Irish Life

GAA Healthy Clubs

Healthy Clubs, Healthy Bodies, Healthy Minds.

Measuring the Impact of the Irish Life GAA Healthy Clubs Programme.

A Social Return on Investment Evaluation
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LIST OF ABBREVIATIONS

HCP: Healthy Club Programme
GAA: Gaelic Athletic Association
ToC: Theory of Change
HCO: Healthy Club Office
SROI: Social Return on Investment
HSE: Health Service Executive
NHS: National Health Service

Executive Summary

The Irish Life GAA Healthy Club Programme (HCP) is the GAA's flagship programme to promote health and wellbeing in Ireland outside of its official games structures. Based on the settings approach, it aims to support GAA clubs and communities to achieve locally defined health and wellbeing goals that also reflect the national policy agenda for sport, physical activity, mental health, and preventative health. It has the potential to strengthen the GAA's inclusivity and role within communities by reaching a wider and more diverse audience. The HCP first began in 2013 with a pilot phase involving 16 clubs. By Phase 5 (2022-23) it had engaged 447 clubs.

In 2021, the GAA commissioned Just Economics to carry out a Social Return on Investment Analysis (SROI) of the Healthy Club Programme. The evaluation followed a mixed-methods study design based on the Social Return on Investment (SROI) framework. SROI is a methodology that compares the social, economic, and environmental value of a programme with its cost to estimate the social return.

In 2022/23 the HCP engaged 447 clubs and involved 1,912 volunteers. These volunteers organised 2,389 activities accessed 184,598 times by 92,299 individuals. Activities are spread across six areas: physical activity (44%), mental fitness (10%), healthy eating (7%), substance use/ gambling (6%), community development (24%) and diversity/ inclusion (9%).

This SROI model includes benefits to three stakeholder groups: participants, volunteers, and wider society. For participant outcomes, the WELLBY approach was used to value improvements in life satisfaction. This draws on guidance for wellbeing appraisal developed at the London School of Economics and endorsed by the UK Treasury. This resulted in a value per participant of €3,140.

In line with SROI guidance, volunteers are treated as both an input and an outcome in the model. The number of hours invested by volunteers in the programme is approximately 102,292 annually, and we can value this using the 2022 minimum wage at €1.1 million. However, this compares with health and wellbeing benefits to volunteers of €3.7 million. For wider society outcomes, we have inferred benefits to health services from changes in the service use as a result of participation (€620,000). For the HSE/NOSP, which contributes €140,000 of funding, the return from these savings is 4.4:1. The total value of the programme is almost €50 million. The headline return ratio is therefore 19:1, suggesting that €19 of value is generated for €1 of financial, volunteer, and in-kind investment.

For participants, there are very high levels of satisfaction with the activities and clear health and wellbeing benefits. Participants report:

- Increases in physical activity (10-25%)
- Adopting of healthier behaviours (40%)
- New hobbies (17%) and friendships (51%)
- Improvements in life satisfaction, connectedness to other people and the community (the latter seeing the largest change)

For the GAA itself, we find the following benefits:

- Greater involvement by participants in the GAA (joining, taking their children to training or attending games) (77%)
- Improved reputation (78%)
- More members/volunteers

Demographic data show that the programme engages an equal mix of men and women and is attracting participation from outside the GAA core base. If we were to generalise from our survey to all unique participants (92,299), we estimate that across the programme, it has engaged 10,152 individuals that had no previous involvement with the GAA and 38,227 individuals who were not closely connected to the GAA.

However, representation of BAME (Black and Minority Ethnic) communities, people with additional needs and older people is low.

These groups are underrepresented across all sports; hence they have been identified as a priority for the HCP which aims to bring to life the GAA's manifesto 'Where We All Belong'.

For volunteers, 89% were satisfied with their volunteering experience. Life satisfaction increased from 7.6/10 at baseline to 8.5/10. They also report higher levels of community connectedness and connection to other people than at baseline. These improvements in wellbeing are higher than for participants. 25% of volunteers had no previous involvement with the GAA and many started out as participants, suggesting that the programme is operating as a gateway for volunteering.

Participating clubs reported:

- Changes in policies and procedures such as smoke and vape free venue
- Healthy eating at training and after games
- Increases in the proportion of clubs that consider their club to be welcoming, representative of the community and well-utilised
- Some improvement in the ease at which volunteers are recruited/retained

The report contains a series of recommendations to improve the reach and effectiveness of the programme. These include the development of strategies to access hard to reach groups, addressing key health priorities for Ireland, improving branding and communications, better use of GAA facilities, developing the regional structure, and new research priorities.

The Irish Life GAA Healthy Club Programme is emblematic of the direction of travel for the GAA in 21st century Ireland. It aims to be an inclusive, progressive, and dynamic programme that builds social capital and changes health and wellbeing behaviours by starting where people are at. As a light touch, low-cost intervention it has made significant progress in its first ten years. The economic analysis shows that even on a conservative basis, the value of the prevention achieved thus far substantially outweighs the cost of investment.

As the HCP matures and reaches a more diverse audience and those with higher health and wellbeing needs, it has the potential to increase its social value even further. This programme has successfully demonstrated proof of concept and it should now be mainstreamed within the GAA. There is also a strong case for increased funding for the programme to enable it to grow and reach more people and communities more effectively.


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1 Introduction

Good health is an important part of what constitutes a good life, and being in either good or bad health has profound implications for people's chances of leading a fulfilling and happy life.[1]

Due to dramatic advances in healthcare, life expectancy has improved steadily over the past half century.[2] At the same time, the incidence of a range of non-communicable diseases (NCDs) has increased, the costliest of these including mental ill health, dementias, diabetes, and cardiovascular diseases.[3]

As we live longer lives, this increases the pressure on health services and the challenge of achieving healthy aging remains a pressing concern in developed countries. In addition, inequalities in health outcomes remain stubbornly high and, in some countries, have been on the increase.[4]

The concept of 'everyday health' aims to promote better lifestyle decisions to create a healthier society, and combat rising rates of chronic disease, obesity and mental illness. A 'settings approach' promotes everyday health by reaching people in existing spaces where they gather to promote healthy messages, activities, behaviours.

The GAA, as the largest sporting organisation in the country with strong brand loyalty and significant reach into local communities, is uniquely placed to undertake health promotion at scale.

The Irish Life GAA Healthy Club Programme (HCP) is the GAA's flagship programme to promote health and wellbeing in line with the settings approach. It aims to support communities to achieve locally defined health and wellbeing goals that also reflect the national policy agenda for sport, physical activity, and health.

The GAA commissioned Just Economics to conduct an evaluation of the HCP between 2021 and 2023. This report provides an overview of the background, methodology, research findings and recommendations. Longer verisons of these sections are available in the appedenices.

[1] OECD (2019) Better Life Index https://www.oecdbetterlifeindex.org/topics/health/

[2] Ezzati, M., Friedman, A. B., Kulkarni, S. C., & Murray, C. J. (2008). The reversal of fortunes: trends in county mortality and cross-county mortality disparities in the United States. PLoS Med, 5(4), e66.

[3] Pretty, J., & Barton, J. (2020). Nature-based interventions and mind–body interventions: Saving public health costs whilst increasing life satisfaction and happiness. International journal of environmental research and public health, 17(21), 7769.

[4] Marmot, M. (2020). Health equity in England: the Marmot review 10 years on. Bmj, 368.

2 About the Irish Life GAA Healthy Clubs Programme

The Irish Life GAA Healthy Club Programme first began in 2013 with a pilot phase involving 16 clubs. By Phase 5 (2022-23) it had engaged 447 clubs.

The project sets out to help GAA clubs explore how they support the holistic health of their members and the communities they serve. It has the following three aims:

1. Initiate new health-promoting activities that directly address local needs (health/well-being deficits or excluded groups)

2. Mainstream best practice healthy behaviours across the core business (Gaelic Games) of the club (e.g. around alcohol, diet, substances and mental health)

3. Provide a framework for formalising existing health promotion activities that are in line with HCP goals to support those activities and facilitate learning across groups that are delivering them.

At the time of research, it was in its fifth phase of roll-out, and has established the following priority areas, informed by both public policy and local needs identified by participating clubs:

- Physical activity for non-playing members (e.g. Ireland Lights Up walking initiatives, Men on the Move, Social Gaelic Games and others)

- Diversity and inclusion (e.g. intercultural awareness and diversity training, All-Stars programmes and inclusive game opportunities)

- Community development (e.g. Covid response, Ukrainian response, charitable fundraising, age-friendly clubs, youth leadership, critical incident response)

- Mental fitness (e.g. suicide awareness training, emotional literacy support)

- Substance use and gambling awareness (e.g. training and education, policy development, Smoke and Vape free clubs)

- Healthy eating (e.g. Recipes for Success, club guidelines)

- Environmental sustainability (Green Clubs programme covering thematic areas: biodiversity, water, waste, energy, and transport.)

The programme supports GAA clubs to a) identify what they are already doing well, b) identify areas for improvement, and c) empower them to ensure that everyone who engages with their club benefits from the experience in a health-enhancing way, be they players, officers, coaches, parents, supporters, or members of their local community. For a full list of activities and levels of participation in each priority area during Phase 5, see Appendix 6.

The healthy club model, which is based on national and international best practice, also aims to embed a health promotion philosophy in a club while integrating health into the day-to-day club activities in a sustainable way.

The HCP is supported by the GAA Community and Health Department, who are a team of eight staff working across all six priority areas. Voluntary Provincial and County Health and Wellbeing Committees provide support at a local level cross all four provinces and 32 counties. A national steering committee, with representatives from funders, sectoral experts, and long-standing high performing Healthy Clubs, provides oversight.

Clubs must follow a seven-step process to become a healthy club. This process usually takes place over an 18-month period. Clubs must document their progress on an online Healthy Clubs Portal and when verified, they will gain recognition as a Foundation Level Healthy Club. Clubs have the option to maintain Foundation level healthy status or proceed to Silver and/or Gold.

An initial pilot evaluation of the HCP was conducted in 2018. It found significant improvements in the health promotion practices of participating clubs compared to control clubs.[1] The evaluation recommended the continued support and roll-out of the programme. It also recommended that the GAA club should be formally recognised by the Irish public health sectors as a viable setting in which to deliver health promotion.

The GAA launched a new strategic plan in 2022[2] and HCP activities cut across many of its stated objectives. However, it is particularly aligned with the Clubs and Community pillar, most notably in relation to the following objectives:

- Champion the importance of diversity and inclusion to inspire players and members to participate in our games and activities;
- Accelerate support for Clubs striving to respond to the impact of population changes in their local communities;
- Formalise engagement with governments at central and local levels to pursue mutually beneficial goals and initiatives (e.g., urban, and rural regeneration, health and wellbeing, physical activity, social inclusion).

A full literature review that locates the HCP within the Irish context and wider literature can be found in Appendix 1.

[1] Lane, A., Murphy, N., Regan, C., & Callaghan, D. (2021). Health promoting sports club in practice: a controlled evaluation of the GAA Healthy Club Project. International journal of environmental research and public health, 18(9), 4786.

[2] GAA (2023) Aontas 2026: Towards One GAA for All. GAA Strategic Plan 2022-2026. https://www.gaa.ie/api/pdfs/image/upload/eaet9kdjj5xfaggbxylm.pdf

3 Methodology

The evaluation follows the Social Return on Investment methodology, which is discussed more fully in Appendix 2. It has three main aims and objectives:

1. Understanding the impact of the programme

2. Capturing learnings to strengthen the programme, especially relating to how the HCP model could be scaled

3. Establishing the cost-effectiveness of the approach

It is a mixed methods study incorporating both qualitative and quantitative data. Whilst player/member health is an important element of the programme, an in-depth study of outcomes from these activities was out of scope for this research. This was therefore only addressed qualitatively as part of the initial stakeholder engagement.

The purpose of the qualitative data collection was to develop a Theory of Change to underpin indicator selection and to inform programme improvement recommendations. Case studies were also used to highlight different aspects of the way in which the HCP operates and to identify any challenges with implementation. 55 individuals took part in the following qualitative data collection:

- Workshops (x3) with senior managers, the HCP steering group and volunteers to inform the Theory of Change

- Interviews with participants

- Case study research (x3)

Quantitative data was used to test assumptions in the Theory of Change and to generate data for the economic valuation exercise, Several sources of information were used to support findings on outcomes for participants (see Table 1 for a summary).

Stakeholder	Data collection	Sample size (n)
Participants	Retrospective survey (all clubs) Phase 5 Clubs before and after matched survey Irish Life Every Step Counts Challenge[1] Before Irish Life Every Step Counts Challenge After (not matched)	349 50 85 125
Volunteers	Before survey After survey (not matched)	200 73
Clubs	HCP portal data on attendance etc. Before survey After survey	370 161 58

Table 1: Summary of quantitative data collection

[1] This walking challenge tracks participants' steps over 5 weeks via the Irish Life MyLife lifestyle app.

4 Theory of Change

A 'theory of change' (ToC) sets out how an organisation uses its resources to deliver activities that lead to change in the short-, medium-, and long-term.

The objective of developing a ToC is to identify the full range of changes that result from an intervention. Outcomes were identified for participants, volunteers, clubs, the GAA and wider society. This section summarises the ToC findings, a full description of the development process and findings can be found in **Appendix 3**.

The following main outcomes were identified for participants in Healthy Club activities:

Life satisfaction: general sense of wellbeing and satisfaction with life

Health and health literacy outcomes: This refers to increases in physical activity or the adoption of healthy behaviours

Increased social networks: this was especially – but not exclusively - important to people who moved to the area, were at risk of loneliness or isolation (e.g. new mothers, older people) or had integration needs (e.g. asylum seekers)

Community connectedness: this describes a different phenomenon to social networks, referring instead to a feeling of connectedness to a local area or defined community

As well as promoting health within communities, being a Healthy Club also means focusing on the health and wellbeing of players. This includes activities such as smoke and vape free campuses, anti-bullying, healthy foods around games, health literacy of players (e.g. mental health, substances etc.).

The intention is that over time, healthier members and players will lead to better outcomes – in the widest sense - for clubs and their communities. However, we were told that currently, for many county boards, success is defined narrowly around performance in competitive games. Yet, anecdotally, we were told that clubs that performed the best were often also healthy clubs and that there isn't necessarily a trade off between these goals.

The HCP was developed in part to promote the GAA's wider contribution to Irish life with a view to catalysing positive change throughout the Association.[1] The pace of change within clubs varies greatly. HCP officers told us that some clubs were still dominated by a handful of families and that there were concerns about the long-term prospects for those clubs. Moreover, contrary to the GAA ethos, insularity might mean that these clubs do not feel welcoming to new members. Whilst this was not considered a widespread problem, it was one that needed to be tackled to ensure the sustainability of these clubs.

Some of the debate around opening up the GAA membership and facilities came down to a divergence in views on whether the promotion of Gaelic games was the core aim of the GAA or whether these were a means to achieve the health and social development of Irish society. The 'traditionalists', we were told, would see the games as an end in themselves and this created tension within some clubs and executives. However, advocates of the more inclusive narrative also made the case that ultimately expanding the membership base and range of activities was a way to promote Gaelic games. Examples of how this might happen was HCP participants going on to become members and volunteers, playing the games themselves, or taking their children to training.

[1] While the primary goal of the GAA remains the delivery of Gaelic games opportunities for young boys and men, an integration process has commenced at national level with the Ladies Gaelic Football Association (LGFA) and the Camogie Association (CA), with former President of Ireland Mary McAleese appointed as the independent chairperson of the steering group. However, many clubs have moved ahead of this initiative and to date over 500 clubs in Ireland already operate under an integrated 'One Club Model'. The HCP has always targeted the three organisations.

Finally, from a societal perspective, the HCP should over time promote the health and social development of Irish society. As part of that, the initiative seeks to promote a socio-cultural shift towards 'everyday health' so that responsibility for health promotion is shared across Irish society. Additional qualitative findings can be found in the case studies in Appendix 6.

The HCP theory of change is summarised in a diagram in Figure 1.

WHAT IS THE CONTEXT/NEED?

- Increase in health risk factors such as obesity, mental health
- Importance of voluntarism and social capital to health and wellbeing
- Aging population and requirements for healthy aging
- Fragility of volunteering model
- Need for greater diversity and inclusiveness in GAA to promote relevance and sustainability

WHAT IS HCP DOING?

- Formalising and promoting healthy club activities and healthy behaviours within clubs
- Formalising and supporting existing programmes
- Sharing best practice
- Supporting clubs to set up new activities
- Structured programme for clubs to progress towards healthy club status
- Keeping health and wellbeing on GAA agenda

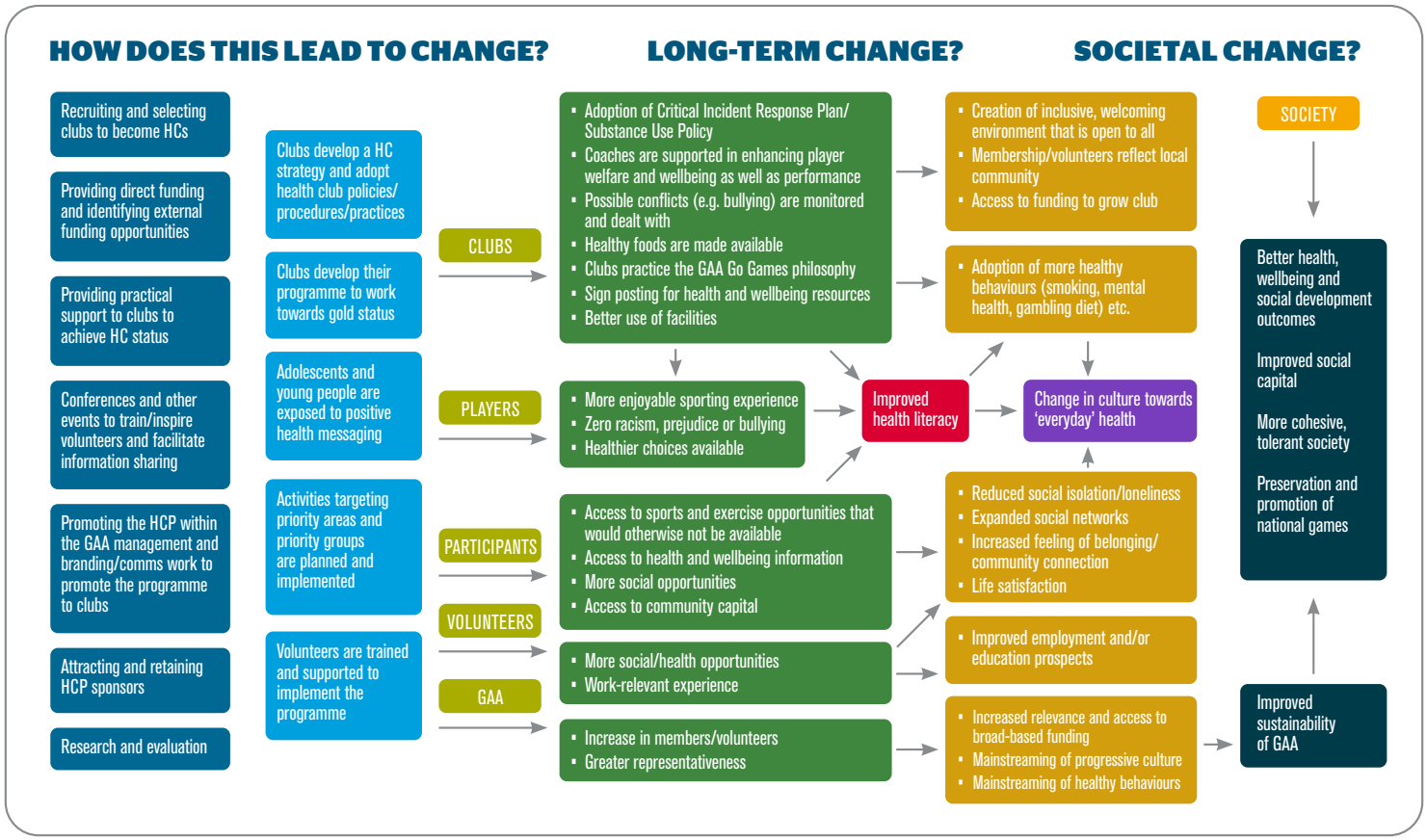

Figure 1: Theory of Change for the HCP

5 Findings

This section sets out the findings from the quantitative research, starting with outcomes for participants. A fuller discussion of these findings can be found in Appendix 4.

FINDINGS FOR PARTICIPANTS

KEY FINDINGS

- 11% of participants have had no previous involvement with the GAA and about one-third have been living in their community for less than five years.
- Low participation amongst BME groups, people with disabilities and older people.
- Participants take part in an average of two activities each suggesting one activity is a gateway to further participation
- 85% of respondents strongly agreed that they would like to see their club expand these kinds of activities in the future.
- Strong majorities also agreed that they would recommend the HCP activities to others and that they would participate in HCP activities themselves again (97% and 95% respectively).
- 40% of respondents reported that they had adopted healthier behaviours for themselves and/or their families since getting involved.
- 51% of respondents told us that they had made new friends in their community and 17% had taken up a new hobby or activity since taking part
- Participants reported higher levels of life satisfaction, community connectedness and connection to other people than at baseline

A central objective of the programme is to involve a broader section of the population in the GAA. Demographic data show that the programme is reaching a slightly higher proportion of participants identifying as female than male (51% vs. 46%), with around 3% identifying as non-binary. Survey data suggest that 11% of participants have had no previous involvement with the GAA and about one-third have been living in their community for less than five years. In terms of other target populations, 61% of people reached are classified as 'general community' and 27% are 'club members'. However, beyond that there is limited reach within other target populations such as BME groups, people with disabilities and older people.

On average, respondents participated in approximately two activities each, suggesting that participation in one activity is leading to wider participation. This aligns with anecdotal evidence that the popular community walking initiative 'Ireland Lights Up', in particular, acts as a gateway to other activities.

The most common motivations for taking part were 'taking part in a community activity' (75%), 'getting more physical exercise' (71%), 'meeting new people' (66%) and 'improving my mental health or wellbeing' (58%).

Participants reported very high levels of satisfaction with the programme. There was strong agreement with statements that the activities were enjoyable, well-organised and well-publicised. 85% of respondents strongly agreed that they would like to see their club expand these kinds of activities in the future. Strong majorities also agreed that they would recommend the HCP activities to others and that they would participate in HCP activities themselves again (97% and 95% respectively).

This was supported by some very positive comments across both surveys:

"Healthy clubs are becoming the backbone of GAA clubs, bringing a new lease of life to clubs. It gives community members choice and is brilliant for the non-playing GAA member."

"I love the fact that the Healthy Club is inclusive for all. And serious issues like menopause, mental health, addictions etc are addressed in a safe and secure environment."

"My son takes part in the All Stars team. I find it to be an amazing outlet and am so delighted this programme is available."

Across all three surveys, participants reported an increase in physical activity (n=475), ranging from a 10% increase on the cross-project surveys to a 25% increase on the Irish Life Every Step Counts Challenge survey. On the retrospective survey, 40% of respondents reported that they had adopted healthier behaviours for themselves and/or their families since getting involved.

In line with these findings, respondents noted the importance of the health benefits to them:

"Excellent for physical, mental and emotional health"

"I have recently joined a gym"

"Recovering from long Covid and helpful for getting fitness levels back"

Consistent with the ToC for the programme, we expected to see wellbeing outcomes both directly (via the organised social activities) and indirectly (via the increased physical activity and social connectedness). Real-time data showed:

- Increases in life satisfaction (0.21-0.75,)
- Increases in connection to others (0.41-0.5)
- Improved community connectedness (0.64-0.68).

Although these may appear as small improvements, research finds that wellbeing tends to be quite resistant to change, meaning that even major life events like parenthood and partnership only lead to small improvements in life satisfaction. [1]

In addition, 51% of respondents told us that they had made new friends in their community and 17% had taken up a new hobby or activity since taking part.

Reflecting the quantitative findings above, respondents often mentioned community and social benefits in their free-text responses:

"I love these communities activities, great initiatives that make people more conscious about their health and it's easy to apply on a daily basis"

"I love the way that I feel more connected to my community and how welcoming everyone was towards me. I have established lifelong friendships"

"Our club has become the hub of our community with other services coming to us to ask for opinions, and support for other activities and also to be event holders"

FINDINGS FOR THE GAA

KEY FINDINGS

- 36% of participants were not closely connected to the GAA (members, players or volunteers)
- If we were to generalise from our survey to all unique participants (92,299), this translates to 38,227 individuals that were not closely connected to the GAA.
- 77% of retrospective respondents have gone on to do other activities of value to the GAA including joining, volunteering, taking part (themselves or their children) or attending games.
- 78% also told us that they had a better perception of the GAA as a result of taking part in HCP activities.

