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The health promoting sports club in Finland—a challenge for the settings-based approach

SAMI KOKKO, LASSE KANNAS and JARI VILLBERG
Research Center for Health Promotion, Department of Health Sciences, University of Jyväskylä, FIN-40014 Jyväskylä, Finland

SUMMARY

The purpose of this article is, first, to compile a frame of reference for the health promoting sports club and, second, to develop standards for the concept. This concept is based on the settings-based health promotion approach. Sports clubs are a new setting for health promotion, which until now has been little examined from a settings point of view. Nevertheless, this concept has much potential. For example, sports clubs attract a large number of children and adolescents and their educational nature can be considered to be informal. The present standards were developed using the Delphi method. The researcher, in cooperation with a panel of experts (experts in health promotion, n = 11, and experts in sports clubs, n = 16), sought to create a consensus statement on the standards. At the preliminary stage of the study 64 original standards were created on the basis of existing literature and the principles of the Ottawa Charter. During the three rounds of the Delphi process 15 standards were evaluated as the most important. After the Delphi process, the researcher modified the standards by eliminating overlap, interpolating seven standards to involve all strategic areas of the Ottawa Charter and creating a preliminary typology of the standards. At the subsequent stages of the study, indicators for these standards will be drafted and tested in practice. Therefore, this study would provide tools for determining and evaluating how health promoting a particular sports club is.

Key words: adolescents; health promotion; sports club; standards

INTRODUCTION

The Ottawa Charter pointed out the importance of settings in health promotion. 'Health is created and lived by people within the settings of their everyday life; where they learn, work, play and love' (WHO, 1986). It also emphasized the importance of finding new settings in which to carry out health promotion. Health promotion is not the responsibility of the health sector alone, but extends beyond healthy lifestyles to well-being. Thus, collaboration between settings must be enhanced to attain settings-based approaches which have holistic and wide-ranging perspectives (Dooris, 2004).

The settings-based approach has been utilized in regional and local health promotion projects (e.g. Healthy Cities) as well as in several institutions such as the health care institution and hospitals [e.g. (Johnson, 2000; Pelikan *et al.*, 2001)], schools [e.g. (Lynagh *et al.*, 1997; St. Leger, 2001)], universities [e.g. (Tsouros *et al.*, 1998; Xiangyang *et al.*, 2003)], workplaces [e.g. (Chu *et al.*, 2000; Noblet, 2003)] and prisons [e.g. (Department of Health, 2002; WHO, 2003)]. So far, the settings-based health promotion approach has been little examined in settings related to sports [e.g. (Jackson *et al.*, 2005)]. However, research has been conducted in Australia focusing on the potential of sponsorship and advertising, within sports settings, for promoting both general health awareness and structural changes [e.g. (Corti *et al.*, 1995; Crisp and Swerissen, 2003)].

The first aim of this article was to determine the frame of reference for the health promoting sports club. The second aim was to create the standards for the health promoting sports club. Similar standards have been created for a health promoting hospital (Grone *et al.*, 2004), a health promoting prison (Department of Health, 2002) and a healthy school (Department for Education and Employment, 2001).

ARGUMENTS FOR THE SETTINGS-BASED APPROACH

Settings-based health promotion is based on the idea that changes in people's health and health behaviour are easier to achieve if health promoters focus on settings instead of individuals (Whitelaw *et al.*, 2001). The major goal of this approach is to influence the development of environments and that of organizational culture and ethos. Individual changes remain a part of health promoting activities, but there is an orientation to act on a wider front, i.e. what the Ottawa Charter proclaims to be health promoting actions: building healthy public policy, creating supportive environments, strengthening community activities, developing personal skills and reorienting health services.

The efficacy of the settings-based approach is derived from its environmental emphasis. As Green *et al.* (Green *et al.*, 2000) argue, the settings-based approach, provides an ecological perspective as the key focus. Thus, the context within which health promotion and health occur can be defined and understood. Furthermore, the settings-based approach is instrumental for identifying a frame of reference by which the planning and implementation of health promotion would be maximally effective and for observing the particulars of different settings. The settings-based approach has two essential dimensions as follows: (i) a setting constitutes the context within which and through which health appears; and (ii) a setting offers an effective way to study and understand the determinants of health and to attain and influence individuals and communities (Goodstadt, 2001).

YOUTH SPORTS CLUBS AS A SETTING FOR HEALTH PROMOTION

Generally, the social justification for adolescent activities in sports clubs has been based on the significance that sports have for individual and communal growth and development. From the health promotion point of view, it has been argued that youth sports have a positive influence on adolescent health and health behaviour. At the same time, many studies have found explicit contrasts in the health behaviours of adolescents participating in sports club activities.

