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Organisational Readiness and Capacity Building Strategies of Sporting Organisations to Promote Health

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Abstract: This paper explored the readiness of Victorian State Sporting Organisations (SSOs) in Australia to implement health promotion (HP) programs and sought to understand how they implemented capacity building strategies to promote health. Ten SSOs that received funding to develop and implement HP were recruited for the study. Interviews were conducted with key staff from SSOs and focus groups were undertaken with their Boards of Management. Factors analysed were SSO organisational readiness and capacity building strategies to implement change in organisational processes, organisation and resources, and systems and controls. SSOs made a concerted effort to create and support sport and recreation contexts that promote healthy behaviours. A number of SSOs achieved changes in their culture and systems by implementing formalised and systematic programs such as the club development program. The club development program supported the implementation and sustainability of HP throughout the organisational system of the SSO. These changes, however, were dependent upon organisational readiness; particularly climate and capacity, whereby financially “well off” SSOs had the capacity to engage in HP in a significant way. This paper highlights opportunities and challenges for policy makers to fund HP within sporting organisations; especially when the delivery of sport is a more immediate responsibility than HP.

Key words: Sport policy, health promotion, organisational change

1. Introduction

The primary goal of sport and recreation organisations is to provide individuals and communities with opportunities to participate in sport, recreation and physical activity. At the community level, these organisations often provide a combination of structured, unstructured, competitive and non-competitive programs that are delivered by volunteers in sporting clubs. Most community-based sports clubs are supported and potentially governed by National and/or State Sporting Organisations (NSOs and SSOs, respectively) who manage national and state competitions, focus upon coach, official, and player development, promote diligent management in community-based sports clubs, provide insurance coverage for players, assist in facility development, and seek to increase and maintain participation in their sport (Hoye, Smith, Nicholson, Stewart, & Westerbeek, 2009).

In Australia and other parts of the world such as Finland and the US, sport and recreation organisations have been encouraged to provide healthy environments such as smoke-free environments, sun protection, and safe alcohol practices; particularly through legislative and policy approaches (Bormann & Stone, 2001; Corti et al., 1995; Eime, Payne, & Harvey, 2008). The use of sport and recreation organisations to achieve non-sporting objectives is not new among policy makers. Sport and recreation organisations have long been perceived as a vehicle to achieve a range of non-sporting objectives including nationalism, social rights of citizenship, and a wide range of health objectives. For example, in 1956 the South African policy of apartheid drew international attention to the institutionalised racism of the Nationalist party and opponents of the South African government called for other nations to sever economic and sporting contacts (Polley, 1998). More recently, sport and recreation organisations have been required to address a wide range of policy issues including social capital, improving health, job creation, economic regeneration and the stimulation of tourism (Coalter, 2007; Houlihan, 2008). For instance,

sport policies from Australia, Canada, England, and New Zealand during the period 1999 to 2006 have included reference to social capital, whereby governments implicitly believe that participation in sport generates increased social cohesion, social connectedness, and increased community wellbeing (Hoye & Nicholson, 2008). Similarly, participation in sport and physical activity is promoted internationally to ease the financial and social impact of a range of chronic diseases associated with physical inactivity (Priest, Armstrong, Doyle, & Waters, 2008; Sparling, Owen, Lambert, & Haskell, 2000).

Whilst the use of sport and recreation organisations to achieve non-sporting objectives is not new among public policy makers, the way in which sport has been touted to improve health has progressed from a passive and symbolic settings approach to one that is more ambitious, active and programmatic; particularly in Australia. The settings-based approach is contemporary to health promotion (HP) theory and is built on the principle that change is not solely focused on individuals and their health problems, but that changes are generated in organisations and communities to ensure the development of environments that support population-wide changes in health-related behaviour (Whitelaw et al., 2001). Setting-based approaches have ranged from the more conservative and passive model where settings provide communication channels and access to participants to deliver individually-focused HP messages and activities; to the more ambitious and comprehensive model that seeks to develop policies and bring about structural and cultural changes within organisations and communities (Whitelaw, et al., 2001).

In Australia in the late 1980s, many sport and recreation organisations were sponsored via schemes designed to facilitate the replacement of tobacco industry sponsorship of sport with health-focused sponsorship. This was consistent with the more conservative and passive settings approach; whereby, the setting was a vehicle to deliver health messages. More recently, health-focused sponsorship of sport and recreation organisations has facilitated a

more 'active' model through sponsorship to develop and implement HP policies including smoking free areas, healthy food choices, and safe alcohol practices (Corti, et al., 1995; Dobbins, Hayman, & Livingston, 2006; Swerissen & Crisp, 2004). This approach focused upon tightly defined topic areas and assumed that policy changes in the setting would influence individual behaviour by making the 'healthier choice, the easier choice'. To date, there is limited evidence that policy changes within sport settings result in individual behaviour change; although it has been reported that a policy banning alcohol in American college-sporting stadiums reduced arrests and assaults at the venue (Bormann & Stone, 2001).

While sport and recreation organisations might be less focused on overtly achieving public health objectives; there is an acknowledgement by key stakeholders in these organisations that the implementation of health-related policies and practices positively impacts on sport participation, club membership, and hence the viability of sport (Eime, et al., 2008). The active use of sport and recreation organisations to achieve broad public health objectives is a relatively new strategy by governments and health organisations, and hence requires sports organisations to implement changes to the planning and delivery of their sport. Considering the differing organisational values and goals across sectors (eg. health vs sport) and the varying capacity of sporting organisations this is a challenging initiative. To date, research has not explored the organisational readiness and capacity building strategies of sporting organisations to achieve a range of social and health outcomes, despite their increasing involvement in health-related programs. Understanding the organisational readiness and capacity building strategies of sport and recreation organisations is important for assisting policy makers, practitioners and funding bodies from both the health and sport sectors to make decisions about the promotion of health through sport, and is useful for gaining stakeholder support, empowering others to implement change and institutionalising change (Kotter, 1995; Oakland & Tanner, 2007).

The purpose of this study, therefore, was to explore the readiness and capacity building strategies of SSOs to implement HP activities that encourage healthy behaviours and contribute to public health objectives. The study was set in Victoria, Australia; and specifically SSOs that had been sponsored to develop and implement HP policies and practices by the Victorian Health Promotion Foundation (VicHealth). VicHealth is an agency that was established by the Victorian Parliament as part of the Tobacco Act of 1987 to promote good health and prevent ill-health.

A description of sport policy in Australia, along with a review of organisational change in sport is outlined below to contextualise the study. This is followed by the theoretical framework, results and discussion. The results of the study are presented within the key themes of the theoretical framework (i.e., organisational readiness for change and implementing change) and the discussion highlights the opportunities and challenges for policy makers to fund HP within sporting organisations.

1.1 Sport Policy in Australia

The evolution of sport policy in Australia has been heavily influenced by government policy. Prior to World War II, government involvement in sport was limited and mostly focused on elite participation and facility development (Hoye & Nicholson, 2009). Indeed, government sport policy in Australia was relatively absent until the 1972 Commonwealth election when future Prime Minister Gough Whitlam declared ‘there is no greater social problem facing Australia than the good use of expanding leisure’ (Whitlam, 1972); and subsequently a Commonwealth government portfolio for recreation, and by association sport, was established (Hoye & Nicholson, 2009). Almost a decade later an elite training institute, known as the Australian Institute of Sport was established (1981) further reinforcing an elite focus in sport policy.

Government sport policy in Australia has primarily focused upon the development of sport to ensure “pathways and structures are in place to enable people to learn basic movement skills, participate in sports of their choice, develop their competence and performance and reach levels of excellence” (Sports Council, 1993). More recently, Australian government sport policy has digressed to encompass development through sport which emphasises social objectives and sees sport as a tool for addressing challenging social and developmental issues (Houlihan & White, 2002). For instance, the *Partnership for Health Scheme* (2003-2007) an initiative of VicHealth attempted to target multiple levels of influence on individual behaviour, such as physical activity, smoking and alcohol use by focusing on the broader sport policy and physical environment in which sport is played. Specifically, the *Partnership for Health Scheme* sponsored SSOs to develop health-related sport policy and ultimately healthy and welcoming sporting environments (HWEs) (e.g., smoke-free settings, responsible serving of alcohol, sun protection, health eating, injury prevention and welcoming environments). It was expected that SSOs would communicate and encourage the development of these HWEs in their affiliated community-based sports clubs (VicHealth, 2003).

The development and implementation of HWEs seeks to bring about significant structural and cultural change within sport and recreation organisations and this often requires organisations to transform to meet a new strategic and operational challenge. As such, these organisations were presented with a new, complex and challenging purpose, which was in addition to their provision of sport and recreation competition, training, and/or events.

1.2 Organisational Change in Sport

Successful organisational change is highly dependent on an organisation’s readiness (i.e., organisational culture, strategy or direction) and capacity to change (i.e., systems) (Oakland & Tanner, 2007). Understanding an organisation’s readiness for change is

important for gaining stakeholder support, providing appropriate leadership and direction, and planning change programs (Oakland & Tanner, 2007). Organisational change is an under-recognised area in HP practice (Heward, Hutchins, & Keleher, 2007); although it is crucial for bringing about planned changes that enhance an organisation's ability to address health issues (NSW Health, 2001).

