filles et a remarqué le problème de fidélisation et d'abandon ou de décrochage sportif des filles. Ainsi, le porteur du projet a misé sur la prévention, notamment sur la construction de repères vis-à-vis de l'alimentation et de la diététique, pour améliorer le bien-être global des joueuses et ainsi fidéliser le public féminin au sein du club.

L'opportunité

Le porteur du projet était responsable de l'école de foot garçons, avait organisé des stages pendant les vacances au cours desquels il avait invité sur quelques demi-journées, des extérieurs sur le handisport ou encore l'arbitrage. Il avait fait appel à une diététicienne pour intervenir auprès des jeunes joueurs mais l'échange s'était avéré très magistral, sans pratique et donc ça n'avait pas laissé de traces. Le lancement du projet, sur la saison 2018-2019 s'est appuyé sur les compétences de mamans de joueuses, qui étaient dans la nutrition, la pâtisserie, la garde d'enfants, pour construire des contenus et des activités, avec l'idée de lancer quelque chose de pérenne. Le projet a démarré par la constitution d'un livret pour que les filles puissent manipuler, utiliser et écrire. Le livret a été illustré par la sœur du porteur du projet, gratuitement.

Aujourd'hui, l'action a été élargie par la création d'une version simplifiée du livret s'axant sur les collations, et à destination des parents pour les catégories de foot à 5 garçons (4 à 9 ans) et par l'intégration de l'action dans le projet du club et dans le règlement du club, pour les parents et les licenciés, lors de la refonte du projet du club.

Les principes d'action de l'action

Le principe majeur de l'action est de transmettre des conseils nutritionnels, sans stigmatiser, ni normaliser l'alimentation, par un livret et des ateliers de sensibilisation. La porte d'entrée est la nutrition du sportif et l'optimisation de la performance et du bien-être via l'alimentation, ce qui a amené d'autres réflexions. L'autonomisation des joueuses sur leur alimentation, dans les achats, les recettes, la composition des plats est visée.

Les objectifs du projet

L'objectif majeur du projet est de sensibiliser les jeunes filles de l'école de football et leurs parents à une alimentation saine, et par ce biais, aborder d'autres comportements citoyens et de santé.

L'objectif du projet est de pouvoir aller plus loin en proposant un niveau 2 pour les filles ayant participé cette saison, mais aussi d'aller sur d'autres thématiques, notamment sur l'hygiène de vie, le sommeil, les écrans, les réseaux sociaux, pourquoi pas du soutien scolaire, maintenant que le projet est mis en place et reconnu au niveau du club. « Du coup ça [le trophée Philippe Seguin] nous permet aussi de sensibiliser les décideurs, les membres du bureau, les mairies, à l'utilité, l'évidence, même, de notre mission extra sportive auprès des jeunes en particulier... ça va lancer des projets »

Le porteur du projet souhaite structurer un projet pédagogique autour de cette action : « Ce qui me gênerait un petit peu c'est qu'on ne profite pas de cette dynamique pour enclencher autre chose. Est-ce que le club va pouvoir mettre en avant un vrai projet pédagogique, qui inclut des éléments forts, dont le projet nutrition ? Pour l'instant, c'est en train de se structurer, de se formaliser, de passer d'une action à succès à un vrai fil rouge ancré dans les principes pédagogiques du club. »

Le contenu de l'action

Plusieurs activités ont été lancées :

1) La création d'un livret pour les pratiquantes, qui soit ludique et coloré, qui permet de présenter les principes de l'action et d'écrire à l'intérieur. Il comprenait des conseils, le témoignage d'une joueuse professionnelle, des recettes. Le livret est disponible en ligne sur le facebook et le site internet du club

2) L'organisation d'ateliers de sensibilisation, en utilisant des emballages pour expliquer les groupes d'aliments, présenter différentes collations, préparer des recettes, identifier le petit déjeuner idéal, le menu idéal pour les tournois. Par exemple : « Voilà, il y avait trois menus, ou quatre... Je crois qu'il y en avait trois. Trois menus qui avaient été retenus. Faut savoir la plus petite devait avoir sept ou huit ans, donc ça couvrait quand même une grosse gamme d'âges. Et donc ça a été, ça a été proposé comme ça, et très rapidement, sur les tournois, on a retrouvé les mêmes menus, ce qui était assez rigolo, donc voilà, tout ça, ça a bien marché, ça a donné du sens, on a fait le lien à ce moment-là entre le foot, la performance et le travail qu'on avait fait en amont sur la prévention et la nutrition. »

3) La création d'un groupe WhatsApp pour communiquer avec les parents sur les menus et l'alimentation

4) L'intégration d'exercices sur l'alimentation dans les séances d'entraînement : « par exemple, on les met en équipe, et puis sous forme de relais, elles partent avec leurs ballons, j'ai installé des plots, des coupelles, plus ou moins grosses, un peu partout, répartis comme un champ de mine, quoi, et puis elles s'approchent, elles regardent en dessous, et il y a un aliment, j'ai imprimé quelque chose. Donc il peut y avoir aussi bien une barre de céréales, de l'eau, du jus de fruits, que du saucisson, et un hamburger, et des frites, et un truc comme ça. Il y a un petit peu de tout. Et le thème, bah ça dépend, ou bien on constitue une collation d'après match idéale, ou bien un repas d'avant match, ou bien un petit déjeuner d'avant match, chaque fois ça change, et du coup, en relais, comme ça, elles doivent ramener à chaque fois un élément et s'arrêter quand il faut. »

5) Des moments informels, au cours desquels des situations personnelles sont abordées, en fonction de la disponibilité et de l'envie des filles après les entraînements.



Les partenaires du projet/ de l'action

Différents partenariats ont été sollicités pour lancer l'action : avec une illustratrice et un imprimeur pour créer le livret. Une maman diététicienne, une maman pâtissière et une maman garde d'enfants ont réalisé les contenus sur la base de leur activité professionnelle.

Ces professionnels ont participé sans contrepartie, pour rendre service ou simplement en apposant leur logo sur les documents produits.

Une joueuse canadienne professionnelle a été sollicitée et est venue soutenir le projet et servir d'ambassadrice du projet.

D'autres clubs, notamment de basket ont contacté le porteur de projet pour transformer le livret pour d'autres publics, ce qui n'a pas été fait à l'heure actuelle, mais semble faisable pour le porteur du projet. La Fédération Française de Football a également contacté le club pour faire un projet de livre avec des interviews des joueurs, des intervenants, etc.