Although the HCP is ostensibly a community intervention, as discussed above, it emerged through stakeholder engagement that there are significant potential benefits for the GAA itself and these were also tested in the quantitative research.

As mentioned, about 11% of participants had no previous involvement with the GAA and 36% were not members, volunteers or players. If we

[1] Pretty, J., & Barton, J. (2020). Nature-based interventions and mind–body interventions: Saving public health costs whilst increasing life satisfaction and happiness. International journal of environmental research and public health, 17(21), 7769.

were to generalise from our survey to all unique participants (92,299), we would estimate that across the programme, it has engaged 10,152 individuals that had no previous involvement with the GAA and 38,227 individuals that were not closely connected to the GAA.

77% of retrospective respondents have gone on to do other activities of value to the GAA including joining, volunteering, taking part (themselves or their children) or attending games. 78% also told us that they had a better perception of the GAA as a result of taking part in HCP activities.

In the comments, several respondents mentioned the value of improving diversity, increasing the reach of the GAA and going beyond the Gaelic Games remit:

"This is a wonderful project to get the wider community involved in activities that were never available to them previously."

"Has brought some new life to the community and has given the understanding that the GAA is not just for those on the pitch."

"It gives a great opening for people not directly involved in playing with the club ...more and more [our club] is becoming the hub of the entire community... it's been a wonderful boost to our small rural club and community."

FINDINGS FOR VOLUNTEERS

KEY FINDINGS

- The HCP has 1912 active volunteers, giving 5 hours per week over an average 10.7 week period
- 62% had participated in a HCP activity prior to becoming HCO and for 25% of those this was their first involvement with the GAA
- 80% were motivated to volunteer because of a belief in the GAA's role in supporting the health and wellbeing of its community
- 89% were satisfied or very satisfied with their experience of being a volunteer
- Volunteers reported higher levels of life satisfaction, community connectedness and connection to other people than at baseline, However, their wellbeing was generally higher than the general population at baseline suggesting they do not have high needs in this area.

The HCP has 1912 active volunteers. Data captured from the clubs on volunteering suggests an average input of 5 hours per volunteer per week over an average 10.7 week period of activity per annum.

Before becoming Healthy Club Officers, 70% had been members or volunteers, and 30% had been players. 62% had participated in a HCP activity prior to becoming HCO and for 25% of those this was their first involvement with the GAA. These data suggest that HCP volunteers are currently quite embedded in the GAA and local area. But, over time, we would expect to see this increase as the programme reaches new communities.

The main motivation for volunteering is a belief in the GAA's role in supporting the health and wellbeing of its community (80%). Other common motivations include: giving something back, passion for their club (both 60%) and promoting a particular activity (47%).

The volunteering experience is reported on very positively (89% were either satisfied or very satisfied). Large majorities agreed that they found the experience rewarding, understood and could implement the programme, felt supported, were motivated to continue and would recommend the role to others.

Research finds that Volunteers tend to have healthier lifestyles, lower incidence of mental ill health, and live longer.[2] In Irish research, volunteering, community involvement and civic engagement have been found to correlate positively with social capital measures.[3] Consistent with this, volunteers also reported higher levels of life satisfaction (0.85), community connectedness (1.6) and connection to other people (1.3) than at baseline. These improvements in wellbeing are higher than for participants.

One caveat is that volunteer needs in these areas are low given how high the baseline scores are. Endogeneity is often a criticism of correlations between volunteering and wellbeing and we see this in this dataset also: people who chose to volunteer had higher than average wellbeing prior to volunteering. However, we also see significant increases over a relatively short period of time and this supports the wider literature on the wellbeing benefits of volunteering.

[2] Pretty, J., & Barton, J. (2020). Nature-based interventions and mind–body interventions: saving public health costs whilst increasing life satisfaction and happiness. International Journal of Environmental Research and Public Health, 17(21), 7769.

[3] Healy, T. (2005). The level and distribution of social capital in Ireland. Journal of the Statistical and Social Inquiry Society of Ireland, 35, 56.

Some of the qualitative responses support these findings:

"Getting involved as the HCO has been so reciprocally rewarding for me. As a club member with a very poor playing background it helped me to stay active in the club and to support my sons involvement in the senior team. It has been rewarding for me personally, in my family and has deepened my connection with the community."

"I have thoroughly enjoyed taking part and setting up the healthy club in my club."

"... overall it has been a great escape"

FINDINGS FOR CLUBS

KEY FINDINGS

- Baseline data for clubs entering the programme in 2022 (Phase 5 clubs) showed a lot of room for improvement on club-level obectives (e.g., only 10% had a smoke and vape free campus, only 20% provided healthy food following games and about half of clubs were monitoring bullying incidents.)
- There were significant improvements at follow-up including 92% reporting their club has an inclusive and welcoming atmosphere and 77% that the membership reflects the local community
- There were small improvements in the perception of the difficulty in recruiting and retaining volunteers, however, these are still challenges experienced by the clubs (only 28% agreed that they had not difficulty recruiting volunteers at follow up.

Baseline data from the club survey showed some room for improvement on key healthy club policies. For example, only 10% had a smoke and vape free campus, only 20% provided healthy food following games and about half of clubs were monitoring bullying incidents.

At follow-up, we can see improvements across all areas, especially the utilisation of facilities, the offer to non-playing members and the prioritisation of health and wellbeing. At follow-up 92% thought their club has an inclusive and welcoming atmosphere and 77% that the membership reflects the local community.

Retention of volunteers is not a major problem for clubs but it also increased from 36% to 45% between baseline and follow-up. As identified in the qualitative research, recruiting volunteers remains a challenge. Although we see a small increase in the proportion agreeing that they have no difficulty in recruiting volunteers, this is still only 28% at follow-up. 43% of clubs disagreed with this statement at follow-up and 9% strongly disagreed (down from 13% at baseline). However, It should be remembered that these clubs have just started out on their healthy club journey and this is the right direction of travel. They may experience further downstream benefits from greater inclusivity and use of facilities. As one respondent put it:

"I hope that it continues to incrementally improve. This is a marathon, not a sprint."

There were positive endorsements of the programme provided by some respondents:

"...The energy that the HCP has delivered has led to successful applications for over 80k in funding to develop access to health and wellbeing facilities at the club for new users as well as our core base of playing members."

"Our two flagship programmes...have been extremely well supported. Feedback has been very positive and we are encouraged to continue these programmes next year."

"The HC project is a fantastic idea and will reap huge benefits for clubs and more importantly communities."

Respondents also provided some recommendations for ways in which they would like to see the programme develop, and identified some areas in which they needed support:

- Workshops for pre-teens on racism and discrimination, healthy minds and body, and first aid
- Development of green clubs initiatives (e.g. littering on the sideline was identified as an issue)
- Financial assistance towards first aid, side-line first aid and CPR training
- Group activities for older men who are difficult to engage
- More insurance cover for activities
- Greater connection with other HC Volunteers to get ideas and build confidence in the role
- More support for writing up the portal
- Support with cross-community engagement in Northern Ireland

6 Valuation

This section summarises the findings from the SROI model. A full description of the approach and technical details can be found in Appendix 5.

APPROACH TO VALUATION

The SROI model includes benefits to three stakeholder groups: participants, volunteers and wider society. The GAA and clubs are excluded due to a lack of data to link them to monetisable outcomes. For wider society outcomes, we have inferred benefits to the health services from changes in health behaviours.

For participants and volunteers, we have used the WELLBY approach in line with the latest guidance for wellbeing appraisal developed by the UK Treasury.[1]

We know that wellbeing is a multifaceted concept. The WELLBY assumes that the underlying change in wellbeing is 'total' (i.e. as well as directly measuring changes in life satisfaction, it captures any factors that contribute towards it). In the case of the HCP, these contributing factors would include social capital and physical health benefits, which the WELLBY value therefore encapsulates.

Although more research on social capital and sport is required, from the available evidence it appears increasingly likely that the social element of sports is just as important as the physical in organisations like the GAA, and that this involvement may be beneficial for health independently of the physical benefits of playing.

For the health services, we have used secondary data on the effectiveness of social prescribing (e.g. prescribing lifestyle changes) to link participant outcomes with reductions in the use of GP, outpatient and inpatient services.[2]

Throughout the analysis, we have used the most conservative estimates at all time to ensure that the analysis does not overclaim benefits.

ADDITIONALITY

Additionality describes the net benefit of an organisational activity or intervention beyond what would have happened anyway without the intervention. To fully capture additionality an experimental research design is required (i.e. the use of a control group). However, place based initiatives, such as this one, operate as open systems – that is, they are in a constant state of interaction with their environment, which makes them unsuitable for controlled trials.

Yet, rather than assume all observed outcomes are additional, we have made some assumptions on additionality from the available data. Data from the club survey finds that 62% of activities are new activities that have started as a result of the HCP. In addition, we made an estimate of attribution (i.e. the proportion of the observed outcome that was as a result of the HCP rather than other factors). This was the percentage that stated that the programme influenced their physical activity outside of the programme either 'a great deal' or 'a lot' (41%).

[1] HM Treasury (2021) Wellbeing Guidance for Appraisal: Supplementary Green Book Guidance https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/1005388/Wellbeing_guidance_for_appraisal_-_supplementary_Green_Book_guidance.pdf

[2] In the Republic of Ireland savings will accrue to the HSE and in Northern Ireland savings will accrue to the NHS

INPUTS

There are three inputs that we have included in the model. First, we have cash donations that cover the running costs of the programme. As well as the GAA itself, funding is provided by Irish Life, the HSE/National Office of Suicide Prevention and the Tomar Trust. Amounts from these sources total €755,783 per annum.

In line with SROI guidance, volunteers are treated as both an input and an outcome in the model. The number of hours invested by volunteers in the programme is approximately 102,292 annually, and we can value this using the minimum wage at €1.1 million. However, this compares with health and wellbeing benefits to volunteers of €3.7 million.

Finally, we know that the programme could not operate without the support of the wider GAA facilities and infrastructure. A comprehensive SROI requires us to include the value of this in-kind benefit. We put a conservative estimate of 100% of running costs (€755,793). This brings the total input costs to €2.4 million.

TOTAL VALUE AND SROI RATIO

The total value of the programme is almost €50 million. The largest beneficiary group is participants with an annual value of €45 million.

The SROI ratio compares the input cost of the programme with the benefits. The headline return ratio is therefore 19:1, suggesting that €20 of value is generated for €1 of financial, volunteer and in-kind investment. For the HSE/NOSP, which contributes €140,000 of funding, the benefit from savings to the health service is 4.4:1.

Finally, as we have seen, benefits to volunteers outweigh the volunteer inputs by a ratio of 3.5:1.

Due to the lack of longitudinal data, we have only assumed one year of benefit. Were we to see the benefits become a structural feature of participant's lives, the value would increase. The benefit set out here should therefore be considered an underestimate of the true value.

7 Recommendations

This section sets out the recommendations that emerged from all of the strands of research described above.

SCALING AND FUNDING THE HCP.

Based on the evidence presented in this report, there is a clear case for mainstreaming/scaling the HCP and using it as a mechanism for further health promotion. However, the programme will require more support for clubs and the national team if the remaining recommendations are to be achieved.

There is a case for future funding coming from both within and outside of the GAA. The programme brings clear benefits to the GAA, practically and reputationally, and is of clear strategic importance. Some of the priority areas (e.g., substance use and gambling) are externalities for the GAA as they are partly generated by sport in general and by wider societal cultural norms. The GAA has taken a leadership role here, banning gambling sponsorship at all levels of the Association and by not accepting alcohol sponsorship for inter-county level competitions or teams. Nonetheless, it may continue to benefit indirectly and HCP activities in this area enable the GAA to further offset its impact in these areas.

In addition, wider health and wellbeing benefits merit increased public funding, especially where the programme can demonstrate an ability to reach important target groups.

STRONGER FOCUS ON UNMET NEEDS/ TARGET GROUPS

Although the programme is having success in reaching some of its target groups (i.e. women and those that have recently moved to the area), there is more to be done to further its goals of expanding outside the traditional population base. Data suggest that minority groups, older people, and people with additional needs are underrepresented. Whilst this is by no means unique to the GAA/HCP,[1] as a key objective of the programme is progress towards this it is important to highlight. Moreover, due to wider issues with diversity in sport, it is even more pressing that the HCP has a robust response to promote inclusivity.

Data are not available on participation by income groups, but we know that access to sport follows a social gradient in Ireland[2] and we might expect lower rates of participation by people from disadvantaged backgrounds. In addition, the data show that baseline wellbeing scores are above average suggesting on average that the programme is reaching people with lower needs.

Following the logic of working with people's starting points, the HCP should consider what kinds of approaches, communications and activities would encourage participation from these target groups. This not only helps to reach HCP objectives but – as the research shows – is starting to benefit the GAA by broadening the pool of members and by providing a gateway to volunteering and participation in Gaelic games by non-traditional groups. Lessons can also be drawn from experience of the burgeoning All Star programme for persons with additional needs (details of which can be found in the case study in Appendix 6)

It should be noted however that this is a larger objective for the GAA than can be achieved through the HCP. For example, gender and diversity representation need to be reflected in management structures at club, county and national level. The potential for the HCP to provide further pathways for female leadership into executive roles needs to be harnessed and replicated across other parts of the organisation. The traditional pathway into officer roles in the GAA has been from retired players. As these are currently all male this should be broadened through the national integration process with LGFA and Camogie.

[1] Sport Ireland, Diversity and Inclusion in Sport https://www.sportireland.ie/sites/default/files/media/document/2022-05/Sport%20Ireland%20Policy%20on%20Diversity%20and%20Inclusion%20in%20Sport.pdf

[2] Lunn, P. (2006). Fair play?: Sport and social disadvantage in Ireland. ESRI.

COMMUNICATING THE BENEFITS OF VOLUNTEERING

As discussed above, the GAA runs a highly successful volunteering model[3] that is the envy of other sporting and non-sporting organisations. However, this was described as 'fragile' with administrative and regulatory barriers taking their toll.

The HCP creates an additional burden on the volunteering model (i.e. another post that had to be created). The findings here show that the benefits of volunteering -which are widely demonstrated in other research - outweigh the costs. This finding should be communicated to volunteers, whilst also acknowledging the in-kind benefit that they bring to the GAA through their unpaid work.

BRANDING AND COMMUNICATIONS

GAA clubs have always operated to serve their local communities and respond to local needs, and as our case studies show (see Appendix 6), local people are taking initiative to respond to the needs in their communities. Our research has therefore taken account of additionality and it is important that this is part of the story of the HCP.

On the other hand, the internal communications and branding of the HCP is often weak. The HCP may have been instrumental in supporting an activity to get off the ground, but this is not necessarily well-understood by the volunteers and participants. Better internal communications are therefore required to ensure that the understanding of the impact of the HCP is more successful.

This is not just about promoting the HCP brand but about ensuring that the objectives and ethos are shared by participants to create a greater sense of belonging to the everyday health movement. This should work alongside any new communications strategy to reach underrepresented groups as described above. It should also plug into any national GAA communications/marketing strategy: elevating the profile of the HCP helps demonstrate the Association's commitment to its values and communities, while bringing to life its manifesto 'Where We All Belong'. As with the other recommendations set out here, any additional communications work undertaken by HCP staff will require resourcing.

USE OF GAA FACILITIES

The size and quality of GAA facilities are immense. Even the smallest rural communities have enviable, well-maintained sporting and community facilities. Indeed, in our case study research, we found that these can be lifeblood for the community where there are limited places to gather (see **Appendix 6**).

Part of the goal of the HCP is to ensure that good use is made of these facilities. Our club survey shows that volunteers believe that a significant improvement has been made compared with baseline (at follow up 90% either agree or strongly agree that they are being well-utilised compared with 59% at baseline). By extending the facilities for use beyond Gaelic games and those within their playing years, the HCP has the potential to create significant value. This is especially pertinent in the context of limited funding available for community sports and facilities. It is important that this outcome continues to be monitored to ensure that facilities are maximised.

BALANCING 'TOP DOWN' & 'BOTTOM UP' PRIORITIES

In line with the GAA ethos, the HCP funds locally defined goals and allows for the clubs to develop their project ideas at the grassroots. This is a very important part of the programme and a key strength. In practice however, some of the more successful activities - All-Stars inclusive programmes, Ireland Lights Up and Gaelic for Mothers and Others to name but a few – have been replicated across the country. This is also a strength of the programme.

Whilst the team manages the top down/bottom-up tension well, there may be a case for providing some more direction for clubs such that activities are better connected to national priorities/health needs. A greater focus on mental health and physical activity amongst target groups are some of the areas that have already been mentioned as requiring greater focus. We would recommend therefore, communicating with clubs about these needs and identifying evidence-based programmes that could be trialled and potentially replicated.

However, it must be recognised that what can be achieved by a small delivery team and volunteers is limited, particularly as it seeks to increase the diversity of participants. There may be an opportunity for a more active role for key stakeholders such as the HSE that could utilise networks including the Health Promotion and Improvement Unit. For example, the HCP could be formally included in its plan of work as a delivery network.

[3] Lane, A., Murphy, N., Regan, C., & Callaghan, D. (2021). Health promoting sports club in (practice: a controlled evaluation of the GAA Healthy Club Project. International journal of environmental research and public health, 18(9), 4786.

8 Conclusions

The Healthy Club Programme is emblematic of the direction of travel for the GAA in 21st century Ireland. It aims to be an inclusive, progressive, and dynamic programme that improves health and wellbeing by reaching people across the community.

The findings from this evaluation suggest that much progress is being made towards this goal. The HCP has been widely adopted, with thousands of active volunteers and tens of thousands of participants engaging in varied, needs-led activities. The economic analysis shows that, even on a conservative basis, the value of the prevention achieved thus far substantially outweighs the cost of investment.

However, there is more to be done and this is especially important in the context of rising and more complex health needs, widening health inequalities and limited public resources to address them.

Within the clubs, there was a sense that healthy behaviours were being mainstreamed. This was thought to potentially remove the need for the project over time as all clubs became healthy clubs. This was also the case where HCP activities were embedded and had a 'life of their own'. Where this is happening, it is evidence of the settings approach in action (i.e. where the lines between the intervention and mainstream behaviour become blurred). However, it was thought that there would continue to be a role for the HCP as new health challenges emerge and to ensure a focus on hard-to-reach groups: older men, adolescent girls, new communities and the very inactive.

Achieving sustained behaviour change in health is extremely challenging,[1] as it requires permanent changes to the brain and body that only occur from repeated practice. [2] If the HCP can demonstrate that this is possible, especially amongst groups with the greatest health needs, the benefits would be considerably greater than those described in this evaluation.

[1] Kelly, M. P., & Barker, M. (2016). Why is changing health-related behaviour so difficult? Public health, 136, 109-116.

[2] Pretty, J., & Barton, J. (2020). Nature-based interventions and mind–body interventions: Saving public health costs whilst increasing life satisfaction and happiness. International journal of environmental research and public health, 17(21), 7769.


Healthy Club


Irish Life
GAA
Healthy
Clubs

Appendix 1: Literature Review

1.1 INTRODUCTION

Good health is an important part of what constitutes a good life, and being in either good or bad health has profound implications for people's chances of leading a fulfilling and happy life.[1]

Due to dramatic advances in healthcare, life expectancy has improved steadily over the past half century.[2] At the same time, the incidence of a range of non-communicable diseases (NCDs) has increased, the costliest of these including mental ill health, dementias, diabetes, loneliness and cardiovascular diseases.[3]

As we live longer lives, this increases the pressure on health services and the challenge of achieving healthy aging remains a pressing concern in developed countries. In addition, inequalities in health outcomes remain stubbornly high and, in some countries, have been on the increase.[4]

Whilst there has long been an understanding of the value of prevention, this agenda has taken on a new impetus due to the pressures of an aging population and rising associated costs.[5] In Ireland, 90% of the total healthcare budget is spent on the 30% of the population with chronic diseases.[6]

Place-based health interventions have become more widespread as a means to promote behaviour change and increase the balance of positive health behaviours relative to negative ones. However, achieving prevention through behaviour change is difficult[7] and successful public health responses at the population-level remain rare.[8] Programmes designed at the population-level are fundamentally different to those designed around individuals, as they must reach large numbers of people with effective low-cost interventions.[9] Since the end of the Covid-19 pandemic, there has been a decline in sports participation and volunteering and whilst there was a small narrowing of the age and gender gaps in 2022, there was a widening of the social gradient in sport participation.[10]

A 'settings approach' to public health promotion identifies the places and social contexts where people live, work and socialise to disseminate health promotion ideas and activities. Sports organisations have increasingly been recognised as appropriate locations for this approach.[11]

The literature review was carried out as part of the Irish Life GAA Healthy Club Programme (HCP) evaluation, the full findings of which can be found here.

The purpose of the review is to locate the programme within the Irish context and to relate it to international best practice in the field of place-based health promotion.

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1 OECD (2019) Better Life Index https://www.oecdbetterlifeindex.org/topics/health/

2 Ezzati, M., Friedman, A. B., Kulkarni, S. C., & Murray, C. J. (2008). The reversal of fortunes: trends in county mortality and cross-county mortality disparities in the United States. PLoS Med, 5(4), e66.

3 Pretty, J., & Barton, J. (2020). Nature-based interventions and mind–body interventions: Saving public health costs whilst increasing life satisfaction and happiness. International journal of environmental research and public health, 17(21), 7769.

4 Marmot, M. (2020). Health equity in England: the Marmot review 10 years on. Bmj, 368.

5 Pretty, J., & Barton, J. (2020). Nature-based interventions and mind–body interventions: Saving public health costs whilst increasing life satisfaction and happiness. International journal of environmental research and public health, 17(21), 7769.

6 RCPI (2017) Response to Public Consultation for 'Ireland 2040 – Our Plan'https://www.npf.ie/wp-content/uploads/2017/09/0348-Royal-College-of-Physicians-of-Ireland.compressed.pdf

7 Kelly, M. P., & Barker, M. (2016). Why is changing health-related behaviour so difficult?. Public health, 136, 109-116.

8 Pretty, J., & Barton, J. (2020). Nature-based interventions and mind–body interventions: Saving public health costs whilst increasing life satisfaction and happiness. International journal of environmental research and public health, 17(21), 7769.

9 Davis, A., & Herman, E. (2011). Considerations and challenges for planning a public health approach to asthma. Journal of Urban Health, 88, 16-29.

10 Sport Ireland (2022) Irish Sports Monitor https://www.sportireland.ie/sites/default/files/media/document/2023-08/2022%20ISM%20Full%20Report%20200829.pdf

11 Lane, A., Murphy, N., Regan, C., & Callaghan, D. (2021). Health promoting sports club in practice: a controlled evaluation of the GAA Healthy Club Project. International journal of environmental research and public health, 18(9), 4786.

There were four strands to the review:

1. Health and wellbeing needs in Ireland
2. Sport and social capital
3. The effectiveness of place-based health interventions
4. The effectiveness of the settings approach
5. Previous SROIs in sport

This section also discusses challenges in evaluating these types of initiatives.

1.2 HEALTH AND WELLBEING NEEDS IN IRELAND

Ireland has seen some significant improvements in public health in recent decades, most notably a large improvement in life expectancy, which, at 83 is now amongst the highest in the EU.[12] This increase was driven by sharp reductions in mortality from cardiovascular diseases and cancer because of changes in risk factors (such as smoking), and improved treatments.

Several negative lifestyle issues remain, and 35% of all deaths in Ireland in 2019 could be attributed to behavioural risk factors, including tobacco smoking, dietary risks, alcohol consumption and low physical activity.[13] Although tobacco smoking has dropped to slightly below the EU average (17%), nearly one-third of adults report regular heavy alcohol intake, which is well above the EU average. There are signs that alcohol consumption among younger people has peaked and adolescent binge drinking across Europe is at its lowest level since 2003.[14] In Ireland, binge drinking among adolescents is now less widespread than across the EU (28% compared to 38%).

