

Good practices and health policy analysis in European sports stadia: results from the 'Healthy Stadia' project

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SUMMARY

Sport plays an important role within society and sports stadia provide significant settings for public health strategies. In addition to being places of mass gathering, stadia are often located in less affluent areas and are traditionally attended by 'harder to reach' communities. Unfortunately sports stadia and the clubs they host are rarely perceived as places that promote healthy lifestyles. Fast food, alcohol and tobacco are commonly advertised, served and consumed during sports games giving the spectators and TV fans contradictory messages concerning healthy choices. As part of a wider programme of work part-funded by the European Union, a study was therefore designed to explore current 'good practice' relating to positive health interventions in sports stadia across a number of European countries. Using a specially designed questionnaire, information about health policies and good practices relating to food offerings in stadia, physical activity promotion among local communities, tobacco policy, positive mental health initiatives, environmental sustainability practices and social responsibility policies were collected in 10 European countries (England and Northern Ireland, Finland, Georgia, Greece, Ireland, Italy, Latvia, Poland, Spain and Sweden) involving 88 stadia. The audit results show that stadia health policies differ considerably between specific countries and sports. Based on the literature analysed, the examples of good practices collected through the study, and the subsequent instigation of a European Healthy Stadia Network, it shows that there

is considerable potential for stadia to become health promoting settings.

INTRODUCTION

The idea of health promotion operating beyond the context of the individual is one that has grown in popularity over the past 20 years, predominantly following the World Health Organisation's Ottawa Charter for Health Promotion in 1986. The approach is reflected in terms such as Settings for Health (Baric, 1991) and Health Promoting Environments (Nutbeam, 2007).

This setting-based approach to health promotion derives from the strong assumption that the more supportive a social and physical environment is for healthy lifestyle choices the easier individuals' health behaviours are modified (Goodstadt, 2001; Whitelaw *et al.*, 2001). The settings-based approach to public health interventions is now well established, most notably by Healthy Schools (Clift and Jensen, 2005), Healthy Cities (De Leeuw and Skovgaard,

2005), Healthy Hospitals (Johnson, 2000; Pelikan *et al.*, 2001) and Healthy Prison Programmes (Whitehead, 2006; Møller *et al.*, 2007). Until recently sport stadia have rarely been perceived as places designed for the promotion of healthy lifestyle and improvement of employees', players', visitors' and local society's health (Jackson *et al.*, 2005; Dobbinson *et al.*, 2006; Kokko *et al.*, 2006, 2009).

In most European countries, sports stadia are traditionally located in less affluent areas surrounded by dense, low-quality housing. They usually play a very important role within and beyond the community with millions of people attending a sports stadium each week, to watch their team, to work or to use the stadium's facilities. This is often expressed in a strong loyalty to the club/stadium. Young- and middle-aged men, many of them with low educational attainment, in the most deprived areas of Europe constitute a high percentage of supporters. These groups are not easy to reach with health information and education about health determinants. Health literacy levels in such groups are mostly low and health behaviours far from recommended.

Sports stadia therefore offer an important setting for reaching large numbers of people and for improving public health and reducing inequalities, addressing determinants such as nutrition and physical activity, tobacco, alcohol and urban development, and tackling specific target groups including men's health and workforce health. In particular they may assist in communicating health promotion messages. However, sports stadia/clubs are rarely perceived as places for promoting healthy lifestyles. Moreover products like fast food, alcohol and tobacco are commonly served and advertized during sports games in many countries giving the spectators and TV fans inappropriate messages concerning healthy choices. However, there is evidence that some fans would prefer to be served healthier food at least (Ireland and Watkins, 2010).

The Healthy Stadia concept was developed in 2005 in the UK when both a charity, Heart of Mersey, developed a pilot programme with stadia based across Merseyside (Haig and Crabb, 2006) and the North West Regional Public Health Group commissioned The Healthy Setting Development Unit, at The University of Central Lancashire, and the Federation of Stadium Communities to carry out a three-phase programme enabling sports clubs in the North West to work towards becoming Healthy Stadia.

These two organizations defined a healthy stadium as: 'one which promotes the health of visitors, fans, players, employees and the surrounding community. It is a place where people can go to have a positive, healthy experience playing or watching sport' (Crabb and Ratinckx, 2005).

