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# The operational context of care sport connectors in the Netherlands

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## Summary

To stimulate physical activity (PA) and guide primary care patients towards local sport facilities, Care Sport Connectors (CSCs), to whom a broker role has been ascribed, were introduced in 2012 in the Netherlands. The aim of this study is to describe CSCs' operational context. A theoretical framework was developed and used as the starting point for this study. Group interviews were held with policy-makers in nine participating municipalities, and, when applicable, the CSC's manager was also present. Prior to the interviews, a first outline of the operational context was mapped, based on the analysis of policy documents and a questionnaire completed by the policymakers. A deductive content analysis, based on the theoretical framework, was used to analyse the interviews. Differences were found in CSCs' operational context in the different municipalities, especially the extent to which municipalities adopted an integral approach. An integral approach consists of an integral policy in combination with an imbedding of this policy in partnerships at management level. This integral approach is reflected in the activities of other municipal operations, for example the implementation of health and PA programs by different organisations. Given the CSC mandate, we think that this integral approach may be supportive of the CSCs' work, because it is reflected in other operations of the municipalities and thus creates conditions for the CSCs' work. Further study is required to ascertain whether this integral approach is actually supporting CSCs in their work to connect the primary care and the PA sector.

**Key words:** physical activity promotion, primary healthcare, PA sector, intersectoral collaboration, broker role, operational context

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## INTRODUCTION

In order to stimulate physical activity (PA), in 2012 the Dutch Ministry of Health, Welfare, and Sport introduced neighbourhood sport coaches (*Buurtsportcoach*), to whom a broker role is ascribed. Some of these coaches, the so-called Care Sport Connectors (CSCs), are employed specifically to stimulate intersectoral

collaboration between the primary care and the PA sector in order to guide primary care patients towards local PA facilities. The PA sector covers all PA services in the neighbourhood, i.e. sport clubs, fitness centres, PA lessons at community centres, and walking groups. This connection is desirable because primary care-based PA

interventions are effective in reaching physically inactive adults (Eakin *et al.*, 2000). However, patients prefer to stick with the known and secure environment of primary care PA facilities rather than participate in unknown or untried local facilities (den Hartog *et al.*, 2014; Meijer *et al.*, 2012). The general idea is that CSCs facilitate the connection between the primary care and the PA sector; professionals in these sectors collaborate; activities to promote PA will be implemented; these activities reach certain target groups; target groups will become more physically active; and health outcomes will improve. A blueprint for CSC implementation was deliberately not presented, allowing municipalities to implement CSCs in line with local needs and contexts.

Almost simultaneously with the CSC funding, the Dutch government delegated tasks in the field of public health to the municipalities, in order to organise the care and support of residents closer to the residents. Therefore, responsibilities and resources regarding the organisation of care were transferred from central government to local government. Municipalities are also expected to work on a more integrated basis in the social domain (Dutch Ministry BKZ, 2013). This decentralisation requires a change in the method of care, in which integrated community care with a focus on prevention and health is central (Dutch Ministry BKZ, 2013). The manner in which municipalities shape these changes will have an impact on the functioning of professionals with responsibility for prevention and health promotion.

Because of the differences in the implementation of the CSC funding and the current changes in the Dutch public health system, the context in which the CSCs are working can and will be different. These context-related factors might influence the success of an intervention, program, and policy, and are therefore important to take into consideration in studies on the impact of an intervention, program, or policy (Ndumbe-Eyoh and Moffat, 2013; Glasgow *et al.*, 2012). An important step in studying the impact of a broker role on improving intersectoral collaboration is to have insight into how the CSC role is integrated with other operations of the municipality. Although some studies focus on the broker role (Harting *et al.*, 2010; Langeveld *et al.*, 2016; Hagen *et al.*, 2015), to our knowledge not much is known about the impact of the operational context on brokers' work. Therefore, the aim of this study is to describe the operational context of the CSC.

## METHODS

This study is part of a larger project in which a multiple case study is being conducted in nine municipalities

spread over the Netherlands from 2014 to the end of 2016 to study the role and impact of the CSC in connecting the primary care and the PA sector, and residents' participation (Smit *et al.*, 2015).

### Study design

This study was a qualitative study, started with the development of a theoretical framework used for an analysis of policy documents, and questionnaires and semi-structured interviews with policymakers of nine municipalities to study the operational context in which CSCs were working.