Overweight and obesity rates have also increased (18% amongst adults and 19% amongst adolescents), pushing them above the EU average. Around one-third of Irish adults consume unhealthy foods at least once a day, however a high proportion of Irish adults consume vegetables daily and they are also among the most physically active in the EU.[15] A pre-pandemic report by Sport Ireland showed that participation in sport in Ireland was on the increase, with close to half of people reporting that they participated in sport at least once in the past week.[16] Ireland consistently had a higher prevalence of mental health disorders than the EU 27 average across all age groups, but especially amongst young people, and women and girls. [17],[18]

Despite some mixed objective health indicators, Ireland consistently has the highest self-perceived health status in the EU,[19] as well as high self-reported wellbeing.[20] High self-reported health and wellbeing tend to be associated with countries with strong social security and health systems (such as in Scandanavia),[21] [22] making Ireland something of an outlier.

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12 Government of Ireland (2022) Health in Ireland: Key Trends 2022 https://www.gov.ie/pdf/?file=https://assets.gov.ie/241598/8a6472b4-83cf-45ec-88c9-023e0c321d8c.pdf#page=null

13 European Commission (2021) State of Health in the EU: Ireland Country Health Profile 2021 https://health.ec.europa.eu/system/files/2021-12/2021_chp_ir_english.pdf

14 EMCDDA (2016) The 2015 ESPAD Report http://www.espad.org/report/home

15 Eurostat (2019) Statistics on sport participation https://ec.europa.eu/eurostat/statistics-explained/index.php?title=Statistics_on_sport_participation&oldid=542365

16 Sport Ireland (2019) Irish Sports Monitor https://www.sportireland.ie/sites/default/files/media/document/2020-09/irish-sports-monitor-2019-report-lower-res.pdf

17 Lynch, F Mills, C Daly, I Fitzpatrick, C Challenging times: a study to detect Irish adolescents at risk of psychiatric disorders and suicidal ideation. J Adolesc 2004; 27: 441-51.

18 Government of Ireland (2023) The Mental Health of Children and Youth People in Ireland file:///C:/Users/eilis/Downloads/255533_1a16e7f3-f24a-4f77-a98a-755d262ecab4.pdf

19 Government of Ireland (2022) Health in Ireland: Key Trends 2022 https://www.gov.ie/pdf/?file=https://assets.gov.ie/241598/8a6472b4-83cf-45ec-88c9-023e0c321d8c.pdf#page=null

20 OECD (2012) Exploring Determinants of Subjective Wellbeing in OECD Countries: evidence from the World Values Survey https://www.oecd-ilibrary.org/content/paper/5k9ffc6p1rvb-en

21 Samuel, R., & Hadjar, A. (2016). How welfare-state regimes shape subjective well-being across Europe. Social Indicators Research, 129, 565-587.

22 Delaney, L., Wall, P., & O'hAodha, F. (2007). Social capital and self-rated health in the Republic of Ireland: Evidence from the European Social Survey. Irish Medical Journal, 100(8), 52-56.

1.3 SPORT AND SOCIAL CAPITAL

One explanation for the gap between subjective and objective data in Ireland is that subjective reports are mediated by above average social capital.[23] [24] Evidence consistently shows an association between these indicators and health status. In a meta-analysis of international research Gilbert et al.[25] reported that social capital indicators have a strong and consistent positive relationship with self-reported health with the behaviours of reciprocity and trust being the strongest predictors. Self-rated health has also proved to be a good predictor of future health care needs and mortality.[26] Conversely, loneliness and social isolation have been found to significantly increase mortality.[27] Loneliness also increases annual GP visits 1.8-fold and annual A&E visits 1.6-fold.[28]

Volunteers tend to have healthier lifestyles, lower incidence of mental ill health, and live longer.[29] In Irish research, volunteering, community involvement and civic engagement have been found to correlate positively with social capital measures.[30]

The GAA is a major facilitator of voluntarism in Ireland, although recent data on the scale of this is currently not available. ESRI research from 2005[31] found that:

- 6 per cent of the adult population, or 42 per cent of all sports volunteers, volunteer for the GAA, compared with 17% for the next largest sport: soccer.
- A third of sports memberships are with the GAA (which uniquely has more members than players) with a relatively even spread of membership by age and social class
- 60% of all attendances were at GAA games
- 60 per cent of men and 51 per cent of women considered that making new friends and acquaintances was an important benefit they obtained from sport

Although more research on social capital and health is required, it appears increasingly likely that the social element of sports is just as important in organisations like the GAA, and that this involvement may be beneficial for health independently of the physical benefits of playing. As Delaney and Fahey argue: "sports policy in Ireland should recognise those social aspects of sport, taking account of the social bonding, community involvement and general contribution to the effective functioning of society which they help bring about, and frame policy accordingly".[32] Promoting those relationships is a key objective of the HCP and will be explored further in this research.

1.4 THE EFFECTIVENESS OF PLACE-BASED HEALTH INTERVENTIONS

Community-based interventions refer to multicomponent interventions that generally combine individual and environmental change strategies across multiple settings aiming to promote well-being among population groups in a defined local community.[33] Evidence on the effectiveness of community-based health interventions is somewhat mixed.

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23 Durand, M. (2015). The OECD better life initiative: How's life? and the measurement of well-being. Review of Income and Wealth, 61(1), 4-17.

24 Patterson, J. M., Eberly, L. E., Ding, Y., & Hargreaves, M. (2004). Associations of smoking prevalence with individual and area level social cohesion. Journal of Epidemiology & Community Health, 58(8), 692-697.

25 Gilbert, K. L., Quinn, S. C., Goodman, R. M., Butler, J., & Wallace, J. (2013). A meta-analysis of social capital and health: a case for needed research. Journal of health psychology, 18(11), 1385-1399.

26 Singh-Manoux, A., Guéguen, A., Martikainen, P., Ferrie, J., Marmot, M., & Shipley, M. (2007). Self-rated health and mortality: short-and long-term associations in the Whitehall II study. Psychosomatic medicine, 69(2), 138.

27 Holt-Lunstad, J. (2021). Loneliness and social isolation as risk factors: The power of social connection in prevention. American Journal of Lifestyle Medicine, 15(5), 567-573.

28 Pretty, J., & Barton, J. (2020). Nature-based interventions and mind–body interventions: saving public health costs whilst increasing life satisfaction and happiness. International Journal of Environmental Research and Public Health, 17(21), 7769.

29 Pretty, J., & Barton, J. (2020). Nature-based interventions and mind–body interventions: saving public health costs whilst increasing life satisfaction and happiness. International Journal of Environmental Research and Public Health, 17(21), 7769.

30 Healy, T. (2005). The level and distribution of social capital in Ireland. Journal of the Statistical and Social Inquiry Society of Ireland, 35, 56.

31 Delaney, L., & Fahey, T. (2005). Social and economic value of sport in Ireland (pp. 16-23). Dublin: Economic and Social Research Institute. https://www.esri.ie/system/files?file=media/file-uploads/2015-08/BKMNINT180.pdf

32 Ibid.

33 International Encyclopedia of Public Health (Second Edition) (2017) Commmunity-based Interventions https://www.sciencedirect.com/topics/medicine-and-dentistry/community-based-intervention

A systematic review from 2003 found that community-based programmes – with the notable exception of HIV prevention programmes – have had only modest impact.[34] In 2014, Fry et al. report that community-based programmes have been found to be influential in changing individual behaviour and health-related community policies but do not produce significant changes in health outcomes, even over the long-term.[35] Their own systematic review found no significant impact on objective or subjective measures of health once controls were introduced. Further systematic reviews of interventions to improve physical activity and reduce smoking found disappointing results.[36] [37]

However, these studies have been hampered by a lack of good quality evaluation data and it may be that they are having some impact that their potential was not being fully realised.[38]

The challenge for these programmes is to mount a sufficient countervailing challenge to reverse widening trends in health inequalities, and evidence of this happening has not yet been observed in the data.[39] It is especially difficult to link interventions like parenting courses, or health promotion with tangible health outcomes. Finally, creating lasting health changes in the context of wider local economic dynamics is very challenging. In response to the measurement challenge, Petersen (2002) argues that measures of social capital are a good 'leading indicator' of these health outcomes.

1.5 THE SETTINGS APPROACH

Taking a settings approach to health promotion means addressing the contexts within which people live, work, and play and making these the object of inquiry and intervention. It is rooted in a socio-ecological model (SEM), which moves away from individual understanding of health promotion and instead integrates the material, biological, social, and cultural aspects of public health.[40]

The approach also takes account of the needs and capacities of people to be found in different settings.[41] The goal of the settings approach is to create supportive environments for optimal health. The model's key principles include flexibility, community participation, partnership, empowerment, and equity.[42]

The previous evaluation of the HCP as a settings approach43 found that clubs using the structures demonstrated a commitment to health and community engagement as well as a significant improvement in their overall orientation to health promotion, compared with controls. They also found that the health promotion message is pervading into many aspects of the GAA club.

1.6 PREVIOUS SROI REPORTS IN SPORT

The economic benefits of sport are reasonably well-researched and several countries have estimated the contribution to GDP from sport. These range from 1% in Canada, 1.7% in the UK to 2% in the US and Hong Kong.[44] A more recent study for Australia

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34 Merzel, C., & D'Afflitti, J. (2003). Reconsidering community-based health promotion: promise, performance, and potential. American journal of public health, 93(4), 557-574.

35 Fry, C. E., Nikpay, S. S., Leslie, E., & Buntin, M. B. (2018). Evaluating community-based health improvement programs. Health Affairs, 37(1), 22-29.

36 Baker, P. R., Francis, D. P., Soares, J., Weightman, A. L., & Foster, C. (2015). Community wide interventions for increasing physical activity. Cochrane Database of Systematic Reviews, (1).

37 Ogilvie, D., & Petticrew, M. (2004). Reducing social inequalities in smoking: can evidence inform policy? A pilot study. Tobacco Control, 13(2), 129-131.

38 Nickel, S., & von dem Knesebeck, O. (2020). Do multiple community-based interventions on health promotion tackle health inequalities?. International Journal for Equity in Health, 19(1), 1-13.

39 Crew, M. (2020). The Effectiveness of Place-Based Programmes and Campaigns in Improving Outcomes for Children: A Literature Review. A National Literacy Trust Research Report. National Literacy Trust.

40 Geidne, S., Kokko, S., Lane, A., Ooms, L., Vuillemin, A., Seghers, J., ... & Van Hoye, A. (2019). Health promotion interventions in sports clubs: can we talk about a setting-based approach? A systematic mapping review. Health Education & Behavior, 46(4), 592-601.

41 Poland, B., Krupa, G., & McCall, D. (2009). Settings for health promotion: an analytic framework to guide intervention design and implementation. Health promotion practice, 10(4), 505-516.

42 Neufeld, J., & Kettner, J. (2014). The settings approach in public health: thinking about schools in infectious disease prevention and control. National collaborative center of infectious diseases: University of Manitoba.

43 Lane, A., Murphy, N., Regan, C., & Callaghan, D. (2021). Health promoting sports club in practice: a controlled evaluation of the GAA Healthy Club Project. International journal of environmental research and public health, 18(9), 4786.

44 Nana, G., Sanderson, K., & Goodchild, M. (2002). Economic impact of sport. Hong Kong Sports Institute. https://citeseerx.ist.psu.edu/document?repid=rep1&type=pdf&doi=c7f935f848a437c4ce3a7d5e85ce13aa77577954

found it to be 2-3%.[45] This may reflect the fact that the contribution of sport is thought to be on the increase due to the growth in markets that are related to the sports sector.[46] Sport Ireland have estimated the Gross Value Added (GVA) contribution of sport to be 1.4%, up from 1.1% a decade previously.[47]

Benefits that have been established include:

- Direct economic benefits from jobs, income and taxation revenue within sporting organisations
- Indirect economic benefits from jobs, income and taxation revenue via ancillary services such as tourism and entertainment
- Indirect economic benefits from health and wellbeing (e.g. productivity and reduced absenteeism and disability benefits)
- Indirect economic benefits from improved child development and education
- Reduced healthcare costs

However, negative impacts have also been quantified in some studies including the public sector costs of hosting major sporting events,[48] sporting injuries, substance use, problem gambling and antisocial behaviour.[49]

Although there are many sources of economic benefit, many argue that these still do not capture the intangible – yet potentially highly valuable - impacts of sport.[50],[51] SROI provides a framework for capturing benefits like social connections, wellbeing, civic pride and volunteering.[52]

Consequently, there has been substantial growth in the use of the SROI methodology. A recent systematic literature review produced a final data set of 284 SROI studies relating to sport. In line with the wider research on the value of sport, SROI ratios tend to be very positive, and the review reported ratios of between 3:1 and 124:1.[53]

Although there is widespread agreement on the need for methods to assess social value both of sport and more generally, SROI has been the subject of some criticism in the academic field regarding its practical and conceptual limitations.[54],[55],[56] The limitations generally refer to the subjectivity in the choice of monetary values

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45 Hughes, D., Saw, R., Perera, N. K. P., Mooney, M., Wallett, A., Cooke, J., ... & Broderick, C. (2020). The Australian Institute of Sport framework for rebooting sport in a COVID-19 environment. Journal of science and medicine in sport, 23(7), 639-663.https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7200343/

46 Araújo Vila, N., Fraiz Brea, J. A., & de Araújo, A. F. (2019). Health and sport. Economic and social impact of active tourism. European journal of investigation in health, psychology and education, 10(1), 70-81.https://www.mdpi.com/2254-9625/10/1/7

47 Sport Ireland (2021) Researching the Value of Sport in Ireland. https://www.sportireland.ie/sites/default/files/media/document/2021-09/vos-report-final-19-07-21.pdf

48 Taks, M., Kesenne, S., Chalip, L., & Green, C. B. (2011). Economic impact analysis versus cost benefit analysis: The case of a medium-sized sport event. International Journal of Sport Finance, 6(3), 187.

49 Keane, L., Hoare, E., Richards, J., Bauman, A., & Bellew, W. (2019). Methods for quantifying the social and economic value of sport and active recreation: a critical review. Sport in Society, 22(12), 2203-2223.

50 Eckstein, R., & Delaney, K. (2002). New sports stadiums, community self-esteem, and community collective conscience. Journal of Sport and Social Issues, 26(3), 235-247.

51 Coalter, F. (2005). The social benefits of sport (Vol. 17). Edinburgh: SportScotland. https://sportscotland.org.uk/documents/resources/thesocialbenefitsofsport.pdf

52 Nicholls, J., Lawlor, E., Neitzert, E., Goodspeed, T., & Cupitt, S. (2017). A guide to social return on investment. London, the cabinet. Office. 2009.

53 Gosselin, V., Boccanfuso, D., & Laberge, S. (2020). Social return on investment (SROI) method to evaluate physical activity and sport interventions: a systematic review. International Journal of Behavioral Nutrition and Physical Activity, 17(1), 1-11.

54 Farr, M., & Cressey, P. (2019). The social impact of advice during disability welfare reform: from social return on investment to evidencing public value through realism and complexity. Public Management Review, 21(2), 238-263.

55 Green, K. R. (2019). Social return on investment: a women's cooperative critique. Social Enterprise Journal, 15(3), 320-338.

56 Maier, F., Schober, C., Simsa, R., & Millner, R. (2015). SROI as a method for evaluation research: Understanding merits and limitations. VOLUNTAS: International Journal of Voluntary and Nonprofit Organizations, 26, 1805-1830.

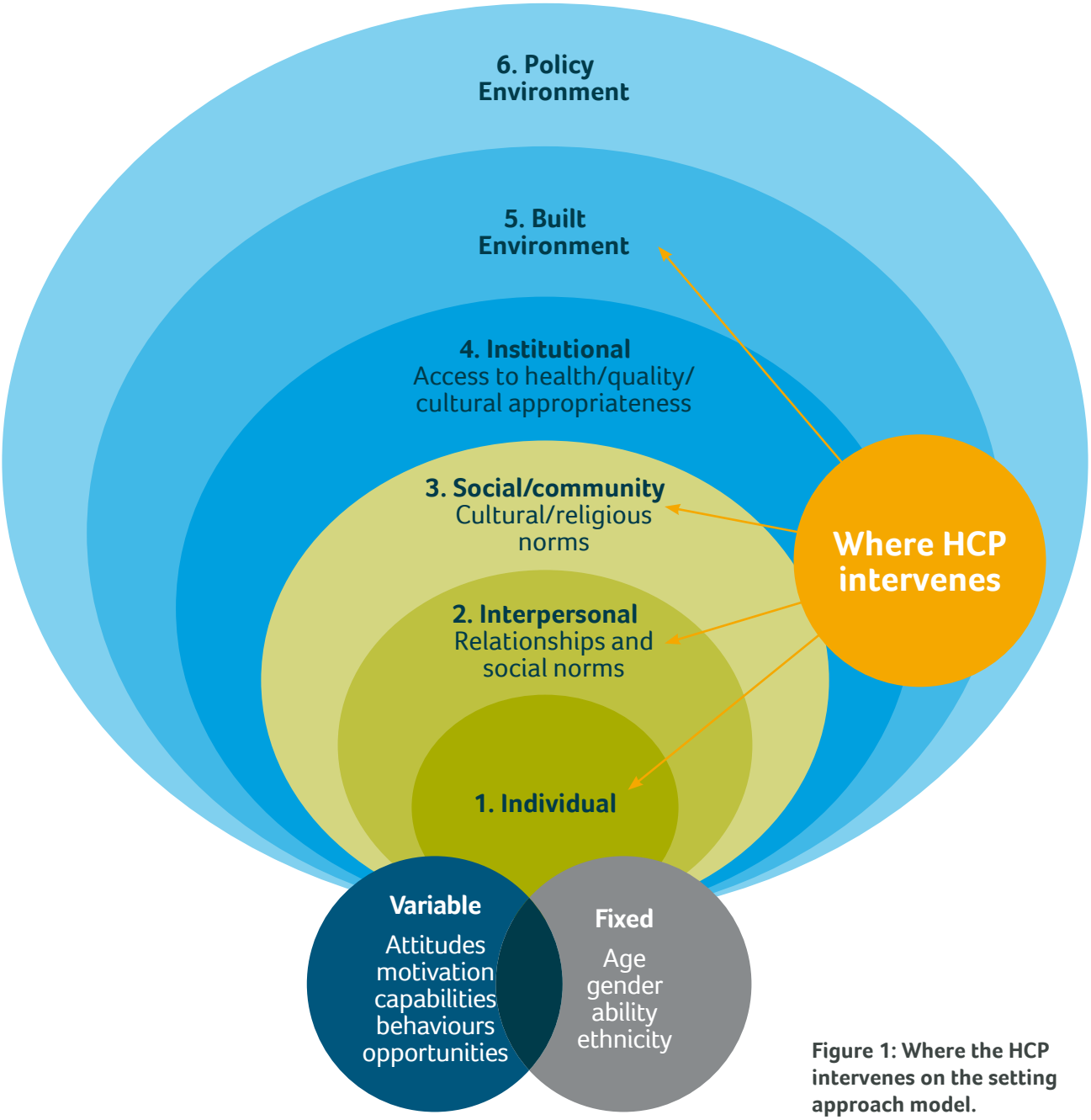


Figure 1: Where the HCP intervenes on the setting approach model.

and the quality of underlying data to support assumptions. For example, Gossellin et al found that less than half (47%) of the SROI studies in their review used quantitative methods to measure outcomes, suggesting that valuations were based on generalisations from qualitative findings. Although this departs from SROI guidance,[57] there is no rigorous assessment of the strength of these analyses to ensure that they meet accepted social science and SROI standards.

In light of these issues, it is important that comparisons of interventions are avoided (unless conducted as part of the same analysis). Even where the same valuation methods and assumptions are used, contextual factors can complicate the ability to directly compare interventions and should only be done with a deep understanding of how these can impact on observed outcomes.

An example of this is a recent high-profile SROI analysis conducted on behalf of UEFA and applied by the FAI to soccer in Ireland.[58] This study is based on a methodology developed for UEFA and shared with football associations internationally. It found that grassroots football in Ireland delivers €1.8 billion in value to Irish society.

Contrary to SROI guidance, the methodology has not been made publicly available due to commercial sensitivity.[59] However, from what can be deduced from the available reporting, there are important methodological differences between that study and the one presented here. These are as follows:

- The study has only included the benefits side of the balance sheet and not the costs. It has therefore not reported a return ratio as is common in SROI
- In line with that, it has assumed some inputs to soccer such as volunteering have a value of zero. Volunteering is only included as a benefit despite the considerable non-monetary contribution that volunteers make to sport
- The FAI benefits are based on international research on the value of being involved in sport but no direct measurement has taken place with sports participants. Whilst this has value, it a) does not give us much new information about the value of soccer in an Irish context and b) it does not generate real-world recommendations to support continuous improvement objectives explicit in all evaluation. Questions relating to who takes part, in what context and the specific benefits for subgroups of players are also absent
- The 'disbenefits' of soccer – substance use, gambling, anti-social behaviour, injuries - are not included

A final point to note is that the scope of the UEFA/FAI study is very different to the one set out here. We have only considered the benefits of a small inhouse project that represents a fraction of the GAA budget and social impact, whereas the UEFA/FAI study included the benefits of soccer nationally. Such an analysis of the GAA may be timely but is outside of the scope of what is presented here.

57 Nicholls, J., Lawlor, E., Neitzert, E., Goodspeed, T., & Cupitt, S. (2017). A guide to social return on investment. London, the cabinet. Office. 2009.

58 FAI (2021) UEFA SROI Study Confirms €1.8BN Impact https://www.fai.ie/domestic/news/uefa-sroi-study-confirms-%E2%82%AC18bn-impact

59 SROI was developed with philanthropic funding and was subject to a creative commons licence. The aim was to avoid the privatisation of the intellectual property underpinning it so as to further the social value it sought to reveal.

Appendix 2: Methodology

This appendix sets out the aims and objectives of the evaluation, key research questions, and provides an overview of the evaluation design and methodology.

2.1 EVALUATION AIMS

The evaluation follows the Social Return on Investment methodology, which is discussed more fully below.

It has three main aims and objectives:

1. Understanding the impact of the programme
2. Capturing learnings to strengthen the programme, especially relating to how the HCP model could be scaled
3. Establishing the cost-effectiveness of the approach

2.2 ABOUT SOCIAL RETURN ON INVESTMENT (SROI)

SROI is a framework for understanding, measuring and managing the outcomes of an organisation or intervention. It is particularly useful where an organisation has impacts across a 'triple bottom line' (i.e. social, economic and/or environmental), or where many stakeholder groups are affected. It was developed from social accounting and cost benefit analysis and has much in common with other outcome measurement approaches.

SROI is distinct from these methodologies in the following ways:

It includes benefits to all relevant stakeholder groups, not just those that accrue to the State, or 'the economy'.

It places a monetary value on all outcomes – including non-traded outcomes - so that they can be compared to the investment. This results in a ratio of total benefits to total investments. For example, an organisation might have a ratio of €4 of social value created for every €1 spent on its activities. The ratio aims, therefore, for a holistic representation of value.

It is principles-based to ensure that all SROIs follow a prescribed methodology

It is a participative methodology. Stakeholders are engaged at key stages of the analysis to ensure that the appraisal is 'measuring what matters'.

While the ratio is important, a good SROI combines qualitative, quantitative, and participative methods of evaluation and presents narrative and financial information that tells a story of change. The information should also help organisations focus on those activities that create the most social value to drive continuous improvement and maximise impact.

SROI is a relatively new methodology that has flourished outside of academia. Whilst this makes it very accessible, it also means that there is much variability in how it is applied, as it has lacked the peer review of other approaches. This means there is much variation in how it is applied. Consequently, it is important that comparisons of interventions are avoided. See Appendix 1 for a fuller discussion on the use of SROI in sport.

2.3 DATA COLLECTION

QUALITATIVE

55 individuals took part in the following qualitative data collection:

- Workshops (x3) with senior managers, the HCP steering group and volunteers to inform the Theory of Change
- Interviews with participants
- Case study research (x3)

Table 1 summarises the qualitative data collection

Case studies involved either an in-person visit, or where this was not practical an online workshop with participants and volunteers. Additional materials relating to the case study were also consulted. Between 7 and 10 individuals were involved in discussions with the researcher per case study.

Stakeholder group	Method of engagement	Number of people
The GAA	Workshop	14
HCP Steering group	Workshop	11
Volunteers	Workshop	7
Participants	Interviews	10
Total		43

Table 1: Stakeholder groups included in the research

QUANTITATIVE

Several sources of information were used to support findings on outcomes for participants (see Table 2 for a summary).