En réaction à une publication Facebook, le porteur de projet a été encouragé à déposer le projet aux Trophées Philippe Seguin. Ensuite, il a monté le dossier et cela a lancé la reconnaissance du projet en France.

L'évaluation

Le porteur du projet avait conçu la dernière page du livret comme une auto-évaluation, mais n'a pas pu récupérer les livrets, même si les pratiquantes s'en sont servie pour s'autoévaluer. Il n'a pas fait d'évaluation des activités, mais il se fonde sur les retours, notamment celui-ci : « Le seul retour que j'ai, pour moi, c'est les parents qui me disent que c'est formidable et que du coup ils vont mettre ça en place, mais est-ce qu'on peut vraiment se fier... ».

Des exemples de réussite du projet sont cités par le porteur, comme « Je pense qu'à partir du moment où elles font les courses avec les parents, qu'elles constituent leur pique-nique, qu'elles font, qu'elles participent à la collation, les retours des parents, c'est : « Oh la la, JB, tu nous as... tu nous ennuies, avec ton truc, là, on était à Carrefour, elle m'a fait toute une scène pour prendre ça au lieu de ça, du coup ça nous coûte cher, c'est du bio, c'est du bio ou du complet, j'aime pas, c'est du machin, mais bon, elle a son truc ». Voilà. Enfin, en gros, c'est ça. Donc moi, ça me, voilà, ça me convient, on peut se dire, ils peuvent râler, mais bon, du moment qu'ils le font, c'est que quelque part ils sont d'accord, et puis voilà. Donc en fait, leur... leur participation elle est là, en fait elle sert, c'est simplement une influence sur les choix alimentaires des parents. » Ou encore « Les Pringles, c'est extraordinaire. Un paquet de Pringles, c'est cylindrique, ça se mange comme ça, c'est formidable. Bon, voilà, quoi. Il y a toujours des petits, des petits ratés, mais ça donne l'occasion à d'autres filles de dire : « Ah non, mais là tu... T'abuses, là. C'est pas du tout... c'est pas du tout recommandé, on n'est pas du tout dans les... dans les clous, quoi ». »

Dans les effets inattendus du projet, le porteur cite d'abord la contribution à « à fédérer la... la communauté, quoi, en fait, de parents et de filles, et de partenaires, et en fait ça a beaucoup influé sur le sportif, mais au-delà des résultats purement, comment dire, physiologiques, quoi... métaboliques, enfin, ça, ça a contribué à vraiment créer une autre dynamique, à savoir que par exemple la qualité de nos collations, elles sont remarquées aussi par les autres clubs qui nous font la remarque, qui sont contents de venir, les autres joueuses, on les voit arriver, ah bah elles sont contentes après le match, même si elles ont pris une dérouillée »

L'ancrage dans un modèle théorique ou des données scientifiques

Le projet trouve un ancrage dans les connaissances des professionnels bénévoles sollicités, mais pas dans un modèle théorique précis.

Les limites du projet/ de l'action

Une des limites des projets de prévention et de promotion de la santé au sein des clubs de sport est la limite des ressources humaines et le focus central sur les aspects sportifs. Les entraîneurs ne sont pas très intéressés par l'aspect éducatif, puis il est important de répondre aux attentes de chacun. Dans un premier temps, le club a reconnu le projet et est resté à disposition du porteur, sans soutien actif. Le projet n'a pas été intégré directement dans le projet pédagogique, qui est en cours de refonte et qui va probablement intégrer le projet « Mission nutrition » au vu de sa reconnaissance par les trophées Philippe Seguin.

Les moments clés du projet

Un premier moment clé est l'échec des ateliers de sensibilisation mis en place pendant les stages, parce que la pédagogie n'était pas adaptée au public.

Un deuxième moment important a été le démarrage de la collaboration avec les mamans et le réseau du porteur du projet, qui avaient envie de monter le projet et la dynamique collective a fonctionné et permis un nouvel élan, et une meilleure définition du projet, de ses principes, de son approche.

Le troisième moment clé est la reconnaissance et la valorisation, qui a projeté le projet dans une autre dimension, et lui a donné une légitimité, en termes de prestige, d'exposition, qui va permettre d'aller plus loin.

Si c'était à refaire

Une des limites pour le développement du projet est le temps, avec deux séances par semaine d'entraînement, dont une seule qui se prête mieux au projet, cela fait seulement 30 séances à l'année et ne permet pas de faire passer tous les messages. Cette limite se pose aussi, parce que les pratiquantes sont là pour faire du foot et pas uniquement se centrer sur la nutrition.

Le porteur du projet mentionne qu'il aurait également fait plus d'évènements, de sorties avec les équipes, comme une journée d'intégration, la galette des rois, des temps avec les parents.

Les conditions pour reproduire l'action

Le porteur de l'action avait une visée importante de l'utilisation du football pour travailler les comportements de santé et était déjà reconnu par les parents comme étant sensible à ces thématiques.

Le porteur du projet estime que la pratique du football féminin est plus orientée vers une pratique pour le plaisir, qu'une pratique pour la performance et pour devenir professionnel du football.

Le financement au lancement du projet a été minimal (200 livrets à 8,10 euros pièces), qui ont été financés grâce à un partenariat avec un imprimeur local, qui a ajouté son logo sur les documents. Ensuite, les produits pour les ateliers n'ont pas coûté cher (20-30 euros). Le budget pour l'après match a été utilisé pour transformer les collations (par des recettes, un changement de produits), pour qu'elles soient plus saines.

Les compétences professionnelles du porteur projet, en création de contenus vidéo, en diffusion sur les réseaux sociaux ont été utilisées. Le porteur de projet n'aime pas être sur le devant de la scène, car c'est avant tout une réussite collective dont il ne veut pas prendre tout le crédit, mais se prête à l'exercice car la cause en vaut la peine. Une des clés de la réussite identifiée par le porteur du projet est le sens donné au message, en incluant le football.