### Theoretical framework

In order to study the context in which CSCs were working, a theoretical framework had to be developed. The CSC is a new function, and a framework specific to the context in which CSCs are working was not yet available. Although existing frameworks in the field of political science (Sabatier and Mazmanian, 1979; Rütten *et al.*, 2010) or organisational science (Mintzberg, 1979) are available, these frameworks were not suitable for this study, as these are only directed at municipal policy. To study the operational context of the CSC, the broader system in which the CSC is working needs to be studied, including the primary care and the PA sector. As CSCs have the task of connecting the primary care and the PA sector and stimulating primary care patients to become physically active, it can be argued that CSCs are working in the public health system. Therefore, public health capacity mapping was used as a starting point, because it evaluates a system's ability to fulfil its specific functions within a set of resource constraints and does not provide answers about the actual performance of health systems (Aluttis *et al.*, 2013).

On the basis of a literature search, in-depth interviews with experts in the field of public health, and a workshop at the Dutch conference for Public Health, we developed with the research team a framework to study the CSCs' operational context. This framework was based on Aluttis *et al.*'s (2013) country-level framework for public health capacity, Meyer *et al.*'s (2012) conceptual model for public health systems and services research, and Bagley and Lin's (2009) rapid assessment tool for public health system capacity in Australia. These frameworks and tools were used because they were developed recently, were based on a literature search on public health capacity, and were the most applicable to the aim of this study. Aluttis *et al.*'s (2013) conceptual model contains the following domains: leadership and governance, organisational structures, workforce, financial resources, knowledge development,

and country-specific context with relevance for public health. Meyer *et al.*'s (2012) conceptual model is an adaptation of Handler *et al.*'s (2001) model and contains eight fundamental elements of organisation capacity: fiscal and economic resources, workforce and human resources, physical infrastructure, inter-organizational relationships, information resources, system boundaries and size, governance and decision-making structure, and organization culture. Bagley and Lin's (2009) tool consists of four categories: policy development, resources, programs, and organizational environment. Based on their frameworks, a first framework was developed. In order to ensure that the framework fitted with the Dutch context, we consulted three experts in the field of public health to discuss the final design of the framework.

This approach resulted in a framework to study CSCs' operational context, which consisted of five domains: policy, organisation, resources, programs, and partnerships (Supplementary Material, figure 1). The tools developed by Aluttis *et al.* (2013) and Bagley and Lin (2009) were used to operationalise the domains for the CSC context (Table 1).

### Policy

Policy is operationalised for both the public health and the PA sector, and consists of the existence of a public health policy, a PA policy, an integral policy relating to health and PA, and the implementation of an integral policy. To identify municipal integral policy relating to health and PA, the following indicators were used: 1) PA was part of the health policy, and 2) vitality and participation were part of the PA policy. Implementation was operationalised if other initiatives in the area of health-care, public health, and PA promotion besides the CSC were implemented, and if the CSC role was stated in the policy.

### Organisation

Organisation consists of the structure and culture of the organisation. The structure was operationalised by how the CSC funding was implemented (number of CSCs, target group, sector), CSC' function profile, and the presence of professionals in the field of public health and PA promotion. Culture was operationalised in terms of who and how professionals in the field of public health and PA promotion were directed in their work.

### Resources

The resources were operationalised on the basis of availability of financial resources for health promotion, PA promotion, and an activity budget for the CSC.

### Programs

This domain was operationalised on the basis of the existence of health promotion and PA programs implemented in the municipality.

### Partnerships

This domain was operationalised by the existence of different partnerships in the field of public health, the PA sector, between both sectors, and at management level between the municipality and other organisations in the field of public health and the PA sector in the municipality.

How these domains influence one another and their potential interaction is not known yet (Aluttis *et al.*, 2013; Meyer *et al.*, 2012; Bagley and Lin, 2009). In addition, the theoretical framework was presented and discussed at the Dutch Conference for Public Health (Leenaars *et al.*, 2015). During this workshop, participants discussed the importance of certain domains and interactions between the domains and added some minor nuances, but no relevant issues were raised in relation to the theoretical framework that would lead to an adjustment of the framework. Therefore, it was decided within the research team not to determine possible interaction in the framework, but to identify whether a possible interaction could be determined based on the different context of this study.

### Setting and study population

This study was conducted in the nine municipalities that were also participating in the larger project (Smit *et al.*, 2015). In two municipalities, the number of inhabitants was more than 300,000, in four municipalities the number of inhabitants was between 100,000 and 300,000, in three municipalities the number of inhabitants was fewer than 100,000 (CBS, 2015).

To study the CSCs' operational context, group interviews were held with policymakers from both the public health department and the PA department of each municipality, and CSCs' manager. In this way, relevant stakeholders of the CSC could interact with one another and this enabled us to gain more information about the CSCs' operational context. Together with the CSC manager, a health department policymaker and a PA department policymaker were selected and invited to participate in the interview. In two cases, the policymaker of the PA department was also CSCs' manager (Table 2).