First, existing data collected by the clubs and inputted to a bespoke portal. These were mainly output data relating to participants, volunteers, gender and range of activities.

Second, a retrospective survey of participants from phases 1-4 (clubs that entered the programme before 2022) was developed to capture longer-term changes for participants. This was disseminated through social media and the Irish Life 'My Life' app. The total number of respondents was 346 (social media (n=151), Irish Life app (n=195)).

The third source of data was a prospective 'before' (baseline) and 'after' (follow-up) survey of Phase 5 participants to capture data in real time. The baseline survey was disseminated through Healthy Club officers in advance of starting new activities in the autumn of 2022. The baseline survey was completed by 113 individuals, including some parents of children that were participating (n=10). Participants were asked to provide their email addresses to complete the follow-up, which about half of the baseline participants did.

This resulted in follow-up surveys being disseminated in the Spring of 2023, with 50 valid responses that could be matched to baselines. Due to the small number of child outcomes data gathered, we have not included these in the analysis. We make recommendations for further research on this, especially the All-Stars programme.

Irish Life also conducted a pre- and post-survey of their Every Step Counts participants', which included the same questions on exercise and wellbeing as were in included in the Phase 5 survey. Although limited to participants in the Every Step Counts walking challenge delivered by clubs, this is a significant intervention delivered by HCP/HCO officers and is therefore interesting to report on here also (the initiative has attracted approximately 30,000 participants in each of the last two deliveries).

A HCO volunteer survey was distributed at the Irish Life GAA Healthy Club orientation day in March 2022 (n=200) and a follow-up was completed online in summer 2023 (n=73).

Finally, a club baseline survey was completed by HCOs at the same conference (n=161) and a follow-up was completed online in summer 2023 (n=58).

Stakeholder	Data collection	Sample size (n)
Participants	Retrospective survey Phase 5 before and after matched survey Irish Life Every Step Counts Before Irish Life Every Step Counts After (not matched)	349 50 85 125
Volunteers	Before survey After survey	200 73
Clubs	Output data on attendance etc. Before survey After survey	370 161 58

Table 2: Summary of quantitative data collection

Appendix 3: Findings from stakeholder engagement

In this appendix, we describe the findings from the qualitative research where we engaged a range of stakeholders including managers, participants and volunteers. The ultimate aim of this was to develop a Theory of Change for the programme, however, additional information was gathered which is also reported on here.

3.1 DESCRIBING THE THEORY OF CHANGE

A 'theory of change' (ToC) sets out how an organisation uses its resources to deliver activities that lead to change in the short-, medium-, and long-term.

The objective of developing a ToC is to identify the full range of changes that result from an intervention, where those might be positive/negative, direct/indirect, and intended/unintended, that can then be evidenced quantitatively.

The goal of stakeholder engagement when developing a ToC is to reach 'saturation'. This means that it is not necessary to engage a statistically representative or large sample, but rather to continue to engage research participants until it appears that all material changes of the intervention have been uncovered.

The HCP ToC is summarised in Figure 1. The remainder of this appendix describes the activities undertaken as part of the HCP and how this leads to change (outcomes) for the individuals, society, clubs, and the GAA as a whole.

HCP ACTIVITIES

As described in the introduction, the HCP promotes and initiates healthy club activities across the priority areas of physical activity, diversity and inclusion, community development, mental fitness and substance use and gambling, healthy eating and sustainability as well as promoting healthy behaviours across both club membership and the wider community. Specifically, this includes:

1. Formalising and supporting existing programmes in clubs
2. Sharing best practice and creating a community of practice
3. Supporting clubs to set up new activities targeting identified needs
4. Structured programme for clubs to progress towards healthy club status
5. Enabling access to accredited/approved health partners (statutory, charitable/voluntary, commercial)
6. Embedding the health agenda in the strategic and day-to-day activities of the Association
7. It also aims to place the local GAA club at the heart of the community, making it a hub for health in the locale.

Participating clubs can progress from foundation through silver and gold status as they achieve a set of milestones on their journey towards becoming a Healthy Club. Each club recruits a Healthy Club Officer and project team who coordinates the activities locally and liaises between the HCP and the club executive. Outcomes were identified for the following stakeholder groups:

- Participants and volunteers
- Clubs
- Wider society
- The GAA

OUTCOMES FOR PARTICIPANTS AND VOLUNTEERS

The following main outcomes were identified for participants:

- **Increased social networks:** this was especially – but not exclusively - important to people who moved to the area, were at risk of loneliness or isolation (e.g. new mothers, older people) or had integration needs (e.g. asylum seekers).
- **Community connectedness**: this describes a different phenomenon to social networks referring instead to a feeling of connectedness to a local area or defined community. It tends to be fostered through volunteering, as described above and should have an additional wellbeing benefit
- **Life satisfaction**: general sense of wellbeing and satisfaction with life
- **Health and health literacy outcomes**: Most HCP activities relate either to physical health activities, or health literacy. We would expect to see either increases in physical activity or the adoption of healthy behaviours

For volunteers, we would expect a similar set of benefits. In addition, one interviewee described education and career benefits from the volunteering experience.

OUTCOMES FOR SOCIETY

From a societal perspective, the HCP should over time promote the health and social development of Irish society. As part of that, the initiative seeks to promote a socio-cultural shift around health so that it becomes everyone's responsibility rather than something that the health service is exclusively responsible for. This relates to the idea of 'everyday health' and a move away from an emphasis on sickness towards wellness.

OUTCOMES FOR CLUBS

Thus far the ToC has focused on the first objective relating to the HCP activities. However, the second objective around mainstreaming healthy behaviours within clubs is equally important and was recognised by staff as not getting as much attention as it might.

This tranche of work focuses on three different target groups:

- All members who attend club events by a) providing smoke and vape free campuses and b) encouraging a culture of 'taking part', respect, tolerance and an anti-bullying culture
- Young players who are being offered healthy food and other health promotion messages
- Players in the competitive games structure that are educated about substance use, mental health and other relevant health literacy

There are three tiers within the HCP structure: foundation, silver and gold and each stage has a set of policies/procedures and practices (criteria) that need to be met to progress to the next stage. It should be noted that these measures are largely output indicators, and some could benefit from additional evidence. For example, further research would be required to estimate the extent to which smoke/vape free campuses led to reduced smoking/vaping, second hand smoke inhalation or smoking/vaping cessation. On the other hand, the measures are easy to report upon, which reduces the administrative burden on volunteers. They are also an indication of some distance-travelled towards the final outcomes.

The intention is that over time, healthier members/players will lead to better outcomes – in the widest sense - for clubs and their communities. However, we were told that currently, for many county boards, success is defined narrowly around performance in competitive games.

The HCP promotes a wider Theory of Change for county boards that focuses on the health and social development objectives for a wider constituency of local people. This does not have to come at a cost to club or county performance. Anecdotally,

we were told that clubs that performed the best were often also healthy clubs and that a 'win-win' is possible. Nonetheless, it was thought that not enough time was spent on re-evaluating performance and this wider purpose at club and county board level. (It is important to note that county boards have invested in supporting the HCP through the establishment of County Health & Wellbeing Committees, which act as the appropriate volunteer structure to support Healthy Clubs – both those currently active in the programme and those aspiring towards future participation – at county level.)

OUTCOMES FOR THE GAA

The GAA is both a community organisation and a sports association. However, given the focus of its games in the public imagination, it can be challenging to communicate the importance of the former role.

The HCP was developed in part to promote the GAA's wider contribution to Irish life with a view to catalysing positive change throughout the Association. This has included an emphasis on recruiting women as volunteers and participants and supporting the implementation of the mission, vision, and values of the Association as well as its strategic plan objectives through initiatives like the All-Stars programme.

While the primary goal of the GAA remains the delivery of Gaelic games opportunities for young boys and men, an integration process has commenced at national level with the Ladies Gaelic Football Association (LGFA) and the Camogie Association (CA), with former President of Ireland Mary McAleese appointed as the independent chairperson of the steering group.

However, many clubs have moved ahead of this initiative and to date over 500 clubs in Ireland already operate under an integrated 'One Club Model'. Similarly, the HCP has always been targeted at the three associations (GAA, LGFA, and CA) and has a high representation of integrated 'One Clubs' within its cohort of participating clubs. Building on this, a need has been identified across the three organisations to widen membership to women, new communities, people with additional needs and those that do not have a background in Gaelic Games.

In some clubs, the situation is more pressing. Participants talked about the risks to the GAA of insularity and diminishing relevance due to the socio-cultural homogeneity of members. HCP officers told us that some clubs were still dominated by a handful of families and that they were concerned about the long-term prospects for those clubs. Moreover, contrary to the GAA ethos, these clubs might not feel welcoming to new members.

Some of the debate around opening up the GAA membership and facilities came down to a divergence in views on whether the promotion of Gaelic games was the core aim of the GAA or whether these were a means to achieve the health and social development of Irish society. The 'traditionalists' we were told would see the games as an end in themselves and this created tension within some club and executives. However, advocates of the more inclusive narrative also made the case that ultimately expanding the membership base and range of activities offered was a way to promote Gaelic games and the long-term viability of the GAA. There were several means by which this might happen: HCP participants becoming members, playing the games themselves, taking their children to training or volunteering. This was seen as both better for the health and social development objectives and for the sustainability of the games longer-term.

WHAT IS THE CONTEXT/NEED?

- Increase in health risk factors such as obesity, mental health
- Importance of voluntarism and social capital to health and wellbeing
- Aging population and requirements for healthy aging
- Fragility of volunteering model
- Need for greater diversity and inclusiveness in GAA to promote relevance and sustainability

WHAT IS HCP DOING?

- Formalising and promoting healthy club activities and healthy behaviours within clubs
- Formalising and supporting existing programmes
- Sharing best practice
- Supporting clubs to set up new activities
- Structured programme for clubs to progress towards healthy club status
- Keeping health and wellbeing on GAA agenda

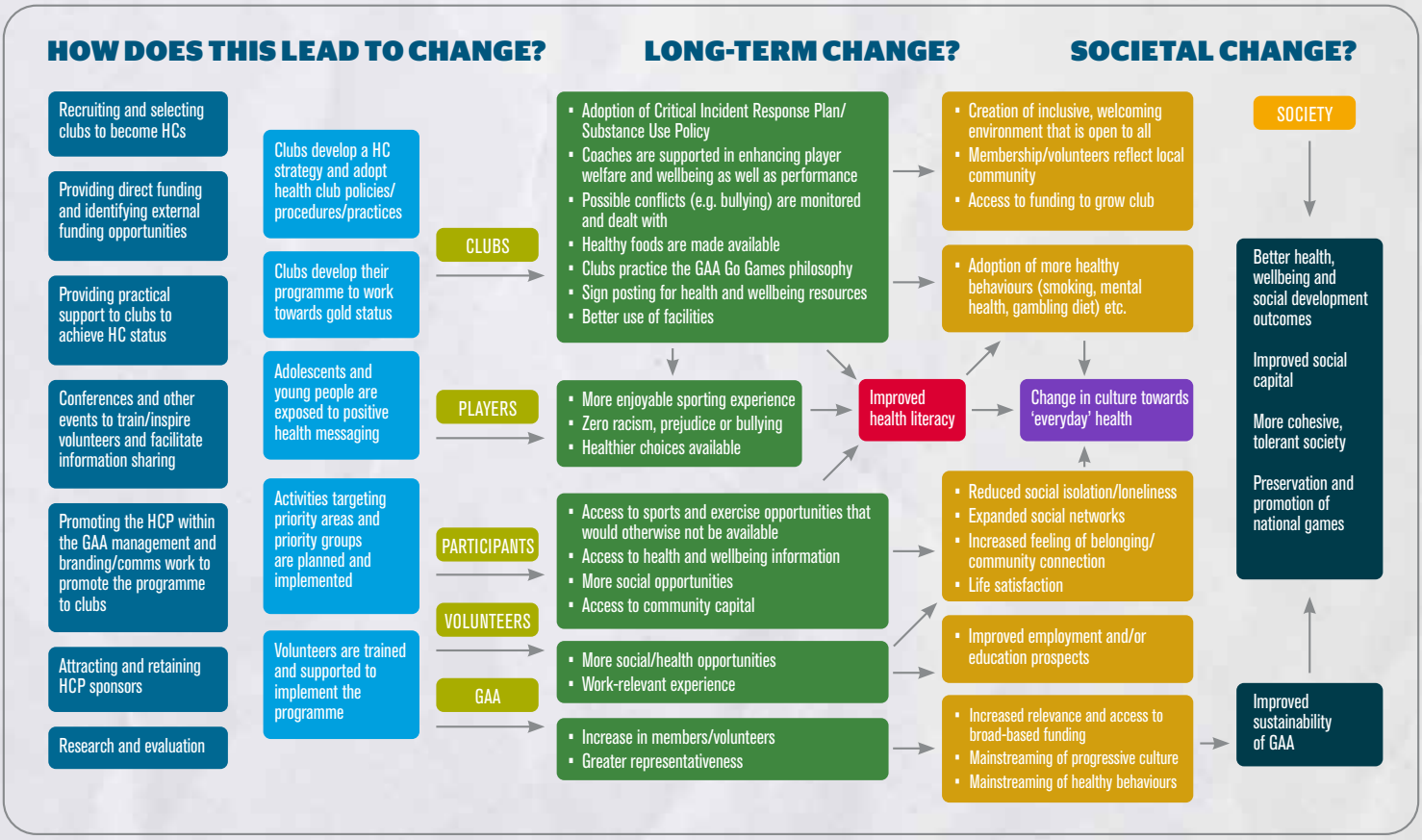


Figure 1: Theory of Change for the HCP


GAA
AIB
AIB
AIB
Allianz
Medtronic
O'Neills


SuperValu
GAA
oneills
Errigal
GROUP

Appendix 4: Quantitative findings

This appendix sets out the findings from the exiting data, surveys and the economic analysis across each stakeholder group. We first provide an overview of the output data before going on to summarise the findings for participants, clubs, volunteers, and the GAA itself. The section concludes with findings from the three case studies.

OUTPUT DATA

Output data are gathered directly from the clubs as part of the ongoing monitoring of the programme. Phase 5 data are valid as of August 2022 when 370 of the 447 participating clubs had submitted to the HCP online portal.

In 2022/23 the HCP reached 447 clubs and involved 1912 volunteers. These volunteers organised 2389 activities accessed 184,598 times. Figure 1 shows a breakdown of the activities that participants are engaging in. As we can see, physical activity makes up 44% with around half of these participating in the national initiatives Ireland Lights Up and the Steps Challenge. The programme is reaching a slightly higher proportion of participants identifying as female

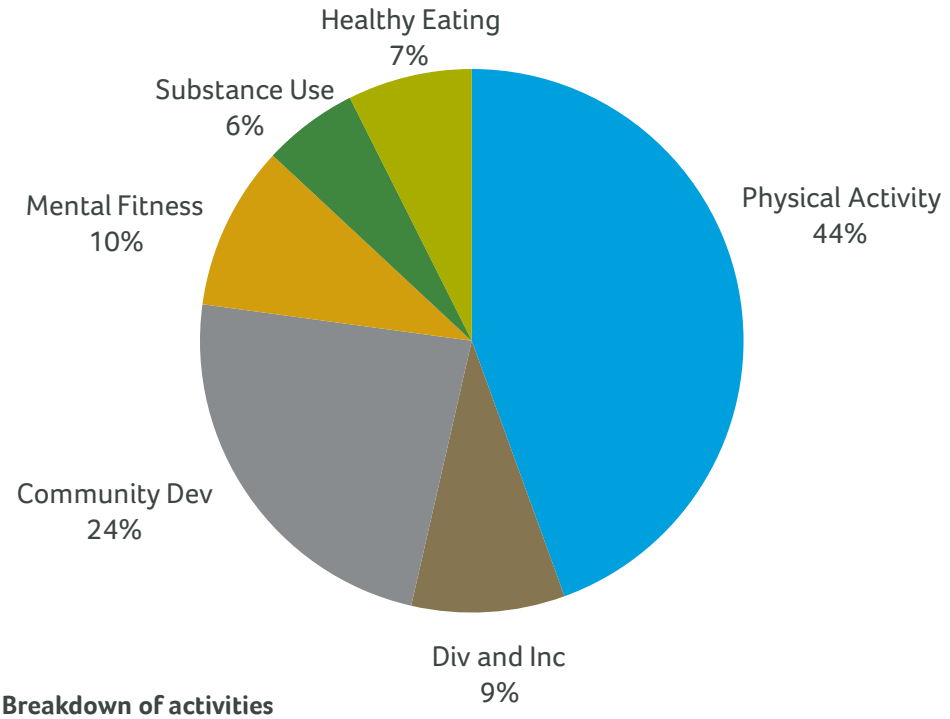


Figure 1: Breakdown of activities

than male (51% vs. 46%), and around 3% identifying as either non-binary or preferring not to state.

A breakdown by target group is displayed in Figure 2. 61% of people reached are classified as 'general community' and 27% are 'club members'. However, beyond that there is limited reach within other target populations. There may be an overlap within these categories but it is not clear where this occurs.

4.1 OUTCOMES FOR PARTICIPANTS

In general, we report on the outcomes from the three data sources (retrospective, matched sample, and Irish Life Every Step Counts Challenge) separately. However, where appropriate, we combine answers to give an overall picture of the responses (e.g. on demographic data). The steps challenge data are limited to two questions, so we only report on that in the relevant sections.

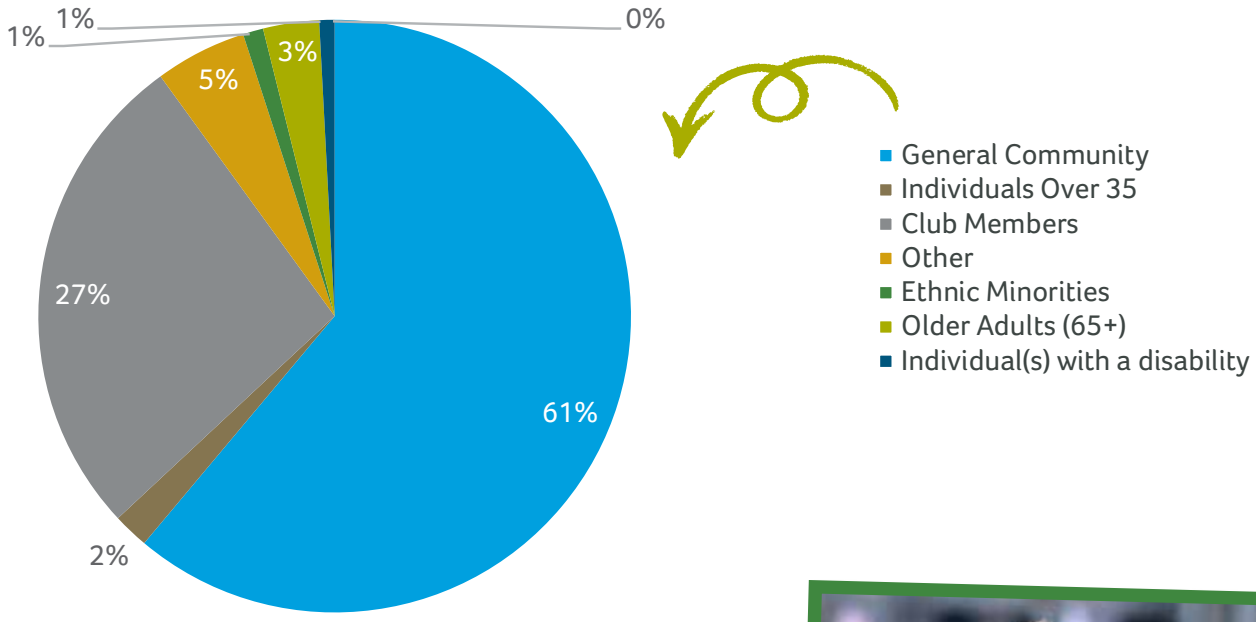


Figure 2: Breakdown of participants by target group

DEMOGRAPHICS

Across both surveys, there was a good spread of respondents in terms of geography, gender and age (see Figure 3). However, consistent with the monitoring data above, representation amongst non-White Irish and people with additional needs is low.

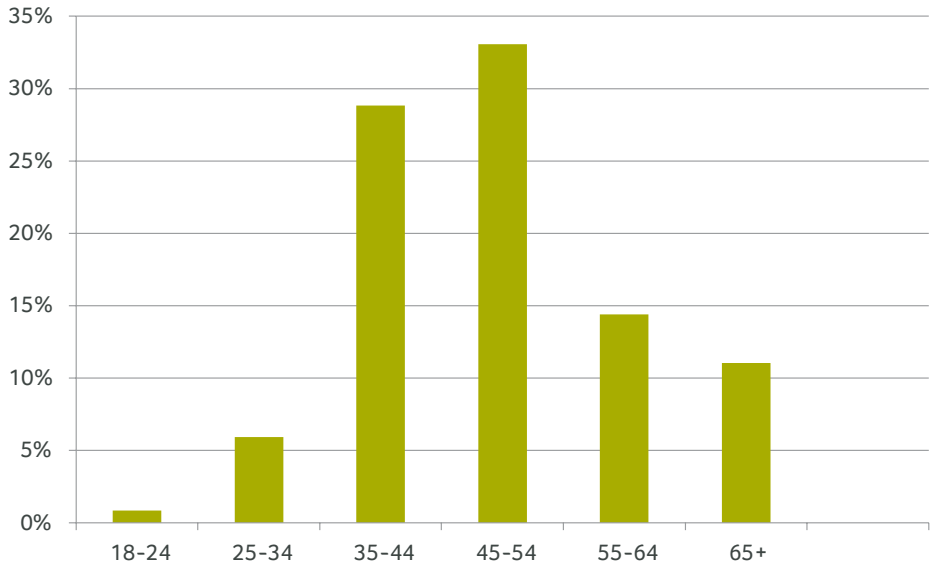


Figure 3: Age of respondents

Over half have been connected to their community for 10 years or more. However, one-third have been connected for five years or less, suggesting that the programme is providing opportunities for newcomers to the area to get involved (Figure 4).

The demographic data give us an interesting insight into the extent to which certain objectives are being achieved by the HCP. In the first instance, it aims to reach a new constituency that have not been traditionally involved in the GAA. Demographically, this would include women, Black and Minority Ethnic (BAME) Communities and people with disabilities. In addition, it would include people who have recently moved to the local area who may not have historical links with the club.

We can see therefore that the programme has a good reach with women and amongst people who have recently moved to the local area. However, it would suggest that there is under-representation of people with disabilities and people from BAME communities. Although there is some spread across the age groups, it suggests room for improvement with over-65s.

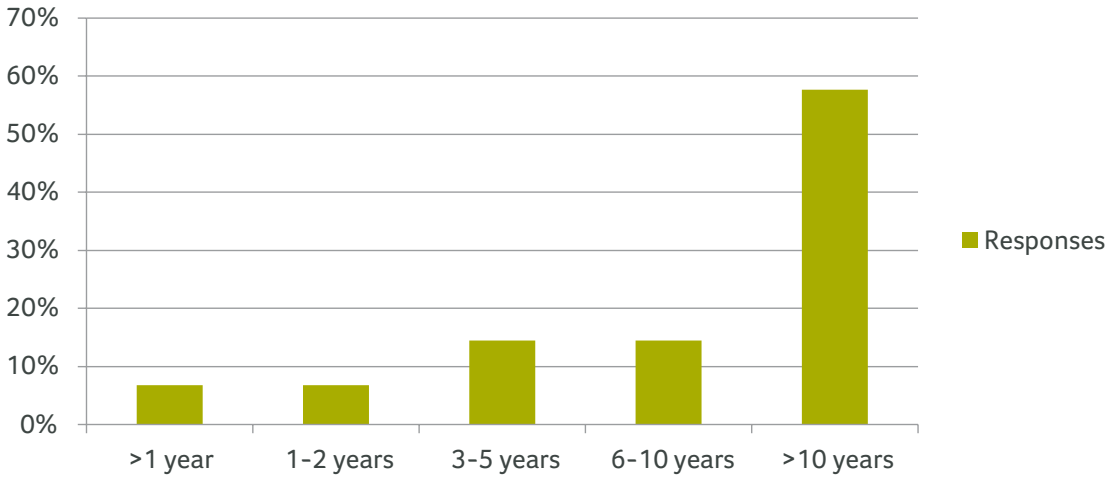


Figure 4: Length of time respondents have been connected to the area in which their club is based

ACTIVITIES

When we combine the activities that participants were engaged in we see a similar spread as with the portal data with physical activity and community development dominating. On average, respondents participated in approximately two activities each, suggesting that participation in one activity is leading to wider participation. This aligns with anecdotal evidence that Ireland Lights Up – in particular - acts as a gateway to other activities.

