David Conrad · Alan White *Editors*

Sports-Based Health Interventions

Case Studies from Around the World

Springer

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Foreword by Mike Farrar CBE



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Foreword

No one should underestimate the global challenge of poor health and chronic disease. Governments of all political persuasion and levels of resource are increasingly facing an impossible task of spending more of their country's GDP on health care than their economy can sustain. In short, poor health and lifestyle problems are crippling their people and their finances.

And so what are the solutions to these problems? Simple—we need to help people make healthier choices in their lives, be it diet, exercise or managing alcohol misuse and stopping smoking. Easy to say, hugely difficult to do. But that is only if we continue to try and connect to people in the traditional ways. What this wonderful book tells us is that there are different and better ways to connect to each of us and help us to change our lives for the better.

In this book you will find chapter after chapter of evidence and knowledge about how, by embracing the power of sport, we can enable real change in people's lives. Not by hectoring or preaching but by inspiring and supporting. The power of sport may well be the single biggest means to engage some of the most unhealthy members of our communities, whether the issues be physical ailments, mental health problems or social isolation. It has the ability to influence our emotions—speaking to our hearts as well as our heads.

The editors and contributors have produced a definitive account of not only why sport matters but how it influences our health and our attitudes to our lives. Not only does it capture the evidence, it then gives us a huge number of practical examples of how to design and deliver sports and health programmes and get great results.

As someone who has spent a substantial part of his career working in leadership roles within the NHS and the sports community, I have been frustrated by the failure to build understanding between sectors in order to utilise the ability of sport to promote health. This book is invaluable in addressing this problem, and all I can say is I wish I had had this book sooner.

Mike Farrar, C.B.E., R.C.G.P., R.C.P.

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Preface

This book offers an insight into how sport and public health can come together to create innovative projects that reach into communities in a way that mainstream health services find difficult to achieve. While a myriad of excellent projects are aimed at increasing sports participation as a goal in itself, we have chosen to focus this book on those projects where sport is used primarily as a means to engage hard-to-reach individuals with broader public health interventions. The case studies featured in this book, whether they be aimed, for example, at achieving weight loss, empowerment, overcoming trauma or emotional distress or increasing uptake of immunisation, demonstrate the almost limitless potential for developing innovative and imaginative sports-based interventions across the spectrum of public health activity. Our aim is to showcase examples from around the world of innovative sport and health work in order to fire the imagination of readers, inspire new initiatives and share valuable lessons learnt in this emerging and exciting field.

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Leeds, UK — Alan White

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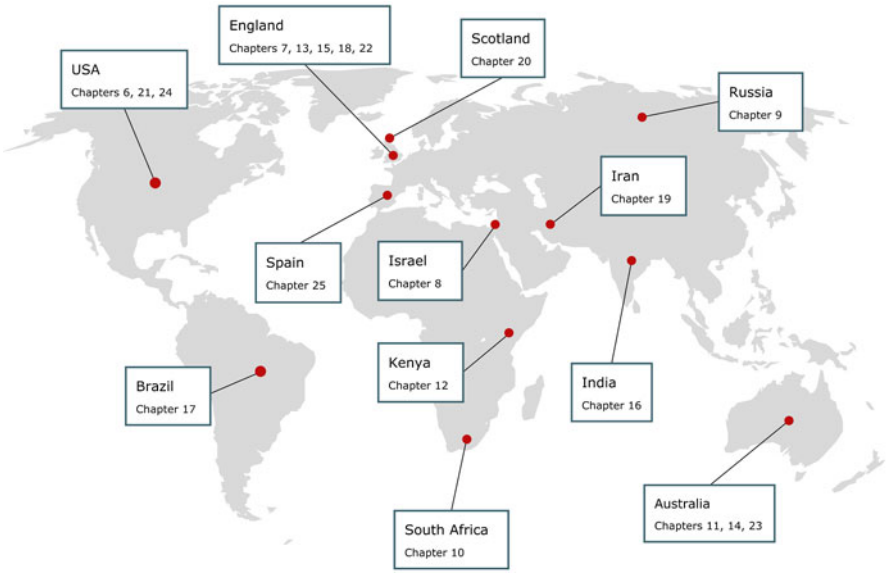


Fig. 1 Map of case studies

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About the Editors

David Conrad, M.A., M.Sc., M.P.H., F.F.P.H., is a consultant in public health at Hertfordshire County Council in the UK. He has published papers on a wide range of public health topics and, together with Professor Alan White, has coedited two other books for health professionals—*Men's Health: How To Do It* (published by Radcliffe in 2007) and *Promoting Men's Mental Health* (Radcliffe, 2010).

Alan White, Ph.D., R.N., is the founder and codirector of the Centre for Men's Health at Leeds Beckett University (formerly Leeds Metropolitan University) in the UK. He was also a co-founder of the Men's Health Forum (England and Wales) charity and the chair of the board of trustees for 12 years; he is now a patron. Alan is a board member of the International Society for Men's Health.

Alan has recently headed up an international team of academics to complete 'The State of Men's Health in Europe' Report for the European Commission. He was part of the writing team for the European Commission 'Study on the Role of Men in Gender Equality'. His research includes the evaluation of the Premier League Health Initiative and 'Tackling Men's Health' with the Leeds Rhinos, and he was a collaborator on the recently completed 'Football Fans in Training' study with the Scottish Premier League.

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About the Authors

Maria Abraham is a health and wellbeing manager for the Tottenham Hotspur Foundation in the UK. She previously worked in advertising for 10 years in her native Finland as well as in London and 10 years in the fashion industry in London before studying health promotion at university with a focus on social marketing and men's health. Before joining the Tottenham Hotspur Foundation in November 2010 as a health and wellbeing manager, Maria worked with the Men's Health Forum as an intern and with the social marketing agency Hey Moscow as a freelance account manager.

Abhijeet Barse is the CEO of Slum Soccer (www.slumsoccer.org) working with the youth of India using soccer as an instrument to transform lives. He has taken on a whole new dimension as Slum Soccer looks to build a pan-Indian presence with new centres and empowering and equipping more and more individuals to spread the good work. For more than a decade, Abhijeet has reached out through his organisation to the destitute, the recovering alcoholics and victims of domestic abuse, transforming their lives into something positive and meaningful—all of this, through a game of soccer. He strongly believes in the power of sport for development and that every child should be able to play and express his or her own love for sports. He was elected as a board member of streetfootballworld (www.streetfootballworld.org) in 2012 on the basis of his efforts with Slum Soccer. In 2013, he was selected as an Acumen India fellow.

Christopher Bunn joined the Institute of Health and Wellbeing at the University of Glasgow, UK, in 2013 as the research associate on the Football Fans in Training evaluation. He studied sociology at the University of Cambridge. His Ph.D. was a multisited ethnography that analysed faith-based organisations involved in welfare provision in relation to New Labour's 'third way' politics. Chris also specialises in the sociology of health. He worked as a social scientist at the Institute of Metabolic Science in Cambridge (www.ims.cam.ac.uk), as part of a team that conducted a randomised controlled trial of peer support for people with type 2 diabetes. From this he established an interest in peer- and group-based interventions and the links

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such interventions can have with community-led groups. Through this work on Football Fans in Training, he has continued to develop his interests in group-based health interventions and third sector partnerships.

David Carless, Ph.D., is a reader in narrative psychology in the Institute of Sport, Physical Activity and Leisure at Leeds Beckett University (formerly Leeds Metropolitan University) in the UK. His research—which draws on psychology, sociology and the performing arts—uses storied forms of communication to understand and represent human experience. Through a variety of narrative, performative and arts-based methods, David's work explores how identity and mental health are developed, threatened or recovered in physical activity and sports contexts. His work has been disseminated through keynote presentations, live performances and invited book chapters and has been published in a number of interdisciplinary international journals. David is co-author, with Kitrina Douglas, of *Sport and Physical Activity for Mental Health* (Wiley-Blackwell, 2010).

Samson Bwalya Chama holds a doctorate and a master's degree in social work. He is an associate professor of social work at Oakwood University, Huntsville, Alabama, USA. His research focuses on HIV and AIDS and its impact on youth, children and families. His research agenda includes poverty and its implications for communities; child welfare, policy and programming; and human rights. He is a member of the following organisations: Council on Social Work Education (CSWE), International Federation of Social Workers (IFSW), National Association of Social Workers (NASW), International Society for Prevention of Child Abuse and Neglect (ISPCAN) and International AIDS Society (IAS).

Kitrina Douglas is an independent researcher and an ambassador with the National Coordinating Centre for Public Engagement, has a fractional appointment at Leeds Beckett University (formerly Leeds Metropolitan University) and is a visiting fellow at the University of Bristol in the UK where she gained her Ph.D. Her research interests are in the areas of physical activity and mental health, narrative inquiry and creative performative methodologies. She has carried out research for a variety of agencies, including the Department of Heath, NHS Trusts, UK Sport, Addiction Recovery Agency and the Women's Sport and Fitness Foundation. She is among a small number of academics pioneering autoethnography and poetic, storytelling, songwriting and performance methodologies in physical activity, sport and health research and has used these approaches in peer-reviewed journal publications, books and book chapters, evaluation reports and activity guides.

Luke Dowdney, M.B.E., is the founder and director of Fight for Peace (FFP), an international non-profit organisation which uses boxing and martial arts combined with education and personal development to realise the potential of young people in communities that suffer from crime and violence (www.fightforpeace.net).

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Luke founded FFP in Rio de Janeiro in 2000 and is now replicating the programme internationally via the Global Alumni Programme. The FFP Academy in East London was opened in 2007. Luke was also the founder and coordinator of the Children and Youth in Organised Armed Violence Programme (COAV) at Viva Rio in Brazil. Luke is also the CEO and founder of LUTA Sportswear. Established with private equity funds, LUTA is the world's first 'life-changing sportswear' and gives half its profits to Fight for Peace to support sports and education projects for young people in communities affected by crime and violence (www.luta.co.uk/www.luta.us).

Luke has a master's degree in social anthropology from the University of Edinburgh (Scotland) for which he wrote his dissertation on violence and the lives of Brazilian street children. Luke is the author of *Children of the Drug Trade*: *A Case Study of Children in Organised Armed Violence* that focuses on the role of minors in Rio de Janeiro's drug factions and *Neither War nor Peace* which compares the armed role of children and youth in armed groups in ten nonwar countries across four continents. In 2013 Luke was nominated by Edinburgh University to its senatus academicus for the degree of doctor *honoris causa* in recognition of his work in establishing Fight for Peace.

Luke was a keen amateur boxer; in 1995 he was British universities' light-middleweight boxing champion and has coached youth boxers at FFP since 2000. In June of 2004 Luke was awarded an M.B.E. by Queen Elizabeth II for 'services to the prevention of child exploitation and violence in Brazil'. During 2006 Luke became an Ashoka fellow and received an UnLtd Level 2 Award for his work as a social entrepreneur. In April 2007 Luke won the prestigious 'Sport for Good Award' at the Laureus World Sports Awards in Barcelona. In 2008 Luke was invited by Tony Blair to be an ambassador for Beyond Sport, and in 2009 he was made a Young Global Leader by the Schwab Foundation for Social Entrepreneurship, a sister organisation of the World Economic Forum. In 2013 Luke was awarded the Beyond Sport Innovation Through Sport Award.

Claire Drummond is a senior lecturer at Flinders University in South Australia. Her research is in the area of school nutrition education and school canteens, and she has been a lead CI in a number of high-profile research grants in the area of health-promoting schools and childhood nutrition education.

Murray Drummond is a professor and director of the SHAPE Research Centre (Sport, Health and Physical Education) at Flinders University in South Australia. His primary research interests revolve around children, masculinities, health and sport.

Sam Elliott is a lecturer in Sport, Health and Physical Activity at Flinders University in South Australia. He is a qualitative researcher with interests in youth sports participation, Australian football culture and sport for community development. His current research interests are based around qualitative research with a particular interest in contemporary social issues in sport and parental influence in children's sport.

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Ana N. Fadich, M.P.H., C.H.E.S., is the vice president of Men's Health Network (MHN) in the USA, a national non-profit, educational health organisation, dedicated to improving the health and wellbeing of men and their families, reaching them where they live, work, play and pray. Ana's focus is on programmes and health education. As a certified health education specialist (CHES), Ana creates targeted disease education materials addressing men's health, develops and implements awareness programmes and educational events, provides guest lectures at conferences/meetings and manages the Men At Work wellness programme at employer sites nationwide. Ana holds a bachelor of science (BS) degree in biological sciences from Mount St. Mary's College in Los Angeles, CA, and a master of public health (MPH) degree in health education and health promotion from the University of Southern California: Keck School of Medicine. She currently resides in Washington, D.C.

Cindy Gray is a Lord Kelvin Adam Smith fellow in health behaviour change at the University of Glasgow in the UK. She is building a programme of research drawing on psychological and sociological theory to increase understanding and inform practice around how to engage hard-to-reach groups in sustained positive lifestyle change. A particular focus is on exploring the potential of community organisations with which individuals feel a personal connection/affiliation to deliver healthy lifestyle interventions that are attractive and acceptable to different target groups. Other projects include using the prison setting to deliver healthy lifestyle information to high-risk men, developing an understanding of older people's perceptions about sedentary behaviours to inform future interventions and integrating social scientific theory with developments in digital technologies to design mobile phone apps to support people in adopting sustained positive health behaviours.

Nick Hart is chairman of Millwall Supporters Trust and writer and editor of the regular fanzine *I Left My Heart at Cold Blow Lane*. Nick Hart's day job is that of a housing manager for a London-based housing association. He first attended Millwall Football Club in 1972, became addicted and has never quite shaken the habit.

Margaret Hellard is the head of the Centre for Population Health at the Burnet Institute in Australia. Margaret's work has focussed on infectious diseases, preventing their transmission and identifying the impact of these infections in vulnerable populations. A researcher and clinician, her principal research interests are in the epidemiology of blood-borne viruses (HIV, hepatitis B and hepatitis C), sexually transmitted infections and improving the management of individuals who already have the infection.

Lyn Hester has a B.S. degree from Oklahoma State University in the USA, is now a semi-retired author and has had a wide-ranging career, latterly working as a talk show host with KSBI-TV. From 1986 to 1992 she was director of Public Relations/Development with INTEGRIS Southwest Medical Center, Oklahoma City, and subsequently held a number of senior positions in public relations and marketing, in the course of which, among other achievements, she developed a community services department including delivery of senior services, a Hispanic initiative, men's health

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provision, mentoring programmes, free medical clinics and a gang intervention programme. She has served on a number of community organisation boards, written several children's books and speaks nationally on the benefits of humour.

Jane Hocking is associate professor at the Melbourne School of Population Health, University of Melbourne, Australia. She is an epidemiologist whose research interests include the epidemiology and control of sexually transmitted infections, particularly *Chlamydia trachomatis*, and the sexual health and sexual practices of young Australian adults. Jane's research has included conducting Australia's first population-based chlamydia prevalence survey among young women, evaluating chlamydia screening opportunities in sporting clubs, randomised controlled trials investigating different methods to increase chlamydia testing in general practice and a longitudinal study of young Australian women that aimed to measure STI incidence. She is currently leading a trial evaluating whether annual chlamydia testing for young adults in general practice can lead to a reduction in chlamydia prevalence.

Kate Hunt leads the UK Medical Research Council's programme of research on gender and health at the MRC/CSO Social and Public Health Sciences Unit, Glasgow University, and is associate director at the Unit. Her research on gender and health reflects a long-standing interest in how social constructions of gender impact on men's and women's risk and experiences of morbidity and how they may impact health behaviours (including help-seeking behaviours). Much of her research has an explicitly gender comparative approach. In addition to the development and evaluation of the Football Fans in Training programme, her recent projects include systematic comparisons of men's and women's use of primary healthcare services, utilising both large-scale routinely collected primary care data and qualitative data; examinations of media presentations of aspects of health and illness and of images of smoking and drinking in popular films on young people's uptake of these behaviours; and men's experiences of gender 'atypical' illnesses such as breast cancer. Kate has been committed to interdisciplinary approaches to understanding and improving health since undertaking her undergraduate degree in human sciences at Oxford University.

Sami Kokko works as a senior researcher at the University of Jyväskylä, Finland. He was one of the first researchers globally to combine settings-based health promotion and youth sports club activities. Currently Sami is leading a research consortium in Finland, expanding the research focus from settings-based variables (in youth sports clubs) to also include young athletes' individual health behaviours and health status. This is a national 3-year research programme funded by the Ministry of Education and Culture in Finland.

Before his academic career Sami played ice hockey for 16 years and has worked in ice hockey clubs as a coach and head of coaching. Sami has purposely kept closely in touch with sports practice at all times, and in all his studies, there is always an aim to develop practical tools to support the end users' daily work. Despite his strong background in ice hockey, Sami is interested in all kind of sports—both professionally and recreationally.

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Fabian Yuh Shiong Kong is a hospital trained pharmacist in Australia with over 15 years of public health experience in the combined fields of clinical pharmacy, harm reduction and toxicology. After completing his master's in epidemiology, he began working in the area of adolescent sexual health—primarily in relation to chlamydia epidemiology and surveillance in the general practice setting. He also works with essential drugs programmes in resource limited settings, in particular with East Timor where he has been involved since 2004.

Alison Leary is the clinical lead for the match day medical service/BASICS scheme at Millwall Football Club in the UK. Alison has spent the majority of her career in the NHS and public sector. She is a scientist, author and registered nurse who holds a postgraduate degree in medicine. In 2012, the Millwall Matchday Medical Service became an approved British Association of Immediate Care Scheme—the first stadium in the UK to achieve this.

Jim McKenna is professor of physical activity and health and head of the Active Lifestyles research centre in the Carnegie Faculty at Leeds Beckett University (formerly Leeds Metropolitan University) in the UK. He has an extensive portfolio of peer-reviewed publications and grants covering interventions and community evaluations, spanning schools through workplaces and working with older adults. Jim is currently working with colleagues on the long-term evaluation of a staged recovery intervention targeted on wounded injured and sick service personnel, based on inclusive sports and adventure education. As well as teaching both PG supervisors and Ph.D. students, he is director of studies for a range of funded Ph.D. students. Recent projects range from a qualitative investigation of self-care promotion by doctors and nurses in Syria to quantitatively evaluating the outcomes of health promotion campaigns delivered through professional football clubs in England.

Jordi Monés, M.D., Ph.D., is a board member of FC Barcelona in Spain, responsible for the medical area. Professionally he is an ophthalmologist and vitreoretinal specialist and researcher, director of the Institut de la Mácula i de la Retina (macula and retina institute) and director of the Barcelona Macula Foundation: Research for Vision. Monés graduated in medicine and surgery from Barcelona University; specialised in ophthalmology at the Barraquer Institute and in diseases of the macula, retina and vitreous at the Massachusetts Eye and Ear Infirmary at Harvard University and at the Technological and Advanced Studies Institute at Monterrey; and gained a Ph.D. summa cum laude in medicine and surgery from Barcelona University.

Outside the sports field, Dr. Monés is a leading researcher in international clinical trials for degenerative macular and retinal diseases, and his dream is to find a cure for blindness secondary to retinal and macular degeneration. He has taken an active part at the front line in research into new drugs, in the design and development of protocols for new molecules and in the search for improved treatments both for age-related macular degeneration and vascular diseases of the retina (vein thrombosis, diabetic retinopathy and macular oedema) and has contributed to the revolution seen at present in the treatment of these diseases that cause blindness.

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In research his particular fields of interest are macular diseases, choroidal neovascularisation, macular degeneration, antiangiogenic therapy, antiplatelet-derived growth factor therapy, geographic atrophy, retinal degeneration, retinal transplant, optogenetics, neural and mesenchymal stem cells, macular oedema and vitreoretinal and macular surgery. He is founder and medical director of the Barcelona Macula Foundation: Research for Vision, dedicated to fighting blindness, supporting and conducting research in retinal diseases that currently have no treatment. Dr. Monés is scientific advisor of various research groups. At Institut de la Macula I de la Retina, Dr. Monés conducts Phase I, II and III clinical trials.

Dr. Monés is a member of Club Jules Gonin and a member of 12 scientific societies, including the Macula Society, the Retina Society, the American Society of Retina Specialists, the American Academy of Ophthalmology, the Association for Research in Vision and Ophthalmology, the European Vision Institute, EURETINA, and the European Association for Vision and Eye Research.

Enouce Ndeche Born and raised in Kenya, Enouce Ndeche first became aware of the positive effects of community awareness, support and service when he completed 100 h of volunteer service for a high school requirement. Enouce has held a variety of other positions within the sports and voluntary sectors. He was a longtime volunteer for the Special Olympics. From 2000 he managed the National Youth Sports Coaches Association and Parents Association for Youth Sport in Kenya. In 2003, he founded Vijana Amani Pamoja (VAP), a charity organisation that uses football as a metaphor for social change addressing various issues including HIV/AIDS, TB, sexual health, reproductive education and anti-corruption.

Enouce obtained diplomas in project management from the Kenya Institute of Management and sport pedagogy from the International Council of Sport Science and Physical Education, and the American College of Sports Medicine (ACSM) (longdistance learning).

Stephen D. Petty has been in health care in Oklahoma in the USA for the past 27 years, working in a number of areas including public relations, marketing, physician relations and business development.

For the past 20 years, he has been with INTEGRIS Health, Oklahoma's largest health system, serving as the administrative director of Community and Employee Wellness for the state. In this role, he oversees the health system's employee wellness programme and community benefit activities, including community outreach through free clinics, senior health and wellness, community education, Hispanic outreach, men's health, mentoring in public schools, childhood obesity programmes, diabetes, cancer and Alzheimer support groups and community health and education events.

He started the INTEGRIS Men's Health University programme in 2004, to create a consistent programme of education and awareness about the importance of men's health in the state of Oklahoma. The programme consists of health screenings and physician and health professional lectures and seminars for men across the state, with an emphasis on underserved and minority men. He has presented this programme

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across the country and at the International Society of Men's Health Conference in Vienna, Austria, in 2009.

Steve received his bachelor's degree in advertising from Central State University and his master's degree in public relations/communications from the University of Oklahoma. He completed a certification for community benefit professionals through St Louis University and is one of only six professionals in the USA with this graduate certification.

He serves as a member of the Men's Health Network in Washington, D.C., is on the board of directors and executive board of the Oklahoma Chapter of the American Red Cross and the South Oklahoma City Chamber of Commerce, is past president of the Oklahoma District Attorney's Good Samaritans Board, and is incoming chairman of the board for the American Public Health Association's Men's Health Caucus.

Andy Pringle is reader in physical activity, exercise and health at the Institute of Sport, Physical Activity and Leisure at Leeds Beckett University (formerly Leeds Metropolitan University) in the UK. He has worked in higher education for over 20 years following a career in health promotion. Andy's research involves assessing the effectiveness of physical activity and health interventions, including working with a number of football clubs evaluating their health improvement programmes. He has led a number of national evaluations, including the evaluation of Premier League Health, a national programme of men's health improvement in Premier League football clubs. He also led the National Evaluation of the Local Exercise Action Pilots for Sport England, Department of Health and Natural England. He publishes his research in international peer-review public health journals. Andy also contributes to the development of physical activity and public health guidance at a national level including work for the National Institute of Health and Care Excellence. Andy is both a keen hill walker and football supporter.

V.G. Raghvendran aka Raghav is curriculum in charge at Slum Soccer in India (www.slumsoccer.org). He developed Slum Soccer's training sessions, assists coaches with training methodologies and measures the impact on its target groups. Drawing on participant feedback he continually reviews the curriculum to ensure that Slum Soccer's curriculum is up to date. Recently, he has worked on incorporating life skills, such as discipline, communication, creativity and responsibility, more effectively into the training sessions. Raghav is a voracious reader, loves music and is a Liverpool fan.

Jane Riley is a management consultant in the UK whose recent work includes commissions for Rugby League Cares, the NHS Confederation, the Leeds Teaching Hospitals NHS Trust and the Institute for Health and Wellbeing at Leeds Metropolitan University. This follows over 20 years in the civil service where she was responsible for developing and delivering a range of strategies and policies. Most recently, Jane was deputy regional director of Public Health for Yorkshire and the Humber,

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working on weight management, Change4Life, promoting physical activity and better nutrition, workforce wellbeing, and the health and wellbeing of children and young people. Prior to this, Jane was director of policy and liaison at the Academy for Sustainable Communities (part of the Department for Communities and Local Government) looking at the interconnections between employment, transport, culture, education, health and other services; project manager for the Department of Health's Review of Arts and Health (which demonstrated the scale of the business case for investment in the arts); and director of Policy and Development at NHS Estates (an Executive Agency of the Department of Health) responsible for NHS ProCure 21, the introduction of integrated supply chain management into NHS capital investment, promoting better design and high-quality environments in healthcare facilities and policies on clean hospitals, better hospital food and the more effective use of the NHS estate. Jane was previously head of Purchasing Policy, working in the team that developed the original commissioning function for NHS health authorities and GP commissioners.

Alice Sampson is a criminologist and community researcher in the UK whose main interests are the prevention of domestic violence, hate crimes and street fighting and how policies and practices can be improved for those who are living in the poorest and most violence-prone neighbourhoods across the world. Alice is codirector of the Centre for Social Justice and Change, University of East London.

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Through his work with Football 4 Peace International, Graham has travelled extensively to Germany, Ireland, Jordan, Israel and the Palestinian Occupied Territories in the capacity as international partnership manager, mentor and researcher. He has also made study visits to Cyprus and South Africa and has contributed to various conferences and seminars across the world.

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Jack Sugden is a Ph.D. candidate at the University of Technology, Sydney, Australia, focused on using sport as a tool for conflict resolution in the Pacific Islands. His previous experience includes a B.Soc.Sci. in international politics from Manchester University and an M.A. in comparative ethnic conflict from Queens University, Belfast.

Jack has made several visits to Germany, Israel and the Palestinian Occupied Territories in the capacity as project leader, mentor and researcher with Football 4 Peace International. He also spent time at the University of Johannesburg as a consultant researcher, where he co-authored the resource 'Play Life'—a guide on sport for social development and health in the townships in South Africa.

Jan Teulingkx holds a master's in clinical and theoretical psychology from the University of Louvain and is a creative storyteller who joined the world of advertising following a career as a writer for TV and various entertainment media.

In 2007 he came to Saatchi & Saatchi Brussels as creative director, during which time he helped put Saatchi Brussels on the map as a reference point for innovative, integrated creative work in Europe. In 2012 Jan was appointed deputy executive director of Saatchi EMEA where he continues to drive innovation while overseeing the agencies' work across the region.

With an international career spanning Budapest to Buenos Aires, his work has been recognised by major international awards from D&AD, Eurobest and NY to Clio and Cannes Lions. Recent accolades include Gold & Silver Euroeffies for initiatives with FC Barcelona (Barça) and the European Commission (EC).

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Stefan Vetter was born in 1964 in Thun, Switzerland. In 1991 he finished his professional education at Berne's medical school, obtaining a Swiss physician's state diploma. After 6 years of postgraduate specialisation, he became a psychiatrist and psychotherapist. Psychotherapeutically he was trained in Tübingen, Germany. In 1997 he also finished his thesis and obtained a doctorate in medicine at the University of Zurich. From 1998 to 2002 he worked as psychiatric consultant in different state hospitals before he funded the Centre for Disaster and Military Psychiatry at the University of Zurich, running it fulltime until 2009. As part of this role, he provided

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assistance following several large-scale disasters and in post-conflict development aid work between 2001 and 2008. Scientifically, his main focus is psychiatric and psychological care for survivors of large-scale traumatic incidents. Since 2009 he has been lead physician of the Center for Integrative Psychiatry, Psychiatric University Hospital Zurich, working with therapy refractory patients.

Vikrem Vybav works in the operations team of Slum Soccer in India (www.slumsoccer.org) and handles Football Development. He works closely with the coaches, curriculum and monitoring and evaluation team and is a part of the strategic team responsible for setting up new community centres. In 2013, he represented India and Slum Soccer at the Youth Leadership Programme conducted by the United Nations Office on Sport for Development and Peace (UNOSDP) in Gwangju, which brings together youth working with sport for development and peace at grassroot levels.

Vikrem holds a bachelor's in engineering and worked for 4 years in the field of high-voltage energy before switching careers to work in the field of development through sport. He loves to play football and is an Arsenal fan. He also is a movie buff.

June Webber is past district governor of Rotary International District 9350 Cape, South Africa, Namibia and Angola and *Kick Polio Out of Africa* campaign coordinator. She resides in Cape Town, at the foot of the majestic Table Mountain at the tip of Africa. With a background in event management and public relations, June was ideally equipped, and well-positioned, to conceptualise and coordinate the *Kick Polio Out of Africa* pan-African campaign from the Cape to Cairo, in the run of and during the 2010 FIFA World Cup Soccer Tournament hosted by South Africa. June has held numerous Rotary International portfolios since her governorship. The campaign was driven by her as a tangible legacy of her contribution to Rotary's polio eradication efforts, during her tenure as chair of the Reach Out of Africa Committee (Southern Africa).

Sally Wyke is deputy director of the Institute of Health and Wellbeing, Glasgow University, in the UK. Her research has focused on helping people manage and maintain their health, reduce risk of ill health and manage their symptoms and illnesses. She is interested in policy and programme evaluation, in evaluation methodologies and interdisciplinary approaches to the design and evaluation of complex interventions and programmes. Her work covers organisational and individual approaches to supporting people in all social positions to: live healthily and reduce risk of illness; manage multiple conditions, particularly long-term conditions; consult early with symptoms that might be cancer; enable health and wellbeing in later life; and self-manage illness. Recent projects include investigation of how information based on personal experiences is used and incorporated into health information resources; how primary care can support people to live well with multimorbidity; and developing accessible patient-reported outcome measures for use in quality improvement.

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Part I
Sport and Health: Setting the Scene

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Chapter 1
Introduction to Sport and Public Health

David Conrad and Alan White

The Reach of Sport

There is no doubt that sport plays a very important role in society; all over the world you will see children and adults engaging in some form of sport, whether it be soccer, boxing, mountain biking, ice hockey, running or any number of other activities (Box 1.1). People participate in sport not only through playing it, but also through involvement in its infrastructure—the coaching, volunteering, security, grounds management and club level organization that play an essential role in making sport happen. In the UK alone, football has over 500,000 volunteers in addition to being played by over seven million adults and a further five million playing in schools [1].

The reach of sport is immense—the Olympics, Tour de France, Rugby World Cup, New York Marathon and Cricket World Cup, for example, all attract huge global audiences, with the 2010 FIFA World Cup being watched by over 3.2 billion people around the world (46.4 % of the world's population) [5, 6]. According to a recent market analysis, fans in Europe and the United States spend an average of 4–8 h per week consuming sport; in Brazil the average is over 10 h per week and in China over 11 h per week [7]. Interest in sport transcends age, often providing the only occasions in which all generations of a family come together for a common purpose.

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Box 1.1 What Is Sport?

Sport is a very broad concept that includes a wide range of activities and has been defined in a number of ways. Usually there is common agreement that for an activity to be described as a sport it should involve some form of physical activity and competition (either between individuals or teams), and be organized in some way, with a set of agreed rules and regulations (often with some form of national and/or international body overseeing its governance). For the purposes of sport and development work, however, often much broader definitions are applied. The United Nations Inter-Agency Task Force on Sport for Development and Peace has defined sport as:

> all forms of physical activity that contribute to physical fitness, mental well-being and social interaction. These include play; recreation; organized, casual or competitive sport; and indigenous sports or games. [2, p. 2]

The European Sports Charter employs a similar definition:

> all forms of physical activity, which through casual or organized participation, aim at expressing or improving physical fitness and mental wellbeing, forming social relationships or obtaining results in competition at all levels. [3, p. 1]

For the purposes of this book we have restricted our focus to those activities which would typically be recognized as sports by the general public in the countries in which they are commonly undertaken, rather than including other forms of exercise or physical activity. Although all of the case studies in Part Two involve physical sports in some way, we also acknowledge that an activity does not necessarily have to be primarily physical in order to be considered a sport—both chess and bridge are recognized as sports by the International Olympic Committee [4], for example, and chess-based projects do feature in sport and development work.[1]

Overall audience demand for sport has grown as increased use of the internet, social media, and mobile technology, such as smart phones and tablets, have brought major changes in the way that sport is consumed, while at the same time television viewing figures have remained undiminished [7]. Sport has one of the most developed communication platforms in the world, with the potential to reach nearly all populations globally [8]. It enjoys extensive horizontal webs of relationships at the community level and vertical links to national governments, sports federations, and international organizations [8], such that when something happens in sport its effects can ripple out locally, nationally, and internationally.

[1] See Box 1.5.

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Sport has been described as a "global language" [9] through which an understanding of shared rules and underlying philosophy of fair competition—of "sportsmanship"—resonates around the world. The idea that sport is a universal good, with fair play and the idea of competition open to all, transcends many social, cultural, and political divides [10]. Sport can communicate powerful messages about the need to come together as one community—perhaps seen most strikingly in the idea of the "Olympic Truce" which, every 4 years, allowed athletes and spectators from all city-states in Ancient Greece to come together in one setting in a spirit of peace. The concept of the Olympic Truce was reintroduced to the modern Olympic Games in the 1990s and led to the establishment in 2000 of the International Olympic Truce Foundation and the International Olympic Truce Centre to promote a culture of peace, cultivate international understanding, facilitate the observance of the Olympic Truce, and mobilize the youth of the world in the cause of peace [11]. The modern Olympic Movement also promotes a message of equality—the London Olympic Games in 2012 were the first in which every country had a female representative and now for a sport to be considered for inclusion in the Olympics it must have both a male and female equivalent.

The unique role of sport in society and its ever-strengthening capacity to reach people across the geographical, social, and political landscape give it huge potential as a vehicle for communication and engagement. Sport's power to deliver a message makes it a highly valuable, but underutilized, public health tool—one which can be used in tackling a wide range of public health problems.

Threats to Global Public Health in the Twenty-First Century

Public health in the twenty-first century is concerned with a very broad range of issues which affect our physical and mental well-being—from lifestyle factors and social determinants of health such as crime, education, and community cohesion to outbreaks of infectious disease, wars, and natural disasters. Although extremely broad in its scope, public health has one simple defining characteristic which sets it apart from other fields of medicine—a focus on the health of populations rather than individuals. Whether the population in question spans several continents or comprises a small group of people, the principle of acting on the basis of the health needs, or the threats to the health, of the collective remains central.

A growing number of health challenges are facing the global population today, many of which, ironically, are as a result of advances in public health and social reforms. Efforts to tackle the traditional root causes of many diseases (sanitation, clean water, food quality), and improvements in obstetric and child care, have led to reductions in premature death from communicable diseases. As life expectancy has increased, however, so have the opportunities for non-communicable diseases, such as heart disease and cancers, to have an impact on our lives [12]. Many populations are experiencing growing levels of obesity due to westernization of the diet and increasingly sedentary lifestyles. Physical inactivity also directly raises the risk of

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coronary heart disease, type-2 diabetes, and breast and colon cancers, and can shorten life expectancy, accounting for 9 % of premature mortality worldwide (5.3 million deaths) [13]. In China, physical inactivity contributes between 12 and 19 % to the risks of developing the five major non-communicable diseases (coronary heart disease, stroke, hypertension, cancer, and type-2 diabetes), and is responsible for over 15 % of the country's yearly healthcare costs and lost economic output due to poor health or premature death [14]. In many countries, alongside this growth in non-communicable disease remains the burden of communicable disease, with AIDS, polio, tuberculosis, malaria, diphtheria, and dengue, for example, still major causes of death and disability in low- and middle-income countries [15, 16].

Many populations suffer war or natural disasters, such as earthquakes, draught or flooding, with a huge impact on both physical and mental well-being [17]. Climate change is predicted to make disasters related to extreme weather more frequent and widespread occurrences [18], as well as having broader implications for public health (for example, through its anticipated impact on food prices) [19].

Broader public health issues, such as crime, poverty, unemployment, lack of decent housing, and poor education, continue to be important determinants of physical and mental well-being [20], with high levels of deprivation associated with numerous health problems and a growing health divide in developed countries between the wealthy and the poor [21].

Current health systems in many countries are already incapable of meeting the needs of the populations they serve [22], while the increasing global population[2] and greater numbers reaching old age[3] mean others are set to follow suit if action isn't taken to tackle the world's burden of poor health. Greater effort must be put into tackling public health problems "upstream" through preventative action focused on effective, low-threat interventions that can truly engage the populations they target. Sport's potential to be utilized in this endeavor is now increasingly being recognized by a broad range of professionals, athletes, and organizations around the world.

Policy Agendas

The emergence in the twenty-first century of sports-based public health initiatives has been underpinned by a growing recognition, reflected in the policies of key international bodies, of the need to find more effective ways to engage the public with health issues, to build partnerships across sectors and of sport's potential as a vehicle for development work.

[2] Estimated to reach 9.6 billion by 2050.

[3] The current global life expectancy of 69 years rising to 76 years in 2045–2050 and 82 years in 2095–2100.

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United Nations

The United Nations (UN) has long recognized the right to access and participate in sport and play. The 1959 UN Declaration on the Rights of the Child recognized every child's right to play and recreation, followed in 1978 by the United Nations Educational, Scientific, and Cultural Organization (UNESCO) recognizing sport and physical education as a fundamental right for all. These principles are reflected today in the ethos of the global sport and development organization, Right To Play (Box 1.2), with which the UN has worked closely since its inception in 2000. The UN's longest running partnership with a sport organization began as early as 1922, however, when the International Labour Organization (ILO), now part of the UN system, and the International Olympic Committee (IOC) established institutional cooperation, later reinforced through a series of partnerships between the IOC and UN system partners.

In 1993, the UN General Assembly (UNGA) adopted resolution 48/11 "Building a peaceful and better world through sport and the Olympic ideal", which revived the ancient Greek tradition of Olympic Truce, calling for all hostilities to cease during the Olympic Games. Since then, similar resolutions have been adopted every 2 years prior to each Summer and Winter Olympic Games, supporting the mission of the International Olympic Truce Foundation and the International Olympic Truce Centre.

The establishment of the UN's Millennium Development Goals (MDGs) in 2000 marked the beginning of a period of greater recognition and support of a broader role for sport in tackling social issues. Eight MDGs were set, with a target date for achieving them of 2015:

1. Eradicate extreme poverty and hunger
2. Achieve universal primary education
3. Promote gender equality and empower women
4. Reduce child mortality
5. Improve maternal health
6. Combat HIV and AIDS, malaria, and other diseases
7. Ensure environmental sustainability
8. Develop a global partnership for development

Sport was recognized as a viable and practical tool to assist in the achievement of each of the MDGs as part of a broad, holistic approach [23]. In 2001, the first Special Adviser to the UN Secretary-General on Sport for Development and Peace was appointed, and the UN Office on Sport for Development and Peace (UNOSDP) was established to promote sport as an innovative and efficient tool in advancing the UN's goals, missions, and values.

In 2002, the UN Secretary-General convened the first meeting of the newly established UN Inter-Agency Task Force on Sport for Development and Peace. The Task Force brought together UN funds, programmes, and specialized agencies that use sport in their activities in order to ensure coordination and sharing of lessons

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learned, and to encourage the UN system to incorporate sport into its efforts to achieve the MDGs. In 2003, the Task Force published its landmark report, "Sport for Development and Peace: Towards Achieving the Millennium Development Goals", which concluded that well-designed sport-based initiatives were practical and cost-effective tools to achieve development and peace objectives and that sport should be increasingly considered by the UN as complementary to existing activities. The same year saw the first International Conference on Sport and Development in Magglingen, Switzerland and the first UNGA Resolution "Sport as a means to promote education, health, development, and peace" being adopted (58/5), proclaiming 2005 as the International Year for Sport and Physical Education.

In 2004, the UN Sport for Development and Peace International Working Group (SDP IWG) was launched at the Athens Summer Olympic Games. The group emerged from the work of the Task Force, with a steering group including the UNOSDP and Right To Play and a 4-year mandate to articulate and adopt policy recommendations. This work culminated in the 304 page report "Harnessing the Power of Sport for Development and Peace: Recommendations to Governments", which was presented at the Beijing Olympics in 2008 [8]. The report provided guidance on developing effective policies and programmes, and set out evidence and recommendations to governments in five areas:

- Sport and health: preventing disease and promoting health
- Sport for children and youth: fostering development and strengthening education
- Sport and gender: empowering girls and women
- Sport and persons with disabilities: fostering inclusion and well-being
- Sport and peace: social inclusion, conflict prevention, and peacebuilding

On completion of the report, the SDP IWG was given a further mandate to support knowledge exchange and promote the integration of the policy recommendations in these five areas into the national and international development strategies of national governments.

The 2005 International Year for Sport and Physical Education saw 125 UN Member States involved, with 20 international and over 18 regional conferences organized, highlighting the role of sport in issues of development, health, culture, environment, peace, gender, and education, including the second International Conference on Sport and Development. The first UN-IOC Forum, organized jointly by the UNOSDP and the IOC, was held in 2010 in Lausanne, Switzerland and a High-Level Roundtable "The Value of Sport as a Development Tool" was held at UN Headquarters in New York, attended by the UN Secretary-General, Heads of State and Government Representatives.

In 2011, a 32-page educational comic book, "Score the Goals—Teaming Up to Achieve the Millennium Development Goals", was launched at the UN in Geneva by Spain and Real Madrid goalkeeper, Iker Casillas, and the UN Secretary-General's Special Adviser on Sport for Development and Peace. The project was an inter-agency collaboration between several UN partners, including the UNOSDP, UNAIDS and the Stop TB Partnership. The story featured 10 well-known football UN Goodwill Ambassadors who become shipwrecked on an island on their way to

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playing an "all-star" charity football game and have to tackle the eight MDGs before being rescued. "Score the Goals" was devised to raise awareness and understanding of the MDGs among children aged 8–14 years and encourage them to take action through activities provided in an adjoining educational guide. The comic book was awarded the Special Jury Prize of the 2011 Peace and Sport Awards in Monaco.[4]

At a national level, the UN's sport for development and peace work is typically undertaken by a wide range of different UN system organizations, including UNAIDS, UNESCO, and the United Nations Children's Fund (UNICEF), through practical initiatives with local implementing partners. An emergence of partnership working between government health agencies and sports clubs and organizations at national and local level has also been strongly underpinned by the policies of another organization in the UN system—the World Health Organization (WHO).

World Health Organization

The WHO has long recognized the role of sport in promoting regular physical activity to improve health, reflected, for example, in the 2004 Global Strategy on Diet, Physical Activity and Health (DPAS) [24] and the 2008 Action Plan on Prevention and Control of Non-Communicable Diseases (NCDs) [25]—both developed and endorsed by the World Health Assembly. Although not necessarily making explicit reference to sport, some of the WHO's key policy documents have also provided a foundation for the idea of using sport as a vehicle for broader public health work, rather than simply encouraging it as a form of physical activity.

The 1986 Ottowa Charter for Health Promotion [26] highlighted the need for multi-sector approaches to health, focussed on the communities and the settings in which people lived their everyday lives, calling for action to:

- *Put health on the agenda of policy-makers in all sectors and at all levels*: directing them to be aware of the health consequences of their decisions and to accept their responsibilities for health.
- *Create supportive environments*: recognizing that, because societies are complex and interrelated, health cannot be separated from other goals—the inextricable links between people and their environment demanding a socioecological approach to health.
- *Strengthen community actions*: through community development, drawing on existing human and material resources in the community to enhance self-help and social support, and to develop flexible systems for strengthening public participation in, and direction of, health matters.
- *Develop personal skills*: enabling people to learn, throughout life, to prepare themselves for all of its stages and to cope with chronic illness and injuries—

[4] See Box 1.5.

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facilitated in school, home, work, and community settings, by way of action through educational, professional, commercial, and voluntary bodies and within the institutions themselves.
- *Reorient health services*: supporting the needs of individuals and communities for a healthier life, and opening channels between health and broader social, political, economic, and physical environmental sectors.
- *Move into the future*: where health is created and lived by people within the settings of their everyday life, in which they learn, work, play, and love.

The 1992 Sundsvall Statement built on the Ottawa Charter [27], calling for the creation of supportive environments with a focus on settings for health. This was followed by the 1997 Jakarta Declaration on Leading Health Promotion into the twenty-first century, which emphasized the value of particular settings (ranging from mega-cities to schools and workplaces) for implementing comprehensive strategies and providing an infrastructure for health promotion. The Healthy Settings approach, which first emerged from the WHO strategy of Health for All in 1980 [28] and was developed further by these documents, went on to form the basis of Europe's Healthy Stadia initiative.[5]

The Jakarta Declaration emphasized the clear need to break through traditional boundaries within government sectors, between governmental and nongovernmental organizations, and between the public and private sectors to create new partnerships for health. The promotion of social responsibility for health among both the public and private sectors was also declared a priority for health promotion in the twenty-first century.