Research has indicated that adolescents who participate in sports club activities, for example, smoke less but use as much alcohol and illegal drugs as those not involved in sports club activities (Aaron *et al.*, 1995; D'Arcy *et al.*, 1997; Garry and Morrisey, 2000). In some aspects (e.g. heavy drinking behaviour, using snuff), adolescent members of sports clubs manifest even more negative health behaviours than other adolescents (Chakravorty *et al.*, 2000; Koski, 2000; Nelson and Wechsler, 2001; Kannas *et al.*, 2002; Rimpelä *et al.*, 2002). There are also research results on the high use of performance-enhancing drugs among athletes [e.g. (Bents, 2004; Waddington *et al.*, 2005)]. It should be noted that gender differences have been found among youth sports club participants. However, these differences are not consistent, varying between studies and between health behaviours.

A paradoxical conflict exists also between the ideology and the practices of sports clubs when it comes to health promotion. For example, in Finland 83% of sports clubs in 1986 and 79% in 1996 reported that a healthy and temperate lifestyle was an important or fairly important ideal in their activities (Heikkala and Koski, 1999). However, research indicates that health promotion has not been actively pursued in sports clubs. For example, junior ice-hockey coaches carried out health education in only 4% of team events during a season. Moreover, this education consisted mainly of spontaneous and informal remarks (Kokko and Kannas, 2004).

It can also be argued that health promoters have not generally paid attention to the potential of youth sports clubs as a setting for health promotion. Sports have been used mainly to prevent some specific health problems or risk behaviours such as alcohol use (Werch *et al.*, 2003), drug use (Goldberg *et al.*, 2000) and infectious diseases (Howe *et al.*, 2003) or as a tool for juvenile offender rehabilitation (Andrews and Andrews, 2003). Youth sports clubs have the potential to be much more. The health promoting sports club concept seeks a broader view of the use of sports and sports club activities for promoting

the health of children and adolescents. In other words, the concept encourages youth sports clubs to adopt health promotion as a fundamental principle of their activities [e.g. (Kokko, 2005)].

CHARACTERISTICS OF THE CRITERIA FOR A HEALTH PROMOTING SPORTS CLUB

Based on the Ottawa Charter and the principles of a health promoting school, as well as research and practical experiences related to sports clubs, Kannas (Kannas, 2000) created criteria for a health promoting sports club. These criteria are as follows: (i) club management culture; (ii) interaction between the club and parents; (iii) networking; (iv) goals of action; (v) intoxication policy; (vi) health education; (vii) health promotion and health education training of coaches and officials; (viii) physical environmental factors; (ix) health promoting coaching/instruction; (x) club health services; (xi) health viewpoint in sponsorship; and (xii) health barometer.

An important task for club management is to create a positive atmosphere regarding health promotion. Parents are a very important interest group with whom sports clubs could cooperate on health issues. Through networking, sports clubs could build cooperation with health organizations, allowing them to receive expert advice. Health promotion should be on the agenda of every health promoting sports club. Health promoting sports clubs should also have intoxication policy guidelines. To fulfil its role in health education, a sports club engages coaches and other officials to provide education in this area. Health education training for coaches and officials may involve specific health training or inclusion of health issues as part of basic training sessions. Physical environmental factors relate mainly to the conditions under which sports activities take place (Kannas, 2000; Kokko, 2005).

Furthermore, health promoting coaching/instruction implies a wider perspective than health education alone, i.e. suitable nutrition during a tournament, safety issues during practice sessions or stages of adolescent development regarding strength training. Club health services include sports injury prevention through education and treatment through the use of first aid equipment and the first aid skills of coaches. Clubs could also advise, direct and inform coaches, officials and parents on how to act in the case of an accident (local sports doctors, insurance policies, etc.). The aspect of health could be taken into account in sponsorship agreements. A health barometer, in this context, means that a sports club evaluates its health and health promotion status at regular intervals (Kannas, 2000; Kokko, 2005). These criteria were used for the basis of the preliminary stage of the present study.

YOUTH SPORTS CLUBS: THE CASE OF FINLAND

In Finland sports club activities have a dominant position in the leisure-time activities of adults, children and adolescents. Approximately 40% of children and adolescents (10–18 years old) participate in sports club activities (Koski, 1999; Kannas *et al.*, 2002). In addition, the Finnish sports system, for the most part, represents the spontaneous activity of civil society (Koski, 1999). In practice, this means that sports clubs have an especially focal role in organizing and implementing sports. The Finnish sports system consist of 38 national level sports and physical activity organizations, 75 sports federations and 6000–7800 sports clubs (Koski, 1999). The population of Finland, in 2004, was 5.2 million (Statistics Finland, 2005).

From the point of view of health promotion, Finnish youth sports clubs can be seen to have both obligations and opportunities. The main obligation arises as a result of the financial support that sports federations and clubs receive from the state and municipalities. As compensation for such financial support, the public administration can expect that sports federations and clubs participate in health promotion.

The first opportunity facing the clubs is that sports club activities involve a large number of Finnish children and adolescents and their families. This enables sports clubs to promote the health of not only children and adolescents but of involved adults as well. The second opportunity is the informal nature of sports clubs as an educational setting because children and adolescents voluntarily participate in such activities. This allows for more freedom to carry out health education and promotion than, for example, a school would have. The third opportunity concerns the fact that coaches are important authority figures for adolescents. Coaches greatly affect

young people in health issues. This influence can be conscious or unconscious, positive or negative. The fourth opportunity consists of the fact that health and a healthy lifestyle have a positive impact on sports performance. When athletes maintain a balanced diet, sleep enough and do not use intoxicants, etc., they perform better.