### Procedure

In total, nine group interviews were held with 25 participants between November 2015 and January 2016. The interviews took place at the policymakers' workplace

**Table 1:** Operationalisations of the theoretical framework to map the operational context of the CSC

Domains	Operationalisation
Policy	<p><i>Integral health and PA policy</i></p> <ul style="list-style-type: none"> <li>• Other sectors were involved in: the development of the health policy / PA policy (e.g. welfare, PA)</li> <li>• State the priorities of the health policy / PA policy</li> <li>• Vitality and participation is part of the health policy / PA policy</li> <li>• Sport and PA is part of the health policy / PA policy</li> </ul> <p><i>Implementation</i></p> <ul style="list-style-type: none"> <li>• The CSC has a role in the implementation of the health policy / PA policy</li> <li>• Other initiatives besides the CSC are implemented to establish a connection between both sectors</li> </ul>
Organisation	<p><i>Structure</i></p> <ul style="list-style-type: none"> <li>• The number of CSCs in the municipality</li> <li>• The sectors in which the CSCs are working</li> <li>• The target group they are targeting</li> <li>• The most import tasks and competences of the CSC in your municipality</li> <li>• Other professionals working in the field of public health and the PA sector (for example, health broker, sport consultant, elderly adviser)</li> </ul> <p><i>Culture</i></p> <ul style="list-style-type: none"> <li>• The direction of the CSC (whom and how)</li> <li>• The municipality role in connecting the CSC with other professionals in the field of public health and PA sector.</li> </ul>
Resources	<p><i>Financial resources</i></p> <ul style="list-style-type: none"> <li>• The budget for preventive activities</li> <li>• The budget for PA promotion</li> <li>• The availability of an activity budget for the CSC</li> </ul>
Programs	<ul style="list-style-type: none"> <li>• Existing health promotion programs implemented in the municipality (implementation by which organisation, and target group)</li> <li>• Existing PA promotion programs implemented in the municipality (implementation by which organisation, and target group)</li> </ul>
Partnerships	<ul style="list-style-type: none"> <li>• Existing partnerships in the municipality between: <ol style="list-style-type: none"> <li>1. Primary care professionals</li> <li>2. PA professionals</li> <li>3. Primary care vs. PA professionals</li> <li>4. Public health</li> <li>5. Management level: municipality, public health and PA organisations</li> </ol> </li> </ul>

and lasted on average 1.5 hours. The interviews were conducted by two researchers (KL and EVB) in Dutch. At the beginning of each group interview, participants were informed about the procedure and signed an informed consent.

Before the interviews, current policy documents regarding the municipalities' health and PA policy were analysed regarding the five domains of the theoretical framework by one researcher (KL or EVB). In addition, participating policymakers received a questionnaire prior the interview to enable the collection of information regarding the five dimensions of the theoretical framework. Questions asked were for example: *'How is*

*the CSC funding implemented in the municipality? and 'Name five major partnerships available to the CSC in the municipality.'* The document analysis and questionnaires were used to gain a first insight into the operational context of the CSC and to summarise and describe this operational context in each municipality in line with the five domains of the theoretical framework. This summary was presented to the policymakers and used to guide the interviews.

The interview topic list was based on the theoretical framework. At the beginning of each topic (one of the five domains of the theoretical framework), the researcher presented a summary of the domain based on

**Table 2:** Study participants, topic list of the interviews, and code list used in the analysis

Study participants					Topic list of the interviews, and code list used in the analysis	
Municipality	Participants				Domains	Top-down codes
Inhabitants	Polycymaker PA	Polycymaker health	Manager CSC	Total	Policy	
1. 100,000–300,000	1	1	1	3	Organisation structure	<ul style="list-style-type: none"> <li>• Integral health and PA policy</li> <li>• Implementation</li> <li>• CSC funding</li> <li>• Other functions</li> <li>• Function profile</li> <li>• Directing</li> </ul>
2. 100,000–300,000	1	1	1	3	Resources	<ul style="list-style-type: none"> <li>• Budget for PA promotion</li> <li>• Budget for health promotion</li> <li>• Budget for the CSC</li> </ul>
3. <100,000	1	Not available	1	2	Programs	<ul style="list-style-type: none"> <li>• Programs health promotion</li> <li>• Programs PA promotion</li> </ul>
4. >300,000	1	1	1	3	Partnerships	<ul style="list-style-type: none"> <li>• Partnerships at management level</li> <li>• Partnerships at operational level</li> </ul>
5. >300,000	1	1	2	4		
6. 100,000–300,000	1 <sup>a</sup>	1	0	2		
7. 100,000–300,000	2	1	1	4		
8. <100,000	2	1	1	4		
9. 100,000–300,000	1 <sup>a</sup>	Not available	0	1		
<b>Total</b>	<b>10</b>	<b>7</b>	<b>9</b>	<b>25</b>		