These concepts have been fundamental to the emergence of sport and public health work, which has been built on a recognition of the potential of sports venues as health-promoting settings, the value of innovative partnerships to take joined-up approaches to tackling health and social problems in communities, the role of sports clubs and organizations in supporting the communities on which they rely, and the responsibility of sportspeople and sports clubs as role models, particularly for young people.

In 2002, the WHO and its partners launched a campaign to clean sports of all forms of tobacco—tobacco consumption and exposure to second-hand smoke, and tobacco advertising, promotion and marketing. "Tobacco Free Sports—Play it Clean!" was made the theme of the 2002 World No Tobacco Day and the United States Centers for Disease Control and Prevention (CDC), IOC, Federation Internationale de Football Association (FIFA), Olympic Aid and other regional and local sports organizations joined the campaign. Tobacco-free events were organized all over the world, including the 2002 Salt Lake City Winter Olympic Games in the United States and the 2002 FIFA World Cup in the Republic of Korea and Japan.

The WHO has continued to stress the importance of making health promotion a responsibility for all sectors and the need to work in cooperation beyond the tradi-

[5] http://www.healthystadia.eu

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tional boundaries of the health sphere. The 2005 sixth Health Promotion Conference in Bangkok reinforced the call for all organizations to play a central role in developing new strategies for tackling the global burden of disease by making the promotion of health a requirement for good corporate practice. The 65th World Health Assembly in 2012 adopted a global target to achieve, by 2025, a 25 % reduction in premature mortality from non-communicable diseases, recognizing that achieving this target would require multi-sectoral action through the development of partnerships at national and global levels.

In 2011, co-financed by the European Commission, the WHO Regional Office for Europe published an analysis of recent national sports strategies in the Member States of the European Union (EU) with recommendations for policy-makers on enhancing sports promotion. The report placed an emphasis on the role of sport in the prevention of non-communicable diseases and the need for intersectoral partnership working, capitalizing on synergies with other public health efforts, taking a life-course approach and ensuring robust evaluation [29].

European Commission

In 2007, the European Commission (EC) issued a White Paper on Sport which highlighted sport's societal role and its usefulness as a tool in development policy [30]. Although at that time the EU Treaties did not include a specific legal base for EU action on sport, the White Paper highlighted how the EU's competence in many other policy areas—including public health, education, vocational training and youth policy, and economic and social cohesion—had had a significant impact on sport within the EU. Although EU-level cooperation and dialogue on sport was greatly enhanced by the White Paper, the absence of a legal basis for EU action on sport meant that its sports policy was seen as lacking status and coherence [31]. This situation was rectified in 2009, with the inclusion of Article 165 in the Lisbon Treaty on the Functioning of the European Union (TFEU) which provided that:

> The Union shall contribute to the promotion of European sporting issues, while taking account of the specific nature of sport, its structures based on voluntary activity and its social and educational function [32].

Article 165 gave the EU a sport "competence" which for the first time allowed for the development of a dedicated sports policy and the direct funding of sports-related programmes. The EU is now able to directly carry out actions to support, coordinate, or supplement the actions of the Member States in the field of sport without the need to justify this action with reference to other Treaty competencies. This has opened up a much greater range of opportunities for EU institutions to fund sport-based programmes in areas such as health promotion, social inclusion, and violence prevention.

In 2010, a study on "The Lisbon Treaty and EU Sports Policy" commissioned by the European Parliament [33] reported three priority areas for EU action—health-enhancing

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physical education; the recognition and encouragement of volunteering in sport; and the development of sport activities as a tool for social inclusion. These topics featured prominently in response to a consultation exercise with Member States and a broad range of sport organizations, and were also clearly aligned with priority areas set out in the White Paper on Sport. The study report also called for a focus on evidence-based policy-making and supporting the development of a well-researched evidence base.

In December 2011, the EC issued a Communication on "Developing the European Dimension in Sport" [34]. Informed by the findings of the 2010 study and further consultation with a wide range of stakeholders, the communication identified a list of key themes which should be made priorities in the EU agenda for sport, including health-enhancing physical activity; the fight against doping; voluntary activity and non-profit sport organizations; and social inclusion in and through sport, including sport for people with disabilities and gender equality in sport. Attention was drawn to sport's potential to facilitate social cohesion and social inclusion of minorities and other vulnerable or disadvantaged groups, especially among young people; to contribute towards better understanding among communities, including in post-conflict regions; and to make a major contribution to the reduction of overweight and obesity and the prevention of non-communicable diseases. The EC also acknowledged the need to protect athletes and citizens from negative aspects of sport, such as doping, violence, and intolerance, and set out its role in a number of areas, including:

- Encouraging the mainstreaming of gender issues into sport-related activities
- Supporting activities aimed at fighting against racism, xenophobia, homophobia, and related intolerance in sport
- Supporting transnational projects and networks in the area of health-enhancing physical activity
- Supporting transnational projects promoting social integration of vulnerable and disadvantaged groups through sport and related exchange of good practice

The Communication echoed the report of the 2010 study in emphasizing the need for a sound evidence base to inform policy-making, including comparable EU-wide data on social aspects of sport.

Based on a proposal adopted by the EC 3 months earlier, the EU Council adopted the first ever Recommendation on sport, notably on promoting health-enhancing physical activity (HEPA), in November 2013 [35]. Member States were recommended to develop national strategies, policies and action plans for promoting HEPA across the sectors of sport, health, education, environment, and transport, reflecting the EU Physical Activity Guidelines. A monitoring framework was also set out, with a minimal set of reporting requirements for all member states, which will be implemented in cooperation with the WHO to avoid the duplication of data collection.

Although early European sport policy has so far focused primarily on the benefits of physical activity when making explicit reference to the contribution of sport to health, many of the social factors highlighted also contribute to the wider determinants of health. In addition, there are many other dimensions to sport's potential as a tool for health improvement which could be incorporated into future initiatives.

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The Role of Sport in Tackling Public Health Problems

There are a great many well-established benefits to both physical and mental health of engaging in solitary or team sport (Chap. 2 in this book discusses the health benefits of sports participation). Certainly, there is no doubt that getting more people engaged with sport would pay a great public health dividend. It has been estimated that in England, for example, if a million more people across the country played sport each week, it would save the taxpayer £22.5 billion in health and associated costs over the course of their lifetimes [36].

Taking up sport as an adult, however, requires great determination [37], with those who have been inactive as children tending to be inactive as adults, especially those who smoke, are overweight and less well-educated. Efforts to tackle health inequalities often necessitate that public health interventions aimed at improving lifestyles are targeted primarily at those from poorer socioeconomic backgrounds, yet this target group also tend to be the least likely to take up sport and other physically active pursuits. A Dutch study of the impact of neighborhood inequalities found that those in the most deprived areas were least likely to take part in any form of sporting activity [38]; this is despite sports facilities tending to be more likely to be based in areas of higher social deprivation [39].

Unarguably, there is a pressing need to increase physical activity levels in many parts of the world and there is a substantial role for sport to play in addressing this challenge. The power of sport as a potential tool for public health, however, lies not simply in the direct health benefits accrued by its participants, but also in the vast reach that it enjoys through its wide fan base, supported by sophisticated media networks. Increasingly, there is recognition of the many opportunities to capitalize on this by utilizing sport in a wide range of public health activity, including health promotion, screening and immunization, peacebuilding and community development, and disaster response.

Health Promotion

One of the simplest approaches is to use existing sports events as a way of targeting a large and often diverse group of people outside of traditional health settings, at a single time and place, where they feel comfortable and already choose to go. This can be done passively through making use of the various advertising and sponsorship opportunities normally used by commercial advertisers [40]; however, sports venues offer lots of potential to engage audiences with more proactive and attention-grabbing health promotion activities. For example, taking health promotion to sports venues can be a particularly good way to reach large groups of men when combined with novel or entertaining awareness-raising tools. In the United States, for example, the Lehigh Valley IronPigs—the Philadelphia Phillies' AAA-minor league baseball team—introduced the first urinal video gaming system at their Coca-Cola Park ground in 2013 to raise awareness of prostate cancer. Sponsored by the Lehigh Valley Health

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Network, the system incorporates screens installed above the urinals which display the game. The user's urine flow controls a virtual snowmobile, with points accumulated for knocking into targets. At the end of the game, the user receives his score and a code which he can enter on a website to have his username and score displayed alongside others' on video displays in the ballpark. Users are also prompted to consider whether they have experienced any urination problems which may be a sign of prostate cancer. In the United Kingdom, other examples of tools which have been used to attract the attention of men attending sports events include the "Peeball", a less hi-tech piece of urinal-based gaming equipment supported by The Prostate Cancer Charity,[6] which was utilized as part of Leeds Metropolitan University's[7] "Tackling Men's Health" work with rugby-goers [41], and the plastic "Gentleman's Ball Scratcher" developed by NHS Liverpool to engage men in testicular cancer awareness-raising efforts and used in their health promotion work with football supporters.

Tying a particular sports setting or personality directly into the health promotion messages or materials which are being used to engage with the audience, rather than simply relying on the conventional communication tools which might be used in any setting, can be particularly effective for generating interest. Such an approach might involve working with a specific sports club, for example, to theme a campaign or materials with the branding of the club or include endorsements from relevant sports personalities. Incorporating sports branding in this way can help not only to make health promotion campaigns and interventions more interesting to the sports audience and grab their initial attention but can also help with legitimizing that interest. This can be particularly valuable where there may be suspicion of outside organizations and government health campaigns, or when targeting men in a culture where the dominant construct of masculinity is at odds with men showing concern about their own health. One high profile example of this approach is the European Commission and professional football club FC Barcelona's "Quit With Barca" stop smoking intervention (Chap. 25) which incorporated the club's branding and support from the players into a dedicated smartphone app. In another example from Cambodia, UNESCO and UNICEF collaborated to communicate HIV/AIDS prevention messages through a national poster campaign featuring four well-known athletes from the sports of swimming, Khmer boxing, soccer, and running.

Aside from the potential to target audiences at scheduled sports events, professional sports venues commonly have rooms and conference facilities for hire which can also provide a more accessible and appealing alternative to traditional settings in which to hold health events and interventions. Again, there is the notion of an intervention being legitimized for its sports-fan audience by its association with a sports venue, as well as the less threatening environment of a familiar setting which is positively associated with leisure time. This approach has been used successfully by the "It's A Goal" project, a mental health promotion intervention based around soccer metaphors which is delivered on the premises of English professional soccer clubs (Chap. 22).

[6] Now Prostate Cancer UK http://prostatecanceruk.org

[7] Now Leeds Beckett University

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Many of the projects featured in this book involve the design of dedicated interventions which tie a sports element in with the delivery of health education, sometimes over the course of several days or weeks. Soccer-based HIV/AIDS prevention programmes are a particularly common example of this type of project. In Mozambique, UNICEF, the ILO and Right To Play (Box 1.2) have run coach-to-coach training programmes focused particularly on using interventions such as sports festivals on World AIDS Day to mobilize communities and deliver health messages [2]. In 2004, UNAIDS and the IOC began to collaborate to use sport as a tool for HIV/AIDS prevention, jointly producing a toolkit on the subject for the sports community and establishing an intensive communication and awareness campaign on HIV/AIDS prevention through sport during the 2004 Olympic Games in Athens [42]. Another way to use sports venues to promote health is through efforts to make the venues themselves healthier places for people to be; this has been seen particularly in the case of sports stadia (Box 1.3). Stadia from across Europe which have committed to the concept of Healthy Stadia—defined as "those which promote the health of visitors, fans, players, employees, and the surrounding community… places where people can go to have a positive healthy experience

Box 1.2 Right to Play

Right To Play is a global organization which uses sport and play to educate and empower children and young people to overcome the effects of poverty, conflict, and disease in disadvantaged communities. Founded by four-time Olympic gold medalist Johann Olav Koss, the organization had its origins in Olympic Aid, a fundraising body established at the 1994 Winter Olympic Games to help people in disadvantaged areas of the world. Olympic Aid transitioned to an official implementing NGO and was renamed Right To Play in 2000, with programmes running in seven countries by the end of 2001.

The organization served as the Secretariat to the UN Inter-Agency Task Force on Sport for Development and Peace in 2002 and then as Secretariat of the UN Sport for Development and Peace International Working Group for 4 years from its launch at the Summer Olympic Games in Athens, Greece in 2004.

Right To Play is supported by a global network of professional and Olympic athletes from more than 40 countries and its programmes are facilitated by over 600 international staff and 13,500 volunteer coaches working in more than 20 countries affected by war, poverty, and disease in Africa, Asia, the Middle East, Latin America, and North America. Coaches are local leaders and teachers who are trained in Right To Play's specially designed programming, implementing the programmes based on the needs of their communities, with the primary aim of achieving behavior change.

By 2012, Right To Play was reaching one million children through regular weekly activities, 49 % of whom were female.

To find out more about the organization visit: http://www.righttoplay.com

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Box 1.3 Sports Stadia

Stadia are found in nearly every locality, with over 11,000 existing across the world, including over 730 in Africa, more than 1300 in Asia and in excess of 4300 in Europe. As car ownership increased there was a shift to siting stadia out of towns, where land is more easily available and there is better access for vehicles. In the late 1980s, however, there was a revival in locating stadia within cities as a result of economic development initiatives and to make them more accessible to both their core fan bases and their commercial sponsors [44]. Many countries now take a very proactive approach to the design and build of sports stadia, with location seen as of prime importance in order to ensure that their surrounding communities are served as well as the sports which are played within them [44].

Sports stadia have always tended to be built in areas of high deprivation, former urban renewal areas, enterprise zones, or industrial areas, due to the availability of cheap land and the recognition that such large-scale developments are less likely to cause local upset in such locations [45]. There is a tendency for replacement stadia to be near to the old ones to retain their sense of identity and local support, although, in the case of large sports clubs, many supporters travel considerable distances and ticket costs have often priced-out local, more impoverished, supporters.

Increasingly, large sports clubs have been responding to the needs of their supporters [46], and also to national and international policy and legislation, to make their stadia healthier and safer environments, through such measures as:

- Smoking bans
- Alcohol restrictions
- Availability of sun screens
- Healthy eating opportunities
- Safety measures
- Access for the disabled
- Anti-vilification/anti-discrimination policies

Sporting organizations and clubs have begun to recognize the important role they play outside of the actual sports which they represent. Larger clubs typically have Corporate Social Responsibility (CSR) as an integral part of their organizational brand and are willing to support initiatives that enhance their standing in the local community. In part, this is a reflection of their recognition that their facilities are mostly located in deprived areas of towns and cities.

Sports clubs also have to follow local and national legislation to avoid censure [47]; for example, stadia in the United Kingdom with a capacity of over 10,000 have to comply with the requirements for a safety certificate, which include having adequate medical and first aid arrangements.[8] Some professional football clubs, such as England's Millwall FC in South London (Chap. 18), are developing their medical facilities beyond the basic first aid and "scoop and run" into "see and treat", with GPs and nursing staff providing support to many individuals who are either identified as having problems whilst at the game or prefer to use the club's facilities instead of their other local providers.

[8] http://safetyatsportsgrounds.org.uk

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playing or watching sport"—are brought together by the European Healthy Stadia Network in order to learn, share best practice, and act as an advocacy voice for issues concerning sports and health. The Network has developed a toolkit which consists of a step-by-step guidance plan, detailing the basic steps needed to roll out Healthy Stadia initiatives, and a library of case studies collated from stadia participating in the programme [43].

Screening and Immunization

There are examples from around the world of sport being used successfully in efforts to increase the uptake of screening and immunization. Right To Play, for instance, has partnered with a number of agencies to promote vaccination and immunization, including the Global Alliance for Vaccination and Immunisation (GAVI) and the WHO.

One approach is to tie in an uptake drive with a dedicated sport event—using the event as the means to attract the target audience and offering screening or immunization alongside in situ. In Ghana, for example, a sports festival was organized by government ministries, the WHO, UNICEF, the Vaccine Fund and Right To Play to mobilize rural communities for immunization with the 5-in-1 vaccine, resulting in over 4000 people being vaccinated in 1 day. Where a dedicated event is staged especially, it may also be possible to tie in health promotion messages directly with the sports activities themselves.

The approach of using a sports theme and the endorsement of sports personalities or teams to "brand" a health promotion campaign can also be used with awareness-raising campaigns designed specifically to improve uptake of screening or immunization. In Zambia, government ministries, UN agencies and NGOs combined a large-scale advertising campaign using sports stars from various sports with local sports events for a national measles vaccination campaign in 2003 in which approximately five million children were vaccinated. For the 2003 Cricket World Cup, UNICEF conducted a national polio eradication campaign in India using the national cricket team to promote polio vaccination in television commercials, competitions and events in the weeks leading up to the tournament, during which volunteers manned vaccination booths in schools and public places around the country, as well as vaccinating door-to-door in one state. Other examples which illustrate how this kind of approach can form the basis of very high profile and large-scale campaigns are the soccer-themed "Kick Polio Out Of Africa" project (Chap. 10) and, in the US, the annual "A Crucial Catch" breast cancer awareness and fundraising campaign run by American football's National Football League (NFL) in partnership with the American Cancer Society. "A Crucial Catch" runs throughout October, during which NFL games feature players, coaches and referees wearing pink game apparel, on-field pink ribbon stencils and special game balls, along with the sale of campaign branded merchandise. In recognition of the campaign, the NFL was awarded the ESPN Federation/Governing Body of the Year Award at the Beyond Sport Summit and Awards in 2013 (Box 1.4).

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Box 1.4 Beyond Sport

Launched by former British Prime Minister Tony Blair in June 2008, Beyond Sport is a global organization that promotes, develops, and supports the use of sport to create positive social change across the world. Supported by a number of major sports organizations, governing bodies and commercial sector partners, it seeks to identify inspirational projects, people, and organizations in the field, celebrate and support their achievements, share best practice, and inspire further work. The organization has a number of high-profile Ambassadors, including political and sporting figures, and social entrepreneurs.

Beyond Sport's work includes:

- The Beyond Sport Awards—an annual awards programme which provides a package of funding and business support to projects across the world that use sport to address issues within their communities
- The Beyond Sport Summit—an annual event that brings together the best sport-led social innovators with influential global leaders to address sport's role in driving positive social change
- Beyond Sport United—an annual one-day event bringing together the leaders of the world's most popular sports with a powerful group of star names and influential figures to explore and expand the role of their organizations in social change
- Beyond Sport World—an online networking platform that allows organizations across the globe involved in sport and development to connect and promote their activities

To find out more about the organization visit: www.beyondsport.org

Peacebuilding and Community Development

Although sports participation can be a solitary endeavor, it is mostly a shared experience, bringing with it a sense of belonging and a sense of worth in addition to the benefits of increased physical activity. Sport is increasingly being recognized and used successfully as a low-cost and high-impact tool in development and peacebuilding efforts. Instilling the values of sport through structured teaching and sports activity can help people to accept their differences and develop new ways of dealing with tension and conflict:

> Peace is not merely a state of absence of war: peace is taught, learned and transmitted. Fair play, morality, trust in others, teamwork, social integration, listening, discipline and talent: sport is a universal language in which one rule unites everyone. Much more than a game, it is a tool for dialogue, brotherhood and respect that transcends political, social, racial, ethnical and religious differences that are often at the heart of conflicts in this world. [48, p. 3]

In Somalia, UNICEF and UNESCO have delivered sports programmes that train young people in peaceful conflict resolution skills and support inter-district and

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regional sport-peace tournaments, helping to rehabilitate and reintegrate young people living in a post-conflict situation. Numerous other initiatives, such as Football4Peace in Israel-Palestine and Ireland (Chap. 8) and Fight4Peace in Brazil and the United Kingdom (Chap. 17), along with international organizations, such as the International Olympic Truce Foundation, Peace and Sport (Box 1.5) and Right To

Box 1.5 Peace and Sport

Founded in 2007 by Modern Pentathlon Olympic medallist and world champion Joel Bouzou and based in Monaco under the High Patronage of HSH Prince Albert II of Monaco, "Peace and Sport, L'Organisation pour la Paix par le Sport" (known as Peace and Sport) is an organization which works for sustainable peace throughout the world. Peace and Sport promotes the practice of structured sport and sporting values to educate young people and help foster social stability, reconciliation, and dialogue between communities in areas made vulnerable by extreme poverty, recent conflict, or lack of social cohesion.

Peace and Sport's objectives are to:

- *Use the rules of sport* as an educational tool to encourage a spirit of citizenship essential to integrate vulnerable youngsters into society.
- *Raise awareness* among the private sector, political decision-makers, and government representatives about the potential of sport to act as a vector for peace.
- *Encourage* the international sports movement to act to make a valuable contribution to peace.
- *Unite energies* by creating synergies between public and private sectors in a concrete and efficient manner in vulnerable areas around the world.
- *Involve international corporations* so that they are more conscious of the role sport has to play in determining their corporate social responsibility and local development policies.

The organization's main activity comprises:

- A *networking platform* and a *resource center* to enhance collaboration between stakeholders.
- Locally-based *projects in the field*, delivered in collaboration with NGOs.
- The *Peace and Sport International Forum*, where all stakeholders can meet and exchange ideas.
- The *Peace and Sport Awards*, which reward initiatives and individuals who make a difference in the field.

Examples of Peace and Sport's projects include: table tennis-, Ju-Jitsu- and badminton-based initiatives for disadvantaged and displaced children and young people in Colombia; "Chess for Leadership and Creativity" in youth

(continued)

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Box 1.5 (continued)
centers in Israel-Palestine; and an annual "Friendship Games" in the Great Lakes Region of Africa which brings children together through sport, conveys messages of peace and raises awareness about topical issues such as HIV/AIDS and environmental protection.

To encourage the use of sport as a tool that can be adapted to and set up in a wide range of environments, Peace and Sport have published an *Adapted Sport Manual*, which is available on the organization's website [49]. The manual is intended for anyone wishing to lead young people through sport, including teachers, youth workers, and coaches. It provides information sheets explaining how sports can be set up, tailored, and used as an educational and social tool in community settings, as well as guidance on building makeshift sports equipment from natural resources and recycled waste.

To find out more about the organization visit: www.peace-sport.org

Play, are currently utilizing sport to promote tolerance and a sense of togetherness in divided communities around the world. Sport can also form the basis of interventions aimed at reducing crime, improving life chances, and building cohesion in communities affected by high levels of deprivation and social problems. Numerous sports-based projects work to provide young people with positive role models and a sense of purpose and participation in society, and instill self-discipline, aspirations, and self-belief. In the United Kingdom, for example, "StreetChance" is an inner-city cricket initiative that engages young people living in areas affected by youth crime and anti-social behavior. The initiative is a partnership between the Cricket Foundation, Barclays Spaces for Sports and, in London, the Metropolitan Police Service and Cricket for Change (a charity originally set up as the London Community Cricket Association following the Brixton Riots in 1981). StreetChance aims to increase aspiration, promote mutual respect, and enhance relationships with others (including schools, police, and the wider community) by providing structured coaching and competitive opportunities for young people. There are 32 StreetChance projects across London, including six specialist girls' projects, and others in cities around the United Kingdom, engaging with over 28,000 young people in total.[9] In Romania, UNICEF has used a sport-based project to motivate children in the Roma community to regularly attend school, as well as build confidence and self-esteem, particularly among girls, by providing an opportunity for participation in team sports, conditional upon school attendance and academic performance.

[9] http://www.streetchance.org

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Disaster Response

Disasters, such as earthquakes, hurricanes and terrorist attacks, present perhaps the most visible and immediate public health challenges, with potentially large-scale impacts on mental as well as physical health often accompanied by the loss of vital infrastructure. While sport activities may not be the first thing that springs to mind when faced with such a situation, they have been used successfully in interventions tackling the long-term effects of disasters such as the 2003 Bam earthquake in Iran (Chap. 21) and the 2004 Beslan school siege in Russia (Chap. 9).

In the first stage of disaster response, the priority is to make people safe, rescue the injured, bury the dead, establish makeshift housing for survivors and assess the scale of the damage. The chances of finding survivors after the first week are small and at this point the response shifts into a second stage in which authorities and relief organizations work together to plan out the immediate services needed to make life possible for those who have survived the disaster. After another couple of weeks, however, when rescuers have left and media interest has begun to dwindle, a disillusionment phase typically begins in which survivors feel forgotten about at a time when the task of rebuilding their lives and communities has barely begun. It is in this phase that sports-based interventions incorporating psychosocial support can play a role in helping survivors, especially children and young people, to deal with their emotional trauma in a positive and safe environment, building self-confidence and bringing communities together to generate much-needed social capital [50].

In many ways, wars can be seen as a type of manmade disaster, resulting in similar turmoil and emotional trauma, not only for civilians but also for those fighting them. Sport has been used in the rehabilitation of soldiers with post-traumatic stress disorder (PTSD) and physical injuries [51] as well as former child soldiers, such as in Sierra Leone, where UNICEF partnered with Right To Play to incorporate sport into its Community-Based Reintegration programme.

Critical Perspectives on the Role of Sport in Public Health

While sport offers an impressive range of opportunities to support efforts to improve the physical and mental health of populations around the world, it is important to acknowledge that the basic concept of utilizing sport in the pursuit of public health goals is not without challenge. There are a number of issues which need to be recognized and adequately addressed when using sport in public health work, in order to ensure that the many positive benefits of sport are maximized and any risks of harm are minimized.

One obvious criticism of sport is that in many ways it could be argued to have been responsible for reinforcing unhealthy gender stereotypes and behaviors. The sexualization of female sports figures in the media [52], hypermasculine orgies of spectator violence [53] and sexism towards female officials [54], are some of the more blatant illustrations of the problem, although the subject could easily fill a

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book in itself. There is also the danger of health professionals themselves inadvertently contributing to gender stereotyping by becoming so enthused by the power of sport to reach a male audience that they forget that there are also plenty of men and boys who have no interest in sport at all [55].[10]

Another argument is that the same capacity for sport to create a sense of belonging and identity which offers so much potential for peacebuilding and community work, if channeled in the wrong direction, can just as easily lead to tribalism. There is a fine line between healthy sporting rivalry and heartfelt hostility which divides communities and nations instead of bringing them together. Those who grew up with the English football violence of the 1980s, for example, would need little reminder that sport is not always a force for good. Sport environments are no more immune from society's ills than any other social domain [8]. In 2012, a WHO official declared the use of performance-enhancing drugs in sport to be a public health issue [56], while other examples of displays of cheating, as well as racism, disrespect of authority, and aggression at sporting events—whether among the crowd or on the field—are not hard to come by. In 2014 even a charity ice hockey match between New York firefighters and the New York Police Department descended into a mass brawl [57].

Unless steps are taken to avoid these kinds of problems, they can certainly counteract the positive values and messages of sport and lead to the creation of negative role models [8]. It could even be argued that sport is fundamentally a negative influence on children and young people—instilling an unnatural sense of competition and pressure to win that is unhealthy both for individuals and for society. While we may like to think that children's sports activities, at least, are conducted in a spirit of "it's the taking part that counts", the reality is often very different, with overenthusiastic parents on the sidelines frequently behaving in ways which have a negative impact on the young participants [58]. Some have even questioned whether competitive sport is compatible with children's best interests according to the UN Convention on the Rights of the Child [59].

While many of the case studies in this book show the potential of using sports venues as a setting for health interventions, one could argue that this risks inadvertently endorsing by association what are often essentially unhealthy places. Although the European Healthy Stadia Network has been leading a drive to turn things around in one part of the world, generally sports stadia are rarely perceived as places that promote healthy lifestyles—especially when it comes to the refreshments on offer to spectators [60]. While there may be genuine enthusiasm by the stadium management to support health promotion, this is frequently at odds with the prominent advertising of alcohol, gambling, tobacco, and fast-food industry sponsors—generous benefactors which many sports clubs are reluctant to upset [46].

One also can't assume that participation in sport necessarily goes hand-in-glove with a healthier lifestyle—aside from the issue of doping, research shows that

[10] Gender issues in sport are discussed further in Chap. 4.

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sportspeople (as well as sports fans) drink more hazardously than non-sportspeople [61] and plenty of high-profile sports stars have found themselves pictured in the press with cigarettes in their mouths [62]. Then, of course, there's the ever-present risk of sports-related injuries—from minor mishaps due to ground hardness in junior cricket [63], for example, to life-changing injuries and even fatalities.

A major issue for concern is the competing mix of influences at play in the world of sport, which exists in a tension between the voluntary, the commercial, and the public spheres. Sport's potential as a vehicle to reach and engage large and diverse audiences is a byproduct of its global popularity and visibility, much of which is the result of its enormous success in the commercial sphere. Inevitably, though, the commercial world is driven by objectives which are frequently at odds with those of the voluntary and public sectors. Whether it be fast-food companies sponsoring the Olympics [64], alcohol manufacturers sponsoring soccer and rugby matches [65], winter sports stars posing in their underwear in glossy men's magazines [66], or an offer of free sports equipment for schools in exchange for the consumption of chocolate bars [67], controversy around the commercial association of sport with values and products incompatible with the public health agenda is a common occurrence. Merging the world of public health with a world in which good intentions and commercial interests bubble away in one enormous casserole pot is certainly not without risk—bring an enthusiastic professional sports star on board to front a health promotion campaign 1 week and you might find that they're the face of a new advertising campaign for junkfood the next [68].

Ultimately, the mixing of public health work with commercial sports partners will probably always be open to a degree of controversy. Even the NFL's award-winning "A Crucial Catch" campaign has attracted criticism. As well as questioning the percentage of revenues from campaign merchandise which goes to cancer research, some have argued that the repeated large-scale focus on a single issue robs other health causes of much-needed attention and is simply a prime example of what is termed "cause-related marketing", motivated primarily by a desire to broaden the NFL's brand appeal in order to attract a new female consumer base, rather than an altruistic desire to improve public health [69, 70].

Conclusion

Sport has long played a hugely important social and cultural role globally, with a vast reach which continues to expand even further with developments in consumer technology in the internet age. Sport is also now recognized as having plenty more to offer beyond the provision of entertainment and a vehicle for engaging in physical activity. From dedicated international organizations to small one-off projects, a great deal of energy around the world is now being put into utilizing the power of sport for social good—much, if not all, in the pursuit of outcomes which have direct or indirect relevance to some aspect of public health. Sport is being used to communicate health messages, increase immunization uptake rates, tackle childhood

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obesity, raise awareness of diseases, build social capital, empower young women, promote peace and help communities to deal with the trauma of disasters.

As the global public health challenges of the twenty-first century can only be tackled by working beyond the boundaries of the health sector and finding more imaginative and effective ways of reaching and engaging populations, it is vital that we take advantage of sport's unique capacity to connect with people across social, geographical, and political divides. While merging the spheres of sport and public health will always be open to controversy and never without some risk, managed appropriately, sport offers a rich seam of opportunity to those who endeavor to improve the health of the world's expanding population—one which remains only partially tapped.

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Chapter 2
How Can the Health System Benefit from Increasing Participation in Sport, Exercise and Physical Activity?

Stephen Zwolinsky, Jim McKenna, and Andy Pringle

Introduction

Three major interacting factors influence human health and longevity: environment, behaviour and genetics. In efforts to improve population health, and given our limited control over genetics, one obvious approach to improving health is to direct resources to the management of environmental and behavioural factors. However, while huge leaps have been made in reducing environmental factors through hygiene, safety regulations and vaccinations, relatively little has been done to address behavioural causes [1]. This shortfall has typically been based on a failure to grasp what the evidence-base is now showing about the responsiveness of participants to well-developed interventions [2].

Recognising the strong epidemiological links between behaviour and health outcomes, especially those connected to the rising rates of non-communicable disease, technologically advanced nations like the United States and many European countries have revised their approaches to public health. More specifically, their interest has shifted toward promoting low-cost, highly effective healthy lifestyle behaviours. In this process, critical thinking continues to be revised about how best to achieve (1) sport engagement (beyond spectatorship), (2) involvement in exercise and/or (3) being more physically active in daily life; these issues play out individually, population-wide and globally. This shift has been so profound that accumulating these behaviours is now a core priority for every health system with aspirations of success and sustainability. However, many influential figures within these systems

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have yet to recognise the distinctive nature of these behaviours. They fail to resist the temptation to conflate the behaviours and continue to assume that interest in one equates to interest in the others. Getting this right offers the best basis for delivering the considerable potential of each approach; all are underpinned by a concern to support more people to generate extra energy expenditure.

According to Fineberg [3], and linked to this evolution, a successful and sustainable health system must be able and willing to adapt to these new demands. For example, the term 'health system' is preferable to 'healthcare system' as the solutions need to focus on the ultimate outcomes of interest. These outcomes should address population-wide issues as well as improving individual health, instead of supporting a formal system of care designed primarily to deal with illness. For Fineberg, a successful twenty-first century health system will have three main attributes (1) healthy people attaining the highest level of health possible; (2) superior care that is effective, timely, patient-centred, equitable and efficient and (3) fairness, meaning that treatment is applied without discrimination to all individuals and families regardless of age, gender, ethnicity or identity. For sustainability, contemporary and future-proof health systems will have to be affordable, adaptable and acceptable to key constituents. This clearly links to community-based provision of sport-based behaviours and points to the promotion of sport and its near-neighbours—exercise and physical activity—as being central to the new approach.

However, the reality is that no single change will make any ailing health system successful and sustainable. Success will not be achieved by solely aiding prevention, only championing competition, relying on identifying comparative effectiveness, establishing commercial influence, only paying family doctors more to promote this lifestyle or 'simply' by reengineering the medical system. It may require all these changes and more. Central to this understanding is that it will be unwise to assume that competitive sport can be the mainstay of any Public Health strategy, not least because so few people can sustain this level of behavioural—or indeed, exertional—intensity. Furthermore, the negative experiences that it can produce for participants—perhaps through conflation with school-based experiences—can be so detrimental that it undermines any subsequent interest in living actively, making it more than counter-productive. The promotion of 'sport' will need to be handled with some delicacy and refinement to deliver on its promise.

To help facilitate the changes that better public health will need, it is important to establish innovative policies and practices. Since a core notion for better public health is that more is done to help the least healthy, it is crucial to move beyond the assumption that increased activity can only be achieved by promoting sport or by encouraging activities based on conventional notions about sport. This is important because sport comes with many subjective understandings, but—and this shocks many sport advocates—in many of the long-term inactive, previous experiences of sport are so aversive that they cause outright rejection of even the idea of ever becoming involved. Central to these aversive experiences are those relating to competition and to handling high level exertion; when competition entails social judgements of competence and social standing, for many inactive individuals this is a powerful reason *not* to engage.

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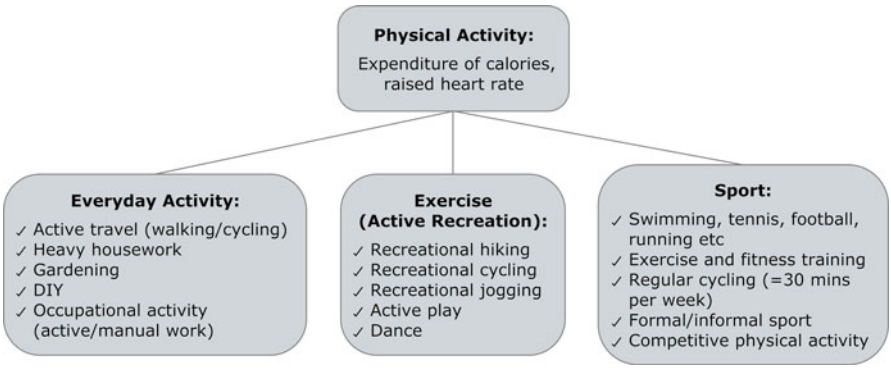


Fig. 2.1 Forms of physical activity. Adapted from the Department of Health, 2011 [7]

While policy directed at promoting more active communities is well intentioned, and based on the latest and strongest research, under recruitment of previously inactive individuals remains a central problem. This situation continues to point to a substantial shortfall in how to translate policy into practices that produce the greatest positive effect [4, 5]. Central to this shortcoming, we suggest, is an overreliance on identifying sport as the parent discipline of a triumvirate that also features exercise and physical activity (see Fig. 2.1). Instead, and alongside the good work that conventional programmes of sport does for those who *are* attracted to competition and exertion and so on, we suggest that different programmes are needed that will attract inactive audiences. These programmes are more likely to feature exercise and/or physical activity, while sport programmes should be expected to continue attracting their target audiences and to do better at reaching into those target audiences.

We further suggest that the easy assumptions which underpin a general promotion of 'sport' also underpin ill-founded notions about how easy it is for inactive people to change their behaviour. The existing literature is replete with evidence confirming that behaviour change is demanding and that—in relations to total body movement—individuals are highly sensitive to differences in mode, frequency and intensity of that activity. If this literature is correct, these lazy assumptions need to be challenged to arrest the dramatic increase on health systems that are attributable to inactivity.

The scale of harm that results from not offering accessible and attractive programmes is due to the negative health effect of inactivity on most bodily systems. These are equivalent to, and in some instances even outweigh, the effect of other lifestyle behaviours. The comparative case of anti-smoking is illustrative of key issues. For example, even though the risk of inactivity is thought to be comparable to smoking one packet of cigarettes a day [6], only 21 % of the population smoke, whereas it is common in many countries for less than 40 % of adults to meet current physical activity targets [7, 8]. For this reason, among others, it is alarming that sport, exercise and/or physical activity are so underutilised as a prevention strategy [9], let alone as a treatment.

There is also timeliness about promoting more lifestyle-based interventions. The prevalence of inactivity-related conditions and their impact on Public Health

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services is such that many contemporary health systems are unlikely to survive in their current forms. As Fineberg [3] has pointed out, many systems now require wholesale and urgent change to meet the needs imposed upon them. However, to do this they will have to overcome a range of formidable challenges and these must not be overlooked, since they are potent individually and worse when combined.

One challenge links to the financial constraints resulting from funding cuts. This highlights the urgency of supporting prevention efforts, which will reduce the incidence of disease and improve lifestyles. Health system managers may also face opposition in their attempts to improve staff productivity while enforcing pay freezes or worsening working conditions, which, ironically, may make physical inactivity more likely for staff charged with promoting activity. Further, the staff who service medical systems are well known for sacrificing their personal needs for those of their patients, which only undermines the case for active living. Another challenge links to managerial capacity for enacting these changes, based on current experience and training. Finally, there is concern that reorganisation will impede attempts to achieve greater integration of service [10]. Ultimately, diminishing resources will necessitate more so-called *joined-up* thinking from public sector organisations to enact the most cost-effective solutions.

The health system in the United Kingdom has recently undergone a facelift in an attempt to combat such problems. The recent worldwide economic crisis meant that the National Health Service (NHS) was required to increase annual productivity by 4 % [11]. This convinced the government to introduce two fundamental changes. Firstly, local commissioning groups became responsible for purchasing hospital and community services. Secondly, increased competition was introduced with the aim of increasing productivity among providers of hospital and community services through the greater use of non-NHS providers [10]. This change is likely to allow greater support for socially based understandings of 'health', which will include prioritising building friendship networks and improving quality of life as much as altering blood lipid profiles or reducing levels of body fat. This clearly plays into the hands of existing sporting provision.

This chapter aims to show that inactive communities which increase participation in sport, exercise and physical activity will benefit health and fitness. By implication, these changes in biological status can have far-reaching implications for contemporary health systems. To establish an appropriate representation of the pros and cons associated with this approach, the discussion also will explore the benefits and potential risks of increased participation. Finally, we explore examples of good practice, including the deployment of a particular evaluation framework, as they apply to using sport, exercise and physical activity to improve Public Health.

Defining Physical Activity, Sport and Exercise

Encouraging and enabling participation in sport, exercise and physical activity requires coherent articulation of the exact nature of each discipline to generate engagement. Clear delineation between these constructs already exists; therefore clarity concerning characterization is essential to promote uptake, especially among inactive individuals.

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Physical activity is an umbrella term, of which sport and exercise are two significant and meaningful forms (Fig. 2.1). We propose that physical activity encapsulates the full range of major movements undertaken by any individual, including those not subject to structure or form. According to Bouchard and Shephard [12], physical activity represents any bodily movement produced by skeletal muscle resulting in energy expenditure above a resting level. Clearly, this definition encompasses a wide range of ambulation and movement not related to sport or formal exercise. At the same time, it integrates the pleasure and the health benefits that might accrue from being active through gardening, walking or doing housework. It also includes activity which is incidental to pursuing some other purpose, such as walking to and from work or gardening to grow vegetables for the table. Importantly, the appeal of incidental physical activity should not be confused with upholding any interest in either sport or exercise, or indeed, of even being convertible into such an interest.

It is also important to have a clear understanding of what sport is and how it is defined, so that its overall appeal in a population can be identified. McKenna and Riddoch [13] suggest that sport (a subset of physical activity) comprises structured competitive situations governed by rules. However, it is essential to remember that some activities, considered by their participants and administrators as sports, do not always sit comfortably within this conceptualisation. One of the most contentious issues that impedes the promotion of sport as a health-promoting behaviour is the role that intense competition may play; as compelling as it is for those who enjoy winning and losing, it is equally repulsive to many others who have much to gain from increasing their activity levels.

While exercise can occur as a consequence of participating in sports, it can also be practised outside a sporting environment for its own sake. This differentiates sport from exercise. Exercise is usually seen to be volitional, planned, structured and repetitive with particular fitness-related objectives in mind. It has been described as ‘A form of leisure-time physical activity with a specific external objective, such as the improvement of fitness, physical performance or health (in which the participant is advised to a recommended mode, intensity, frequency or duration of such activity)’ [12].

When assessing physical activity, sport and exercise it is useful for practitioners to be aware of the five basic dimensions—typically drawn from studies centred in the training paradigm—of all physical activities and how they relate to fitness outcomes and to health-related benefits:

1. *Frequency*—how often an individual takes part, usually stated as the number of sessions per week.
2. *Intensity*—how hard an individual is working, typically categorised as light, moderate or vigorous, referring to rates of energy expenditure (kcal/min), metabolic rate (METs), oxygen consumption (mL/kg min) or heart rate (beats/min).
3. *Time/duration*—time spent on a single bout of activity.
4. *Type/mode*—a qualitative descriptor such as walking, jogging or running.
5. *Volume*—total quantity of physical activity expressed over a specified period. Usually as kcal/day or week. It can also be expressed as MET hours/day or week.

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Defining Health and Fitness

Beyond distinguishing the different modes of achieving additional energy expenditure, there are two further relevant and important terms. Worldwide, individuals involved with the task of improving health and fitness will hold distinctive and diffuse understandings of these terms. This highlights the need for clarity and transparency among providers. Despite having independent definitions, the terms 'health' and 'fitness' are often used interchangeably, which can impede the adoption behaviours of inactive individuals. However, some standard definitions have endured the test of time, and they highlight what additional energy expenditure might contribute to the health of many individuals within society.

Conceptually, health ranges from the narrow technical to the all-embracing moral or philosophical standpoint [14]. In everyday use, health is seen as having positive and negative components. From a negative standpoint, health is simply the absence of disease. Through a positive lens, health represents a state of well-being; complete and optimal physical, mental, social and spiritual functioning. It has been interpreted by Bouchard and colleagues [15] as a *human condition with physical, social and psychological dimensions*, *each characterised on a continuum with positive and negative poles*; *positive health is associated with a capacity to enjoy life and withstand challenges*, *it is not merely the absence of disease*; *negative health is associated with morbidity and*, *in the extreme*, *with mortality*.

Therefore, health can be considered to be an all-embracing concept; it has objective, subjective and individualised elements, meaning that it cannot be solely measured by objective physical criteria.

In contrast, fitness represents the physical expression of an important element of health. For physiologists—and doubtless many sports coaches—fitness deals specifically with the capacity to perform certain tasks. Also referred to as 'exercise capacity' [16], fitness is conventionally thought of in terms of an individual's capacity to achieve a physical goal. Increased exercise capacity leads to enhanced health status in men and women including improved lipoprotein profiles, carbohydrate metabolism, lower blood pressure and weight loss [17]. Further, the literature highlights the positive effects of aerobic activity on cognitive functioning across the life cycle [18]. This offers another, perhaps overlooked, reason for promoting involvement with physically demanding activities. This may explain why so many lay definitions integrate the notion of mental fitness into their understanding.