In 2007 a European Healthy Stadia Programme was established and coordinated by Heart of Mersey following a successful application to the European Union in the framework of public health programme. Alongside the UK partners (Heart of Mersey and the University of East London) the programme brought together 'Associate Partners' from several European countries including Finland, Georgia, Greece, Ireland, Italy, Latvia, Poland and Spain and over 30 collaborative partners, including UEFA, European Public Health Alliance, the European Heart Network and the World Heart Federation who are still deeply involved in the programme. The general assumption of the programme was that sports stadia are ideally placed to support health improvement and reduce health inequalities through the loyalty shown towards the clubs' brand, the locality of stadia within the more deprived areas, the interaction of the stadia within the local community and the numbers of people who use the stadium facilities on a regular basis, including employees, fans and those using the stadia for non-sporting events. The programme (now superseded by a European Healthy Stadia Network) is managed by a steering group with a secretariat hosted by Heart of Mersey. This paper draws upon the responses and findings of a key work package within the European Programme—an audit process carried out to examine current policies and practices that promote health at sports stadia across a number of European countries. It should be noted that the audit process was not intended to provide a comprehensive comparative analysis across all European states, but to give the programme's steering group an insight into examples of current health policies and practices and to consider their potential for future use as health promotion activities.

AIM OF THE STUDY

The aim of the study was to examine current policies and practices which promote public health at sports stadia within Europe.

OBJECTIVES

- To develop a robust questionnaire examining current policies and practices in sports stadia within Europe.
- To summarize and analyse data from current practices that promote community health at sports stadia within Europe and consider their potential for future use.
- To share best practice between different sports, sports stadia and with other collaborative partners.

STUDY DESIGN AND METHODOLOGY

The study was conducted over a 12 month period between November 2007 and November 2008. The study focused on sports stadia offering a wide range of sports and received returns from 10 European countries: UK (including Northern Ireland), Finland, Georgia, Greece, Ireland, Italy, Latvia, Poland, Spain and Sweden. It collated, summarized and assessed current policies and practices that promote community health at sports stadia within Europe. A common framework detailing the criteria of healthy policies and practices was developed drawing on previously used health settings approaches (Johnson, 2000; Dooris, 2004), and on the experience of partners who have undertaken similar exercises. Thus the following steps were taken:

Literature and website review

A literature study was undertaken to identify previous research relating to the adoption of health policies and practices in sports stadia. In addition, information relating to health policies and practices displayed on the websites of individual sports stadia/clubs, sports leagues and governing bodies of sport was also analysed to contextualize likely current practice. These themes included: food provision and food-related policies; smoke-free policies and sale of tobacco products; alcohol policies; activities that promote mental health; transport policies promoting walking and cycling; stadia which demonstrate leadership through corporate social responsibility; urban regeneration initiatives with sports stadia which consider community health implications and wider social determinants.

Key informant approach

The questionnaire was modelled on findings from the preliminary literature and website review and previous work undertaken in North West England (Crabb and Ratinckx, 2005). Key informants for additional advice and feedback on a draft form of the questionnaire were identified via collaborative partners, and included personnel employed by sports stadia, sports governing bodies and collaborative partners. To ensure high quality and consistency of feedback, partners were provided with detailed templates to be used with key informants.

Dissemination of questionnaire

A final version of the questionnaire was sent to each country coordinator and translated where necessary. They were then distributed to sports stadia/clubs in the countries aligned to each Associate Partner. Each Associate Partner was responsible for the selection of at least three suitable sports stadia/clubs for further distribution of the Healthy Stadia questionnaire, while there was no maximum limit to how many stadia or sports organizations were contacted. In addition, significant support was offered in the mail out process by UEFA who contacted national football associations within Europe to disseminate the questionnaire to their member clubs.

Content analysis

Assessment of what constitutes 'good practice' was developed and inclusion/exclusion criteria determined and agreed with the Programme Steering Group. Quantitative data was analysed using appropriate statistical packages and qualitative data via 'content analysis'. Findings from both methods were cross-checked against each other to increase the reliability of the findings.

Agreement on the key elements of 'good practice'

Targets were agreed so that examples of community health practice in sports stadia were drawn from as wide a geographical range as possible and to reflect stadia of different sizes and in varying settings.

The questionnaire collated information from each stadium in terms of capacity, its year of construction, sports played and its ownership.