<sup>a</sup>Also manager CSC

the questionnaire and policy analysis. In this way, participants could check the data and were invited to make corrections or additions. Subsequently, in-depth questions were asked regarding the participants' perceptions about the CSC role in the five domains of the operational context. Questions asked were for example: 'What is the reasoning for the way the CSC funding is implemented?' and 'In what manner is the CSC stimulated to join/use the partnerships/programs for his work to connect the primary care and the PA sector?'

### Data analysis

All interviews were audiotaped and transcribed (intelligent verbatim style). Both the interview transcripts and the policy documents were coded (Table 2) and analysed using software for qualitative analysis (Atlas.ti). A deductive content analysis was conducted to study the CSCs' operational context (Elo and Kyngäs, 2008). After the data were read, meaningful text fragments were identified, coded, and clustered by two researchers (X and Y) on the basis of the theoretical framework as described above. During the analysis process, no new concept surfaced that could not be tied in with the other five domains and variables in the framework. The coding was compared between both researchers and

differences were discussed to reach consensus about the codes assigned by the researchers. After the data analysis was completed, the results were discussed within the research team. Citations were translated into English by a translation agency.

In order to describe the CSCs' operational context, the results of the three data collection methods were combined. The data from the policy documents and questionnaires were used to describe the five domains of the theoretical framework, and the interviews with the policymakers were used as a further explanation of the CSCs' operational context.

## RESULTS

### Policy

#### Integral health and PA policy

In eight municipalities, PA was part of health policy. However, in three of these, the focus was mostly on youth. Therefore, an integral health policy was under development in these municipalities. In one municipality, PA was not part of health policy. Seven of the nine municipalities included vitality and participation in their PA policy. In the other two municipalities, PA policy focused mostly on youth, and therefore an integral PA policy was under development.

Irrespective of whether PA or the vitality and participation were mentioned in their health and PA policy, all policymakers stated in the interviews that PA was used as a means to stimulate a healthy lifestyle among their residents. Therefore, PA was an essential part of the implementation of both health and PA policy.

*“Why do you, as a council, want people to exercise more? Why would you? Well, because it contributes to healthy citizens, citizens in good health and vitality, a healthy and vital town.”* (Municipality #6)

### Implementation

All policymakers mentioned the importance of the connection between the primary care and the PA sector, mostly as a means to stimulate the health of their residents, especially residents who could benefit from PA, like primary care patients and the elderly.

*“It truly is about people getting more involved in PA and then you automatically focus on the target groups that now, as yet, do not or hardly exercise and then you step into the care domain and so the relationship with care work is extremely important.”* (Municipality #7)

In five municipalities, other initiatives besides the CSC were implemented in order to establish a connection between the primary care and the PA sector; for example, a pilot project in which professionals collaborated in order to stimulate primary care patients to become physically active. In some municipalities, the CSC was directly involved in these programs. In the other four municipalities, no other initiatives to stimulate a connection between the primary care and the PA sector were implemented. In these municipalities, the CSC was responsible for this connection.

Four municipalities stated the role of the CSC in their health policy ( $n = 3$ ) or in their PA policy ( $n = 1$ ), and the CSC was partially responsible for policy implementation. Although the other five municipalities did not state the CSC's role in their policy, policymakers mentioned that the CSC role was important for the implementation of both health and PA policy.

*“The CSCs are actually working within their community on behalf of the council. So yes, they are in fact our most advanced posts in these villages and neighbourhoods.”* (Municipality #2)

### Organisation

#### Implementation of CSC funding.

Two different approaches to the implementation of the CSC funding could be distinguished: 1) CSCs

working only from the PA sector and 2) an integral approach in which CSCs were working from care, welfare, and PA organisations, or a partnership between primary care, welfare, and PA organisations.

#### *CSCs working only from the PA sector.*

In four municipalities, CSCs were working from the PA sector: in three municipalities, CSCs were working at the municipality's PA department, and, in one municipality, the CSCs were working at a PA organisation in the municipality. According to the policymakers, it was the most logical choice, because other matters concerning PA in the municipality were also organised at the department or the organisation. In addition, the CSC had a central part in the implementation of PA policy and therefore the PA department could better direct the CSC.