Fitness can be achieved through most forms of sport, exercise and physical activity. For example, an older person taking up jogging may experience gains in flexibility and aerobic capacity, e.g. they may be able to stay on a treadmill longer as the workload (speed or incline) increases. Subsequently, they may be able to undertake daily tasks with increased ease and vigour, while also avoiding the negative consequences of sedentary pastimes. Recent research indicates that an increased aerobic capacity can improve cognitive functioning across the life course, adding further reason for promoting involvement in moderate-intensity physical activity wherever possible [19]. There are also indications that in children, fitness is linearly associated with academic achievement and performance [20, 21].

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'Fitness' is clearly a relative term, and can become ambiguous in lay contexts. Use of the word is shaped by individual needs and desires, and is also dependent upon political, economic, social and cultural contexts. Employees may think of themselves as 'fit' if they are simply able to complete their tasks at work. In contrast, an international middle distance runner with a slight injury may be considered 'unfit'; when they cannot compete at the national championships. To complete our hypothetical loop, a middle-aged obese individual with diagnosed cardiovascular disease who has recently been discharged from hospital, may be described by doctors as 'fit' to return to work. The runner is significantly fitter in general terms, but, weighed against his individual needs, has been declared unfit. This distinction sustains two further, though related, concepts: health-related fitness and performance-related fitness.

In summary, health is an all-embracing indicator or expression of a person's state of being, whereas fitness is one aspect of this which deals with capacity to perform tasks. Neither is solely confined to physical condition, and a crucial contemporary issue is to understand the relative importance of physical activity behaviour over any risks that it might produce [22, 23].

Exercise Is Medicine

From the earliest recordings of human history, participation in sport, exercise and physical activity has been associated with improvements in health and fitness. This relationship has been further defined by years of scientific research showing a clear causal connection between activity and health status [1]. Equally important, research continues to show that important indices of Public Health are responsive to interventions that successfully support additional energy expenditure in community settings [24]. This has led experts to concur that 'exercise is medicine'.

One of the earliest studies driving this concept forward involved 31,000 male employees of the London Transport Executive. This study compared the occupational physical activity of bus drivers and bus conductors [25]. The results identified that the more active bus conductors displayed a reduced relative risk when compared to their more sedentary, driver, counterparts. A further groundbreaking study, the Harvard Alumni Study, estimated energy expenditure from self-reported participation in sport, walking and stair climbing [26]. After adjusting the results for age, smoking and hypertension, researchers identified a clear dose-response relationship between increased physical activity and reductions in death due to coronary heart disease. These studies, and others like them, gave us the first empirical insights into the benefits of an active lifestyle, whether based on sports, leisure-time activities or occupational energy expenditure.

Over the past half century, data have been accumulating that being unfit or physically inactive—resulting from a lack of exercise and/or sports participation—has major negative health consequences throughout the lifespan [27]. Being physically active, however this is achieved, is thought to be the best buy for public health and has numerous well-established benefits [28]. These benefits include prevention and

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reduction of the risk of all-cause mortality, cardiovascular disease, coronary heart disease, stroke, type-2 diabetes, obesity, osteoporosis, poor psychological well-being and mental health, and some cancers [7]. While it is not possible to detail all of these benefits here, we will address the benefits for cardiorespiratory fitness.

We begin by outlining the logic for promoting sports that build cardiorespiratory fitness. Cardiorespiratory fitness is a key component of many effort-based sports, including team sports like football, hockey and basketball and of individual activities like tennis, rowing and cross-country running. Therefore, increasing participation rates in these sports will improve participants' fitness levels. This, in turn, will profoundly impact on mortality and morbidity rates for those individuals, communities and populations who are most at risk. Yet, the evidence is compelling beyond its face value; it is also vast, robust and consistent [9, 29], as are the relationships between physical inactivity and various health complications [17].

Putting this into a Public Health context, low cardiorespiratory fitness, as an attributable fraction (i.e. the proportion of all health problems or deaths that can be attributed to the risk factor) for all-cause mortality, accounts for *more* deaths in men and women than smoking, diabetes and obesity combined [27]. Notwithstanding that the death rates associated with physical inactivity are consistent in different populations [30, 31], the association between cardiorespiratory fitness or physical activity and disease holds, even after statistical adjustment for blood pressure, weight loss, lipoprotein profiles, carbohydrate metabolism and other confounding variables [17]. Given this independent effect, data suggest there is something inherently beneficial, although unexplained, to the value of exercise for health [9].

The growing arguments around 'how much for what benefit' continue to be refined. This information is probably most relevant for regular, committed exercisers, especially runners. The old maxim that *What doesn't kill you only makes you stronger*, is often used, whereas the reality is that mortality benefits are best accumulated by running over shorter distances, specifically <20 miles per week [32]. This research suggests that higher mileage, faster paces, and more frequent running are not associated with better survival. Data indicate a U-shape relationship between all-cause mortality and running, with longer weekly distances trending back toward reduced mortality benefit. These data confirm the value of exercise prescription based on notions associated with training, while its complexity may explain why so few health practitioners willingly engage with activity promotion at a level beyond 'Do some'. This, along with their access to communities underserved by conventional activity-promoting services, makes them especially well placed to promoting physical activity, and possibly exercising, leaving the promotion of specific doses of exercise to specialists.

However, the logic of altering physiological function to improve health can also be applied to domains beyond sport. Other work has confirmed the cardiovascular protection afforded by occupational activity [25, 26] and of a 'lifestyle' approach to being active [7]. Given the rise of sedentary occupations, there is a growing need for sport, exercise and physical activity that are structured and performed for a specific reason. While there is evidence that higher intensity exercise will optimise fitness and health gains [33–35], this intensity is harder to sustain both within an exercise

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bout and through longer-term involvement. Thus, it is appealing to fewer people and, possibly, most attractive to those who self-select to this intensity. While these individuals may enjoy better health than less active individuals, public policy is rarely based on these groups. Worse, understanding about inactive people suggests that when expectations exaggerate the exertion required for even a modestly successful engagement, they can deter even a try-out, let alone sustained engagement.

Instead, in many countries, including the United Kingdom and United States, regular moderate-intensity activity is promoted. The thinking is that more people can sustain this level of involvement, meaning that this will have a stronger Public Health impact. All things considered, it is important to acknowledge that even though high-intensity training may offer optimal cardio-protection in some instances; this is difficult for most inactive adults to sustain. Indeed, there is considerable evidence that the biological markers of high exertion are such that they can be interpreted negatively [32]. This experience can result in increased attrition from sport, exercise or physical activity interventions, making it almost entirely counterproductive at a population level. The intensity and prescription have to be matched to the needs and abilities of the individual.

These issues are important when the idea of becoming more active is discussed. They are, potentially, even more sensitive when broached in the context of being unwell or experiencing a disease. In countries like the United Kingdom and the United States, General Practitioners and Physicians are often in the frontline of the exercise prescription process for individuals in this situation. However, recent research from the United States [36] showed that physicians advised just over one-third of patients to begin or continue to do exercise or become more physically active. Even though these figures represent a 10 % increase since 2000, and notwithstanding that some patients will be unsuitable for an exercise prescription, most patients who can benefit from increased physical activity are still not being encouraged to undertake it.

Even though the reasons are unclear—and solutions even less obvious—this process is also differentiated, with groups being more or less likely to be encouraged to undertake activity. For example, at every measurement point [36]; women were more likely than men to have been advised to become more active. The percentage of adults advised to exercise increased with age up to 64 years, and then declined. Adults aged 18–24 had the smallest increase in rates of being advised to become more active, and since 2000, remained the age group receiving the least encouragement. Further, and potentially because of its ubiquity and of the particular value of physical activity in remediating its effects, adults with diabetes were more likely than individuals with cardiovascular disease, hypertension and cancer to have been advised to exercise. Lastly, obese adults were almost twice as likely as individuals of a healthy weight to have been advised to undertake exercise or physical activity.

Collectively, this suggests that medical practitioners appreciate that exercise really is medicine, and while the practice of promoting physical activity is on the increase, it remains a reactive—and not a universal—approach. It also hints at a lack of appreciation of the value of preventive intervention based around physical activity, exercise and/or sport. These figures also confirm that considerable ground has to

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be made up to ensure that physical activity is prescribed to all who have the capacity to engage. Here the challenge is to acknowledge the determinants inherent to the 'tough sell' of what advocates clearly see as a 'best buy' [37]. In the context of most health systems being able to fund fewer doctors and nurses, the capacity of these systems for achieving widespread adoption of sport, exercise and/or physical activity must be questioned.

Risks of Sport and Physical Activity

An old epidemiological adage suggests *Ain't no effects without side effects*; this applies to every Public Health initiative that encourages participation in sport and moderate-intensity exercise and/or physical activity. This is linked to the overall aim of optimising well-being while managing the risks that emerge while pursuing progress—typically achieved by manipulating exercise intensity [3]. Therefore, it is important to remember that, just as the health benefits accrue from increased participation, so too do the associated risks.

While the risks of participation in low-to-moderate-intensity activities are relatively small [38], more vigorous pastimes—including sports participation—bring elevated risk profiles, regardless of an individual's athletic ability [9]. Sports injuries can be severe and cause significant discomfort, disability, and reduced short-term productivity. They can also be responsible for substantial medical expense, whether or not this is acknowledged by event organisers or by participants. The working rule seems to be that the more demanding and vigorous the activity, the more demand is placed on the body, which increases the risk of injury. Unsurprisingly, activities involving physical contact with others are associated with higher than normal rates of contact-related injuries, while repetitive activities bring higher rates of injury linked to repetition.

From the F.I.T.T. acronym (frequency, intensity, time, type; see above) that underpins exercise prescription, intensity represents the major injury risk factor emerging from involvement in sport and exercise. While more vigorous forms of exercise and sport are characterised by increased risk of sudden cardiac arrest, this remains a relatively rare feature [38], even allowing for the media attention that it can sometimes secure. It is also especially rare in young athletes, but where it does occur seems to be linked to previously undiagnosed hereditary congenital cardiovascular disease. While pre-screening remains contentious, there is some evidence of its capacity to prevent harm [39, 40]. Given these potential complications, gauging the depth of such problems is a requirement for any individuals promoting sport and physical activity. With distinctive demands, each activity and sport has its own injuries and injury mechanisms; therefore, it is beyond our scope to discuss specific sports in full detail. However we will discuss general issues affecting musculoskeletal injury and sudden cardiac death.

The risk of musculoskeletal injuries increases with intensity and with the volume of the activity. It is important that engagement is managed to allow for sufficient recovery between *training* sessions. Even starting a walk–jog programme will require

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days of rest between sessions to ensure adequate recovery, especially among people with long histories of inactivity. For people engaged with competitive sport, it is also important that *practice* sessions—which tend to be more directly linked to competitive elements of performance—are also regulated carefully. At the start of any new programme, it is important to understand the motivational significance of undertaking a session without having recovered from a previous session. The well-known phenomenon of delayed onset of muscle soreness (DOMS), which emerges within 24 h of exercising and can last up 5 days post-exercise, can profoundly affect enjoyment and/or satisfaction [41]. This, in turn, will affect the likelihood of subsequent engagement, depending on how each individual places meaning on these symptoms. Staff who grasp the close interconnection between bodily symptoms and motivation are differently suited to promoting physical activity to newcomers compared to those who only appreciate the sequence and timing of biological adaptation.

Research suggests that physically active adults tend to experience a higher incidence of leisure-time and sport-related injuries than their less active counterparts [42]. Jogging is perhaps the most frequently endorsed way of becoming more engaged with exercise and even this mild form of exercise carries risk. Injury incidence per exposure (which covers the full range of experience) varies from 7 to 59 per 1000 h of running [43–45]. However, in the only study assessing novices' preparation to complete a 4-mile (6–7 km) event [46], 21 % of the 532 (306 women) runners had at least one running-related injury. Among these novices the incidence of running-related injury per 1000 h of exposure was 33 (95 % CI, 27–40), and the number of injured participants was 20.6 per 100 runners. Given this markedly high incidence of injury in novice runners, the potential for effective preparation prior to engagement, including muscle strengthening and preventative interventions, is high.

Interestingly, adults who meet the current physical activity recommendations by performing moderate-intensity activity have an overall musculoskeletal injury rate comparable to inactive adults [47]. While the injury rate reported among active men and women during sport and leisure-time physical activity is higher compared to their rates while not undertaking these activities, inactive adults report more injuries during the extensive time they spend in non-sport and non-leisure-time activities. For exercisers, this lower injury incidence during non-leisure time may be attributed to their increased fitness levels—including increased endurance, strength and balance [48]. Given that injury—even just the fear of injury—is one of the primary reasons for not engaging in activity and sport, this research suggests that leading a physically active lifestyle is no more likely to result in musculoskeletal injury than living a sedentary lifestyle. Moreover, if undertaken appropriately, leading an active lifestyle can generate a range of physiological, psychological and psychosocial benefits [7] that will not be attained by sedentary individuals.

As with musculoskeletal injuries, the risk of sudden cardiac arrest (or myocardial infarction) is low in asymptomatic—or undiagnosed—adults during moderate-intensity activities [49]. However, and this must be recognised, vigorous exercise carries a transient increase in sudden cardiac death [50], and the greatest risk is found in people who do not habitually perform vigorous exercise [46, 51]. This risk is especially elevated when these habitually sedentary individuals also have latent or documented coronary artery disease [52]. For example, a 50-year-old man with risk

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of sudden cardiac arrest who performs vigorous exercise or sport, will increase his risk 100 times during the activity; further, this risk remains elevated for an hour post-exercise [6]. This contrasts to the situation of the individual who regularly performs vigorous exercise such as running for one or more hours per week. In this case, the individual would have a 42 % lower baseline risk of having the event, and a lower risk for exercise-associated cardiac arrest. Further, the relative risk of myocardial infarction during vigorous exercise, compared with that at all other times of the day, is 56 times greater among men who exercise infrequently and only five times greater among men who exercise frequently [53].

Although absolute numbers of sudden cardiac deaths during exercise are low, screening—provided by simple instruments like the Preparation and Readiness for Exercise Questionnaire (PAR-Q) [54]—will provide important information about the possible risk. Measures to prevent harm should not stand alone; they are most effective when integrated into a sequence of prevention. Importantly, and notwithstanding the value of subjective estimates of risk (e.g. 'that surface looks a bit bumpy, so if we run on it, we might risk some ankles being turned') it is important that provision and practice is developed and refined using more systematic approaches. For effective injury prevention, risks must be identified and described—epidemiologically—in terms of incidence and severity, and the factors and mechanisms that play a part in the occurrence of injuries have to be identified. Practitioners should look to introduce measures that are likely to reduce the risk or severity of injuries. Finally, the effect of the measures must be evaluated by repeating the first step which will lead to a time trend analysis of injury patterns. Ultimately, the evidence that the benefits of participation in sport, exercise and physical activity outweigh the risks is unequivocal [38]. Yet, knowing the risks associated with them is important to help minimise the risk, in order to maximise the benefits.

How to Use Sport to Get More People Active and Lower Health Risk

The London 2012 Olympic and Paralympic games captivated the United Kingdom and a global audience. No doubt it will have inspired some individuals, determined to emulate their heroes, to get into sport. It is highly likely that this involvement positively influenced their health. However, whilst global sporting events like this can cause a significant short-term surge in sports participation levels, maintaining long-term enthusiasm and engagement is more problematic [55]. Fundamentally, without the necessary infrastructure and encouragement, any claims about 'legacy' relating to the public health benefits of such sporting spectaculars have questionable veracity. To contribute to better public health, and to deliver on claims that sport is part of generating a healthier community, the challenge is to deliver a long-term step change in the number of people who regularly engage in sport. With the relatively limited appeal of sport across the community, it makes sense that attention also falls to the different constituencies who are more attracted to exercise and to physical activity.

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Since 2006, in the United Kingdom there has been a 1.4 million increase in people playing sport at least once a week; the total of people engaged is now 15.3 million. With a population in excess of 60 million, the relative appeal begins to become clear. However, this figure looks even less impressive when the number of people engaged 3 or more times per week is identified—7.3 million. This confirms that most adults, 53.2 %, still play no sport at all, while relatively few are firmly committed [56]. Levels of physical activity are equally concerning; only 4 in 10 men and 3 in 10 women in the United Kingdom meet recommended physical activity guidelines by participating in 150+ min of weekly moderate-intensity physical activity [5]. This figure reduces further when adults 65+ years are considered [7]. With similar profiles reflected worldwide [57], it is unsurprising that physical inactivity is a major public health problem of the twenty-first century [58].

One way to improve these figures and use sport to get people more active would be to target children. Sport England recently outlined how they plan to create a sporting habit for life through a youth sports strategy—although the strategy, unhappily, shows little appreciation of how habits are formed [55]. The approach proposes to raise the proportion of 14–25 year olds who regularly play sport, this being the age group who start out as being among the most engaged in sport, but then withdraw from formal sport in greatest numbers. The strategy will be underpinned by five principles. First is to build a lasting legacy of competitive sports in schools. Second, links between schools and community sports clubs will be improved. Third, the governing bodies of sport will focus on youth groups. Fourth, investment will be made into facilities. Finally, more attention will be paid to utilising communities and the voluntary sector. Achieving these principles could help increase participation rates and reduce the burden on global health systems.

Beyond sport, around the world different societies regard physical activity as a key priority of many health agencies. Emerging evidence has highlighted that initiatives to promote physical activity are more effective when health agencies form partnerships and coordinate efforts with other organisations, including schools, businesses, policy, advocacy, nutrition, recreation, planning, and transport agencies and health systems [59]. Other effective public communication and informational approaches for promoting physical activity include community-wide campaigns, mass media campaigns, and decision prompts [24]. Initiatives to increase social support for physical activity within communities, specific neighbourhoods, and worksites can also effectively promote physical activity [60].

Comprehensive school-based strategies encompassing physical education, classroom activities, after-school sports, and active transport also have the potential to increase physical activity in young people [61]. Environmental and policy approaches can create or enhance access to places for physical activity with outreach activities. Equally, infrastructural initiatives through urban design of land use and planning at community and street scales and active transport policy and practices are effective [24]. To properly support initiatives for the promotion of physical activity, workforces need to be trained in physical activity and health, core public health disciplines and methods of inter-sector collaboration [62]. Although individuals need to be informed and motivated to adopt physical activity, the public

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health priority should be to ensure that environments are safe and supportive of health and well-being [59].

In efforts to advance active lifestyles and population physical activity, growing attention has focused on the value of mass participation events [63]. Typically, and notwithstanding their portrayal as sporting events, these events promote engagement with *exercise*. However, for some participants, the event can cross into becoming *sport*, when they attempt to win and/or to improve their performance. While this can be powerfully motivating for these individuals, the downside—for organisers at least—is that less active participants gauge the behaviour of these individuals to understand what the events are really all about. Once this is established, the less active participants can see how well they might fit in—or not. Our experience is that the more competitive the event, the less likely it is for first-timers and less active participants—who typically have low confidence about their engagement and with their physical identity to engage in subsequent events. Crucially, and notwithstanding the symbolic value of mass events, better Public Health through physical activity, exercise and/or sport requires sustained involvement. Event and programme organisers who aspire to making a contribution to Public Health—and who may claim public funding using this logic—would do well to keep this uppermost in their planning. One of the most difficult tasks that event promoters face is to ensure that *exercise* events are not hijacked by sport zealots to use the events to demonstrate physical superiority over others, as many inactive people assume.

On the other hand, when these events are experienced as being inclusive, they can encourage participation of groups left unreached by conventional approaches and who demonstrate less than optimal levels of physical activity. These groups include adult women and the elderly [64]; and increasingly adult men too. However, for inactive people, even the suggestion that these events are sporting may undermine engagement precisely because they associate them with previous experiences of sport. Typically, these experiences can be unpleasant and aversive, which sports advocates may fail to sufficiently appreciate. Among the most aversive of these effects—as related to adult engagement with physical activity and/or exercise—are associations with unfavourable comparisons with others, emphasis on beating others, and high intensity of effort (which is especially problematic for subsequent engagement in untrained individuals) [37]. Unhappily, and pointing to a direction for further work, negative experiences of school physical education—and its conflation with school sport—often feature strongly in the accounts of people who remain stubbornly inactive as adults.

'Parkrun' offers one such mass participation event with considerable public health potential for those who can engage with the idea of exercising. In this programme, now being adopted around the world—but originating in the United Kingdom—a network of free weekly, timed, 5k runs are supported and enacted in public parks. Findings suggest that not only is 'Parkrun' attractive to non-runners, with women, older adults and overweight individuals well represented, but also that it may increase physical activity and well-being among community members [65]. Participants also indicate that participation—and the exercise that underpins engagement with the Parkrun programme—brings important psychological and social benefits, especially among the sizable proportion of non-runners that Parkrun helps to support into regular moderate-to-vigorous intensity exercise. It is also important to

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consider the full panoply of benefits that involvement in such group-based exercise might generate. At first glance these may seem unconnected to public health, yet so often they influence a trajectory that ends up complementing the public health agenda. For example, outcome evidence suggests a graded and progressive public health benefit linked to the regularity of engagement; much of the enhanced social and mental functioning being linked to the style of Parkrun events, while better physical functioning links to both the Parkruns themselves and to the preparation runs that underpin that involvement.

However, it is important to recognise that mass participation events need to be packaged in the right way to encourage regular engagement. When these events become conflated as sport, physical activity and exercise events, this is often counter-productive and increases attrition across the constituent parts. Further, to enhance public health gain, these events must go beyond supplementing the activity of the already-active (although this is laudable in its own right), or offer a replacement for another less attractive option. The best return on the public health pound/dollar is to encourage participation among those individuals who need it most, i.e. the least active 20 % of the adult population [17]. Any programme that achieves optimum provision for sport, exercise and physical activity will be held in high regard.

Using the RE-AIM Framework: Evaluating What Works: And Doesn't—In Relation to Achieving Participation and Health Benefits

Remembering the fundamental differences between physical activity, exercise and sport will be crucial to increasing participation levels at individual, population and global level. Furthermore, increased intensity or poorly matched interventions often lead to increased drop out. It is, therefore, important to utilise evaluation frameworks that allow practitioners to identify the key components to match participants to programmes, and at the right intensity.

Contemporary guidance recommends that interventions, including those concerning sport, exercise and physical activity, should be effectively evaluated, and where possible strategies should include an economic component [66]. Understanding that evaluating interventions can prove challenging [67], a number of helpful frameworks exist to help shape the design of evaluations. One such example is RE-AIM, conceived by Glasgow and colleagues to evaluate health promotion activities. RE-AIM provides a comprehensive framework to assess not only the effects of interventions at different levels of the behaviour change continuum (Reach, Adoption & Maintenance) [68], but also the process (Implementation) [69] which influences the impact (Effectiveness/Efficacy) of the interventions and how this is achieved.

RE-AIM was originally used for reporting the results of research into health promotion activities [70], and was later used for reviews of the literature on health promotion and disease management activities in different settings [71]. Following concerns to translate research into practice, RE-AIM has been used to plan, implement and

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evaluate interventions in a logical manner [72]. With that in mind, RE-AIM has been used in the evaluation of sport and physical activity interventions with a range of groups, including children [73, 74]. It has also been used with adults [68, 75] and those with chronic health problems [76]. With the location for health improvement in mind, RE-AIM has also been used to evaluate interventions in a range of settings including, primary-care [77], workplace [78] and the community [79].

Given the need to assess both impact and process outcomes, RE-AIM has excellent synergies for evaluating community health interventions. Recently it has been used to guide assessments on the effectiveness of football-based health improvement interventions [80]. *Premier League Health* was a £1.63 m 3-year national programme of men's health promotion delivered in and by 16 top-flight professional English Premier League and Championship football clubs [81]. Funded through the Premier League's Creating Chances programme [82], the complex evaluation included quantitative outcome measures to ascertain changes in key lifestyle behaviours and qualitative data (from a range of interviews and card sort procedures) to consider wider outcomes and learning about effective processes.

Premier League Health aimed to improve the health of male football supporters presenting with unhealthy lifestyles and who were not engaging with health services [80]. Interventions were delivered through health trainers and allied health professionals employed by the clubs [83, 84] and were made up of match day activities and weekly classes and groups [2]. PLH comprised an array of programmes: ranging from offering sport engagement (i.e. football) in one club, promoting exercise (i.e. circuit training and running) in another club, and promoting low level physical activity in yet another. As such, PLH showed the considerable ingenuity that can be achieved by considering the interplay of sport, exercise and physical activity. Crucially, PLH drew on the latent appeal of professional football—possibly to men who used to play football—to engage in a programme located in sporting venues but not necessarily based on sport.

Using the principles of RE-AIM, self-report measures were used to assess the number, demographic and health profiles of men who were reached, adopted PLH and maintained changes in behaviour [80]. Process investigations, such as semi-structured interviews with male participants and the health trainers, were also undertaken [85]. Collectively these measures aimed to identify the influential Implementation (RE-AIM) characteristics impacting on men's behaviours across the behavioural continuum [2]. The impact (Effectiveness) emerging from PLH has subsequently been reported [80, 83].

Using RE-AIM to Increase Participation with Men: Premier League Health, a Case Study

PLH represented a unique contribution to understanding both the effects of football-based interventions and the process by which the active design characteristics for engaging, and keeping, men involved played out. Using RE-AIM, for evaluations

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such as PLH, highlights the necessity to sculpt interventions around an intrinsic model of health that considers *what really matters to you* as opposed to *what's the matter with you*—consequently, using intervention mapping principles [86] with a view to informing practitioners on assessing needs, planning, implementing and evaluating gender-specific football-based health interventions. Key learning from PLH is displayed in Box 2.1 below.

Around 4000 men adopted PLH, the majority presenting with unhealthy lifestyles, and demonstrating limited awareness of their problematic health behaviours.

Box 2.1 : Lessons from Premier League Health

PLH provided a unique opportunity to explore how the power of elite football clubs can influence the health of men. We have outlined a selection of ten of the most important lessons learnt from PLH. These should be seen as key considerations for planning, implementing and evaluating men's health interventions delivered in and by professional football clubs.

1. Use all the assets the club has to offer: Utilise the badge, players (where possible) branding, communication channels, and mascots to get publicity. Further, make use of facilities and fully engage volunteers and supporters groups.
2. Consult your target audience when designing interventions. Use social marketing to understand what will motivate—and discourage—potential participants.
3. Build support networks, make it a social event. This is a key aspect of widening men's social capital and a real help in times of crisis.
4. Ongoing activities with no pre-defined engagement periods (e.g. 12 weeks) are more participant-friendly. They are more likely to induce change.
5. Recognise the importance of identifying and working with partners that have access to your target audience. Businesses and settings with a high proportion of males (construction sites, taxi ranks, pubs, betting shops, takeaways etc.), and voluntary organisations or charities can reach out to those who are unemployed, socially excluded and most health-needy.
6. Don't preach health messages. Have open and frank discussions in short bursts (around 10 min), and make it relevant to what the men are doing.
7. Don't restrict activities to just football. Provide an array of fun and enjoyable sports and inclusive activities that may be more suitable for all participants.
8. Don't put out too much complex information. Simple messages and language work best. You can refer people to other sources if they want more detail.
9. Don't expect everything to happen all at once and work first time. It takes time to get established, and requires momentum for word-of-mouth to work.
10. Evaluate and follow up all projects so you can show impact and lessons learnt. Think about this from the start, set realistic aims and objectives, and keep on top of data collection and input.

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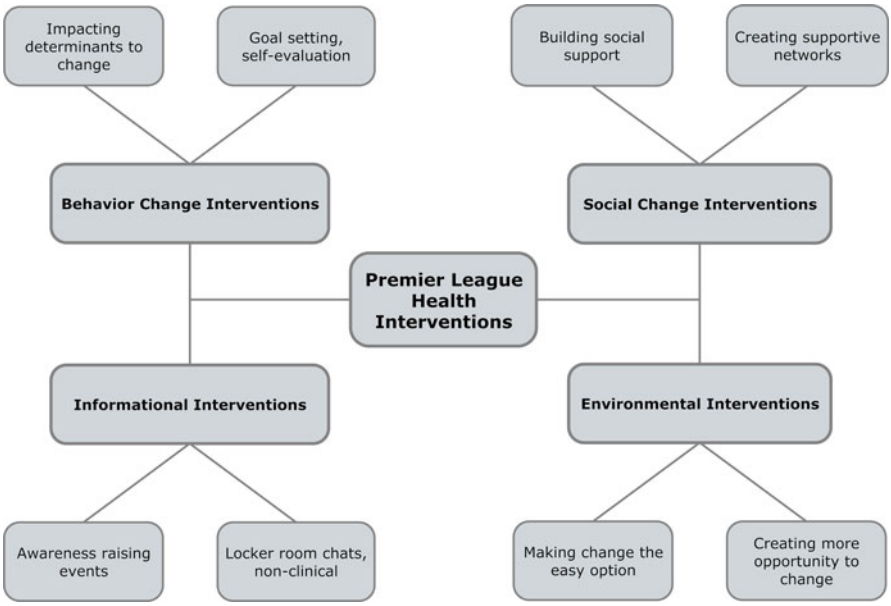


Fig. 2.2 Examples of Premier League health interventions

Over a third reported 'never' seeing their doctor and more than half 'never' used a health advice service, meaning these men were unlikely to be reached through health improvement activities delivered in these settings. PLH resulted in statistically significant improvements in a range of health behaviours for the majority [80]. The design of gender-specific health improvement programmes delivered in football settings raised a number of important considerations. These included the use of familiar environments and focusing interventions on men's interests and hobbies, building men's trust and confidence in the programme, developing realistic physical activity options and creating a socially inclusive atmosphere, especially important for men with no or limited social networks. Examples of some of the types of interventions are shown in Fig. 2.2 below. The health trainers delivering the interventions offered significant expertise when planning and delivering the PLH programme and were instrumental to its success. Collectively, it was design factors such as these that impacted on the health of many men.

Conclusion

Worldwide, increasing the number of physically active people through sports and/or exercise participation can generate system-changing benefits for individuals, communities and health systems. However, uptake evidence suggests that engaging inactive people—even for one-off events—can be a tough sell, even though there

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are many well-documented benefits associated with participation in sport, exercise and physical activity which are valid, robust and consistent [9, 29]. To generate these benefits, physical activity—which can be undertaken universally—needs to be packaged in a way that individuals can incorporate into their daily lifestyle with minimal burden. Conflating distinctive behaviours—sport, exercise and physical activity—typically creates confusion and that can generate mixed messages which make it difficult to communicate with reluctant individuals. Further, the experience of PLH has shown that attention focused on generating precise and enjoyable experiences will minimise the attrition of people who do become involved. At all times it is important to be mindful of the risks associated with increased participation so we can do all that is necessary to minimise the dangers and maximise the benefits.

Throughout this chapter we have argued that it is important that sports advocates do all they can to consider how what they want to promote can be delivered to address the full panoply of interest in exercise and/or physical activity. As tough as this is for sports advocates to hear, this may even include creating some distance from the aversive notions that target audiences may hold about 'sport' or 'exercise'. The evidence confirms that it is unwise to conflate these behaviours or to assume that what catalyses one interest group will have equivalent effects in others. Yet, PLH shows how even the most committed sporting groups—like professional soccer clubs—can grasp the need to offer something other than conventional sport to attract inactive groups. This evidence also shows that this approach can be successful, even if only because it attracts participants through their latent interest in sport.

As increased participation rates generate the 'biggest bang for your buck' with the least active 20 % within society [17], this places attention on promoting engagement of the most sedentary and insufficiently active segments of the community. Importantly, these groups can hold unfavourable assumptions about what 'sport' means and about how 'exercise' is relevant to their daily lives. For this reason, it is important to carefully address their needs and to create interventions that fully meet their needs. In this understanding—and we offer this as a stark assertion—offering more sport to people who do not like sport cannot be the way to better public health.

Further, low active groups typically face substantial barriers to participation and, by dint of their ongoing inactivity, have little capacity to tolerate levels of exertion that many sport and exercise advocates might regard as derisory. This underlines the need for reconsidering the relevance of physiologically oriented themes within exercise prescription; these have more to do with training than with the types of physical activity that they can undertake. Once inactive individuals undertake even some physical activity they may aspire to progress into exercise or even sport, but this must not be at the expense of engaging with activities they can sustain.

However, for all this to occur, resources need to be effectively directed and targeted towards addressing behavioural factors of change. Consequently, individuals within health systems—not health systems themselves—must be willing and capable of adapting to the changing climate to make the necessary alterations successful and sustainable. Understandably, this will not be easy, but this can be assisted by changes to policy and practice regarding the promotion, adoption and maintenance of physically active lifestyles requiring buy in from the key stakeholders.

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Taking a message from contemporary behaviour change theory, it makes sense that any such changes bring quick rewards and represent the smallest change that can be enacted within the existing resources. The reality is that low cost, high performance, cost-effective methods and techniques are needed to deliver on the promise that is represented by exercise as medicine.

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Chapter 3
Sport as a Vehicle for Health Promotion (and More)

Sami Kokko

Background

Sport is a global and universal movement, which reaches millions of people throughout the world and regardless of their nationality or social background, for example. On the other hand, cultural, social, physical, and financial factors, in particular time and space, determine the possibilities for people to take part in sport-related activities. This unfortunately also means that factors such as race, gender, and socioeconomic status can limit people's opportunities to participate in sport. Different factors also come into play in sport settings, making each unique. This, in turn, creates a need for tailor-made interventions which recognize the characteristics of the specific setting and the people in it. This chapter focuses on providing some theoretical insights on how to utilize and/or integrate health- or social-related issues into sport settings and organized sports activities particularly. Sports activities refer here mainly to ones in which individuals take part in physical activities themselves, excluding some of the types of intervention featured elsewhere in this book, i.e., the ones targeted to spectators; however, some of the reflections will be pertinent to these interventions as well.

Due to its wide reach, sport has long been used as a vehicle to tackle a variety of issues, such as peacebuilding, or the prevention of certain diseases. However, the potential of sports stadia and organized activities, like sports clubs, as settings for health promotion has only recently being recognized. In the early stages, sports venues were primarily regarded and utilized as platforms for sponsoring and advertising [1, 2]. In Australia, tobacco sponsoring and advertisement were prohibited and replaced with equivalent health-related ones.

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One of the forerunner movements among organized sports has been so-called ‘developing life skills through sport’, which has focused mainly on organized sport for children and adolescents [3]. This work is based on the recognition that sport can provide an arena in which not only to implement sport-related activities, but also to help young people develop in other areas beyond increased physical activity. The main objective of these interventions has been to enhance the positive development of individuals through a process of support from adult mentors. However, it should be noted that, as well as being beneficial, the outcomes of participation in organized sport activities can also be negative [4], such as increased antisocial behavior [5].

The other fairly common way of utilizing sport and sport settings is to focus on one particular health or social issue, as is very well demonstrated in this book. There is nothing wrong in this approach and, as we can see later in this chapter, it is very often a reasonable and the most feasible first step. However, increased awareness of the ‘health’ end of the health-disease continuum (salutogenic approach) has increased the focus on people’s health-related resources, rather than their risk-factors for certain disease, in modern health promotion [6]. A more comprehensive approach has been argued for in which a chronic physical condition is seen as just one aspect of a person’s state of health, for example. One product of this more comprehensive approach, settings-based health promotion, is introduced here.

The Settings Approach

Within the past 30 years or so, the focus in global health promotion has shifted from a traditional biomedical–epidemiological illness-centered perspective towards wider recognition of the social and environmental determinants of health inherent in settings [7]. This way of thinking highlights the definition and understanding of ‘environmental’ factors that influence the health of individuals or communities directly or indirectly. Previously, people’s lifestyle decisions were seen as depending on individual choices and decision-making that were freely made without any influence of the context or living conditions. This meant that individuals’ health, or in fact ill health, was center-stage. Health promotion was equal to individual-centered disease prevention through a focus on individual health behaviors, including physical activity behavior, which was mediated through individual factors, such as knowledge of the benefits of physical activity or motivation etc. Today it is recognized that people’s health, along with individual-based factors, is mediated through settings-based factors. This, in turn, has widened the determinants of health to emphasize contexts of living, as is well demonstrated in one of the fairly recent definitions of health promotion:

> Health promotion aims to empower people to control their own health by gaining control over the underlying factors that influence health. The main determinants of health are people’s cultural, social, economic and environmental living conditions, and the social and personal behaviours that are strongly influenced by those conditions [8].

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In addition to these pragmatic aspects of the focus on settings, a key factor behind the increased theoretical and strategic interest in the settings approach has been the ecological perspective of health promotion, which demands that individuals not be treated in isolation from the larger social units in which they live, work, and play. These essentially sociological and anthropological perspectives expanded health promotion beyond the largely psychological perspective or dominance of its forerunners in health education, social marketing, and behavior modification.

Different settings are also important in health promotion because of the way that they shape contextual boundaries. Context, in turn, is central to ecological approaches in health promotion and public health, where people's health-related opportunities and behaviors can be supported through organizational policies and environmental changes [9–11]. Settings also represent a fundamental aspect of practice, recognizing the particular needs and living (working, schooling, recreational) circumstances of the target groups of interventions [12]. Settings define the audiences of interventions (individually, collectively and organizationally), and the channels for predisposing, enabling, and reinforcing factors of health-related behaviors. The incentives required to assure the cooperation of the setting will be partly determined by the position of health promotion relative to its core-business [13]. The setting itself, in most cases, is also framed as a target of intervention, with community-wide programs usually involving multiple and varied settings [14]. Most health promotion activity is bound in time and space within settings that provide the social structure and context, i.e., setting-specific features for planning, implementing, and evaluating health promotion.

The settings approach, evidently, has become one of the fundamental international foundations of health promotion. The first two initiatives using the approach were focused on cities and schools. Thereafter, workplaces, universities, hospitals, and prisons have been targeted. Many of these setting-based initiatives have spread across countries, continents or even worldwide [15]. Lately, there has been a drive to broaden the reach of the settings approach into non-traditional, non-institutional settings [8, 16], with projects being established, for example, in beauty salons, farms, sports clubs and/or organizations, and sports arena/stadia.

The diminished focus on individuals in health promotion does not mean that individuals are ignored. Indeed, individuals' behaviors and decision-making processes remain principal factors determining their health, but the emphasis is clearly placed on the settings and ecological factors that shape, limit, or enhance those behaviors and decisions. One often forgotten factor in settings-based work is the reciprocal determinism between a setting and the behavior of the people within it—the setting can shape and constrain health-related behaviors (and by changing the environment it is possible to modify these behaviors or actions), but at the same time behaviors or actions of people also influence the setting [17, 18]. Ideally, an intervention will empower and equip people with the health literacy and knowledge to adjust their behavior to changing environments or adjust the environment to their changing needs [19].

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Different Models for Addressing Health and Social Issues in Sport Settings

To execute health promotion in settings is not the same as to plan and develop health-promoting settings or settings-based practice [20]. The key question in settings-based health promotion is how strongly the setting in question is involved in its development. Settings are typically divided into five models (passive, active, vehicle, organic, and comprehensive) [21] in which, to achieve the best possible results, the experts' role is to act as agents of transformational change, stimulating the people within the setting to begin changing it. The setting can be, and perhaps at early stage needs to be, used as a strategic route to the key stakeholders. Still, the usage of the setting as a passive channel of communication should only be a first step in undertaking settings-based health promotion and not regarded as an end in itself.

In the first and most traditional model (the passive model) the setting, unsurprisingly, has a fairly passive position—'only' offering a channel for outside experts to reach the people in that setting. Sport settings offer existing channels and social environments for developing sporting adolescents' health knowledge and skills, In this model, health promotion is usually done with a focus on a specific health or social problem and implemented by an outside expert, without a clear relationship to the core-business of the particular sport setting (e.g., athlete development in sports clubs), separately from sport activities and without input from stakeholders in the setting (except in allowing the work to happen).

In the second model (the active model), the significance of the setting is acknowledged and it is viewed as a facilitator of individual health goals. Individuals and their health goals remain the primary focus, but attempts are made to support individual change through setting-based factors, e.g., changes in individual dietary habits may be pursued through dietary counselling and other supporting measures such as addressing the food offered through canteens and/or vending machines at sports venues. The idea is to use the immediate resources of the setting to help promote the health of individuals. Long-term changes in the settings are not usually targeted, but may occur as 'by-products'.

The third model (the vehicle model) still concentrates on individual health but recognizes the contextual factors too. There is an aim to generate changes in the setting itself, but this is done by executing, initially, individually oriented health promotion programmes. It is believed that when people become more aware of, for example, the positive effects of healthy nutrition, a receptive atmosphere develops towards wider changes in setting-based factors e.g., an established practice of considering nutritional issues in all sport activities and events within the setting. Health promotion and its specific individual targeted programmes are seen as vehicles through which desired effects and changes can be achieved in the setting.

In the fourth model (the organic model), the focus shifts to pursue the health of individuals and communities through the development of the setting, with emphasis on the sum of individual, i.e., daily processes. In this model, health promotion is viewed as the development of psychosocial organization-related structural and

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personnel factors in the setting. It also involves grass root level activities, but mainly activities on a wider scale, e.g., communication within the organization, building mechanisms, and training and developing the personnel of the organization, i.e., health-promoting measures. In addition to influencing behaviors and effecting changes in the setting, the goal of health promotion is also to develop the working culture and ethos of the setting. The measures focus on enhancing communal participation, development, and activity. In the context of sports (clubs), this means defining health promotion criteria and taking measures on a wide scale and in the long term.

The fifth model (the comprehensive model) can be viewed as an ideal model of health promotion. In it, the setting is seen as an independent entity (but still part of the wider ecological environment). The aim of this model is to effect direct and fairly big changes in the structures and culture of the setting. Thus, experts should recognize right in the beginning the action modes and attributes that promote or prevent change. This model is based on the assumption that individuals are relatively powerless to effect any significant changes in health issues only by themselves; therefore, changes should be made in the setting. These changes guide individuals in a health-promoting direction without them even realizing or paying attention to the process. The health promotion measures affect the deep structures of organizations. In the context of sports this means effecting changes in the goals or rules of the setting in question. To effect changes in these deep structures, the highest decision-making bodies should be the target of the measures. It should be noted that the aim of this model is not to change the fundamental purpose for which a sport setting has been established, but to realize more health promotion as a part of its activities. In the best case scenario, health and social issues are integrated into the existing and possibly new operations. In this model, the so-called 'systems approach' should also be acknowledged [22]; this means that the focus is on the whole setting, instead of only parts of it.

The fifth model requires that health or social promotion has a strong foothold in the particular sport setting. As this is rarely the case, the application of the comprehensive model to a sports club is not easy, at least in the case where this work is starting at the outset—in this case the initial task is to establish a status for health promotion in the given sport setting, even if that is only in keeping with the first (passive) model channel in the first instance.

To conclude, the above models describe the different positions a sport setting could have in promoting health and social aspects. The first models refer mostly to exploiting settings to reach specific target groups, whereas the latter ones refer to a comprehensive, dynamic, and people-in-the-setting-sensitive approach. In health promotion, there exist both initiatives with comprehensive aims and dynamic means as well as initiatives with limited aims and static, centralized means. The important thing is to recognize where the intervention in question is placed and thereafter whether there are possibilities to develop it to the next step (model).

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Case Example: The Health-Promoting Sports Club (HPSC) Model

The Health-Promoting Sports Club (HPSC) model was established in Finland in 2004 [23]. Before this there were no concepts or models in the sports field reflecting the principles of settings-based health promotion. To establish a basis for defining a Health-Promoting Sports Club, it was necessary to begin by reviewing other similar initiatives and set a theoretical frame of reference based on the overall fundamentals of the settings approach [23].

In keeping with these principles and the approach of the fourth and fifth models listed above, the role of a club and club-level actors to take the first move was deemed essential [24]. In practice, a club should first determine its orientation towards health promotion i.e., what part does health promotion play when compared to sports-oriented aims? The role of outside experts is to generate these discussions and considerations and act, as mentioned earlier, as agents of transformational change. One of the fundamental issues before expert actions, is to give sufficient priority to health-related issues to achieve change and ensure that a link between the core-business of the setting in question and health promotion is established and communicated to all the actors in the setting—in a sports clubs context this means a clarification of how health promotion would support athlete development. Athlete development is the key factor for most of the sport actors, with an understanding that this should not only apply to those aiming to achieve at the top of their field. In addition, it should be carefully considered what wording should be used to communicate the club's health promotion message—usually the most suitable way is to translate health concepts into the language of sport in order to appeal to the target audience.

