

Prevalence of health promotion policies in sports clubs in Victoria, Australia

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SUMMARY

In recent years, some health agencies offered sponsorship to sporting associations to promote healthy environments by encouraging clubs to develop health-related policies. However, the extent to which these sponsorship contracts reach their stated aims is of concern. This study aimed to quantify levels of policy development and practice in sports clubs for each of five key health areas, namely smoke-free facilities, sun protection, healthy catering, responsible serving of alcohol and sports injury prevention. Representatives from 932 Victorian sports clubs were contacted by telephone with 640 clubs (69%) participating in the survey. Results suggested that the establishment of written policies on the key health areas by sports clubs varied widely by affiliated sport and health area: 70% of all clubs with bar facilities had written policies on responsible serving of alcohol, ranging from 58% of tennis clubs to 100% of diving and surfing clubs. In contrast, approximately one-third of sports clubs had

a smoke-free policy, with 36% of tennis, 28% of country football and 28% of men's cricket clubs having policy. Moreover, 34% of clubs overall had established sun protection policy, whereas clubs competing outside during summer months, [diving (86%) and life-saving (81%)] were most likely to have a written sun protection policy. Injury prevention policies were established in 30% of sports clubs, and were most common among football (56%), diving (43%) and life-saving (41%). This study suggests that policy development for health promotion can be achieved in sports clubs when it is well supported by health agencies and consideration is given to the appropriateness of the specific behaviours to be encouraged for a given sport. Communication between associations and clubs needs to be monitored by health agencies to ensure support and resources for policy development to reach the club level.

Key words: policy; sponsorship; sport

INTRODUCTION

The sport setting has significant potential in improving community health outcomes, particularly in a country like Australia where sport participation and supporters are an integral part of its cultural identity. In 2001–2002, nearly two-thirds or 9.1 million Australian adults participated in sport and physical activities (Australian Bureau of Statistics, 2003). Overall, 31.4% of the Australian adult population participated in sport and physical activities that were organized by a club, association or other organization (Australian Bureau of Statistics, 2003).

The Ottawa Charter (1986) highlights the important role of the environment in promoting individuals' health behaviours (World Health Organisation, 1986). In structured community settings, such as sports organizations, policy development is considered pivotal in driving changes to create supportive environments promoting individuals' health behaviours. Thus, encouraging policy development by sports clubs might provide far-reaching health benefits to the greater community.

To health professionals, the goals of sport, namely 'participation in physical activity' and

'community cohesion', are compatible with those of health promotion efforts. Nonetheless, the degree to which essentially voluntary run organizations with diverse structures, resources and facilities can be influenced to participate in a health promotion focus is of interest. Getting healthy lifestyles on the agenda in the social environment through sporting settings is an attractive goal for health promotion, given the setting's potential to reach elusive target groups such as junior, social and elite competitors, and to spectators, supporters and the wider community. Furthermore, policy development in the sport setting is an understudied area of health promotion research (Jackson *et al.*, 2005).

In Victoria, a state of Australia, many different sports are played, with over 100 sporting associations currently listed with the government department of recreation (Sport and Recreation Victoria, 2002). However, many sporting events were traditionally sponsored by tobacco and alcohol advertising, and in some sports a culture of alcohol and tobacco use persists (Holman *et al.*, 1997; Snow, 1999). In 1987, the state government introduced a levy on tobacco sales partly to fund replacement of tobacco advertising at high-profile sport and arts events earlier to a national ban on tobacco advertising. In Victoria, and soon after in four other states, health promotion foundations were established with this money. The model of using tobacco taxes for health promotion was also adopted in New Zealand and Massachusetts (Giles-Corti *et al.*, 2001).

In the same manner that the corporate world is able to enhance their community standing and promote key advertising messages through sponsorship contracts allowing signage and other rights at popular sporting events, the Victorian Health Promotion Foundation (VicHealth) sought sponsorship of sporting and other organizations principally to promote healthy environments in the community. The programme investments in the first 4 years were \$25.8 million with over 90 sports sponsored (VicHealth Foundation), and more recently, in 2001, \$5.4 million distributed (VicHealth). Three other health promotion foundations in other states established similar programmes with their funding (Giles-Corti *et al.*, 2001). Originally, VicHealth offered sponsorship contracts to state sporting associations (state associations), with funding provided in return for marketing of health messages at major sporting events. In later years funding was provided on the basis of policy development

in key health areas to promote healthy environments in the sponsored sport (Australian Institute of Primary Care, 2001). The aim of the programme was not only to improve health behaviours among players affiliated with these sports, but also to influence the broader community by providing role models.