*“The PA department here had the expertise at their disposal, and the people who were responsible for the execution and who had more or less done the same work for years on end were there. And we also would like to have more say over the things the CSC is about to do, and, if you have this within your department, you have more control over it.”* (Municipality #2)

#### *Integral approach.*

Three municipalities employed the CSC at both primary care, welfare, and PA organisations. The policymakers in these three municipalities believed that, in this way, the connection between the primary care and the PA sector would be established more easily.

*“And you can only connect if people are half in the one and half in the other or, in any case, this makes it easier.”* (Municipality #1).

Another advantage of this approach was that the different organisations' expertise could be used and the co-funding was easily arranged. Despite the advantages, two municipalities also mentioned some difficulties in this approach: the organisations' own interests and differences in work conditions.

*“So you do have a directing issue. Of course, it is about collaboration at the level of content, but the question is, yes, to what degree do people do their thing, which might lean towards the interests of an organisation itself rather than towards the interests of your funding.”* (Municipality #4)

In two municipalities, a partnership was created between primary care, welfare, and PA organisations as part of the CSC funding. In one municipality, the CSC was part of this partnership and together they developed



a plan of action to stimulate PA in the neighbourhood. According to the policymakers, this would lead to support among professionals in the neighbourhood and support the CSCs in their work.

*“We wanted to have support in the neighbourhood and we actually wanted to just also say they know, they know and they themselves have a sense of what works best in that neighbourhood. So just let us have confidence in that, and we let it go.”* (Municipality #5)

In the other municipality, the partnership organisations received the CSC funding to enable them to organise an activity to promote PA among the residents together with an organisation from another sector. A CSC was not appointed in this municipality, because the partnership already existed and the CSC funding was used to support the participating organisations in their work.

*“Then I thought, yes, that funding is there and we have a well-oiled collaborative network, it is only in terms of finance that it now starts to crunch. . . . And we have now more or less used it as a financial impetus, but so that people would not quit for the reason that they could not financially. . . . eh, are put under time pressure by their own organisation, that they would not be in this situation.”* (Municipality #9)

### Function profile

In one municipality, conditions and requirements were determined for organisations as a prerequisite for receiving the CSC funding. In order to receive the funding, the organisation had to organise an activity to promote PA among residents together with an organisation from another sector and be part of the partnership for at least six months. In the other eight municipalities, a CSC function profile was outlined.

In two of the eight municipalities, in which CSCs had a broader aim, stimulating PA was mentioned as a means to promote residents' health. The CSC in one municipality was employed to decrease health inequalities, promote residents' health, and build preventive structures with professionals. In the other municipality, the CSC was employed to stimulate a healthy active lifestyle among residents.

*“Look, the CSC funding is actually mainly focused on using sports as a tool, for other goals. It is not so much about these sports and exercise as it is about sports and exercise in order to become healthy and participate. This is also how it is looked upon within the PA*

*domain, like yes, we believe PA is very important, including in terms of health and also in terms of participation. And we believe that this in itself already provides opportunities to enhance PA and the PA infrastructure.”* (Municipality #4)

CSCs in these municipalities had a broker role in which they had to stimulate collaboration between professionals so that activities would be organised or existing activities would be connected with one another. An important feature was that activities needed to be assured by existing organisations and that the CSC would not remain responsible for the activities.

One municipality focused mostly on primary health-care professionals and stimulating an integral approach to promote residents' health.

*“They have been assigned to put health into the lime-light in the neighbourhood and to ensure that there are sufficient collective activities and look into the need for health-improving initiatives and, to do so, they need other parties. For this, they need their network.”* (Municipality #1)

The other municipality focused mostly on the PA sector and increasing sports clubs' capacity to work with other target groups or offer new PA activities.

*“In other words, the CSC in particular is required to play an important role in this, to make it possible for these clubs to develop the capacity to set up these types of activities, to be able to guide and support them and also provide continuity in this. The CSC plays an important role in the initial stage, with the aim of having them focus on new things once it is up and running. . . . and that these clubs take over.”* (Municipality #4)

In the other eight municipalities, the CSCs' main formulated aim was to stimulate PA among residents. Health promotion was often mentioned by policymakers as a side effect. In the other two municipalities, CSCs had a broader aim, and stimulating PA was mentioned as a means of improving residents' health.

In four of the six municipalities in which CSCs had the task of stimulating PA, policymakers stated that CSCs should guide residents towards local PA facilities or eliminate barriers that hinder residents from becoming physically active by, for example, coordinating a coherent PA offer. Collaboration with other professionals was often mentioned as an important task because it enabled the CSC not only to reach the target group, but also to stimulate collaboration between the sectors.