AIM OF THE STUDY

The purpose of this study was to determine the most relevant standards for the health promoting sports club. Using the Delphi method, the researcher, in cooperation with a panel of experts, sought to formulate a consensus statement on the most relevant standards.

DESCRIPTION OF THE DELPHI METHOD

The Delphi method is a group consensus approach and applicable to, for example, evaluating a public institutional setting (Kuusi *et al.*, 2000). It has been used in health-related studies (De Meyrick, 2003) and in the medical field to reach a consensus on complex or new issues in a systematic manner (Linstone and Turoff, 2002).

The Delphi method relies on a panel of experts and has three principal advantages as follows: anonymity, iteration and feedback (Adler and Ziglio, 1996; Kuusi *et al.*, 2000). Anonymity is a distinctive feature of the method. The experts make their evaluations without knowing the other panellists. Therefore, it can be assumed that the experts portray their true opinions on and perceptions of the issues under examination. Iteration means that the method consists of many rounds, usually two to four. Consequently, the experts can revise their answers. Iteration can also improve the reliability of the method, if statistical issues are taken into account. Feedback means that the respondents are allowed to see the results (group opinion) of the previous round. In other words, individual experts are allowed to learn the group opinion before completing the next questionnaire.

The Delphi method has been applied in various ways such as through interviews, questionnaires, Internet-based discussion areas or a mixture of such means. When a questionnaire method has been adopted, the different implementation processes have usually been quite diverse. For example, the initial questionnaire has varied between a completely open-ended type, a completely structured type and a mixture of the two (Jones and Hunter, 1995; Neutens and Rubinson, 2002; Scheibe *et al.*, 2002).

SAMPLE

The population of the study comprised Finnish health promotion experts and sports club experts. Health promotion experts represented, for example, researchers, National Health Institution officials and state officials. Sports club experts represented the interest group (sports clubs) from six of the highest ranking youth sports in Finland (football, ice-hockey, floor ball, track and field, cross-country skiing and swimming). Thus, the expert panel consisted of a total of 27 (varying from 24 to 27, depending on the round) experts in health promotion (n = 11) and sports clubs (n = 16).

Just over half of the experts were male. Most of them were married or cohabited, and had between one and four children. For two-thirds of the experts, their children participated in sports club activities. However, the children of sports club experts were more often involved in sports club activities than those of health promotion experts. Most of the experts had an academic degree; 6 held a doctorate and 10 a master's degree. The others had a collegiate or comparable degree. Two-thirds of the experts had worked for more than 6 years in their current position. Also, for two-thirds of the experts, their current assignments had a nationwide geographical perspective and, for one-third, a local perspective. The experts evaluated their own experience in health promotion and sports club activities (Table 1). Taken together, the experts had wide ranging experience in these areas.

MEASUREMENT

The study was carried out using an electronic questionnaire. It was sent to the experts via email and their answers were also received via email. For the first round, the questionnaire was partially structured but contained some open-ended questions. The question used was 'How important is the standard in question

Table 1: Background of the respondent population (n = 27) (HP, health promotion experts; SC, sports club experts)

	HP (f)	SC (f)	Total (f)
Gender			
Male	6	10	16
Female	5	6	11
Marital status			
Marriage/common-law marriage	7	16	23
Single/divorced	4	0	4
Children's sports club participation			
Yes	5	13	18
No	1	1	2
No children	5	2	7
Experience in health promotion			
Very much or much	10	9	19
Some	1	6	7
Little or none	0	1	1
Experience in sports club activities			
Very much or much	7	16	23
Some	2	0	2
Little or none	2	0	2

when describing the health promoting sports club?' In the first round there were 64 standards to be evaluated on a 4-point Likert scale. These standards were distributed under categories that were somewhat similar to the criteria of Kannas (Kannas, 2000). Then, the standards were evaluated by the experts. For example, concerning the standard 'Coaches and other officials give a good example through their own behaviour' the experts evaluated its importance for the health promoting sports club on the response scale as follows: 'very important', 'important', 'less important' or 'not important'. In open-ended questions the experts were invited to propose new standards. In the later rounds, the questionnaire was completely structured except for an option to make general suggestions.

The main functions of the second round questionnaire were, first, to verify the results of the first round and, second, to evaluate new standards. The response scale used was similar to that of the first round. In the third round, the panellists were asked to choose the 10 most important standards out of standards that had emerged as 'very important' in the previous rounds and to rate these 10 on a scale of 1–10. The experts were also asked to evaluate the feasibility of third round standards (for this a 4-point Likert scale was used). The question used was 'How easy/difficult do you consider it is to achieve this aim?' The response options were as follows: 'very easy', 'relatively easy', 'relatively difficult' and 'very difficult'.