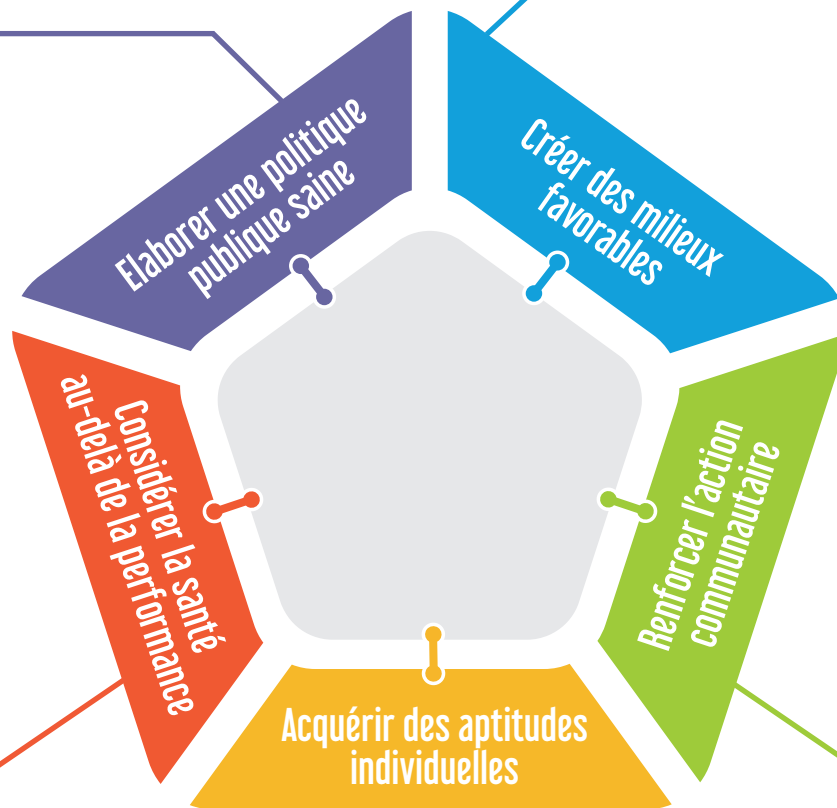
Il est important de garder l'essence de l'activité sportive pratiquée et d'apporter un contenu ciblé par rapport à cette pratique. Une seconde clé du projet est l'investissement fort des parents et bénévoles autour de l'action, qui se sont beaucoup investis, ainsi que le soutien (passif) du club, qui donne carte blanche aux actions proposées. Une troisième clé du projet est la proximité entre le porteur du projet et les entraîneurs des différentes équipes, qui a permis une coordination fluide du projet. Le porteur du projet résume ces facteurs par la phrase suivante : « Entourez-vous correctement, nommez un chef de projet et donnez du sens ».

Dans la mise en place du projet, le porteur a beaucoup appris en termes de compétences psychosociales, relationnelles et de communication, pour pouvoir gérer le succès et l'échec notamment. Il a appris la patience et la résilience, notamment sur les retombées et l'assimilation des principes du projet.

Éléments clés au regard de la Charte d'Ottawa

- > Le projet devrait être inscrit dans le nouveau projet du club de sport
- > Le livret et le flyer ont été mis à disposition des équipes pour promouvoir une alimentation saine

- > Les collations et menus lors des tournois et des entraînements ont été adaptées par les pratiquantes
- > Par le projet, le lien entre les pratiquantes, les entraîneurs, les parents a été plus convivial et positif

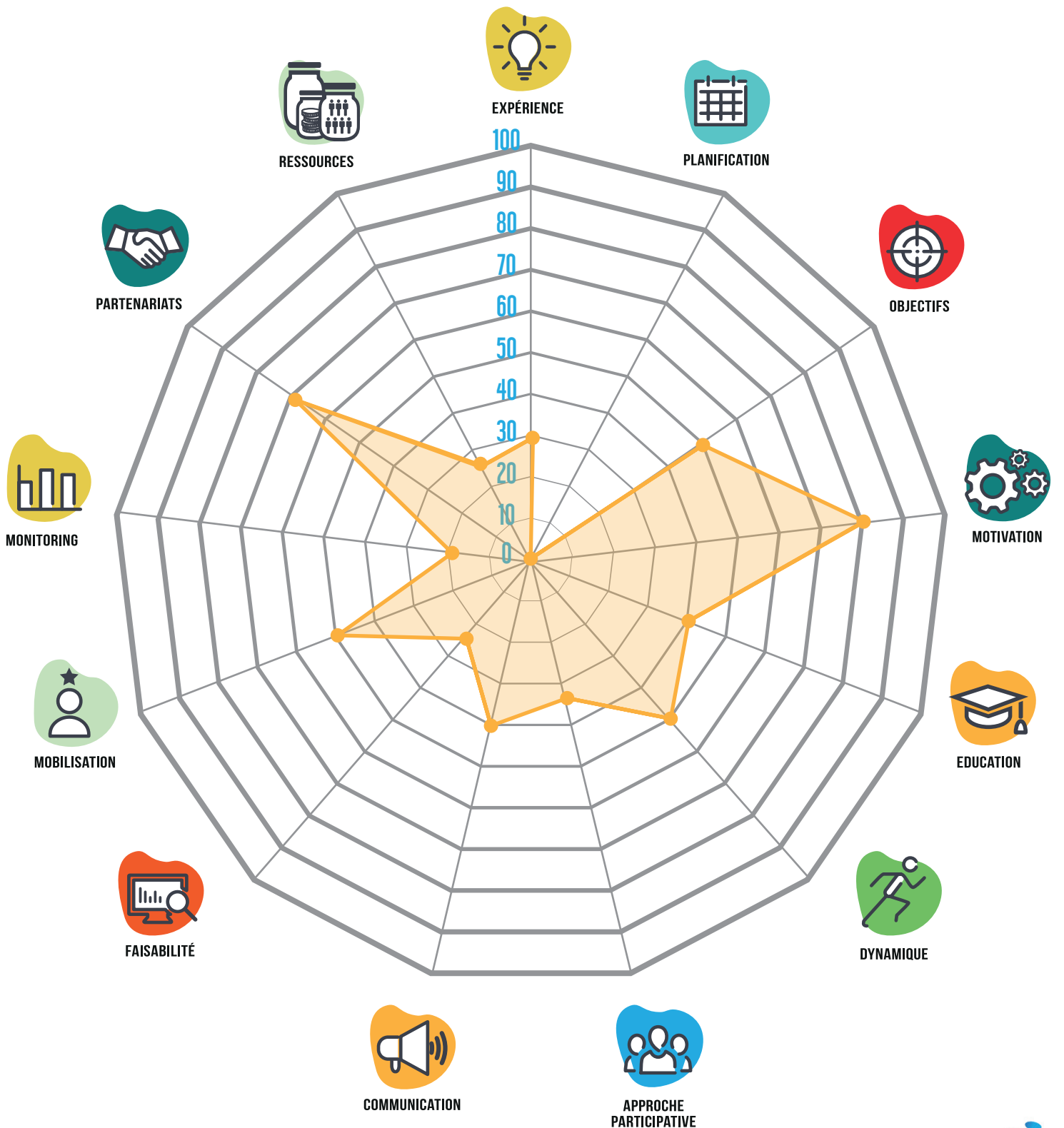


- > Par cette action, et d'autres prévues, le club souhaite jouer un rôle social et sociétal auprès des jeunes qu'il encadre

- > L'action a permis d'impliquer plusieurs parents bénévoles et de transformer les pratiques alimentaires familiales
- > La reconnaissance du club par cette action va permettre la naissance d'autres partenariats au niveau local

- > Les pratiquantes ont appris les principes de l'alimentation saine, à choisir leurs aliments, leurs collations, etc.