These sponsorship contracts were implemented in partnership with a number of health agencies. VicHealth decided which health message was most appropriate for specific sports and events and formalized the contractual agreements. Health agencies were then assigned to assist with the implementation of health promotion requirements. Those sponsorships implemented by the Cancer Council Victoria's Quit and SunSmart programmes focused mainly on promoting smoke-free facilities and sun protection in clubs. Responsible serving of alcohol and provision of healthy food alternatives in clubs with bar and catering facilities and other messages were also encouraged over time. Other health agencies implemented these messages with different emphasis to other state associations. The benefits of the sponsorship strategy seemed promising from the outset, with written policies on smoking and sun protection established as early as 1990 in some sports (VicHealth and Victorian National Heart Foundation, 1996). Owing to licensing laws, which regulate serving of alcohol, alcohol policy was in place in many clubs by 1980. Furthermore, a study assessing long-term sponsorship of Victorian life-saving associations suggested that this strategy was highly effective in promoting sun protection behaviour at the club level (Dobbinson *et al.*, 1999). Despite this success, there is concern as to whether sponsorship contracts in reality reach their stated aims (Crisp and Swerissen, 2003).

Communication of the sponsorship requirements was expected to impact on the club level, yet clubs were neither involved in negotiating sponsorship contracts nor directly funded. There is little research on the processes involved in utilizing peak bodies such as sporting organizations to convey information to the local level where the changes to health-promoting environments need to occur. Crisp and Swerissen suggest that sponsorship is best evaluated in terms of policy and practice at the club level (Crisp and Swerissen, 2003).

This study was initiated to quantify policies and practices at the club level in the 11 state

associations assisted by SunSmart and Quit. The types of sport clubs serviced at the time of the study were Australian Rules football, men's and women's cricket, tennis, canoeing, diving, life-saving and surfing. Clubs were assessed according to each of the five key health areas, i.e. smoke-free club facilities, sun protection, healthy food choices, responsible serving of alcohol and sports injury prevention. Barriers and supports for policy development in clubs were also assessed.

METHODS

Study design

The sampling frame was a mix of a 'census' of sports with smaller club membership and a 'random sample' of sports with larger club membership. From April to June 2001, representatives from 932 sports clubs were contacted by telephone, with 640 (69%) club representatives completing the interview. Clubs from metropolitan Melbourne ($n = 378$) and regional Victoria ($n = 262$) were interviewed. The main reasons for non-participation were as follows: difficulty in obtaining a suitable contact to interview (21%); interviewers being unable to schedule a time for the interview within the survey period (17%); no reply from clubs (11%); clubs no longer active (5%); contacts not at the club level (5%); and refusal to participate (4%).

Interview schedule

The interview schedule took ~20 min. to complete. Characteristics of the club were sought, including membership size, season of

competition, season of social activities and clubs' annual income. A set of 17 questions, assessing policy development for the five key health areas, formed the main part of the interview. Furthermore, a number of club practices in relation to the five health areas were measured. Perceived barriers to establishing policies and support for policy development were also explored, and included questions on communication with state associations and club ownership and, or control over facilities.

Statistical analyses

Simple descriptive statistics were reported to characterize club environments, policy development and practices promoting health in the sport setting. Assessment of policies was limited to clubs with facilities such as clubrooms, canteens or bars. Factors associated with the policy development in each key health area were explored using bivariate statistics [χ^2 and Kruskal-Wallis (H)]. Comparisons were made by club region (with clubs assigned as either metropolitan or regional by postcode using unpublished data on statistical locations provided by the Australian Bureau of Statistics) and within sport type (football, cricket, tennis and water sports). Significant differences are reported at an alpha level of 0.05 ($p < 0.05$).