In the Phase 5 baseline survey, participants were asked about motivation to participate in the HCP (n=112).

The most common responses were 'taking part in a community activity' (75%), 'getting more physical exercise' (71%) and 'meeting new people' (66%). This was closely followed by 'improving my mental health or wellbeing' (58%). Other motivations included: 'new hobby/social activity' (34%) and 'improving my child's health or wellbeing' (28%) (see Figure 5).

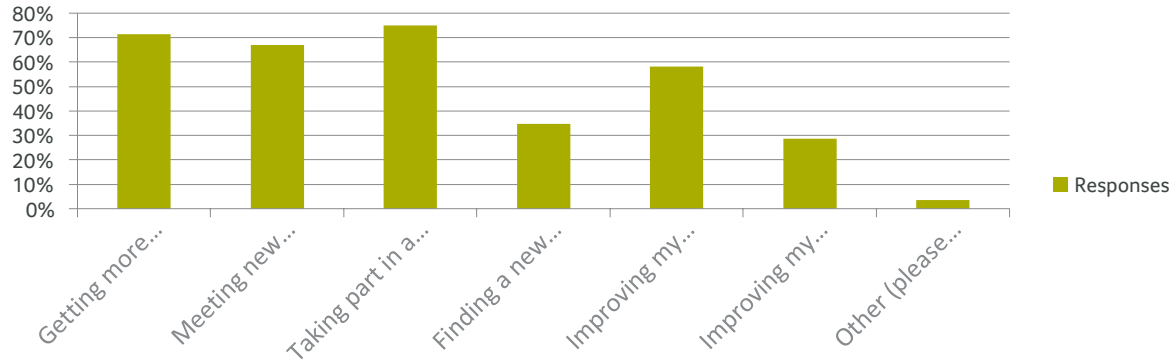


Figure 5: Motivations for taking part

Phase 5 participants reported a high level of satisfaction with the quality of the programme(n=50) (see Figure 6). There was strong agreement with statements that the activities were enjoyable, well-organised and well-publicised. 85% of respondents strongly agreed that they would like to see their club expand these kinds of activities in the future. Strong majorities also agreed that they would recommend the HCP activities to others and that they would participate in HCP activities themselves again (97% and 95% respectively).

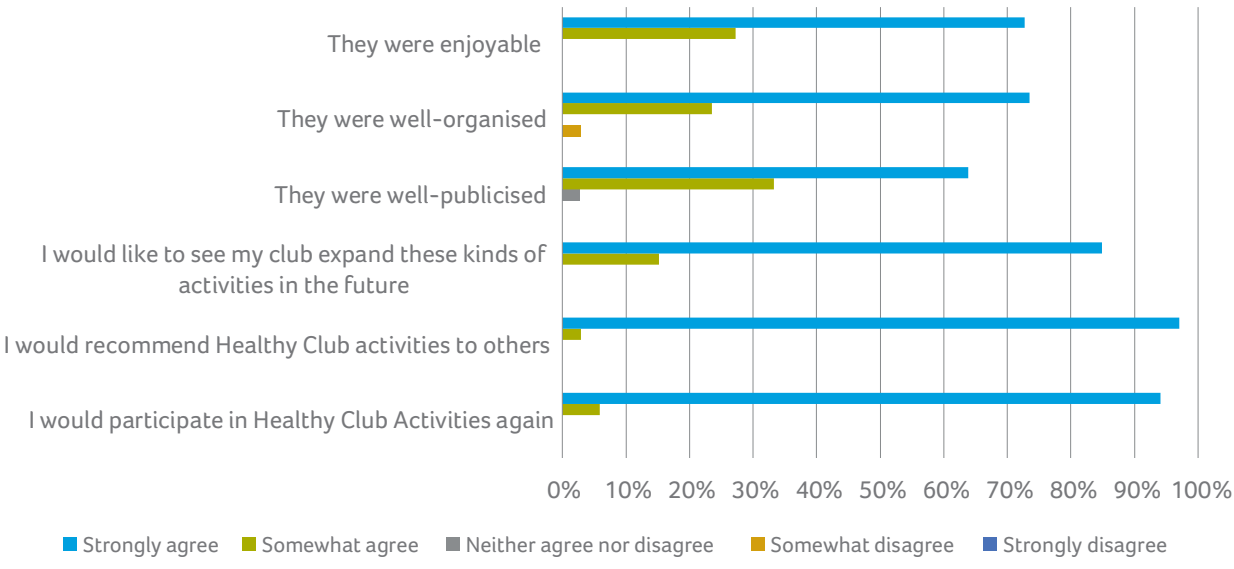


Figure 6: Satisfaction with programme delivery

This was supported by some very positive comments across both surveys:

"Healthy clubs are becoming the backbone of GAA clubs, bringing a new lease of life to clubs. It gives community members choice and is brilliant for the non-playing GAA member."

"I love the fact that the Healthy Club is inclusive for all. And serious issues like menopause, mental health, addictions etc are addressed in a safe and secure environment."

"My son takes part in the All-Stars team. I find it to be an amazing outlet and am so delighted this programme is available."

"New lit up walkway in our club is fantastic to have & so safe for walking"

OUTCOME 1: PHYSICAL ACTIVITY

A central outcome for the HCP – and a strong motivation for those that participate – is increased physical activity. This outcome was measured in each of the three surveys where respondents were asked to report on the change in the number of days of exercise they participated in (a minimum of 30 minutes of physical activity that raises the heart rate such as brisk walking). Respondents came from the pool of almost 30,000 participants in the Every Step Counts Challenge. This challenge, delivered through the HCP, sees clubs encourage members to download the MyLIfe App – a personalised health and wellbeing app that, amongst other metrics, allows participants track their daily steps as part of bespoke walking challenges. Surveys can also be issued to users of the app, as was done in this case.

During Phase 5 and the Steps Challenge in January/ February 2023 this was asked in real time (before and after the activity) and on the retrospective people were asked to reflect on how their exercise had changed.

Across all three surveys participants reported an increase in physical activity (n=475). On the retrospective and Phase 5 we see a 10% increase in health scores before and after the intervention (9% for men and 11% for women) (Figure 8) but this is higher for the Healthy Club Steps Challenge which saw a 25% increase. This makes sense given the exclusive focus on exercise in the Steps Challenge.

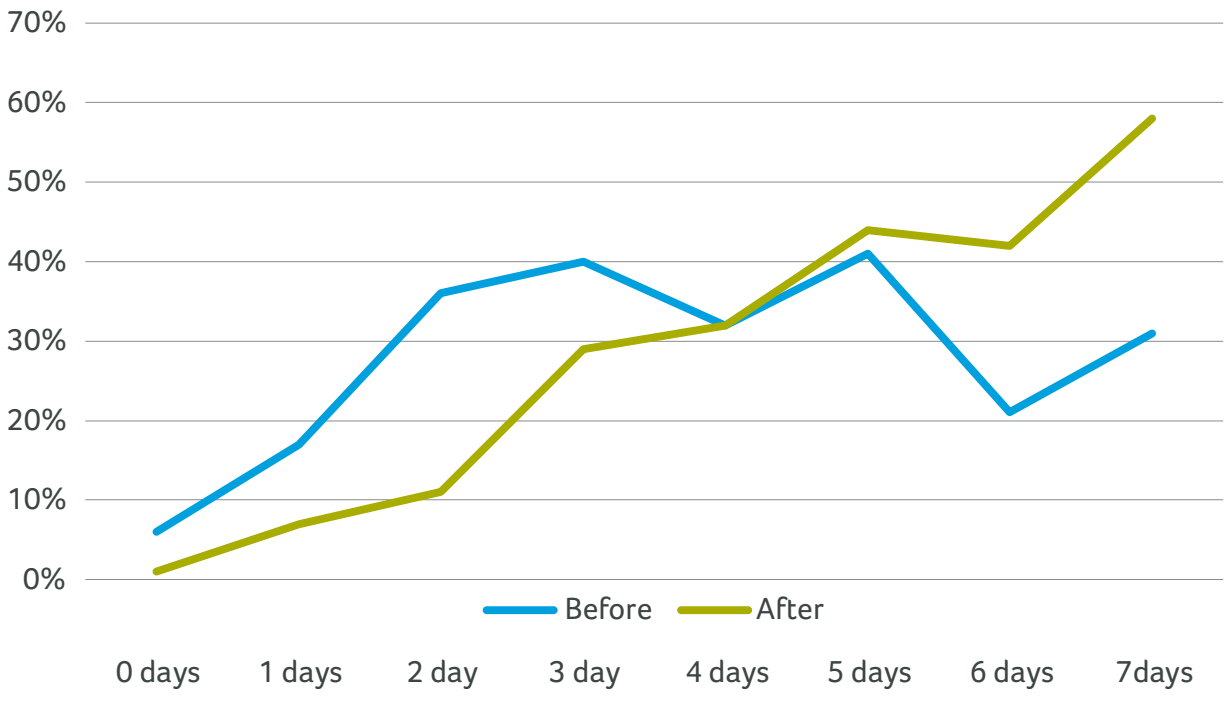


Figure 7: Change in number of days of exercise Phase 5 and retrospective.

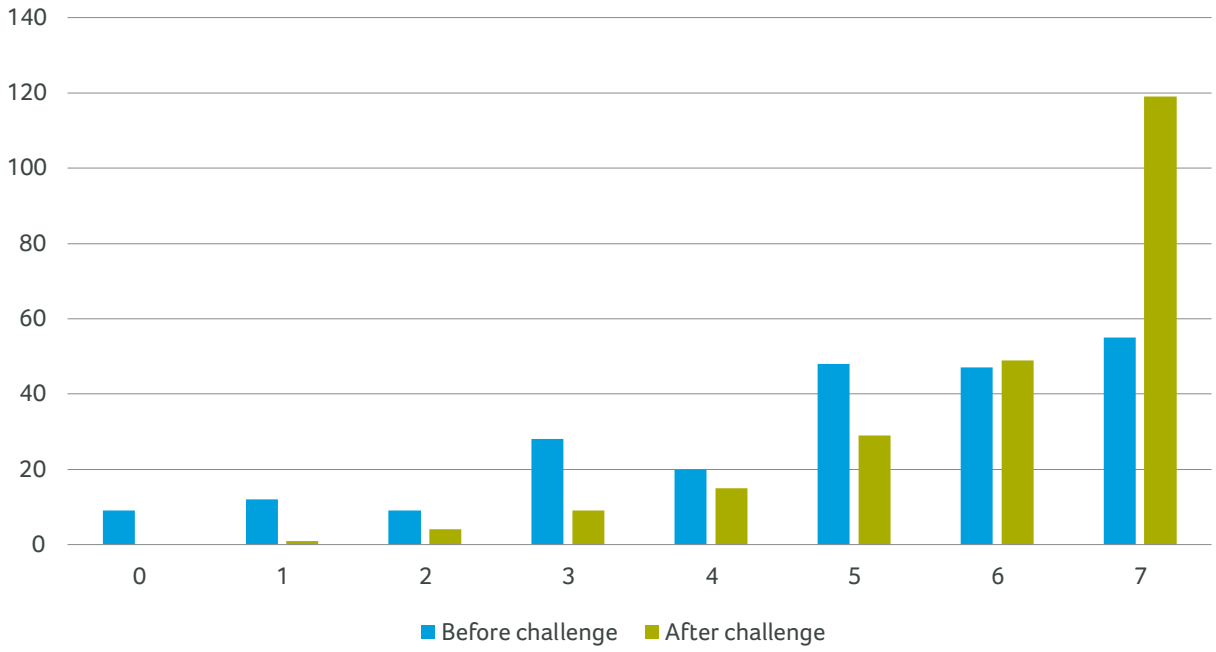


Figure 8: Number of days of exercise before and after challenge. (Source: Irish Life MyLife App)

We also asked Phase 5 respondents whether they thought involvement in the HCP influenced the extent to which they participated in physical activity (see Figure 9). As we can see, 19% selected 'a great deal' and 22% selected 'a lot'. The largest category was 'a moderate amount' at 44%. Only 11% selected 'a little' and 3% 'not at all'.

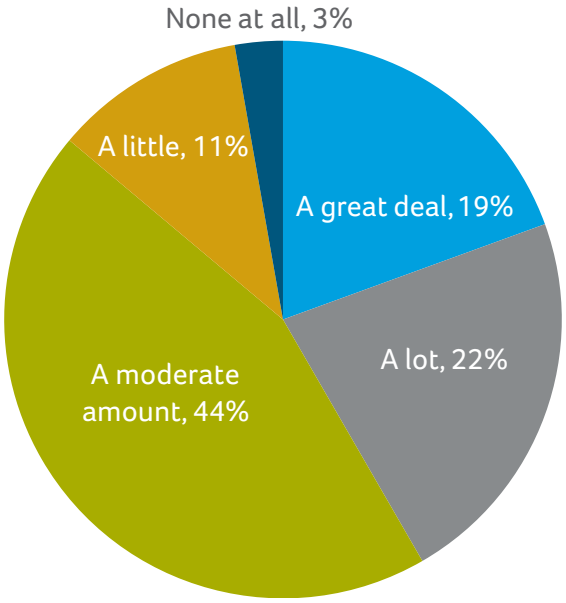


Figure 9: Extent to which involvement in HCP influenced physical activity

In addition, on the retrospective survey 67% of respondents reported that the programme had influenced the amount of physical activity that they now engage in. This gives support to the longevity of the physical activity outcome after the activities end, as these participants may have participated some years back. On this survey, 40% of respondents also reported that they had adopted healthier behaviours for themselves and/or their families since getting involved.

In line with these findings, respondents noted the importance of the health benefits to them:

"Excellent for physical, mental and emotional health"

"I have recently joined a gym"

"Recovering from long Covid and helpful for getting fitness levels back"

OUTCOME 2: WELLBEING

Consistent with the ToC for the programme, we expect to see wellbeing outcomes both directly (via the organised social activities) and indirectly (via the increased physical activity and social connectedness).

There are several sources of data on direct wellbeing outcomes that we can draw upon. These are as follows:

- Phase 5 participants were asked to score three domains of their wellbeing - life satisfaction, connection to other people and connection to their community – on a scale of 1-10 (n=50)

- The same questions were included in the Every Step Counts challenge evaluation
- (baseline, n=92, follow-up n=125)

- Participants of these surveys and the retrospective survey were asked to report on
- how the programme contributed to their overall wellbeing

Across both the Phase 5 and the Steps Challenge survey, we see increases in all three domains of wellbeing (Table 1).

Domain of wellbeing	Average scores at follow up (Steps Challenge)	Average scores at follow-up (Phase 5 survey)	Increase (Steps Challenge)	Increase (Phase 5)
Life satisfaction	7.81/10	7.28/10	0.72	0.21
Connected to others	7.43/10	7.35/10	0.41	0.5
Connected to community	7.04/10	7.21/10	0.68	0.64
Average			0.60	0.45

Table 1: Increase in wellbeing scores across two surveys

The average life satisfaction across the sample at baseline was 7.07, which Is slightly higher than the OECD average for Ireland of 7.[1] The change in life satisfaction on the Steps Challenge survey is shown in Figure 10.

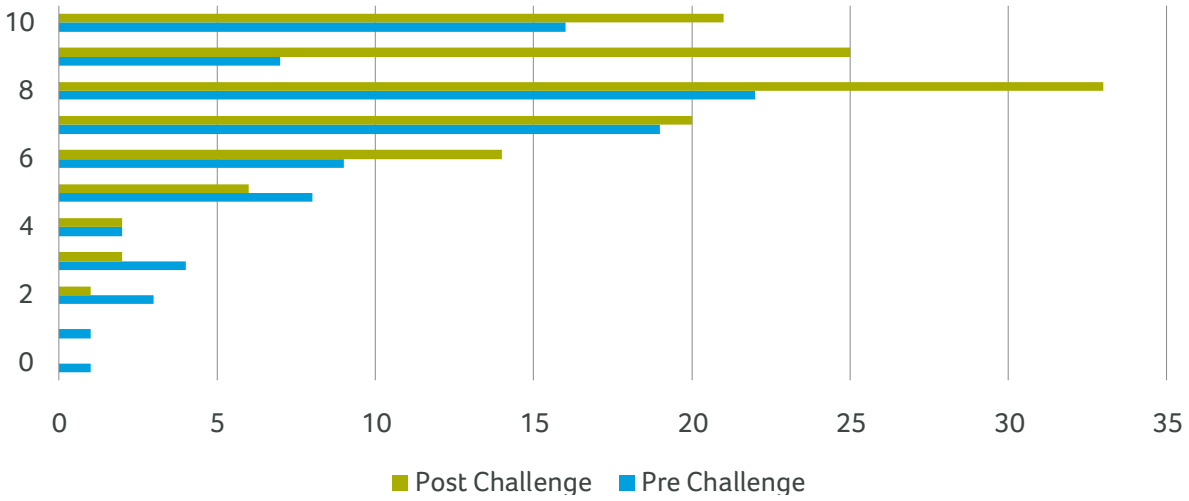


Figure10: Change in life satisfaction before and after Ireland Lights Up

[1] OECD (no date) Better Life Index https://www.oecdbetterlifeindex.org/countries/ireland/

Although this may appear to be a small increase, it is important to recognise that wellbeing tends to remain quite static, and it can be difficult to achieve increases through policy interventions. For example, the difference in life satisfaction scores between baseline and follow-up was close to the difference between Ireland and the OECD average (3% and 4.5% respectively). As we will see when it comes to valuation, for a light touch intervention like the HCP, this should be seen as a very positive outcome. Figure 11 for example shows the effect of major life events on life satisfaction/happiness. As we can see, major life events like parenthood and partnership only lead to small improvements.

Significant Life Event	Women/Men	Effect on LS/Happiness (on 1-10 Scale)	Changes in 5 Years after the Life Event
Partnership	Women	+0.5 to +0.7	Stable
	Men	+0.4 to +0.5	
Partnership	Women	+0.4	Stable
	Men	+0.2	
Separation/Divorce	Women	-0.5 to -1.0	The rising by +0.5 after 4-5 years
	Men	-1.0 to -1.3	
Widowhood	Women	-0.6 to -1.0	Then returning completely after 1 year
	Men	-0.5 to -1.0	
Loss of Employment	Women	-0.4	Then falling to -1.2 after 5 years
	Men	-0.4	

Figure 11: Relationship between major life events and life satisfaction/happiness

Source: adapted from Clark and Georgellis (2013)2 by Pretty et al. (2020)[3]

A second source of data on wellbeing is the retrospective survey (n=330) where respondents were asked to reflect on their sense of connection to their local community and their satisfaction with life as a result of taking part. Across both domains, 81% either agree or strongly agree with the statements (Figure 12).

[2] Clark, A. E., & Georgellis, Y. (2013). Back to baseline in Britain: adaptation in the British household panel survey. Economica, 80(319), 496-512.

[3] Pretty, J., & Barton, J. (2020). Nature-based interventions and mind–body interventions: Saving public health costs whilst increasing life satisfaction and happiness. International journal of environmental research and public health, 17(21), 7769.

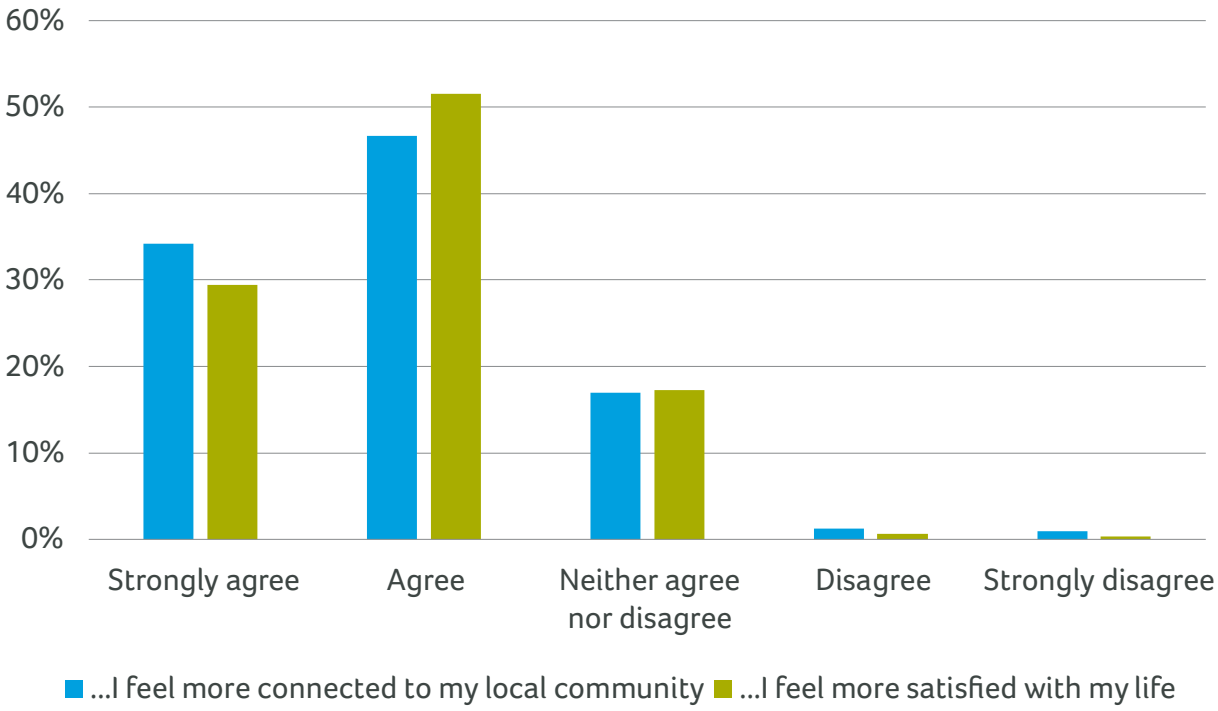


Figure 12: Wellbeing outcomes from retrospective survey

In addition, 51% of retrospective respondents told us that they had made new friends in their community and 17% had taken up a new hobby or activity since taking part.

Reflecting the quantitative findings above, respondents often mentioned community and social benefits in their free-text responses:

"Great initiatives which improve community relationship"

"I love these communities activities, great initiatives that make people more conscious about their health and it's easy to apply on daily basis"

"I love the way that I feel more connected to my community and how welcoming everyone was towards me. I have established lifelong friendships"

"Our club has become the hub of our community with other services coming to us to ask for opinions, and support for other activities and also to be event holders"

4.2 OUTCOMES FOR THE GAA

Although the HCP is ostensibly a community intervention to improve the health and wellbeing of local people, it emerged through stakeholder engagement that there are significant potential benefits for the GAA itself.

The participant survey assessed the extent to which progress was being made on widening access and improving the perception of the GAA. First, we asked on both surveys about the prior level of connection to the GAA. Figure 13 shows the breakdown of responses to this across both surveys (n=463).

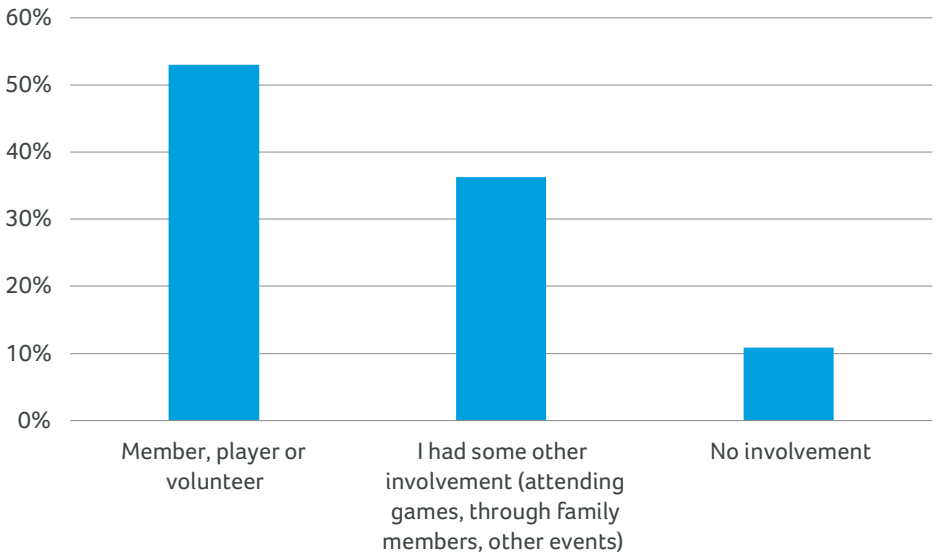


Figure 13: Previous connection to the GAA

Both surveys had the same proportions stating that they had no previous involvement with the GAA (11%). Across both surveys, 36% were not members, volunteers or players, demonstrating that close to half were not closely connected to the GAA but were more distantly connected (e.g. as supporters). If we were to generalise from our survey to all unique participants (92,299), we would estimate that across the programme, it has engaged 10,152 individuals that had no previous involvement with the GAA and 38,227 individuals were not closely connected to the GAA. Retrospective participants were also asked whether they had moved on to have a greater involvement with the GAA since they took part in the HCP activity. As we can see from Figure 14, 77% have gone on to do other activities of value to the GAA including joining, volunteering, taking part (themselves or their children) and attending matches.