Éléments clés au regard du modèle du club de sport promoteur de santé



Éléments clés au regard du modèle du club de sport promoteur de santé



Communication

Dès le début de l'action, le porteur du projet a été sensible à communiquer les activités, notamment par des vidéos sur les réseaux sociaux (COM3), pour le club et pour l'extérieur (COM4).



Dynamique

Une bonne connaissance du public et l'échec de la mise en place des premiers ateliers a permis au porteur du projet de tenir compte des interactions entre les pratiquantes, le club et les familles, pour mettre en place l'action (DYN2).



Education

Le porteur du projet a sensibilisé son équipe d'entraîneurs (EDU2) et s'est entouré de bénévoles pour mener à bien son action (EDU3). Il a créé des outils de sensibilisation variés (livret, ateliers, exercices spécifiques (EDU5).



Expérience

Lors de l'échec des premiers ateliers, le porteur du projet s'est rendu compte qu'il fallait qu'il adapte son action (EXP1) et a persévéré dans sa mise en place, malgré l'absence de soutien fort et formel des dirigeants du club (EXP2). Le porteur de projet a fondé son action sur le constat qu'il faisait sur le surpoids des joueuses pendant leur pratique (EXP6).



Faisabilité

Le porteur du projet décrit le projet comme étant à ses débuts, et fonde la réussite sur l'investissement en ressources humaines dont il a pu s'entourer (FAIS2).



Objectifs

Des objectifs généraux ont été définis pour le projet (OBJ1), ils ont surtout été traduits dans le livret dans un langage spécifique au football (OBJ3). Ces derniers devraient être intégrés au projet du club lors de sa refonte.



Mobilisation

Le porteur de projet a été très actif au niveau de la mobilisation, en mobilisant une joueuse professionnelle (MOB1), de parents-experts (MOB2 et MOB4) en santé, en s'identifiant comme référent de l'action (MOB3) et en mobilisant les parents et l'entourage pour soutenir le projet (MOB4). La prochaine étape sera de faire du plaidoyer auprès des élus locaux (MOB5) et de la fédération (MOB6) pour avoir plus de soutien.



Monitoring

Le suivi des actions a été fait de manière informelle tout au long du projet, en notant l'évolution des comportements des filles et la dynamique en place (MON1).



Approche participative

Les actions proposées dans le cadre du projet ont été valorisées, par l'inscription et la récompense aux Trophées Philippe Seguin (APP4). Les parents et l'entourage des joueuses ont été impliqués fortement dans l'action (APP6).



Partenariats

Plusieurs partenaires ont été identifiés (PART1) et sollicités (PART2), avec une négociation de leur implication pour lancer le livret et le projet.



Planification

La planification de l'action n'a pas été anticipée à long terme, mais plutôt sur la saison, en fonction des opportunités. La volonté du porteur de projet est de baser le projet du club sur les actions en cours (PLAN7).



Ressources

Le porteur de projet a évalué principalement les ressources humaines disponibles (RES2), et les compétences dont elles disposaient (RES3) pour mettre en place le projet. Ensuite, il est en train d'identifier les outils (RES4) et les financements (RES5) mobilisables pour améliorer l'action.



PROSCeSS

PRoMOTION de la Santé dans les Clubs Sportifs

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THÈSE DE DOCTORAT

Promouvoir la santé au sein des clubs de sport (PROSCeSS) :

du développement de la théorie à l'intervention

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Présentée en vue de l'obtention

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Contexte théorique :

En 1986, l'Organisation Mondiale de la Santé (OMS) a appelé les acteurs de la santé publique à investir dans des milieux de vie variés pour promouvoir la santé (Organisation mondiale de la Santé, 1986). Les milieux doivent être développés pour promouvoir la santé au sens large, comprenant le bien-être mental, physique et social, plutôt qu'un seul comportement de santé. L'élaboration de milieux pour la promotion de la santé devrait également en impliquant les différents acteurs en utilisant une approche participative (Kok et al., 2017). Outre la Charte d'Ottawa de 1986, de nombreux documents internationaux et nationaux ont appelé les milieux de vie à promouvoir la santé. La Stratégie sur l'alimentation, l'activité physique et la santé aborde le risque croissant de maladies non transmissibles et reconnaît l'importance de la promotion de l'activité physique et de l'alimentation pour aider à combattre ces risques (Organisation mondiale de la Santé, 2004). Le Plan d'action mondial pour l'activité physique 2018-2030 souligne l'importance du leadership, de la coordination et d'une réponse globale pour encourager et soutenir un mode de vie actif (Organisation mondiale de la Santé, 2019). Spécifique au contexte français, la Stratégie nationale de santé 2018-2022 donne la priorité à la santé, incluant la promotion d'une alimentation saine et d'une activité physique régulière. (Ministère des Solidarités et de la Santé, 2018).

L'approche par milieu de vie en promotion de la santé est dérivée du modèle socio-écologique de la santé, qui considère que l'environnement (le milieu de vie) influence fortement la santé des individus (McLeroy et al., 1988). Des milieux tels que les hôpitaux (Johnson & Baum, 2001), les universités (Dooris et al., 2014), les écoles (Schools for Health in Europe, 2014) et les prisons (Baybutt & Chemlal, 2016) ont mis cette approche en œuvre avec succès. Ainsi, le club de sport, qui s'apparente également à un milieu de vie, même s'il est moins traditionnel, pourrait s'en inspirer pour contribuer à une société plus 'saine' en promouvant la santé. L'Eurobaromètre 2017 a indiqué qu'il y avait 16 millions de participants et 3 millions de bénévoles dans les clubs de sport (European Commission, 2018). En outre, il existe plus de 100 fédérations sportives avec plus de 700 000 clubs de sports associés en Europe. Le club de sport a fait l'objet de recherches afin de comprendre les ressources nécessaires pour accroître les actions de promotion de la santé dans ce milieu (Kokko et al., 2006). Un concept initial a été développé pour inclure trois niveaux de clubs de sport : le club de sport en tant que milieu (macro), la gérance du club (mésa) et les pratiques d'entraînement (micro). Chaque niveau intègre quatre déterminants de la santé : culturel, économique, environnemental et social (Kokko, 2014). Cependant, la littérature montre que l'approche par milieu de vie est souvent mise en œuvre de manière inappropriée dans les clubs de sport (Geidne et al., 2019).