The strategic change process of Canadian NSOs facilitated by Sport Canada between 1983 and 1996 has been one of the most extensively researched areas of organisational change in the non-profit sector and specifically in sport. Sport Canada provided financial support to NSOs to transform the amateur sport system from a volunteer-controlled to a professional and bureaucratic organisational design (Amis, Slack, & Hinings, 2002, 2004; Kikulis & Slack, 1995; Kikulis, Slack, & Hinings, 1995; Slack & Hinings, 1992). The intention of Sport Canada was to optimise performances at the 1988 winter Olympics in Calgary and summer Olympics in Seoul (Amis, et al., 2004). Amis et al. (2002) found that over the 12-year period organisations that opposed the change entered into a period of superficial conformity, mainly in response to the financial incentives provided. On the other hand, organisations with members that held values similar to those of Sport Canada were successfully engaged in the transition process. Organisational change within the Canadian NSOs was also highly dependent on leadership, and specifically the leader's interests, motivation to change and capacity to initiate change (Amis, et al., 2004). In addition, Amis, et al. (2004) found that NSOs that had an organisational structure in which volunteers were willing to share power with professional staff were more likely to engage in the transformation and adopt changes across the organisation. Clearly, in the sport and recreation context, the organisation's leader may act as either a driving or resisting force in the change process. Leadership is, therefore, an important variable for examination with respect to facilitating HP changes within sport and recreation organisations. Similarly, leadership and

organisational commitment were the most frequently reported factors that supported organisational changes to implement HP within various settings outside of sport and includes public health units (Berentson-Shaw & Price, 2007; Riley, Taylor, & Elliott, 2003), hospital settings (Groene & Jorgensen, 2005; Johnson & Baum, 2001), and school settings (Cass & Price, 2003; Inchley, Muldoon, & Currie, 2006)

Within many organisational change programs, understanding an organisation's capacity is crucial for designing capacity building strategies in order to implement change (Casey, Payne, & Eime, 2009). Capacity building has been conceptualised in a number of ways in the literature. The NSW Health Department (NSW Health, 2001) has been instrumental in developing a framework for capacity building and referred to capacity building as a set of strategies that can be applied both within programs and across systems to lead to greater capacity of people, organisations and communities to promote health. These key areas for strategy development include organisational development, workforce development, resource allocation, leadership and partnership.

The organisational capacity of community-level sporting organisations has been explored by some (Misener & Doherty, 2009; Sharpe, 2006); although none have explored capacity at state or national sporting organisational levels. Others have also explored capacity in the context of non-profit organisations, which include sport (Backman & Smith, 2000; Stid & Bradach, 2009). At the community sport club-level, studies with a qualitative and single case design have reported that human resource capacity was “the most critical factor influencing goal attainment for the club” (Misener & Doherty, 2009) (p. 478); and that strong relationship and network capacity was “beneficial for attaining required resources whether human, technical or material” (Misener & Doherty, 2009) (p. 473). Furthermore, Sharpe (2006) comments that the “tendency to professionalise community services reduces the space

for volunteer participation in a way that favours some members of the community over others and perpetuates inequalities related to class, educational status and cultural capital.” (p. 399).

2. Theoretical Framework

The theoretical framework is presented below using change management guidelines and approaches, as well as, capacity building frameworks. The engagement of SSOs in HP programs like the development of HWEs seeks to bring about structural and cultural changes within the organisations and communities and requires the organisations to transform to meet a new strategic and operational challenge. Change management is well documented in the business and management literature (Kotter, 1995; Lewin, 1951; Oakland & Tanner, 2007; Waddell, Cummings, & Worley, 2000).

Planned change emerged as a framework from the work of Lewin (1951) who identified three stages of change: 1) unfreezing, or reducing those forces that maintain an organisation’s behaviour; 2) movement, which shifts the behaviour of the organisation, department, or individual to a new level; and 3) refreezing, or stabilising the new behaviour by reinforcing the new organisational culture, norms, policies, and structures. In the HP field, however, there are few examples of managing planned change (Heward, et al., 2007). Goodman, Steckler and Kelger (1997) have proposed a four stage model for change that is applicable to HP and includes: awareness raising (Stage 1), adoption (Stage 2), implementation (Stage 3), and institutionalisation (Stage 4). This framework assists change agents to devise and implement strategies in each of the four stages to promote change. For example, awareness raising (Stage 1) requires the change agent to consider how they can stimulate interest and support for organisational change at the senior levels; whilst adoption (Stage 2) involves planning for and implementation of a policy or program (Goodman, et al., 1997). Implementation (Stage 3) is concerned with the training and material support needed to introduce change; and institutionalisation (Stage 4) focuses on the long-term maintenance

of an innovation (Goodman, et al., 1997). The business management literature has developed more detailed change management theories to improve business performance (Kotter, 1995; Oakland & Tanner, 2007). These theories may assist the development of organisations to practice HP by promoting an understanding of the social, economic, organisational and political systems within which HP programs take place and facilitating successful navigation of short and long term program changes.

In addition to Goodman's (1997) four stage model for change, the models of Kotter (1995) and Oakland and Tanner (2007) are applied to this study to explore the development of SSOs for HP action. Kotter (1995) highlights eight sequential steps to transforming an organisation and these include: establishing a sense of urgency, forming a powerful guiding coalition, creating the vision, communicating the vision, empowering others to act on the vision, planning for and creating short-term wins, consolidating improvements and producing still more change, and institutionalising new approaches. The organisational change guidelines documented by Kotter (1995) may be considered as a culture-based theory to change whereby organisational leaders engage staff members and/or stakeholders in the change process to identify problems and then develop shared strategies for improvement. Identifying organisational problems requires an understanding of organisational climate, culture and capacity (Goodman, et al., 1997). Organisational climate is defined as the characteristics that distinguish one organisation from another, is based on the collective perceptions of those that live and work in that environment, and that influence their behaviour (Nutbeam & Harris, 2004). Organisational culture is often used interchangeably with organisational climate, but organisational culture is distinguished as meaning a set of values and assumptions about an organisation that have formed over time, is more stable and more resistant to change than organisational climate (Nutbeam & Harris, 2004).

More recently, Oakland and Tanner (2007) have further conceptualised organisational change and emphasised the two interacting cycles of change: the organisation's readiness for change (e.g., culture-based approach), and implementing change (systems-based approach). Oakland and Tanner (2007) suggested that many change programs often launch into the implementation of change, without understanding or developing the organisation's readiness for change. Understanding the organisation's readiness for change is important for gaining stakeholder support, providing appropriate leadership and direction, and planning change programs (Oakland & Tanner, 2007). In addition, many change programs that launch into implementation begin by focusing on changing behaviours and implement staff training programs; rather than addressing the organisational processes and structures that support particular behaviours that are not congruent with the prescribed changes or desired outcomes (Oakland & Tanner, 2007). The first interacting cycle of Oakland and Tanner's (2007) model represents readiness for change which involves a) understanding the key drivers for change within and outside the organisation; b) providing leadership and direction to turn the need for change into expectations (e.g., values, aims, measured objectives and targets); and c) robust planning. The second interacting cycle is implementing change and involves building capacity to make changes to the a) organisational processes (e.g., the processes that drive the way the organisation and resources work); b) organisation and resources (e.g., structure, roles, competencies and resource deployed); and c) organisation's systems and controls (e.g., performance measures and technology).

Considering the point that it is crucial to understand an organisation's capacity to implement change and that capacity building strategies are required to implement change (Casey, Payne, & Eime, 2009); a capacity building framework has been integrated into the organisational change framework, particularly to understand how SSOs implemented organisational changes. Capacity, and more specifically capacity for HP has been

conceptualised as a set of strategies that can be applied both within programs and across systems to lead to greater capacity of people, organisations and communities to promote health. The capacity building framework recommends that strategies span five key action areas: organisational development, workforce development, resource allocation, leadership and partnership (NSW Health, 2001). Together, these key action areas are considered to: 1. facilitate the development of infrastructure to deliver HP programs; 2. enable the establishment of partnerships and organisational environments so that partnerships and health gains are sustained; and 3. establish the capability to solve problems (NSW Health, 2001).

Figure 1 displays the data analysis framework applied to this study and highlights the integration of Kotter (1995) and Goodman et al., (1997) theories of change and the capacity building framework (NSW Health, 2001) into Oakland and Tanner's (2007) two interacting cycles of change.

<Insert Figure 1 about here>

3. Research Method

3.1 Sample Selection

This study used a stratified-purposeful sampling method to select SSOs with major variations. The purpose of selecting major variations was to control for variables that may influence the results of the research. The variables suspected to influence the results in this research included the funding for HP programs (i.e., VicHealth funding) and the organisational complexity of individual SSOs. A total of 51 SSOs initially received funding from VicHealth in 2003, to implement the *Partnership for Health Scheme*. In 2005, one SSO was no longer funded under the scheme, reducing this number to 50 SSOs. The funding allocation for each of the 50 SSOs ranged from \$20,000 to \$670,000 per financial year over four consecutive years (2003 – 2007). In terms of organisational complexity, individual SSOs

varied in the number of Effective Full-Time (EFT) staff (range: 0.5 – 165.5 EFT staff), annual turnover (range: \$12,800 – \$13,945,526), number of clubs (range: 4 – 1,229) and membership (range: 650 – 157,000). Therefore, a matrix that included these key variables was developed to cluster the SSOs into four groupings so that ten SSOs could be selected for in-depth interviews. The allocation of SSOs to the four groups was largely based on the funding allocation and the number of registered clubs and members.