Areas covered in the study included:

- Food and nutrition: healthy eating options, alcohol awareness.
- Physical activity: promoting physical activity in the community especially among women, seniors and disabled people.
- Smoking: no smoking policy, restrictions on tobacco sales and advertizing.
- Mental health (dealing with anti-social, racist behaviour and/or organized violence/hooliganism).
- Environmental care such as renewable energy, recycling, walking/cycling/public transport routes and car sharing.
- Social responsibility, reducing social inequality by employment of disabled people, involving popular sports players as health promotion and fair-play leaders in a community.
- Community engagement, partnership working, policies related to advertizing and sponsorship.

RESULTS

Eighty eight completed questionnaires were returned and analysed by the International Sport Projects Association, Oravais, Finland.

Characteristic of the respondents

In the study, 88 stadia from 10 European countries replied to the audit. The distribution by participating countries and ownership of stadium is presented in Table 1.

The respondents provided detailed information about the year in which the stadium was built, the stadium capacity, the most frequent stadium users, sports played and additional activities held within the stadium (Table 2).

Indexed to a median value, stadia were used for one or two sports disciplines out of a total of 30 different sports. The most popular were football, athletics and rugby. Figure 1 shows distribution of different sports disciplines on the stadia participating in the good practices audit.

Table 1: The number and ownership of stadia participating in the audit by country

| Country | No. of public stadia | No. of private stadia | Total |
|------------------------------|----------------------|-----------------------|-------|
| England and Northern Ireland | 2 | 27 | 29 |
| Finland | 1 | 2 | 3 |
| Georgia | 21 | 3 | 24 |
| Greece | 2 | — | 2 |
| Ireland | 1 | — | 1 |
| Italy | 5 | — | 5 |
| Latvia | 1 | 2 | 3 |
| Poland | 10 | — | 10 |
| Spain | 8 | 2 | 10 |
| Sweden | — | 1 | 1 |
| Total | 51 | 37 | 88 |

Table 2: Background information about the responding stadia

| Stadium characteristic | Number of stadia |
|--------------------------------------|------------------|
| Year built | |
| <1900 | 8 |
| 1901–1925 | 7 |
| 1926–1950 | 7 |
| 1951–1975 | 11 |
| 1976–2000 | 42 |
| >2000 | 13 |
| Capacity of audience | |
| <1000 | 9 |
| 1001–5000 | 19 |
| 5001–15 000 | 28 |
| 15 001–30 000 | 16 |
| 30 001–50 000 | 11 |
| >50 000 | 5 |
| Number of sports disciplines played | |
| 1–2 | 45 |
| 3–4 | 34 |
| 5–6 | 6 |
| ≥7 | 3 |
| Stadium users groups | |
| Sports clubs | 88 |
| Schools | 73 |
| People with disabilities | 68 |
| Voluntary/community sector | 62 |
| Companies | 59 |
| Additional stadia activities | |
| Concerts | 36 |
| Conferences/exhibitions | 26 |
| Private functions (such as weddings) | 21 |
| Others | 5 |

Health policy

The analysis of health policies and activities undertaken by stadia is shown in Table 3. All stadia explored at least one issue but none addressed all of those listed.

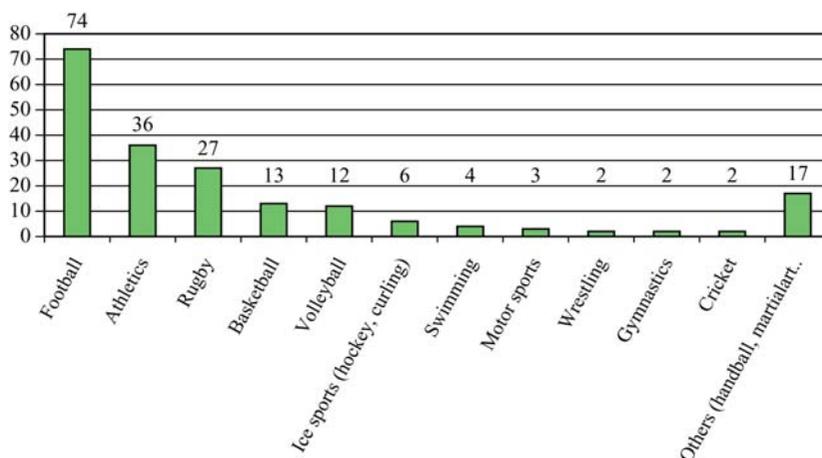


Fig. 1: Characteristics of sports stadia participating in audit by sports played.