If a club has clarified and agreed on the issues above, next it should create the best possible preconditions for those leading the daily activities (club officials and coaches). This, for example, means that a club needs to ensure that all club officials and coaches have proper competence to deliver health promotion, with extra training provided where needed. Thereafter, it is a question of the coaches acting to shape the environment to support individual (young athlete) learning and be proactive in addressing health-related issues on a daily-basis.

With these principles, the concept of HPSC has so far been used to assess the extent of health promotion in youth sports clubs in several European countries [25–27] as well as Australia [28, 29]. It has been found that in Europe youth sports clubs and/or coaches generally have a positive attitude towards health promotion, but this positivity has not yet converted into practical activity; neither by the clubs nor coaches [25–27]. The widespread adoption of the comprehensive model described above particularly still appears to be a far-away goal. While issues close to sports performance featured heavily in clubs' coaching guidance and coaching activity, a much more passive approach was taken to wider factors relating to the sports club setting and other health issues [25]. On the other hand, there are some indications of a higher level of health promotion activity taking place in clubs where a comprehensive approach has been adopted [13].

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The model of HPSC has to date been mainly used as a research tool for describing the current state of health promotion among youth sports clubs. On the basis of the results some guidelines to support health promotion development in clubs have been created [30]. Some clubs have started development work and many have expressed an interest in doing so. Future work in this field will concentrate on creating feasible, effective, and long-lasting interventions, which will be scientifically evaluated. Valid and reliable tools for this evaluation will also be created and tested.

Conclusion

The aim of this chapter was to discuss the theoretical grounds and different forms of activities for sport settings to promote health and social issues, starting from a passive approach right up to becoming a comprehensive health-promoting setting. Today, when many societies face health problems with complex causes, such as lack of physical activity and sedentary lifestyle leading to increased obesity and overweight, health promotion has more societal importance than ever. Sport attracts a lot of people who participate in it in a variety of ways through personal choice and interest, making it one of the most potentially powerful settings in which to practice future health promotion.

In Part II of this book, a variety of success stories in the field of 'sport for health' are presented. Readers may wish to critically review these cases in the light of the issues discussed in this chapter and consider where the opportunities are to create even more sophisticated interventions in the future.

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Chapter 4
Public Health in Sporting Settings: A Gender Perspective

Alan White

Introduction

Running public health initiatives within a sport setting seems such a simple and effective solution to getting more people healthy and well, but, as we have seen in the introduction, organised sport is a powerful institution with very deep meaning and influence within society and therefore is not without its challenges [1]. Robertson [2] and Spandler and McKeon [3] have warned against seeing the use of sport as a vehicle for public health work as being unproblematic, as it is associated with negative as well as positive connotations. Sport is recognised as a contested setting for public health work. Impossibly fit and able athletes and sportsmen and women compete in front of a crowd being fed on alcohol, fast food and gambling. Sport itself can be violent; the support of the club can become tribalistic and create very negative factions; stakeholders have vested interests they want to maintain; and the media and the clubs' PR machinery can stir up emotions, for good or harm.

Sport is also a very gendered setting, in that it can have different resonances for men and women. The opportunity of participating in initiatives run within a sporting setting has to be matched with a desire to participate, with the appeal for men and women being influenced by their past and current experiences of sport, both as a supporter and as a player.

> The significance of sport as a site for male identities and ideological forms of masculinity can be used to account for the continued resistance to including women at the site of sport, and hence the re/production of women's sport as an inferior product for a less discerning and sophisticated audience. [4, p. 187]

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This chapter seeks to explore the meaning of sport and fandom for both men and women and in so doing it aims to identify the potential barriers and facilitators to using sport for public health work.

Women's Participation in Organised Sport

There has been a world-wide exponential growth in women's sport and the numbers of women who are active supporters of clubs is at an all time high, such that initiatives that combine a strong public health/preventative agenda aimed at women in the sporting setting have great potential for success. Kay [5] has argued that young women can accrue an array of benefits from sport participation, beyond the physical benefits of increased activity, including empowerment, improved confidence and improved educational prospects, and relations with peers and teachers.

The potential of sport for women has also been recognised by the United Nations, which considers sport as a key vehicle to empower girls and women (see Box 4.1). Since the 1978 milestone of sport being recognised as a 'fundamental right for all'[1] the move to enhance women and girls' participation in sport has been actively supported and developed by the UN. In 2011, the Human Rights Council passed Resolution 18/23: *Promoting awareness, understanding and the application of the Universal Declaration of Human Rights through sport and the Olympic ideal* [6, p. 31]. This Resolution was based on promoting the values of respect, diversity, tolerance and fairness and as a means of combating all forms of discrimination, and has particular resonance for women as globally there has been a history of their exclusion within sport. There is also an assumption, based on the 'Girl Effect', that girls can be the catalyst of social and economic change for their families, communities

Box 4.1 : The Third Millennium Development Goal: To Promote Gender Equality and Empower Women

- Sport helps improve female physical and mental health and offers opportunities for social interaction and friendship.
- Sport participation leads to increased self-esteem, self-confidence and enhanced sense of control over one's body.
- Girls and women access leadership opportunities and experience.
- Sport can cause positive shifts in gender norms that afford girls and women greater safety and control over their lives.
- Women and girls with disabilities are empowered by sport-based opportunities to acquire health information, skills, social networks, and leadership experience [9, p. 12].

[1] http://www.un.org/wcm/content/site/sport/home/sport

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and countries and that their engagement in sport can be a way of bringing about a profound change in society [7].

The chapter on Slum Soccer within this book is one prime example of girls' and women's sports-based interventions challenging gender expectations, but others also exist, such as within the British–Asian community, where women are actively engaging in football as a means of overcoming stereotypes and challenging inequalities [8].

Women's engagement in organised sport has not been straightforward. Even the opportunity for girls to engage in sport at school is not universally accepted and is only recent in some countries. In America, it was in 1972 that the Educational Amendments Bill was passed, including a section, Title IX, prohibiting discrimination against girls and women in federally funded education—girls having previously been routinely overlooked in school sport provision. Since the Bill was passed, there has been an increase in women engaging in sport,[2] but it is noticeable that this took time to take effect and the benefits are only now being fully seen. Nor was this problem restricted to America. In Scraton et al.'s interview study [10], top-level sportswomen from across Europe in the late 1990s reflected on the lack of interest in girls' sports at school and the absence of local clubs for female-only sport. In Europe, the opportunity to play in competitive sport has only recently been allowed to develop away from hockey and netball into football and other more traditionally male sports.

Outside of the school, women's participation in organised sport has also been a challenge [11]. In Britain, women's football had its greatest boost during the First World War, when women replaced men's football with their own teams and tournaments, but this was met with fierce opposition from the Football Association—a ban on women's football in England using existing sporting arenas continuing until the 1960s [12]. Similar objections to women's football were seen in Germany, where prohibitions on the support given to women's clubs were enforced by the German Football Association (DFB) until the 1970s [13]. This situation has, indeed, existed world-wide; in Brazil, for instance, women were forbidden by law to play football until 1979 [14]. The useful book by Hartmann-Tews and Pfister [15], gives a further international perspective on the struggle that women's sport has had to endure to be accepted. Thankfully, there is a greater acceptance in the sporting world now for women's football [16] and this is creating a new environment for women to participate in sport generally. But, considering the relatively short time span since many of these restrictions were lifted, though progress is being made rapidly, there is still a lot of ground to make up. The growth of women's sport has, however, been greatly supported by the Olympics, with the 2012 Games being the first at which every country had female representation, and with the Organizing Committee for the Games now insisting that any new sports introduced must include women's events.[3]

[2] http://www.feminist.org/research/sports/sports12.html

[3] http://www.olympic.org/women-sport-commission

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It is not yet time to be complacent, however, for the aspiration of the Olympic legacy leading to higher levels of inclusion within sport can still be restricted by the way sport is defined and supported:

> … the [UK] government's very definition of sport appears to be the partial 'competitive sport for sport's sake' which encapsulates the sporting practices of a relatively small demographic; [and if] defined this narrowly, the majority of the population, disproportionally women, will be further disenfranchised in relation to sport. This will work against the 2012 legacy aspiration of the right to sport for all. [17, p. 271]

Indeed, despite the developments listed above, there are still relatively few women belonging to a sports or athletics club, with higher participation levels tending to be seen in events such as charitable marathons and walks, and with various surveys suggesting that keep fit classes and swimming remain the preferred form of exercise for many women [18]. Even though the Olympics did create an increase in women's desire to take part in sport, there have not been major increases in the numbers actually taking part, such that there is still a strong need to find ways of enabling women, especially those in more deprived areas, to become active and to remain engaged.[4]

In part, the problem is due to the way that women perceive sport and whether they see it as an activity they want to pursue. In a South African study of recreational preferences, gender was found to be the most important predictor of the importance of the sports field as a recreational environment (67.8 % of men saw it as 'important' or 'very important' compared to 70.2 % of women seeing it as 'unimportant') [19]. A recent survey by the Women's Sport and Fitness Foundation in the United Kingdom found the proportion of women participating in sport had declined, although there was a latent desire to be more active and engaged.[5]

A Spanish study of university students' motivation to engage in physical activity found a statistically significant difference between male and female respondents [20], with early negative experiences of sport limiting the possibility of revisiting sport as a leisure time activity in later life. Green's [21] study of young 'non-sporty' girls highlights how even girls who are actively engaged in sport in their younger childhood quickly absent themselves from sports in their teenage years. A UK study on why girls aged 15–16 drop out of sport found that embarrassment, pressure to succeed, or a self-perceived lack of ability in PE lessons were key factors, but it was also noted that lack of support from teachers, existing stereotypes of sport being a 'manly' thing to do and competing obligations were also important factors in dropping out [22].

Craike et al. [18], found that Year 11 students made a shift from competitive sport being for fun towards physical activity as a way of avoiding putting on too much weight, managing anger and finding relief from schoolwork. But there was also a change in the way that both boys and girls became more conscious of how they were perceived by others. Few other early experiences put the boy's and girl's

[4] http://www.wsff.org.uk/system/1/assets/files/000/000/265/265/4bfd5faba/original/Trends_Women's_Participation.pdf

[5] http://www.wsff.org.uk/system/1/assets/files/000/000/265/265/4bfd5faba/original/Trends_Women's_Participation.pdf

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success or failure on such open display as does sport. For adolescents, trying to create a place for themselves in the world, sport shows their bodies and their performances in a way few other aspects of their lives achieve:

> By Year 8 the boys were becoming more competitive and aggressive and less inclusive. This period coincides with the time when young women are becoming more self-conscious about their appearance, particularly in front of boys. It also coincides with the period when young women become more interested in socialising and in less competitive forms of physical activity. [18, p. 160]

Similar findings came from an Australian study, where girls were concerned about the way they were perceived by others in what they saw as a predominately male world of sport [23].

In an analysis of how women who were physically active on leaving school maintained their engagement Guérin et al. [24], found that early experiences of positive physical activity as a child, coupled with good social support and nearby good quality welcoming facilities, were key factors. Hirvensalo and Lintunen [25] also found that it is difficult for women to become active if they have no previous history of being active, especially if they hold strong perceptions of sport being a male pursuit. This is especially the case for older women, though the transition to retirement can offer some the opportunity to re-visit sport and other forms of physical activity as a means of engaging in new, and health-enhancing, activities.

According to the Women's Sports Foundation,[6] women drop out of sport due to:

- Lack of access
- Safety and transportation issues
- Social stigma
- Decreased quality of the experience
- Cost
- Lack of positive role models

Women's participation in sport generally tends to be strongly linked to their socioeconomic circumstances and also to their age, with younger women and those in the highest socioeconomic quintile being more likely to participate, and with the most vulnerable women, those living in socially disadvantaged communities, being the least likely to participate in organised sport or be physically active and having high levels of sedentary behaviour [26]. An Australian survey of women's participation in organised sport also noted that women's educational attainment, level of poverty, ethnicity, proficiency at English and level of social contact were all implicated in their likelihood of engaging. A German project aimed at getting women with difficult life situations into sport found that often it was existing policies and procedures relating to usage of facilities that were a significant barrier [27]. What was required was a careful analysis of available assets along with negotiation with external organisations to make progress.

[6] http://www.womenssportsfoundation.org/en/sitecore/content/home/support-us/do-you-know-the-factors-influencing-girls-participation-in-sports.aspx

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The power struggles that exist within women's sport can also create an unwelcoming environment for extended female participation. Velija [28] notes that in women's cricket there are divisions based on social class and sexuality that influence how women engage with the sport (see also Flintoff et al. [29] and Sartore and Cunningham [30]). The perception of women's sport as having a strong lesbian component can also lead to negative press coverage in some countries, which may also influence participation rates [31]. Another factor which could negatively affect an individual's decision to participate in sport is the often very public scrutiny of female athletes' physical appearance, such as the persistent online abuse faced by British Olympic swimmer Rebecca Adlington (although it is worth noting that neither the perpetrators nor victims of such internet 'trolling' are exclusively male or female [32]).

Women as Spectators of Sport

Melnick and Wann [33] note that, for boys, their peers are the strongest determinant of which club they are associated with, whereas girls have a broader range of factors that affect their choice, with parents being particularly important [34, 35]. Ben-Porat [16] found that, in his Israeli cohort of female fans, it was parents, followed by male friends/boyfriends who helped decide which team to support and the intensity of their interest in the game. This importance of early male influence on women's identification with sport generally was also found in the work of Liston [36], such that, by the time girls leave childhood, they will have already made lifelong decisions regarding their allegiance, or not, with any particular sport and club.

In all sports there has always been a strong female presence, with passionate support given to teams, but this has only recently been acknowledged and studied within academic literature [37–40]. Within some sports, women now account for significant proportions of the match day attendances, with Rugby League in the United Kingdom [41] and Australian Rules Football (AFL) [39] standing out as having a very high and loyal female fan base. It is estimated that women comprise 43 % of the 33 million sports fans in the United Kingdom [42].

Significant changes in the match day experience in the United Kingdom arose as a consequence of the 96 deaths at the Liverpool vs. Nottingham Forest FA Cup semi-final match at the Hillsborough stadium in 1989 [43]. The report on the disaster by Lord Justice Taylor forced all the major clubs to move to all-seat stadia and this, along with more intensive stewarding of the crowds and the use of CCTV to reduce crowd hooliganism, created a safer, more 'civilised' [44, p. 472] environment for women and families.

Pope [44] also notes that increasing female spectatorship has been mirrored by other changes in the politics of sport, such as the realisation that women are now a key factor in the economic survival of the game, with the greater the club's ability to be female-friendly, the greater the income. There is a view, however, that even though this financial benefit has been welcomed, from attendance through to being

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more likely to buy merchandise and clothing, women are still not fully accepted and are more seen as 'token' fans [45, p. 141] with women's role as 'authentic fans' still being subject to question [43, 44].

Women's willingness to engage in sport is limited by their restricted exposure to women's sport, it generally being only the male game that is available for their consumption [46, 47]. The investment in sports stadia for essentially male sports has been criticised as a means of further belittling women's place within society [48]. The creation of new arenas by mostly male benefactors can be viewed as positive in certain respects, but, at the same time, as having the effect of strengthening male dominance in a rapidly changing world. Preserving male supremacy has negative effects on both the male and the female population, through the limiting of a shared future and making the risk of continued harmful sexual stereotyping the more likely. In a world where equality should be the goal, opportunities are needed to mutually create an understanding of our potential and our failings, which can only happen in shared settings.

In the early days of organised sport, support for football and other sport was limited to attendance at the actual event, whereas with the emergence of radio and television, and now much greater use of social media, a far wider audience has become possible [16]. However, the media coverage of sport has had both a positive and a negative effect on women as spectators, as it carries with it messages that can be seen to be very gendered [49].

Women's sport has seen an increase in its national and international coverage, but there is still less than 5 % of sports media coverage devoted to women's sport.[7] The coverage that does occur can be problematic, where women's sport can find itself silenced or trivialised and sexualised [50, 51]. This lack of coverage also results in reduced female role models for girls and women to entice them into sport and physical activity.[8]

There is change happening, however, with the high profile sacking of two reporters on the Sky sports channel for their disparaging remarks relating to a female assistant referee [3]. The *BlogHer* profiles suggest a view of sport that rejects its perception as a male domain and considers it solely in terms of spectatorship; rather, they reflect women's active and participatory relationship with sports [52].

Men's Participation in Organised Sport

Sport has a significant place in many men's lives, through playing or watching or even ignoring, to the extent that many men's whole sense of themselves as a man is tied up with their experiences of sport [53–56]. This is a worldwide phenomenon starting at an early age [57, 58] and sport is soon recognised as a possible career

[7] http://www.wsff.org.uk/the-challenge/the-challenge-elite-sportswomen

[8] http://www.independent.co.uk/sport/general/others/special-report-womens-sport-has-far-to-go-but-the-wheels-turn-slowly-8735036.html

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choice for boys [59, 60]. With the huge salaries paid to top footballers, and increasingly in other sports, it is seen as a profitable possible career for lads with talent and can act as an incentive to invest the time and effort required for success.

There is ample evidence that many boys and men have benefited greatly from having sport as a part of their lives. Taking part in sport gives an outlet to boys 'physicality' where they need to expend energy and enjoy the experience of being active, developing and honing new skills along with the pride in performing in front of others [61–63]. Participation in contact team sports is an expected part of a boy's life, and has been seen to be a central component of the preparation for 'manhood' in many cultures [53, 64]. Ironically, it may also be the case that some of the supposed problems of men's attitudes to ill-health—ignoring pain, fighting on, acting tough—may be a result of their sport participation socialisation process [2].

Being part of a team gives a sense of belonging, pride in achievement, a perspective on winning and losing, and also an acceptance of the need for commitment and passion in what you do [65]. Much of men's social capital is caught up with locations and actions rather than a reliance on broad groups of friends, such that workplace, sports venues and pubs become settings where men 'hang out with their mates' [66]. Conversations about sport become a major part of the common linkage between men, with high levels of social capital caught up in knowledge of sport [67, 68].

The benefits of sport are also very evident in the improvement in health and both physical and mental well-being through the engagement in physical activity generally [63]. Emotional resilience is acquired through the development of self-esteem, self-confidence, communication skills, conflict resolution skills and a sense of belonging [65]. It is of note that sport is also one of the few arenas where men are seen to cry in public and to display emotions, sharing success and failure as a common experience [69].

Engaging in sport is an acceptable mechanism for increasing boys' and young men's social status and peer popularity; there is a significant amount of social standing tied up with their bodies and their performance at school, with the athletic muscular body seen as the archetypal male [54, 62, 70]. Sport also provides a forum for talking about the body and body image for adolescent boys that is not available elsewhere and as such helps to locate the boy's body alongside his peers and in the eyes of potential partners [62, 70].

Success in sport can also act as a substitute for other areas of life where other forms of masculine behaviour fall short [71, 72]. It can also be important when one is seen to be engaging in behaviour deemed by one's peers to be 'non-masculine', such as being academically gifted [73]. Frosh et al. [74], in their analysis of adolescent boys' views of growing up, found that especially Black and Afro-Caribbean males would define themselves in terms of their sporting prowess, with bookwork and other scholarly activity being seen as a sign of unmanly behaviour.

There can also be negative effects on those boys who, for whatever reason, cannot conform to the expected 'type', through lack of ability, coordination, competitiveness, or interest and aptitude [75, 76]. The playing field is such a visible space in which to be seen to fail. Robertson's study [2] exploring men's attitudes towards

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masculinity and preventative health practices included interviews with gay and disabled men as well as heterosexual able bodied men, who relived the 'hatred' of being the last person picked for a team or the feelings of failure caused through lack of skill or interest in the game. The gay and disabled participants felt especially excluded, particularly the gay men who saw organised team sport as being so aggressively heteronormative that non-participation and non-identification were seen as the safest option [77]. This is not, however, an available option in school physical education (PE) classes for those boys who are same sex attracted or are unsure about their sexuality [78]. Mainstream sport has been criticised as being 'overwhelmingly homophobic' [77, p. 225].

Plummer [75] also talks of the experiences of boys and men who fail to 'measure up' to what is viewed as appropriate peer-endorsed masculine behaviour, with homophobic terms used for any man, of any sexuality, as a legitimate weapon of censure. He sees this resulting in what he calls 'sportophobia' and a general avoidance of sport.

There are wider negative effects of sport. Though organised sport was created with the intention of giving young middle class men an outlet for their physicality, it was in part hijacked as a means of giving men private space in a world changing as a result of feminism. The creation of a 'male preserve' where men could revert back to some kind of masculine archetype was seen as important in the latter half of the nineteenth century and the start of the twentieth century, and it has been noted that, as the suffrage movement developed, so did organised sport: [67, 79]

> For women, particularly at these levels in the social hierarchy, were increasingly becoming a threat to men, and men, we should like to suggest, responded among other ways, by developing rugby football as a male preserve in which they could bolster up their threatened masculinity and, at the same time, mock, objectify and vilify women, the principal source of the threat. [79, p. 12]

It is of note that, with the increasing movement of women into sporting settings, there has been a rise in the fantasy league, which Davis [80] suggests is becoming a new space for White males to create a male (White) bastion in sport:

> In many respects, fantasy sport leagues act as an 'Old Boy's Club' that allows men to communally meet, bond, and redefine what it is to be masculine. Within this space, men can act like men without fear of feminization. [80, p. 261]

Sport has offered men a forum for extreme behaviour in a rarefied 'zone of permission' [16], with few other opportunities for them to join in violating society's taboos—violence, physical contact, nakedness, obscenity, drunkenness and the maltreatment of property [79, 81]. Male initiation rituals, which usually involve the expectation/threat of humiliation, partaking in extreme acts and excessive alcohol consumption, are meant to create a feeling of belonging and also a place within a team for both the neophyte and the experienced player [82]. Sport also creates a version of masculinity that can be valorized in lewd songs and created through activity sanctioned as male bonding behaviour, which provides a space to mock not only women, but also homosexual men [79]. Such activity results in sport acting as a reinforcing agent in wider societal sexual divisions [83], with the power to influence generation after generation of men and women.

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Pringle and Hickey [84] discuss the wider problem of hyper-masculine behaviour in sport, which is typified by men feeling that they have to out-perform each other in practices seen as masculine to demonstrate their belonging on the team. This leads to overindulgence in drinking and the sexualisation of women, coupled with excessive competition and training demands. They suggest that some of the individuals involved do recognise this as both an ethical and a moral problem, but they lack the tools to be able to manage the situations differently as they would be going against their teammates and friends. It is seen to be possible to avoid being 'problematic men', but this usually involves quietly refusing to participate in the extreme behaviour, which then generally results in them eventually leaving the sport or changing clubs. The suggestion by Pringle and Hickey [84] is that change in culture within a sport or a sport club is difficult for individual sportsmen to achieve, but that the more they are individually supported to question their practices the more likely that overall change will occur. Circumstances tend to work against the latter outcome, however, as being a member of a team can have the effect of limiting exposure to alternative forms of masculinity as well as restricting social contact with women, as the team and the game dominate time and opportunity for experiencing other life-ways [85].

Though on the sports field hyper-masculine talk is used by coaches, it does not necessarily transfer into everyday practice of masculinity [86]. There are other signs that lads playing sport are not bound to be this mimic of hegemonic masculinity, with sportsmen now representing more metrosexual and tolerant forms of being [87]. The banning of initiation practices [82], coupled with much greater tolerance and understanding of homosexuality in sport, has resulted in a reduction in homophobia and homohysteria, which has been greatly helped by anti-discrimination legislation and broader cultural and societal changes in understanding and acceptance [88, 89]. This permission to be more inclusive has in part been driven by general trends in society, but has also been helped by prominent sportsmen, such as David Beckham [90], who are offering alternative life-ways for boys and men to follow.

Not all men are frightened away from sport by their early experiences, but many men competing at high levels during their school and University days drop out once they enter into the world of work because of competing pressures on their time. Getting back into sport can be a problem due to decline in competence and fitness levels making some reluctant to re-enter sport as they cannot compete in the way they used to [25]. Nevertheless, re-establishing a relationship with sport often happens when men become fathers, when they not only take their children to watch matches, but are also involved in their own sporting development, with fathers (and mothers) taking on coaching, refereeing and other helping roles [91]. There is also a general realisation, and fear, of the *spectre of the wheezy dad* prompting fathers to get fitter and in better shape [92], such that re-entering into a sporting environment is not impossible as long as it is done in a way that makes it safe and also without fear of loss of face.

For many men (though not all [93]), returning to sport is also linked to losing weight, as there is a male gendered preference for increasing physical activity as opposed to dieting in order to achieve weight reduction [94]. This is reflected in the

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growing number of public health initiatives within the sporting setting that have a weight reduction objective for men, as seen in this book and elsewhere [95].

Men as Spectators of Sport

Worldwide the majority of attendees at matches are male, as are the consumers of print, radio, television and the rapidly growing online coverage of sport [42].

There is an intense loyalty seen for the club or team supported, with allegiances often being developed early and lasting a lifetime. As mentioned earlier, parental influence, friends and other male role models are strong predictors of an individual's commitment to a team [34], with important memories of attending or watching matches with fathers and other relatives. It is one of the few events where fathers and sons traditionally shared social space, which has a powerful resonance for both [34].

The 1980s and 1990s were a time when the tribalistic aspect of spectatorship emerged with many, mostly men, engaging in high levels of violence against rival football supporters. Having heroes, and a narrative of combat and fight, are important in the mythology that fills many men's and boys' imaginations when it comes to watching sport [49]. Sport spectatorship often provides an arena in which very traditional masculine values still thrive in a changing world:

> At this historical moment when hegemonic masculinity has been partially destabilized by global economic changes and by gay liberation and feminist movements, the sports media industry seemingly provides a stable and specific view of masculinity grounded in heterosexuality, aggression, individuality, and the objectification of women. [68, p. 160]

But as seen above, improvements have been occurring for a number of decades, with active policing and other measures achieving a reduction in violence, in extreme behaviour both on and off the pitch and in sexist, racist and homophobic chanting [55, 79].

Conclusion

Significant changes are being seen within society for both men and women, which are being mirrored in the way that sport is developing. Greater awareness of female sports, more effective stewarding of games, monitoring of sports media and less tolerance of discriminatory practices are making the sporting setting more appealing for many. This is not to say that there may not be some gendered backlash if care is not taken, as there are some elements that would like to see the exclusion of women and the old hyper-masculine traditions continue. Nevertheless, gender is recognised as being continually reproduced and cannot be seen to be set in stone [96], such that although there have been very problematic aspects to sport with regard to both men and women this does not mean they are immutable and unalterable.

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Hopefully, as the environment for women's participation becomes more normalised, with greater acceptance of female sport and a growing intolerance for misogynistic practices, younger girls are now facing an unimpeded path into the sporting world. Recognition that girls' experiences of sport at school need to be re-thought to maximise the likelihood of retaining participation is of great importance, however, and girls-only sessions have been found to be effective at enticing girls back into sport and other forms of physical activity, especially if accompanied by a re-focusing on the needs of young women in the development of programmes, services and facilities within the school environment [18].

Women's fight to get acceptance and equality within sport and also within the wider society [8], coupled with the emerging more female-friendly arena environment, has seen massive changes in the way that women now view sport, both as participants and as spectators. Though this is not a completed journey, with prejudice and barriers still being experienced, there is now much broader scope for reaching out to women through the medium of sport.

The relative absence of relevant case studies within this book suggests that there have been few women's sports initiatives that have taken a broader public health approach in the way used to reach out to men. Most of the initiatives seen with women are aimed at raising their participation in sport, increasing physical activity or with the specific intention of empowering them. This might be because there has not been the need to reach out to women for public health purposes in this way as other approaches are more effective, or it may be that this approach has not been considered before and could be very worthwhile.

Sport certainly has resonance with many men, which does help explain the large number of male-only initiatives that are already reaching out to men in a sporting setting. The increasing intolerance of homophobia, sexism and racism and a closer scrutiny of behaviour, both on the pitch and in the stands, are making the game more appealing for many men, and there would therefore seem to be opportunity for even greater use of sport-based public health interventions here.

The key message that comes from an analysis of sport through a gendered lens is that engaging in public health work in this setting has great potential, but is not without its issues. New and existing initiatives need to be aware of the power of sport to be a huge asset in working with men and women, but it must be entered into carefully.

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Chapter 5
Sport and Public Health Partnership Working

David Conrad and Maria Abraham

Introduction

For those explicitly tasked with achieving significant and sustained improvements in a population's health, whether it be the population of a small town or a large country, the challenge is immense. Public health as a whole has a wildly varying track record of successes and failures. While some seemingly impossible goals (such as the eradication of smallpox) have been achieved, other challenges which—in theory, at least—appear relatively straightforward (such as tackling the West's spiralling obesity rates) have so far proved beyond our capabilities. Nevertheless, we stick to our goals, knowing that public health is rarely a game of 'quick wins' and 'low hanging fruit'. We comfort ourselves with the knowledge that the results of our efforts will only be seen in years, decades or even generations to come, while periodically re-energising ourselves with new variations of longstanding mission statements to shrink health inequalities, change a nation's eating habits and 'give every child a healthy start in life' [1]. Working in public health certainly requires one to be an optimist, but in order to achieve meaningful outcomes one is also required to be a realist.

Increasingly, we have come to understand the devilish complexity of many of the world's public health problems and the challenges of achieving seemingly simple lifestyle changes in real communities, where people's circumstances, motivations,

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barriers and influences frequently prove more varied, more nuanced and more unpredictable than we might have hoped. The public's stubborn refusal to conform to the convenient cold logic of our textbook models of behaviour change continues to bewilder and frustrate us [2]. The typical problems which modern public health exists to address have been described as 'wicked issues'—difficult to define, lacking clear workable solutions, socially complex, interrelated and with multiple causes which are not confined to the remits of single sectors or organisations [3]. Based on the principle that a similarly multifaceted and joined-up approach is essential to tackling these 'wicked issues', the concept of partnership working has become established as an essential tool of modern public health practice. Since the late 1990s, it has particularly taken hold in the United Kingdom, where 'partnership working' has permeated the public health discourse to such an extent that any explicit assertion of the need to be doing it would probably be regarded as a truism.

In order to practice partnership working, public health professionals must, of course, identify suitable and willing stakeholders outside of their own departments and organisations with whom they can partner and who will add tangible value to their efforts to improve the health of the population. Sport, with its myriad manifestations spread across the public, private and third sectors, coupled with its transcendence of social and geographical boundaries, offers a rich mine of opportunities for collaborative public health working. This chapter aims to fire the imagination of readers working within dedicated public health roles, departments and organisations by flagging-up some of these opportunities, outlining some key principles and pitfalls of partnership working, and highlighting an example of a 'public health-sport' partnership which is working to address men's health in the London borough of Haringey.

Opportunities for Working with Sports Partners

In the Introduction to this book we discussed the breadth of public health activity to which sport can contribute and the importance of seeing it as more than just a way to encourage physical activity. The potential for public health professionals operating at local level to work in collaboration with sports partners is similarly broad. Inevitably, opportunities will vary from one place to another depending on the scale of the sport economy—some localities will be home to wealthy professional sports clubs whose brands have national or even global reach, while the sport infrastructure in otherwise similar areas may be limited to an unglamorous municipal swimming pool or tennis court, for example. The reach of sport is such, however, that wherever in the world you are based there should be a good chance of finding accessible potential sports partners—even if a little imagination and detective work is required to track them down. Depending on local circumstances, the list may include:

- Local government
- Schools with physical education/sports facilities
- Community centres with indoor and/or outdoor sports facilities

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- Public and privately owned leisure centres and gyms
- Local amateur and professional sports clubs
- National public bodies with a remit to increase participation in sport (e.g. Sport England[1])
- Governing and organising bodies of individual sports (e.g. English football's Premier League with the Premier League Health initiative [4])
- And local, national and international sports-based charities and development organisations (e.g. Right To Play)[2]

You may wish to work with an individual sports club, organisation or sportsperson in a bilateral partnership or pull together a number of partners to work together. Partnerships may be short term and tied to a single project or they may be enduring collaborations with a long-term view implementing multiple projects. Determining which type of partner—and what type of partnership—is most appropriate will depend on a range of factors, including the available funding and resources, and the specific aims of the work. Some of the potential ways in which public health professionals can work with sports partners are briefly highlighted below, along with accompanying examples from the United Kingdom:

- *Enlisting the support of a local sports club or sportsperson with a positive media profile to promote a message or raise awareness of your work*—e.g. in 2008, the public health department in Sefton, Merseyside enlisted Liverpool FC soccer star Jamie Carragher for the media launch of a new physical activity strategy at a local leisure centre [5].
- *Partnering with local sports clubs to host public health interventions in sports venues*—e.g. The Tackling Men's Health initiative in Leeds was a collaboration between the Leeds Rhinos rugby club, two local public health departments, Leeds Metropolitan University, the government Department of Health and other health partners to deliver health promotion interventions on match days [6].
- *Bringing sports partners together with a range of other stakeholders from across sectors to take a whole systems approach to tackling a public health issue*—e.g. England's 49 County Sports Partnerships (CSPs)[3] are networks of local agencies committed to working together to increase the number of people taking part in sport and physical activity. Partners include national governing bodies of sports and their clubs, school sport partnerships, local government, local public health departments, sport and leisure facilities, and many other sport and non-sporting organisations.
- *Commissioning sports clubs to deliver public health interventions*—e.g. the public health department in the London borough of Haringey commissioned Tottenham Hotspur Football Club's Tottenham Hotspur Foundation (THF) to deliver 3000 health checks in the community to men aged 40–74 (see below).

[1] http://www.sportengland.org/

[2] http://www.righttoplay.com/

[3] www.cspnetwork.org

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Achieving Effective Partnership Working

The potential to build constructive public health-sports partnerships is limited by little more than the imagination, but one must resist the temptation to rush in without a clear plan and some essential caveats ringing in the ears. It would be easy to fall into the trap of assuming that the concept of collaborative working is such an apparently straightforward and logical one that the mere existence of a partnership must by default lead to a positive impact on an area of work. While partnership working may seem instinctively to be a universally beneficial approach to tackling public health problems—pooling resources, sharing expertise and learning, and addressing complex issues from multiple angles, unfettered by professional or organisational boundaries—in practice, the effectiveness of public health partnerships has proven far less consistent than the rhetoric that surrounds them. A study of public health partnerships in nine localities across England from 2007 to 2010 found that they were often little more than facades of collaborative working behind which a 'silo mentality' prevailed, with an unwillingness among partners to share information or resources, or to put sufficient effort into making the partnership a success [3].

Whether working with a single sports partner on a short-term, one-time project or aiming to build a substantial long-term collaboration with a number of partners, there are some important principles of effective partnership working for ensuring a positive, mutually beneficial relationship which will add real value and achieve results:

- *Focus on relationships*, *not structures*—too often the focus of a partnership becomes its own structure and processes, with momentum slipping away as meetings-about-meetings and eternal angst over membership, governance and terms of reference sap the life from the project. Experience has shown that achieving the perfect structure is a never-ending and futile quest [7]. Don't be afraid to create looser, more flexible partnerships which are grounded in good, practical working relationships rather than artificial structures. Evidence shows that less formal and more organic operational partnerships with high levels of trust and goodwill are typically the most effective [3]. Ensuring positive relationships in a partnership is important not just for the success of that project, but for building your reputation as someone that sports partners want to work with in the future.
- *Understand the needs and wants of your partners*—always strive to understand the needs of your partners and potential partners and ask yourself why they would be interested in partnering with you or your organisation. In recruiting and working with sports partners your focus shouldn't be solely on what they can do for you, but on establishing a mutually beneficial exchange. Also, keep in mind that while some sports clubs or sports personalities have a brand that you may wish to associate your work with to achieve publicity and credibility with a target audience, your organisation may also have a brand which other partners see advantages in being associated with. Particularly when working with partners in the private sector, there can be sensitivities around public and third sector organisations being seen to be endorsing private enterprises or supporting commercial interests. Equally, when choosing a partner to help publicise or be the public face of a

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project or campaign, remember that it's not unheard of for a sports team or sport celebrity with a very positive public image one week to experience a dramatic change in fortunes the next which you may not have bargained for!

- *Have a clear purpose*—a big part of not getting bogged down in the formalities and processes of a partnership is keeping the focus on clearly defined objectives which all partners understand and are motivated to achieve. For a partnership to be successful it should be clear from the outset how it will add value—one should never be set up to 'tick a box' of collaborative working or simply to create a network of stakeholders as an end in itself [7]. Partnerships which are clear about their goals and objectives will be more effective than those which are unsure of the purpose of their own existence [3]. As much as possible, the partnership's stated objectives should be practically focused, rather than laudable mission statements about 'reducing health inequalities' or 'tackling childhood obesity' to which the specific practical contribution of the partnership remains a mystery. Purpose matters more than structure [7].
- *Focus on outcomes and monitor performance*—once a partnership has a clearly stated practical purpose, it should be straightforward to then attach specific outcomes to it and ensure that there is a robust process by which the achievement of those outcomes can be assessed [3]. Keeping in mind the S.M.A.R.T. acronym (Specific, Measurable, Achievable, Relevant and Time-bound) will stand you in good stead when establishing purpose and outcomes.
- *Clarify roles and responsibilities*—of course, it's not enough for the partnership as a whole to have a clear purpose and objectives if the contribution of individual partners towards achieving those goals isn't also clearly set out. It's not uncommon to find partnerships in which no one appears to have any conception of what their own task is in the collective endeavour except to turn up to meetings and sound supportive of what all the others are doing. An equally ineffective variation of this is the partnership composed entirely of people who believe that their role is to suggest work for the other partners to do—a belief which necessitates them to use all their expertise to pour scorn on each others' suggestions so as to shoot down anything that might send some work in their own direction. Effective partnerships have ownership of targets and share responsibilities [7], with all partners aware of their own (and each other's) roles and responsibilities [3].
- *Identify bespoke solutions*—the duration of the partnership, the number and range of partners, and the degree of formality appropriate will vary depending on the purpose and scale of the project, as well as the context in which you're working. Partnerships aren't a one-size-fits-all solution [7]. In some situations, for example, it's important to establish quite long-term partnerships which can be given the time necessary to establish trust and joint methods of working and to begin to deliver results. Sometimes, pooling budgets is an appropriate way to ensure that a partnership has a practical focus and the capability to be more than just a 'talking shop'. On the other hand, it's important to resist the temptation (or pressure from others) to over-complicate partnership arrangements unnecessarily—for some types of work, a small-scale partnership of limited duration, with minimal formality and structure, will be the best way to achieve your purpose.

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The Power of Football and Partnerships: Tottenham Hotspur Foundation's Men's Health Work

Tottenham Hotspur Football Club (commonly known as Spurs) is an English professional soccer club located in Tottenham, London, which plays in the Premier League—the top tier of English football. THF was established as a Registered Charity in 2006 with significant investment from Tottenham Hotspur Football Club. It provides sports, health, training and education programmes in the community—creating opportunities, encouraging enterprise and innovation, promoting social cohesion and enhancing life skills. THF works predominately within the London Boroughs of Haringey, Waltham Forest, Enfield and Barnet and the District Council of Epping Forest but has also undertaken various overseas projects, including work in South Africa, Sri Lanka, India and China.

THF uses sport, in particular football, as well as the power of a Premier League badge, to engage hard-to-reach groups in life-changing community-based projects. This is achieved by working with a wide range of partners, including central and local government departments, schools, colleges, businesses and charitable trusts, to design programmes that engage with all sections of the community.

One aspect of THF's work is its Health & Wellbeing Department's men's health work in Haringey. The work is undertaken in close partnership with the local public health department and guided and driven by the Haringey Health & Wellbeing Strategy, one of the focuses of which for 2012–2015 being inequalities in men's health. Reducing lifestyle risk factors for cardiovascular disease and increasing awareness of early symptoms of cancers in men aged over 40 are particularly important to addressing this issue; however, reaching men can be a challenge. Men visit the doctor 20 % less frequently than women and are also much less likely to have regular dental check-ups or to use community pharmacies as a source of advice and information about health. Smoking cessation programmes and weight management services run by the National Health Service (NHS) are also less well used by men than women. With this in mind, the partnership between THF and the Haringey public health department led to an innovative ongoing programme of work, using the power of football to engage men outside of traditional health settings. The different elements of this partnership work are described briefly below.

Haringey Men's Health Group

The Haringey Men's Health Group (HMHG) is a multi-agency working group, set up to implement the recommendations of a local government review on men's health. The group meets quarterly at Tottenham Hotspur's White Hart Lane stadium and includes representatives of THF, the local Clinical Commissioning Group,[4]

[4] Clinical commissioning groups (CCGs) are NHS organisations set up by the Health and Social Care Act 2012 to organise the local delivery of NHS services in England.

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local pharmacies, the Drug and Alcohol Action Team (DAAT), the Men's Health Forum,[5] the local NHS Health Trainer Service,[6] a local healthcare provider and Haringey public health department.

THF Community Health Checks

Funded by the Premiere League Charitable Fund and Haringey public health department, THF has been commissioned to deliver 3000 NHS Health Checks[7] in the community targeting men aged 40–74. The Community Health Check programme has been successful in reaching men who are reluctant users of GP services and are at risk of developing CVD or Type-2 diabetes.

Cancer Awareness Initiatives

Since 2011, THF has supported the local implementation of the national 'Be Clear on Cancer' awareness campaign, funded by the National Awareness and Early Diagnosis Initiative (NAEDI). This work has been undertaken in partnership with Arsenal in the Community—the equivalent of THF for Spur's North London rival, Arsenal FC—and a number of other NHS and third-sector partners.

The aim of the campaign is to increase lung and bowel cancer survival rates through raising awareness of the early signs and symptoms among high risk and hard-to-reach groups in the community across five boroughs of London, empowering those with symptoms to visit their doctors. Diverse and specially trained Community Health Ambassadors have engaged in nearly 100,000 one-to-one conversations with the public in places such as pubs, community centres, bus stops, streets, local businesses, libraries, shopping centres and DIY stores.

Tottenham Hotspur Football Club, its players and staff continued their commitment to promoting awareness and early detection of cancer symptoms through the 'NHS Get to know cancer' campaign. 'Get to know cancer' aims to ensure every Londoner can recognise the signs and symptoms of cancer and feels confident to consult their GP as soon as they notice something unusual.

The Club committed to using its appeal and high-profile platform to raise awareness of the symptoms of cancer, promoting early diagnosis amongst its fans and the community with the message that cancer is 'not only treatable, but beatable' if detected early.

[5] http://www.menshealthforum.org.uk/

[6] Health Trainers are local people who have been extensively trained to provide free confidential one-to-one support and guidance to adults wishing to improve their general health and make positive lifestyle changes.

[7] http://www.healthcheck.nhs.uk/

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> It has been great working in partnership with the Tottenham Hotspur Foundation and Arsenal in the Community, raising awareness about the need for early detection of cancer and supporting local communities to live healthy lifestyles. We greatly value their links with the communities of North London and the services they provide. It is our aim to reduce cancer inequalities and the sustained effort of partnership working is important in achieving this aim.
>
> Martin Powell—Cancer Awareness Nurse, Cancer Research UK

Game of Two Halves

Game of Two Halves was a preventative mental health programme with both a football element and a strong pastoral one, delivered through a partnership between THF peer mentors, a child and adolescent psychiatrist representing Haringey Child and Adolescent Mental Health Services (CAMHS), Haringey Youth Offending Service, Haringey Octagon Pupil Referral Unit and four local schools. It was targeted to young boys who were at risk of being excluded from mainstream education. Exclusion from school places young people at significant risk of further causes of social exclusion, such as antisocial and offending behaviour, drug and alcohol misuse, and emotional and mental health issues.

The programme used talking components and football to explore emotion and behaviour expressed on the pitch and ways in which participants could take this learning with them into the classroom and school environment. It was evaluated using a specially developed evaluation package, which in itself was an innovative way of assessing emotional literacy and insight. The evaluation package used tools that are readily available within most CAMHS, together with tools which are specific to the language of Game of Two Halves.

> The thing that helped me the most was the group discussions. The fact that we shared our problems with each other, helped solve them together and learned strategies to take into school really made a positive impact on me. Next year I will be in Year 11 and on task to getting a lot of GCSEs. I already have a B in History and a C in Maths, and I hope to get much more.
>
> Game of Two Halves participant

Active with Ease

The Active with Ease project was developed by Haringey public health department and Health Trainer Services to assist adults aged 18+ who do very little or no physical activity to become more active in order to benefit their health.

The project offers one-to-one practical support through Health Trainers on how to become and remain active in the long-term. The Health Trainers' role involves working with people over six sessions to set physical activity goals and to help them to stay motivated. Additionally, there is the opportunity to participate in free sport/physical activity sessions designed to cater for the needs of those who are new, or returning, to exercise.