Grouping the SSOs into clusters was a difficult and complex task, particularly since there was variation between the cases within a given group. The ten SSOs were chosen by first selecting the extreme outliers in the total sample which included the SSO with the highest funding allocation and EFT staff; as well as the SSO with the lowest funding allocation and EFT staff. Secondly, the median number of EFT staff was calculated for each of the four funding categories and the two SSOs that corresponded as close as possible to the median EFT staff were selected. This was to ensure that there was commonality in terms of capacity within a grouping, whilst allowing for variation between the groupings. The grouping process resulted in SSOs being categorised for analysis as very large, large, medium and small SSOs. The boundaries for grouping the SSOs are provided in Table 1 in the supplementary file.

3.2 Data Collection and Analysis

The Chief Executive Officer (CEO)/Executive Officer (EO), or a staff member nominated by these individuals was invited to participate in one-on-one interviews. Members from the selected SSOs' Board of Management were also invited to participate in focus group discussions to gain collective perceptions of those involved in the organisation. The interviews and focus group discussions sought to understand the climate and culture of the organisation and to explore capacity building strategies to promote health through sport. A topic list was used to guide the interviews and focus group discussions and was informed by

the organisational change (Goodman, et al., 1997; Kotter, 1995; Oakland & Tanner, 2007) and capacity building theoretical frameworks (NSW Health, 2001). Participants were first asked to broadly describe their organisation by identifying the characteristics that distinguish their organisation from another (i.e., climate) and their key strategic focus areas (i.e., culture). Participants were then asked to comment on the factors influencing the adoption and implementation of HP activities and programs (i.e., key drivers). Finally, participants were asked to describe the types of organisational changes their organisation had undergone to implement HP activities and programs. A summary of the interview schedule is outlined in the supplementary file in Table 2.

The interview and focus group discussions were transcribed verbatim and then coded and broken down into themes, which were then examined against the key research questions. The data were analysed by the lead author, one case at a time and the information was displayed in matrices as described by Miles and Huberman (1994) to allow cross-case analysis. A content analysis method was used to identify the presence of relevant themes within the text (Krippendorff, 2004). In order to determine the validity of the findings, the themes and a selection of coded transcripts were randomly checked by the co-authors. Creswell and Miller (2000) suggest that this method of peer debriefing provides an avenue to challenge and confirm interpretations; and hence increase trustworthiness of the findings.

4. Results

4.1 The Participants and Organisational Characteristics

A total of eight interviews and ten focus group discussions were conducted. Interview participants were CEOs (n=1) or Executive Officers (EOs) (n=2) or an individual nominated by the CEO and held a position in senior management (n=5). In two SSOs (medium and small SSO) discussions were only held with the board of management as the EO and senior

staff were not available and non-existent in one case. Those organisations with CEOs were very large, large, and medium. The small SSOs had only EOs.

The SSOs represented a range of sports including contact (n=2), limited contact (n=3) and non-contact sports (n=5); were team (n=4), individual (n=5), or a combination of both (n=1); and were played on a field (n=5), court (n=4) or were aquatic (n=1). Eight SSOs governed sports that participated in international competitions, and three of these SSOs were Olympic sports.

The profiles for the very large, large, medium and small SSOs are presented in Table 3. The allocation of SSOs to these profiles was largely based on the number of registered clubs and members. The very large SSOs received a total of \$900,000 or more from VicHealth to implement health promotion and this tapered down to \$125,000 or less for small SSOs over the four year funding period. Funding was predominantly equivalent to the SSOs registered clubs and members.

<Insert Table 3 about here>

4.2 *Organisational Readiness for Change*

Using the integrated theories and frameworks shown in Figure 1 – readiness for change was conceptualised as understanding: the organisational capacity, climate, and culture; the drivers for change; and planning for HP. The results are presented under these key headings.

4.2.1 *Organisational Capacity, Climate, and Culture*

The organisational capacity of SSOs to promote health through sport was described as ranging from “untapped” (very large SSO) through to “very limited” (small SSO). Very large and large SSOs tended to report high levels of capacity for HP; particularly since their organisational climate included high numbers of registered members, a diverse range of SSO-based sport and HP programs, being staffed by a number of professionals, and having strong

partnerships (and funding arrangements) with government bodies and/or commercial sponsors. In addition, very large SSOs were better funded by VicHealth to implement HP; thus were often in a better position to offer a wide range of sport and HP programs. Nevertheless, there was a strong perception that external funding for HP was imperative regardless of organisational capacity or climate. The reliance on external funding and resource dependencies are presented later in the results within the section titled organisational processes. In comparison, medium and small SSOs reported lower levels of capacity as they had a small membership base, smaller range of SSO-based sport and HP programs, and tended to rely more heavily on volunteers to implement SSO-based sport and HP programs. Small SSOs commented that their organisations were financially insecure and highly dependent upon volunteers to operate the organisation. The following passage highlights the instability of these SSOs and emphasises the informal operation and volunteer control of the organisation.

We are definitely a poor organisation, which means we don't actually have officers per-se, we don't have core positions, we all do other jobs, so its actually a group of volunteers getting together to run the sport the best way we can with little money.

(small SSO)

The organisational climate and capacity of the SSOs in this study is summarised in Table 4.

<Insert Table 4 about here>

Using Nutbeam and Harris's (2004) definition of organisational culture – a set of values and assumptions about an organisation that have formed over time, are more stable and are more resistant to change; organisational culture was operationalised through the organisation's strategic focus areas. In the analysis of the data, four strategic focus areas were

identified and these included themes relating to competition, implementing HP in sport, club development, and business operations.

4.2.1.1 Competition

There was a strong focus by most SSOs on competition, and particularly elite sport and the provision of pathways for participants to progress in sport (i.e., player pathways). This was even more prominent among those SSOs that were involved in the Olympic Sport program or had international competitions. The following passages highlight the emphasis on competition and performance pathways, particularly to ensure financial stability and competition success.

... because it's an Olympic sport, it is always mainly geared towards elite competition and we try to get as many people as we can into the Olympic and Commonwealth Games ... that's the main priority focus there....from the organisation's point of view that's the main priority for the Board, making sure that we stay viable ... (small SSO)

Some SSOs did emphasise community participation as a strategic focus area; however, they were focused on growing participation for “elite sport” as the end outcome. The following passage highlights this perspective.

We focus primarily on what we term participation within the community. Our expertise has grown by working with the grass roots level of our sport and we're heavily involved in constructing the base for [our sport] to grow to the elite level. (very large SSO)

4.2.1.2 HP strategies in sport

All SSOs commented that they were implementing HP strategies through sport, such as increasing sport participation among health inequality groups (e.g., disability, migrant, indigenous) and creating healthy and welcoming sporting environments. The

conceptualisation of HP in sport, however varied between SSOs. In particular, it was more common for very large SSOs to discuss ‘upstream’ determinants of participation in sport, such as facility access and program structure. As such, these organisations were more likely to have recognised the need to change the delivery mode of sporting programs or the use of facilities for sports programs. For example, the following passages highlight the SSOs level of awareness of emerging trends in participation in physical activity.

... we are becoming a lot more aware of what we need to do to engage these people in the game (i.e., non-traditional demographic groups). They don’t necessarily want to wear [all the equipment], the rules are too complicated, the game is too long or whatever ... so what we are trying to do is to make the game as easy for them to play and engage in as possible. (very large SSO)

In comparison, large, medium and small SSOs were more limited to ‘midstream’ and ‘downstream’ health promotion initiatives such as health education and awareness-raising approaches. A participant from an SSO that operated informally and under volunteer control rationalised this limited focus by stating that they “would like more pamphlets to give to people coming [to sport programs] that say this is how you should be eating, because generally they are people with low educations and they don’t get that information, so [they don’t understand] if you eat this stuff its better for you, if you do this its better for you...” (small SSO). In addition, it seemed that some SSOs had far less confidence in their ability to address health issues through sport as described in the following passage.

I am not sure we can do it, I don’t think we can actually achieve health objectives through [our sport] at the moment... we would need to have an awareness campaign to try and change perceptions of people, but us going out there and doing ad-hoc programs is not going to meet health objectives because to get that change and get

people to start thinking about health and sport going together you need the whole industry almost looking at it across Victoria. (large SSO)

The lack of confidence in this SSO's capacity to address health-related objectives resulted in organisational resistance to develop, implement, or sustain programs for health inequality groups, which was a current funding priority of VicHealth. A lack of confidence in the SSO's capacity to address health-related objectives, however, was not common across all SSOs. Other SSOs including some small SSOs appeared to be more confident in their capacity to address health-related objectives because they were already working with health inequality groups and/or traditionally attracted low socio-economic groups to their sport.