Table 3: The scope of health policy interventions on the stadia participating in good practices audit

| Type of health promotion activity | Number of stadia | % |
|--|------------------|------|
| Tobacco policy | | |
| Smoking prohibited throughout | 34 | 38.6 |
| Smoking permitted only in designated area | 15 | 17.0 |
| Sale of tobacco prohibited | 54 | 61.4 |
| Total stadia with some form of tobacco control policy | 49 | 55.7 |
| Diet and nutrition | | |
| Beverages offered at the stadium | | |
| Alcohol | 57 | 64.8 |
| Carbonated drinks | 87 | 98.9 |
| Water | 86 | 97.7 |
| Fruit juices | 83 | 94.3 |
| Any initiative to encourage responsible alcohol use | 19 | 21.6 |
| Healthy eating policy | 16 | 18.2 |
| e.g. provision of healthier food options to fans and/or staff; commitment to low salt or low-saturated-fat food products | | |
| Designated person dealing with food/healthy food issues | 23 | 26.1 |
| Physical activity promotion policy | 44 | 50.0 |
| e.g. active travel plans promoting walking and cycling to stadium, fitness classes and/or reduced gym membership for staff | | |
| Interventions to support positive mental health | 29 | 33.0 |
| e.g. anti-racism and anti-violence policies, work placements for mental health service users | | |
| Environmental care | 33 | 37.5 |
| e.g. active travel plans, recycling schemes, energy and water efficiency programmes | | |

More than a half of sports stadia (55%) had some *tobacco policy*. In two-fifths of stadia smoking was prohibited throughout and in 15 stadia, it was permitted only in specially designed areas. Moreover, in about two-thirds of the analysed cases, tobacco sale was forbidden as well. Of the 45% stadia with no antismoking policy, most are from Georgia where there is a high prevalence of smoking and tobacco sales.

Only 16 out of 88 stadia have developed a *healthy eating policy*—for example, commitment to supply at least one type of healthier food

option within the stadium. One-quarter employed a specially designated person to deal with food/healthy food issues. Owing to subcontracting of food outlets within stadia, 56% believe that they have very little control or influence on what is sold.

In the areas surrounding the stadium, only four stadia could successfully affect what was sold and 77% believed they had a low influence on this matter.

Although alcohol beverages were available in the majority of stadia (57 out of 88), a

responsible alcohol use policy appeared in only one-fifth. Billboards or poster advertisements against alcohol use, informing about its harmful influence on health, were the most common activities. One stadium declared a support programme for patients recovering from alcohol addiction.

Nearly half (47%) have developed a *physical activity policy* for staff, visitors or members of the local community. In most places, sports facilities are free of charge for staff. In some cases, lunch breaks were prolonged to enable physical activity participation. Most stadia also organize open sports events for the local community as well as reduced gym prices or free sports classes (usually football, fitness or dance) for young people. Three-quarters of sports stadia had a sports offer for disabled users.

Of the four policies relating to healthy lifestyles (tobacco policy, alcohol awareness policy, policy on healthy eating, policy promoting physical activity), only 20% of stadia had developed three out of the four lifestyle policies, with 18 of these stadia under private ownership and only five under public ownership, a discrepancy that was anticipated before conducting the audit. Further cross-analysis of those stadia adopting three out of the four lifestyle policies revealed the following: concerning geographical location, 11 were from the UK, with 3 from Finland and a further 2 each from Poland and Spain; concerning date built, 8 were built between <1900 and 1974, with another 9 built between 1975 and 2008 and finally, concerning sports played at the stadia, 16 hosted football, 4 hosted rugby, with a further 3 more each coming from athletics, volleyball and basketball (note that these include multi-purpose stadia).

Positive mental health support interventions were rather rare (33% of the respondents had a policy which supported positive mental health) and usually carried on together with municipality as a part of a broader programme.