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THF provides 'Walking Football', various levels of cycling training and 'Walking Tennis' for the Active with Ease Programme participants. Other partners include Haringey Council Leisure Services, Fusion Lifestyle[8] and Tottenham Community Sports Centre.

iMen50+

iMen50+ was a pilot programme coinciding with the National Men's Health Week in 2011 which focussed on the theme of 'Men's Health Online'. iMen50+ took place in the Learning Zone at White Hart Lane stadium, harnessing the glamour of the Premier League club to inspire men to attend and develop their IT skills.

The 7-week programme improved Internet and IT skills of men aged 50+, starting from basic mouse and keyboard skills and moving on to setting up email and communicating via Skype. The main focus was on developing Internet research skills to enable the men to navigate their way to trustworthy health information sites and steer away from misleading information (such as 'miracle cures' with commercial incentive), or self-diagnosing and self-medicating using counterfeit drugs on offer online. To offer one-to-one support to the participants, the programme was supported by THF's young volunteers, interns and work placement students.

After completing the programme, 89 % of the participants reported that they were now using computers independently either at home or at a library. 100 % reported that they would like to have the programme extended, while 83 % expressed their interest in attending the next course as a mentor to new participants. Most of the participants came to the programme on their own but made friendships within the group which continued after the programme had ended, using email to keep in touch.

Guys and Goals

Guys & Goals was a men's health programme, funded by the Premier League Charitable Fund and Haringey public health department, targeting men from deprived communities in Haringey and Enfield. The programme took place 2 days a week over a 10-week period. Each session consisted of 60 min of physical activity and a 30 min workshop on various health-related issues, such as weight management, healthy eating, mental wellbeing, male-specific cancers, smoking and drug and alcohol misuse. Participants were recruited using various marketing techniques as well as referrals from Haringey and Enfield Health Trainers, the local DAAT and IAPT (Improving Access to Psychological Therapies).[9] Other partners in the project

[8] http://www.fusion-lifestyle.com/

[9] http://www.iapt.nhs.uk/

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were the charity Bowel Cancer UK and BUBIC (Bringing Unity Back Into The Community),[10] a community-based organisation that provides support for drug users, ex-drug users, their family and friends. Over the 3 years in which the programme ran, it engaged with over 250 men.

> A guy would come down and talk to you about your health which was the interesting aspect of it really. It's not just coming and kicking a ball or running around, you're learning something about your diet, your health and what to do about it if you're ever concerned.
>
> Guys & Goals participant

Social Marketing Project

Currently, most Haringey health initiatives are offered in the east of the borough, where deprivation and health inequalities are greatest. There is limited insight, however, into men at increased risk of cardiovascular disease in this area and their health-seeking behaviour. This lack of insight into the specific target population has been a barrier to identifying, isolating and directing resources in the most appropriate, impactful and meaningful way. Currently, in the main, all males are targeted and treated as one homogenous group in the east of the borough, despite the unlikelihood of them sharing identical levels of health literacy, health motivation and personal efficacy capabilities. A social marketing project is therefore being undertaken in order to enable audience segmentation and prioritisation approaches to be used in future work, ensuring the optimum use of capacity and resources at a time of extreme budgetary pressure for the borough.

The aims of the project are:

- To establish why men do not access primary care services that address the prevention and detection of cardiovascular disease.
- To gain insight into what would make health services (that address prevention and early detection of CVD) more attractive to men in the east of Haringey.
- To map the findings against how specific services are currently provided.
- To make recommendations for services based on the research findings and mapping work.
- To build local capacity around social marketing.

Man MOT Haringey

With funding from the Department of Health, the Men's Health Forum is running a project in partnership with THF, Haringey Council and others to provide an online health advice service built around its Man MOT concept and designed by and for

[10] http://www.bubic.org.uk/

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men in the borough. Man MOT is a free, confidential online health advice service through which men can 'chat' directly to a GP (or other health professional) about any health problem at all via a computer, tablet or smart phone with no appointment needed. The site has a 'blokeish' but not 'laddish' feel and offers men friendly, confidential and knowledgeable advice from people whom they can trust. A national service (www.manmot.co.uk) has already been piloted and evaluated. Man MOT Haringey is intended to provide a localised version of this website concept, targeted specifically to men in the borough.

Conclusion

The world of sport offers a wide range of opportunities for innovative public health partnership working. By making the effort to identify potential sports partners in your area and ensuring a strategically driven but practically focused approach based on some key principles of effective partnership working, a powerful new dimension can be brought to the work of public health organisations.

We hope that the 20 case studies which follow in Part II of this book will serve to further illustrate the many different ways in which sport can be utilised to achieve public health outcomes, sparking ideas which will plant the seeds of future public health-sport partnerships all over the globe.

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Part II
Case Studies

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Chapter 6
Time Out for Your Health: A Sports-Based Health Intervention Approach with American Football Teams

Ana N. Fadich

Background

Most people are aware that men live shorter, less-healthy lives than women [1]. They are more likely to be the victim of a violent crime, die in a car crash, commit suicide, and be injured at work. Men also have higher death rates from nine of the top ten diseases, are more likely to be uninsured and far less likely to receive routine preventive care. Hundreds of thousands of men die from preventable causes; millions more have chronic illness, injury, or disability that could have been prevented.

One of the biggest challenges facing those of us who work in men's health is reaching men and boys and getting them to take on a more active role in their own health. Men's Health Network (MHN) is a national non-profit organization in the United States which has developed a strategy that has been highly successful in achieving this goal. The approach is simple: rather than wait for men to ask for help (which, in most cases, will not happen anyway), we bring health screenings and other important educational materials to where men are—and, for a lot of guys, that is at a sporting event.

Generally speaking, American men—even those who are not die-hard sports fans—have an almost intuitive grasp of sports and often look up to and try to emulate their favorite players. This knowledge can be used effectively to attract boys, men, and their entire families to health screening programs.

The events are titled *Time Out for Your Health* because, although we are focusing on education and awareness for men and boys about their health, we are also reaching out to women. Anyone 18 years of age and older is welcome to participate in screenings provided, but we ensure male-specific screenings, like prostate and testosterone, are available.

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Our goal is to make getting healthy a fun, family-oriented activity by making it less of a chore. By incorporating photo opportunities with cheerleaders, alumni players, sports memorabilia (such as Super Bowl rings and trophies) and unique experiences, such as being in the player's locker room, men and families can feel like they are getting a once-in-a-lifetime opportunity.

Aims of the Project

Time Out for Your Health was created to raise awareness of men's health in a forum that would make men feel comfortable and also involve their families. The term, "time out" is heard in nearly all sports across the globe and everyone understands the meaning and what they are supposed to do when they hear it: gather round the coach and listen up. In this case, MHN is calling a "time out" to men who are not taking an active role in their own health and well-being. We are encouraging men and boys to go to their healthcare practitioner to discuss their game plan for good health. Personal health is inseparable from family health, and when a family is healthy and maintains healthy habits, the community as a whole grows stronger and healthier.

Many men enjoy sports, whether watching or playing, and anthropologists and social scientists agree that it is in a man's nature to be competitive—with his friends, co-workers, and even himself [2]. Working with professional sports teams to bring health awareness and disease prevention messages to male fans and their families can turn what might otherwise sound like an unpleasant afternoon into a day of fun and friendly competition.

Whether their team is a Super Bowl champion or was 0–16 last season—fans are dedicated to their team. They know the players, stats, and team history, and they will argue with friends, family, acquaintances, and strangers about why their team is far better than the others. Our goal is to get men to be as dedicated to maintaining their health as they are dedicated to their teams—for their sake and that of their families.

MHN, in partnership with a number of American football teams, reaches men with messages specifically designed to subtly draw parallels between a man's personal health and that of his team (Box 6.1). For example, just about everyone knows that a team cannot function without its starting quarterback, whose job is to move his team towards the end zone by handing the ball off to a running back or passing it to a receiver. Most people know that the offensive line has to protect that quarterback from getting sacked and losing yardage. We relate this to a man's physical health by explaining that his heart is his quarterback. If he builds up his offensive line (immune system) by eating healthy foods, exercising, making regular visits to his healthcare provider and keeping an eye out for symptoms or unusual changes, that offensive line will have a better chance of knocking out any disease that might make him sick and setting him on a path towards a long and healthy life.

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Box 6.1. Why We Utilize American Football as a Setting

Although some sports enthusiasts deny it, American football is the most popular spectator team sport in the United States [3]. It is also a sport that has managed to develop significant family ties, so much so that identification with a team—whether professional, collegiate, or even high-school, whether perennial winner or an also-ran—often becomes part of a family's identity, and team memorabilia items become valued (and sometimes squabbled over) inherited items.

The National Football League (NFL)—the overarching business and regulatory body for the sport—has taken great pains to cultivate the image of the game and its players, transforming them from mindless gladiators in one of the most physically punishing sports, into stand-up community contributors. The NFL has done this by encouraging alignment between players, teams, and the sport in general with philanthropic and community-support organizations such as the United Way whose mission includes supporting programs that promote health, nutrition, and wellness throughout the community.

American football players—probably more than those of any other sport—are seen by many as the pinnacles of sexual desirability and virility. Female cheerleaders, who are so iconic to the game, reinforce these images showing that equally athletic and attractive women are drawn to and participate in the spectacle of the sport. Thus, involving cheerleaders in screening programs provides not only a draw for men but also for women.

Even coaches contribute to the game's image. Coaches are known as rugged individualists and strong leaders who epitomize the best—sometimes the worst—of maleness. The life and death of legendary football coach Vince Lombardi, who gained notoriety with the Green Bay Packers, is a cautionary tale that can be used to transmit important health lessons to men. Lombardi is considered a man's-man: a smart, accomplished, charismatic leader, mentally and physically tough. Unfortunately, Lombardi's toughness ultimately proved stronger than his smarts. In his early 50s Lombardi complained constantly of digestive discomfort and, despite access to the best available medical care, he ignored his symptoms, choosing instead to focus on his work. Later, when the symptoms became too severe to ignore, he finally gave in to the constant urging from family, friends, and his employer and sought treatment. However, he refused to get a full workup, and accepted only symptomatic care. Three years later, he was admitted to hospital and, after exploratory surgery, was diagnosed with terminal cancer of the lower gastrointestinal tract. He died soon thereafter vowing to the end of his life to "fight" the cancer. Handled properly and respectfully, stories like these of how misplaced machismo all too often leads to terminal health problems, can be used as modern-day fables that may help motivate men to more actively engage in their own health sooner rather than later.

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How the Project Was Set Up

In the late 1990s, MHN began its work reaching men in venues where they are likely to gather in large numbers: sports events. The partnership began with the Washington Redskins, but has expanded to include events for fans in the cities of Dallas, TX, Seattle, WA, Cleveland, OH, Philadelphia, PA, and others. The individual teams provide the perfect location for fans/participants to come enjoy a day full of fun and education. Attendees are attracted by the promise (always delivered on!) that they will enjoy unique experiences, such as:

- Visiting the team or visitor's locker rooms or other generally off-limit areas
- Meeting current and former players
- Having a photo taken with the cheerleaders
- Entering to win autographed memorabilia, such as game day balls, jerseys, or helmets
- Possibly winning game-day tickets and/or stadium tour passes
- Purchasing team merchandise at a discount

MHN works with leaders in the industry to plan and execute these events. These include organizations that provide health information, the local hospital/clinic partner of each team, state and local government officials who believe in the cause of men's health and other community outreach groups. Funding for these projects typically comes from a collaborative effort by the individual sport teams, MHN and their affiliated local, regional, and national groups and partners.

One of the biggest advantages of performing screenings at sports venues is that the comfortable, familiar environment often reduces the anxiety that many men feel when thinking about going to see a healthcare provider. Men, who might be wary of getting blood drawn in a medical office, have many distractions to take their mind off of the procedure while at the stadium. In addition, being in a place where other men are there for the same reasons makes it easier to join in and may even bring up a competitive "if-he-can-do-it-I-sure-as-hell-can-too" feeling.

At the first *Time Out for Your Health* educational screening event, MHN provided free health exams including:

- Blood pressure
- Cholesterol
- Glucose/diabetes
- Prostate-specific antigen (PSA) and Digital Rectal Exams (DRE) for prostate health
- Bone density scans for osteoporosis
- Spirometry tests for lung capacity
- Body composition and grip strength assessments

Since that first event, the types of screenings have expanded to include:

- Electrocardiograms (EKG or ECG) for heart health
- Stroke assessments
- Low testosterone
- Vision screenings for glaucoma
- Mammograms for women
- HIV

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While the specific screenings offered will vary between locations, one element has remained constant throughout the years: one-on-one consultations with experienced health professionals. This may be the most important part of the entire event, because most of the screenings provide immediate results to participants. Hospital partners for each team volunteer their practitioners (M.D., D.O., P.A.), nurses (R.N., N.P.), and health educators who can explain the results of each test, offer healthy lifestyle advice to participants and make referrals to specialists as needed.

Local community groups—including the Boys' and Girls' Clubs of the region, Veteran Service Organizations, clinics, and government benefit enrollment officials—are invited to staff tables and provide their health information so the public will know what resources are available in their communities. National organizations with local chapters, such as American Heart Association, American Lung Association, American Cancer Society and the COPD Foundation, are also present to provide awareness of their specific disease states and to answer any questions that participants may have upon completion of their screenings.

Time Out for Your Health events are essentially plug-and-play, easily modifiable to different team sports, and cities, and even countries. Regardless of the venue, before organizing and developing any screening event, it's essential that you know your participant demographic, the people you intend to serve, the community they live in, and the health issues they're most concerned about. In the United States we utilize the Healthy People 2020 demographic information on major metropolitan areas. Their statistics come from the National Health Interview Survey (NHIS). Partner with the local hospitals and clinics to see what issues they are encountering on a regular basis. In the United States it is well documented that African American men have higher risks of developing and dying from prostate cancer, Hispanic and Latino men have higher risk factors for diabetes and heart problems [1].

Delivery of the Project

Individual NFL teams have seen the importance of raising health awareness in the community, particularly among their male fans. By partnering with MHN, these teams are able to give back to the fans who regularly support them. Team management is involved from the earliest stages of organizing an event. They provide the location where the screenings will take place, whether that's in the players' locker room, visiting team locker room, concourse level overlooking the field, or club section of the stadium. We find that hosting the event in typically closed off-areas gives the fans a player's-eye perspective of the stadium. They can follow the path their favorite player takes to get to the locker room and to the field, and see where he gets ready on game day.

Educational screening events usually take place in the stadiums during the off-season or on a day when the team is playing an away game or has a bye week (1 week off). This makes for a more pleasant experience—without traffic, congestion, and interference. Occasionally, we hold events on game day. In these cases, the team designates a separate area outside the stadium for the screening; this gives all fans who are attending the game a chance to get their health checked before entering the stadium.

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Because the logistics of putting together a screening event can be so complicated, it typically takes several months to properly plan and promote. This includes coordinating team and individual player/alumni, and cheerleader schedules, site availability and the participation of partner organizations. There are also questions about staffing, the types of screening to be offered, media and public relations outreach campaigns, and, of course, funding.

Promotional materials such as flyers, social media messages, and television/radio promotions are produced and distributed to the surrounding communities. Flyers are displayed at community centers and various businesses around town and/or delivered via mail or distributed door to door. Creating Facebook events for the screening makes it easy for community members to get information via social media and RSVP. Press releases and PSAs (public service announcements) about the events go out over the news wires to local and regional print and broadcast outlets for inclusion in their community calendars and social media sites. MHN spokespeople are often invited to promote the events on local radio, TV stations, or newspapers, as well as to answer questions from listeners who call in the radio shows about men's health and the goals of the event.

Event Day

As soon as participants enter the stadium; they are greeted by friendly, knowledgeable MHN staff who get them registered and answer any initial questions. Every attendee receives a bag of educational materials which include local resources, brochures, pamphlets, and booklets about men's health and what women need to know about men's health issues. Additionally, the bags women receive include information specific to women's health needs, thanks to our partnerships with various women's health groups. Part of the registration process includes completing medical consent forms and receiving a "menu" of all the screenings that will be offered at the event. The menu also serves as a "report card" where screening personnel will write participants' individual results so they can show them to their personal healthcare provider at a later date. Although participants provide personal information for their tests, we only receive the aggregate data of results from our hospital screening partners. The patients are contacted by doctors directly if there are health concerns arising from results.

After registering, participants proceed down the stadium tunnel leading to the locker room area (or designated screening location site). Along the way, they are able to visit with the many local groups and organizations that are hosting tables with their information. Groups include Veteran Service Organizations, local chapters of many national organizations (i.e., American Heart Association, COPD Foundation, etc.), community health clinics, and benefits enrollment specialists who can assist those who do not presently have insurance coverage enroll in state plans. An important part of this event is to showcase the community organizations and programs available for people to use.

As participants enter the screening area, MHN staff/volunteers guide them through the stations. Individual screening results are usually available within a few minutes and the screening technician records the results on the participant's report card.

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For some tests the participant will also receive an informational sheet explaining the test and results in more detail.

The first stops for participants are the basic health screening tests. Body composition and grip strength assessments are taken initially. Then they proceed to the next stations and within 5 minutes the testing machines provide the test results on cholesterol and glucose levels.

Depending on the type of health awareness being promoted at the actual *Time Out for Your Health* event, we may offer some or all of the following tests below:

- *Spirometry*. This test measures participants' lung function using peak flow meters. Peak flow meters measure how well air exits the lungs by having individuals blow air into a tube as forcefully as possible. Devices such as peak flow meters can be useful in the diagnosis of common lung conditions such as asthma, and can aid in the diagnosis of respiratory illness.
- *Osteoporosis*. Although osteoporosis is usually considered a female disease, it is affecting more and more men. The screening requires a participant to remove his/her shoe and sock of the non-dominant foot (based on the dominant hand). The foot is placed in an X-ray machine which scans the heel and displays an image on the screeners' computer that shows bone density in the heel and relates it to overall bone density. Test results come in the form of two scores: *T*-score (used to estimate the risk of developing a fracture; compares amount of bone to person of same gender with peak bone mass) and *Z*-score (the amount of bone an individual has compared with other people in their age group, size, and gender).
- *PSA* blood draw screening.[1]
- *DRE*, performed in a curtained off area for patient privacy.
- *Electrocardiogram* (EKG or ECG), performed in a curtained off area for patient privacy.
- *Testosterone* a blood draw testing for levels of testosterone in the blood (see Footnote 1).

Outcomes and Evaluation

Outcomes

Most screenings performed at the *Time Out for Your Health* events provide immediate results to the participants. Some of the results require more lab time for testing. A few weeks after the screening event, MHN receives the aggregate results from the day. Those are compiled into a report and presented to the partnering organizations.

[1] In the case of PSA and testosterone levels, immediate results are not available. Venipuncture blood draws are required for these tests and require lab analysis for accuracy. Results are sent to participants 1–2 weeks after the event.

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These events draw hundreds to thousands of people from within the fan community, some travelling many miles. Average screenings range from 100 to 600 participants in a given day. But the educational outreach portion of our event reaches even more participants who did not go through a screening. There are many partners and friends who attend along with a participant.

Our data show that about 66–70 % of men who participate in the screenings say they will follow-up with their primary care physician following the event to discuss results.

Evaluation

Evaluations of each event are done as participants are leaving the stadiums. Staff members ask participants about their experience and any comments they may have. Follow-up surveys are sent to participants who provided email addresses on their consent forms for future correspondence.

When the program is a multi-year event, we have had many participants who return and will bring their "report card" from the previous year to use as their own comparison. They will also voluntarily provide information about their experience at the healthcare provider's office post event. They feel a sense of accomplishment with it all.

Future Work

As long as sports are played, and as long as men remain interested in those sports, MHN will continue to use various sporting venues to provide screening and education to the public. Reaching men where they are comfortable has proven to be very successful. Relating men's health to that of a team or a particular play in sports can help to explain health in a way that a man can understand more easily. One of MHN's goals is to get individual teams and entire leagues to support men and men's health in the same way they already do for women's health and breast cancer awareness.

The point is to increase communities' awareness of health issues and let them know that being diagnosed with a disease or illness is not a death sentence, but can provide a path to a long healthy life. Taking preventive measures to identify potential health issues and monitor or treat them while they're still in the early stages can help save lives. But these options have to be available to the public. Involving each NFL franchise would pave the way for other professional sports organizations across the country to follow suit: basketball, soccer, hockey, baseball, NASCAR, etc. While the populations who participate in and watch these sports vary by location, the health messages remain the same: men need to learn more about their health and take a more active role in managing it.

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Lessons Learnt

Over the course of our collaboration with American football teams, MHN has learned that men are open to the idea of taking better care of themselves. However, men tend to see healthcare as a chore that's all the way at the bottom of their to-do list, and they won't do it if it requires them to take time away from their family, or keeps them out of work. Providing screenings in sporting venues goes a long way towards resolving both issues. Having fun while taking care of one's health will make it easier to go and do it again the following year, and the year after that. By learning about the importance of routine testing and the purpose of each test, we believe that men will be less intimidated of going to their healthcare provider and will be more likely to establish a long-term collaborative relationship with that provider.

We also learned that the entire family unit benefits from these screening and educational events. Men learn that they are role models to their children and other family members/friends. Every man learns how important he is within the family unit—how if he were suddenly taken out of the picture, his family and children would suffer from a life without him. What would his children do if they were forced to grow up without their father in their life? How does a spouse take care of the household and family without a support system there to assist her? Where will the extra financial support for the family come from when his income is lost?

Women know that men are more vulnerable than men make themselves out to be. Sometimes men overplay their symptoms when they are sick with a cold or flu. But those same men may pass off chest pain as heartburn, or attribute back pain to lifting a heavy load at work, when it could be something entirely different—and far more serious. Women who attend our educational screening events receive valuable information on how to communicate with the men in their lives about health, symptoms to pay attention to, and how to get their loved one to a healthcare provider's office for routine visits. By attending the screenings and getting screened alongside their partners, women are showing a unified front, that they support the men in their lives.

Children learn from their parents' behavior. And when parents maintain proper nutrition and physical health, their children are more likely to live healthier lifestyles in the future. By attending these events with their parents, children begin to see preventive health screenings as a positive, and normal, part of life. When they see daddy getting his blood drawn to check for possible health problems, they will be less frightened of doctor's needles and shots as they age and be more likely to make regular visits to a healthcare provider. And when they see daddy taking an extra serving of vegetables instead of another steak and dollop of mashed potatoes, they get the clear message that eating healthy is important.

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Acknowledgements I want to acknowledge my colleagues at MHN and the employees and volunteers who work so diligently to make these events a success. A huge amount of preparation takes place in the days and weeks leading up to each event, and we'd be lost without their dedication and commitment.

I also want to acknowledge MHN's partner organizations and sponsors for providing the support that ensures that these events happen each year. Thanks to their support and dedication to the communities we serve, so many men and their families have been able to diagnose health issues, *before* they became serious conditions. It is fair to say that lives have been saved.

Above all, I want to acknowledge and thank the men, women, and families for taking an active role in their own health and well-being, for encouraging their loved ones to come out and participate in our free health screenings, and for supporting our mission and goals throughout the years. Seeing each one of them at the events is truly what makes my job worthwhile.

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Chapter 7
The Bristol Active Life Project: Physical Activity and Sport for Mental Health

David Carless and Kitrina Douglas

Background

There is widespread awareness of the increasing prevalence of mental health problems around the world. This is accompanied by increased prescription of medications (such as antidepressants) intended to alleviate the symptoms of mental health problems and has led to concerns regarding the sufficient availability of psychological therapies (such as cognitive behavioural therapy, counselling, psychotherapy). When combined with the current financial constraints within the NHS, these factors underline the need for affordable initiatives which have the potential to (1) help those within the community who are currently experiencing mental health problems and (2) support those at risk of developing mental health problems through, for example, the social exclusion and marginalisation that result from adverse life experiences, unemployment, disability, homelessness, or alcohol/substance misuse.

Physical activity is one possible intervention. Several reviews conclude that physical activity can provide mental and physical health benefits for people experiencing mental health problems [1–4]. While highlighting areas for further research, most reviews suggest there is sufficient evidence to justify the use of physical activity as a primary or adjunct intervention for mental health.

Less research has been published regarding the benefits of physical activity for people with serious mental illness (SMI). A 2007 review [5] was able to locate only ten studies since 1981 that explored the relationship between exercise and psychosis. A number of studies have, however, been published since this review and these—when combined with pre-existing studies—provide compelling insights into a range of benefits which accrue for some people who have been diagnosed with SMI through regular involvement in physical activity or sport:

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- Involvement in sport or exercise can help individuals recreate a positive sense of self and identity in the wake of the traumatic and damaging experiences that constitute SMI [6]. In this way, sustained engagement in physical activity helps an individual literally 'recover' a sense of who they are as a person which can serve as a foundation for increasing involvement in vocational, community, leisure and/or social activity.
- Scheduled physical activity sessions offer a sense of structure to a person's day or week, helping reinstate a sense of purpose and meaning to one's day-to-day life [7].
- Physical activity provides opportunities for social experiences, engagement and interaction which are highly valued by some users of mental health services [8].
- Participation in physical activity boosts some people's confidence and self-esteem [9].
- Physical activity provides valuable opportunities for receiving and giving social support and experiencing a sense of community [10].
- Involvement in physical activity can help generate a sense of optimism and hope in the wake of the kinds of challenging experiences that comprise and accompany SMI [11].
- Regular participation in physical activity can improve physical health and fitness among people with SMI [12–14].

In sum, this research supports the 'grass roots' awareness among many service users and some mental health professionals of the ability of physical activity to make a positive and personally valued contribution to the lives of people who have been diagnosed with SMI.

Despite this awareness, physical activity provision in mental health settings is still not routine practice. Instead, beacons of good practice tend to be somewhat isolated initiatives arising through the efforts of one or two committed and dedicated advocates. A primary reason for the absence of more widespread provision stems from the lack of sustained investment in physical activity provision for mental health. This connects to the observation that health professionals and policymakers trained in medical or psychological interventions are often unwilling to accept physical activity as a beneficial intervention [15]. A secondary reason concerns the initiation and maintenance of a physical activity programme being a challenging endeavour for both service users and service providers [16, 17]. A third reason (arguably) concerns the scarcity of published research-based resources providing a rationale for physical activity provision *and* information on the practicalities of delivery. This absence has been repaired (in part at least) with the publication of a text dedicated to the theory and practice of physical activity provision in mental health contexts [18].

Aims of the Project

The Bristol Active Life Project (BALP) was initially developed to provide sport and physical activity provision for people with SMI in the Bristol area. Specialised provision was made to cater for the particular and challenging needs of this client group. BALP's vision was to be a beacon of good practice in mental health provision

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for individuals with SMI through promoting positive health and social inclusion, and providing pathways for future employment in sport for individuals with SMI.

The aims of BALP are to:

1. Address the barriers to participation for people living with SMI through the development of inclusive sessions and mainstream activities.
2. Address the health inequalities for all people living with SMI through a variety of physical activity opportunities and health promotion.
3. Support and develop existing BALP groups and work towards making them sustainable.
4. Develop a range of activities/events, such as leagues and tournaments, for service users to join.

How the Project Was Set Up

BALP was set up by physiotherapists working within the NHS, initially running without dedicated funding. In 2005, BALP was awarded funding for 3 years from the Football Foundation, the United Kingdom's largest sports charity, which allowed the expansion and development of the initial project. The development included: (1) expansion of the number of activity sessions; (2) the utilisation of qualified sport/activity coaches (this role had previously been filled by mental health staff); (3) supporting clients to pursue coaching qualifications, thereby creating opportunities for personal development, employment and inclusion.

At this stage, a partnership was established between Avon and Wiltshire Mental Health Partnership NHS Trust (AWP) and Bristol City Council (BCC). While it was the responsibility of AWP to identify clients, session type, location and duration, maintain databases and supply mental health staff, it was BCC's responsibility to administer the grant, identify and supply qualified coaches, liaise with sport facilities and contribute staff to oversee and develop the project. In addition to equipment provided through the Football Foundation grant, BCC also funded the purchase of equipment and storage at local venues.

Delivery of the Project

Structure of BALP

When BALP began, clients were AWP service users referred to one of eight physical activity or sport groups (football, badminton, table tennis, tennis, basketball, gym sessions, swimming, walking). Clients completed a referral form with their care coordinator or keyworker and, from the information provided, suitable sessions were identified. The referral coordinator would then contact the client with the details of available sessions. Both the client and support worker attended the first two sessions but in subsequent sessions the client attended independently. At all

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sessions, two personnel were present—either two mental health staff or one coach and one mental health staff member.

At this stage, access to sessions was lost once the individual was discharged from AWP services. Given that some service users felt the sport groups had become the most important event in their week, and a vital component of their mental health, it seemed disingenuous to deny discharged individuals access to sessions. This recognition led to a restructuring around 'closed', 'open' and 'mixed' sessions in year 4 of the project:

- *Closed sessions* were aimed at individuals who were engaged in AWP services. Referral was via the AWP intranet. A coach and an AWP staff member attended all sessions.
- *Open sessions* were for those unable to access mainstream activity provision. These people may have been in the care of the voluntary sector, engaged by AWP and living independently, or could self-refer. Sessions were run by a coach who had undergone mental health awareness training (a mental health professional did not support sessions).
- *Mixed sessions* were a mixture of the above. Individuals engaged with AWP could access these sessions and a mental health worker was present to support her/him. All other individuals attended unsupported.

An additional reason for the shift from closed to open groups was the desire to maintain sessions despite financial constraints. Therefore, where a particular session had a history of low attendance, the structure was modified. This led to some sessions being offered as an open or mixed group, while some sessions were amalgamated, or locations changed.

Initially, the partnership was driven by AWP and there was little external awareness of the project. Therefore, other agencies were not in a position to refer individuals to BALP. During 2009–2010, a newly appointed Development Officer established links with partner agencies, providing details of what BALP offered. By 2012, 18 partner agencies had access to the referral pathway.

Outcomes and Evaluation

Who Accesses BALP?

In years 1–3, a total of 485 clients were referred to BALP. Over this time, new referrals increased from an average of 2 per week to 3.5 per week. In years 4–6, 334 referrals were received. During this time, 140 referrals were clients engaged in mental health services, while the remainder were clients who self-referred or were referred by partner agencies. Initially, around 70 % of referrals to sessions were male. To tackle this inequality, the project team made a concerted effort to attract female participants. By year 5, there had been an increase in female participation with 39 % female, 58 % male and 3 % preferring not to identify. By year 6, the number of women participating had risen to 56 % of referrals.

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Approximately 80 % of referrals were from people who self-identified as British. Of non-British referrals, 13 % identified their ethnicity as Eastern European, Western European, Somali, Indian, Asian, Chinese, Caribbean, Pakistani, African, or Other. The remaining 7 % preferred not to complete this question. Across years 4–6, 47 % of people identified themselves as having a disability (which included mental and emotional distress, physical impairment, learning disability). Information on sexual orientation was provided from 311 questionnaires between 2009 and 2012. Of these, 65 % of participants self-identified as heterosexual, 32 % preferred not to say or did not complete the question, and 3 % self-identified as gay, lesbian or bisexual.

Sessions Delivered and Attendance Figures

By 2012 over 30 different types of physical activity were delivered through regular weekly sessions, special competitions, 'taster' sessions as well as partnered sessions with, for example, a community group. Activities included: aerobics, African dance, badminton, basketball, gym, football, martial arts, Tai Chi, swimming, tennis, trampolining, walking, a women's exercise group and yoga. The total number of sessions delivered each year is illustrated in Fig. 7.1.

In years 1–3, a total of 1154 activity sessions were delivered, with a total of 6150 attendances. This equates to an average session attendance of 5.33. In years 4–6, the total number of sessions had increased to 1993, with 9183 attendances. Although the number of sessions fell from year 5 to year 6, the number of attendances

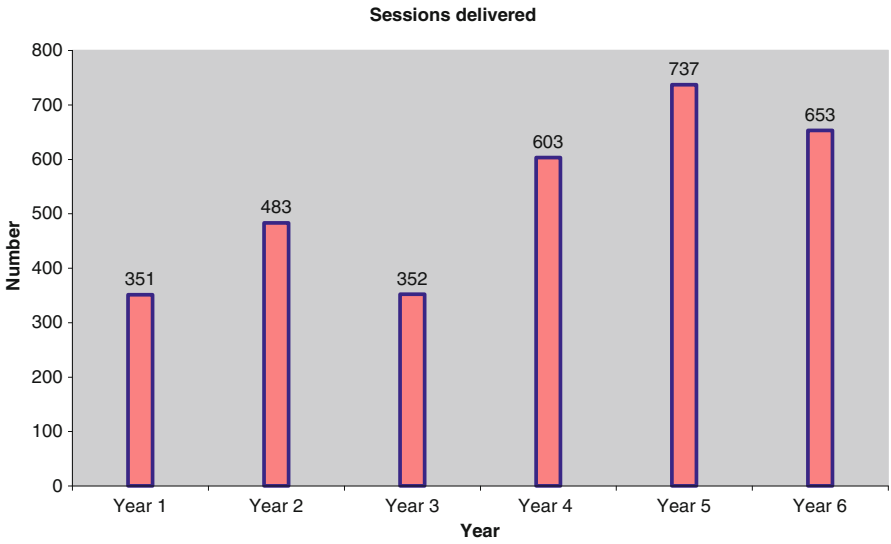


Fig. 7.1 Number of sessions delivered in years 1–6 of BALP

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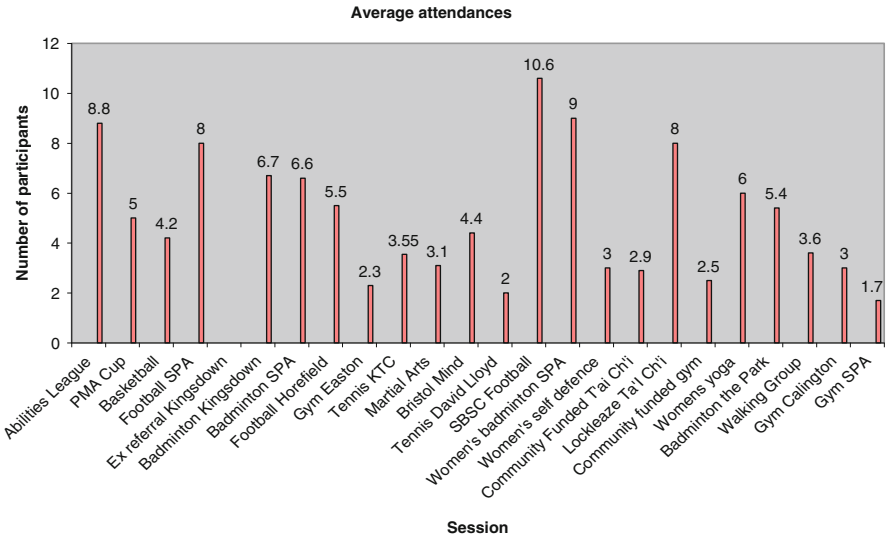


Fig. 7.2 Average attendance for each session by sport activity

continued to increase. In year 4, there were 2615 attendances, in year 5 there were 3003 attendances, and by year 6 the number of attendances had risen to 3565.

The average attendance figures for each activity session are shown in Fig. 7.2.

Low participation results in ineffective use of BALP's resources, so the project team was highly responsive to continually evolving participation rates. However, it is significant that interest in a particular physical activity is not necessarily a good predictor of whether an individual will attend the session; there remains a significant 'step' in the participation process between referral and attendance.

Several further initiatives were offered alongside the regular sessions to encourage participation, motivation, social inclusion and transition:

- Sport events (e.g. tournaments, leagues)
- Transition initiatives linking with public clubs (e.g. tennis, badminton, martial arts, running, cycling)
- Education (e.g. coaching qualifications, nutrition workshops, physical activity/mental health awareness)

Evaluation

Alongside the funding award was a requirement for ongoing evaluation, a report of which we provided for years 1–3 in 2008 [19] and years 4–6 in 2012 [20]. The following data sources were included:

- Documentation of the activities and sessions
- Analysis of referral and attendance figures

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- Analysis of client feedback sheets
- Analysis of BALP Quarterly Reports
- Conducting and analysis of service user forums
- Interviews with representatives of partner agencies
- Interviews with service users
- Observations and discussions with service users and staff
- Email correspondence with service users
- Interviews with coaches

Social scientific methods of analysis were used to explore the data. These included descriptive statistical analyses, thematic analysis of the qualitative data, linking themes with theoretical constructs and aims of the project, and verifying emergent findings via multiple sources of data. Aspects of these findings have been published in book and journal form [18, 21].

Participant Experiences

In the evaluation of years 1–3 [19], service users suggested BALP activities contributed to quality of life, created social inclusion and relationships and provided opportunities for valued and meaningful activity. Positive experiences grouped around five themes:

1. A sense of *meaning* in one's life through providing something to do
2. *Relational* experiences through being *with* and *for* others
3. *Achievement* through improving personal skills
4. Feelings of *well-being* and perceptions of positive health
5. Sense of *discovery* or adventure through going somewhere and doing something

During this period, nine clients obtained coaching qualifications and BALP received national recognition for its achievements from the National Institute of Mental Health in England. It was awarded the *Positive Practice Award* for tackling physical health inequalities and received formal recognition from the Chairman of AWP NHS Trust. The 2008 evaluation report concluded that, 'the project has met all of its objectives and should be considered a beacon of good practice in mental health provision for individuals with serious mental illness through promoting positive health, social inclusion and providing pathways for future employment in sport for individuals with SMI'. These successes helped the BALP team secure funding for continuation.

The 2012 evaluation [20] explored how BALP is experienced by service users. This understanding is critical as it reveals the contributions that an intervention makes to individuals' lives. The four areas we discuss below shed light on the: (1) personal effects of involvement in BALP; (2) particular strengths of BALP groups; and (3) difficulties people have experienced with BALP groups.

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Overall Experience

Overall, BALP is extremely well received by the people who access its sessions. The overwhelming majority of responses and comments were positive and appreciative of the real and tangible benefits service users described. The following excerpts provide a sense of this:

> I look forward to the walks on a Thursday afternoon. I find it very therapeutic and a nice, friendly group of people. A good atmosphere. (Male, walking)
>
> I enjoy the football sessions on Friday afternoon at St Paul's Academy because it is a friendly and safe place to be. My confidence has improved and I have now joined another football team that plays up at the Downs. Playing football at BALP has been a stepping stone in my recovery. (Male, football)
>
> I participate in the health walk on Thursday afternoon … Thursday afternoon splits up my week, giving me something to look forward to … The help I get from this walk and the disability charity keep me going. (Male, walking)

As these comments suggest, the kinds of benefits experienced through BALP are wide-ranging and individual-specific. General strengths include:

- The range and variety of sessions available in one place (i.e. a particular venue) and through one programme is valued because it provides a variety of different activities accessible through a single point of entry, allowing individuals to try out and 'get into' new activities.
- A sense of *satisfaction* and pleasure from seeing through an activity session—simply 'completing it' is valuable in its own right.
- Contributing to the development of BALP provision is important to some—a sense of influencing future provision is *empowering* and motivating.
- BALP is sufficiently flexible and adaptable to *accommodate changing personal needs*; participants described needing more intensive support at some times than others.

Social Structure and Ethos

BALP groups offer something experienced as qualitatively different to public activity groups, relating to the social structure and ethos of the sessions. Many people consider these qualities to be critical to their on-going involvement and the benefits they experience. Participants found the BALP groups to:

- Provide a valuable opportunity to *make friends* with people through 'built in' social opportunities both during activity and afterwards.
- Be more *friendly*, *welcoming and accepting* than public groups; the sessions allow people with similar issues to come together in an ethos of understanding and tolerance of each other's lives; as one individual put it: 'No-one's going to hold it against you that you have a mental health problem, 'cause they know up front'.
- Be more *caring* than other groups might be—'they don't go so hard'; there was a perception that BALP groups were less aggressive than other groups as

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members 'go easy' on each other when necessary and are not *overly* competitive or combative.
- Be characterised by a sense of mutual and reciprocal *support* because everybody knows what it's like—'you're all in the same boat'.

The importance of the social ethos of sessions can only be fully appreciated in light of the experiences that often accompany SMI. In the words of one individual, it can feel like *nothing happens* in one's day-to-day life. Thus, the scheduled and regular activity that BALP offers can be seen as hugely important in a person's week. As another puts it, BALP sessions are the *only time I really see people*. The following remarks were made by a female group member:

> I started my activities with the self-defence group … and it was the first activity which I started to do after leaving hospital so it was really a very important event in my life … Why it was so important, first of all, because I was recently out of hospital, and I had a really bad self image, because I was still very, very overweight and I was extremely unfit. And because the whole atmosphere of both groups was constant encouragement and support and people around were understanding and no-one was doing negative remarks, I felt that it was a pleasure to do physical activity … Let's say I wasn't performing very well, no-one would laugh at me, everyone was really friendly and I felt accepted as I am, so I didn't have to worry about the problems I had. I probably wouldn't be so keen to join an ordinary group or gym or do any sporting event if it wasn't in this specially designed group for people who have mental health problems. I just felt I am able to relax and just do my best, but I don't have to be perfect, I am accepted as I am.

This account captures eloquently the kinds of issues that many members of BALP have raised—that as a result of challenging experiences of SMI, a socially sensitive and accepting group atmosphere is important. The fact that BALP groups are tailored and targeted specifically for people with mental health problems is a defining characteristic of their success and appeal.

Qualities of Coaches and Leaders

One common item of feedback relates to the qualities of the BALP coaches and leaders. For the most part, this feedback was extremely positive. Personal characteristics (friendliness, accepting nature, relaxed demeanour, respectfulness, flexibility, supportive, approachable, encouraging) were frequently mentioned and highly valued. This is reflected in the following excerpts:

> The BALP workers are really friendly and encouraging and not judgmental. (Male, football)
>
> I find the walking group a very relaxed and friendly experience and atmosphere. The most relaxed group I've ever been in. I think this is down to the brilliant choice of [names] as group leaders. (Male, walking)
>
> If you are unwell, you can take time off and resume the class when you're better as instructors are flexible. Because there are two instructors, classes can be small, therefore more care can be taken on each individual student, which is crucial for people with long term illness. (Male, martial arts)

During one service user forum, participants spoke of the importance of particular individual coaches, leaders, or group members in keeping activity groups up and running. One particular coach (himself a previous service user) was mentioned as

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someone who had done much to sustain certain groups. This point reflects the person-dependent nature of the BALP project. Particular individuals are appreciated as 'driving' BALP and making personal sacrifices and efforts that allow positive experiences to be enjoyed by many.

A second issue concerns the perceived quality of the coaching input that was offered during sessions. In addition to the personal qualities above, participants appreciated coaches who:

- Allow the individual to play at their own level while providing motivation and stimulation to strive for improvement.
- Offer input concerning technique and how to improve specific skills which are necessary for overall play to develop (for example, the serve in badminton).

The provision of appropriate tuition was valued by a number of participants who cited this as an incentive to maintain participation—because learning was pleasurable and led to observable improvements in one's ability. One female member of a badminton group had this to say:

> I think [name] who runs it on a Wednesday is very, very approachable, friendly, he's lovely. He's great fun to be with, easy to get on with and he provides you with special tuition on the technique, so it's not the case of just hitting the shuttle across the net but he also teaches you all the moves as well. That's really, really good because it helps to motivate and stimulate you so, you know, so I can play badminton.

Critically important is coaching provision *appropriate* for the needs, abilities and aspirations of group members. Clearly, mixed ability groups make this challenging, though not impossible. Noteworthy in mental health contexts are *expectations*—research has identified the damaging effects of low expectations among some mental health professionals and the way these can limit the hopes and potential of service users. The following account illustrates:

> My mental health support worker took me to an aerobics class. It was a 'mainstream' class, but I was allowed to attend under the BALP banner at a reduced rate. My support worker kept saying 'well done!' to me. She said it so loudly that everyone in the class could hear. I felt so embarrassed, patronised and self-conscious. I didn't go back to the class again as it was boring, but also because I felt everyone knew there was something different about me because of the way my support worker treated me.