4.2.1.3 Club development

The majority of SSOs reported that their organisation's key strategic focus area was club development. Club development was conceptualised as supporting clubs to manage day-to-day operations, create healthy and welcoming environments, increase participation and promote inclusive participation. Club development was a strategic focus to "sustain and grow participation".

In terms of sustaining and growing participation, a number of SSOs commented that their sport could be played by individuals from a range of age groups (i.e., "it is one of those sports that it is a lifelong activity, you can play when you're older and play it when you are younger." very large SSO). However, this did not seem to be mirrored in the types of sports programs offered by SSOs; particularly in terms of age. Many SSOs had introduced programs targeting health inequality groups. However, the conversation about increasing participation and improving health outcomes was predominantly related to youth. The following passage highlights one SSO's focus on youth participation and emphasises the initial engagement of

individuals in sport to ensure that their children played the sport in the future rather than re-engaging and/or maintaining participation levels throughout one's life:

...if you get boys and girls playing as four and five year olds, where they are more likely to have involvement in the game either playing in a traditional setting for a club or they play at school, when they get older their kids will play. (very large SSO)

One SSO participant, however, rationalised this focus on young people stating that “I think anecdotal feedback and statistical data indicates that if you engage people in particular sports when they are primary age (i.e., 5 – 12 years) there is a greater potential for them to come back to that sport later in life.” (large SSO). This statement reflects a passive approach to re-engagement and maintenance in sport participation, rather than targeted strategies for a wide range of demographics, interests and lifestyles.

4.2.1.4 Business operations

Four SSOs identified business operations as a key strategic focus area for their organisation and this was in terms of corporate services and marketing, infrastructure development, and/or financial planning. The theme on financial planning included the SSO's need to demonstrate the value of investing in HP; and especially for engaging non-traditional participants in sport and as registered members. One large SSO was concerned about the focus on low socio-economic groups, as non-traditional participants from a HP perspective. They were finding it difficult to address financial barriers to sport participation; thus their confidence to engage this type of group within their traditional club structure and as new members was low.

4.2.2 Drivers for Change

The majority of SSOs felt that their organisation had undergone a significant shift in terms of implementing HP. They described the change from ad-hoc promotion of healthy messages (e.g., “it was about posting signs.” large SSO) to specific HP programs and policies that aim to contribute to community health and wellbeing or address challenging social and environmental issues such as alcohol use and socially inclusive environments.

The key drivers influencing changes in HP among SSOs can be categorised as external and internal drivers of change. External drivers included funding from, and shared goals with VicHealth, social and community changes, social responsibility to contribute health and wellbeing, and broader HP policies in other settings. Internal drivers were related to leadership within the SSO.

The primary factor reported to influence the adoption of HP within the SSOs was external funding from VicHealth. The majority of SSOs and especially small SSOs commented that “well if they hadn’t asked us to do it, we probably wouldn’t have done it, not in a formal way” (small SSO). Others commented that “it would have been very difficult for us to do that (i.e., HP) without funding because we are not resource heavy” (large SSO). Second, many SSOs reported shared goals with VicHealth primarily because the SSO had recognised that HP strategies provided an opportunity to grow their membership, and had identified social and community changes “so we respond to things [the community] want” (medium SSO). In addition, some SSOs were conscious that they had a social responsibility to contribute to community health and wellbeing and they “need to be very careful who we actually align with...(for example) we made a decision that we won’t seek or accept funding from any organisation that promotes alcohol” (large SSO).

Third, broader HP policies that had been implemented within other settings were identified as a factor influencing the adoption of HP. For example, HP policies and practices

were “through the whole State, its in schools, they promote wearing hats in the school grounds” (medium SSO). Finally, leadership from senior level management and board members within the SSO helped to facilitate changes to adopt HP. Leadership from within the SSO was crucial to embed HP within the organisation in the long term as senior management did not want to be putting in submissions for funding and “when the funding period finishes the program falls over...we needed to make that [program] part of our core business so that it is sustainable” (very large SSO). This level of planning for sustainability was particularly evident among the financially stable SSOs. However, in comparison to the views of the SSOs senior level management, the SSOs respective NSO tended to be more focused on “developing the next champion” (very large SSO).

The factors inhibiting the adoption of HP were primarily internal organisational factors that were related to the SSO’s affiliated clubs. The majority of SSOs commented that a barrier to HP implementation in sport was that the onus for implementing sport-related HP policies and practices was on community sports clubs. Implementation was perceived as difficult because clubs often lacked volunteers, and volunteers were bombarded with other priorities such as issues around the drought and compliance with day-to-day club operations and running competition seasons. The following passages highlight these common perceptions among SSOs.

They’re all volunteers and we can’t mandate things, we can’t say ‘you must do this and you must do that’...so we provide a lot of incentives to get clubs to be good citizens and we just promote those clubs who are really doing a great job as well.
(very large SSO)

... the volunteers that are there, continually come back to us and say ‘hey we have just been bombarded with so many more compliance requirements’ some of those are

central to [the sport] and some of them are not central and that could be around HP for example. (very large SSO)

4.2.3 Planning for HP

The decision-making processes for SSOs to identify and decide on the HP issues that were relevant and important ranged in the level of sophistication from informal and ad-hoc discussions to the sophisticated use of partnerships and research to inform and design HP activities and practices. Small and medium SSOs tended to have informal and ad-hoc planning of HP which generally involved discussions by management staff and board members who typically identified any shared goals and/or benefits for adopting particular HP activities (e.g., “We make valued judgements, we get quite a lot of requests and we do sit around at the Board table and discuss the benefits to the person making the request, the benefits to the organisation, or the benefits to our members and make a valued judgement around those applications.” large SSO). Very Large and large SSOs, however, were more likely to go beyond the identification of shared goals and/or benefits to employ the use of partnerships and research to inform and design HP activities and practices. In comparison, a small SSO commented they did not have capacity to identify research that would help inform their practice. Finally, the majority of SSOs had centralised decision-making processes whereby board approval was required; although in one case the decision-making process for HP was delegated to individual staff (e.g., “its centralised back to who tends to deliver the program” large SSO).

4.3 *Implementing Change*

Using the integrated theories and frameworks shown in Figure 1 – implementing change was conceptualised as understanding how SSOs were building capacity to implement and sustain HP within their organisation. Specifically, the NSW capacity building framework and Kotter’s Eight Step model of Organisational Change were overlayed with the Oakland and Tanner framework to develop a more comprehensive approach to understanding the organisational processes, organisation and resources, and systems and controls associated with the development of HP in sports organisations. The description of how SSOs built capacity to facilitate the implementation of HP is described below under the three key headings – organisational processes, organisation and resources, and systems and control.

4.3.1 Organisational Processes

Organisational processes focused on understanding the organisational structures, systems, policies or practices that were implemented to drive the way SSOs address health through sport. Organisational processes also sought to explore how these new organisational structures, systems, policies or practices were communicated, how others were empowered to implement them and how these changes were being consolidated and institutionalised.

In all cases, SSOs had an organisational commitment to HP with community health and wellbeing being commonly articulated within their strategic plans. Some of these health and wellbeing strategic plans were then operationalised by developing templates on sport-related HP policies and practices for both SSO-organised events and for their affiliated clubs. Very large (n=3) and large SSOs (n=1) were more likely to have implemented (or were implementing) a formalised and systematic approach to support their affiliated clubs with HP. This included the introduction of “club development programs” that encouraged and

supported clubs to develop and implement sport-related HP policies and practices through a recognition and reward system that promoted “best practice”.

In addition, the club development programs included support from development officers to help clubs plan and implement sport-related HP policies and practices. In fact, the club development programs were the only definite and sustainable strategy implemented by these four SSOs that empowered their clubs to implement HP, provided recognition and rewards for these changes, and provided evidence of sustainable changes to support HP as part of their core business. In comparison, the other SSOs (mostly medium and small) communicated “passively” to their affiliated clubs through the provision of sport-related HP policies and practices via the internet, email or newsletters.

In terms of consolidating and institutionalising HP changes, external funding tended to dominate the conversation among all types of SSOs about their capacity to continuing implementing HP activities and programs. External funding was perceived to “give a much better opportunity to reach a wider audience” (very large SSO); and “the funding does not change the values that we aspire to ... it changes our capacity to deliver them...funding is important for us to be able to reach our population and do things that we want to do, but its not going to alter the way we think about things ...” (very large SSO). As such, the majority of SSOs perceived that their capacity for HP was heavily dependent upon external resources for implementation, particularly since HP was not their core business.

External resources were perceived to be imperative, even by the very large SSOs with high levels of internal organisational capacity, for a number of reasons. First, the SSOs perceived that they needed external funding to build problem solving capabilities within their organisation and with other organisations to see “what works and what doesn’t work” (very large SSO) in addressing health and social issues, such as alcohol use, violence, and engaging health inequality groups in sport. This was particularly since it was perceived that other

sectors, such as the health sector were also unsure how to address health and social issues within communities.