In the retrospective survey, we also asked participants whether they had a better perception of the GAA because of taking part in the HCP. As we can see from Figure 15, a large majority agreed or strongly agreed with this statement (78%).

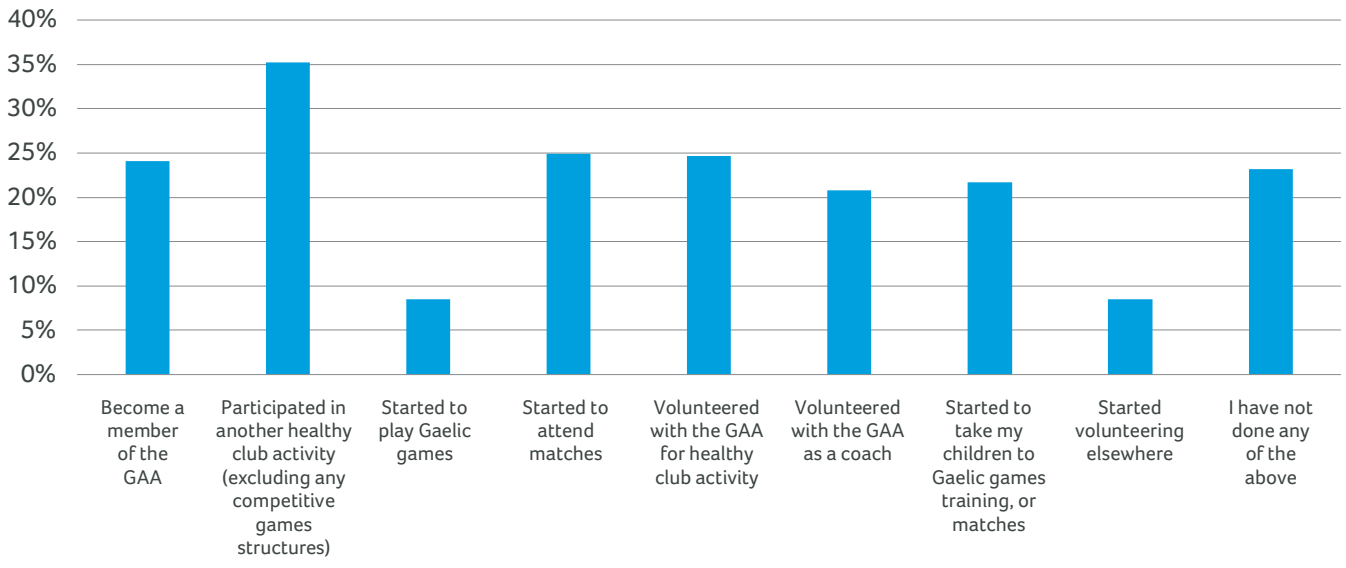


Figure 14: Involvement in other GAA activities since taking part in the HCP

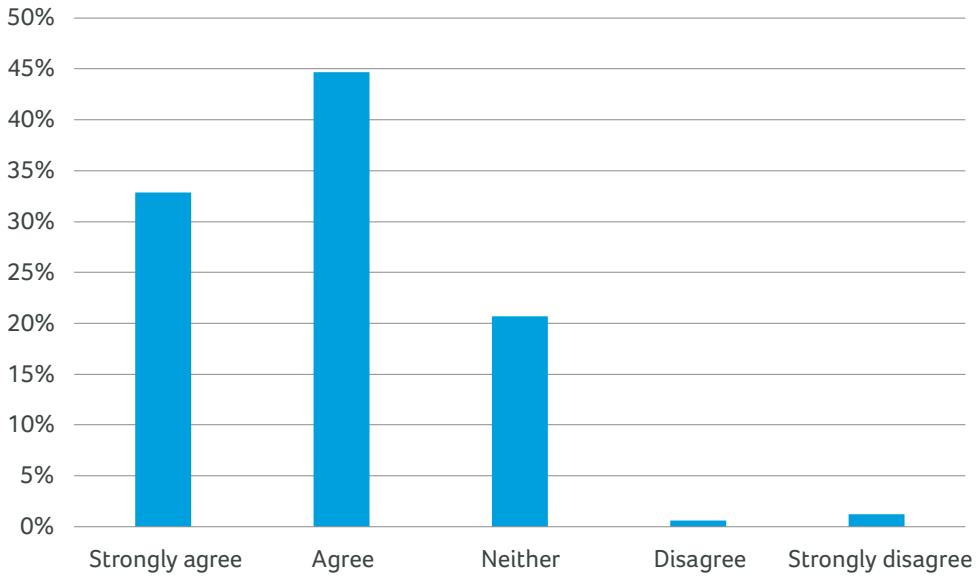


Figure 15: Perception of the GAA following participation

In the comments, several respondents mentioned the value of improving diversity, increasing the reach of the GAA and going beyond the Gaelic Games remit:

"This is a wonderful project to wider community involved in activities that were never available to them previously"

"Has brought some new life to the community and has given the understanding that the GAA is not just for those on the pitch."

"I think the Healthy Club initiative has been a fantastic development for GAA club reaching out to their communities"

"Being part of GAA encourages more inclusion in my community"

"It gives a great opening for people not directly involved in playing with the club ...more and more [our club] is becoming the hub of the entire community... it's been a wonderful boost to our small rural club and community."

4.3 OUTCOMES FOR VOLUNTEERS

VOLUNTEER INPUTS

Data captured through the HCP portal show that there are currently 476 Healthy Club Officers across the programme that oversee a Healthy Club team of volunteers in their club. The average number of volunteers per club is 4.3. This means that the programme has 1912 active volunteers. Data captured from the clubs on volunteering suggests an average input of 5 hours per volunteers per week over an average of 10.7 week period of activity p.a.

DEMOGRAPHIC DATA

Health Club Officers (HCOs) completed baseline and follow-up surveys about their experiences of being a volunteer. The baseline was distributed at the HCP orientation day at Croke Park in March of 2022 and a follow up email was sent to all HCOs a year later.

There were 194 baseline responses from volunteers. Out of 169 Phase 5 clubs, we had a response from 79%. Around 23% clubs had more than one respondent and we have retained these in the sample, as they are still HCP volunteers.

70% of the sample are female (1 identified as non-binary and 1 as other). Only 4 respondents (2%) considered themselves to have a disability. 96% of the sample are White Irish, 2.5% are Other White Background, with two individuals selecting Mixed Background and Other categories. These demographic data are similar to those gathered in the participant surveys.

70% of volunteers have been connected to their community for 10 years or more. About 20% are connected to the community for 5 years or less.

Before becoming HCOs, 70% had been members or volunteers, and 30% had been players. See Figure 16 for a breakdown of previous involvement.

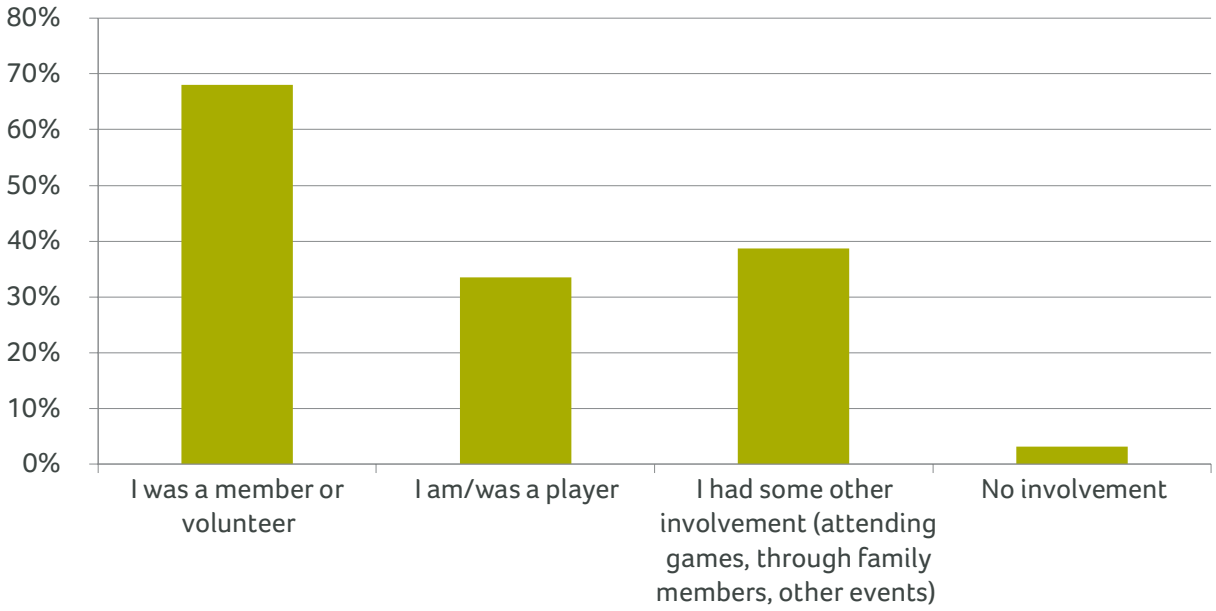


Figure 16: Previous involvement of volunteers with GAA

However, 62% had participated in a HCP activity prior to becoming HCO and for 25% of those (n=31) this was their first involvement with the GAA. These data suggest that HCP volunteers are more embedded in the GAA and local area. However, this is intuitive as volunteers will be drawn initially from people with connections to the GAA. Over time, we would expect to see this increase as the programme reaches new communities.

Figure 17 shows a breakdown of volunteers' motivations to become HCOs. A majority believe in the GAA's role in supporting the health and wellbeing of its community (80%). Other common motivations include: giving something back, passion for their club (both 60%) and promoting a particular activity (47%). Smaller proportions want to meet new people (24%), gain new skills (15%) and access new hobbies (7%).

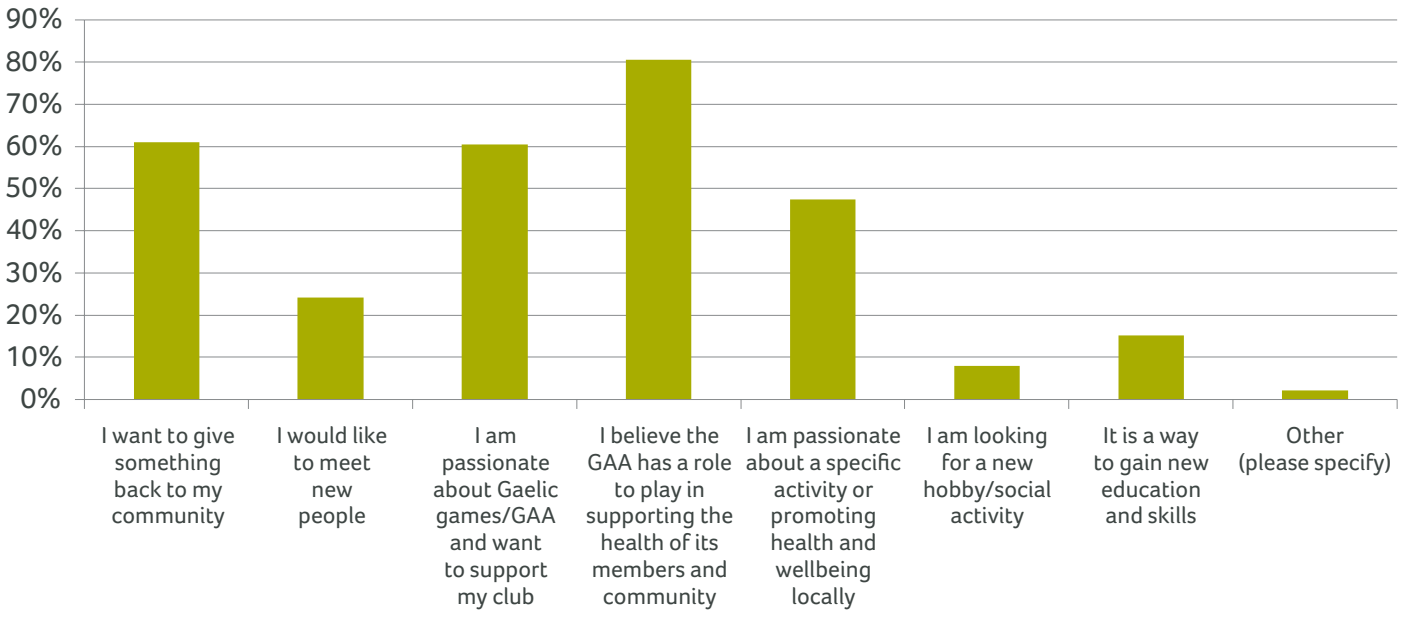


Figure 17: Motivation to become a volunteer

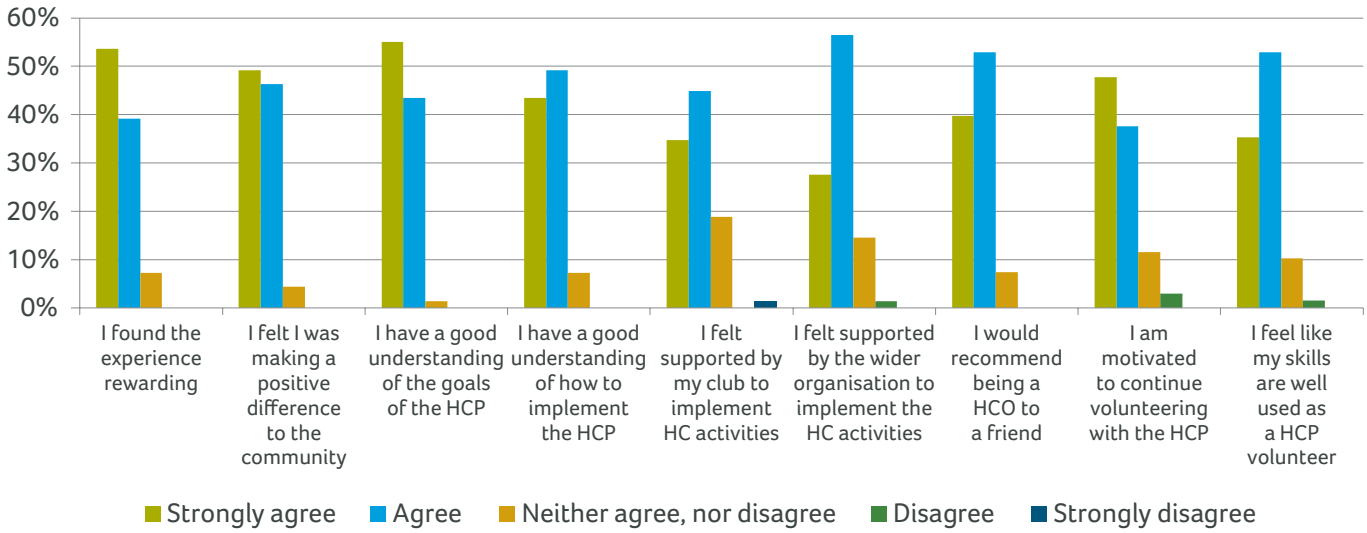


Figure 18: Volunteer experience of being a volunteer after one year in the HCP

VOLUNTEER EXPERIENCE

Volunteers were asked about their experience of being a volunteer. As we can see from Figure 18, respondents are very positive about the experience with large majorities agreeing that they found the experience rewarding, were making a positive difference, understood and could implement the programme, felt supported and that their skills were being well-used, were motivated to continue and would recommend the role to others.

Figure 19 shows the level of overall satisfaction with being a volunteer. As we can see, 89% are either satisfied or very satisfied and only 9% are dissatisfied.

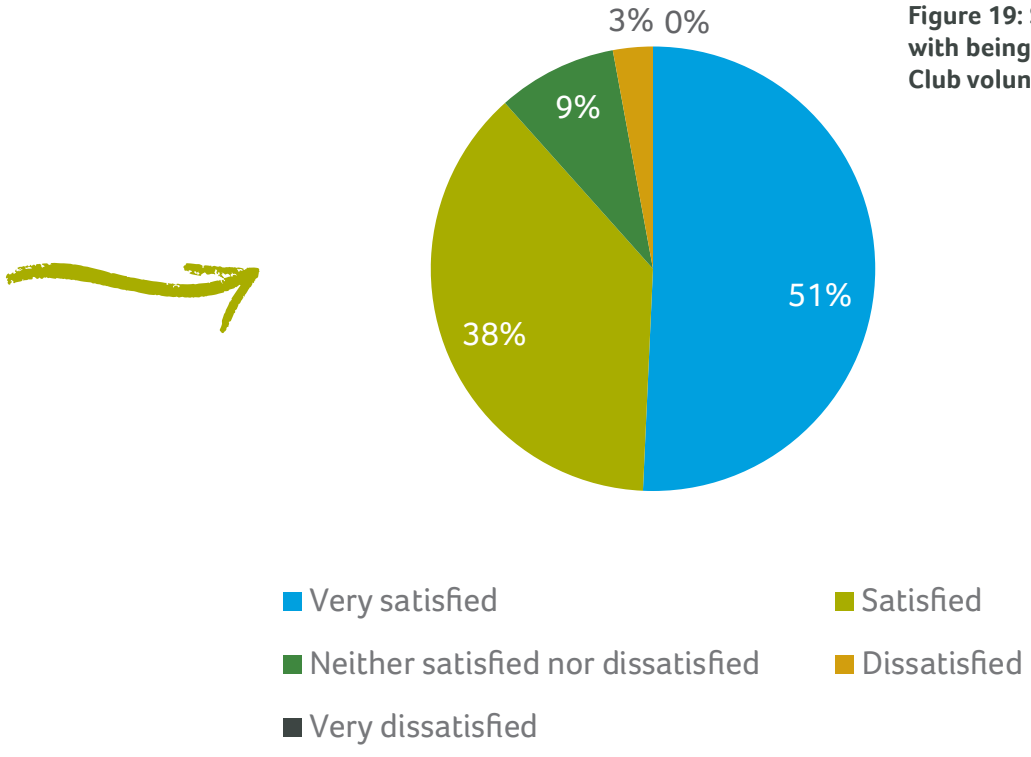


Figure 19: Satisfaction with being a Healthy Club volunteer

VOLUNTEER WELLBEING

As discussed in the literature review, there is a relationship between volunteering, social capital and wellbeing. We would expect therefore to see an improvement in wellbeing scores between baseline and follow-up. Table 2 shows the mean responses before and after.

	Overall, how satisfied are you with your life nowadays?	Overall, how connected do you feel to other people?	Overall, how connected do you feel to your community?	Overall, how satisfied are you with how you use your time (work, career, hobbies)?	I understand the importance of actively managing my health (e.g. diet, exercise, mental health)
Baseline average	7.6	7.6	7.1	6.8	8.9
Follow-up average	8.5	8.9	8.7	8	9.9
Difference	0.85	1.3	1.6	1.2	1

Table 2: Wellbeing scores at baseline and follow-up

As we can see, there are increases across all domains of wellbeing. As with participants, we see the greatest gains in connection with community. Life satisfaction at baseline is already high, and above average at 7.6. However, at follow-up, respondents report a score of 8.5, suggesting that the experience contributes significantly towards personal wellbeing.

Understanding of healthy behaviours is also high at baselines but rises close to 10 at follow up. These findings would suggest that volunteers are gaining more wellbeing benefits than participants, including a big increase in satisfaction with how they use their time.

However, it can also be observed that their needs are lower given the high baseline scores. Nonetheless, it supports the wider literature on the wellbeing benefits of volunteering. Endogeneity is often a criticism of correlations between volunteering and wellbeing and we see this in this dataset also: people who chose to volunteer have higher than average wellbeing. However, we also see significant increases over a relatively short period of time.

Some of the qualitative responses support these findings:

"Getting involved as the HCO has been so reciprocally rewarding for me. As a club member with a very poor playing background it helped me to stay active in the club and to support my sons involvement in the senior team. It has been rewarding for me personally, in my family and has deepened my connection with the community."

"I have thoroughly enjoyed taking part and setting up the healthy club in my club."

"Personally, health issues with my family have inhibited me completing even more projects/events for the healthy club but over all it has been a great escape"

4.4 OUTCOMES FOR CLUBS

As mentioned above, clubs work through a HCP process from Foundation through to Silver and Gold accreditation. Following the close of Phase 5, 224 clubs have achieved Foundation status, 105 have progressed to Silver and 47 have achieved Gold healthy club status.

To capture progress against key milestones, HCOs completed baseline surveys for their club at the HCP conference in the summer of 2022. (It is relevant to note that the respondents' clubs were just entering the programme at the time of completing this survey and would be required to demonstrate significant movement across areas of policy and practice within 18 months in order to achieve their future accreditation as a Healthy Club.)

Baseline data showed room for improvement on key healthy club policies (Figure 20). Fewer than 10% had smoke and vape free campuses and around a third provide sign posting, have adopted the critical incident plan, or have adopted the substance abuse policy. Only 20% provided healthy food following games. About half of clubs were monitoring bullying incidents and supporting coaches to enhance player wellbeing as well as performance. 70% practice the GAA Go Games philosophy (promoting participating for all over competition at juvenile level).

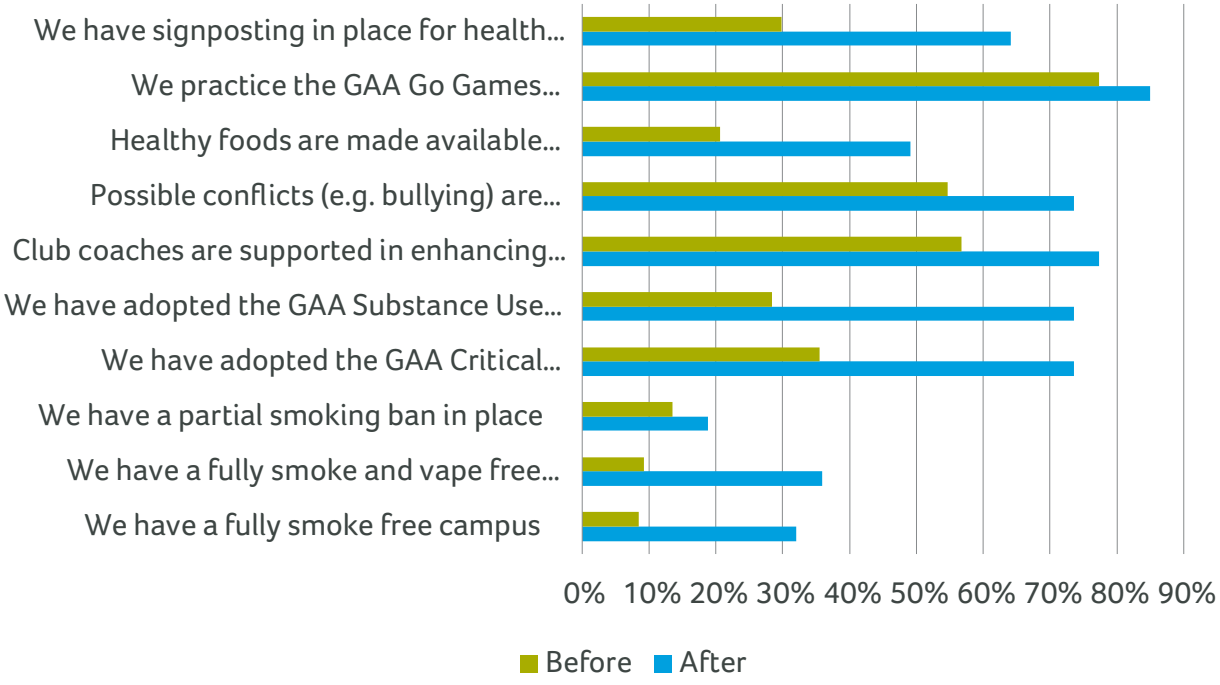


Figure 20: Change in policy adoption between 2022 and 2023

Figure 21: Change in levels of satisfaction with progress in priority areas

Figure 21 shows the proportion of respondents that are satisfied or dissatisfied with the performance of their clubs in the priority areas at baseline. We can see for all the areas – with the exception of community development – respondents are more dissatisfied than satisfied. The areas of the lowest levels of satisfaction are substance use and sustainability.