DATA COLLECTION

The implementation of the study ensured the three principal advantages of the Delphi method. Anonymity was guaranteed throughout. For example, the questionnaires were sent separately to each respondent so that their email addresses would remain confidential. The study consisted of three rounds. The feedback was collected by the researcher and sent to each expert along with the questionnaire of the next round. The respondents were shown only the combined results of the previous round, not the statistical procedure or the detailed results (e.g. group-specific results).

The Delphi process began with a preliminary stage where the researcher created 64 standards based on existing theory and literature, mainly on the Ottawa Charter (WHO, 1986), but also on the criteria of Kannas (Kannas, 2000) (Figure 1). In the first round, the experts evaluated these 64 standards and proposed 17 new ones. Thus, the experts evaluated a total of 81 standards during the second round. In the third round, the panellists ranked the 10 most important standards out of the 33 that had emerged as 'very important' in the previous rounds, and evaluated their feasibility.

STATISTICAL ANALYSIS

The data were entered and analysed with SPSS 12.0 software. In the first round, the data were reviewed by frequency distribution. Then, for each standard, the experts' answers were graded ('very important' = 3, 'important' = 2, 'less important' = 1 and 'not important' = 0). The order of importance (from 'very important' to 'less important') was determined by the mean values of the combined answers of both expert groups and by the per cent distribution of the standards. For example, 'very important' standards had to represent more than 50% of all answers. No standards were eliminated after the first round.

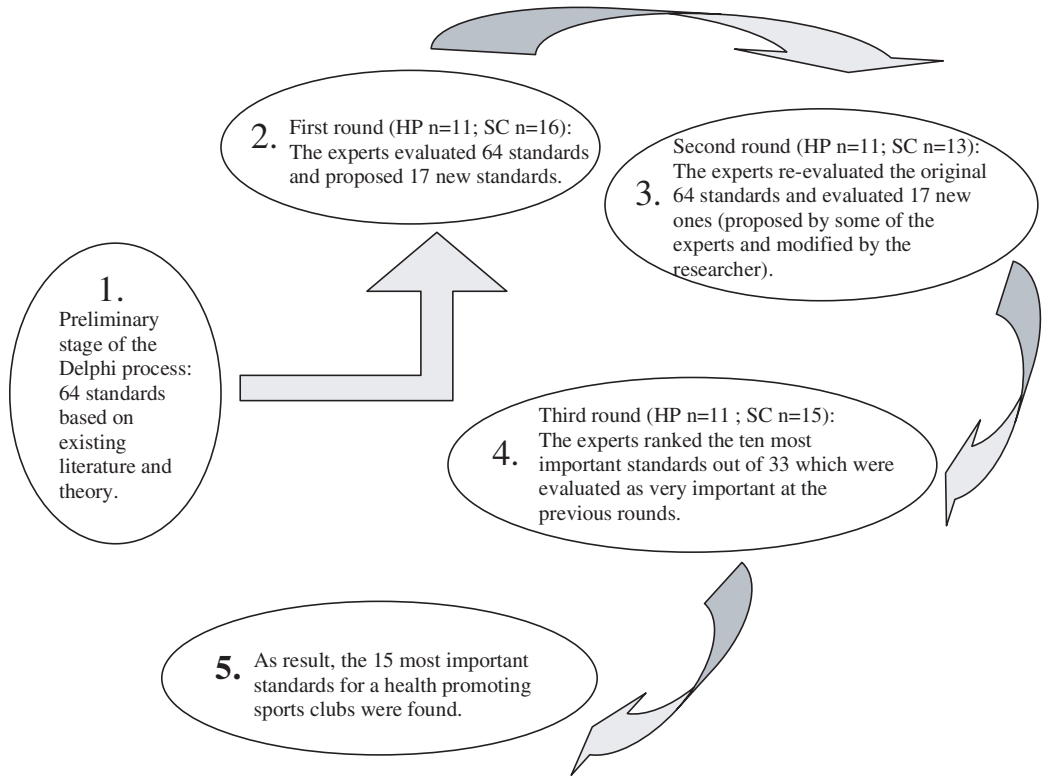

Fig. 1: Study design and progress (HP, health promotion experts; SC, sports club experts).

In the second round, the same statistical analyses were employed as in the first round. However, seven standards were added to the list of 'very important' standards on the basis of strong expert opinion, as well as high mean values and per cent distribution (a proportion in excess of 50%) in one expert group.

In the third round, the points for each standard were allocated as follows: 10 points for each number 1 ranking, 9 points for each number 2 ranking, continuing to 1 point for each number 10 ranking. If a standard did not occur in the top 10, a value of 0 was given. The points for each standard were summed up and their mean values calculated (total of all experts). Then, the standards were ranked in order of importance. The intersection was drawn to the value of 2.0. In the other words, the standards whose sum mean values exceeded 2.0 were added to the list of the most important ones. Similarly, the standards whose sum mean values were below 2.0 were eliminated. For the feasibility question, the answers were analysed similarly to the first and second round standard answer analysis, excluding the order of importance. The essential parameter for these questions was the mean value.

RESULTS

In the first round, the panel consisted of 11 health promotion experts and 16 sports club experts. Of the 64 standards created by the researcher, the experts evaluated 23 standards as 'very important', 36 as 'important' and 5 as 'less important'. The panellists proposed 17 new standards in the first round. The researcher modified these standards to match the previous ones.