Second, in addition to addressing health and social issues, the SSOs identified that their organisation had other priorities and more immediate responsibilities for supporting clubs to deliver organised sport such as occupational health and safety legislation and regulations. These responsibilities were also reported to be compounded by the need to address environmental issues such as ground conditions and facility development for some SSOs since some sporting grounds had been identified by local councils as being unsafe to play on due to hard surfaces from prolonged drought. A respondent commented that “My point is that we have got a responsibility to create awareness, educate and develop so that [community club] people can meet those compliance obligations as well as the more clever things [like HP outcomes]” (very large SSO).

Third, the volunteer nature of community sport was highlighted as a primary factor influencing SSO capacity to address health and social issues. The majority of SSOs identified that resources to provide high levels of support to the community level was crucial to “encourage clubs to develop a plan at the club, which looks at more than just playing the game each week, but to look at the long term aspect of their club environment, their facilities, and how they might link with the different stakeholders around the community” (very large SSO). This point is particularly relevant since, community clubs were reliant on volunteers who were burdened with issues of compliance (e.g., occupational health and safety) and had limited and/or poor succession planning of club administration.

Fourth, external funding was required to employ program development staff with expertise to promote the sport, as well as, develop strategies that “engage the target groups and then monitor and evaluate...there is a fair bit involved in running a successful program” (very large SSO). A small SSO commented that they lacked expertise to engage specific

target groups and they often did not have “a lot of time to do all that research...what I need is a list of four people who are really good presenters and what their topics are so I don’t have to go searching around trying to find them...we need things that really help us straight off... I need to be spoon fed; it makes it easier I don’t mind admitting ... spoon feed me and I don’t have to waste time ringing around.” (small SSO)

Finally, the need to provide additional sporting facilities was identified as an increasing financial burden on some SSOs since “we haven’t got enough facilities or venues to cater for the numbers who are playing now or have an interest in playing” (very large SSO). The lack of facilities made it difficult for some SSOs to meet the needs of new groups of participants (e.g., women’s change rooms) or to engage new participants in modified versions of the sport such as small-sided games.

4.3.2 Organisation and Resources

Organisation and resources was primarily conceptualised as the resources deployed to support the implementation of HP within SSOs. This included exploring how change was supported through workforce development opportunities, human and financial resources available, and the existence of relationships and networks.

Workforce development for HP among SSOs primarily included opportunities organised by VicHealth or peak health organisations such as multicultural advisory organisations as part of their funding arrangements. The planning of professional development for staff by SSOs themselves, however, seemed to be ad-hoc with few SSOs identifying a formal process to develop the HP skill set of their staff. One SSO identified that the lack of HP skills among sport development officers was related to the absence of HP units in their undergraduate training. The following excerpt highlights this perception.

...it has become more and more academic and a development officer as such is a person who usually comes pretty new out of university, and they are very good hands on and they deliver a very engaging sequential sports program, and they can coach really well and they can promote the sport very well, and that's what their skill set is. It is not necessarily gathering data and being aware of all the benefits that come associated with what they are doing ... its very much like well this week I have to visit 15 schools, I have to deliver 25 clinics, I'm going to hit 250 kids or give out some brochures about the sport or promote the sport for our website, maybe a gift giveaway and then try to get them to participate in a local club, that's what they do.

(very large SSO)

For some SSOs, it seemed that HP and evaluation skills were lacking because staff positions were generally filled by individuals who "have come through our pathways so they're usually [participants] themselves, they've been involved in the elite pathways or they have played the game for a long period of time" (large SSO). The type of tertiary qualifications staff had completed appeared to be secondary (e.g., "I think all the team have tertiary qualifications, so they all have beautiful minds and they are all keen to progress their careers within the sports world. I encourage them all to do training and development programs that are appropriate for each area that they manage and within that there would be lots of opportunities for them to participate in that" large SSO).

In terms of the financial and human resources available to implement HP activities, the three very large SSOs were able to generate their own income; a significant proportion of which was generated from their membership base. These organisations also had a substantial number of employees some of which were employed as development officers (range 3 – 21 staff) and who had a specific role to implement HP among other club-related programs. In general, most SSOs integrated HP into existing staff positions rather than creating specific

HP positions. Another Large SSO, who did not generate the same level of income as the very large SSOs, was also able to employ development officers. In comparison, the remaining SSOs generally relied on their volunteers to implement HP who were often under high volunteer workloads that involved more immediate responsibilities of sport delivery such as organising training, competition, and ensuring these complied with occupational health and safety standards. Furthermore, the small SSOs generally reported lacking financial resources to even run their sporting events.

In relation to the existence of relationships and networks, the majority of SSOs had identified and established partnership networks with other sectors and organisations to address a range of health and social issues through sport. These partnership networks included inter-sectoral partnerships, with organisations such as State and Local government, and welfare, disability, and cultural-specific organisations. SSOs also reported a number of intra-sectoral partnerships such as those established with other sporting bodies, such as Regional Sports Assemblies and other SSOs.

It was common for very large and large SSOs to report a greater depth of inter-sectoral partnerships than other SSOs. For example, two very large and one large SSOs identified the need for strategic partnerships with the education sector to address the increasing need for more sports facilities; another very large SSO identified potential partnerships with the retail industry to promote participation in physical activity; particularly since it provided retail businesses with an opportunity to “increase their sales”; whilst another very large SSO had a “local government consultant” to support facility development. In addition, two very large SSOs appeared to encourage the development of partnerships amongst their affiliated clubs in a constructive and systematic way. For example, one had implemented a funding scheme whereby local clubs had to demonstrate “a 3-way partnership” with other sectors such as local government or schools to access grants from the

SSO. In comparison, medium and small SSOs did not report formal strategies to encourage partnerships at the club level. One large SSO identified that more localised funding from VicHealth was required as the implementation of many health-related sports programs was dependent upon volunteers and SSO's "don't control the club".

A range of factors were described to influence the SSOs capacity to develop partnerships with other sectors. These included: a lack of synergies or shared goals between organisations; short-term funding cycles restricted the organisation's ability to plan long-term; and it was perceived that other sectors lacked understanding of sport's potential to contribute to health and wellbeing. The media were also highlighted by one SSO to inhibit the development of partnerships by SSOs because they often did not "do enough to promote the good news stories" (very large SSO). Only one small SSO found it difficult to develop partnerships and felt this was because of a lack of understanding about their sport among other community organisations.

4.3.3 Systems and Controls

Systems and controls were conceptualised as information and evaluation systems to monitor the implementation of HP by SSOs. Only four SSOs had implemented a formal program to integrate HP into their core business – the club development programs which provided clubs with best practice HP policies and practices. Of these four organisations, the monitoring of sport-related HP policies and practices within their club development programs was in its infancy. One large SSO commented that they relied on "general feedback" to know whether club committees and coaches were implementing HP; although the organisation was creating a formal process, whereby clubs register the implementation of new sport-related HP policies and practices.

In most other SSOs (n=6), the implementation and evaluation of HP into core business were informal, ad-hoc, and in some cases monitoring systems were absent. Whilst very large and large SSOs were developing systems to measure the inclusion of sport-related HP policies and practices within their affiliated clubs, they also identified that their organisation was “not strong enough in evaluation and running surveys” (very large SSO); and lacked staff “with the right skills and focus to run the programs, because you don’t want to just run programs...you need to do the research and ... to evaluate the impact of doing it, so I think that takes some skills” (very large SSO). These SSOs identified that they needed evaluation support and/or skill development to measure the impact of sport and HP programs on health behaviours, and to measure the attitudes and knowledge of sport-related HP policies and practices among club administrators. Only one SSO (very large SSO) was planning to address the lack of evaluation skills among staff with training. In comparison, most other SSOs, and especially small SSOs did not identify evaluation skill development as a strategy to build organisational capacity for HP.

5. Discussion

The aim of this study was to explore the readiness of SSOs to adopt HP and to understand how they implemented HP to encourage healthy behaviours and contribute to public health objectives. This study assists policy makers and practitioners from both the health and sport sector to make better decisions about funding sport and recreation organisations to implement HP programs. The study revealed that SSOs had integrated HP as part of their strategic focus and that the adoption of HP was being reinforced by factors beyond VicHealth funding. Whilst SSOs were making a concerted effort to create and support sport and recreation contexts that promote healthy behaviours and physically active lifestyles, most were not prepared to use their members’ funds to support HP as core business;

particularly since the delivery of sport took precedence and HP was perceived as a less immediate responsibility. Nevertheless, at least four SSOs in this study were able to make sustainable changes in their culture and systems that supported the implementation of HP into their core business through their club development program.

From a HP perspective, this study found that the very large and some large SSOs had the capacity to engage in HP in a significant way and could promote the development of health through sport to a large proportion of the population via their large membership base. These SSOs achieved greater changes in their systems and culture through the implementation of formalised and systematic controls to encourage change and development throughout their organisational system (i.e., community-based clubs). For example, they had implemented formal and active communication strategies such as club mentors and club development programs that included club incentives, rewards and/or recognition for their affiliated clubs. As suggested by Kotter (1995) these types of strategies are important for managing change as they help to identify and communicate emerging trends, encourage groups to lead change efforts, and plan for short term wins which can help to consolidate changes and produce further improvements. In comparison, SSOs with a small membership base, very few professional staff, and greater volunteer control operated in more simplistic ways to implement HP and seemed to be more resource dependent on the little funding they were provided. As such, they were more reliant on individual funding relationships which are tenuous from a sustainability perspective. One SSO in fact lacked confidence in HP and as a consequence there was organisational resistance to adopt some HP activities such as working with individuals from health inequality groups.