RESULTS

The clubs surveyed varied widely in their membership size, resources and access to and control of facilities. In general, clubs with larger membership were better resourced (Table 1). The season

Table 1: Club membership and annual income of all sports clubs by state affiliation

Club affiliation	Total members of clubs surveyed	Median members per club	Proportion of clubs with available income over \$20 000 (%)
Victorian Amateur Football Association (VAFA) ($n = 15$)	2040	100	73
Victorian Country Football League (VCFL) ($n = 93$)	22 344	150	68
Victorian Metropolitan Football League (VMFL) ($n = 57$)	16 498	220	61
Victorian Cricket Association (VCA) ($n = 177$)	14 815	70	28
Victorian Women's Cricket Association (VWCA) ($n = 34$)	3612	85	44
Tennis Victoria ($n = 189$)	37 847	120	13
Victorian Canoe Association ($n = 25$)	1508	30	12
Victorian Diving Association ($n = 7$)	735	100	14
Life-saving Clubs ^a ($n = 32$)	7922	200	31
Surfing Victoria ($n = 11$)	923	70	9

^aIn all tables 'Life-saving Clubs' refers to clubs affiliated with the Royal Life Saving Society and the Surf Life Saving Association.

of sporting competition also varied widely. Football (Australian Rules football) clubs mainly competed in autumn/winter, whereas cricket and life-saving competitions were held mainly during the spring/summer months. Tennis, canoeing, diving and surfing competed year round.

Communication channels from state associations to clubs are crucial to the strategies used to promote policy development at the club level. The majority of clubs (80%) affiliated with Victorian football and cricket associations communicated with their governing body via a regional district affiliate, whereas clubs from tennis, life-saving, canoeing, diving and surfing more commonly had direct communication with their state association (65%). Of those who liaised directly with their state association, communication was frequently by letter (96%). However, the majority of clubs also used newsletters, telephone and face-to-face meetings.

Policy development was the responsibility of particular individuals in only 142 (22%) clubs. Within these clubs, the secretary (49% of clubs) or president (33% of clubs) was most likely to take on this task. In the 78% of clubs that did not designate responsibility for policy development to one individual ($n = 498$), this work was most commonly undertaken by the committee (91% of clubs).

The prevalence of written policies on the five key health areas varied widely by affiliated sport and health area (Table 2). Across all sports a large proportion of clubs (70%) with bar

facilities had developed written policy on responsible serving and management of alcohol, ranging from 58% of tennis clubs to 100% of diving and surfing clubs. In contrast, written smoke-free policies were established in only just over one-third of sports clubs, with policy development particularly prevalent among metropolitan football clubs [73% Victorian Amateur Football Association (VAFA); 61% Victorian Metropolitan Football League (VMFL)].

Smoke-free

Clubs where policy development was the responsibility of one individual were significantly more likely to have a written smoke-free policy (44%) than clubs that did not appoint an individual to this position (33%) ($\chi^2 = 5.58$, $df = 1$, $p < 0.05$). Regional analyses revealed that clubs situated within the metropolitan area ($n = 369$) were significantly more likely to have a written smoke-free policy (45%) than clubs from regional areas (23%) ($n = 262$) ($\chi^2 = 33.99$, $df = 1$, $p < 0.05$). Existence of smoke-free policies also varied widely among clubs from different sports. Football clubs ($n = 164$) were significantly more likely to have written smoke-free policies than other sporting clubs taken as a whole ($n = 467$) (43% cf. 33%; $\chi^2 = 5.78$, $df = 1$, $p < 0.05$). A majority of life-saving clubs also had written smoke-free policies (65%). Clubs with a written smoke-free policy were significantly more likely than clubs with no policy to prohibit smoking in eating

Table 2: Established written policies by sporting association

Club affiliation	Smoke-free (%) ^a	Sun protection (%)	Healthy catering (%) ^b	Responsible alcohol (%) ^c	Injury prevention (%)
VAFA ($n = 15$)	73	7	27	67	73
VCFL ($n = 93$)	28	13	19	78	51
VMFL ($n = 56$)	61	5	5	76	60
Total Football ($n = 164$)	43	10	15	76	56
VCA ($n = 176$)	28	43	8	66	24
VWCA ($n = 34$)	27	53	12	71	24
Tennis Victoria ($n = 189$)	36	35	4	58	16
Victorian Canoe Association ($n = 20$)	15	36	0	0	16
Victorian Diving Association ($n = 6$)	33	86	0	100	43
Life-saving ($n = 31$)	65	81	28	82	41
Surfing Victoria ($n = 11$)	18	18	0	100	18
Overall prevalence of policies of those with relevant facilities	36	34	10	70	30
Overall clubs	35	34	9	45	30

^aSmoke-free percentages are drawn from the number of clubs with at least some facilities or a clubhouse ($n = 631$).

^bHealthy catering percentages are drawn from the number of clubs with catering facilities ($n = 561$).