It seems essential to provide a balance which offers ability-appropriate tuition and encouragement alongside a sensitivity to the possibility that some individuals may require greater levels of support than others, on one day more than another, or with certain types of task. While instances of criticism were rare, the problems raised tended to be grouped around sessions where the coach:

- Did not help motivate the individual to improve their skills
- Treated participants as if they had no skills
- Gave insufficient information to help participants move on
- Was perceived to hold low expectations regarding people with mental health problems
- Was perceived to act as if group members had physical disabilities
- Overly controlled sessions

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Individual Life Context

While separate strands of experience can be deduced from the data (as above), it is a more holistic understanding which takes into account each individual's life context that is most revealing of the delicate and subtle interplays which shape the way BALP is experienced. What a particular individual *needs* can be understood as a unique 'fingerprint' shaped by factors such as personal biography, life experiences, symptoms, difficulties, abilities and aspirations. While certain themes may recur across different lives, the interaction of these themes differs from person to person. As a result, there is no standard 'recipe' or format that can be prescribed for how an activity group should be run because what is required will depend on the unique needs of the particular group member. In practice, this means that successful provision is always a delicate task that takes into account each individual's needs and preferences.

One female member of gym and badminton groups shared this description of the challenges she faces in attending an activity session:

> If you got your PC out and ran like, fourteen web searches, and eight lots of Photoshop and Word for Windows, it would gradually crank to a halt. And that's exactly what going to the gym is like for me. It's like, putting myself in a position of vulnerability, having to meet lots of new things, people that aren't necessarily predictable, I can't always say who's going to be there, or who's not going to be there. And that's aside to any other symptoms I have. I have problems of people controlling me, and so I have to do a lot of CBT around that in order to be able to cope with the fact that it's a coached session. And, you know, it's, people think, 'Oh! It's just a badminton session!' But it's not, there's a hell of a lot more to deal with.

While this description powerfully portrays the significant challenges service users can face in attending activity groups, it also highlights the person-specific nature of those challenges.

Feedback from some group members pointed to the benefit of 'women-only' groups and/or 'closed' groups. For example:

> I find the BALP yoga class a good space to be in … for a variety of reasons: I feel comfortable because it is women only, but more importantly because it is exclusively for people with mental health problems. This one is crucial for me. I know that AWP has been forcing many service users to go to 'mainstream' classes in the misguided notion that it's somehow 'social inclusion'. I have attended many 'mainstream' classes in the past and this has invariably left me feeling 'the odd one out.' I have had to avoid conversations with other people going to the class as they inevitably ask 'what do you do?'. If I say that I'm not employed, they want to know why. This leaves me feeling uncomfortable. I feel unable to state that I have mental health problems because of the stigma and discrimination which I know, from bitter experience, will follow. The yoga class is perfect as none of us have to pretend. We can be ourselves and feel safe that we are with other service users who will know, understand and empathise with any difficulties we are experiencing. Mental health problems are difficult enough to live with without feeling that we have to put on an act in order to fit in with other people's ignorance and prejudice. I fail to understand why other marginalised groups are allowed to meet, but when it comes to mental ill-health we are expected to be thrown into any situation which can make us feel as if we don't belong or have to conceal who we really are.

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In this account, several positive aspects of BALP groups are voiced. Yet it is important to note this woman's attendance is dependent on the unique qualities of specialist ('closed') sessions. Similar qualities are raised in the following excerpt from a letter (sent to the Physical Activity Development Officer) in which a Community Specialist Practitioner/Mental Health Nurse on the Early Intervention in Psychosis team speaks of the changes observed in one individual:

> I am writing to you because I would like to feedback that the Bristol Active Life Project has been an integral part of [name]'s recovery from first episode psychosis. [Name]'s confidence has increased in social situations and he is more able to catch buses to and from places. This has been partly due to attending BALP football sessions where the environment is open, friendly, supportive and welcoming. [Name] is now playing football for a local team which demonstrates that BALP has been a positive stepping stone in his recovery.

This suggests that, through providing personally meaningful benefits, involvement in BALP has—for this individual—played a valuable part in recovery. While it is beyond the scope of this chapter to explore how this might be the case, the possibility raises a significant and important point. In our research [18], involvement in sport and/or exercise was indeed considered by some individuals to be important in their journey towards recovery from SMI. Based on the feedback we have received from BALP participants, this possibility seems very much alive and, therefore, a major and important contribution of BALP to the lives of many people with mental health problems.

Future Work

At present, BALP is continuing to run a timetable of activities at four leisure centres around Bristol. In partnership with PUMA Martial Arts, Knowle Lawn Tennis Club and Great Western Runners, BALP now provides access to mainstream activities. New initiatives being trialled are: (1) a mentoring scheme to support participants travelling to and from sessions and help with integration, (2) a 'gym buddy' scheme, to provide participants with guidance and support for structured exercise in the gym, (3) promotion of volunteering opportunities, with support, training and mentoring of volunteers. Funding is currently uncertain.

Lessons Learnt

1. The value of activity provision
   Over 6 years, BALP has proved to be a highly successful intervention that makes valued activity opportunities available for people with considerable need, at reasonable cost. Service users consistently described the experiences BALP offered as personally meaningful and beneficial for their mental health and their lives generally. BALP has demonstrated the long-term benefits and sustainability of a citywide physical activity programme

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targeted at people with mental health problems. A critical goal of future programmes is to preserve the qualities of BALP. The supportive social ethos, high-quality coaching and leadership and the availability of diverse activities through a single point of contact are three key qualities. These qualities should be at the centre of future activity programmes for people with SMI.

2. The challenging journey from referral to attendance
   Moving from referral to regular attendance is challenging for many people with mental health difficulties. Finding ways to support individuals through this journey is critical.[1] A minority of coaches and partners assume that some service users lack motivation or are 'not trying hard enough' to get to sessions. This view stems from an inadequate appreciation of the challenges many service users face. A more informed response is to understand the barriers many clients face. Partners described, for example, the social anxiety that clients may experience when facing a new activity, new people and/or unfamiliar places. Negotiating this, they felt, necessitated intensive personal support. Developing trusting relationships—built around sustained personal contact—is critical in the journey from referral to attendance. An additional difficulty moving from referral to participation is cost. Fifty percent of BALP participants have a disability—many have low fixed incomes. On-going reductions of state benefits are a major concern and are likely to adversely impact participation.
3. Provision for women
   BALP successfully increased participation among women by listening to what women wanted from the sessions (e.g. women-only sessions and new activities such as dance, aerobics and yoga). When attempting to encourage activity among women it is important to remember that many women had poor sport and physical activity experiences at school. Past memories of school sport are difficult to erase. Partner agencies flagged up the high number of female clients who have been sexually or physically abused. Given that most coaches are male, we should not be surprised when some women do not attend a session, regardless of how much they may wish to. Here again, the importance of a trusting coach-client relationship is critical. It is sometimes necessary to take a step backwards and recognise the first step for many people is not the sport or activity, but a cup of coffee and a chat in a familiar environment. For some coaches this strategy may feel too passive. Yet there is evidence that for many women, and some men too, this type of strategy will be productive long-term.
4. Educational provision for coaches and leaders
   Given the importance of quality coaching/leadership and the coach–client relationship, education and development of coaches/leaders is paramount.

[1] For guidance see Carless and Douglas [22].

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This should focus not only on the technical knowledge and skills necessary to coach a particular sport/activity, but also mental health awareness raising and education to encourage and support coaches and leaders in developing a sensitive and person-focused orientation. In our experience, this kind of understanding and awareness is best achieved through intensive exposure to, and reflection on, the experiences, needs and challenges faced by diverse client groups.

5. Support for families and carers
   Recent research suggests greater attention should be focused on supporting carers. The feedback we have received from carers of BALP participants shows family members appreciate the respite BALP provides. The use of 'buddies' as volunteers who are empowered to support service user participation has been particularly successful. Future initiatives might also consider how family members and carers can be included in ways that support not only the service user, but carers too.

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Chapter 8
Football 4 Peace: An Activity-Based Community Relations and Reconciliation Initiative

Graham Spacey and Jack Sugden

Background

The need for effective conflict resolution strategies has increased since the end of the cold war, with the emergence of numerous regional and sub-regional conflicts around the world.

The transition from conflict towards negotiation, cessation of violence and peaceful resolution is complex and occurs across several levels, including resolution, reconciliation and reconstruction [1], with the process often starting at the top with politicians. Such decisions, however, are not often made without input and pressure from important political constituencies both locally and internationally, which often express themselves through unifying public opinion into favouring a resolution to conflict. 'This support does not happen instantly but usually comes after an issue has been brought up, fought for and deliberated in various forums, including NGOs dedicated to the cause of peace and conflict resolution' [2, p. 8].

Traditional approaches to peace tend to focus on state-level solutions, excluding the people on behalf of whom peace is being sought and ignoring the power that populations have to make or break the peace process [3]. Attention is focused on tackling direct violence rather than its structural and cultural causes [1] and fails to answer the question of 'what is needed to sustain a constructive process?' [4, p. 66].

The increase in discourse on peacebuilding has led to an emerging widespread agreement amongst scholars and practitioners that 'effective and sustainable peace-making processes must be based not merely on the manipulation of peace agreements made by elites, but more importantly on the empowerment of local

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communities torn apart by war to build peace from below, targeting those who have lived and known conflict first hand within an environment in which hatred is most salient' [5, p. 215].

With this in mind, there are conflicts that are recognised as fundamentally irresolvable and where 'transformation' is preferable to 'resolution'. Lederrach [4, p. 26] states that:

> the challenge is one of how to build and maintain the house of peace… reconciliation is not pursued by seeking innovative ways to disengage or minimise the conflicting groups' afflictions but instead is built on mechanisms that engage the sides of the conflict with each other as human beings.

This is often termed as 'coexistence' and is built upon the establishment of structures, processes and the training of people over a generational time frame. Rather than following a 'melting pot' thesis, the aim of this approach is to bring people together to achieve something alongside each other.

Sport, in all its forms, has been described as an international language bringing people together to overcome cultural differences, awakening hope and spreading an atmosphere of tolerance [6–8] Its power comes from its popularity and many large sporting organisations claim sport's holistic qualities as their own in a demonstration of corporate social responsibility. The International Olympic Committee, however, has taken a cautious approach, stating that '*Sport alone cannot enforce peace. Sport alone cannot maintain peace*' [9]. Sport is one cultural forum which forms part of a massive, multidimensional jigsaw puzzle in order for sustainable peace to be achieved. Specific grass roots, civil society, interventions must be coupled with more broadly influential policy communities and those elements of political society that hold the keys to peace [3, p. 20].

In the following sections we hope to outline how Football 4 Peace International (F4P) has attempted to meet the challenges in using sport for peace and reconciliation and demonstrate how the initiative is being adapted and utilised in various contexts and countries, including Israel, Jordan and Ireland.

Aims of the Project

Since 2001, the University of Brighton have been operating a pioneering sport-based peace project named F4P (Figs. 8.1 and 8.2). The key emphasis of F4P is the teaching and practical application of values—most notably neutrality; equity & inclusion; respect; trust; responsibility. These values are designed to help to resolve conflict and promote community reconciliation among young people through sport-related activities and elements of outdoor education [10]. Its aims are adapted for each place and space but its overarching objectives are fourfold:

1. Provide opportunities for social contact across community boundaries
2. Promote mutual understanding

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Fig. 8.1 Children participating in the F4P programme



Fig. 8.2 Children participating in the F4P programme

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3. Engender in participants a desire for and commitment to peaceful coexistence
4. Enhance sport-related skills and technical knowledge

How the Project Was Set Up

F4P was established in 2001 as 'The World Sports Peace Project' under the direction of a retired Baptist Minister, Rev. Geoffrey Whitfield and has its founding in Israel. The initial task of the initiative was to simply provide an opportunity for Arab, Jewish, Druze and Circassia children living within the internationally recognised borders of Israel to meet and participate together in mixed teams and groups [11]. Over the following years, it grew in size and structure, influencing similar work in other places and spaces across the world. For example, in 2010, a programme was launched in Jordan with scouting groups centred in and around the City of Irbid in the North West of the country.

Partners with local knowledge have been integral to the initiative's development and it is this understanding which has influenced how the methodology and curriculum have been developed.

The programme follows a unique values-based coaching methodology which uses a holistic model of coaching whereby participants intrinsically learn fair play, good relations and citizenship through sport. Spiritual, moral, social and cultural development is learnt through the physical [10]—learning by doing and following the example set by positive role models in the form of trained coaches, teachers, local youth/community workers and volunteers. These individuals are trained in the methodology alongside activities designed to develop leadership and mentoring skills in order for them to progress and, over time, develop skills and acquire experience to be able to train others within their own communities, creating sustainability.

Delivery of the Project

A specific 'on-pitch' and 'off-pitch' curriculum was developed to provide the opportunity for young people from different and divided communities to learn to play and work together so that distrust might be overcome and bridges built for understanding and appreciation of each other in peace. Following Lederach's theory on conflict transformation, by having children from different communities playing on the same team, the intention was to build trust and support, foster personal development, forge new friendships and encourage an appreciation of the skills and talents of others.

In tandem, a coaching development programme centred on an international training residential camp and focusing on peer to peer education was developed. Coaches charged with delivering the programme within their communities were trained in a

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neutral place overseas which would allow them to bond without the distractions of conflict around them. This allowed them to foster the behaviour and ideals they would ultimately be asking of the participants in their projects. Coaches were first trained in the methodology. Many were well respected within their communities and had a great deal of coaching experience already, so the emphasis was on understanding and applying the values-based methodology and demonstrating its differences and benefits in comparison to using traditional coaching methodologies.

Those with the potential, or who were tasked by their communities to lead projects, received 'tier two' leadership training. They were given the skills and knowledge to organise and run their own programmes and staff, and assisted in the training of others in the methodology.

With time, a few were trained as Mentors. These individuals had the ability to train and mentor coaches and leaders. They in turn ran 'cascade training' events in their communities supported by their mentees in a programme designed to train new coaches. These events were designed to build local capacity and were often bespoke and adapted to encompass the unique circumstances within those areas, to include different sports and activities, or to highlight and respect specific cultural and religious nuances and traditions, for instance Circassian culture or female participation.

Outcomes and Evaluation

Outcomes

The belief that joint sporting activities can contribute to community development between groups stems from research on regularly scheduled 'Sport for Development' programmes in the developing world. These projects have proven to be successful in promoting long-term cross-cultural understanding in societies as deeply divided as Bosnia and Herzegovina [12], Sierra Leone [13], Liberia [14], South Africa [15] and Northern Ireland [16].

F4P relies heavily on the contact hypothesis which states that intergroup contact can be effective in reducing negative intergroup stereotypes and mutual prejudices, provided that certain conditions are met The primary conditions for effective intergroup contact are [17, p. 117]:

1. Equal status of both groups in the contact situation;
2. Ongoing personal interaction between individuals from both groups;
3. Cooperation in a situation of mutual dependence, in which members of both groups work together toward a common goal;
4. Institutional support—involvement and acquiescence of local authorities is evidential.

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Over its 12 year evolution the project has clearly been working to meet these requirements, and has succeeded in most aspects. At all levels equality and cooperation are certainly endemic throughout the work of the project, from the planning stages and training of volunteers and local leaders in the training camps to the coaching on the ground. To some extent this satisfies the need for ongoing personal interaction; however, this only takes place sporadically throughout the year; between the children on the ground in Israel it is generally non-existent outside of project time.

Essentially the project was about co-existence, which was integral to its success and the reason why so many people from different communities are enthusiastic about getting involved in its processes. However, in the case of Israel, F4P's real purpose now appears to have been about contributing to the general civic project in addressing what co-founder, Professor John Sugden terms as the 'siege mentality' of Jewish-Israelis. The programme has made a small contribution to the necessary conditions of a civic democracy, as a possible precondition, or product of, peace at state level between Israel and an independent Palestinian state. Thus, sport is the hook for the children, whereas for local actors at the next level, working towards coexistence is the attraction. Whether all the local leaders are completely aware of these ideas behind the project, in terms of working towards a civic society, is unclear. This presents a problem as, according to Norton, [18, p. 278] '*uncertainty about the processes and overall goals of a peacebuilding mission risks unleashing a progressively worsening 'imposition-ownership-divide*'. F4P is not overly vocal about its support for radical change and neither does it attack societal inequalities head-on, but by preaching the core values of respect, responsibility, trust, equity and inclusion on the pitch, field and court, the idea is that the children and coaches are exposed to different ideas about how to perceive/treat the other group, which could extend beyond the project.

Whether this happens or not is difficult to measure. The children's attitudes towards each other certainly progress throughout their time within the initiative and the demeanour of the local coaches and volunteers also appears to alter for the better. Community relationships from continued involvement in the projects, year after year, do appear to grow stronger and this is evident via participant observation, yet it is difficult to evidence as how does one measure a change of heart? In regard to its work in Israel in physical terms, F4P began life there in 2001 with one community and 100 children; by 2012, it involved 46 communities and 1500+ children in 14 different Cross Community Sport Partnerships (CCSP), including one for females only.

Evaluation

There has been extensive research on F4P over the years and various papers, dissertations and books have been published by various academics and students at Masters and Doctoral levels. These have focused on the impact on the children participating in CCSP projects; curriculum development; volunteer coaches' experiences; political challenges; cultural challenges; practical challenges; motivation; and theoretical concepts and methods of evaluating the work [19].

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Formal monitoring and evaluation has run alongside this research. F4P programmes have been monitored and evaluated in different ways and no one method has been used throughout. This is usually because each programme is unique and what is being monitored and evaluated in one is not necessarily what is needed in another. Different partners and funders required specific information for their own reporting and the role of one partner at times was limited to one aspect such as delivering training, recruiting communities, mentoring or supplying volunteers; therefore, harmonisation and standardisation were not always feasible.

The 'Playing for Peace' action was one element of F4P Israel and F4P Jordan from 2009 to 2012 and was designed to enhance and grow existing work through the training of new coaches and recruitment of new communities. Funded by the European Union there was extensive monitoring, reporting and auditing of both the work on the ground and the finances and relationships between the partners behind the scenes. Whilst much of the design of the action fitted well around the existing work there were elements that were made to meet the criteria outlined by the EU. This created some issues as one partner was chosen over another to 'lead' because others were not eligible to as they were either governmental or were domiciled outside of Israel. The action had little consideration for adaptability and existing partner arrangements, with roles swapped and others made which did not necessarily match the skills and expertise of individuals working on the programme or the organisations they worked for.

The partners, however, also had varying extents of interest on what and how to report to the EU. Some were disengaged from the whole process, whilst there was fear by some that any failure or negative evaluation would impact on any possible future funding. The partner who set the objectives at the start of the process passed the role of monitoring and evaluation to another partner who passed it onto the University of Brighton after their staff changes and priorities and level of commitment towards the action changed. Whilst the action was a success in terms of its positive impact on the communities involved, reporting to the EU was more about finance, facts, figures and lists and the evaluation of monitoring reports by project leaders failed to directly answer all the original objectives, despite producing a great wealth of information to develop the programme further and the action itself changing throughout the 3 years. Fortunately, a multi-method approach had been adopted for the academic research by the University of Brighton on several aspects of the overall initiative. Through the established feedback forums and monitoring/evaluation forms, some additional questionnaires and interviews by academics, evidence could be found for each objective.

There have been more harmonious arrangements. The evaluation method adopted in F4P Ireland was developed in collaboration with 'Cooperation for Ireland' and was deemed as an '*appropriate way to monitor the impact of any similar programme in the future*' by the Justice Associates [20] in their independent evaluation in 2011. The main element of the method is pre- and post-programme surveys. Statements relating to sport, equality and diversity and the prospect and experience of contact with different people were devised. Respondents were invited to agree or disagree with each statement. The extent of agreement or disagreement with the statements

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would represent the attitudes or feelings of the children completing the surveys. Any change in the attitudes expressed between the pre- and post-programme surveys would be likely to reflect the impact of the programme. This was confirmed in the 2008–2011 cycle where there were improvements from baseline to post-intervention scores in all statements but one.

F4P has sought to include qualitative as well as quantitative data, as much of the work depends on people's hearts, minds and opinions, which are very difficult to measure. Questionnaires were also administered to participating teachers, club coaches and programme coaches in Ireland to gauge their thoughts and views as well. Teachers from Special Educational Needs (SEN) Schools from both sides of the Irish divide stated that pupils have started to develop life skills and identify opportunities to make friends outside of the class environment. The programme has positively changed their behaviour and interactions with others. The statements by the SEN teachers involved in F4P Ireland are similar to those made by their contemporaries in England, Israel and Jordan. It is this extensive academic enquiry across all programmes that has not only helped F4P develop and enhance its curriculum and methodology but also prove its success and adaptability.

Future Work

The F4P programme in Israel has provided a tried and tested formula that has been adapted to a range of circumstances in other places and spaces.

In March 2013, following a tradition of holding training camps for its volunteers, F4P ran a week long training camp in Derry/Londonderry, Northern Ireland [21]. The workshop doubled as the annual training event for the F4P Ireland programme as well as a demonstration event to various interested parties. The intention was to exhibit the impact the methodology could have for possible interested stakeholders as well as introduce further sports into the training mix. Participants gained the skills to develop and adapt what they had learnt during the programme to multiple sports in multiple contexts.

There were 116 participants mostly from Ireland/Northern Ireland with a large number of guests from England, France, Germany, USA, Cyprus, Columbia and South Africa. Significant numbers enrolled on sport and physical education-related courses from the University of Brighton, University of Ulster and University of Johannesburg who attended. Non-governmental organisations and governing bodies took part and sent delegates or observers including: Peace and Sport; Coaching for Hope; Streetfootballworld; Commonwealth Youth Exchange Council; Irish Football Association; Ulster Hockey; Ulster Boxing Council and the Gaelic Athletics Association. The event was visited by President Michael D Higgins of the Republic of Ireland on his state visit to the city who praised the work of F4P, stating: 'We need groups from all religious and cultural backgrounds to build vibrant societies based on the principles of equality, respect for diversity and an openness to work in solidarity with other communities'.

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In the United Kingdom, schools and colleges regularly visit the University of Brighton to experience F4P activities and festivals, and participate in team building or leadership training days where young people experience the values-based curriculum. Often the work is not named Football 4 Peace but the values-based approach has become an underlying ethos within physical education teacher training and coach education at the University and demand in terms of participation from schools and training by students has grown year on year. Some have begun using the values-based teaching methodology as a pedagogical model in order to deliver cross-curricular teaching through thematic teaching and learning with Humanities, Geography and Citizenship as well as dealing with whole school issues [21]. Led by Physical Education Teacher, Joanna Gardiner, Helenswood School for Girls in Hastings use elements of the methodology within their Physical Education curriculum. During inter-house sport events, pupils who demonstrate the values are rewarded by teachers. Bishop Bell School in Eastbourne take their new intake of Year 7 pupils off timetable so they can spend the day experiencing F4P activities. Physical Education teacher Annie Murray leads the programme within the school which understands the potential it has to foster positive relationships between pupils. As in most secondary schools, the children arrive at Bishop Bell from a number of smaller primary feeder schools. The children have to make friends as well as adapting to the new school environment and the day is seen as a way of giving them the tools to do this earlier on. The F4P day is part of a wider scheme at Bishop Bell to help children adjust and to tackle bullying which now runs annually. Both schools value the programme as the activities help to bond and motivate the pupils as well as giving them a 'physical' experience of the values.

The University of Brighton are also using the methodology within Higher Education. In partnership with the Justin Campaign in 2012 a successful pilot adaption of the 'F4P Festival' was used to promote awareness of, and tackling, homophobia within football to students. The organisation regularly ran a sport plus model where 'football tournaments' would get people involved and then learn about the cause. The new model has an emphasis on celebration rather than competition and much of the 'learning' takes place in and around the game on the field in a structure that is designed to heighten positive interaction between teams. The festival is different and possibly unique to conventional football tournaments in that its format emphasises the core values of the F4P curriculum without de-emphasising competition whilst simultaneously raising awareness of the cause. Teams are encouraged to: interact and swap players; wear fancy dress; self-referee; self-substitute; be of mixed gender and ability. Music is played and in between games or substitutions, players are asked to make comments and statements about their feelings towards homophobia, biphobia and transphobia in sport.

Sports clubs and local councils too are seeing the benefits of the values-based approach. In 2012 children from the town of Eastbourne in England took part in a pilot Football 4 Peace Coaching Camp in conjunction with Eastbourne Town Football Club. The event was backed by Eastbourne Borough Council and the National Health Service. The camp was aimed at not only developing and instilling the values within children but also: promoting health awareness and active, healthy

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lifestyles; developing communication skills; enhancing interaction; breaking down inhibitions; promoting cooperation and sharing. Parents reported changes in attitudes and higher motivation to participate in other activities. The 2013 event was supported by the local Member of Parliament, Steven Lloyd, who said 'In a town like Eastbourne it's great for young kids to be given the opportunity to learn life skills—ethics, responsibility and respect; but doing it in a fun way around football and I think that's really, really important'.

Outside of Europe, a partnership with the University of Johannesburg is forming. Manuals for both primary and secondary schools have been developed based on the values-based approach in indigenous African sports and games [22]. The manuals are expected to be formally adopted in state schools across South Africa and are also widely used in Namibia, Zambia and Lesotho.

The focus of F4P is now on developing bespoke and general training resources and workshops for individuals, groups and governing bodies with a view to issuing recognised qualifications/formal accreditation in the future. The emphasis will be on giving others the necessary skills to use the methodology within their own existing work as well as creating opportunities for trained coaches to volunteer and gain experience in other settings through internships to help enrich their own work and programmes. This is a more sustainable model and will help to disseminate the methodology and enrich the sport for development and peace sector.

Lessons Learnt

F4P continues to makes grass-roots interventions into the sport cultures of the places and spaces in which it has been adopted while at the same time making a contribution to political debates and policy development around physical education, sport and outdoor education. Due to its growth and popularity, F4P has attracted interest from officials from other societies plagued by ethno-religious division. In addition to those attending the Irish international training camp in 2013, the project has had delegates from Somalia, Estonia, Greece, the Philippines and Cyprus attending past events in order to learn from the programme with the possibility of employing it at home. The programme, however, is not a one-size-fits-all model—it must be adapted to local contexts and frameworks. What is universal is the coaching methodology which can be applicable in most contexts almost anywhere with minimal resources.

In the past, peacebuilding efforts have been criticised for their tendency to produce a 'pile of peacebuilding stones rather than a sustainable peace' [23, p. 9]. The focus on practices which work as satellites to the various projects and take place at different times of year is positive in terms of developing cross-community contacts with sustainability in mind. This correlates with organic peacebuilding theory which champions local ownership in the quest for sustainability. The holy grail of modern peacebuilding, this is the process

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and final outcome of the gradual transfer to legitimate representatives of the local society, of assessment planning, decision making and control of phases of the peacebuilding process, with the aim of making external peace and state building assistance redundant [18, p. 254].

To a lesser extent, facilitating ownership and sustainability of the project by its stakeholders is central to its work, co—founder Dr. Gary Stidder emphasising how the long-term goal in Israel was to 'make ourselves redundant' [11, p. A6] In 2011 the question was, after 11 years in Israel, how much closer was F4P to achieving that goal? There was some deliberation between those facilitating the work on the ground as former Israeli football international and volunteer Ali Ottman implied. When asked whether the projects would work without the help of the EU coaches he replied decisively: 'No… without the European coaches getting Jewish and Arab kids here together would be hard.'

In terms of progression, the furthest F4P and projects like it can go is through facilitating: facilitating ownership of the process, cooperation between communities and handing over the tools and knowledge so that local actors can contribute towards an equality-based civic society. More generally, civil society organisations have limited access to track one tools such as coercive diplomacy; they can point to the carrot but are unable to heft the stick needed to guide non-progressive government towards concessions in favour of a pragmatic solution [23]. This is a major critique of civil society intervention and peacebuilding, as often efforts lack formal linkages to track one actors and rely on the 'ripple effect' model of effecting change at state level which is often deemed as insufficient www.football4peace.eu. Here F4P is no different, regarding the involvement of the Israeli Sports Authority, which although fuelling accusations of F4P being linked to normalisation, has increased over time. This was a positive development and key to F4P's work, when as Prof. John Sugden says: 'Ten years ago it was doing nothing for community relations' [11, p. A4] Furthermore such a wide base of local volunteers and participants also sends a message in terms of the belief in coexistence. This is however, the extent to which F4P and CSOs like it can really have an effect on policy.

As of 2013, F4P Jordan continues as a recognised non-governmental organisation named the 'Irbid Centre for Football Training'. The programme in Israel continues across the country as 'Sport 4 Life' led by the Israel Sport Authority. A governing panel is made up of key figures from the local community and, as in Ireland, has expanded the work into other sports and activities. Whilst there is involvement from those overseas to help with the interventions and to continue mentoring and training, the locals themselves have full ownership over the programme. Indeed, a change of heart is difficult to measure; however, the growth in participants and the successful 'handover' at all levels is certainly testament to the model's success within the volatile context of Israel/Palestine.

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Chapter 9
Resilience Enhancing Program for Youth Survivors of the Beslan School Hostage-Taking

Stefan Vetter

Background

Posttraumatic stress disorder (PTSD) is a highly prevalent disorder (lifetime prevalence range, 7.8–14 %), frequently co-occurring with depression [1]. Estimates suggest that 42–48 % of patients with PTSD also have a major depressive disorder (MDD) [2]. Furthermore, PTSD is just as highly associated with the development of other comorbid psychiatric disorders, addiction, dysfunctional health behavior, escalated levels of psychosocial disabilities, somatic complications, and frequent utilization of healthcare resources [3–5]. Despite the availability of evidence-based treatments, such as selective serotonin reuptake inhibitors as well as cognitive-behavioral therapy, outcomes feature just modest degrees of improvement, with more than 50 % of patients remaining refractory to treatment for MDD or PTSD [1].

The Beslan school hostage-taking (also known as the Beslan siege) began on 1 September 2004 when armed Chechen separatists took more than 1200 school children and adults hostage at School Number One in the town of Beslan in the Russian republic of North Ossetia. The siege left 331 people dead, including 186 children, and more than 700 people were injured.

Following the Beslan school hostage-taking, in addition to psychiatric and psychotherapeutic treatments, a number of psychosocial programs, under the auspices of the North Ossetian Ministry of Education, were offered to the child and youth survivors by staff of the local psychosocial education center "Doverie." As anticipated, 2 years later, in spite of the wide range of therapeutic and psychosocial programs offered, a substantial quota of treated child and youth hostages remained psychologically and socially impaired, having a major impact on school performance

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and professional training. Following a systematic assessment of these impairments by teachers, a resilience enhancing program was designed as a second-line psychosocial and therapeutic intervention, realized, monitored, and evaluated.

Aims of the Project

The primary goal of the project was to offer an add-on intervention module for all children and youth hostages who were still suffering from psychological and functional impairments 2 years after the hostage-taking. Therapy refractory, comorbid mental health problems are mainly perpetuated by a perceived absence of control over the outcome of a situation (learned helplessness) [6], self-handicapping strategies in response to non-contingent success [7], and attributional biases (a sort of social cognitive bias that refers to systematic errors during evaluation of possible reasons for their own and others' behaviors) [8]. With children and young people, very often their family members' behavior may have a substantial sustaining influence either on their recovery or their continuous malfunctioning with regard to mental problems [9]. So it seemed to make sense to take these children and young people for a short time out of the family setting and to allow them to benefit from totally different social surroundings.

On this basis, we decided to offer weekly camps during official school holidays, so that nobody would miss any school lessons. In order to prevent additional regressive and destructive psychological effects on our target group, we opted against a mere mental healthcare perspective with trauma-focused interventions. This might have become a sort of self-fulfilling prophecy, blocking any recovery. Therefore, we selected resilience enhancement and development as the basis for our intervention. We hypothesized that the young people would benefit from enhancement of their emotional, mental, and social capacities to overcome the adversities they faced. Research has shown that building resilience among survivors of high-risk environments can help develop and maintain: social competence, empathy, caring, problem-solving skills, critical and creative thinking, task mastery, and a sense of purpose and social connectedness [10]. Problem-solving skills are a particularly strong predictor of improved resilience in children and young people in the long-term, as improved problem-solving skills can enhance the possibility that future life challenges will be resolved successfully [11–15].

Conceptually, our program was based on the developmental psychology perspective of resilience, first conceptualized by Luthar [16–20]. The basic definition of resilience is: "A dynamic process encompassing positive adaptation within the context of significant adversity. Implicit within this notion are two critical conditions: first, an exposure to significant threat or severe adversity, and secondly an achievement of positive adaptation despite major assaults on the developmental process" [16, 21]. Past research on psychological resilience has identified four key protective factors that can contribute to the development, support, and sustaining of resilience processes in children and young people; they are: (a) healthy attachments

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to related and unrelated older adults who provide them with support, encouragement, and guidance; (b) healthy and connected peer relationships; (c) effective problem-solving skills and coping strategies; and (d) community involvement, in support of the common good [15, 22–25]. These protective factors are interactive with resilience factors, as both help develop, and can later help sustain, resilience processes and trajectories [11].

Our goal was to design a program that incorporated these four protective factors for enhancing the development of resilience processes and to add some cognitive-behavioral elements to cope with learned helplessness, self-handicapping strategies and social biases. The approach was to combine sport activities and safety training with integrated, but hidden, therapeutic rehabilitation activities in a group setting. Specifically, the program provided: (a) medical first aid, cardiopulmonary resuscitation (CPR), and lifesaving rescue techniques; (b) mountaineering and survival skills training; (c) alpine sport activities, such as skiing, climbing, and alpine hiking; and (d) informal arts, play and supportive discussion groups. The last element was primarily designed to offer participants assistance in sorting out emotions provoked by other program activities. These sessions were informal and primarily supportive in focus, with no special training offered to the therapists and no particular therapeutic approach or intervention emphasized. Individual support was administered in cases where a child's behavior suggested that the daytime or evening activities provoked exacerbation of psychopathology. Psychologists then addressed the children's experiences and emotions within the group.

It was anticipated that each of the listed components would foster resilience via multiple mechanisms. For example, the physical activities in the mountain wilderness were expected to build internal resilience though boosting confidence, supporting the experience of positive emotions, improving somatic health, and encouraging a climate of solidarity, both with peer participants and adult leaders. It is important to note that the actual outdoor activities and training were conducted by rescuers (emergency medical technicians and professional mountain guides) from the North Ossetian Search and Rescue Services, a department of the Russian Federal Ministry for Emergencies. All participating rescuers were professionals who had been involved in the liberation of hostages, and were thus considered as heroes by participants. All psychosocial therapists and psychologists were locals with university degrees and all attended specific courses for psycho-traumatology prior to participating in the camp. We then opened the camps to healthy and well-functioning children and young people, matched in age and gender. These integrated healthy peers and adults served as social role models. Last, but not least, mountains are a good location to be confronted with fears and anxiety. Comparable medical first aid and cardiopulmonary resuscitation training were strong triggers for hostage survivors to re-experience the traumatic event, learning to stand and not to avoid the situation and acquiring at the same time effective coping mechanisms, being empowered by their new skills to help any injured victims in the future. This also erased lingering feelings of guilt at having survived the tragedy and not having helped their deceased friends and family members enough.

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How the Project Was Set Up

For 3 years following the Beslan school hostage-taking, the Swiss Department of Development and Cooperation (SDC) fully financed a number of psychosocial programs under the auspices of the North Ossetian Ministry of Education. Already in December 2004 a fully functioning psychosocial center was operational and offered sports and play interventions for all children and young people of Beslan in individual or group settings, supplemented by counseling for parents. It included close cooperation with local schools, teachers, mental health professionals, hospitals, and the North Ossetian State Medical Academy, becoming a knowledge exchange platform and offering educational courses for professionals under the auspices of the North Ossetian Ministry of Health, which were accredited for professional recertification. Last, but not least, the North Ossetian Institute of Humanitarian and Social Research was helping to scientifically monitor the majority of these programs together with the Centre of Disaster and Military Psychiatry, University of Zurich, Switzerland. Local public health and social support systems were empowered by using only local professionals, involving them in drafting the program and training them according to the needs of the program. This created new jobs instead of letting them vanish and meant that all interventions could be applied on a medium- to long-term basis without any cultural or language barriers.

The idea of resilience enhancement camps was born during one of the regular staff meetings when the problem of therapy refractory disorders had been repeatedly a key topic. Due to our already long on-site activities and well-set-up network, it was rather simple to get fast access to local decision makers and to convince them of an add-on program. Because we wanted to have the ideal role models as trainers we recruited rescuers (emergency medical technicians and professional mountain guides) for the actual outdoor activities and training sessions from within the North Ossetian Search and Rescue Services, a department of the Russian Federal Ministry for Emergencies. Quite close by, the community of Tsey, SDC already had a training center in the mountains, which was adapted without big efforts for our needs. Again in cooperation with the recruited specialists, the educational contents were developed and afterwards the necessary training material ordered, including a training doll for cardiopulmonary resuscitation, suitable for children, which was named later “Gosha.” At the same time, the scientists involved developed a monitoring program and prepared the file for ethical review.

Finally, it was very important to invest special efforts in public relations. Due to the continuous cooperation with local teachers and mental health professionals, they were at once ready to support the idea and to actively help with the recruitment of children and young people for the intervention camps. At the same time, many offers had been made from abroad for survivors to spend holidays somewhere overseas, which made it harder to make a local mountain camp attractive enough so that the target population would prefer it over a fancy trip abroad. To achieve a kind of exclusive selling point for our intervention, we were able to provide participants with certification in accordance with the official standards for medical rescue and

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first aid in the Russian Federation. Everyone passing the certification process received an official diploma and an official rescue service jacket, both of which accorded a degree of social status. As soon as this aspect became public, many children enlisted themselves for the camps. The hardest task was making contact with parents and convincing them to let their offspring participate in the program. The North Ossetian Mountains are quite infamous for their stone and snow avalanches, as well as vicious torrents after storms. Secondly, many of the parents were quite overprotective, out of an understandable fear that they may lose another child. But, after explaining personally the principles of the camp and what we tried to achieve, most of the parents agreed to let their children attend. The more camps there had been already, the easier recruitment was, due to very positive "word of mouth" publicity.

Delivery of the Project

Our 1-week mountain camps were designed for 20 participants, who were taken by bus to the mountain station Tsey, approximately a 2 h bus drive away from the city of Beslan. During the trip at least one psychosocial therapist and always one research psychologist were on board and made an initial assessment of each participant's level of resilience with a paper and pen version of the usual psychometric test. In the camp there were always two psychosocial therapists or psychologists, four to five rescue workers and one to two cooks on site. Each rescue worker was assigned to a group and these groups were competitive between each other.

In the morning, the first theoretical classes of medical first aid were held, followed by practical exercises till lunch. After lunch, the outdoors mountaineering and mountain rescue activities took place until dinner. After dinner there were recreational activities, play and discussion groups for all the children and young people. Having been engaged in about 10–12 h of activity most participants found it easy to fall fast sleep at night.

On the sixth day in the afternoon, there was first a final theoretical and practical exam to get the rescuer certificate. After some sports, there was an early dinner, shorter evening activities and early sleep. Just after midnight, the children were then woken up for a night exercise. The premise for the exercise was that two psychosocial therapists had carelessly left the camp, had an accident and fallen into a ravine, injuring themselves. Luckily one had her mobile phone with her and could call for help. Participants were divided into two groups and had to rescue the two casualties, organizing themselves, being observed and rated by their trainers. These rescue exercises took 3–4 h and when everyone was back at the camp a big early breakfast was served around open fires. After this, it was already time for packing and driving back to Beslan. During the journey back, a research psychologist retested each participant. Six months after returning home, all participants and their parents were visited by a research psychologist in order to conduct a third round of testing as well as interviews with their parents.

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Outcomes and Evaluation

Outcomes

An initial outcome of the program was the high level of satisfaction among participants, their parents and staff. Many parents were astounded by how changed and self-confident the participants were already on their return. Dysfunctional children were much more active and engaged more easily in social interactions.

To evaluate our program we used a longitudinal study design with measures at three points in time. Resilience was measured with the Connor-Davidson Resilience Scale (CD-RISC), one of the few scales created to exclusively measure resilience [10, 26]. We translated the scale into Russian, then back to English, and validated it before using it with our camp participants. Our four objectives for the data analysis were: (a) to describe the sample; (b) to compare cross-sectional resilience scores, at baseline and follow-up assessments, by age, gender, and hostage status; (c) to analyze the effect of the intervention on within-participant changes in CD-RISC scores and to explore variation in the intervention effect by the extent of reported direct and indirect trauma experiences from the school tragedy; and (d) to test the reliability of the CD-RISC in our sample.

Our findings indicated that the program intervention had a measurable effect on subsequent self-reported resilience levels within individuals. The average sample member reported statistically significant increases in resilience from the baseline value, at both the end of the 1-week intervention and at 6-month follow-up. Former hostages had lower resilience scores than non-hostages at baseline and immediately after the program; but hostages experienced greater gains in resilience than non-hostages 6 months after the program's completion and reached a level very close to that of non-hostages at baseline. Participants with high losses and injuries had significantly lower resilience than those in the lowest categories at the baseline measure, but reported greater increases in resilience from the baseline to the second follow-up. Last, but not least, effect sizes (d) from the start of the program to follow-up were $d=0.23$ for hostages and $d=0.32$ for non-hostages. At our final 6-month follow-up, the effect size between baseline and third measurement increased for hostages to $d=0.45$ whereas the effect size for non-hostages was just $d=0.09$.

Evaluation

From the outset, we monitored all subprograms running in Northern Ossetia. Our detailed findings and conclusion were published in the peer-reviewed journal, Child and Adolescent Psychiatry and Mental Health [27]. Although field research with traumatized populations always bears some limitations from the perspective of scientific methodology, we were able to show a positive effect of our intervention camps. The effect size for changes in resilience over time was after 1 week just

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small, but still positive—meaning that all participants had a little better resilience after the camp than before, probably due to a general effect you may often find in therapeutic groups just after the treatment cycle. Very promising were the effect sizes associated with 6-month follow-up, which suggest a medium effect of the overall program in our target group. The long-term effect among the matched peer participants suggests no long-term changes, but also indicated no negative or harmful influence. Striking in our results was that after 6 months our interventional target population showed CD-RISC scores very close to those of their peers. From reports of their parents and teachers all of them were able to improve a great deal, reaching more or less adequate levels of functioning for their age, and stayed continuously reintegrated in their peer groups.

Future Work

More such 1-week group interventions for therapy refractory individuals with PTSD should be offered and monitored in the future, especially because of their highly cost-efficient nature and likely effectiveness. Economical crisis restricted funding from 2009 onwards, so that all of the Swiss staff members involved in the program are now working in different areas of mental health. But all of us believe in what we have done and we would try to do anything possible to offer the benefit of our experience and expertise to public mental health systems, governments, and relief organizations wishing to set up and evaluate similar such programs.

Lessons Learnt

There is no reason why locally adapted intervention programs similar to ours could not be run anywhere. But we would not suggest simply replicating it like-for-like but rather to apply its principles and adapt it for the specific traumatic experience, local sociocultural settings, health beliefs and social networks. This cannot be done immediately after a critical incident but first needs a period of learning and understanding. We therefore prefer medium-term programs which enforce local public mental health systems to any immediate and short-term interventions offered from abroad. Reportedly our participants did much better than children who had been abroad and away from home, very often several times, as a result of such interventions. We would therefore advise everyone to accept guidance in recovery and empowerment models and to strengthen social networks on site rather than to weaken them in taking individuals out. Doing so might help these individuals but it may traumatize others at the same time. Let me finish this chapter by illustrating my last thought with a sentence from a mother with PTSD in Beslan: “First the terrorists took my daughter away; and now I lost somehow my son, my last child, to programs abroad, being away for more than 6 months now.”

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Chapter 10
Rotary International's Kick Polio Out of Africa Campaign

June Webber and Chris Skinner

Background

PolioPlus

In 1985, Rotary International, one of the largest non-profit service organizations in the world, with over 1.2 million members working in 30,100 Clubs in more than 160 countries, created PolioPlus—a programme to immunize all the world's children against polio by 2005—Rotary's centennial.

To date, the PolioPlus programme has now committed over one billion US dollars to the protection of more than two billion children in 122 countries. For as little as 60 cents a child can be protected against the virus for life. These funds are providing much needed polio vaccine, operational support, medical personnel, laboratory equipment and educational materials for health workers and parents. With its community-based network worldwide, Rotary is the volunteer arm of the Global Polio Eradication Initiative. Rotary volunteers assist in vaccine delivery, social mobilization, and logistical help in cooperation with national health ministries, the World Health Organization (WHO), UNICEF, and the US Centers for Disease Control and Prevention. Recently the Bill & Melinda Gates Foundation provided grants totaling US$405 million to Rotary to assist in this programme. Rotary itself through its own fundraising efforts raised US$228 million.