Despite the implementation of formalised and systematic controls to sustain HP by very large and large SSOs, most openly stated that they lacked expertise to design and evaluate sport programs for a wide range of population groups (i.e., health inequality groups:

culturally and linguistically diverse, indigenous, people with disabilities etc.) and/or to tackle a wide range of health and social issues. These are some of the most difficult tasks confronting health policy makers and practitioners in the twenty-first century (Blair, 2009; Hoyer & Nicholson, 2009; Mummery & Brown, 2009). Furthermore, sport programs have not been rigorously evaluated in the published or unpublished literature to examine their overall effectiveness, socio-demographic factors affecting participation, or cost-effectiveness (Coalter, 2007; Priest, Armstrong, Doyle, & Waters, 2007; Priest, et al., 2008). Therefore, there is little evidence to inform practice and future research needs to determine how sport and recreation programs can serve as interventions to promote the development of healthy behaviours and promote physically active lifestyles for individuals and communities (Henderson, 2009).

This study also found that there was a tendency among SSOs to focus more heavily on youth, and particularly junior participation and competition than other age groups. This is not surprising considering the dominant youth culture of sport and previous government attention (and funding) to elite sport performance. Scheerder et al. (2006), however, reported that the late adolescent years appear to play a crucial role between youth and adult sport participation. Therefore, if health policy makers and practitioners are to continue engaging sport and recreation organisations in HP, especially to increase population levels of physical activity through sport participation, greater attention is required to develop strategies for adolescents and adults. This is particularly important considering that participation in sport declines with age (Australian Bureau of Statistics, 2007; Vilhjalmsson & Kristjansdottir, 2003); yet participation in sports clubs is suggested to enhance the health benefits of PA, and in some cases, more so than other forms of PA such as gymnasium-based activities (i.e., fitness centre) or walking (Eime, Harvey, Brown, & Payne, 2010).

The findings of this study are consistent with the findings of others (Casey, Payne, & Eime, 2009; Hall et al., 2003; Misener & Doherty, 2009; Sharpe, 2006) in understanding organisational capacity of sporting organisations. Similar to regional and community-level sporting organisations, SSOs were typically resource dependent and lacked the ability to acquire external funding for HP (Casey, Payne, & Eime, 2009; Hall, et al., 2003). Only those SSOs that were able to generate their own income through a large membership base had the capacity to formally sustain programs that deviate from their core business. Furthermore, these SSOs had a greater depth of inter-sectoral partnerships and funding relationships in which to elicit capacity. Partnerships can extend beyond the exchange of services to contribute to social capital, such as social support, reputation in the community, and reciprocity among partners (Misener & Doherty, 2009); although many are not realised in the sport system (Allison, 2001). In this study few partnerships were established between SSOs; particularly to build programming expertise and to share resources such as their club development programs.

Sport and recreation organisations have primarily adopted a business model to guide their organisational structure. Commercial factors such as the need to maximise membership and associated income in a competitive marketplace have influenced the adoption of a business model (Robinson, 2008); and this potentially limits the development of intra-sectoral partnerships. SSOs could benefit from sharing resources to build programming expertise to design sport programs and develop health-orientated policies rather than working independently on the same issues. Diverse skills and expertise are required to design sport programs especially when there is evidence that motivation for sport participation may be subject to socio-cultural influences, as well as demographic variables such as age and gender (Weinberg, Tenenbaum, McKenzie, Jackson, & Anshel, 2000; Yan & McCullagh, 2004).

To further compound the complexity of designing sport programs for diverse groups, Hanlon and Coleman (2006) found that whilst there were a range of policies and strategies recommended by researchers and SSOs, most community-based sport and active recreation clubs were unaware of, reluctant, or unable to provide opportunities for diverse groups; and especially people from culturally diverse backgrounds. In this study SSOs also voiced their inability to mandate policies and strategies at the club level. Therefore, if SSOs are to have a real impact on participation in sport, particularly by diverse groups, government policy and support to SSOs must be targeted to encourage coordinated community level engagement.

A more extensive approach to engagement between SSOs and clubs would be a community development approach. This approach has shown some positive, although very preliminary results in sport programs. For example, Tennis Canada implemented the 'Building Tennis Communities (BTC)' strategy in 2001-2002, which aimed to increase and sustain participation in tennis via funding to deliver alternative sport programs to the traditional club-based system (Vail, 2007). A major benefit to the use of community development approaches was that it enables local leaders to identify their needs and implement solutions that benefit both the community and increase sport participation (Vail, 2007).

Community development approaches are time and resource intensive and this was evident in Tennis Canada's BTC strategy. Furthermore, a number of implementation barriers were experienced in the BTC strategy which have also been highlighted by others in sports organisations (Casey, Payne, Brown, & Eime, 2009). First, Vail (2007) found that the BTC program champions tended to focus on growing their club membership rather than growing tennis in the community at large. This was evident as much of the programming and activities were only offered at club facilities and not throughout the communities on public courts or at schools. Second, partnership building by champions within the strategy was at a very

preliminary stage and most required training which clearly indicated that community development approaches require particular skill sets. The current study found that one way SSOs attempted to positively influence change in volunteer driven clubs was to provide resources and implement club development strategies as these provide opportunities to build club capacity and establish HP environments and practices.

The BTC program illustrated an example of an intra-sectoral community development approach, although it was not focused on the development of health through sport but on the promotion of participation per-se. An example of an inter-sectoral approach to the development of health through sport is the African-based Education Through Sport (EduSport) program. This program was part of the “Kicking Aids Out!” network and the program worked with various National Governing Organisations, religious groups, schools, sports associations and government institutions to use sport, recreation or other forms of physical activity to promote empowerment and HIV/AIDS education and health (Coalter, 2007). Policies that target an inter-sectoral approach to the development of health through sport, such as those in the African program may be required to further drive health-related programs in SSOs and their affiliated clubs. Isolating the “sports effect” to the program, however, was problematic as the program operated in a broader social context, the program was new, and resources and expertise were limited; hence the environment was not conducive for undertaking robust research and evidence was sparse (Coalter, 2007). Furthermore, it is unknown whether the inter-sectoral African program reported by Coalter can be translated to a traditional western sporting system.

Coalter (2007) states that most sports programs that seek to develop health through sport “tend to be more complex organisations/programmes than many traditional sport development programs, not relying solely on ‘sport’ to achieve their desired intermediate impacts and outcomes. In addition, they are dealing with much more fundamental economic,

cultural and health issues” (p. 87). The findings of this study support the development of policies to promote the implementation of health-related programs in sporting organisations (i.e., impact). However, there is a lack of evidence of clear outcomes demonstrating the link between sport and health (Coalter, 2007) which may ultimately limit the sustainability of programs arising from these policies.

This study intended to contribute to understanding how sporting organisations can promote health. The theoretical frameworks applied to this study were useful in understanding organisational readiness and exploring how capacity was built to facilitate change. The sample was limited to SSOs in Victoria Australia, and therefore, the findings can not be generalised to all sport and recreation organisations. Nevertheless, the study supports and extends earlier research that explored the capacity of Regional Sports Assemblies (RSAs) to promote health (Casey, Payne, & Eime, 2009). In the Australian state of Victoria RSAs are largely state-government funded, independent, legally incorporated, not-for-profit organisations that support and promote participation in sport. Similar to SSOs in this study, funding supported RSAs to successfully adopt HP and like SSOs HP practice was reliant on external funding (Casey, Payne, & Eime, 2009). Compared to RSAs, however, the delivery of sport was a more immediate responsibility than HP for SSOs and this is most likely influenced by the RSAs independence from NSOs, governance of sport, and elite participation.

5.1 Implications for Policy and Practice

From a policy perspective, there is a desire by governments to look to sport for assistance in solving health-related problems such as declining levels of physical activity and increasing obesity of Australians (Coalter, 2007; Hoye & Nicholson, 2009). This focus emphasises social objectives and sees sport as a tool for addressing challenging social issues (i.e., development through sport), which to date has been primarily used in third world countries

for promoting education, gender equality, and combating HIV/AIDs pandemics (Coalter, 2007). Currently, government attention (and funding) of elite sport performance combined with the dominant youth culture of sport, and lack of systematic and robust evaluations of sport programs limits the ability of sporting organisations to contribute to Australia's health. Specifically, if sport is to be used as a setting to promote healthy behaviours and promote physically active lifestyles there are a number of ways policy makers and funding bodies could further develop and sustain the changes made so far.