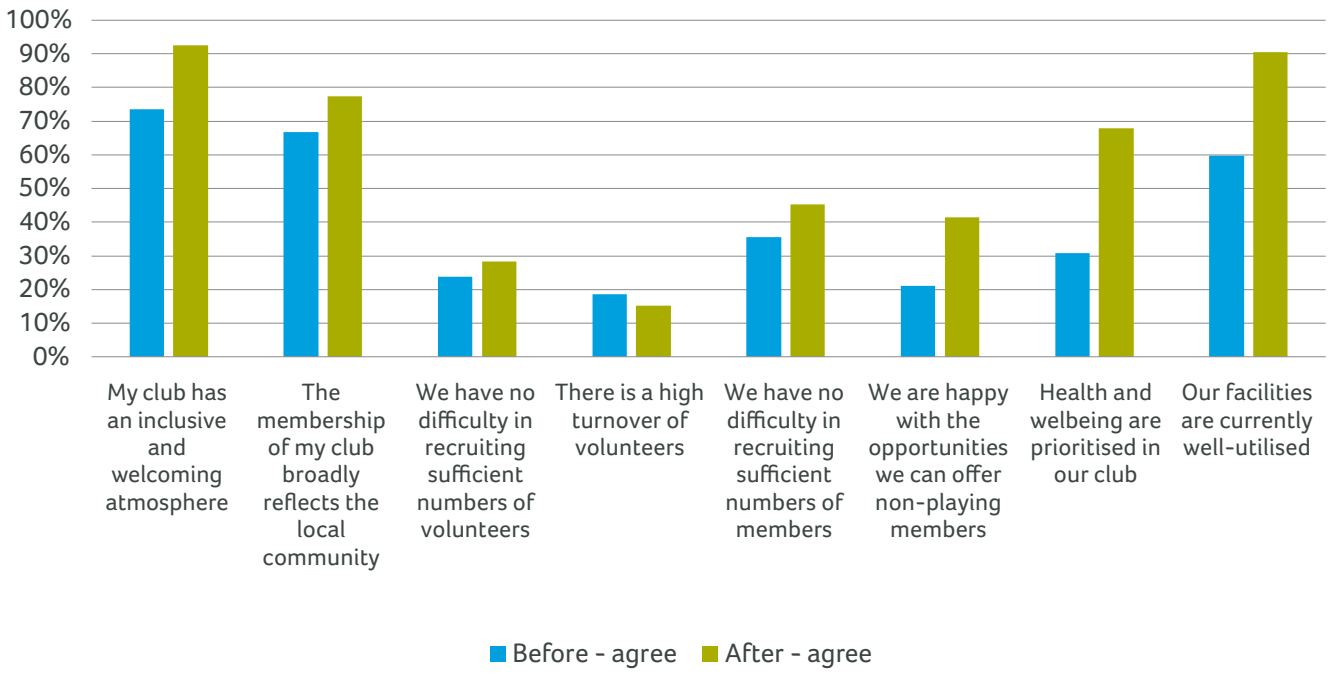


Figure 22: Change in proportion agreeing with statements about this club

Finally, we asked participants whether they agreed with a series of statements about their clubs. Figure 22 shows the change in the proportion of respondents that agree with those statements. We can see improvements in all areas, especially the utilisation of facilities, the offer to non-playing members and the prioritisation of health and wellbeing.

At follow-up 92% thought their club has an inclusive and welcoming atmosphere and 77% that the membership reflects the local community. Retention of volunteers is not a major problem for clubs and has seen a small improvement. The proportion saying that they had no difficulty in recruiting members increased from 36% to 45%. As identified in the qualitative research, recruiting volunteers remains a challenge. Although we see a four-percentage point increase in the proportion agreeing that they have no difficulty in recruiting volunteers, this is still only 28% at follow-up. 43% of clubs disagreed with this statement at follow-up and 9% strongly disagreed (down from 13% at baseline). Again, it should be remembered that these clubs have just started out on their healthy club journey and may experience further downstream benefits from greater inclusivity, more use of facilities and the wider range of activities on offer. As one respondent put it:

"I hope that it continues to incrementally improve. This is a marathon, not a sprint."

There were positive endorsements of the programme provided by some respondents:

"We have benefitted from the programme in terms of what we do as a Club, but also in how open we are to new projects and partnerships. The energy that the HCP has delivered has led to successful applications for over 80k in funding to develop access to health and wellbeing facilities at the club for new users as well as our core base of playing members."

"Our community have benefited greatly from the Healthy Club Project. Our two flagship programmes - Tues Morning Club for older people 60+ & All-Stars Programme for Adults with additional needs - have been extremely well supported. Feedback has been very positive and we are encouraged to continue these programmes next year."

"Healthy club project is a fantastic idea and having support from other clubs as well as county and Croke park is excellent."

"The HC project is a fantastic idea and will reap huge benefits for clubs and more importantly communities."

Respondents also provided some recommendations for ways in which they would like to see the programme develop, and identified some areas in which they needed support:

- **Workshops for pre-teens on: racism and discrimination, healthy minds and body, and first aid**
- **Development of green clubs initiatives – littering on the sideline was identified as an issue**
- **Financial assistance towards first aid, side-line first aid and CPR training**
- **Group activities for older men who are difficult to engage**
- **More cover with insurance for activities**
- **More connection with other HC Volunteers to get ideas and build confidence in the role**
- **More support for writing up the portal**
- **Support with cross-community engagement in Northern Ireland**

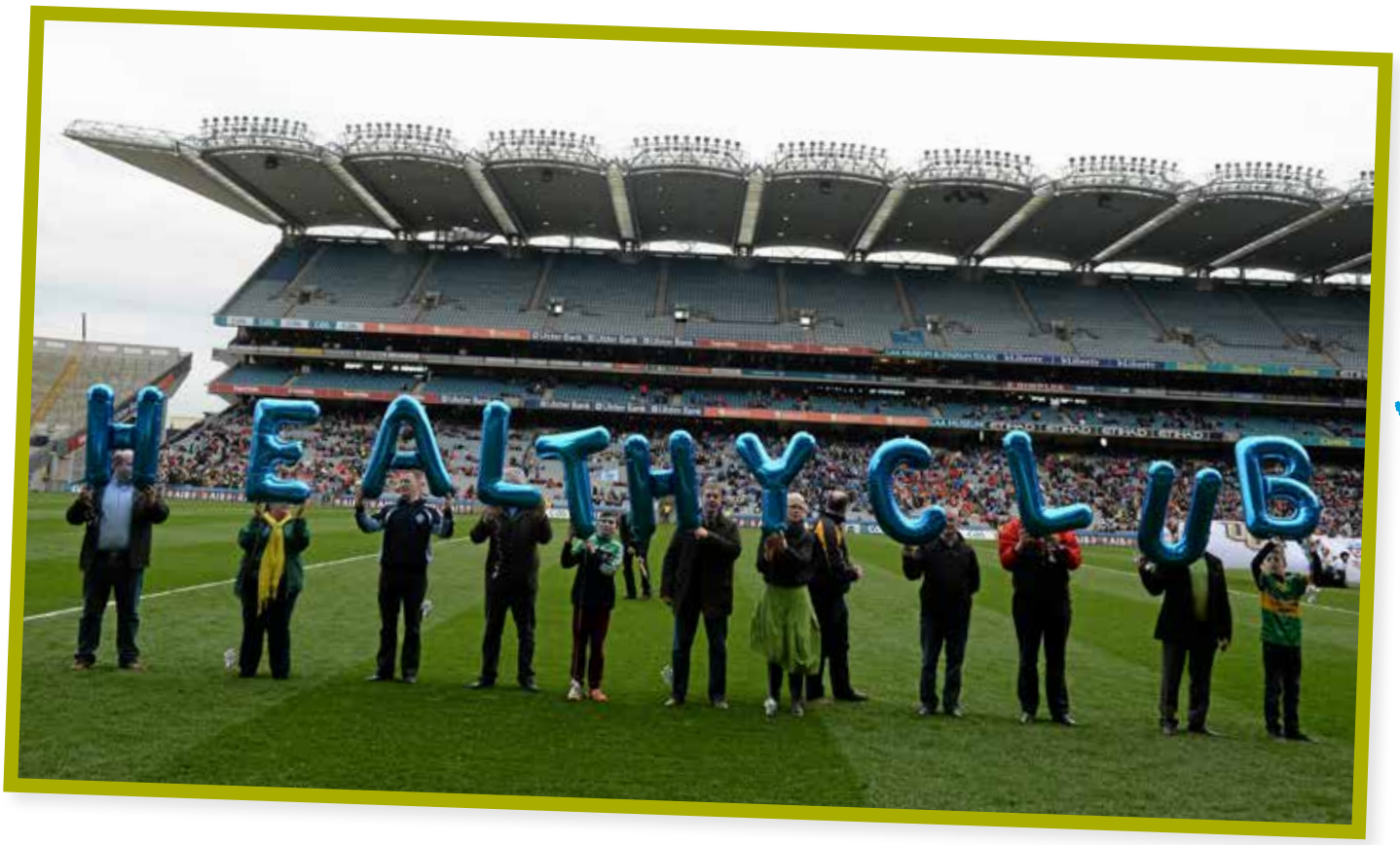
Appendix 5: SROI model

In this appendix, we develop an SROI model for the HCP. We begin by describing the overall approach to valuation before setting out the assumptions underpinning the model, discussing the results and caveats.

The main SROI report describes benefits for five stakeholder groups: participants, volunteers, clubs, the GAA and wider society. However, our valuation will take forward benefits only to three of these – we do not include the benefits to the GAA. Although we make the case earlier that these are significant, linking them to monetisable benefits is very challenging. We would need to make the case that there is a wider societal benefit from outcomes like a more representative GAA membership, but this would require us to explore the national value of the GAA in the first instance, which is out of scope for this project. Such an exercise would be possible, and we would recommend that it is undertaken in the future (see recommendations).

We have also excluded clubs due to the difficulty of making the link between many of the actions such as a smoke and vape free campus and more tangible outcomes like reduced smoking. However, we make recommendations below for ways in which future research could consider these.

For wider society outcomes, we have inferred benefits to the health services, from changes in health, as this is the main public beneficiary as well as a programme funder.



5.1 APPROACH TO VALUATION

Subjective wellbeing is defined by the Organisation for Economic Co-operation and Development (OECD)[1] as "good mental states, including all of the various evaluations, positive and negative, that people make of their lives, and the affective reactions of people to their experiences".

One of the most common approaches to assessing subjective wellbeing is asking people to rate on a scale of 0 to 10 how satisfied they are with their lives nowadays.[2] [3] Most OECD countries now include such questions in their national data collection.

Frijiters and Layard[4] outline the merits of the life satisfaction approach as follows:

It depends on a single question;

The chosen question asks individuals to evaluate their own life situation: it does not require the policy-maker to decide what is or is not more important about a person's experience;

It is a natural step from asking citizens how satisfied they are with services they receive, which they are already used to.

There is now an extensive evidence base to support the validity and reliability of these kinds of subjective wellbeing measures.[5] [6] [7]

This is also in line with the direction of government policy which seeks to develop methodologies to incorporate wellbeing into policy design and budgetary processes.[8]

The thinking around the valuation of life satisfaction has also progressed significantly in recent years. The UK Treasury in its guidance on economic appraisal has long advocated the incorporation of wellbeing and other non-economic outcomes into cost benefit analysis. The most recent iteration endorsed the use of WELLBYs (life satisfaction-adjusted years of life) developed by academics.[9] These are pegged to QALYs, a tool developed by the National Institute for Clinical Excellence (NICE) to support recommendations to the National Health Service (NHS) regarding the cost effectiveness of medical interventions. The QALY takes a value between 0 and 1, where 1 is one year of life in perfect health (no medical intervention).

According to the UK Treasury, the recommended standard value of one WELLBY – a one-point change in life satisfaction for one year is £13,000 (2019 prices and values) with a range of £10,000 to £16,000).[10] The formula for calculating a WELLBY value for an intervention is as follows:

wellbeing valuation =
change in wellbeing x wellby per year

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1 OECD (2013), OECD Guidelines on Measuring Subjective Well-being, OECD Publishing, Paris, https://doi.org/10.1787/9789264191655-en.

2 Organisation de coopération et de développement économiques (Paris). (2013). OECD guidelines on measuring subjective well-being. OECD publishing.

3 CSO (2018) The Wellbeing of the Nation Societal Wellbeing in Ireland 2017 https://www.cso.ie/en/media/csoie/releasespublications/documents/health/Wellbeing_of_the_Nation_FINAL_OFT__-_web.pdf

4 Frijters, P., & Layard, R. (2018). Direct well-being measurement and policy appraisal: a discussion paper. London: LSE CEP Discussion Paper.

5 OECD (2013), OECD Guidelines on Measuring Subjective Well-being, OECD Publishing, Paris, https://doi.org/10.1787/9789264191655-en.

6 Kahneman, D., & Krueger, A. B. (2006). Developments in the measurement of subjective well-being. Journal of Economic perspectives, 20(1), 3-24.

7 Dolan, P., Peasgood, T., & White, M. (2008). Do we really know what makes us happy? A review of the economic literature on the factors associated with subjective well-being. Journal of economic psychology, 29(1), 94-122.

8 Kennedy, F. (2022) Well-being and Public PolicyUtilising a well-being perspective to inform public policy https://www.gov.ie/pdf/?file=https://assets.gov.ie/242244/a37eb08d-217f-449d-90a9-ca1256a803a3.pdf#page=1

9 Frijters, P., & Krekel, C. (2021). A handbook for wellbeing policy-making: History, theory, measurement, implementation, and examples (p. 454). Oxford University Press.

10 HM Treasury (2021). Wellbeing guidance for appraisal: supplementary green book guidance. HM Treasury, London.

5.2 APPLYING THE WELLBY APPROACH TO THE HCP

We know that wellbeing is a multifaceted concept and what the WELLBY assumes is that the underlying change in wellbeing is 'total' (i.e. as well as directly measuring changes in life satisfaction, it captures any factors that contribute towards it).

In the case of the HCP, these contributing factors would be social capital and physical health benefits.

For example, analysis of the British Household Survey (BHS) shows the extent to which different features of life contribute towards variations in life satisfaction in Britain (Figure 1). As we can see, physical and mental health explain almost 60% of the variation with relationships bringing the total to almost three-quarters.

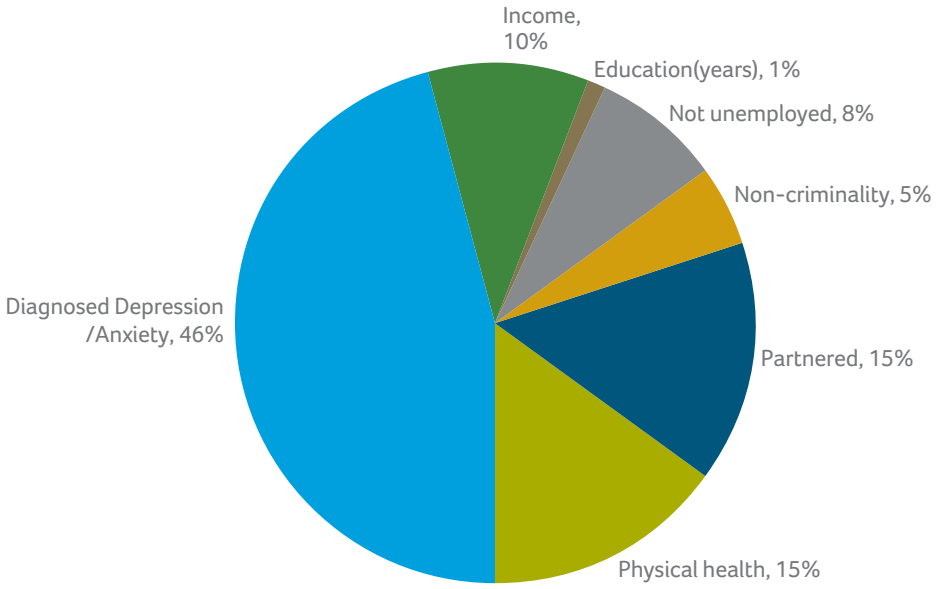

Figure 1: Contribution of other outcomes to variation in life satisfaction in the Britain

Unfortunately, the BHS does not quantify other relationships, or what we might call social capital. However, there is a significant international literature that links social capital to life satisfaction.[11],[12],[13] The risk with valuing each of the three outcomes observed for HCP participants (wellbeing, social capital and physical health) individually is that we risk double counting of the benefits.

Our approach, therefore, for monetising the benefits of the HCP is to value the change in life satisfaction alone, with the assumption that it captures the contribution of all these benefits.

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[11] Elgar, F. J., Davis, C. G., Wohl, M. J., Trites, S. J., Zelenski, J. M., & Martin, M. S. (2011). Social capital, health and life satisfaction in 50 countries. Health & place, 17(5), 1044-1053.

[12] Maass, R., Kloeckner, C. A., Lindstrøm, B., & Lillefjell, M. (2016). The impact of neighborhood social capital on life satisfaction and self-rated health: A possible pathway for health promotion?. Health & place, 42, 120-128.

[13] Zou, T., Su, Y., & Wang, Y. (2018). Examining relationships between social capital, emotion experience and life satisfaction for sustainable community. Sustainability, 10(8), 2651.

5.3 VALUE FOR PARTICIPANTS

Table 1 shows the breakdown in wellbeing by domain, which can be incorporated into the WELLBY methodology.

Domain of wellbeing	Increase	Average scores at follow-up
Life satisfaction	0.21	7.28/10
Connected to others	0.5	7.35/10
Connected to community	0.64	7.21/10
Average	**0.45**	

Table 1: Change in wellbeing by domain

Given the fact that the WELLBY values are derived from life satisfaction, we propose to only use the life satisfaction data in the calculation.

We have two sources of data for this; the Phase 5 survey and the Steps Challenge. Although the Steps Challenge data is based on a larger sample, the benefit of the Phase 5 data is that it tracked the same participants, so we can have greater confidence that the measurements are not because of chance. We propose therefore to use the Phase 5 change (0.21). The UK figure of £13,000 is converted to Euros, giving a value of €14,950. This suggests a wellbeing benefit of €3,140 Euros per year per participant.

This may seem large relative to the size of the change in wellbeing. However, as mentioned earlier, findings from the life satisfaction literature show that movements of +1 on a 0/1-10 scale are difficult to achieve. As Pretty and Barton point out, in the World Happiness Reports the maximum change across whole populations in life satisfaction/happiness over a decade (2005–2006 to 2016–2018) is 1.0–1.3 (5 countries), then 0.5–1.0 (30 countries) and 0–0.5 (43 countries).[14] This demonstrates how valuable small movements are.

The final step is to calculate the total annual value for participants. In 2023, the HCP portal showed that 2389 HCP activities were accessed 184,598 times in 447 clubs (see Table 2).

Output	Number	Source
Number of times activities accessed	184,598	HCP portal
Number of activities	2389	HCP portal
Number of clubs	447	HCP portal
Average Activities per club	5	HCP portal
Average number of weeks activities run for	10.7	HCP portal

Table 2: Data on participants

However, we also know that many participants take part in more than one activity. Whilst this is very positive for the programme, it also means that if we include all participants in our calculations, we risk double counting the benefit, as we cannot assume that the observed change will happen twice. According to our survey participants take part in two activities per year on average. We can use this figure to arrive at an estimate of unique participants: 92,299. 5.4 VALUE FOR VOLUNTEERS

As we have seen, volunteers are key stakeholders of the HCP. They are beneficiaries with clear health and wellbeing outcomes, but their time is also an important input such that the programme could not operate without them.

[14] Pretty, J., & Barton, J. (2020). Nature-based interventions and mind–body interventions: Saving public health costs whilst increasing life satisfaction and happiness. International journal of environmental research and public health, 17(21), 7769.

Later, we will discuss volunteers as an input but here we consider their outcomes. Table 3 sets out data on volunteers from the HCP portal. As we can see, there are 1912 volunteers across the programme, of which 476 are HCOs.

Output	Number	Source
Number of volunteers	1912	HCP portal
Number of HCOs	476	HCP portal
Average team size	4.3	HCP portal
Number of clubs	447	HCP portal

Table 3: Volunteer data

As we have similar outcomes for volunteers as for participants, we have used the same valuation approach. However, the only difference is that the life satisfaction improvement is higher for volunteers (0.85) than for participants (0.21) resulting in a higher wellbeing valuation (€12,708).

5.4 VALUE FOR HEALTH SERVICES

The HSE is a funder of the HCP but also an important beneficiary, along with the NHS in Northern Ireland. As discussed above, achieving improvements in wellbeing and associated health/behaviour change outcomes is challenging at the population level. However, we know from research that these are preventative in nature and lead to reductions in health service use and therefore savings to the health services over time. For example, life dissatisfaction has been found to be significantly associated with being a high-cost health service user in the future, even after adjustment for demographic factors, comorbidity, socioeconomic factors, and health behaviours.[15]

Due to limitations in our study design, it was not possible to capture changes in health service use directly. Our focus throughout has been on lean data collection to ensure high response and completion rates. Surveys that capture service use robustly require very long and detailed questioning that would deviate from the lean data approach.

Instead, we can draw on findings from other studies with a similar focus to estimate the scale of change. Pretty et al.[16] have summarised reductions in health service use from 'social prescribing' programmes. Social prescribing recognises that health is determined by social factors such isolation and loneliness and offers GPs and health professionals a means of referring people to a range of non-clinical community supports similar in nature to HCP activities.[17] Table 4 shows the reductions in different kinds of service use from these programmes.

Type of service	Change
Reduction in primary care use	15-25%
Reduction in Emergency Department services	20-25%
Reduction in secondary care use	35-50%

Table 4: Service use reductions from social prescribing programmes

We can apply these estimates to our population of participants and volunteers. In each case to remain conservative, we have used the lowest estimated reduction. For GP care, we have taken the proportion of the population that have free access to GP care (32%).[18] We assume that 15% of that group have a

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15 Goel, V., Rosella, L. C., Fu, L., & Alberga, A. (2018). The relationship between life satisfaction and healthcare utilization: A longitudinal study. American Journal of Preventive Medicine, 55(2), 142-150.

16 Pretty, J., & Barton, J. (2020). Nature-based interventions and mind–body interventions: Saving public health costs whilst increasing life satisfaction and happiness. International journal of environmental research and public health, 17(21), 7769.

17 HSE (no date) HSE Social Prescribing Framework https://www.hse.ie/eng/about/who/healthwellbeing/our-priority-programmes/mental-health-and-wellbeing/social-prescribing/hse-social-prescribing-framework.pdf

18 Government of Ireland (2022) Health in Ireland: Key Trends 2022 https://www.gov.ie/pdf/?file=https://assets.gov.ie/241598/8a6472b4-83cf-45ec-88c9-023e0c321d8c.pdf#page=null

reduction in GP use (lowest estimate in Table 8). The average annual use of GPs in Ireland is 4.34[19] and a 15% reduction is 0.651 visits. Full public costs of GP are not available, so we assume a nominal value of €53 (the average cost of a GP visit for those that pay).[20] For those that pay for their own GP care there is also a saving that has not been included here.

For Emergency Department visits, we have taken the total number of visits in 2022 (1.5m)[21] and divided it by the population (5.033m). This gives a population average of 0.29 visits. Again, we have used the nominal cost of €100 per visit to value this.[22]

In 2021, there were 59,040 admissions[23] to hospital with an average stay of 5.7 days. This is an admission rate of 0.12 per head of population. The average cost per hospital bed is €878 per day.[24] We can use these data to estimate the proportion of HCP participants that would be at risk of hospital admission and assume a reduction in that risk of 35%. To estimate the cost, we remove them from the calculations the proportion that are likely to have private health insurance (46.4%), based on the national average.[25] For the remaining proportion, we can then estimate the cost saving.