A commitment to *Green Transport and the Environment* was expressed by 38% of the stadia who were advocating a green transport initiative. The most commonly undertaken initiatives were walking/bicycle routes leading to the stadium, provision of free bicycle parking or car-sharing for employees. Quite often stadium management cooperated with local public transport authorities to decrease air pollution. The majority of stadia that are classified as 'new build' or 'renovated' have followed

sustainability initiatives such as energy and water conservation, recycling and litter programmes and even carbon offsetting schemes.

DISCUSSION

Policy development is considered a central step in creating environments that support individuals adopting healthy behaviours and lifestyles (World Health Organisation, 1986; Catford, 2006). However there appear to be relatively few studies evaluating the impact of health-related public policy, in particular, in a sports setting (Jackson et al., 2005). Through a systematic search of the literature, Priest et al. were not able to identify any studies which employed a controlled design to test the effects of policy interventions implemented in sporting settings to promote healthy behaviour change (Priest et al., 2008).

Theoretically sports clubs are an ideal setting to promote community-wide participation in physical activity and to develop healthy and positive environments (Eime et al., 2008). In real-life, however, there exist several problems or barriers to use sport stadia as health promotion settings. Moreover, the actual picture as demonstrated in our European Healthy Stadia Audit is not very optimistic.

Sports stadia paradoxically seem to be quite a difficult setting for health promotion. Undoubtedly there is a huge gap between the offer provided to competitors (best sports equipment, healthy food, specialized medical care and psychological support) and products directed to fans (fast food, fizzy drinks, alcohol, tobacco etc.). Alcohol companies, fast food and carbonated beverage producers and, increasingly, online gambling companies are the main sponsors in sport, hence sports marketing traditionally concentrates on 'unhealthy' products (Stotlar, 1993).

In many cases the main health promoting aims of reducing alcohol consumption, stopping smoking and reducing the consumption of unhealthy foods are in direct opposition to the aims and marketing strategies of many of the main sponsors of sports stadia, their teams and specific competitions, e.g. FIFA World Cup (Collin and MacKenzie, 2006). A study from New Zealand performed by Maher et al. revealed that the sponsorship of popular sports for young people is dominated by 'unhealthy' sponsorship (that is predominately gambling,

alcohol and unhealthy food) relative to 'healthy' sponsorship (Maher *et al.*, 2006), while a recent quantitative study from Australia has demonstrated the exceptionally high prevalence of logos representing food and alcohol companies both within the stadium (including: players and umpire clothing, playing surface, boundary-boards, players kit) and on television during a match (Sherriff *et al.*, 2009).

Fortunately, many other social or environmental health promotion themes—such as promoting physical activity to local communities, children, disabled individuals or older populations, promoting mental health or exposure to UV in sunlight—do not conflict with the business or marketing strategies of sports stadia and sporting organizations.

As mentioned previously, there are only a few studies related to health promotion practices related to sport settings. Moreover, they are limited to only a few countries (Australia, New Zealand, Finland), and their area of analysis is frequently restricted to selected sports (such as football and rugby), provinces or regions or special groups of population (for example children and youth). In a large study performed in sports clubs from metropolitan Melbourne and regional Victoria, Dobbinson *et al.* (Dobbinson *et al.*, 2006) revealed that only 35% of all clubs possess established written policies devoted to smoke-free environments, 45% have policies on responsible alcohol consumption, 30% on injury prevention and 34% on sun protection. Only 9% of all clubs with catering facilities possess established healthy catering written policies. Seventy-five per cent of clubs with catering facilities reported they had no plans for a policy in this health area. Only 2% or 11 of the 640 Australian clubs managed to establish all five health policies.

Bearing in mind the high popularity of recreational sports and physical activity in Australia, as well as many successes in health promotion in this country, it is probably not surprising that none of the European stadia participating in the good practices audit could demonstrate effective health policies or any other achievements devoted to all areas of our survey; that is smoking, alcohol, 'healthy nutrition', promoting physical activity, interventions to support positive mental health or environmental care.

It is worth mentioning that in one-third of the stadia participating in the audit, alcohol consumption was forbidden. In a few countries

(such as Spain and Poland) restrictions on alcohol use or a no smoking policy was the result of legal regulations rather than a particular initiative taken by an individual stadium.