Le projet **PROSCeSS (PRO**motion de la **S**anté dans les **C**lubs **S**portifs) visait à combler les limites scientifiques actuelles de l'application de l'approche par milieu de vie au club de sport, appelée le club de sport promoteur de santé (HPSC – Health Promoting Sports club). Il est basé sur le fait que fournir aux membres, aux encadrants et à la communauté locale un environnement sûr et sain permet de jouer un rôle sociétal fort au-delà de ce qui est classiquement proposé par les clubs de sport c'est à dire la pratique et la compétition sportives (Meganck et al., 2015). Dans ce contexte, le projet PROSCeSS visait à soutenir les clubs de sport dans leurs efforts pour accroître les actions de promotion de la santé. La vision d'un club de sport promoteur de santé (HPSC) repense le club de sport en partant du point de vue que le développement efficace de ce milieu peut : 1) promouvoir le bien-être physique, mental et social de tous les acteurs impliqués dans le club, 2) soutenir les concepts de justice sociale et d'égalité, 3) fournir un cadre sûr et stimulant, 4) préconiser la participation de tous, 5) impliquer les partenaires et les membres de la communauté, 6) intégrer la santé dans les activités quotidiennes du club, 7) fixer des objectifs basés sur les besoins et les attentes des parties concernées et 8) évaluer les actions de promotion de la santé afin d'apporter des améliorations quand et où cela est nécessaire.

Afin de répondre aux limites scientifiques et de développer la vision HPSC, plusieurs questions de recherche ont été formulées dans cette thèse :

1. Comment pouvons-nous mesurer les perceptions de la promotion de la santé dans les clubs de sport?
2. Quelles stratégies peuvent être et ont déjà été utilisées pour promouvoir la santé dans les clubs de sport ?
3. Comment les clubs de sport peuvent-ils intégrer des initiatives de promotion de la santé dans leurs actions quotidiennes ?
4. De quel soutien les clubs de sport ont-ils besoin pour accroître les actions de promotion de la santé ?
5. Comment une intervention peut-elle être co-construite avec les parties prenantes des clubs de sport ?

Pour appliquer une approche par milieu de vie au clubs de sport, répondre aux questions de recherche et proposer des solutions, les objectifs du projet PROSCeSS étaient les suivants : 1) mesurer les perceptions des actions de promotion de la santé dans les clubs de sport, 2) développer un cadre de planification des interventions fondé sur un modèle théorique basé sur le milieu de vie pour soutenir et accompagner les clubs de sport dans leurs efforts de promotion de la santé et 3) capitaliser sur les expériences prometteuses des clubs de sport pour partager les

connaissances et apprendre des autres lors de la mise en œuvre d'actions de promotion de la santé au sein de leurs clubs. Ce travail a été accompli en plusieurs étapes :

- I. Créer et tester les qualités psychométriques d'un outil d'auto-évaluation pour mesurer les perceptions de la promotion de la santé (études 1 et 2).
- II. Développer un modèle théorique des clubs de sport pour inclure les niveaux et les déterminants de la santé (études 3 et 5).
- III. Formuler des indicateurs pour identifier un club de sport promouvant la santé (étude 3).
- IV. Rédiger des stratégies pour mettre en œuvre des interventions de promotion de la santé spécifiques au contexte des clubs de sport (étude 3 et 5).
- V. Identifier les besoins et les attentes des acteurs des clubs de sport lors de la planification des interventions (étude 4).
- VI. Explorer les conditions nécessaires à la mise en œuvre des interventions dans les clubs de sport (études 2, 4 et 6).
- VII. Capitaliser sur les expériences de promotion de la santé des clubs de sport exemplaires (étude 6).

Pour se faire, six études ont été réalisées :

Étude 1 : Mesurer la promotion de la santé dans les clubs de sport : Une étude Delphi modifiée

Contexte et objectif :

L'approche basée sur le milieu de vie est devenue de plus en plus importante en promotion de la santé depuis la Charte d'Ottawa de l'Organisation mondiale de la santé en 1986 (Organisation mondiale de la Santé, 1986). Pour faire progresser cette approche, le club de sport est devenu un milieu de vie intéressant en raison de la population potentielle qu'il peut atteindre. Dans cette optique, le développement d'un outil de mesure des perceptions de la promotion de la santé au sein du club de sport développé au niveau international était l'objectif de la première étude.

Méthodes :

Une étude Delphi modifiée a été réalisée en anglais afin de développer un outil d'évaluation international fondé sur cette approche. Des experts internationaux des secteurs du sport et de la santé ont été invités à participer à la construction du questionnaire. Les items ont été générés ou sélectionnés sur la base de trois études Delphi antérieures et de deux échelles validées au niveau national. L'élaboration a comporté trois séries de réponses en ligne : le premier tour a permis de créer une liste collaborative des items, le deuxième tour a validé les items sur la base de leur pertinence, de leur importance et de leur faisabilité et le dernier tour a classé les items dans quatre catégories de déterminants.

Résultats :

Un consensus a été atteint par 69 panélistes internationaux du domaine de la santé et du sport représentant 13 pays. Un outil validé de promotion de la santé dans les clubs de sport, composé de 62 items, a été développé à 3 niveaux de clubs de sport. Le niveau macro comprend 22 items, le niveau méso comprend 18 items et le niveau micro comprend 18 items. À chaque niveau, les items ont été classés en déterminants culturels, sociaux, environnementaux ou économiques de la santé.

Conclusion :

Cette étude apporte trois innovations importantes : 1- elle est basée sur la théorie, grâce au concept original de clubs de sport promoteurs de santé, 2- l'outil de mesure adopte une approche multi-niveau de l'organisation des clubs de sport et 3- l'outil a été validé au niveau international.