First, SSOs could benefit from the provision of funding to implement formalised and systematic HP controls (e.g., club development programs) throughout the SSOs' organisational system that promote healthy behaviours and promote physically active lifestyles for individuals and communities. Many of the established HP systems and controls developed by very large and large SSOs in this study could be used as best practice tools and would potentially support other SSOs in their organisational development (NSW Health, 2001). From a managerial perspective, this study showed that it was advantageous for SSOs to implement formalised and systematic HP controls such as club development programs as these demonstrate sustainable outcomes for HP delivery.

Second, building organisational capacity is not a fast process and it has been suggested to take several years to achieve (Amodeo, Wilson, & Cox, 1995; Chavis, 1995). Maintaining a baseline level of funding, therefore, is important for continuing to exert influence on SSOs to practice HP, especially when the delivery of sport takes precedence, and HP is a less immediate responsibility. As SSOs progress in their HP expertise and implement formalised and systematic HP controls the organisations may be better equipped to identify new and emerging HP areas and/or target groups.

Third, government policy and funding of sport to specifically address social issues might benefit from grant programs that emphasise partnership-based projects between sport and

various sectors to collaboratively identify, test, implement and evaluate solutions. From a managerial perspective, SSOs also need to consider developing and maintaining a broad range of partnerships to build programming expertise and to share resources such as their club development programs; particularly since partnerships can extend beyond the exchange of services to contribute to social capital (Misener & Doherty, 2009). We therefore, ask SSOs to consider a broader range of partners to grow their sport and address health and social issues; and in doing so collaboratively identify new and more inclusive ways that the community can participate in sporting programs that might differ from the traditional opportunities currently available. As such, sport can not go it alone and we challenge those outside of the sport sector to consider partnerships with these organisations to address a range of health and social issues.

6. Conclusion

This study explored the organisational readiness and capacity building strategies of sporting organisations to promote health. The unique findings of this research highlight that organisational readiness to implement HP was facilitated by sporting organisational capacity and size. Greater levels of organisational capacity and size resulted in more sophisticated capacity building strategies to implement and sustain change. Specifically, the implementation of club development programs enabled SSOs to implement and sustain HP even when the delivery of sport took precedence and HP was perceived as a less immediate responsibility.

References

- Allison, M. (2001). Sports clubs in Scotland. Edinburgh, UK: SportScotland.
- Amis, J., Slack, T., & Hinings, C. (2002). Values and organizational change. *The Journal of Applied Behavioral Science*, 38, 436-465.
- Amis, J., Slack, T., & Hinings, C. (2004). Strategic change and the role of interests, power, and organizational capacity. *Journal of Sport Management*, 18, 158-198.
- Amodeo, M., Wilson, S., & Cox, D. (1995). Mounting a community-based alcohol and drug abuse prevention effort in a multicultural urban setting: Challenges and lessons learned. *The Journal of Primary Prevention*, 16, 165-185.
- Australian Bureau of Statistics. (2007). Participation in sports and physical recreation, Australia, 2005-2006 (pp. 3). Canberra, Australia.
- Backman, E. V., & Smith, S. R. (2000). Healthy organizations, unhealthy communities? *Nonprofit Management and Leadership*, 10, 355-373. doi: 10.1002/nml.10402
- Berentson-Shaw, J., & Price, K. (2007). Facilitating effective health promotion practice in a public health unit: Lessons from the field. *Australian and New Zealand Journal of Public Health*, 31, 81-86.
- Blair, S. N. (2009). Physical inactivity: The biggest public health problem of the 21st century. *British Journal of Sports Medicine*, 43, 1-2.
- Bormann, C., & Stone, M. (2001). The effects of eliminating alcohol in a college stadium: The Folsom Field beer ban. *American Journal of College Health*, 50, 81-88.
- Casey, M., Payne, W., Brown, S., & Eime, R. (2009). Engaging community sport and recreation organisations in population health interventions: Factors affecting the formation, implementation, and institutionalisation of partnerships efforts. *Annals of Leisure Research*, 12, 129-147.

- Casey, M., Payne, W., & Eime, R. (2009). Building the health promotion capacity of sport and recreation organisations: A case study of Regional Sports Assemblies. *Managing Leisure, 14*, 112-124.
- Cass, Y., & Price, P. (2003). Moorefit - Increasing physical activity in adolescent girls using the Health Promoting School framework. *Health Promotion Journal of Australia, 14*, 159-164.
- Chavis, D. (1995). Building community capacity to prevent violence through coalitions and partnerships. *Journal of Health Care for the Poor and Underserved, 6*, 234-245.
- Coalter, F. (2007). *A wider social role for sport: Who's keeping the score?* London & New York: Routledge
- Corti, B., D'Arcy, C., Holman, J., Donovan, R., Frizzell, S., & Carroll, A. (1995). Using sponsorship to create healthy environments for sport, racing and arts venues in Western Australia. *Health Promotion International, 10*, 185-197.
- Creswell, J. W., & Miller, D. L. (2000). Determining validity in qualitative inquiry. *Theory Into Practice, 39*, 124.
- Dobbinson, S. J., Hayman, J. A., & Livingston, P. M. (2006). Prevalence of health promotion policies in sports clubs in Victoria, Australia. *Health Promotion International, 21*, 121-129. doi: 10.1093/heapro/dak001
- Eime, R., Harvey, J., Brown, W., & Payne, W. (2010). Does sports club participation contribute to health-related quality of life? *Medicine and Science in Sports and Exercise, 42*, 1022-1028.
- Eime, R., Payne, W., & Harvey, J. (2008). Making sporting clubs healthy and welcoming environments: A strategy to increase participation. *Journal of Science and Medicine in Sport, 11*, 146-154.

- Goodman, R. M., Steckler, A., & Kelger, M. C. (1997). Mobilising organizations for health enhancement: Theories of organizational change. In K. Glanz, F. M. Lewis & B. K. Rimer (Eds.), *Health Behaviors and Health Education: Theory, research and practice* (2nd ed., pp. 335-357). San Francisco, California: Jossey-Bass.
- Groene, O., & Jorgensen, S. J. (2005). Health promotion in hospitals - A strategy to improve quality in health care. *European Journal of Public Health*, 15, 6-8.
- Hall, M., Andrukow, A., Barr, C., Brock, K., de Wit, M., Embuldeniya, D., . . . Vaillancourt, Y. (2003). *The capacity to serve: A qualitative study of the challenges facing Canada's nonprofit and voluntary organizations*. Toronto, ON: Canadian Centre for Philanthropy.
- Hanlon, C., & Coleman, D. (2006). Recruitment and retention of culturally diverse people by sport and active recreation clubs. *Managing Leisure*, 11, 77-95.
- Henderson, K. (2009). A paradox of sport management and physical activity interventions. *Sport Management Review*, 12, 57-65.
- Heward, S., Hutchins, C., & Keleher, H. (2007). Organizational change - Key to capacity building and effective health promotion. *Health Promotion International*, 22, 170-178.
- Houlihan, B. (2008). Introduction: The growth of institutional and policy complexity. In B. Houlihan (Ed.), *Sport and Society: A student introduction* (2nd ed., pp. 1-2). London: Sage Publications.
- Houlihan, B., & White, A. (2002). *Politics of Sports Development: Development of sport or development through sport*. London: Routledge.
- Hoye, R., & Nicholson, M. (2008). Locating social capital in sport policy. In M. Nicholson & R. Hoye (Eds.), *Sport and Social Capital* (pp. 69-92). Oxford: Elsevier.
- Hoye, R., & Nicholson, M. (2009). Australia. *International Journal of Sport Policy*, 1, 229-240.

- Hoye, R., Smith, A., Nicholson, M., Stewart, B., & Westerbeek, H. (2009). *Sport Management: Principles and applications* (2nd ed.). Oxford; Burlington, MA: Elsevier Butterworth-Heinemann.
- Inchley, J., Muldoon, J., & Currie, C. (2006). Becoming a health promoting school: Evaluating the process of effective implementation in Scotland. *Health Promotion International*, 22, 65-71.
- Johnson, A., & Baum, F. (2001). Health promoting hospitals: A typology of different organizational approaches to health promotion. *Health Promotion International*, 16, 281-287.
- Kikulis, L., & Slack, T. (1995). Toward an understanding of the role of agency and choice in the changing structure of Canada's National Sport Organizations. *Journal of Sport Management*, 9, 135-152.
- Kikulis, L., Slack, T., & Hinings, B. (1995). Does decision making make a difference? Patterns of change within Canadian National Sport Organizations. *Journal of Sport Management*, 9, 273-299.
- Kotter, J. (1995). Leading change: Why transformational efforts fail. *Harvard Business Review*, Mar-Apr, 59-67.
- Krippendorff, K. (2004). *Content Analysis. An introduction to its methodology* (2nd ed.). California: Sage Publications.
- Lewin, K. (1951). *Field theory in social science*. New York: Harper and Row.
- Miles, M., & Huberman, M. (1994). *Qualitative Data Analysis* (2nd ed.). Thousand Oaks: Sage Publications.
- Misener, K., & Doherty, A. (2009). A Case Study of Organizational Capacity in Nonprofit Community Sport. *Journal of Sport Management*, 23, 457-482.