5.5 ADDITIONALITY

Additionality describes the net benefit of an organisational activity or intervention beyond what would have happened anyway without the intervention. It should take account of two related factors: (1) attribution (i.e. the extent to which any observed benefit was attributable to the intervention being evaluated rather than other extraneous factors) and (2) deadweight (what would have happened anyway without the intervention).

To fully capture additionality an experimental research design is required (i.e. the use of a control group). Place-based initiatives operate as open systems – that is, they are in a constant state of interaction with their environment, which makes them unsuitable for controlled trials.[26] These real-world constraints mean that such a design was also not possible in this study and this is an important limitation.

However, rather than assume all observed outcomes are additional, we have sought to make an assessment of additionality though the findings from our qualitative research.

First, in relation to attribution, we know from our case studies that many of the HCP activities were already in progress before the project began. To assess this, HCOs (n=43) were surveyed to obtain an estimate of the proportion that were pre-existing. This varied greatly from 0% in some cases to 100% in others. The average of new activities across the clubs is 62%. Whilst we acknowledge that involvement in the HCP will bring benefits to these activities (e.g. training, funding, networking, access to the community of practice, and wider supports), we also need to apportion some of the benefit to volunteers themselves that initiated the activities. Moreover, some of the activities, like the All-Stars programme obtain funding from outside the GAA and again, this needs to be acknowledged. Taking all of this into consideration, we have used

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19 Collins, C., & Homeniuk, R. (2021). How many general practice consultations occur in Ireland annually? Cross-sectional data from a survey of general practices. BMC Family Practice, 22(1), 1-9.

20 O'Regan. E. (2022) GP visit now costs an average of €53 but life expectancy here is higher than in the North Irish Independent https://www.independent.ie/irish-news/gp-visit-now-costs-an-average-of-53-but-life-expectancy-here-is-higher-than-in-the-north/41429768.html

21 Government of Ireland (2022) Health in Ireland: Key Trends 2022 https://www.gov.ie/pdf/?file=https://assets.gov.ie/241598/8a6472b4-83cf-45ec-88c9-023e0c321d8c.pdf#page=null

22 https://www.hse.ie/eng/about/who/acute-hospitals-division/patient-care/hospital-charges/

23 Healthcare Pricing Office (2021) Activity in Acure Public Hospitals in Ireland http://www.hpo.ie/latest_hipe_nprs_reports/HIPE_2021/HIPE_Report_2021.pdf

24 Tithe an Oireachtais Hospital Beds Data Dáil Éireann Debate, Wednesday - 13 May 2020 https://www.oireachtas.ie/en/debates/question/2020-05-13/662/

25 Health Insurance Authority (2021) Press Release https://www.hia.ie/sites/default/files/Press%20Release_May%202021.pdf

26 Heery, L., Naccarella, L., & McKenzie, R. (2018). "Improvement focused" evaluation of place-based initiatives: An approach to examining three methodologies. Evaluation Journal of Australasia, 18(2), 99-108.

the 62% as the best available estimate.

Deadweight in this instance considers the proportion of individuals that would have gone on to take part in increased exercise without the programme. To assess this, we draw on responses to the question as to whether participants thought involvement in the HCP influenced the extent to which they took part in physical activity outside of the programme. 41% said that it did either 'a great deal' or 'a lot'. We have taken this percentage as a measure of attribution i.e. we have removed 59% of the benefit.

A final feature of additionality is displacement. Displacement may occur: e.g. where a volunteer would have volunteered elsewhere and achieved the same benefit if they had not volunteered here. However, in the absence of any data, we have assumed no displacement. Data sources on additionality are summarised in Table 5.

5.6 PRESENT VALUE

To arrive at the present value for each stakeholder, the net beneficiaries (less deadweight and attribution) is then multiplied by the proxy values set out above. These are set out in Table 9.

In all cost benefit methodologies, it is standard practice to project outcomes into the future. However, due to limited longitudinal data, and to ensure a conservative analysis, we have only included benefits for one year. Whilst we know that some benefits will last into the future, we also know that sustaining healthy behaviours over time is challenging and would expect to see some significant drop off unless further investment is made to maintain the change (e.g. investment in HCP activities in future years). Further research on longer run change is required. Table 5 summarises the present value for each group and Table 6 summarises the economic model.

Stakeholder group	**Present Value**
Participants	€45 million
Volunteers	€3.27 million
Health services	€619,932
Total	**€49.5 million**

Table 5: Present Value of benefits

Stakeholder	Number	Outcome	Indicator	Value	Units
Participant	92299	Wellbeing	Life satisfaction change	WELLBY	92299
Volunteer	1912	Wellbeing	Life satisfaction change	WELLBY	1912
State	30147.52	Reduced healthcare use	Change in GP visit use	Cost of GP visit	19626
	94211		Reduction in A&E appointments	Cost of A&E appointment	5616
	7,736.05				2,707.62

Attribution	Deadweight	Impact	Proxy	Annual value
41%	38%	14380	3140	45,146,588
41%	38%	298	12708	3,785,432
41%	38%	3058	53	162,060
41%	38%	875	100	87,491
41%	38%	422	878	370,381

Table 6: Total benefit by stakeholder and outcome

5.7 INPUTS

There are three inputs that we have included in the model: programme running costs, volunteer time, and GAA overhead.

PROGRAMME COSTS

First, we have the running costs of the programme. In 2022, these were €655,000. Funds were derived from the following contributors:

Irish Life: €350,000

The HSE: €90,000

The National Office for Suicide Prevention: €50,000
The Tomar Trust: €25,000[27]

The GAA: €140,000[28]

VOLUNTEER TIME

Second, we have estimated the value of volunteer time. Although this is not always the process followed, it is generally considered best practice to value outcomes holistically on the cost side if they have been included on the benefits side. It is also important to acknowledge and value the contribution that volunteers make to this project (and the GAA more widely) and a monetary value is one way of making this visible.

As set out in Table 7, there are 1912 volunteers engaged in the HCP. Our club survey found that the average number of hours volunteered per week was 5. We can value these hours by multiplying the number of hours by the minimum wage (€11.80) by the average number of weeks the activities run for 10.7 (HCP portal). This gives a total value of €1.1 million.

This does not take into account the significant volunteer contribution of the 32 County Health and Wellbeing Committees, whose role is to support Healthy Clubs in their counties to achieve their accreditation while initiating new clubs to enter the programme, therefore underestimates the overall volunteer contribution involved in the programme. However, this is consistent with the conservative approach taken throughout the analysis. The purpose is to give an insight into the value of volunteers to the programme, which even on this conservative basis, is almost twice the value of the financial investment made by the programme.

GAA OVERHEAD

Finally, we place a value on the overhead provided by the GAA (e.g. use of club facilities). Whilst the GAA provides some direct funding, there is a large benefit-in-kind provided by clubs in the form of infrastructure and human resources that are not included in the programme running costs set out in Table 10.

It is extremely difficult to put a value on the wider GAA overhead. For the purposes of this report - in discussions with HCP staff – we have assumed the overhead is 100% of the programme cost: €755,793. However, this is likely to significantly underestimate the true value.

TOTAL INPUT COSTS

The total inputs from these three sources are €2.4 million as set out in Table 7.
Table 7: Summary of costs

Cost	Value
Volunteer time	1,074,066
Programme cost	€755,793
Overhead	€755,793
Total input costs	€2,585,653

[27] The Tomar Trust has funded for a four-year period two regional Community & Health coordinators to support the growth of the HCP but also the Community & Health department's wider work in the community. As they commenced in September 2022, and these figures only refer to HCP budgets and spend for 2022, the Tomar Trust contribution will be significantly higher for the years 2023-2025.

[28] This accounts only for the GAA's direct investment in the operations of the HCP and represents only a percentage of the broader investment it makes into the work of the GAA Community & Health department. All personnel in the Community & Health department (beyond the National Healthy Club Coordinator) support the delivery of the HCP while all programmes and partnerships managed by the department feed into the HCP (such as diversity and inclusion, sustainability, youth leadership etc.).

5.8 SROI RATIOS

The SROI ratio compares the cost of the programme (€2.58 million) with the benefits (€49.5 million). The headline return ratio is therefore 19:1, suggesting that €19 of value generated for €1 of financial, volunteer and in-kind investment.

For the HSE, which contributes €90,000 of funding, the benefit from savings to the health service is 4.4:1.[29]

Finally, as mentioned above, the volunteer benefits also outweigh the volunteer inputs (3.5:1).

Due to the lack of longitudinal data, we have only assumed one year of benefit. Were we to see the benefits become a structural feature of participant's lives, the value would increase. The benefit set out here should therefore be considered an underestimate of the true value.

5.9 SENSITIVITY ANALYSIS

There are several assumptions that are highly sensitive to change. First, if we remove the volunteers cost as an input, the SROI ratio increases to 39:1. If we restrict the inputs to the direct financial inputs, the return increases further to 116:1. However, we don't believe either of these adjustments are realistic, as the programme could not operate without the in-kind support from the GAA and/or the volunteer investment.

If we relax the assumption that there is no benefit to participating in a second activity and assume that half of those second-timers get equivalent benefit, the ratio increases to 30:1. However, if we double the value of the overhead, the ratio falls to 15:1.

Finally, increasing the change in wellbeing to 0.72 (the figure reported through the Irish Life's MyLife app.), increases the value of the WELLBY to €10764 and increases the ratio to 48:1.

5.10 CAVEATS AND LIMITATIONS

There are several caveats and limitations to the findings presented here:

- Biases may be present (e.g optimism bias due to the allegiance to the GAA) that inflate the benefits as the majority of measures depend on self-report from participants
- The lack of a true counterfactual means that we may overestimate additionality
- Participants had high wellbeing at baseline, suggesting that participants are not a high-needs group. Although WELLBYs assumes that movements between points on the life satisfaction scale are linear, there is more likely to be a curve (i.e. moving from a 4 to a 5 might be more valuable than from a 7 to an 8). There is even a risk that unless the programme is reaching those with higher needs that it may increase health inequalities by increasing the gap between low and high needs.
- We had insufficient data to segment outcomes by gender or region, which may lead to data loss when averages are included.
- Benefits to the GAA itself, although described have not been included in the economic analysis due to a lack of data. The research has also largely excluded player benefit as these were not in scope.
- Data collection happened in the aftermath of COVID-19, which may impact the findings.

[29] Some of these savings will accrue to the NHS in Northern Ireland

Appendix 6: Case studies and HCP project breakdown

6.1 Case studies

Case study 1

SUPPORT FOR UKRAINIAN REFUGEES

The Aghada GAA club was described by volunteers as an anchor in the community. It covers a large rural area which is very dispersed. There are not many other shops and services, and the GAA was described as the organisation that holds the community together.

"I am the principal of the local school and when I moved to the area, I found it [the GAA] was a great way to meet new people"

About a mile from the club, is the holiday centre Trabolgan, which is currently being used to house hundreds of Ukrainian refugees. The site is quite isolated, there is no public transport and although it is reasonably close to Aghada, there is no footpath, and the road is dangerous to walk on. The volunteers were aware of this and saw an opportunity to support the refugees as part of their Healthy Club activities. They were concerned about the lack of integration and potential for institutionalisation of the residents. They saw sport as an excellent way to connect with people:

"...Ukraine is quite a sporty nation and that the children miss their traditional sports like gymnastics."

However, engaging people was more challenging than expected. Transport is a major challenge for them as most residents don't have cars. However, there were many children already attending the local schools and in the first year (Spring 2022), they organised cars for them to come to training on Wednesday night. They considered going out to the club to train but there were issues with insurance and lack of volunteers who were already over-stretched.

Nonetheless, the whole experience of bringing the kids to training was very successful. In terms of the benefits to the Ukrainian families, the volunteers believe that it is an opportunity for fun and exercise in the first instance. It also gives mothers a break, and if they can get transport themselves an opportunity to meet other people. They also noted that the children lacked male influences as in general the men have stayed in Ukraine, which is something the GAA can offer as well.

"As well as the active side – there is the social side and integration, which is so important"

The volunteers believe that it is incumbent on organisations like GAA to help with integration. The response from the community has been very positive and they have been overwhelmed with support and donations. So far, they have not encountered any negativity:

"...there is great good out there...there is kindness and good-heartedness and that is what I see more than anything."

Nonetheless, there are ongoing challenges. Some children do Ukrainian school outside of normal school hours so are not available for training. Language is also a barrier. At the time of interview, they were not sure what they would do about transport for the coming season. In the future, they would like to have non-GAA games as well and have tournaments like 'fittest family'. They were also considering twinning families but it might be difficult to organise.

The culture of the club was described as 'very welcoming'. It is a 'one club' (i.e. the men's game and women's game are all part of the same organisation) and they believe they are a progressive club.

"It is very community driven...the board let us get on with whatever we want to do within reason"

As well as the Ukrainian work they participate in Ireland Lights Up, are smoke and vape free and provide healthy food to the children. At Christmas they fundraised for Trabolgan and made up 260 present packs and went to deliver them with Santa and a local choir.

They have had their walking track upgraded. Recently two Ukrainian men came in to find out about what happened at the club, and they were invited down to Ireland Lights Up and came with their children. However, they find the budget does not stretch to cover even basic activities.

"We get 100 Euro per year for the lights for Ireland Lights Up but it probably costs 100 Euro per hour."

Volunteers talked about the benefits of being a 'one club', including benefiting in the long-run from fundraising.

"We had our objectors, but we had to remind them that they were not in the GAA to make money."

The benefits to the GAA of bringing new people were described as 'huge'.

"Some of the Ukrainians will probably end up settling here and will have a positive perspective of the GAA."

Case study 2

ALL-STARS PROGRAMME

Maria started an inclusive All-Stars programme for persons with additional needs seven years ago in Raheny GAA. Since then the model has been copied by approximately 160 clubs nationally and growing steadily. Young people with learning disabilities are trained in Gaelic Games and physical exercise for 45 minutes once per week by volunteers.

Maria has a daughter with Down's Syndrome and saw a need for opportunities for physical activity and socialising for young people with disabilities. Many of the young people have been coming since it started and have grown up with it. Although some participants are now adults, they still like to come, and the project will continue as long as there is a need for it. It was noted that services for people with disabilities fall off a cliff at 18 and there are few opportunities for adults. Maria is looking into a version for adults including training adults with disabilities as coaches. For example, of alumni from Allstars may go on to become coaches.

They usually have 8-10 players per week. The sessions start with general warm-ups and then move on to Gaelic Games, practicing specific skills. For example, there is a special plinth for a sliotar, which has been designed especially for people with disabilities and the GAA have now commissioned several of them. They also practice shooting goals, catching and passing.

Parents we spoke with said it was an important physical and social opportunity:

"To be honest, they would be at home on screens otherwise".

They report improvements in gross motor skills, balance, coordination and so on. Maria believes not enough attention is paid to physical health/exercise for young people with disabilities. Some parents report improvements in verbal communication and other social development. It is also an important social opportunity that they enjoy:

"My son comes home and puts his sports clothes on and sits and waits for it to start"

"They really enjoy it"

There are benefits to parents too. They have the opportunity to meet other parents in similar circumstances and some have made friends through the intervention. It is also potentially 45 mins where they get a break and can do some things themselves whilst knowing that their child is safe.

"It is great to have the time, even to go to the supermarket and do some shopping"

Maria recruits young people through special schools and networks. Parents are in a WhatsApp group, which is also a source of information sharing and support. Volunteers are recruited through the parent group and also transition year students in secondary school. Some students really enjoy it and do training, including Lámh[1]. Several of the volunteers are also learning Lámh. One volunteer she has worked with wants to go on and work in the disability sector. Volunteers can stay a long time but there is always pressure to get enough people in who are suitable. They enjoy it and feel giving something back, good experience for some. Some volunteers have previous experience of disability through family members. Others do not and training is provided although this requires a big investment from Maria. There is a great rapport between the volunteers and players with the emphasis on fun and having a go.

Maria had no connection with GAA before All-Stars but considered it the ideal organisation to work with due to its reach, community ethos and the quality of facilities. It was developed around the time Raheny was applying for healthy club status and was therefore the perfect fit. Maria described the healthy club as the most supportive official structure that she engaged with to develop the programme.[2] A notable element is the diffusion of the idea across the country, which the HCP has helped to facilitate. She would also like to evaluate the impact of All-Stars directly on health and wellbeing I.e. gross motor skills, language etc. to create a more scientific evidence base for it.

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[1] Lámh is a manual sign system used by children and adults with learning disability and communication needs in Ireland

[2] While the Raheny All-Stars programme was initiated independently of the HCP, the GAA had in 2017 launched its own inclusive games offering called Fun & Run. The All-Star title was subsequently adopted by the HCP and the model has been extensively promoted through the programme (at conferences, on webinars, and at training events) resulting in significant implementation of All-Stars programmes by Healthy Clubs in recent years.

Case study 3

DADS AND LADS

The Dads and Lads group was formed in St. Colmcille's GAA club, Bettystown, Co. Meath, approximately ten years ago. A need was identified for men to be involved in the GAA when they were past their competitive playing days. The main purpose was to meet up, engage in physical activity, play a few games, and have fun.

They play against other teams a few times a year, meet up socially after a match, and form social connections and friendships. The group plays a very important role for the men in terms of social engagement and mental health. It has helped newcomers to integrate into the community and provides a social outlet in an otherwise busy week of work and family responsibilities. The group highlighted the importance of maintaining physical activity, of being socially connected with others, and having the opportunity of meeting new people particularly new nationalities.

"It showed me it was very good for head space; gents don't talk face to face, we talk side to side, it gave me the opportunity to get to know lads a bit better."

"Its social football, I decided to try it out. It was not overly competitive; you wouldn't get injured. You got to do all the good bits, kicking the ball, having a laugh, it was an alternative, you can't go to the pub midweek, with kids etc. This is an alternative."

"It was great to get back into sport, it was light-hearted, yet still competitive on the pitch. It's great for mental health, men don't tend to talk, and it's been a great support network."

"I'm a Dad with small kids, I want them to have an outdoors outlet. I want activity, and movement, I thought it would be hypocritical if I didn't show that to the kids."

The age profile ranges from those in early thirties up to late fifties. They have drill- based training that is very structured, with one member leading as coach. Others are taking on coaching courses and get to try out new skills with the group. Initially it was focused on circuit training and high fitness, but is now more focused on playing. They have between five and 8 teams in Co. Meath to play against and they can find 15 to 20 players at short notice for games. The group built themselves up gradually and progressed from borrowing kits to purchasing their own. They each pay a little into the group and they have sponsorship. They also pay club membership. The group is very inclusive and there is a strong emphasis on making members feel welcome.

At a national level there has been three large events to showcase the Dads and Lads scheme. They feel there is certainly scope for the GAA to use the mechanism more widely nationwide as the benefits are so tangible. They believe that the mental health benefits are huge and on this basis alone it merits more attention. They feel there should be more two-way conversations with the GAA nationally, rather than what they consider to be a 'top down' approach. It was also felt that the GAA could be more instrumental in helping out such groups with arranging games. It is very ad hoc at present (e.g. the coach getting a text from another group about arranging a match.) This would not have to be a league as such but perhaps a data base of other clubs that have such groups that they could access.[1] They also struggle sometimes to find pitches to play on and thought there might be a role for the GAA in freeing up spaces. The group is led by individuals and they believed that the GAA could play a stronger role in facilitating the running of the groups.

The group also felt that Dads and Lads is a great opportunity for the GAA to market itself in terms of positive mental health and that this was a missed opportunity. The scheme is a strong, positive brand that works. It is inclusive of older age groups but also younger men and men who are not Dads and this could be promoted more.

"I'd like to see somebody at 38, 40 being promoted, he is keeping engaged with his community, he is staying connected. You'd don't just leave GAA when you are finished playing."

There is also evidence that the social connections continue outside of the GAA structure. Some people meet up for coffee, have a chat when out and about, meet up for walks, for golf, to go running etc. The social connections made were described as invaluable to people's quality of life especially in geographical areas that do not have a central community.

[1] The Community & Health department has in 2022 established a relationship with a club match-scheduling App to help facilitate this for Dads & Lads teams.

"In our area it doesn't have a centre, it's a group of pubs surrounded by estates, people are in and out, commuting, if it wasn't for the GAA I wouldn't have gotten to know people... it's integral to a community."

In the future, the group would love the opportunity to feed back their experiences at grassroots level to GAA management and to learn from other groups about what works. They would like to share ideas and have access to a wider network of contacts with groups doing similar activities.

The St. Colmcille's Dads and Lads initiative predates the HCP. They consider themselves to have become 'part of that family' but are clear that no direct support has been provided yet. In fact, when they first started out they encountered some scepticism:

"At that stage the GAA didn't want to know a lot about us, it took a while for the GAA to accept that it is a social thing, we are not trying to take players from junior teams."

Whilst the HCP now provides a 'home' for the initiative and a platform for promoting it more widely, it is not something that could be considered 'additional' at this point. However, the HCP was developed to acknowledge and promote these kinds of initiatives, and where it can provide the kind of supports that the group outline, then more of the value created would be attributable to the HCP over time.

Breakdown of HCP activities by priority areas

Self-reported by Healthy clubs via the Healthy Clubs portal.

Physical activity

Type of Activity	No. of participants
Recreational Rounders	939
Super Games	771
Camán & Chats	244
Healthy handball	161
Gaelic for Lads & Dads	990
Gaelic 4 Mothers & Others	3413
Fitness Classes	2857
Operation Transformation type programme	1585
Men on the Move	446
Other/ Specific physical fitness programme	2953
Ireland Lights Up	18953
Steps Challenge	15469
Other Walking Initiative	21271
Physical Activity Programme + Other (combined stats)	1385

Diversity and inclusion

Type of Activity	No. of participants
Wheelchair Hurling / Camogie	96
Football for ALL (adapted game)	283
All-Star programme (children with additional needs)	1234
Cúl Eile Camps (inclusive sports camp)	399
Fun and Run adapted game	240
National Inclusion Fitness Day	927
Diversity & Inclusion Training	350
Gender Diversity and LGBTQI+ Initiatives	920
Intercultural Activities (Minority Groups/Different Cultures/ Nationalities)	1083
Other/ Specific diversity/ inclusion programme	3188

Substance use & Gambling Awareness

Type of activity	No. of participants
Smoke & Vape-free Club*	14120
Substance Use Awareness/ Education Event	2933
Reduce the Odds Gambling Awareness workshop	409
Other/ Specific substance use/gambling programme	250

***Refers to numbers attending GAA venues that have adopted a smoke and vape free policy**

Community development

Type of activity	No. of participants
Dermot Earley Youth Leadership Initiative (DEYLI)	301
First Aid/ CPR/ Defib Training	2988
Health Screening	3526
Anti- Bullying Initiative / Workshop	1017
Green Clubs/ Sustainability Initiatives	2843
Road Safety Programme	168
Social Initiative for older people	3253
Charity events/fundraisers	18856
Donation campaigns (blood/ stem cells/ organ donation etc.)	856
Digital/ Social Media Awareness Initiative	1188
Covid 19 Community Response	4692
Cancer Prevention workshops	1466
Goldmark Programme for Young Volunteers (Ulster GAA)	22
OCN Young Leaders Programme (Ulster GAA)	3
Other/ Specific community development programme	16975

Mental fitness

Type of activity	No. of participants
Samaritans workshop	694
SAFE Talk (Suicide Prevention training)	581
ASSIST (Applied Suicide Intervention Skills Training)	79
Mental Health Awareness campaigns (GAA Mental Fitness packs/ Little Things / 5 Ways to Wellbeing/ Green Ribbon)	2358
Jigsaw One Good Coach online training	860
Stress Control / Life Skills programme	589
Darkness Into Light	8183
Wellbeing in Sport Online Mental Health course (Ulster GAA)	20
Other/ Specific mental fitness programme	3975

Healthy eating

Type of activity	No. of participants
Recipes for Success	574
Provision of healthy options at training / matches	7370
Nutritional workshops for teams	2545
Healthy Eating online initiatives	46
Cook It Programme (NI)	66
Healthy Food Made Easy Programme (26 counties)	106
Other/ Specific healthy eating programme	1914


Healthy
Clubs

Healthy Clubs, Healthy Bodies, Healthy Minds.