Article:

Johnson, S., Vuillemin, A., Geidne, S., Kokko, S., Epstein, J., Van Hoye, A. Measuring Health Promotion in Sports Club Settings: A Modified Delphi Study. *Health Education & Behavior* 47 (1), 78-90, 2019; <https://doi.org/10.1177/1090198119889098>

Étude 2 : Validation française du questionnaire e-PROSCeSS**Contexte et objectif :**

Les résultats de l'étude Delphi ont montré l'intérêt de différencier les outils de mesure en fonction des acteurs (dirigeants, entraîneurs, pratiquants), car leur activité au sein du club peut avoir un impact sur les perceptions des actions de promotion de la santé réalisées au sein des clubs de sport. Jusqu'à présent, un outil de mesure n'avait pas été créé par une équipe internationale d'experts tenant compte des différences culturelles au-delà des frontières nationales. Ce travail a pris en considération l'organisation à plusieurs niveaux des clubs de sport. Par conséquent, l'objectif de la seconde étude était de tester les qualités psychométriques de chacune des trois échelles (macro, méso, micro) auprès des populations cibles (dirigeants, entraîneurs, pratiquants). Bien que le questionnaire e-PROSCeSS ait été créé en anglais, afin de faire avancer le projet PROSCeSS, la première validation a été effectuée en français.

Méthodes :

Chaque échelle a été conçue en anglais puis traduite en français. La clarté du contenu a été testée en anglais et en français auprès de groupes de dirigeants, d'entraîneurs et de pratiquants par le biais d'entretiens en personne et par téléphone. Les participants ont été amenés à répondre à chacune des questions sur une échelle de Likert en 6 points au moyen de la plateforme

LimeSurvey. L'analyse des données comprenait des statistiques descriptives, une analyse factorielle confirmatoire et la validité prédictive.

Résultats :

Au total, 473 répondants ont participé, issus des trois niveaux (dirigeants, entraîneurs et pratiquants). Au niveau macro, 26 items ont été retenus, 15 au niveau méso et 15 au niveau micro, répartis dans trois ou quatre échelles en fonction du type de déterminants (organisationnel, social, environnemental, économique). Une bonne validité prédictive des échelles a également été constatée, les perceptions de la promotion de la santé étaient inversement liées à l'abandon de leur poste pour les dirigeants et les entraîneurs (perceptions plus faibles = taux d'abandon plus élevé). De plus, des perceptions positives de la promotion de la santé étaient associées à une amélioration des performances et à une meilleure qualité de vie des participants. Les sous-échelles du questionnaire ont montré de bonnes propriétés en mesurant trois des quatre déterminants de la santé (économique, organisationnel, social) à plusieurs niveaux des clubs de sport, mais ne pouvaient pas mesurer la promotion de la santé comme concept global dans les clubs de sport.

Article :

Johnson, S., Vuillemin, A., Epstein, J., Geidne, S., Donaldson, A., Tezier, B., Kokko, S., Van Hoya, A. (*In revision in Health Promotion International*). French validation of the e-PROSCeSS questionnaire: sports actor's perceptions of the health-promoting sports club.

Étude 3 : Le modèle de club de sport promoteur de santé : Un cadre de planification des interventions

Contexte et objectif :

Fournir un modèle théorique et un cadre fondé sur la preuve, y compris des stratégies d'action lors de la planification des interventions, s'est montré utile pour accroître l'efficacité des interventions de promotion de la santé (Michie et al., 2011; Poland et al., 2009; Whitelaw, 2006). En conséquence, l'objectif de cette étude était de créer un modèle de club de sport promoteur de santé et de fournir des stratégies fondées sur des preuves et des composants d'intervention intégrés dans le modèle ; ces composants d'intervention permettant de fournir aux clubs de sport le " comment " de la planification de l'intervention.

Méthodes :

L'équipe de recherche s'est appuyée sur les niveaux prédéfinis des clubs de sport et les déterminants de la santé de l'étude 1 comme base du modèle. Les définitions ont été précisées et un modèle HPSC a été construit. Sur la base d'une revue de littérature (Geidne et al., 2019), les recommandations fondées sur des données probantes ont été formulées en stratégies et

subdivisées en composants d'intervention. Ce travail a été mené en anglais, puis traduit en français pour être utilisable lors de chaque étape restante du projet PROSCeSS. Trois groupes de discussion ont été menés, deux en français et un en anglais (auprès d'experts suédois), afin de catégoriser les composants d'intervention dans le modèle HPSC par niveau de club de sport et par déterminant de santé.

Résultats :

Les niveaux définis pour les clubs de sport comprenaient les niveaux macro, méso et micro. Les groupes de discussion ont permis d'identifier plusieurs autres niveaux qui sont affectés par le club sportif ou qui ont un effet sur lui : l'individu, les fédérations sportives et les acteurs de deuxième ligne. L'analyse de la littérature a permis de formuler 14 stratégies et 55 composants d'intervention (CIs). Ces 55 CIs de chaque stratégie ont été classés dans le modèle : approche participative (49), communication (4), dynamique (4), éducation (4), expérience (10), faisabilité (21), mobilisation (6), monitoring (14), motivation (17), objectifs (6), partenariats (19), planification (45), politiques (13) et ressources (7).

Article :

Van Hoyer, A., **Johnson, S.**, Geidne, S., Donaldson, A., Rostan, F., Lemonnier, F., Vuillemin A. The health promoting sports club model: An intervention planning framework. *Health Promotion International*, 2020; <https://doi.org/10.1093/heapro/daaa093>.

Étude 4 : Construire des clubs de sport promoteur de santé : Une approche participative de cartographie conceptuelle

Contexte et objectif :

Il est connu que le changement organisationnel nécessite le soutien et l'approbation de toutes les personnes concernées (Kok et al., 2017), en commençant par le personnel et en remontant l'échelle proverbiale jusqu'aux dirigeants et aux parties prenantes externes. Les clubs de sport ne sont pas différents dans le soutien qu'ils doivent apporter lorsqu'ils sont amenés à changer leur organisation et à intégrer des actions de promotion de la santé dans leurs habitudes quotidiennes. L'étude 4 avait pour objectif de générer des idées sur le soutien nécessaire pour accroître les actions de promotion de la santé au sein des clubs de sport.

Méthodes :

Une méthode de carte conceptuelle a été mobilisée (Trochim & McLinden, 2017). Les acteurs des clubs de sport ont été invités à générer jusqu'à 5 idées chacun sur la base d'une proposition ciblée. Toutes les idées générées ont ensuite été évaluées par les participants en fonction de leur

importance et de leur faisabilité dans le contexte du club de sport. Les participants ont également classé toutes les idées générées dans des groupes, appelés clusters, de concepts similaires.