In the second round, 11 health promotion experts and 13 sports club experts participated. They evaluated all 81 standards. Of these, 26 were ranked as 'very important' by all experts. In addition, the sports club experts evaluated as 'very important' two standards that were not similarly evaluated by the health promotion experts. The reverse occurred when the health

Table 2: The ranking (third round results) of the most important standards for a health promoting sports club by both expert groups (HP, health promotion experts; SC, sports club experts) and the mean value of the feasibility of the standards, from 1 'very difficult' to 4 'very easy'

Standards for a health promoting sports club	Total	HP	SC	Feasibility ($\bar{x}$)
Health promotion is a part of coaching practice	1.	1.	2.	1.76
Coaches and other officials give a good example through their own behaviour	2.	4	1.	1.92
The sports club's regulations have a written section on well-being and/or health promotion and/or health education and/or healthy lifestyle	3.	3.	5.	2.56
The sports club promotes the 'fair play' ideology	4.	5.	3.	1.96
Health and well-being viewpoints are observed in the sports club's decision-making process	5.	2.	16.	1.88
The sports club pays particularly attention to coaches'/instructors' interaction skills	6.	18.	4.	1.41
The sports club promotes individualistic growth and development	7.	8.	7.	1.32
In coaching, there is health promoting element also beyond sports performance (within the sports club's activities)	8.	9.	8.	1.76
The sports club promotes the 'everyone plays' ideology	9.	7.	11.	2.00
The sports club discusses its regulations with an executive committee, coaches and parents at regular intervals	10.	19.	6.	2.12
The sports club's health promotion activities and/or state of well-being are evaluated in an annual report	11.	6.	27.	1.84
The sports club's regulations have a written section on substance abuse	12.	12.	9.	2.48
The sports club supervises the implementation and functionality of its regulations	13.	10.	13.	1.84
Possible conflicts (e.g. bullying) are dealt with, straightened out and monitored	14.	15.	10.	1.80
The sports club assures that its subgroups have agreed regulations and practices	15.	14.	14.	2.12

promotion experts evaluated five standards as 'very important' but the sports club experts did not agree. These standards were included among the most important ones. Thus, 33 standards were evaluated as 'very important' after two rounds. Forty-one standards were evaluated as 'important' and seven as 'less important'.

In the third round, the experts (11 in health promotion and 15 in sports clubs) were asked to rank the 33 'very important' standards (on a scale of 1–10, Table 2). Fifteen of these were ranked as the most important by all of the experts. In the third round, the experts were also asked to evaluate the feasibility of these standards. In general, the experts thought that the standards were quite difficult to implement. Only four standards out of the 15 were considered not difficult to implement (Table 2). For example, the standard on sports club regulations having a written section on well-being, and the like was thought to be comparatively easy to achieve (mean 2.56), while the standard 'The sports club promotes individualistic growth and development' was seen as 'very difficult' to achieve (mean 1.32).

DISCUSSION

Research concerning sporting venues has indicated that positive attitudes towards health issues and structural changes in sports settings, for example, non-smoking regulations, have become more common owing to sponsorship and advertising (Giles-Corti *et al.*, 2001; Crisp and Swerissen, 2003). Yet, health promotion still is,

at least in Finland, seen as external to sporting activities. Youth sports clubs can be viewed as amateur organizations in health promotion. This must be taken into account when considering the health promotion activities in a sports club. It is not self-evident that youth sports clubs will adopt health promotion as a part of their activities. Initially, in particular, health promotion can be experienced as one more demand placed on the activities of sports clubs. Should this be the case, sports clubs probably will not institute changes on their own. Be that as it may, the settings-based approach appears to be a suitable approach to sports clubs.

The reliability of the study was ensured by carefully adhering to the procedure of the Delphi method and its three principal advantages of anonymity, iteration and feedback. One of these advantages, iteration, can also become a liability. This happened, for example, because the Delphi study consisted of three rounds, which meant three questionnaires for each expert to fill out during a period of 6 weeks. Additionally, the questionnaires were quite long. These factors may have lowered the motivation to complete the questionnaires and may have influenced the answers. On the other hand, by using the same kinds of questions and answer choices in the first and second rounds, the reliability of the Delphi process was increased. The use of email and other software to handle the data reduced the chance of human error. Yet, using an electronic questionnaire caused some problems. These problems, however, did not affect the results of the study. Another problematic issue of this Delphi process was overlapping standards. These overlaps might have caused the exclusion of some standards because the experts' responses may have been divided between two similar standards. Nevertheless, this seems unlikely.

It is highly likely that the most important standards were successfully identified for use in the following stages of the study. However, the standards on which the concept of the health promoting sports club rests should have elements from every strategic area of the Ottawa Charter. The results of the Delphi process indicated that most of the strategic areas were covered quite extensively. Yet, some important elements of health promotion were lacking. Although there were standards concerning these elements in the Delphi study, these standards were simply not evaluated as important enough. Therefore, the researcher modified the standards to conform to the Ottawa Charter action guidelines. Seven standards were added by the researcher to those gained from the Delphi process. As a result, a typology of 22 standards is presented in Table 3. It should be noted that the typology is tentative and based on the Delphi process.