Upwards of US$1 billion per year from all sources is needed in government and donor contributions to fund the final eradication phase, however. This level of

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expense is expected to decrease as wild poliovirus transmission is interrupted in the three remaining polio-endemic countries. Sadly recent terrorist attacks that have killed and wounded health workers and volunteers have prompted the Government of Pakistan to temporarily suspend their vaccination campaign. Likewise the immunization campaign in Northern Nigeria is also experiencing similar disruption—campaigns are continuing but some were delayed and the security situation continues to be monitored closely. Nigeria was the only country to experience more polio cases in 2012 than 2011.

Kick Polio Out of Africa Campaign

Former President of South Africa, Nelson Mandela, in his 1996 address at the Organization for African Unity Summit, originally kicked off the "Kick Polio out of Africa" (KPOA) campaign (Fig. 10.1), when he declared: "Only unified efforts which galvanize whole societies towards these goals will succeed in kicking this virus, that looks so much like a football, out of Africa and eventually out of the world."

As part of this initiative, and to coincide with the FIFA World Cup Soccer Tournament which was held in South Africa in 2010, Rotary International, through its Africa network of Clubs and Districts, launched a 4-month pan-African public awareness campaign to build support for the final push to Kick Polio out of the continent. The campaign focused on mobilizing parents to help with massive anti-polio drives in the Spring of 2010 which targeted over 100 million African children mainly under 5 years.



Fig. 10.1 KPOA logo

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At the heart of the campaign was a signed football which would traverse all the main countries in Africa affected by polio to highlight the programme and in turn gather the names of distinguished African personalities who were happy to identify themselves with the initiative.

Aims of the Project

The objective of the KPOA campaign was to contribute to Rotary's Global End Polio Now campaign by raising awareness and support for Rotary's polio eradication efforts. The campaign approach was twofold, to not only raise awareness in donor countries but also to mobilize communities in polio-affected countries. In particular it was designed to:

- Raise global awareness of the potential, the need and benefit of eradicating polio.
- Help mobilize parents of over 100 million children under the age of five for mass immunizations throughout Africa.
- Build momentum in the lead-up to the World Cup with football-related awareness events to mobilize the public.
- Motivate African Rotary members to hold local events to ensure parents vaccinate their children.
- Inform the public about what Rotary is and the work it is doing in the community.

How the Project Was Set Up

This was one of the most ambitious campaigns of its kind ever to be launched by Rotary International in support of a specific programme. It was both tactically and physically an organizer's nightmare! How does one send a soccer ball through 23 polio-affected countries in Africa in 4 months—with a maximum of 4 days between each stop? This was achieved thanks to the help, passion, and commitment of reputable freight company DHL Express, who provided their services free of charge.

Rotary International's infrastructure of National PolioPlus Committee Chairs throughout Africa, working in collaboration with their Reach Out to Africa Committee, Public Image and Rotary District leadership in 14 districts in Africa helped to coordinate mega community events, where government and health officials would publicly endorse their commitment to the campaign and sign the ball.

The media campaign was handled on three fronts, namely: national organizers in all 23 countries through which the ball was to be shipped; a main coordinator in Cape Town who masterminded the whole campaign; and a team from Rotary International at its headquarters in Evanston, USA who provided logistical support and media outreach throughout the campaign and in follow-up programmes.

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Delivery of the Project

The campaign was launched in Cape Town on February 23, Rotary's birthday, at the prestigious V&A Waterfront complex with the symbolic kicking of a ball by a South African football personality—Hans Vonk—and signed by former Archbishop Desmond Tutu, who himself had been a polio victim as a child. Although he was keen to take an active part in the campaign, his own health did not allow him to do so but he was warmly welcomed as the campaign's Goodwill Ambassador. The old Port Captain's building, an historic building at the harbor, was suitably lit up for the occasion with the Rotary theme "Kick Polio out of Africa" in lights and Table Mountain itself was lit up for the occasion. Elsewhere in Africa, almost at the same time, the Pyramid of Khafre, the second largest of the ancient Egyptian pyramids of Giza, was also similarly illuminated. Throughout the world, other prominent landmarks including Britain's Houses of Parliament, the Sydney Harbour Bridge and Niagara Falls were also lit up.

From the initial launch in Cape Town, the ball then travelled extensively throughout Africa and finally exited through Alexandria, in Egypt on 12 June 2010 with a special event at the Bibliotheca Alexandria. As with the initial launch in Cape Town, the football was literally "kicked-out," this time towards the Mediterranean Sea by Egyptian national team captain Eslam El Shatter. A press conference and ceremony was held which also featured representatives of the Minister of Health, diplomats, dignitaries, and campaign supporters, including Egyptian film star, Hani Salama. The ball was then air-freighted by DHL, who also took responsibility for delivery within Africa, to the Rotary International Convention which was being held in Montreal, Canada at the time; here it was presented to the Rotary International President and was warmly welcomed by the 25,000 assembled delegates at the Convention.[1]

In addition to the extensive media coverage received throughout the continent, a KPOA blog monitoring the progress of the ball was launched and the virtual ball site (www.kickpoliooutofafrica.org) allowed thousands of people to show their support for the push to end polio once and for all. The blog featured the ball's epic journey from country-to-country with detailed information, photos, and videos.[2] The virtual ball site also capitalized on the tremendous global enthusiasm for football preceding the World Cup, particularly in countries with national teams competing in the tournament.

Press releases and social media releases were distributed to media throughout the campaign. The campaign also used paid placements to raise awareness, including ads and public service announcements featuring African celebrities, including artists and notable figures, such as: Desmond Tutu (Fig. 10.2); Nigeria's soccer captain Nwankwo Kanu (Fig. 10.3); Congolese band Staff Benda Bilili; Beninoise singer Zeynab Abib; and Nigerian folk musician Dan Maraya Jos.

[1] http://www.rotary.org/en/MediaAndNews/PressCenter/lightings/Pages/ridefault.aspx.

[2] http://kickpoliooutofafrica.wordpress.com.

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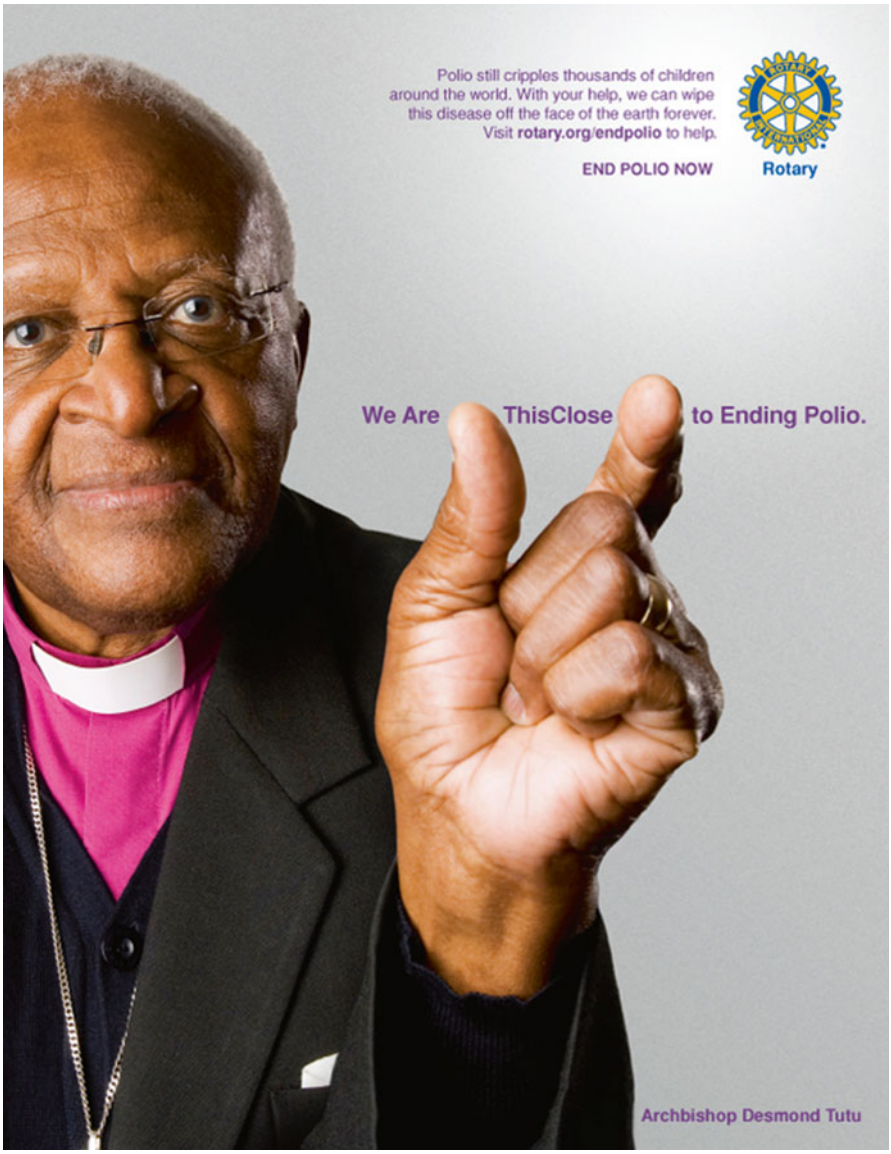


Fig. 10.2 Awareness-raising advertisements showing how close the campaign was to beating the polio scourge—"This Close"

During its 4-month trip (Fig. 10.4), the ball travelled through 23 polio-affected countries before ending its journey at the Rotary Convention in Montréal (Fig. 10.5). Rotary club members throughout the continent welcomed the ball to their individual countries and arranged soccer-related events, press conferences, football games, parades, telethons, and other special events with dignitaries, health officials, traditional African leaders and celebrities.

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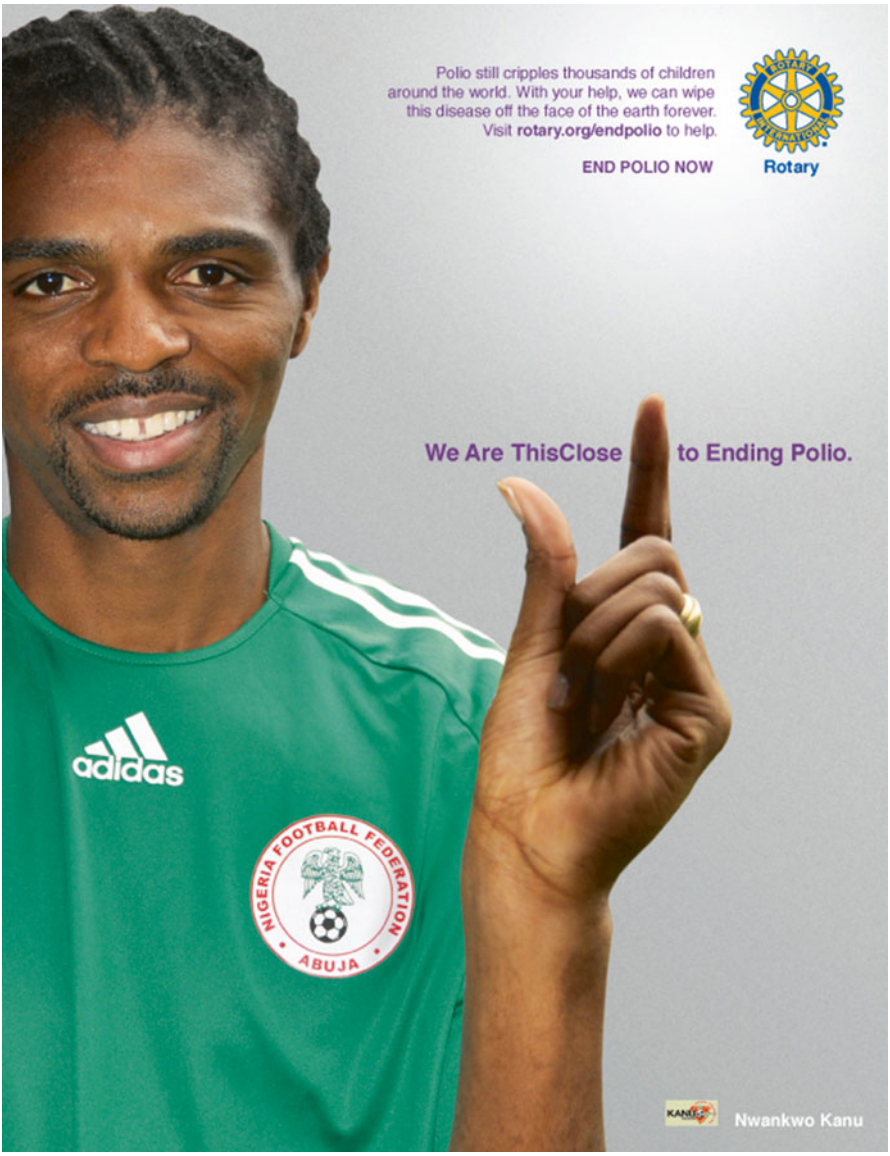


Fig. 10.3 Awareness-raising advertisements showing how close the campaign was to beating the polio scourge—"This Close"

Outcomes and Evaluation

The campaign resulted in unprecedented news coverage, helping to increase the various fund raising ventures which had been set for the programme as a whole and, as well as keeping polio eradication in the public eye. It also resulted in an enhanced public image for Rotary itself. Specific outcomes of the project include:

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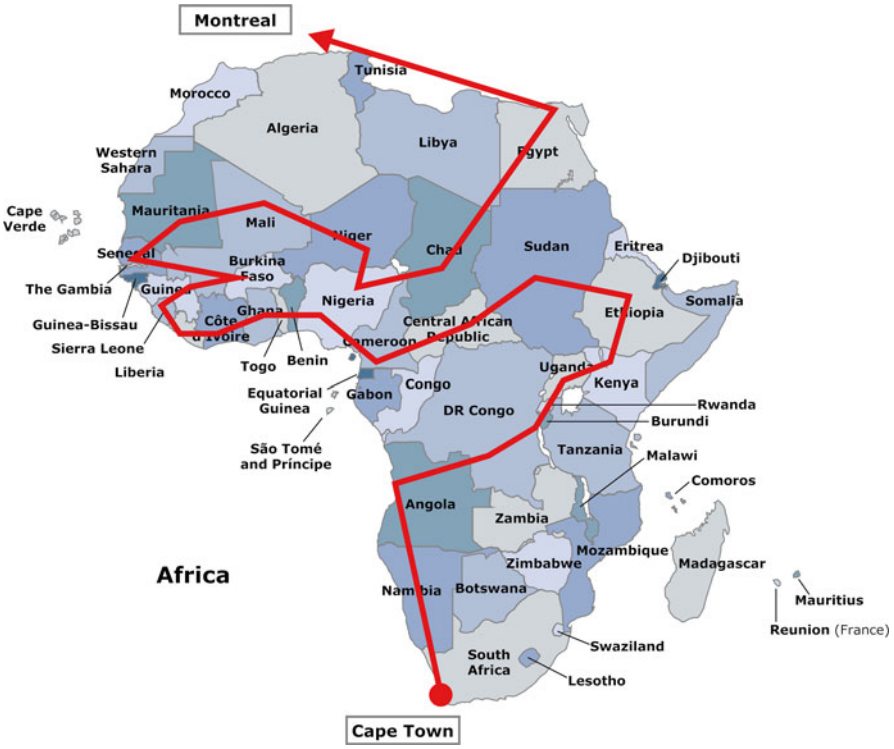


Fig. 10.4 Route of the "Kick Polio Out of Africa" football



Fig. 10.5 The final kick

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Fig. 10.6 The "Kick Polio Out of Africa" website

- Rotary raising the majority of its $200 million challenge to its members and other donors
- The Bill Gates and Melinda Foundation agreeing to match this with its own special $350 million donation
- Impressive media coverage in all 23 countries through which the ball travelled
- Nearly 11,000 signatures gathered on the virtual ball site, demonstrating global support for the campaign (Fig. 10.6)
- A bolstering of critical advocacy and support for the programme by key government officials and traditional leaders in polio-affected countries
- Major endorsement of the campaign by leading world figures, including Bill Gates, co-chair, of the Bill & Melinda Gates Foundation, who personally signed the ball on June 7, in Abuja, Nigeria
- Stimulating other major endorsements of the campaign by businessmen and politicians throughout Africa
- Social media press releases receiving a record 4000 hits during the campaign run (the launch release announcement being Rotary International's highest ever viewed press release)

Future Work

Challenges to Polio Eradication

From a health perspective, polio eradication is now within the world's grasp. But the threat is, if we don't eradicate the disease now, the risk of further crippling and deadly polio outbreaks could continue to threaten the world's children.

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In order to reach the goal of polio eradication, health experts agree that certain primary challenges must be overcome:

- Halting the spread of the poliovirus in the three remaining endemic countries (Afghanistan, Nigeria, and Pakistan), which continue to export it to polio-free areas
- In particular, curbing the intense spread of the poliovirus in northern Nigeria and Pakistan, the recent terrorist attacks on health workers not having helped the situation here
- Rapidly stopping polio outbreaks in previously polio-free countries
- Addressing low routine-immunization rates and surveillance gaps in polio-free areas
- Maintaining funding and political commitment to implement the eradication strategies

All these activities must be tackled with strength and vigor by all the parties concerned, supported by the political will of the leaders in affected countries.

Rotary's Role

It is hoped that, as a result of Rotary's leadership in successfully engaging heads of state, communities and all sectors of civil society throughout the continent, Africa is on the verge of a historic public health success that could have real long-term benefits. One of the critical roles Rotary can continue to play is keeping the spotlight on the progress of polio eradication throughout the world. This is Rotary's strategic advantage within the global partnership, as no other international organization has the collective voice that it carries.

The private sector partnership between Rotary and the Gates Foundation flowing from the PolioPlus campaign has been both exemplary and remarkable. To date (2012) the Gates Foundation has so far provided Rotary with US$405 million in challenge grants for polio eradication. In return Rotary met this challenge with its own fundraising efforts to the tune of nearly $230 million by June of 2012. These grants represent the largest ever given to a volunteer service organization by the Gates Foundation and are a tremendous validation of the approach and success of Rotarians' own efforts.

The Global Polio Eradication Initiative is now recognized as a model of public/private partnership, which is being replicated in other initiatives to control AIDS, tuberculosis, malaria, and measles. The infrastructure created to fight polio, including 145 polio labs, allows the global community to fight other diseases including cholera, measles, and Avian Flu. It has also brought improvements in routine immunization and distribution of malaria bed nets and vitamin A supplements during polio campaigns (these supplements are calculated to have saved some 1.5 million lives).

But above all, the PolioPlus programme has taught Rotarians huge lessons in reaching marginalized populations and engaging community leaders as part of its

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own vision and mission "Service above Self." The world is now at a pivotal point in the history of polio eradication and Rotary continues to play a vital role in its success. The promise Rotary made in 1985 "that no child will ever again know the crippling effects of this devastating disease" can now be fulfilled.

Status of Polio Eradication

Rotary and its partners are on-track to achieve a polio-free world by 2018, with the initiative making progress against all objectives of the plan.

In early 2014, the world celebrated one of its greatest achievements in global health—India being certified as polio-free. India was once considered the hardest place on earth to stop polio. Now, there has been significant progress in two of the three endemic countries—Afghanistan and Nigeria.

The last case of type-3 wild poliovirus was 10 November 2012, strongly indicating that all but one strain of wild poliovirus has been completely eliminated.

Lessons Learnt

The KPOA campaign was the most ambitious programme of its kind ever undertaken by Rotary International in Africa. While it would be difficult to replicate such a large-scale and unique event, the project highlights the potential for utilizing the power of sport in awareness-raising campaigns and demonstrates that with vision and determination it is possible to have a big impact.

Key factors which proved essential to the project's success include:

- Committed organizers who were determined to see the project through no matter what.
- Strong support from partner organizations, including a commercial partner, DHL Express, who were able to see benefits to their own organization, as well as to the campaign, in their involvement in the project.
- Effective media communications and key people who were prepared to handle the promotion of the project in each of the individual countries involved.
- Close, daily monitoring of the project once it was underway to ensure that problems were picked up and dealt with quickly to ensure that it remained on track (inclement weather, rescheduled flights, and staff needing to make special trips when deadlines had been missed were just some of the challenges DHL faced to "go the extra mile" to ensure that the ball arrived as scheduled during its epic journey).

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Acknowledgments We would once again like to thank all those individual Rotarians who gave their time and effort to make the KPOA campaign the success it was. In particular, we would like to thank our many sponsors, especially our primary sponsor DHL Express who made the venture possible by transporting the ball across the African continent…no mean feat… and then onwards to Montreal, Canada for the culmination of the campaign at the International Rotary Convention. Their dedication, commitment, and professionalism went beyond the call of service. We thank them.

Further Reading

The campaign and the subsequent follow-up have been well documented on the website of Rotary International (www.rotary.org), which features a dedicated section chronicling the history and development of PolioPlus.

Readers can follow the Global Polio Eradication Initiation weekly updates on the status of polio eradication at www.polioeradication.org and Rotary's efforts at www.endpolionow.org.

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Chapter 11
Sex and Sport: An Australian Rules Football-Based Chlamydia Screening Initiative

Fabian Yuh Shiong Kong, Margaret Hellard, and Jane Hocking

Background

Chlamydia (*Chlamydia trachomatis*) is the most prevalent bacterial sexually transmitted infection (STI) in the western world [1] and the most common notifiable infectious disease in Australia [2]. Chlamydia diagnosis rates have increased by over 300 % in the last decade in Australia, with 78,763 cases diagnosed in 2012 [3]. Infection is largely concentrated among young adults, with approximately 80 % of notifications being among young men and women aged 15–29 years.

Chlamydia infection can cause significant morbidity, particularly for women; up to two-thirds of cases of tubal infertility and one-third of cases of ectopic pregnancy may be directly attributable to chlamydia infection [4]. As over 80 % of infections in men and women are asymptomatic, screening or testing of asymptomatic individuals is necessary to detect cases and provide treatment.

However, annual chlamydia testing rates among sexually active 16–29-year-olds remain low. In Australia, it is estimated that only about 12.5 % of women and 3.7 % of men are tested for chlamydia each year, mainly through general practitioners [5].

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Mathematical modelling suggests that annual testing rates of 40 % among those aged 16–24 years of age can halve chlamydia prevalence among all age groups within 4 years [6].

Unfortunately, in small rural towns, high visibility and lack of transport often make young people reluctant to seek advice on sexual reproductive health issues due to concerns (even if unwarranted) about the maintenance of confidentiality by health service providers [7, 8]. These issues highlight the need for innovative youth friendly screening programs to increase detection of chlamydia and provide access to treatment and education about chlamydia in the community.

The Sex and Sport project aimed to provide an innovative method for increasing the testing and treatment of 16–25-year-olds in a community setting, using local community sporting clubs in rural areas of the State of Victoria, Australia.

Aims of the Project

The primary aims of the project were:

1. To increase chlamydia testing of young people in a community setting in rural/regional Victoria.
2. To improve access to treatment for STIs in young people in a community setting in rural/regional Victoria.

The objectives of the project were:

1. To establish a chlamydia testing program among 16–25-year-old males and females in rural and regional Victoria.
2. To establish a collaborative network of sporting clubs, laboratories, and health-care providers to participate in the program.
3. To enhance the capacity of community health workers to conduct outreach work for chlamydia testing.
4. To determine the chlamydia prevalence among 16–25-year-old males and females in rural and regional Victoria.
5. To describe the risk behaviors among 16–25-year-old males and females in rural and regional Victoria.

The project was specifically designed to develop and build on the collaborative links with rural and regional community and STI services, as well as linking these regions with Melbourne Sexual Health Centre (MSHC).

How the Project Was Set Up

Australian rules football (Aussie Rules) is an extremely popular pastime in Victoria, Australia, particularly in rural and regional areas, with many young men playing for their local club in the winter months. The project aimed to assess if football clubs

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(and netball clubs for women), would be a feasible and user-friendly setting for young people to be tested and managed for chlamydia.

The project was undertaken in the Loddon Mallee Region of Victoria, Australia, which covers a geographic area representing 26 % of the area of Victoria and 6 % of the population. It is estimated that approximately 80 % of people aged over 15 years in the Loddon Mallee region participate in exercise, recreation, and sport [9].

A pilot study was undertaken in four rural sporting clubs [10] and the results were used to inform a successful application for an Australian Chlamydia Targeted Grant from the Australian Commonwealth Department of Health and Ageing (DoHA).

An advisory committee was established within the first month of the project commencing. The committee met monthly by teleconference and were responsible for overseeing the conduct of the project and providing advice on recruitment. The advisory committee consisted of representatives from community-based organizations, local health services, Indigenous health services, the regional division of General Practice and the health department.

Large pathology services in the region were identified and chlamydia testing was paid for by the project to allow free testing for the participants.

The project had a large capacity-building component, with a full day of training being provided to the two study coordinators in the epidemiology of chlamydia and research methodologies, including ethics and data collection. The study coordinators then recruited and trained local community and women's health workers to recruit, test, and educate project participants in the area of sexual health.

Delivery of the Project

The study was conducted between May and September 2007 in the Loddon Mallee region of Victoria. As outlined previously, to ensure regional capacity building, two regional coordinators were employed and embedded into an existing community health organization to manage the study.

A combination of local contacts and referrals from the advisory committee and community health workers were successfully used to identify clubs, with initial contact usually undertaken by telephone conversation with the coordinator and a club official (e.g., president). Also, local media (e.g., radio, local newspaper) were used to raise awareness and encourage clubs, some of whom were initially reluctant, to become involved in the project. This technique "exploited" the competitive nature of sporting clubs, i.e., if one club was seen to be involved in an interesting project, this created interest in participation in another club, especially given the benefits that participation provided to its members (chlamydia screening and health promotion).

Clubs agreeing to participate were visited 2 weeks prior to recruitment; the project was explained to the players and a question and answer session was held. Club presidents and respected members of the club (e.g., sports coaches) were targeted to also communicate the project's benefits to young people with the aim of improving recruitment success.

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Recruitment was conducted in the club rooms following a training session, with participating clubs provided with refreshments or meals for all club members after training. All players attending the training night were approached by study researchers and asked if they would like to participate. Men and women were eligible if they were aged 16–25 years and had sufficient English skills to give informed consent. After providing written informed consent, players completed a brief questionnaire that asked about sexual activity, knowledge, and history of STIs, alcohol and drug use, and provided a self-collected, first pass urine specimen. Participants were then provided with a "show bag" with condoms and educational material about STIs and available sexual health services.

Urine Testing

Urine samples were stored in an ice-brick-cooled, insulated container and transported within 24 h of collection to the local laboratory where they were tested for Chlamydia trachomatis using Nucleic Acid Amplification technology (Aptima Combo 2 Assay™, Gen-Probe Inc, USA or BD ProbeTec ET System™, Becton Dickinson, USA). Funding for tests was drawn from the study budget.

Provision of Results and Treatment

Participants with negative test results for chlamydia were informed by standard mobile phone short messaging service (SMS; aka text messaging), stating:

> Thanks for your time in the 'Sex and Sport' project. Your urine test did NOT detect Chlamydia. 4 more info call 8506 2327 or sport@burnet.edu.au. 4 sex info call 1800 032 017 or www.mshc.org.au. Useful websites are www.sextxt.org.au, www.yoursexhealth.org and www.likeitis.org.au

Participants with a positive result were telephoned by a sexual health practitioner, informed of their result and offered the options of either attending their local doctor, being referred to a local or regional STI service, or having a telephone consultation with a sexual health nurse and practitioner based at MSHC (via a free call 1800 number) as it was recognized that a number of people wanted their management to be as anonymous as possible.

For participants with a positive test who chose to have a telephone consultation, treatment (Azithromycin 1 g) was posted free of charge to the participants in plain envelopes. Contact tracing was undertaken where appropriate. All but one positive case (96 %) chose to use the telephone consultation with MSHC. Positive cases were also telephoned 3 months after treatment to remind them to be retested for chlamydia by their local healthcare provider.

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Outcomes and Evaluation

Outcomes

Objective	Desired outcome	Outcome
Establish a chlamydia testing program among 16–25-year-old males and females in rural and regional Victoria	Increased chlamydia testing in young people in rural and regional Victoria	Twenty-nine sporting clubs were recruited and 709 participants were tested, of whom approximately 2 % were of Koori (Aboriginal) descent. Ninety-five percent were aged 16–24 years, with 50 % aged 17–21 years. Seventy-seven percent were male
	Increased knowledge of chlamydia infection and sexual risk behavior	Participation rates on the night of recruitment were high (95.9 %; male 95.4 %, female 97.6 %). Eighty-six percent of participating clubs stated that the health of their members was the main reason for participating, with all participating clubs being highly satisfied with the project's methodologies and management
	Development of a cohesive system for testing and management of STIs in rural/regional Victoria that can be transferred to other regions	All participants were provided with information about sexual health and how to prevent the transmission of sexually transmitted infections
Establish a collaborative network of sporting clubs, laboratories, and healthcare providers to participate in the program	A system to be established that enables the testing, communication of results and the management of a chlamydia infection to be provided to patients in an integrated fashion. Participants should be able to attend their local doctor, or regional community health/STI service or the Melbourne Sexual Health Centre (MSHC)	Overall, 709 participants were recruited (and tested) by 28 local community health workers from 29 sporting clubs distributed across the Loddon Mallee region, with testing undertaken by their two large local laboratories
Enhance the capacity of community workers to conduct outreach work for chlamydia testing	Ensure community workers in the local region are appropriately trained so they can conduct the current study and be able to conduct the same or similar work in future years	Twenty-nine community health workers received training in STI education (including a basic overview of the detection, management and consequences of chlamydia infection), basic epidemiology, how to administer surveys and data and urine collection

(continued)

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(continued)

Objective	Desired outcome	Outcome
Determine the chlamydia prevalence among 16–25-year-old males and females in rural and regional Victoria	Measure the prevalence of chlamydia in young people in rural and regional Victoria by collection urine samples after training	Of the 709 urine samples collected and tested (77 % males), 28 were positive for Chlamydia (19 males; 9 females). This young cohort was sexually active, with 77 % having experienced vaginal sex and 20 % having experienced anal sex at the time of the survey
	Ensure the sample size was sufficient to achieve reasonably narrow confidence intervals for the prevalence figures	The overall prevalence of Chlamydia was 5.1 % (95 % CI 3.4–7.3) in sexually active participants—7.4 % (95 % CI 3.5–13.6) among sexually active females and 4.5 % (95 %CI 2.7–6.9) among sexually active males. Prevalence increased with the number of sexual partners in the past year
		Only 19 % of sexually active participants reported having an STI test in their lifetime.
Describe the risk behaviors among 16–25-year-old males and females in rural and regional Victoria	A questionnaire administered asking about sexual and drug-taking risk behaviors	Sixty percent of males and 20 % of females consumed alcohol at short-term "risky" levels at least once a week. "Risky" levels were defined as females drinking >4 standard drinks or males drinking >6 standard drinks in the same day
		Sixty percent had used drugs in their lifetime and 12 % had used drugs in the past month. The most commonly used drugs were marijuana (47 %), ecstasy (23 %), and amphetamines (16 %)
	A system of testing developed with collection of behavioral information that can be linked to the chlamydia sentinel surveillance system in Victoria	Overall condom use was low with only 25 % using a condom the last time they had sex, despite 73 % reporting no problems in accessing condoms. After adjusting for age and number of new sexual partners in the past 3 months, the odds of always using a condom (in the past 3 months) were lower in those aged 20 years and above, males who had six or more sexual partners in the past year and those who used one or more drugs in their lifetime. Condom use was greater among those who had completed high school or had a higher level of education and those who had one new sexual partner in the past 3 months
		STI knowledge was poor, with only one-third of questions being answered correctly by more than two-thirds of participants

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Evaluation

Nineteen evaluation questionnaires about the program were completed (seven community health workers and 12 participants). Among the participants, 92 % reported the project was useful for increasing testing in young people and 83 % stated that it was useful in providing them with STI health information and understanding of sexual behavior among rural youth. Eighty-three percent said the project was useful in learning about an STI service they were currently unaware of and participants further stated they would use these services in the future. Encouragingly, 92 % stated they would be happy to undertake an annual sexual health check-up at their local sporting club and receive results by mobile SMS. Finally, nearly all of the local community health workers who assisted in the recruitment night stated that the integration of services used in the project was "excellent" or "successful" and felt the project would be a useful method for reaching young people.

Sporting clubs were also asked about the acceptability of the project methodology. Completed questionnaires were received from ten sporting clubs (seven participating and three non-participating clubs), with 86 % of participating clubs stating that the health of their members was the main reason for participating in the project. The non-participating clubs declined to participate mainly over concerns regarding members completing the questionnaire, especially regarding their sexual and drug histories.

The DoHA undertook an evaluation of all projects funded through the Chlamydia Targeted Grants Program but the results were not made available.

Further details of the evaluation and full outcomes can be found in the two journal publications related to the project [11, 12].

Conclusion

In conclusion, sporting clubs represent a feasible, acceptable, and innovative community-based setting to screen and provide sexual health information to young people in rural and regional areas, especially for males. Integrating existing healthcare services and tapping into local networks and knowledge are vital to ensure recruitment and messages to youth are sustainable and locally acceptable.

Future Work

After the project's completion and evaluation by the DoHA, the project did not formally continue or develop further due to a lack of ongoing funds.

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Lessons Learnt

The sustainability of the project was an important consideration. Capacity building and training local health workers (who know their community well) to assist in recruitment was a key outcome. Additionally, referral of participants to local health services and using local laboratories allowed the project to integrate these services to provide a cohesive system in the sexual health management of the participants. In doing so, young participants gained valuable knowledge about locally available sexual health services (often a service they had previously been unaware of). In light of the fact that using these rural services comes with a high degree of visibility for the young participants, the "Sex and Sport" project provided participants with an option for an anonymous, free, telephone consultation (and treatment) with MSHC; an option (not surprisingly) used by 96 % of participants.

Successful recruitment of clubs was best achieved by:

- Using local contacts with local knowledge and connections to sporting clubs
- Telephoning and visiting clubs
- Gaining support from club presidents and coaches by promoting the health benefits
- Using incentives, such as providing evening meals, lollipops, condoms, autographed footballs (for logistical reasons, autographed footballs need to be obtained very early in the football season)
- Emphasizing that the testing was only for STIs—not drugs and alcohol
- Using the media (e.g., local newspaper and radio) well before the start of the sporting season and emphasizing the involvement of clubs which had already agreed to participate in order to instill a sense of "not wanting to be outdone" among non-participating clubs in the same region

Of the total time required for the project, recruiting clubs accounted for the biggest proportion (~42 % of total time), followed by making the showbags (~17 % of time), providing results and referral (~17 % of time) and travel time to go to remote clubs (~10 %).

Acknowledgments Maureen Todkill and Susan Rochester—the project's regional coordinators; the local community health workers who assisted with recruitment; the study participants; the participating sporting clubs and their committees; the study advisory committee—Loddon Mallee Primary Care Partnerships, Mallee and Bendigo Divisions of GP, MSHC, Victorian Aboriginal Community Controlled Health Organisation, Department of Human Services.

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Chapter 12
Skillz Kenya: An HIV/AIDS Youth Prevention Initiative

Enouce Ndeche and Samson Chama

Background

AIDS has had a devastating effect on Africa. It has killed 15 million people across the continent in less than 30 years [1] and is the leading cause of death for people aged 15–49 [2]. 2012 figures showed that in Kenya alone 5.6 % of people aged 15–64 years were infected with HIV, equating to approximately 1,192,000 adults living with the disease [3]. Despite intervention from local, national, and international organizations, an estimated 104,137 Kenyans still became infected in 2011 [1, 4].

Young people remain a group significantly at risk of HIV/AIDS, with the 15–24 age group accounting for 41 % of all new infections across sub-Saharan Africa [5]. Young women are particularly vulnerable, as females aged 15–24 are over five times more likely to become infected with HIV than males of the same age [5]. With sexual contact remaining the primary driver of new HIV infections [6], the vulnerability of young people to the disease can be at least partly attributed to increased instances of risky sexual behavior, such as engaging in unprotected sex with multiple partners.

The AIDS pandemic is an unrelenting scourge on Kenya and threatens to reverse the socioeconomic gains made over recent decades. The disease is diverting scare resources to meet the needs of the infected and affected and, having taken a heavy toll on the young and most productive members of society, is negatively impacting national productivity. The infected and affected continue to suffer isolation,

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discrimination, and stigmatization. Countless Kenyan children have been orphaned by the disease; it was estimated that by 2010, Africa would be home to 20 million orphans as a result of HIV/AIDS [7, 8]. With a limited or lack of familial support, AIDS orphans are faced with numerous socioeconomic ills, such as child-led households and many being forced to drop out of school due to the costs involved or to care for younger siblings [9–11].

In impoverished areas of the country, the situation is especially bleak. Residents of low-income and slum areas are particularly susceptible to high-risk behaviors including sex work and intravenous drug use. According to a recent Kenyan study, asset poverty is significantly related to risky sexual outcomes, including early sexual debut and multiple sexual partners [12, 13]. Poor educational levels are also a key factor, as increased educational attainment has been shown to reduce risk of HIV infection [12, 13]. In response to this situation, interventions are being designed with a view to preventing the spread of HIV in Kenya.

Skillz Kenya, run by community-based-organization Vijana Amani Pamoja (VAP)—meaning "Peace Together Youth"—is one such program which capitalizes on the nation's love for soccer in the fight against HIV/AIDS. Introduced to Kenya by the British, soccer is the country's greatest player and spectator sport [14]. In the context of Skillz Kenya, the game is used to both mobilize and engage participants. Using the sport for development model, Skillz Kenya educates vulnerable youth on HIV/AIDS, teaching awareness and methods and life skills critical to prevention. Such an educational approach has been demonstrated to be effective in the fight against the disease [12, 13]. Pitches become classrooms as interactive discussions and group counselling sessions are complemented by soccer games and activities which demonstrate key messages. Skillz Kenya has been running in its current form since 2004. It is delivered in the Eastlands area of Nairobi, home to countless slums and impoverished neighborhoods, where VAP was founded and is still based.

Aims of the Project

Skillz Kenya's long-term aims are strongly aligned with the Kenyan National AIDS Strategic Plan (KNASP) which aims to reduce the rate of new infections by 50 % by 2015 to ensure that the majority of Kenyans who are HIV Negative remain free of the disease. The organization's ambition is for an HIV-free generation. On a short-term basis, the program practically aims to:

- Educate and inform male and female youth on HIV/AIDS, enabling them to avoid contracting the disease
- Build the self-esteem of participants to ensure that they can make healthy and positive decisions when it comes to sex, relationships and lifestyle to avoid contracting HIV and other STDs
- Reduce risky behavior and promote positive behavior change for a healthy and happy life (for example, remaining faithful to one partner, practising safe sex,

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saying no to exploitative relationships with older partners, stopping using drugs—including intravenous drug use)
- Increase access and take-up of HIV testing amongst young people
- Foster a more positive attitude amongst participants to those living with HIV/AIDS to reduce the stigma and discrimination associated with the disease
- Encourage participants' interest in sport and physical activity necessary for a healthy lifestyle

Skillz Kenya targets young people aged 11–20 years from the Eastlands district of Nairobi—a group at particularly high-risk of infection. The district, comprising countless slum and high-poverty areas, is hugely impoverished and receives limited support from major aid agencies and NGOs. Many families live on less than a dollar a day and HIV/AIDS is rampant; girls as young as ten prostitute themselves to buy basic necessities and cases of sexual and physical abuse are all too common. With high levels of unemployment and little economic opportunity, too many young people turn to drug and alcohol abuse and crime.

By providing HIV/AIDS prevention education activities in a soccer-inspired, team-based environment, VAP aims to alleviate health and social issues for vulnerable young people growing up in Eastlands and help them to become responsible citizens of Kenya.

How the Project Was Set Up

In 2003, VAP was originally established as a soccer club to help nurture and develop the sporting talents of boys in Majengo slum in the east of Nairobi. Recognizing the potential to use soccer to create awareness of HIV/AIDS and generate change at the grass roots level, the club was setup by the organization's current Executive Director after seeing first-hand both the huge popularity of the sport and the devastating consequences HIV/AIDS had dealt to the local community.

With the support of Grassroot Soccer (www.grassrootsoccer.org), a major organization which mobilizes the global soccer community in the fight against AIDS, VAP developed its Skillz Kenya HIV-prevention curriculum. The program incorporates interactive and informative discussions, soccer games, and activities and group counselling sessions.

In 2007, VAP started to receive a small amount of funding as a result of a partnership with GlobalGiving, an online fundraising platform which connects donors from around the world with different types of international organizations and slowly scaled-up its work. But it wasn't until 2008 that VAP secured its first funding partner and the Streetfootballworld network—which is supported by Adidas and FIFA amongst others—came on board. This was a major turning point for the organization. There was a fivefold increase in Skillz Kenya interventions as over 1000 beneficiaries were reached, peer educators were employed and program delivery was strengthened as staff training was invested in.

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Today, VAP employs 6 permanent staff and 20 peer educators who deliver the Skillz Kenya program in over 20 schools and community centers across the Eastlands area of Nairobi each year. Using the same sport for development model, VAP has established two additional youth programs addressing female empowerment and corruption in Kenya.

The organization has been receiving funding from individual donors, trusts, and charities and has established a strong network of partners which still includes Streetfootballworld and GlobalGiving.org amongst others—Coaches across Continents, the Egmont Trust, GlobalGiving.org, GOAL Kenya, ForGranted, Giz, Grassroot Soccer, Women Win and 2 Way Development.

Delivery of the Project

The Skillz Kenya program, which is based on the sport for development model, uses soccer to instill knowledge and life skills in vulnerable young people to prevent the spread of HIV in Kenya. It is a 3-month program which is delivered in schools and community centers, targeting youth in high-poverty and slum areas. The majority of interventions take place in schools, where sessions lasting up to an hour and a half are delivered on a weekly basis after the day's lessons are completed. Community centers are targeted during school holidays, where interventions are delivered over 3–5 days.

Intervention sizes vary from 30 to 50, depending on the size of the school or community center and how many young people need to be reached. In larger interventions, young people are often divided into smaller groups for activities.

Skillz Kenya Curriculum

Through a combination of soccer activities and games, interactive discussions and dedicated time for group counselling, the Skillz Kenya curriculum educates and empowers young people, enabling them to make positive and healthy decisions to avoid contracting HIV.

To increase participants' knowledge, the curriculum includes ten sessions which cover practical information about HIV/AIDS, such as: how it is spread; safe sex; the benefits of male circumcision; how having multiple sexual partners increases the risk of infection; the co-relationship between TB and HIV/AIDS; where to get tested; and available medical treatment. The curriculum also addresses relationship and emotional issues, including abstinence, delayed sexual debut, commitment, and monogamy.

Soccer games and activities are used to demonstrate key messages, helping to convey ideas to young participants and ensuring that they are remembered. This element of the program is the most popular and, in addition to their educational purpose, the soccer games and activities act as the "carrot," mobilizing young

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people to participate in Skillz Kenya and helping to ensure that they complete the 3-month program. Games include "Find the Ball" where a participant has to find a ball hidden behind the backs of a team, demonstrating that you don't know who has HIV/AIDS (i.e., the ball); in "Breakaway from HIV," a participant has to dribble several balls into the goal, illustrating that having multiple sexual partners makes achieving your goals harder.

Another key component of the curriculum is the self-esteem building aspect and the development of life skills, such as decision-making and leadership, which is achieved through the soccer activities and games and group counselling sessions. This program component enables participants to put their newfound knowledge into action, helping them to confidently make positive and healthy decisions and resist peer pressure.

Graduation

Participants who attend at least 7 out of 10 sessions successfully graduate the Skillz Kenya program. At the end of each intervention, a celebratory ceremony is held and certificates are presented.

Staffing

During the sessions, program activity is managed and taught by peer educators who act as role models. Peer educators receive in-depth training from senior staff and external partners including Coaches across Continents and Grassroot Soccer. At least two peer educators are present at each intervention with more for larger groups.

Winning Trust

One of the key reasons for the success of Skillz Kenya in reaching at-risk young people is that participants can relate to peer educators and often consider them role models. Peer educators are usually in their teens or early twenties and come from the same slum or high-poverty areas as participants; seeing young people from a similar background leading a healthy and proactive life can be inspirational to Skillz Kenya participants. Furthermore, many peer educators are local soccer stars, which gives them real credibility in the eyes of participants. In Kenya, every town and locality has a team, and players are community heroes.