Résultats :

Les participants ont généré 78 idées au total, dont 34 ont reçu une note supérieure à la moyenne pour l'importance et la faisabilité. Sur la base de ces évaluations, les principaux groupes d'idées identifiés ont été les suivants : accroître la sensibilisation à la promotion de la santé, mobiliser les acteurs pour qu'ils participent aux actions de promotion de la santé, demander l'aide des fédérations sportives et des ministères et former les entraîneurs et les dirigeants.

Article :

Johnson, S., Van Hoyer, A., Donaldson, A., Lemonnier, F., Rostan, F., Vuillemin, A. Building health-promoting sports clubs: A participative concept mapping approach. *Public Health*, 188, 8-17, 2020; <https://doi.org/10.1016/j.puhe.2020.08.029>

Étude 5 : Un cadre pour la promotion de la santé dans les clubs de sport : faire le lien entre participation et données probantes

Contexte et objectif :

Le cadre de planification des interventions HPSC (Van Hoyer et al., 2020) créé dans l'étude 3 fournit des stratégies fondées sur des données probantes et des composants d'interventions produits par une approche descendante (top-down) ; tandis que les idées générées pour le soutien nécessaire dans l'étude 4 (Johnson et al., 2020) fournissent une approche ascendante (bottom-up). L'approche top-down a permis de catégoriser les composants d'interventions et l'approche bottom-up a permis d'impliquer les parties concernées. L'objectif de l'étude 5 était de faire le lien entre les recherches précédentes et l'expérience des parties concernées (Vella et al., 2019).

Méthodes :

Les études 3 et 4 ont été combinées en définissant d'abord quatre nouveaux niveaux des clubs de sport et déterminants de la santé, qui ont été ajoutés au modèle HPSC. Les idées les mieux notées générées au cours de l'étude 4 ont ensuite été formulées sous forme de stratégies ou de composants d'intervention. Enfin, les composants d'intervention ont été classés dans le modèle HPSC par niveau de club de sport et par déterminant de la santé par le biais d'un groupe de discussion.

Résultats :

Les niveaux de clubs de sport nouvellement définis comprennent : les individus, les fédérations sportives, les acteurs de la santé publique et les autorités gouvernementales. Les 14 stratégies initiales ont été ramenées à 13 et 14 composants d'intervention supplémentaires ont été ajoutés. En outre, 9 composants d'intervention précédents ont été modifiés. Le cadre révisé de

planification des interventions du HPSC propose 13 stratégies et 69 CI ciblant 7 niveaux des clubs de sport.

Article :

Johnson, S., Van Hoye, A., Geidne, S., Donaldson, A., Rostan, F., Lemonnier, F., Tezier, B., Vuillemin, A. (*to be submitted to Global Health*). A health promoting sports club framework: connecting participation with evidence.

Étude 6 : Capitalisation des initiatives de promotion de la santé au sein des clubs de sport français

Contexte et objectif :

Les preuves d'efficacité des interventions de promotion de la santé mises en œuvre dans les clubs de sport font défaut. Cette étude a cherché à découvrir comment les interventions du monde réel ont été développées et mises en œuvre dans huit clubs de sport français ayant des projets exemplaires et à voir si le cadre de planification des interventions de HPSC a été appliqué.

Méthodes :

Les clubs de sport français qui ont déjà mis en œuvre des initiatives de promotion de la santé ont été identifiés par le biais des réseaux de clubs de sport. Les documents et les sites web des clubs ont été analysés pour s'assurer que l'initiative de promotion de la santé répondait aux critères d'inclusion, puis le club a été contacté pour des entretiens avec son responsable d'intervention. Les déclarations majeures des personnes interrogées ont été analysées pour identifier les stratégies de HPSC appliquées.

Résultats :

Au sein des clubs de sport, 9 à 13 stratégies (14 maximum) ont été mises en place, mais aucun club n'a mobilisé la stratégie politiques. Quatre compétences essentielles des responsables de l'intervention ont été identifiées : comprendre les parties impliquées, comprendre comment mobiliser les ressources, être capable de communiquer sur l'intervention et être capable de demander des ressources financières.

Article:

Van Hoye, A., **Johnson, S.**, Lemonnier, F., Rostan, F., Crochet, L., Tezier, B., & Vuillemin, A. Capitalization of health promotion initiatives within French sports clubs. *International Journal of Environmental Research and Public Health*, 18(3), 888, 2021; <https://doi.org/10.3390/ijerph18030888>

Discussion générale

À travers ces six études, les clubs de sport peuvent entamer le processus d'intégration d'actions de promotion de la santé dans leurs activités quotidiennes et au sein de leurs politiques. Les recherches collectées dans le cadre de cette thèse constituent un ensemble de recommandations pour préciser les cadres théoriques et les résultats empiriques, afin d'aider les chercheurs et les clubs de sport à planifier et à développer des politiques et des actions de promotion de la santé (Fernandez et al., 2019) en considération des composantes et des mécanismes d'une approche systémique globale. Cette approche est utilisée pour le développement organisationnel et le renforcement des capacités dans de multiples milieux de vie depuis près de cinquante ans (Beer & Huse, 1972). La thèse s'appuie donc sur des méthodes éprouvées en montrant comment les activités organisées au sein des clubs de sport sont interconnectées, intégrées, interreliées et interdépendantes (Dooris, 2006; Skyttner, 2001). Le fait de travailler en lien étroit avec les parties prenantes des clubs de sport, les universitaires et différents groupes de travail, a permis de modifier la façon dont l'approche HPSC est perçue. L'intégration de l'approche participative nous a aidé à comprendre ce dont les clubs de sport ont besoin pour créer un plan d'intervention final et nous a donc permis d'inclure leurs suggestions tout au long des différentes étapes du projet. Chaque étude a ajouté des détails spécifiques pour créer un cadre pour les HPSC en répondant à des questions spécifiques ou en ajoutant d'autres données fondées sur les participants et les preuves pour renforcer les données collectées.