^cResponsible alcohol percentages are drawn from the number of clubs with bar facilities ($n = 380$).

areas, change rooms, kitchens, administration areas and social rooms (89% cf. 49%; $\chi^2 = 111.50$, $df = 1$, $p < 0.05$).

Sun protection

Overall, 34% of clubs had sun protection policies. Policy was generally more prevalent among clubs competing outside during the summer months, with diving (86%), life-saving (81%) and women's cricket (53%) associations having the highest proportion of clubs with a written sun protection policy. The exceptions for summer sports were the tennis clubs (35%) and men's cricket clubs (43%), both reporting lower levels of sun protection policy in place. Clubs in which policy development was the responsibility of one individual were significantly more likely to have a written sun protection policy than clubs that did not appoint an individual to this position (42% cf. 32%; $\chi^2 = 4.27$, $df = 1$, $p < 0.05$). Clubs involved in water sports were generally more likely than other clubs to have written sun protection policies. A high proportion of life-saving clubs had a written policy: for Surf Life Saving Association (SLSA) clubs ($n = 18$) 78% had a written policy and 22% followed unwritten guidelines; for Royal Life Saving Society (RLSS) clubs ($n = 23$) 87% had written policy and 13% followed unwritten guidelines. In addition, all but one of the diving clubs had a written sun protection policy. Although somewhat lower, a reasonable proportion of canoeing clubs had a written sun protection policy when compared with other sports overall (36% cf. 34%; $\chi^2 = 0.04$, $df = 1$, n.s.). Clubs associated with Surfing Victoria reported a low number of written policies (only 2 of the 11 clubs), with the majority of surfing clubs following unwritten guidelines.

Clubs with a written sun protection policy were significantly more likely to sell or provide sunscreen than those without a written policy (77% cf. 42%; $\chi^2 = 74.31$, $df = 1$, $p < 0.05$). In addition, those clubs with written sun protection policies were also more likely than those without a written policy to provide either broad-brimmed hats or legionnaires hats (49% cf. 19%; $\chi^2 = 60.89$, $df = 1$, $p < 0.05$). In the summer months, clubs with a written sun protection policy were significantly more likely than clubs with no policy to limit scheduling of competition programmes (35% cf. 19%; $\chi^2 = 21.01$, $df = 1$, $p < 0.05$) and coaching programmes (79% cf. 58%; $\chi^2 = 28.22$, $df = 1$, $p < 0.05$) to outside peak UV

times. Clubs with a written sun protection policy were significantly more likely to provide portable shade than those with no written policy (51% cf. 29%; $\chi^2 = 30.79$, $df = 1$, $p < 0.05$).

Healthy catering

Development of healthy catering policies, which specifically dealt with healthy food choices, was measured only for those clubs with access to catering facilities such as kiosks, kitchens and canteens ($n = 561$). Seventy-five per cent of clubs with catering facilities reported that they had no plans for a policy in this health area. Only a few clubs with access to catering facilities had developed a healthy catering policy. Compared with clubs with no written healthy catering policy ($n = 505$), those with a written policy ($n = 56$) were significantly more likely to provide at least one healthy food choice (excluding provision of water) in their canteens or kitchens (73% cf. 52%; $\chi^2 = 9.65$, $df = 1$, $p < 0.05$).

Injury prevention

Injury prevention policies were most common among football (56%), diving (43%) and life-saving (41%) clubs, with 30% of sports clubs overall having established policy in this area. There were no significant differences in the prevalence of injury prevention policies between metropolitan and regional clubs (32% cf. 28%; $\chi^2 = 1.27$, $df = 1$, n.s.). In both regions the majority of clubs either followed unwritten guidelines (22% of clubs in both metropolitan and regional areas) or had no plans for a written policy (39% of metropolitan and 44% of regional clubs). In addition, clubs where policy development was the responsibility of one person were not more likely to have a written policy than those clubs without a person in this position (36% cf. 29%; $\chi^2 = 2.65$, $df = 1$, n.s.).

Responsible alcohol

Of clubs with bar facilities ($n = 380$), 70% had a written policy relating to alcohol. A regional analysis revealed no significant differences in policy, with 73% of metropolitan clubs ($n = 221$) and 65% of regional clubs ($n = 159$) having written responsible alcohol policies ($\chi^2 = 3.16$, $df = 1$, n.s.). In addition, designated responsibility for policy development was not associated with actual existence of written policy. Seventy-two

per cent of clubs with a designated person responsible for policy development had a written policy on responsible serving of alcohol; similarly, 69% of clubs without a person in this position had a written policy ($\chi^2 = 0.41$, $df = 1$, n.s.). There was a similar level of implementation for all three responsible alcohol practices (i.e. light beer sold at bar, free unflavoured water provided at bar and bar staff with formal accredited training) among clubs with written policies and those with no written policy (89% in both cases) ($\chi^2 = 0.01$, $df = 1$, n.s.).