Another problematic issue was the level of variation between the different standards. The list of standards contains standards of many levels, from the ideological ('The sports club promotes the ''fair play'' ideology') to the concrete ('The sports club's regulations have a written section on substance abuse'). This must be remembered when considering their implementation in sports clubs. This is especially important because experts noted that most of the standards were quite difficult to implement.

Although the present concept seeks to create general standards for the health promoting sports club, one must note, that in order to succeed one must carefully take into account the particular setting and its special characteristics, for example, the organizational culture, the attitudes and beliefs of key stakeholders, the nature of the practice environment, the developmental history, the internal politics and the broader social, economic and political context (Poland *et al.*, 2000). Similarly, on paying attention to the differences and unique attributes of sports systems and clubs in various countries and cultures by understanding their history and tradition, the organizational framework as an entity must be borne in mind (Heinemann, 1999).

It appears that the optimal concept of the health promoting sports club is a combination of previous literature and theory and information on the daily activities of sports clubs. This knowledge is then supplemented by the innovation of researchers. However, further development is needed. Nevertheless, this concept and these standards provide a useful starting point when considering what health promoting activities a particular sport or sports club setting could comprise.

FURTHER STEPS

This study established the preliminary standards for the health promoting sports club. In its forthcoming stages indicators for these standards will be operationalized and tested. In other words, the standards will be adapted by means of indicators

Table 3: A tentative typology of the standards for the health promoting sports club by the Delphi process, based on a classification of the strategic areas of the Ottawa Charter (a typology consisting of the 15 most important standards by the Delphi method and 7 additions by the researcher)

(I) Health promotion policy
The sports club's regulations have a written section on well-being and/or health promotion and/or health education and/or healthy lifestyle
The sports club's regulations have a written section on substance abuse
Health and well-being viewpoints are observed in the sports club's decision-making process
The sports club supervises the implementation and functionality of its regulations
The sports club's health promotion activities and/or state of well-being are evaluated in an annual report
The sports club collaborates with other sports clubs and/or health professionals on health issues*
(II) Environmental health and safety
The sports club assumes its share of responsibility for a safe sports environment, e.g. reviews the sports environment yearly (in cooperation with the proprietor)*
The sports club provides a sports environment that is free of intoxicants and tobacco during junior activities*
(III) Community relations
Coaches and other officials give a good example through their own behaviour
The sports club assures that its subgroups have agreed regulations and practices
The sports club discusses its regulations with an executive committee, coaches and parents at regular intervals
Possible conflicts (e.g. bullying) are dealt with, straightened out and monitored
(IV) Health education and individual skills
Health promotion is a part of coaching practice
In coaching, there is health promoting element also beyond sports performance (within the sports club's activities)
The sports club assures that health education is carried out*
The sports club provides education on health issues or makes provisions for its members to receive such education*
The sports club pays particularly attention to coaches'/instructors' interaction skills
The sports club promotes individualistic growth and development
The sports club promotes the 'everyone plays' ideology
The sports club promotes the 'fair play' ideology
(V) Health services
Sports injuries are comprehensively prevented and dealt with (including, e.g. the psychological effect of an injury on an adolescent)*
The sports club reviews and communicates treatment policies in a case of a sports injury*

*The researcher's addition.

to evaluate the health promotion characteristics of sports clubs. In this way, this study would provide tools for determining and evaluating how health promoting a particular sports club is. The standards and indicators would also offer a practical tool for sports clubs to include health promotion in their activities. We hope to be able to provide a framework of standards whereby sports clubs can successfully operate as health promoting settings for young people. We also hope to generate discussion about sports clubs as a setting for promoting the health of children and adolescents.

Address for correspondence:
Sami Kokko
Research Center for Health Promotion
Department of Health Sciences
University of Jyväskylä
PO Box 35 (L)
FIN-40014
Finland
E-mail: sami.kokko@sport.jyu.fi

REFERENCES

Aaron, D.J., Dearwater, S.R., Anderson, R., Olsen, T., Kriska, A.M. and Laporte, R.E. (1995) Physical activity and the initiation of high-risk health behaviours in adolescents. *Medicine and Science in Sports and Exercise*, **27**, 1639–1645.

Adler, M. and Ziglio, E. (eds) (1996) *Gazing Into the Oracle: The Delphi Method and Its Application to Social Policy and Public Health*. Kingsley, London.

Andrews, J.P. and Andrews, G.J. (2003) Life in secure unit: the rehabilitation of young people through the use of sport. *Social Science and Medicine*, **56**, 531–550.

Bents, R.T. (2004) Ephedrine, pseudoephedrine, and amphetamine prevalence in college hockey players. *Physician and Sportsmedicine*, **32**, 30–34.

Chakravorty, B., Ahmed, A. and Buchanan, R.J. (2000) Midproject findings from a study of the national collegiate athletic association's policy on smokeless tobacco use. *Substance Use and Misuse*, **35**, 1431–1441.