L'application des étapes étudiées au cours de cette thèse aide les clubs de sport à lancer le processus de changement organisationnel nécessaire pour devenir un lieu de promotion de la santé :

1. Les responsables de l'intervention doivent d'abord procéder à une auto-évaluation par le biais du questionnaire e-PROSCeSS aux différents niveaux afin de fournir une perception des actions de promotion de la santé menées au sein de leur club.
2. Les résultats de l'e-PROSCeSS peuvent aider le responsable de l'intervention à développer ses besoins et objectifs spécifiques pour un projet de promotion de la santé.
3. Les résultats peuvent également être utilisés pour cibler les niveaux du club de sport et les déterminants de la santé basés sur le modèle HPSC, qui doivent être renforcés (ceux qui obtiennent les scores les plus bas sur les échelles e-PROSCeSS).
4. Les composantes de l'intervention de coordination trouvées dans le cadre de planification de l'intervention de HPSC sont utilisées pour aider à la conception, la planification et la mise en œuvre du projet de promotion de la santé.

5. Une fois l'intervention mise en œuvre, il convient de procéder à une évaluation à court, moyen et long terme en administrant une seconde fois le questionnaire e-PROSCeSS pour déterminer si les perceptions se sont améliorées au niveau des clubs de sport ciblés et des déterminants de la santé.

L'application de cette approche étape par étape aide les parties prenantes des clubs de sport à développer et à mettre en œuvre une intervention bien planifiée, fondée sur la théorie et sur des preuves.

Bien que beaucoup de travail ait été accompli pour faire avancer l'approche HPSC, plusieurs questions restent en suspens :

- Les acteurs des clubs de sport n'ont pas été consultés lors de la création du questionnaire e-PROSCeSS (étude 1) ; leur contribution pourrait être une source précieuse pour accroître l'utilité du questionnaire en ajoutant leurs connaissances et leurs expériences.
- La validation de l'e-PROSCeSS (étude 2) a mis en évidence le manque de compréhension de la manière dont l'environnement physique peut affecter la santé des acteurs des clubs de sport. Des résultats similaires ont été montrés dans d'autres études (Kokko et al., 2006; Van Hoya et al., 2015). Par conséquent, davantage de recherches doivent être menées sur ce déterminant spécifique de la santé pour démontrer comment l'environnement peut être un déterminant actionnable pour soutenir la santé.
- Le déterminant culturel de la santé a été remplacé par le déterminant organisationnel de la santé dans le questionnaire, le modèle et le cadre HPSC. Le déterminant culturel de la santé est établi comme un déterminant commun de la santé par l'OMS (Marmot & Wilkinson, 2004). Cela a pu provoquer des incompréhensions et des erreurs lors de la validation (étude 2). Certains items classés dans la catégorie des déterminants environnementaux auraient pu être considérés comme des déterminants culturels ou même sociaux, comme par exemple : '*Mon club de sport est accueillant (ex. dirigeants, entraîneurs, bénévoles, etc...)*' au niveau macro, ce qui a plus à voir avec la culture et les attitudes des acteurs du club qu'avec les structures construites, comme le voulait le sens du déterminant environnemental. Au niveau micro : '*Mon entraîneur se préoccupe des questions de sécurité pendant les entraînements et les compétitions*', ce qui est très vague et pourrait être interprété comme la sécurité du bâtiment et des terrains ou le sentiment de sécurité, par exemple contre le harcèlement. Il pourrait être bénéfique de reconsidérer le déterminant culturel de santé afin de considérer si ce déterminant est mieux compris par les acteurs des clubs de sport comme un déterminant de la santé.

- L'équipe de recherche et les experts a prédéterminé les déterminants de la santé en l'étude 1, en testant de manière confirmatoire un modèle établi, plutôt que de manière exploratoire (étude 2). Cela a pu conduire à forcer les éléments à correspondre à ce que nous considérons comme les déterminants de la santé plutôt que de laisser les données éclairer la décision. Il pourrait être bénéfique de laisser les données éclairer les facteurs du questionnaire plutôt que de laisser les chercheurs faire coïncider les données avec leurs notions des facteurs. De cette manière, les réponses des répondants au questionnaire ont permis de mieux renseigner les items de chaque déterminant de la santé.
- Utile comme point de départ, le questionnaire e-PROSCeSS (étude 2) est un outil d'auto-évaluation. Il faudrait également développer un outil d'audit qui mesure les politiques et les actions réelles effectuées pour promouvoir la santé. Un outil d'audit devrait d'abord être développé pour les ministères nationaux afin d'identifier quelles politiques existent au niveau national pour soutenir les clubs de sport. Une fois cet outil développé, un outil au niveau local pourra être créé pour compléter l'outil national.
- Il est nécessaire de tester et d'évaluer empiriquement le modèle et le cadre théoriques finaux de HPSC (étude 5) dans les clubs de sport. Une étude pilote devrait être planifiée en utilisant les informations collectées dans cette thèse.
- Bien que la recherche fondée sur les preuves et les participants ait été intégrée dans les différentes études, la participation directe des acteurs des clubs de sport (dirigeants, entraîneurs, pratiquants) a été moins fréquente. Les recherches futures devraient se concentrer sur leurs besoins et leurs attentes en organisant des groupes de discussion ou des études supplémentaires de cartographie conceptuelle similaires à celle réalisée dans l'étude 4.
- L'éducation a été une stratégie mise en avant lors de l'étude 3 et très valorisée lors de l'étude 4. Par conséquent, un cours en ligne ouvert et massif (MOOC) devrait être produit pour sensibiliser les acteurs des clubs de sport à 1) l'appel à la promotion de la santé (Organisation mondiale de la Santé, 1986), 2) l'approche de la promotion de la santé basée sur le milieu de vie (Nutbeam, 1998), 3) les avantages de la promotion de la santé au sein de leur club de sport, 4) le renforcement de la capacité des clubs de sport à promouvoir la santé (Casey et al., 2012; Hawe et al., 1997; Sauter et al., 2020), et 5) former à l'application de l'approche HPSC.
- Le rôle de leadership et de coordination des fédérations sportives a été fortement souligné au cours des études 3 et 4. Des indicateurs et des stratégies devraient être recherchés et

développés pour guider les fédérations sportives sur la manière de soutenir leurs clubs de sport affiliés.

- L'étude finale a identifié comment plusieurs clubs de sport français mettent déjà en œuvre des projets de promotion de la santé sans aucune formation ou orientation formelle et appliquent sans le savoir la plupart des stratégies formulées (à l'exception des politiques). Acquérir plus de connaissances en capitalisant sur des programmes exemplaires déjà mis en œuvre dans d'autres pays, tels que le « Healthy Club Project » en Irlande et le « Good Sports Program » en Australie, pourrait aider les clubs de sport.

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