Policy reach

Only 2% or 11 of the 640 clubs managed to establish all five health policies. Nineteen per cent of clubs established both a smoke-free and a sun protection policy (the key policies promoted by the health agencies for the clubs' state associations). Although 2% was a low level of uptake of all five policies, according to the membership details 3275 club members were exposed to this environmental change.

Barriers to developing policies

Clubs were asked questions about barriers to policy development (Table 3). The most common barriers perceived by clubs were the need for more support from health agencies in the form of training or advice (47%) and the need for a sample policy (45%). Compared with clubs that communicated with their governing body through a regional district affiliate, those in direct contact with their state associations were significantly less likely to perceive the need for a sample policy as a barrier (49% cf. 40%; $\chi^2 = 4.71$, $df = 1$, $p < 0.05$).

Table 3: Perceived barriers to policy development for all sports clubs

Responses	%
Need more support from health agency? E.g. training, advice, resources	47
Need a sample policy to follow?	45
Concerns about how to regulate policies?	34
Control over club facilities limited?	31
Club too busy with other priorities?	29
Resistance from club members?	26
Resistance due to cost of changes needed?	21
Difficult in getting the issue on the club's agenda?	9

Note: $N = 639$.

DISCUSSION

Our results show a number of sports clubs in Victoria have developed and implemented policy in five key health areas following the implementation of a sponsorship programme encouraging both social marketing of health messages and healthy policy development. The study also found a number of club attributes that were related to uptake of policy.

The prevalence of policy varied considerably by health issue and by state association. The level of policy on responsible serving of alcohol was consistently high across all sports, whereas policy on healthy catering was consistently low. In contrast, uptake of smoke-free, sun protection and injury prevention policies varied widely by sporting affiliation.

The variable uptake of policy in clubs affiliated with the different sports is likely to be due to a number of factors. Nonetheless, the pattern of uptake is consistent with the duration for which health agencies have supported each state association to develop 'Smoke-free' and 'Sun Protection' policy. One exception was the long-term sponsorship of the tennis association, which resulted in only limited uptake of sun protection policies by tennis clubs. In this case, the health agency focus was less on club environments in favour of education at junior tennis clinics (Segan and Sweeney, 1992).

Relative to other health areas, injury prevention was not the main focus of any of the sponsorship contracts. The higher prevalence of injury prevention policy among the majority of football clubs, and just over 40% of diving and life-saving clubs, is likely to have been the influence of injury concerns within the sport itself.

Notably, the current study demonstrated a significant association between the existence of policy and healthy practices at the club level. Those with written smoke-free, sun protection and healthy catering policies were more likely to provide support for club members to adopt these healthy behaviours. Subsequently, these practices encouraging healthy behaviour may be adopted within the broader community.

In contrast, policy was not significantly associated with service of alcohol practices in clubs. The existing legislation governing these practices (VicHealth and Victorian National Heart Foundation, 1996) is likely to override the need for local policy in this health area. State legislation banning smoking in a range of public dining

areas, including licensed clubs, was introduced after the survey in July 2001. However, this legislation does not cover all sporting club venues and establishment of smoke-free policies is still likely to be beneficial.

Overall, policies were more prevalent in clubs when responsibility for policy development was assigned to a given individual, suggesting that designation may be useful in facilitating policy uptake. Furthermore, clubs perceived several barriers to establishing a written policy, such as a lack of sample policy and a need for further support for policy development from health agencies; highlighting training, advice and resources as important factors in assisting with policy development. These findings suggest that health agencies' delivery of policy training to state associations was limited, whereas the costs and resources to manage direct training for all sporting clubs would have been prohibitive. Less costly strategies for delivering health promotion to diffuse groups might be sought. Dissemination of sponsorship kits was found to be comparable with programme staff delivery in assisting Healthway to promote health messages at sporting events, but at reduced cost (Giles-Corti *et al.*, 2000). Further research is needed to determine the potential of policy kits alone to facilitate policy development in clubs.