Chu, C., Breucker, G., Harris, N., Stitzel, A., Gan, X., Gu, X. *et al.* (2000) Health-promoting workplaces—international settings development. *Health Promotion International*, **15**, 155–167.

Corti, B., Holman, C.D.J., Donovan, R.J., Frizzell, S.K. and Carroll, A.M. (1995) Using sponsorship to create healthy

environments for sport, racing and arts venues in Western Australia. *Health Promotion International*, **10**, 185–197.
Crisp, B.R. and Swerissen, H. (2003) Critical processes for creating health-promoting sporting environments in Australia. *Health Promotion International*, **18**, 145–152.
D′Arcy, C., Holman, J., Donovan, R.J., Corti, B. and Jalleh, G. (1997) The myth of ''healthism'' in organized sports: implications for health promotion sponsorhip of sports and the arts. *American Journal of Health Promotion*, **11**, 169–176.
De Meyrick, J. (2003) The Delphi method and health research. *Health Education*, **103**, 7–16.
Department for Education and Employment. (2001) *National Healthy School Standard Guidance*. Publication of the Department for Education and Employment, Nottingham.
Department of Health (2002) *Health Promoting Prisons: A Shared Approach*. Publication of the Department of Health, London.
Dooris, M. (2004) Joining up settings for health: a valuable investment for strategic partnerships? *Critical Public Health*, **14**, 49–61.
Garry, J.P. and Morrisey, S.L. (2000) Team sports participation and risk-taking behaviours among a biracial middle school population. *Clinical Journal of Sport Medicine*, **10**, 185–190.
Giles-Corti, B., Clarkson, J.P., Donovan, R.J., Frizzell, S.K., Carroll, A.M., Pikora, T. *et al.* (2001) Creating smoke-free environments in recreational setting. *Health Education and Behavior*, **3**, 341–351.
Goldberg, L., MacKinnon, D.P., Elliot, D.L., Moe, E.L., Clarke, G. and Cheong, J.W. (2000) The adolescents training and learning to avoid steroids program: preventing drug use and promoting health behaviors. *Archives of Pediatrics and Adolescent Medicine*, **154**, 332–338.
Goodstadt, M. (2001) Settings—introduction. In Rootman, I., Goodstadt, M., Hyndman, B., McQueen, D.V., Potvin, L., Springett, J. and Ziglio, E. (eds) *Evaluation in Health Promotion. Principles and Perspectives*. WHO Regional Publications. European Series, **92**, pp. 209–211.
Green, L.W., Poland, B.D. and Rootman, I. (2000) The settings approach to health promotion. In Poland, B., Green, L. and Rootman, I. (eds) *Settings for Health Promotion. Linking Theory and Practice*. Sage Publications Inc., California, pp. 1–43.
Grone, O., Jorgensen, S.J. and Garcia-Barbero, M. (2004) *Standards for Health Promotion in Hospitals. Self-Assessment Tool for Pilot Implementation*. WHO, Regional Office for Europe, Copenhagen.
Heikkala, J. and Koski, P. (1999) *Reaching Out for New Frontiers. The Finnish Physical Culture in Transition in the 1990's*. University of Jyväskylä, Department of Social Sciences of Sport. ISBN: 951-39-0551-9.
Heinemann, K. (1999) Sports clubs in Europe. In Heinemann, K. (ed.) *Sport Clubs in Various European Countries. Series Club of Cologne*, Vol 1. Hofmann Verlag and Schattauer, Stuttgart, pp. 13–32.
Howe, W.B., Harmon, K.G. and Rubin, A. (2003) Preventing infectious disease in sports. *Physician and Sportsmedicine*, **31**, 23–29.
Jackson, N.W., Howes, F.S., Gupta, S., Doyle, J.L. and Waters, E. (2005) Policy interventions implemented through sporting organizations for promoting healthy behaviour change. *Cochrane Database of Systematic Reviews*, **2**, CD004809.
Johnson, J.L. (2000) The Health Care Institutions as a setting for health promotion. In Poland, B., Green, L. and Rootman, I. (eds) *Settings for Health Promotion. Linking Theory and Practice*. Sage Publications Inc., California, pp. 175–216.
Jones, J. and Hunter, D. (1995) Qualitative research: consensus methods for medical and health service research. *British Medical Journal*, **11**, 376–380.
Kannas, L. (2000) *Terveyttä edistävän urheiluseuran kriteerejä on kehitettävä (The Criteria for a Health Promoting Sports Club must be Developed). Raportti Nuoret—Urheilu—Päihteet—pienoisseminaari*. Suomen Liikunta ja Urheilu, Helsinki, pp. 19–21.
Kannas, L., Vuori, M., Seppälä, H.-R., Tynjälä, J., Villberg, J., Välimaa, R. *et al.* (2002) Suojaako urheiluseuratoiminta nuoria päihteiltä ja tupakalta? (Does sports club participation protect adolescents from intoxicants and smoking?). *Liikunta & Tiede*, **4**, 4–11.
Kokko, S. (2005) Sports clubs as a setting for youth health promotion. In Hoikkala, T., Hakkarainen, P. and Laine, S. (eds) *Beyond Health Literacy. Youth Cultures, Prevention and Policy*. Finnish Youth Research Network/ Finnish Youth Research Society Publications, 52, Hakapaino, Helsinki, pp. 338–354.
Kokko, S. and Kannas, L. (2004) Terveyskasvatus nuorten jääkiekkovalmennuksessa (Health education in ice hockey coaching of adolescents). *Liikunta & Tiede*, **2**, 45–48.
Koski, P. (1999) Characteristics and contemporary trends of sports clubs in the Finnish context. In Heinemann, K. (ed.) *Sport Clubs in Various European Countries. Series Club of Cologne*, Vol 1. Hofmann Verlag and Schattauer, Stuttgart, pp. 293–316. ISSN: 1239–9809 and ISBN: 951-39-0746-5.
Koski, P. (2000) Nuoret urheilijat ja alkoholi (Young athletes and alcohol). Jyväskylän yliopiston liikunnan kehittämiskeskuksen julkaisuja, **3**.
Kuusi, O., Muukkonen, T. and Linturi, H. (2000) Delfoi menetelmä. Internetlähde: http://www.metodix.com/fi/sisallys/index (The Delphi method, Internet source).
Linstone, H.A. and Turoff, M. (eds) (2002) *The Delphi Method: Techniques and Applications*. University of Heights, New Jersey, Available at: http://www.is.njit.edu/pubs/delphibook/index.html.
Lynagh, M., Schofield, M.J. and Sanson-Fisher, R.W. (1997) School health promotion programs over the past decade: a review of the smokingalcohol and solar protection literature. *Health Promotion International*, **12**, 43–60.
Nelson, T.F. and Wechsler, H. (2001) Alcohol and college athletes. *Medicine and Science in Sports and Exercise*, **33**, 43–47.
Neutens, J.J. and Rubinson, L. (2002) *Research Techniques for the Health Sciences*. 3rd edition. Benjamin Cummings Co., San Francisco.
Noblet, A. (2003) Building health promoting work settings: identifying the relationship between work characteristics and occupational stress in Australia. *Health Promotion International*, **18**, 351–359.
Pelikan, J.M., Krajic, K. and Dietscher, C. (2001) The health promoting hospital (HPH): concept and development. *Patient Education and Counselling*, **45**, 239–243.
Poland, B.D., Green, L.W. and Rootman, I. (2000) Reflections on settings for health promotion. In Poland, B., Green, L. and Rootman, I. (eds) *Settings for Health Promotion. Linking theory and practice*. Sage Publications Inc., California, pp. 341–351.