*“Yes, in my view they [CSCs] should act as a kind of intermediary and let’s say attract people who are interested, and only if it is not possible, only then do something in the way of execution. I would prefer to use the existing PA range as much as possible, there is already quite a lot. It is only the way to get there, to find them, that is too difficult for some people.”* (Municipality #8)

In the other two of these six municipalities, policy-makers attributed particularly an organiser role to the CSC. The CSCs in these municipalities were responsible for the organisation of PA activities or for strengthening initiatives in the neighbourhood. Collaboration with professionals was mentioned as an important task in order to work together on activities or initiatives to stimulate PA.

*“You now see that the one plays a greater role in the organisation in the implementation, which is more the CSC, so to say. However, like, the guidance, support, and referrals of a vulnerable group and becoming aware of such needs, that is more the territory of welfare officers. And these two seek out each other far more, like, you know, the one observes and the other one also has intentions with this target group, and they do need a party that can subsequently develop and implement the supply.”* (Municipality #3)

### Other professionals related to health promotion and PA promotion

The number and diversity of functions differed for each municipality, and in most municipalities it was difficult to gain an insight into the different functions, particularly as these professionals generally do not work at a municipal department, but rather for a public health, welfare, or PA organisation. However, in all municipalities, other professionals working in the fields of health promotion and PA promotion were employed, for example a PA consultant and a health broker. These other professionals can be supportive of the CSCs’ work.

*“In a general position as a community worker, but they do lack this specific senior citizens’ support worker as, say, their liaison officer.”* (Municipality #2)

### Directing

Different forms of directing, related to the different forms of implementation of the CSC funding, could be distinguished. Municipalities that appointed the CSC to their PA department provided direct guidance to the CSC, whereas municipalities that appointed the CSC to an external organisation all directed the CSC indirectly by using a performance agreement with the organisation, in which desired outcomes were formulated. The

organisations that appointed the CSC were responsible for the direct guidance of the CSC.

*“In the decision on the subsidy, or in the requirements that go with the allocation of the grant, we specifically point out that attention should be paid to this connection. However, we as civil servants do not necessarily go around to a neighbourhood team with a view to making this connection. That is... should be at neighbourhood level.”* (Municipality #7)

However, in all municipalities, the management of the CSC or the organisation that appointed the CSC had a facilitating role in which conditions for the CSC were created. It was up to the CSC to actually make a connection with other functions, use, and/or strengthen relevant existing programs and partnerships in the work of establishing collaboration between the sectors at community level and of stimulating the target group to become physically active.

*“You set a framework and especially create room to manoeuvre and to use the framework to get started.”* (Municipality #1)

### Resources

It was hard to obtain information on the budgets for health promotion activities and PA promotion in the municipalities. There was no figure in the budget for health promotion activities per resident in five municipalities, and no figure in the budget for PA promotion available per resident in four municipalities. These budgets were part of the entire public health budget and entire PA budget available in the municipality and therefore hard to assign specifically.

The budget for health promotion activities in four municipalities varied between €0.93 and €2.83 per resident, and the budget in five municipalities for PA promotion varied between €1.00 and €14.12 per resident.

In all municipalities, an activity budget for the CSC was available.

### Programs

In seven municipalities, programs for health promotion and PA promotion were implemented, targeting different target groups. In two municipalities, the programs mostly targeted youth. These two municipalities were in the process of developing a program for the target group, adults. In six of the nine municipalities, the programs were being implemented by different organisations in the fields of public health, PA, and welfare. In the other three municipalities, the programs were being