Policy development is considered a central step in creating environments that support individuals adopting healthy behaviours and lifestyles (World Health Organisation, 1986). However, there appear to be relatively few studies evaluating the impact of healthy public policy (Steckler *et al.*, 1995; Orleans, 2000) and particularly in the sport setting (Jackson *et al.*, 2005). Assessing the extent to which policy can translate into practices that sustain environmental change (Orleans, 2000) and ultimately a community's health behaviours is a vital step in evaluating the potential of policy in maximizing the impact of health behaviour interventions. Furthermore, before introducing a policy more extensively it would be beneficial to understand how policy works at the local level. Clearly, much further research is needed on this area including testing of suitable methods for assessing environmental change.

One limitation of the current study is a reliance on self-report. Although a number of practices were assessed (Dobbinson and Hayman, 2002), we were not able to fully test compliance with established club policies. To comprehensively determine the degree to which clubs implement

practices stipulated in policies, impromptu visits to club facilities during training sessions, competitions and social events could be undertaken.

Moreover, self-report data may be subject to social desirability biases. However, given many clubs reported not having written policies, it appears that there was limited social desirability bias in responses to questions regarding policy development. Reliance on individual committee members to have detailed knowledge of the club environment might also be questioned. Nevertheless, reports by presidents and secretaries of sports clubs have been found to provide authoritative information in relation to injury prevention policy and practice (Donaldson *et al.*, 2003). Furthermore, at least one study within the school setting found a high level of agreement with self-reports and established policies (Dobbinson *et al.*, 2000). Certainly evaluation of the outcomes might have been strengthened by utilizing objective measures.

Another limitation of our study was that, as the sample was based on an uneven distribution of clubs by state association, the findings across all clubs more closely reflected the attributes of affiliated sports with large club numbers, namely football, men's cricket and tennis. From a public health viewpoint, these sports with greater numbers of clubs and members have a greater potential to influence health outcomes for a community by providing supportive environments at their clubs. A few other studies have found positive outcomes for sponsorship and/or policy in the sport setting. Sponsorship of the Scottish F.A. Cup appeared to raise the profile of the Scottish Health Education Group and its messages to football supporters (Hastings *et al.*, 1988). Similarly, several studies not only have established the value of sponsorship in Western Australia in promoting spectator awareness of health messages at sporting events but also community support for and implementation of smoke-free bans at sponsored venues, events and projects (Corti *et al.*, 1997; Giles-Corti *et al.*, 2001). Our study suggests that sponsorship of peak sporting bodies can promote policy development at the club level. Moreover, establishment of policy did appear to translate into reported club practices for three of the five health behaviours. One study in the United States similarly notes the potential effectiveness of policy with reduced arrests and assaults at a college-sporting stadium following implementation of a policy banning alcohol (Bormann and Stone, 2001). Nonetheless, sponsorship

advertising alone was found to have limited reach for SunSmart signage at a Brisbane Cricket Ground (Lynch and Dunn, 2003). This highlights the need for more research to understand the important elements of successful sponsorships.

The progress made in implementing strategies for minimizing passive smoking, exposure to UV in sunlight and excessive drinking in sports clubs is unlikely to have occurred without change in community norms. Each of these health issues has been the subject of high-profile media campaigns in the past, which may have considerably influenced policy uptake at the club level (Hill *et al.*, 1993; Mullins *et al.*, 2000; Australian Government Department of Health and Ageing, 2004). The topical nature of obesity in recent years might be a driver for increased introduction of healthy catering policies and practices to clubs (National Health and Medical Research Council, 1997).

The role of signage at sporting events and clubs might also be further explored in future studies, as signage has been an integral part of the sponsorship requirements for some time. In addition to building community awareness of health issues, signage can be a valuable specific prompt for individuals' actions, such as prompting sun protection behaviour or extinguishing cigarettes in a smoke-free area. These local prompts are likely to help build the efforts of media campaigns in keeping these health issues on the agenda at the 'grass-roots' community level and, thus, supporting the actions of individual sports club committees in their efforts to introduce structural change in their clubs. Lastly, the effect of sponsorship duration, type and quality of resources invested and strategies implemented are worthy of further research.

To conclude, policy uptake is likely to be more prevalent when support from health agencies promoting policy development reaches the club level. The likelihood of policy uptake for a particular health area is also determined by the appropriateness of the behaviour being promoted for a given sport. Our results also provide some evidence that a written policy is likely to encourage health-related practices at the club level.

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