Rimpelä, A., Lintonen, T., Pere, L., Rainio, S. and Rimpelä, M. (2002) *Nuorten Terveystapatutkimus 2001. Tupakan ja päihteiden käytön muutokset 1977–2001 (Adolescent Health Practices 2001. Changes in Tobacco and Intoxicant Use 1977 to 2001). Stakes Aiheita*. Stakesin monistamo, Helsinki, p. 10.

Scheibe, M., Skutsch, M. and Schofer, J (2002) Experiments in Delphi methodology. In Turoff, M. and Linstone, H.A. (eds) *The Delphi Method: Techniques and Applications*. University of Heights, New Jersey. Available at: http://www.is.njit.edu/pubs/delphibook/index.html.

St. Leger, L. (2001) Schools' health literacy and public health: possibilities and challenges. *Health Promotion International*, **16**, 197–205.

Statistics Finland (2005) *Population by Age Group, end-2004*. Statistics Finland, Demographic statistics. Available at: http://www.tilastokeskus.fi/tup/suoluk/suoluk_vaesto_en.html (last accessed 25 April 2005).

Tsouros, A.D., Dowding, G., Thompson, J. and Dooris, M. (eds) (1998) *Health Promoting Universities. Concept, Experience and Framework for Action*. WHO, Regional office for Europe, Copenhagen.

Waddington, I., Malcolm, D., Roderick, M. and Naik, R. (2005) Drug use in English professional football. *British Journal of Sports Medicine*, **39**, e18.

Werch, C., Moore, M., DiClemente, C., Owen, D.M., Jobli, E. and Bledsoe, R. (2003) A sport-based intervention for preventing alcohol use and promoting physical activity among adolescents. *Journal of School Health*, **73**, 380–388.

Whitelaw, S., Baxendale, A., Bryce, C., Machardy, L., Young, I. and Witney, E. (2001) ''Settings'' based health promotion: a review. *Health Promotion International*, **16**, 339–353.

WHO (World Health Organization) (1986) *Ottawa Charter for Health Promotion*. World Health Organization, Copenhagen.

WHO (World Health Organization) (2003) *Promoting the Health of Young People in Custody*. WHO, Regional Office for Europe, Copenhagen.

Xiangyang, T., Lan, Z., Xueping, M., Tao, Z., Yuzhen, S. and Jagusztyn, M. (2003) Beijing health promoting universities: practice and evaluation. *Health Promoting International*, **18**, 107–113.