**Table 3:** Operational context of the CSC of nine municipalities

Municipality	Integral health policy	Integral PA policy	Initiatives (care vs PA)	CSC role as stated in policy	Organisation		Resources			Programs			Partnerships	
					Function profile	Health promotion	PA promotion	Budget CSC	Targeting whole population	Implementation by different organisations	Management	Operational		
1.	Yes	Yes	Yes	Yes	Care, welfare, and sport organisations	PA as a means to stimulate health, broker role to build preventive structures	€2.82 pp	€14.12 pp	Available	Yes	Yes	Yes	Yes	Yes
2.	No	Under development	No	No	Sport department	Organiser role to stimulate PA	Not known	Not known	Available	No	No	No	No	Yes
3.	No	Under development	No	Yes	Sport department	Organiser role to stimulate PA	Not known	€8.18 pp	Available	No	No	No	No	Yes
4.	Yes	Yes	Yes	No	Care, welfare, and sport organisation	PA as a means to stimulate health, broker role to connect activities of both sectors and increase capacity of sports clubs	€0.90 pp	Not known	Available	Yes	Yes	Yes	Yes	Yes
5.	Yes	Yes	Yes	No	Partnership between primary care, welfare, and PA professionals	Stimulate PA by guiding residents towards PA facilities Collaboration with other sectors to reach the target group	€2.30 pp	Not known	Available	Yes	Yes	Yes	Yes	Yes
6.	Yes/no	Yes	Yes	No	Sport department	Stimulate PA by guiding residents towards PA facilities Collaboration with other sectors to reach the target group	€0.93 pp	€9.27 pp	Available	Yes	Yes	Yes	Yes	Yes
7.	Yes	Yes	Yes	No	Care, welfare, and sport organisation	Stimulate PA by guiding residents towards PA facilities Collaboration with other sectors to reach the target group	Not known	Not known	Available	Yes	Yes	Yes	Yes	Yes
8.	No	Under development	No	No	Sport organisations	Stimulate PA by guiding residents towards PA facilities Collaboration with other sectors to reach the target group	Not known	€2.00 pp	Available	Yes	No	No	No	Yes
9.	Yes	Yes	No	Yes	Partnerships between primary care, welfare, and PA professionals	Organisations receive funding to organise an activity together with another sector to promote PA	Not known	€1.00 pp	Available	Yes	Yes	Yes	Yes	Yes

implemented by the municipality only. Some of these programs were implemented by the CSC.

In addition, in five municipalities, programs that CSCs could use or were using in their work to guide residents towards local PA facilities were being implemented.

*“This is, as it were, the toolbox for the CSC and then you get a vast range of programs around it, which, naturally, do coincide with PA.”* (Municipality #4)

### Partnerships

Two types of partnership could be distinguished in the municipalities: partnerships at management level and partnerships at operational level. In three municipalities, partnerships were mostly organised at the operational level; for example, a partnership between sports clubs, a meeting of professionals working in the neighbourhood, or sounding-board groups. Some of these partnerships were organised by the CSC. In the other six municipalities, partnerships at both management level and operational level were organised; for example, collaboration between the municipality and a health insurer, or a partnership between represented organisations. According to the policymakers, partnerships at the strategic level are mostly supportive of the work of the CSC.

*“A great many of these things are mainly at the tactical and strategic level. However, these do set the conditions for a number of other things.”* (Municipality #1)

Table 3 presents a summary of the operational context in the nine municipalities. A complete overview of the operational context in the nine municipalities is presented in [Supplementary material, Table 4](#).

## DISCUSSION

The aim of this study was to describe the operational context of the CSC in nine Dutch municipalities. The results show that this operational context differs. In particular, the extent to which municipalities had adopted an integral approach seems to be different. An integral approach consists of an integral health and PA policy in combination with an imbedding of this policy in partnerships between health and the PA sector at management level. More specifically, this integral approach is reflected in the implementation of other municipal operations: the implementation of CSC funding; the implementation of other initiatives in the fields of public health, care, and PA; and the availability of health promotion and PA promotion programs implemented by different organisations.

The results of this study show that municipalities with an integral approach ( $n=5$ ) implemented the CSC funding in such a way that CSCs were working from different sectors (e.g. care, welfare, PA organisation). In these municipalities, other initiatives in the fields of public health, care, and PA were also implemented, and programs to promote health and PA were implemented by different organisations. In municipalities that adopted a less integral approach ( $n=4$ ), this was hardly present, and CSCs were working only from the PA sector. CSCs in these municipalities were mainly responsible for the connection between the primary care and the PA sector. Given the CSC mandate, we think that the integral approach may be supportive of the CSCs' work, because it is reflected in other operations of the municipalities and thus creates conditions for the CSCs' work.

This integral approach can be characterised as a governance for health, and supports therefore our idea that this integral approach is supportive of the CSCs' work. Governance of health promotes joint action of health and non-health sectors, and requires an integral policy which must be supported by structures and mechanisms that enable collaboration. A governance for health gives strong legitimacy for public health professionals to help them reach out and perform new roles in shaping policies to promote health and well-being (Kickbusch and Gleicher, 2012). This integral approach supports CSCs thus directly and indirectly in their work, because it determines the way in which CSCs are organised and how other municipal operations are organised. However, whether this integral approach is actually supporting CSCs in their work to connect the primary care and the PA sector, or whether other factors could be supportive of the CSCs' work, needs to be further studied; especially because municipalities adopting a less integral approach were often of a small size. Possibly, an integral approach is less necessary because of their small size. Other factors in these municipalities could be supportive of the CSCs' work; for example, short communication lines between departments, and the municipality and organisations. On the other hand, there could also be a difference in the educational level between policymakers of a municipality of a small size, compared to policymakers of municipalities of a large size.