In some countries (e.g. Australia and Finland) there are already efforts to create a health-promoting sporting environment (Crisp and Swerissen, 2003; Kokko *et al.*, 2009). The target issues were similar to our study: smoking, healthy food choices, responsible alcohol management and sun protection. Australian researchers pointed out that at the very beginning of their intervention programme only 8% of sports clubs were smoke-free while in our study the percentage of such stadia was almost five times higher. Both studies placed a strong emphasis on responsible alcohol use.

Physical activity promotion initiatives by sports clubs among children, adolescents and their families are well known in literature (Jackson *et al.*, 2005; Kokko *et al.*, 2006; Eime *et al.*, 2008; Priest *et al.*, 2008). Hence, it seems strange that only 44 sports club (50%) in our study are engaged in such kind of initiative. Koski described that in Finland almost half of the children and adolescents participate in local sports club activities (Koski, 1999). Furthermore, American and Australian research shows that these percentages can even exceed 60% (Howie *et al.*, 2010; Kelly *et al.*, 2010). This illustrates a powerful and untapped potential of stadia in promoting physical activity.

There are some limitations of our study. For example, the sample of stadia was predominantly aligned to countries participating in the project, garnering replies from only 10 countries, thus the group can be not representative to all European stadia. Furthermore, representation of stadia by particular countries differed considerably in numbers and characteristics. Concerning this point, it should be noted that owing to a reliance on third parties such as national leagues and European governing bodies of sport disseminating the questionnaire to stadia, the overall sample size was derived through a 'snowballing' technique. We acknowledge that this technique sets limitations upon our conclusions, but we also assert that the core objective of the study was to gain better insight into current examples of policy and practice, not to conduct a comprehensive, comparative analysis. Another limitation of the study is self-reported data collection. In a few questionnaires, some issues were omitted or spaces

designed for sharing practices or quoting individual examples were left without explanation. This may suggest a social desirability bias, but could also be put down to lack of suitable information on a health topic.

Despite these limitations, this study is according to our best knowledge the first one analysing good health practices in a large group of European countries from West, East, North and South of the continent. Both 'old' EU members as well as former communist countries participated in the study. There was good representation of various sports disciplines, public and privately owned sports stadia as well as small, medium-size and large European stadia, including iconic stadia like Anfield (Liverpool), San Siro (Milan), Emirates (London), and important national stadia such as the Olympic Centre in Riga, Latvia and Finnair Stadium in Finland.

Discussing a theoretical foundation for future health promotion research and practice, Best and colleagues from the University of British Columbia, Vancouver suggest critical next steps towards closing the gap between health promotion research and practice: investing in networks that promote, support and sustain ongoing dialogue and sharing of experience; finding common ground in an approach to community partnering and gaining consensus on the proposed integrating framework (Best *et al.*, 2003). With these comments in mind, it is interesting to note the interplay between national regulatory policies and bottom-up approaches. While regulatory measures at political level are undoubtedly effective at tackling health issues across a population (e.g. smoke-free regulation), successful interventions at a local level—such as health promoting practices adopted by stadia and shared through the European Healthy Stadia Network—also provide a valuable evidence base to help form future regulatory policies at a national level.

An Australian qualitative study performed by Dobbinson *et al.* suggests that policy development for health promotion policies can be achieved in sports clubs when they are well supported by health agencies, when specific behaviours to be encouraged are appropriate for a given sport and when support and resources for policy development reach the club level (Dobbinson *et al.*, 2006).

Finally, we are in agreement with Catford who advocates the need for further applied research in the area of health promotion, going

on to propose that ideally the intervention should also create multiple 'wins' for different stakeholders, thus spreading the benefit to a broader base (Catford, 2006).

In conclusion, this study shows that sports stadia appear to be a good and underestimated setting for health promotion. The Healthy Stadia Good Practices Audit has evoked high level of interest among stadia participating in the study. The majority of participating stadia wish to be kept informed of developments within the programme and express an interest in creating a Healthy Stadia Network. This Network has been subsequently formed in late 2009, and funded in 2010 and 2011 by the World Heart Federation through their partnership with UEFA (for more information, please see: www.healthystadia.eu). Contact has been maintained with stadia who participated in the audit process, and many have developed further policies good practices such as active travel plans, tobacco-free stadia policies and men's health interventions. However, there still exist several key health areas where there is limited good practice, such as the marketing of unhealthy products through sports clubs and healthier food options being offered to fans on match day, and this offers a key common priority for stadia and stakeholders to focus upon.

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