- Mummery, W. K., & Brown, W. J. (2009). Whole of community physical activity interventions: Easier said than done. *British Journal of Sports Medicine*, 43, 39-43.
- NSW Health. (2001). A framework for building capacity to improve health (pp. 1-35). Sydney, Australia.
- Nutbeam, D., & Harris, E. (2004). *Theory in a nutshell: A practical guide to health promotion theories*. Sydney, Australia: McGraw-Hill.
- Oakland, J., & Tanner, S. (2007). Successful change management. *Total Quality Management*, 18, 1-19.
- Polley, M. (1998). *Moving the goal posts: A history of sport and society since 1945*. London: Routledge.
- Priest, N., Armstrong, R., Doyle, J., & Waters, E. (2007). Policy interventions implemented through sporting organisations for promoting healthy behaviour change. *Cochrane Database of Systematic Reviews*, Issue 2. Art. No.: CD004809. Retrieved from doi:10.1002/14651858.CD004809.pub3
- Priest, N., Armstrong, R., Doyle, J., & Waters, E. (2008). Interventions implemented through sporting organisations for increasing participation in sport. [Electronic Article]. *Cochrane Database of Systematic Reviews*, Issue 3. Art. No.: CD004812. doi: 10.1002/14651858.CD004812.pub3
- Riley, B., Taylor, M., & Elliott, S. (2003). Organizational capacity and implementation change: A comparative case study of heart health promotion in Ontario public health agencies. *Health Education Research*, 18, 754-769.
- Robinson, L. (2008). The business of sport. In B. Houlihan (Ed.), *Sport and Society: A student introduction* (2nd ed.). London: Sage Publications.

- Scheerder, J., Thomis, M., Vanreusel, B., Lefevre, J., Renson, R., Enynde, B., & Beunen, G. (2006). Sports participation among females from adolescence to adulthood: A longitudinal study. *International Review for the Sociology of Sport*, 41, 413-430.
- Sharpe, E. (2006). Resources at the grassroots of recreation: Organizational capacity and quality of experience in a community sport organization. *Leisure Sciences*, 28, 385-401.
- Slack, T., & Hinings, B. (1992). Understanding change in National Sport Organizations: An integration of theoretical perspectives. *Journal of Sport Management*, 6, 114-132.
- Sparling, P. B., Owen, N., Lambert, E. V., & Haskell, W. L. (2000). Promoting physical activity: The new imperative for public health. *Health Education Research*, 15, 367-376.
- Sports Council. (1993). Black and Ethnic Minorities and Sport: Policy and Objectives. London: Sports Council.
- Stid, D., & Bradach, J. (2009). How visionary nonprofit leaders are learning to enhance management capabilities. *Strategy and Leadership*, 37, 35-40.
- Swerissen, H., & Crisp, B. (2004). The sustainability of health promotion interventions for different levels of social organization. *Health Promotion International*, 19, 123-130.
- Vail, S. E. (2007). Community development and sport participation. *Journal of Sport Management*, 21, 571-596.
- VicHealth. (2003). Partnerships for Health Scheme (2003-2006), funding guidelines. Melbourne, Australia.
- Vilhjalmsson, R., & Kristjansdottir, G. (2003). Gender differences in physical activity in older children and adolescents: The central role of organized sport. *Social Science and Medicine*, 56, 363-374.

- Waddell, D., Cummings, T., & Worley, C. (2000). *Organisation development and change*. Melbourne: Nelson Thomson Learning.
- Weinberg, R., Tenenbaum, G., McKenzie, A., Jackson, S., & Anshel, M. G. (2000). Motivation for youth participation in sport and physical activity: Relationships to culture, self-reported activity levels, and gender. *International Journal of Sport Psychology*, 31, 321-346.
- Whitelaw, S., Baxendale, A., Bryce, C., Machardy, L., Young, I., & Witney, E. (2001). 'Settings' based health promotion: A review. *Health Promotion International*, 16, 339-353.
- Whitlam, G. (1972). It's time for leadership. Retrieved 22 September 2010, from http://whitlamdismissal.com/speeches/72-11-13_it's-time.shtml
- Yan, J., & McCullagh, P. (2004). Cultural influence on youth's motivation of participation in physical activity. *Journal of Sport Behavior*, 27, 378-390.

Figure 1: Data Analysis Framework: Integration of Kotter (1995) and Goodman (1997) theories of change into Oakland and Tanner's (2007) two interacting cycles of change.

Figure adapted from Oakland and Tanner (2007)

Table 3: SSO Profile – The ranges for HP funding and number of registered clubs and members

Case	VicHealth funding 2003-2007 (AU\$)*	Number of registered clubs*	Number of registered members*
Very Large SSOs (n=3)	900,000+	800+	90,000+
Large SSOs (n=2)	300,000 – 899,999	300 – 799	25,000 – 89,000
Medium SSOs (n=2)	125,000 – 299,999	30 – 299	2001 – 24,999
Small SSOs (n=3)	<125,000	1 – 50#	1 – 2000

*information collected by VicHealth and Sport and Recreation Victoria 2003.

#the range crosses over with the medium SSOs as one small SSO has a high number of clubs yet very few members within these clubs.

Table 4: Summary of the Organisational Climate of SSOs

Very Large SSOs	Large SSOs	Medium SSOs	Small SSOs
Organisational capacity for HP high – untapped; although resource dependent	Organisational capacity for HP medium; although resource dependent	Organisational capacity for HP medium; although resource dependent	Organisational capacity for HP high – limited; although resource dependent
High financial stability from participant registration fees, spectators, attract external funding from government and corporate sponsors	Financial stability due to representation of private clubs and increasing members and participants	Financial stability due to representation of private clubs and community service role	Low financial stability (linked to low membership and inability to attract external funding)
Highly formal operation by executive management, staff and board members	Formal operation by executive management, staff and board members	Same as Large SSOs	Informal operation and volunteer control
Highly organised competitive sports	Organised sport	Same as Large SSOs	Govern less traditional sports in Australia
High number of registered members and clubs	Medium (and increasing) numbers of registered members and clubs	Medium number of registered members and clubs	Low number of registered members and clubs
Community engagement through volunteer resources	Significant challenges recruiting and maintaining volunteers	Same as Large SSOs	Significant challenges recruiting and maintaining volunteers

Appendix A. Supplementary data

Table 1: Four Grouping Boundaries for Selecting SSOs

Group	VicHealth funding range	Number of SSOs in group	EFT staff range	Median EFT staff
1	AU\$500,001+	4	15.5 – 165.5	23
2	AU\$250,001 - \$500,000	11	3.0 – 25.0	11
3	AU\$125,001 - \$250,000	17	1.0 – 19.5	4
4	AU\$80,000 - \$125,000	18	0.5 – 5.0	2

Table 2: Semi-structured interview questions and their themes.

Table 2: Semi-structured interview questions and their themes.				
Oakland and Tanner (2007) Interacting cycles of change		Capacity building framework (NSW Health, 2001)	Sub-Theme	Semi-Structured Interview Questions
Readiness for change	Drivers for change	-	Internal and external factors for change [Establishing urgency ¹]	<ul style="list-style-type: none">Explain any factors influencing your organisation to implement HP.
	Leadership and direction	-	Organisational climate, culture, and (general) capacity ²	<ul style="list-style-type: none">How would you best describe the characteristic that distinguishes your organisation from another?What are the key strategic focus areas of your organisation?To what extent has your organisation incorporated HP into its core business?To what extent does your organisation have the capacity to implement HP?
	Planning for change	-	Creating a vision ¹	<ul style="list-style-type: none">How does your organisation identify and decide which HP issues are relevant and important?
Implementing change	Organisational processes	Organisational development	Organisational structures, systems, policies or practices to address health ³	<ul style="list-style-type: none">What organisational structures, systems, policies, procedures, or practices has your organisation put in place to address health issues?
		Leadership	Communicating the vision ¹	<ul style="list-style-type: none">Once your organisation has decided on appropriate HP strategies how does your organisation communicate these strategies?
			Empowering others to act ¹	<ul style="list-style-type: none">How did your organisation implement HP strategies throughout the organisation and stakeholders (ie. clubs)?How were others recognised and rewarded for implementing change?
			Consolidating improvements ¹	<ul style="list-style-type: none">How are you consolidating improvements in order to produce more HP changes within your SSA? If not why not?
			Institutionalising change ¹	<ul style="list-style-type: none">Can SSAs sustain their HP activities (in the absence of funding)?How can SSAs be further supported to promote health through sport?
	Organisation and resources	Workforce development	HP professional development ³	<ul style="list-style-type: none">To what extent has your organisation provided opportunities for staff and/or volunteers to learn about HP?
		Resource allocation	Human and financial ³	<ul style="list-style-type: none">To what extent does your organisations have human and financial resources to address health issues?
		Partnership	Relationships and networks ³	<ul style="list-style-type: none">To what extent does your organisation have partnerships that support you to implement HP?
	Systems and Control	Organisational development	Evaluation and monitoring systems ³	<ul style="list-style-type: none">How do you know whether different levels of your organisation (eg. staff or clubs) are putting things in place?

¹ Kotter's (1995) Eight step model of organisational change ² Goodman, 1997 Organisational change and development

³ NSW Health (2001) Capacity building framework