Before the study, it was not known how the domains of the presented theoretical framework influence on another and the possible interaction (Aluttis *et al.*, 2013; Meyer *et al.*, 2012; Bagley and Lin, 2009). The results of this study suggest that an integral policy, in combination with an embedding of this policy in partnerships at management level, is an important concept and influence other municipal operations, like organisation and

programs. These possible influences of the domains, based on this study's results, are presented in [Supplementary Material](#), Figure S2. Our findings seem to be in line with other studies investigating factors influencing public health capacity and intersectoral action. These studies mention leadership and strong governance (Bagley and Lin, 2009; Aluttis *et al.*, 2014), partnerships (Bagley and Lin, 2009; Rantala *et al.*, 2014), resources (Aluttis *et al.*, 2014; St Pierre *et al.*, 2008), and policy and a strategic plan (PHAC and WHO, 2008) as important concepts influencing public health capacity and prerequisites for intersectoral action. Although (financial) resources were also mentioned as an important concept in other studies, in this study it was hard to determine the interaction of resources with the other domains because it was hard to obtain information on municipal budgets.

This study provides an insight into how to study the operational context of professionals working in the field of health promotion. This insight is useful because, when the impact of an intervention, program and policy is being studied, contextual factors need to be taken into consideration (Ndumbe-Eyoh and Moffat, 2013; Glasgow *et al.*, 2012). The results of this study are therefore relevant for other researchers because they provide: 1) a theoretical framework for researchers to study the operational context and 2) an insight into factors that need to be taken into consideration in studies on operational context. First, the theoretical framework seems to be a useful way to describe the operational context of professionals working in the field of public health. During the interviews, no other domains relating to CSCs' operational context were identified, and so it seems that the framework includes all relevant domains. It became clear that it is important to have a connection between the strategic and operational level. However, it is not clear how the different domains influence one another. Other studies should reveal whether and how these domains influence one another and the operational context. Whether this framework is, after some changes, applicable to other professionals working in the field of public health should also be explored. Secondly, studying an operational context appeared to be complex and time consuming for both the researcher and the participants, especially because not all municipalities monitor their activities. Using different data collection methods ensured that as much information as possible was collected. In addition, providing the participants a first outline of the operational context, based on information already available to the researchers (for example policy documents), limited the work burden for the participants. The method used in this study is therefore recommended, especially

because in a short period of time a comprehensive insight into the work of the municipality could be outlined.

Evidence is lacking on which operational context or implementation of the CSC funding is the most supportive of, and effective for, CSCs' work, but providing an insight into the current operational context is an important part of any attempt to improve it. Participation in this study was therefore relevant for policymakers because it enabled them to reflect jointly on their policy regarding the CSC role and provided an opportunity to identify strengths and areas for improvement. In addition, the results of this study are relevant for policymakers and municipalities working on a connection between the primary care and the PA sector, especially because the CSC funding was implemented differently and there were differences in municipalities' integral approaches. The results of this study may therefore lead to new insights for policymakers about the CSC role and connections between the primary care and the PA sector.

### Study's limitations

Some limitations need to be taken into account when these results are being interpreted. In order to describe the operational context, information on many different topics was needed. Therefore, it is possible that during the interviews we had not enough time to reflect extensively on all topics. In addition, not all municipalities monitor their activities and therefore it was not always possible to gain a complete overview of the context. However, by using different data collection methods, we were able to collect rich data to describe the operational context of the CSC.

In this study, we described CSCs' operational context in nine municipalities. These municipalities were different in size and population, and the local government is in all probability different in structure, power, and political representativeness. Although these factors may influence how municipalities give meaning to their operations, we disregarded these factors because we were interested in the context in which the CSCs were operating and not in the processes that had led to this operational context.

### CONCLUSION

This study provided a first insight into CSCs' operational context; this context was organised differently in the nine municipalities. In particular, the extent to which a municipality adopted an integral approach seemed to influence its existing operations and thus

whether the operational context was supportive of the work of the CSC. Whether this integral approach is actually supporting CSCs in their work to connect the primary care and the PA sector needs to be further studied. In addition, this study provided a new framework to study the operational context of professionals working in the field of public health. Further research is needed to explore whether this framework is applicable to other professionals.

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## SUPPLEMENTARY MATERIAL

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

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