The positioning of peer educators as role models helps to increase the engagement of participants and make the messages more powerful. This means that participants are more likely to remember HIV-intervention information provided during Skillz Kenya than in more formal settings.

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To help nurture the relationship between themselves and participants, peer educators avoid behaving like a teacher or parent. They instead adopt an informal approach and use local language, and much of the focus of Skillz Kenya sessions is on having fun.

Spreading the Word

Upon graduation, Skillz Kenya graduates are actively encouraged to share HIV-prevention information with their communities and become local ambassadors for the program. This helps to significantly increase the reach of VAP's messages.

Kick "n" Test VCT & TB Screening Annual Soccer Tournament

Each year, VAP hosts its biggest event, the Kick "n" Test VCT (HIV voluntary counselling and testing) & TB Screening Soccer Tournament. The aims of the event, which complement the ongoing Skillz Kenya program in schools and community centers, are twofold:

1. To increase understanding of the co-relationship between HIV and TB (TB is a leading killer of people living with HIV causing one-fifth of all deaths) [15].
2. To provide and encourage HIV and TB testing for at-risk individuals.

Youth teams, made up of both boys and girls, from across Eastlands, Nairobi are invited to compete. Taking place in local grounds, the event also targets communities at the grass roots level with the soccer tournament working to mobilize residents in large numbers. During intervals and half time, players participate in HIV and TB-awareness activities from the Skillz Kenya curriculum which are led by peer educators. For tournaments, VAP has partnered with health institutions, such as the World Health Organization (WHO), Edarp and Family Health Options, to ensure that HIV and TB testing is widely available to players and the local community. Pre- and post-testing counselling is offered and medical referrals are provided to those who test positive for either disease.

To encourage players to get tested, teams not only get points for winning or drawing a match but also for each team member who is screened for HIV and TB. By providing testing in a fun, team-based environment, the process is de-stigmatized and young people are encouraged to find out their statuses. To complete the day's proceedings, the most promising player is declared the tournament's "football champion" and the player who has been most enthusiastic in the HIV and TB-awareness activities is recognized as the "spirit champion."

The Kick "n" Test VCT & TB Screening Soccer Tournament in August 2012, attracted 80 players, with around 300 members of the local community in attendance. One hundred and sixty were tested for HIV with a further 78 benefiting from free TB screening.

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Program Management

A dedicated Skillz Kenya Program Officer oversees the day-to-day management of the program; in fact, the current Program Officer was one of VAP's first ever beneficiaries (where possible, VAP encourages program participants to get involved in the leadership of the organization as peer educators and, in time, senior staff). The Program Officer ensures standards are met and co-ordinates program activity. As part of plans to strengthen the Skillz Kenya program during 2013, master coaches have been employed for the first time. These more experienced team members will assist the Program Officer and provide direct support to peer educators during interventions.

Reaching Participants

To facilitate Skillz Kenya programs in schools and community centers, VAP has a core team of two staff, the Program Officer and a Logistics and Monitoring & Evaluation Officer, who work on the ground within the community. These officers forge relationships with schools and community centers through referrals and by directly approaching decision makers such as head teachers and youth leaders. They are also responsible for mobilizing teams to play in tournaments, including the Kick "n" Test VCT & TB Screening Soccer Tournament. Working from VAP's ground office in Kiambio, a slum area and key target geographic, the officers are always available to provide information and counselling services to the local community on an informal basis.

Promoting the Program

At the regional, national, and international level, Skillz Kenya is actively promoted to stakeholders. VAP continues to identify new stakeholders and secure additional partners to help expand the program, provide funding, and increase the capacity of staff. For example, since 2010 VAP has had a partnership with Nairobi City Council's Education Department which enables the organization to teach Skillz Kenya (and its other programs) in the city's public schools. This level of promotion also enables VAP to connect with other grassroots and community organizations for mutual learning. VAP regularly communicates with stakeholders via its monthly newsletter and social media channels. Senior staff also attend conferences, meetings, and networking events organized by groups such as streetfootballworld, the government Division of Leprosy and TB and Lung Diseases (DLTLD) and the National AIDS & STI Control Programme (NASCOP). VAP has also been hosting an increasing number of international student interns who come in and participate in the different program activities.

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Outcomes and Evaluation

With the support of its partner Grassroot Soccer, VAP has developed a simple and effective monitoring and evaluation (M&E) process for Skillz Kenya which analyzes the program's effectiveness. This process captures demographics and both participants' knowledge and attitudes regarding HIV and their engagement in high-risk behavior both before and after the intervention. By comparing pre- and post-intervention results, any increase in knowledge and positive behavior change as a result of the program is revealed.

Monitoring and evaluation forms are first provided to participants prior to the start of each intervention. Not only is this information later used for comparison with post-intervention forms, but the participants' responses enable peer educators to tailor the program to the group's needs. For example, if the forms disclose that a significant number of participants are engaging in unsafe sex, more time will be spent on this part of the curriculum.

Participants are required to complete the same forms at the end of the intervention and the results are uploaded onto the "Scorecard," an Excel template in which information can easily be added by staff. The "Scorecard" links to Salesforce, an online M&E database which collates and analyzes the results.

Skillz Kenya programs are also monitored via an attendance form and a support visit form, which is completed by a senior member of staff when attending sessions to inspect program quality.

Demographics

Over the period 2003–2013, a total of 16,600 young people graduated from the Skillz Kenya program. Figures from 2010 to 2013 showed that of the 2754 graduates in this period, a small majority were male (56 %).

A total of 89 young people were trained as coaches on the program over the period 2003–2012.

The age breakdown of those who graduated from the program between Jan 2010 and Dec 2013 was as follows:

- 0–9 years—0.7 %
- 10–12 years—47.5 %
- 13–15 years—42.6 %
- 16–18 years—7.6 %
- 19–24 years—1.6 %

2010–2013 data of the pre- and post-intervention Skillz quiz scores indicate how much graduates' knowledge and attitudes around HIV and HIV-related topics changed over the course of the program. Among male graduates, an average prepro-

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gram score of 65 % increased to an average post-program score of 76 %. Female graduates showed a similar improvement, with pre- and post-program average scores of 64 % and 75 % respectively.

Evaluation

Aside from the standard M&E processes which are applied to each and every Skillz Kenya intervention, no formal evaluation of the project has been undertaken. However, to ascertain the development of the program and ensure that it meets its objectives and delivers positive impact to participants, regular reports are provided to funding partners on an ongoing basis.

Future Work

VAP continues to strengthen the Skillz Kenya program in terms of both its content and reach, increasing the number of young people graduating each year. The curriculum will be expanded to include a full insight into TB and the co-relationship between the disease and HIV/AIDS. In previous years, VAP has delivered a separate Stop TB initiative in schools but in future this program will be incorporated into Skillz Kenya. One in four HIV victims die from TB; through tackling this disease, the life expectancy of AIDS patients can be increased.

To ensure that VAP can continue to reach more and more at-risk youth, the organization will not only nurture its current partners but will also work towards bringing on board new partners from both the public and private sectors. With still so many young people in Nairobi, VAP's geographic focus will remain the impoverished area in the capital.

With the support of Grassroot Soccer, VAP is planning to further develop its M&E process to maximize the potential of Skillz Kenya in preventing the spread of HIV amongst at-risk youth.

Lessons Learnt

The concept of using sport as a tool for social development has quickly emerged and is increasingly being recognized internationally as an effective means of reaching young people and conveying health messages. The model has not yet been fully embraced at the community level, however, and there remains work to do in terms of education.

When Skillz Kenya was first launched, it took time to convince stakeholders of the effectiveness of the sport for development model. Teachers, for example, were not sure *how* it could work. When the first interventions

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commenced, some participants were caught off guard as they thought that the program was all about football training. As many of the Skillz Kenya coaches were well-known local soccer players from various community clubs, almost all the participants arrived ready to train. But gradually, as the participants were introduced to the program structure and curriculum, they began to realize that it was an HIV-prevention initiative. As participants realized that the soccer games and activities were not only enjoyable but were also teaching them valuable information about HIV/AIDS, they slowly became more involved in the topic and started to instigate discussions with peer educators and ask questions. Having attracted praise and support from teachers, government departments and international trusts, Skillz Kenya is now in great demand by schools and community centers.

The Skillz Kenya model can successfully be replicated across the world, provided that the country or area in question has a passion for soccer; alternatively, another sport could be used in place of soccer. The sport for social development model is not only restricted to HIV-prevention or health-related issues but can also be applied to multiple other contexts as a means of targeting and engaging young people. Even at VAP, the model is used to address issues of corruption and female empowerment through its two other programs.

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Chapter 13
A Golf Programme for People with Mental Health Problems

Kitrina Douglas and David Carless

Background

The object of golf is to hit a 1.68 in. ball, with a club, around a marked course and into a series of 4.25 in. holes. Players need a combination of skills and abilities to play the game. These have been humorously described as a cross between the fine motor control of a surgeon, explosive power of the sprinter and the tactics of a chess player. Aerobic fitness, strength, power, flexibility, co-ordination, fine motor control and concentration are all relevant. But golf is also extremely adaptable in terms of performing the basic skills. For example, the putt is a small, simple move requiring minimal strength or flexibility. Most facilities have dedicated practice putting greens and many golfers enjoy this challenge as much as playing the full course.

Another feature of the game is the variety of playing facilities available. These stretch from the seaside crazy golf courses costing as little as £1, through to driving ranges, short municipal courses and expensive private member courses. Although the average course is over 4 miles long, there are numerous short courses around the country less than 2000 yards. While traditional clubs can be exclusive, in responding to the needs of a changing population, the English Golf Union have introduced rule changes reflecting a move away from 'member-only' courses. Significantly, golf permits unique opportunities for social interaction. Golf is perhaps the only sport where a male teenager might be seen playing with grandma, something that is unlikely in our national sports of football, cricket and rugby. Age wise, children as young as 4 play while people in their 90s also play.

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It is not the technical difficulties and adaptations of golf that cause the greatest concern in a mental health context. The biggest problem with golf is that it is has a reputation for being elitist, sexist, homophobic, racist, classist and able-bodyist. This issue represents a major concern in the context of people with serious mental health problems for whom the biggest challenge is not the illness itself but, rather, stigma and discrimination [1]. Without doubt, at present, one would be ill advised to take a stigmatised group to most private member courses. However, the increasing diversity of modern golf may offer a *way in* for socially excluded groups—there is the possibility of introducing people with mental health problems to golf and golf to people with mental health problems.

How might golf contribute to social inclusion for people with severe and enduring mental health problems? Firstly, sport is highly valued and viewed as socially significant in our society. It is also an enduring and important element in the social and cultural life of most modern societies and an activity with the possibility of offering meaning and opportunity. Sport is an important part of life for many sectors of society. Secondly, sport has been challenged to make itself more socially inclusive and less elitist. [2] In this climate, can sport be used as a vehicle to challenge society's fear and ignorance of people with SMI *and* as one way to provide this population with opportunities for social inclusion? If so, how might we begin to explore this possibility and what support and adjustments are necessary? Is it possible that golf—a sport that boasts one of the highest participation rates in the country—might contribute? These are some of the overarching questions this project sought to explore.

How the Project Was Set Up

The impetus for the project arose during PhD research being undertaken by the second author (DC) at the University of Bristol [3], which explored the contribution of physical activity to recovery among a group of men with serious mental illness (SMI). This research took place at a mental health rehabilitation day centre where a variety of sport and exercise groups were offered and many service users and mental health professionals were positive about the benefits of these groups. Golf, however, was not an activity previously considered. We decided to explore whether golf might be a beneficial activity for some service users and, despite some understandable reservations, mental health professionals agreed to cooperate with us on this novel initiative.

A charity event was organised to raise approximately £5000 to cover the costs of the programme. This money was significant because it meant that the programme (including equipment, course fees, refreshments, tuition, and minibus transport) could be provided free of charge to service users.

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Aims of the Project

The first aim of the project was for us to 'give back'—to reciprocate—something to the mental health centre and those people with SMI who had participated in DC's PhD research. Was there a way that we, as researchers, could contribute something they might find valuable and meaningful?

Our second aim was to deliver a golf programme that might provide some of the benefits outlined above.

Our third aim was to document the effects of participation experienced by service users. Would service users participate? Would the programme be experienced as beneficial? We explored these questions through an ethnographic research project into the programme's delivery and effects [4–6].

Delivery of the Project

A 9-week golf programme was planned and delivered by the first author (KD) (a qualified Professional Golfer's Association coach), who provided coaching in line with our ethos of facilitating a positive experience for the group members. We sought to take the group from secure and familiar territory into less familiar public golf environments, teaching skills that not only made it possible to play the game, but also to initialise independent participation. We felt it highly important that each member of the group was able to work at their own individual pace, that technical information was purposeful and limited, and that the game was altered to maximise positive experiences and confidence, especially in the early sessions. As with all good coaching, encouraging an enjoyable, socially inclusive atmosphere was important.

The programme progressed from a closely guided form of group coaching and structured organisation, towards an independent (service user-led) format with coaching being offered on a one-to-one basis as required. The programme utilised three settings:

- *Local setting* (Week 1). We facilitated a familiar and comfortable initial session by arranging an introductory talk over a cup of tea at the café in the day centre. The group then made a short walk to a nearby sports centre (familiar to most of the group members) where we had set up an indoor putting course. Here, putting tuition and a light-hearted team competition took place.
- *Driving range* (Weeks 2, 3 and 5). We used a local range which made no special provision for the group, although the staff were sensitive to diversity. The sessions were taught as they might be for any other group of beginners in allotted bays alongside members of the public. The organisation and coaching input were typical of beginner group golf lessons.

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- *Municipal par-3 course* (Weeks 4, 6–9). We chose this setting for several reasons: reasonable cost (£5), easy accessibility (should participants wish to play independently), no membership restrictions, 'après-golf' facilities (space for socialisation and refreshments after play), absence of restrictions on clothing, equipment, or playing standard. During these sessions groups were encouraged to play at their own pace. If players found a hole difficult they were encouraged to pick the ball up and move on—this alteration is common to work with beginner groups.

Following all sessions, refreshments were provided and social time was allocated to allow all group members to interact and relax together.

Outcomes and Evaluation

A key criterion for assessing the success of this kind of programme is attendance. The difficulties faced by people with severe and enduring mental health problems combined with the challenge of commencing a new form of physical activity can result in poor and sporadic participation rates [7]. From this perspective, the attendance figures for the golf programme were surprisingly good. A total of nine individuals signed up for the course and, allowing for scheduled absences, overall attendance was 80 %. In mental health settings, participation provides a clear demonstration of service users' response to the programme as, to coin a phrase, 'people vote with their feet'.

Through our ethnographic research, we sought to understand the characteristics of the programme that led to these (relatively high) participation rates [4]. In what follows, we briefly describe five factors that emerged.

A Safety Net

Initially, we organised and directed most aspects of the programme: the location, the coaching, the length of the session and the activities. We decided how many holes to play and which players would be grouped together. These kinds of close support seemed to provide a necessary *safety net* which was important because: (1) many of the service users required close and intensive support to initiate new activities; (2) the costs were covered, encouraging attendance among individuals with limited disposable income; (3) a relatively directive coaching style helped participants to achieve immediate improvement in terms of the technical skills of the game.

Notwithstanding this safety net, sessions were planned around a gradual transference of responsibility away from ourselves towards the participants. By week 7, most group members were playing independently, while by the end of the programme some of the participants had made independent trips to the course.

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'Bubbling About Golf'

The comments of mental health professionals suggest the programme generated an unusual degree of enthusiasm; for example:

> The days after (the golf sessions) they were still bubbling—sort of their enthusiasm about it—especially in the first three sessions. Like Andrew was saying after the first session, 'That golf was really good!'. 'Cause I missed the putting and he said, 'You weren't at the putting—you missed a good session there!'. And I must admit … he wouldn't have said that before. He wouldn't have said it that enthusiastically.

According to staff, this enthusiasm spread through the centre and affected other clients. In addition to clients, other staff at the centre also had positive responses to the programme. An occupational therapy assistant (not involved in the project) had this to say:

> They (the group members) seem to be really enjoying it—I talk to them in the café. The general feeling was that it was really, really well-accepted and people really, really enjoyed it.

A Relaxing Sport

The low-intensity nature of golf as a form of physical activity was something we hoped might encourage participation. This seemed to be the case—as one group member put it:

> I felt keen, you know, 'cause I felt it was good time out and, you know, it's not as if I'm playing a hectic sport, it's pretty relaxed … that's the beauty of it.

Feelings of relaxation through both the nature and environment of the game were voiced by several other group members and mirrored by one mental health professional who highlighted the importance of low-intensity exercise:

> I think the good thing about golf is, in some ways, it's not too over-physical. Because you get a lot of people with side-effects of the medication, putting on weight, for them to go swimming or them to go to football, or for them to do those sorts of activities is even harder because of all the excess weight they carry.

Caring Golf

From the outset, our ethos was to provide a beneficial experience for each individual and the sessions were planned with this aim in mind. The comments from mental health professionals and our own observations suggest that an atmosphere of 'caring golf' characterised the sessions. Our field notes document a positive, caring atmosphere among participants:

> The positive atmosphere was complemented by a large amount of consideration for each other. There really was, once again, no feeling of competitiveness. Everybody seemed to

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> want everybody else to do well. Ronnie asked the group, 'Can I go next, do you mind?' and Andrew replied, 'No objections at all.' Simple things, but positive, supportive, encouraging, and considerate. (DC, 9 July)

One mental health professional linked the positive atmosphere to an absence of overt or strong competition:

> It is not a competitive sport, you can play competitively, but when you're doing it in that sort of setting it's not competitive, so everybody worked at their own pace and they improved at their own pace and they all gained something from it at different levels. And that's what I think was really, really good. That there was no sort of, 'Oh, I'm better than you', or 'I won that game and you didn't'. It was all very individual and I think they gained from that, I think they found that very valuable, that they could actually see improvement within themselves and not against other people.

Important in creating a caring environment is the coach's approach and philosophy, which emphasised personal improvement and achievement by drawing attention to the positive aspects of each individual's play. The words of another mental health professional highlight some of the personal qualities of a coach that are required to create a caring environment:

> You (KD) are very, you're approachable, and you're human and you have a laugh and you're not just standing there telling them what to do. You were part of it all… but you also had all this knowledge that none of the others of us had so you were a kind of central point really. But yeah, you were friendly and talkative and explained it, explained it well so everyone could understand.

Doing Something 'Normal'

As is common with sporting activity, group members enjoyed the social experience entwined with sharing refreshments after play. Like all groups, they told stories about their play—the good shots and the near misses. Nurturing and encouraging this time was something we felt was critical to the success of the programme. It helped us get to know the group and the group members get to know each other. It was a time that the whole group could be together and it appeared from the 'banter', jokes and laughs that this was an important part of the programme. In a sense, the golf programme gave the participants something positive to talk about beyond their problems—a way of taking a tentative step into a world outside mental health. To realise this possibility, dedicated social time is required to encourage and facilitate social interaction and relationship building.

Future Work

The positive responses from service users and mental health professionals to this project strongly support the need for future initiatives in this area. Despite being initially sceptical of the suitability of golf as an activity for this client group, several

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professionals revised their views in light of the success of the project. For instance, following the completion of the programme, we asked one individual for his views on whether golf is a suitable activity for people with SMI:

> Oh definitely. Before this session, I would never have thought there would be so much interest in it. I would have thought golf would be a good one-off day out sort of thing, not so much eight weeks or so … But now I've seen it and now I've experienced it it's brilliant. We plan to continue it basically, if we can … From the first session out, people concentrated and enjoyed it and everything. Yeah, it's one to continue! It's such a winning combination you wouldn't change it.

Two final pieces of evidence for the programme's success support future golf programmes. First is the successful continuation of the group despite service users now having to contribute to course fees. Since the initial programme, some of the original group members have continued, some new members have joined and attendance has been good. Second is greater awareness generated through the programme of the contribution coaches can make. This has resulted in the introduction of regular coached sessions in football, badminton, tennis and martial arts.

Lessons Learnt

1. *Ethos is critical*. While coaching provision was, in this project, experienced as beneficial, it is equally possible for coaching to be problematic. The ethos and philosophy behind coaching practice is crucial—it is less *what* is done, and more *the way* it is done that matters. Key characteristics of good coaching (in mental health contexts) include: a person-focus, a positive and caring coach–participant relationship and a co-operative orientation (with an emphasis on personal progression and development).
2. *Intensive support is needed*. In light of the challenges faced by many people with SMI, intensive personal support and encouragement is often required, particularly in the early stages of a new programme. Over time, greater independence may be assumed by some individuals, with the ultimate goal of self-directed participation.
3. *Cultural factors matter*. Sport and physical activity are not inherently 'good things' for people with SMI. Some sport/exercise environments might even be considered toxic in terms of their effects on self-esteem, relationships, confidence, wellbeing, diversity and safety. Therefore, the social and cultural environment in which sessions take place needs to be considered and, at times and if possible, carefully modified.
4. *Each individual is individual*. It is not the case, when it comes to sport or exercise, that 'one size fits all'. Instead, provision needs to be tailored to suit each person. In the context of this project, golf was not appealing or appropriate for everybody—some people declined to sign up for the programme. Even among those for whom it was suitable, modification was sometimes necessary to meet personal needs. Attempts to apply a standardised activity 'prescription' will be unsuccessful in terms of both participation rates and outcomes.

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(continued)

5. *Nothing lasts forever*. There is a tendency to judge interventions by whether they are indefinitely sustainable. This project reminded us that even temporary involvement in an intervention can be beneficial. Some group members wanted or needed only a few sessions of activity—this was sufficient to allow them to move on to other things. Programmes should not be judged a failure simply because (some) individuals stop attending after a period of time. Instead, flexibility and adaptability are hallmarks of good practice, initiating (and later stopping) different activity types and formats in response to client needs and interests.

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Chapter 14
The Community Street Soccer Program

Emma Sherry

Background

In developed nations, social disadvantage is representative of a global divide, and social disadvantage is often evidenced in social exclusion. The concept of social exclusion provides a label to refer to the forms of disadvantage suffered by those groups identified as marginalized in some way. According to Barry [1], an individual is defined as socially excluded if:

(a) He or she is geographically resident in a society, but
(b) For reasons beyond his or her control, he or she cannot participate in the normal activities of citizens in that society.
(c) He or she would like to so participate.

Social exclusion can manifest itself in many different ways including unequal access to educational, occupational, and political opportunity. However, Barry [1] identifies that there are "obvious material conditions that have to be satisfied to avoid social exclusion. The most basic is a place to live: those with 'no fixed abode' (whether sleeping rough or moving between shelters and hostels) are excluded from most forms of participation." Reduced comparative income, less access to public transport, and less social contact are all factors that are likely to impact on those classified as homeless [2].

The capacity for sport to act as a vehicle for developing marginalized populations has resulted in programs targeting the integration of marginalized and at-risk individuals and communities, such as refugees, people with a disability, and the socially disadvantaged. The recognition of the need for programs that address the needs of those who are socially marginalized necessitates an understanding of the

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complexity of social disadvantage. Disadvantaged populations display a complex array of issues that necessitate addressing community reintegration, social cohesion, antisocial behavior and drug and alcohol rehabilitation, among others. The labelling of "social disadvantage" correlates with social exclusion, as social exclusion is recognized as a status that relates to lack of social participation beyond a person's control [2].

Social inclusion is acknowledged as a fundamental step in improving disadvantaged people's social situations [3], and sport is beginning to gain attention as a viable medium for promoting social inclusion [4].

Aims of the Project

The Community Street Soccer Program (CSSP) was established to provide a sport program, in this case soccer, for participants drawn from marginalized or socially excluded communities within Australia. The primary aim of the program is to provide new support networks, social skills, and friendship groups to participants, therefore ideally reducing the risk of antisocial or harmful behaviors. The mission of the CSSP is to "promote social inclusion and personal change for participants by providing support and promoting participation, inclusiveness, commitment, and team spirit" [5].

Program participants are drawn from a wide range of individuals experiencing varying levels of disadvantage, including, but not limited to: people with a disability (predominantly mental illness, learning disorders or intellectual disability), recently arrived refugees, people experiencing or recovering from alcohol or substance dependency, Indigenous Australians and long-term unemployed. There are no criteria for participation however, other than a willingness to attend and adherence to the CSSP code of conduct.

How the Project Was Set Up

The Big Issue, an independent street press organization that provides work as magazine vendors to people experiencing homelessness, substance dependency or mental illness, established the Australian CSSP in Melbourne in 2004. George Halkias, a trained psychologist working with The Big Issue, began holding informal soccer "kick-arounds" at a nearby public housing estate on a Wednesday afternoon for the magazine vendors. From this point, George and The Big Issue Australia learnt about the Homeless World Cup (HWC), which was founded just 2 years earlier. Drawing on philanthropists and corporate sponsors, funds were raised for the Australian team to attend the 2005 HWC in Edinburgh. After a successful debut, Federal and State government funding was sought to primarily grow the program nationally and

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importantly, to host the 2008 HWC in Melbourne. This combination of funds from government, sponsors and philanthropists continues today.

Delivery of the Project

The Big Issue CSSP currently operates at 18 sites across Australia, and continues to be managed by The Big Issue, a social enterprise. The project includes a women's program, prison programs and a range of local community programs. Each program has been strategically established in communities identified as being the most disadvantaged in Australia. The focus of the CSSP aligns with an overall commitment to promote independence and self-reliance in marginalized or at-risk individuals, through socially inclusive programs promoting social capital and self-efficacy.

Programs operate at various locations across Australia, running to a schedule of 2-hour weekly training sessions provided by a trained soccer coach and liaison officer, with the program development and management overseen by full-time support staff at the national office. An additional important factor in the delivery of the program is the link to local community support and social welfare agencies, to facilitate opportunities for participants to receive assistance and advice. The structure of peripheral links to community support services is central to promoting the continuation of social participation initiated through the program, and this support has been identified to be necessary to ensure that the initial benefits of sport participation eventuate in social change that benefits participants.

The primary mode of promotion for the program continues to be word of mouth in the local community, facilitated through support and engagement with the community agencies. However it is essential to note the importance of the HWC, as a high profile international event, in the promotion of the grass roots CSSP to the participants, and also to potential staff and funders.

The HWC was established in 2003 by the International Network of Street Papers, and (as stated above) Melbourne, Australia, hosted the 2008 HWC (Fig. 14.1). The HWC was developed to promote social opportunities, including access to support services and interaction with others, for participants experiencing homelessness and associated social disadvantage. Street soccer at the HWC is played with four participants representing their national team, on a small, walled outdoor pitch, to simulate the soccer played in the streets across the world.

The Street Socceroos, are selected from the CSSP program each year as the Australian representative HWC team. To be eligible for selection for the HWC, the athletes must be over the age of 16, have experienced homelessness in the last 2 years, and/or be participating in a drug or alcohol rehabilitation program. Regular participation within CSSP is also required for Australian HWC team selection, as is the ability to cooperate well within the team environment. Australia sent its first team to the HWC in Edinburgh Scotland, in 2005, and has sent a national team to each HWC since [6].

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Fig. 14.1 The Homeless World Cup, 2008

Outcomes and Evaluation

Outcomes

Since its informal beginnings in Melbourne in 2004, the CSSP has engaged more than 5000 homeless, marginalized and disadvantaged people. Over this period, many participants have reported positive changes in their lives.

The CSSP measures its participant and program outcomes via formal evaluations undertaken each year by a partner University (2006–2013 inclusive). These evaluations measure the socio-demographics of the CSSP population, and identify the impacts and outcomes through qualitative interviews with a sample of participants each year, and regular interviews and surveys with coaches and support workers.

The annual evaluations have identified three powerful outcomes for participants across the programs:

1. Increased physical fitness
2. Enhanced sense of purpose and structure
3. Increased social connection and sense of community [7]

In addition to the direct impact on individual participants, Street Soccer is a cost-effective social change program that saves money to the Australian taxpayer. In 2009, an independent study on the program's economic impact found that participation in Street Soccer led to individual behavior change and a reduction in high-risk

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activities. The study estimated every $1 invested in the Street Soccer program generated a saving of $4.30 to the Australian community. Based on the program's operating costs, it estimated that Street Soccer saved society $7 million per year [8].

Evaluation

Formal evaluations of the CSSP have been undertaken annually by the author to investigate the socio-demographics and participant outcomes of the project. These evaluations have been undertaken both to enhance the program in a process of quality improvement, and to meet external funding requirements.

Each evaluation has focused primarily on the outcomes for players from participation in the program, specifically addressing the following research questions:

1. Who are the people accessing the CSSP?
2. What are the motivations for these people to participate in the CSSP?
3. What are the benefits or outcomes that participants receive from participating in the CSSP?

In addition to the participant interviews, coaches and agency support workers involved in the program are also interviewed or surveyed to provide their feedback and reflect on the program and outcomes for participants. Evaluation reports have been presented to The Big Issue and funding bodies for 2007, 2008, 2009, 2010 and 2012, and 2013 [9].

Results from the most recent evaluation study (2013) [7] found:

- A wide variety of participants were engaged in the CSSP across Australia
- Over half of the participants were dealing with issues such as: alcohol and substance abuse problems and mental illness
- There was a small but significant number of participants with an intellectual disability
- The majority of participants reported that they were currently in stable, although not in ideal, accommodation
- Up to one-third of participants were currently employed in some capacity
- Approximately one-quarter of participants were undertaking higher education studies
- Recruitment to the CSSP was found to occur primarily via introduction through friends of existing participants (50 %) or, via a caseworker or support agency (25 %); those remaining were encouraged to attend by family, or approached directly by the CSSP staff

The vast majority of participants attend the CSSP sessions regularly. Reasons for nonattendance included: illness, work commitments and difficult interpersonal relations within the group. Participants identified the locations of the CSSP sessions and access to transport as the barriers to regular participation.

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There is a range of benefits provided by the CSSP, however these benefits are not uniform and were found to be dependent on:

- The attitude of the participant
- The issues or problems the participant is dealing with
- The structure of the program
- The skills and approach of the CSSP staff

The participants identified the following three key benefits:

1. Physical fitness
2. Social connections
3. Provision of structure and relief from boredom

Very few of the participants reported that their complex problems were directly addressed through the CSSP, and any changes were often related more to their support structures. This indicates that the CSSP alone cannot deliver substantive social, health, or emotional changes within people; it acts instead as a complementary service.

The Big Issue CSSP provides a stable, safe and welcoming program for marginalized and socially excluded participants from a broad range of communities, including:

- People in crisis
- Those dealing with substance or alcohol abuse
- Mental illness
- Disability (both physical and intellectual disability)
- Refugees

The CSSP provides the most effective outcomes when working in conjunction with other services, and when it can act as either a catalyst or as an activity that provides weekly structure.

In addition to the annual evaluation reports, peer-reviewed academic research has been published from these studies [10], including work undertaken during the 2008 HWC in Melbourne, Australia [11, 12], an international comparison study with the Scottish HWC team and program [13] and a discussion of the role of the researcher undertaking research with vulnerable communities [14].

Future Work

After a period of rapid growth between 2008 and 2010 with programs established in over 30 locations, the 2013 iteration of the CSSP was consolidated to two prison programs and 16 local community programs, primarily to ensure program sustainability. As the CSSP has been a model sport for development program in Australia, it continues to evaluate and adjust the program delivery to ensure continual improvement, and to meet the needs of funders, however there will be no significant changes to the grass roots model of soccer delivery combined with support structures to develop participants to their best potential.

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Lessons Learnt

The Big Issue Community Street Soccer Program provides a valuable service to homeless, marginalized and disadvantaged people across Australia, evolving organically from a single informal soccer "kick around" into a formalized sport for development program with significant government and sponsor support. Programs such as these are increasingly found in developed nations, to address social exclusion in their local communities, with many using soccer as their sport of choice. Successful replication of the program depends on its development and delivery being adapted to the specific and unique needs of the local community. For example, although under the auspices of the CSSP, the women's program often includes other sports or physical activities to provide variety to the female participants, whereas the program in the Port Phillip Prison includes regular guest speakers and tournaments with supporters to provide valuable interactions with the outside world.

A key lesson learnt from the evolution of the CSSP has been that its rapid growth and expansion proved to be unsustainable, and required the subsequent rationalization of the program delivery sites to those most able to be sustainable in the long-term, or those communities identified as having the greatest need. When building a program over time, it will be important to ensure that each location and iteration of the program is planned, developed, and implemented in such a way as to ensure its long-term success.

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Chapter 15
Promoting Mental Well-being in Rugby League Communities

Jane Riley

Background

Poor mental well-being is one of the most significant health issues both in terms of health and well-being of individuals and their families, and its wider impact on communities, the economy and employment [1]. In any given year 1 in 4 of the population will experience a mental health problem [2] and impaired mental well-being has a very high-cost impact on business and the economy [3]. Misunderstood and feared, the stigma and implications of mental health issues mean that many do not realise they have a health problem or that help can be given; many who do seek help are poorly diagnosed. Men are significantly less likely to seek support or to receive a diagnosis of stress, anxiety or depression [1]. This means that for many their condition and its consequences become significantly worse, with associated problems including alcohol, drugs, relationship breakdown, employment issues, self-harm and suicide.

These issues are more prevalent in more deprived areas, mirroring the traditional heartlands of Rugby League which developed out of the dramatic period at the end of the nineteenth Century which saw the rise of organised sport and the creation of Clubs and leagues, heavily influenced by class, finance and the place of professionalism [4].

Rugby League has a long and proud history of working closely with its local communities, with a key feature of Rugby League being its family appeal: 40 % of regular supporters are female [5] and fans of all ages attend matches and Club-related activities, often in family groups spanning the generations. Each major Club has an independent charitable Foundation which runs community-based activities

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with local health bodies, councils, schools and charities, providing support and activities on education, training and employment, health and well-being, heritage, social inclusion and of course sport, nutrition and physical activity. Research has shown that using sporting settings and sports clubs is an effective way of reaching local communities, particularly those who are most in need but often regarded as 'hard to reach', because media, fans and local people more generally are interested in the Club and the players, and see the players as role models [6–8].

Rugby League Cares (RLC) was created in 2012 to bring together the Rugby League family of charities—the Rugby League Foundation, Benevolent Fund and Heritage Trust—and acts as umbrella and coordinator for the network of local Foundations. Its mission is to enhance and enrich people's lives through the power and positive influence of Rugby League by working with local communities to help them lead a more positive and healthy life through the delivery of high-quality sports, educational, employment, heritage and health-based activities. In 2012 alone, it worked with 600,000 people, providing services with an added value of some £6 million.

RLC, with local Foundations, therefore decided to take action to promote better mental well-being in its local communities. This Chapter looks at the experience and lessons from the first year of the 2-year project which was funded by Sport Relief.

Aims of the Project

The RLC and Sport Relief Mental Well-being Programme was set up to:

- Create and deliver projects for 'at-risk' groups to improve mental well-being
- Raise awareness of the services available and promote pathways for those in need
- Build relationships between Foundations, their local communities and partners—particularly local NHS and expert charities
- Increase capacity within Clubs, giving staff more confidence and knowledge about mental health
- Generate new knowledge of how sport and Clubs can reach and positively influence local communities, which could be shared throughout Rugby League and more widely

How the Project Was Set Up

RLC successfully bid to Sport Relief[1] for £350k funding over 2 years for RLC to work with 12 local Foundations to design and deliver a range of locally focused projects. Each could select the audience(s) they wished to work with, to reflect local skills, priorities and opportunities, provided that the project was linked to the theme of 'mental well-being' and the target audiences were in some way at higher risk of

[1] http://www.comicrelief.com/sportrelief.

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mental ill-health. Each Foundation was to receive £10k in each of the 2 years, subject to satisfactory progress and quarterly reporting.

Nationally, RLC appointed a project manager who provided a 'toolkit' including project plan templates, material on evaluation, lessons from previous projects, facts about mental well-being and national contacts as well as providing one-to-one support in reviewing plans and making contacts. Although all Foundations had track records of delivering health projects, most had less experience of mental health and in addition the initial phases of the programme coincided with a significant shift of responsibilities and personnel within Health and local government organisations. RLC also commissioned the Institute for Health and Well-being at Leeds Metropolitan University to carry out an independent review of the process to identify lessons from year 1.

In addition, RLC ran a mental well-being campaign focused over one weekend (the 'Round 27' campaign) in collaboration with the NHS Confederation,[2] NHS Choices[3] and Leeds Metropolitan University.

Delivery of the Project

The 'Round 27' Mental Well-being Campaign

In September 2012, RLC, Super League Clubs, Leeds Metropolitan University, NHS Choices and the NHS Confederation collaborated to promote mental well-being to rugby league fans over one weekend. Packs of standard material were sent to Clubs including material for websites, programmes and editorials along with branded t-shirts to all Clubs for use in photos and match warm up. NHS Choices produced a bespoke webpage about mental well-being linked to an assessment tool and further information. RLC and Leeds Metropolitan University also surveyed fans at one match to find out what they thought of Rugby League promoting mental well-being.

Community Projects

Each Foundation designed and commenced delivery of a project tailored to one or more 'at-risk' groups within their local communities. Key elements about delivery include:

- Which audiences were selected and why
- What partnerships were developed and with what results
- How resources were used

[2] The NHS Confederation is the national body which represents all those organisations which commission or provide services to the NHS in England. http://www.nhsconfed.org/

[3] www.nhs.uk.

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Foundations could choose one or more audiences within the theme of 'mental well-being'. Most used their existing knowledge to identify the groups with which they wished to work. In many cases, this built on existing expertise (for instance, Warrington Wolves and Salford City Reds added mental well-being to their existing programmes on employment). Others used local information such as the local authority/health joint strategic needs assessment (JSNA) to identify needs and gaps (Wakefield Wildcats, Featherstone Rovers).

Foundations rely on a small number of staff as well as volunteers and input from staff and players at their Club. All set about building partnerships to ensure that appropriate expertise was to hand, referral routes were clear, and to increase available resources.

As the projects varied, Foundations used the funding in different ways, including:

- Some additional staff time
- Travel and subsistence for coaches and participants
- Facilities including catering (often provided free—particularly by Clubs and Foundations—or at reduced rates, by partners)
- Laptops and projectors in order to make better quality presentations off-site
- Materials for events including tailoring existing materials for a new audience
- Carrying out health checks (including costs of testing kits)

All Foundations used some of their own resources, particularly project management and partnership building, and all of their respective Clubs contributed the time and enthusiasm of their staff and players, several of whom talked openly about their own mental well-being and its importance in their professional and personal lives.

Outcomes and Evaluation

Key Output and Outcomes

The following is a summary of activity (not exhaustive) delivered by each of the Foundations and partners in Year 1.

- Bradford Bulls: ran fortnightly reminiscence sessions for targeted older people and two school events for a total of 400 Year 11 young people (age 15–16).
- Featherstone Rovers: responded to an identified gap in services for local carers, holding a Carers' Rights Day (for 93 people) and establishing a monthly Carers' Network (+200 users).
- Huddersfield Giants: targeted young people and adults identified as having (or being at risk of) mental health problems, including a school holidays programme for 30 selected young people.
- Hull FC: delivered physical activity programmes for 47 adults with mental health problems, together with a programme for 17 inpatients at a local secure unit, as

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well as engaging 150 Year 11 and 6th Form (age 16–18) young people through eight educational workshops.
- Leeds Rhinos: trained 28 mental well-being ambassadors in community clubs across the city, with the potential to engage with 10,000 club members.
- London Broncos/London Rugby League: ran a series of mental well-being roadshows at major events in London and the South East of England, including an event for over 500 Olympic Park construction workers (with top tips for mental well-being provided through social media).
- St. Helens Saints: reached over 700 men under 25 and over 50 in priority groups (e.g. unemployed, leaving secure accommodation), including weekly sessions with Job Centre Plus (JCP) providing mental well-being and employment support for unemployed young people.
- Salford City Reds: worked with a local newspaper (readership 234,000) and delivered two match-day events (reaching 7500) to raise awareness of mental well-being and mental ill-health issues.
- Wakefield Wildcats: trained 20 volunteer 'buddies' to support fans with learning disabilities and set up Companion's Card (administered by Carers Wakefield) to enable fans with learning disabilities or mental health problems to attend matches with a fellow fan.
- Warrington Wolves: ran workshops for inmates in a local prison and mental health in-patients, and raised awareness of mental health issues and support for 105 young people in seven Further Education Colleges and school 6th Forms; 45 'at-risk' older people also reached through a range of activities showed an improvement in mental health awareness and well-being and Warwick-Edinburgh Mental Well-being Scale (WEMWBS) questionnaires administered to outreach group participants showed a mean score increase from 42.5 to 58.5.
- Widnes Vikings: identified isolated, vulnerable older people with poor mental health ('Invisible Vulnerables') and delivered a programme of social/physical activities and input from local support agencies to increase resilience and feelings of safety and connectedness.
- Wigan Warriors: delivered a combined mental and physical activity programme to increase resilience and self-esteem ('Tackle It') for 54 men aged 24–75: 80 % achieved 100 % attendance, 90 % set goals to achieve/made significant progress towards lifestyle changes, and 75 % made positive mental health-related changes and continued to engage in health-related programmes, fitness or group exercise on a regular basis (25 % going on to join a local gym).

Creating and Delivering Projects for 'At-Risk' Groups

Partner feedback confirms all Foundations correctly identified key audiences, successfully engaging groups which tend to be socially isolated and cut off from opportunities for activity (such as those with mental health issues, carers, unemployed) or other groups considered 'at-risk' including school pupils, young adults and over 50s.

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In several cases, partners were inspired to join in because they recognised that their local Foundation was taking forward an important part of the local agenda. Feedback is that the Foundation and Club's brand and position in the community have been fundamental in engaging their target populations.

There is a general lack of understanding and therefore a stigma associated with mental health. In many cases people do not realise that their mental health is impaired (or they do not receive a correct diagnosis) or that support is readily available. Whilst people may recognise that they need to look after their physical health, many do not appreciate that they can also take steps to promote their own mental well-being, build resilience and increase their levels of satisfaction with life through relatively simple steps [9], for instance through social networks and physical activity—both objectives of the Sport Relief projects. Participants at schools and Clubs reported increases in understanding and awareness of symptoms, what is 'normal', where to obtain support for themselves and others. Some highlighted drugs as a particular concern and Foundations then covered this in more detail in collaboration with local services.

Foundations agree that the public engagement of players and the Club in talking about mental health and their personal challenges has made an important contribution to engaging audiences and tackling stigma. Stressing that physical injury and poor mental health have many similarities has been a useful analogy in stressing the importance of resilience but also how mental ill-health is not the fault of the sufferer.

Physical activity has a beneficial impact on mental well-being and all these activities build social capital, another determinant of mental health status as well as its physical benefits (such as Huddersfield's Good Mood League). Many participants have reported improvements in their mental well-being (Warrington saw a 16-point rise in the WEMWBS score), with several going on to other programmes including six signing up for a City and Guilds Course following Hull's programme, and a number reporting that they had joined gyms (Wigan) or were maintaining their activity levels through other programmes.

One of the most interesting findings was that as a result of their work with partners, most Foundations added additional 'at-risk' groups once they realised that there were opportunities to reach more people. For instance, from discussions with partners, Saints Foundation found that St. Helens had significant numbers of people aged 18–25 rapidly becoming depressed after losing their jobs. Saints recognised that the Club and Foundation could have a useful role here, given their status in the community and as a result developed a very effective partnership with JCP which has enabled JCP to reach their target audience. JCP commented:

> We have worked with Saints for a number of years on projects but the timing of the Saints' Sport Relief project has helped us to look at local needs in a different way. A number of clients who have health issues around depression are now engaging with Saints which can only benefit these people and help them to return to the job market.

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Greater Awareness of Services/Signposting

All Foundations established links with local services for signposting and onward referrals:

- Many participants said that as a result of the programme they now knew where to get help
- Foundations were able to enlist GPs, mental health, housing, employment and training specialists to be on hand at events
- Some ran additional sessions with specialists in response to requests from participants
- Hull in particular found that they were able to refer on participants who were in need of specialist support but who were not currently under the care of their mental health trust

Given the sensitivity of the information and limited resources, the projects have so far not generated comprehensive data on what happens to those who are signposted or referred on, although proxy measures suggest some success, including take up, retention, numbers of interactions, people asking for literature and feedback from partners.

To promote mental well-being, as set out above, RLC ran a campaign over the weekend of Round 27 (beginning of September 2012). Although the time available was very short, reducing RLC's ability to promote the initiative as extensively as it would have wished, packs of standard material for websites and programmes and branded t-shirts were sent to Clubs for local adaptation. Several ran mental well-being events often in collaboration with their mental health trust, gaining local press attention.

NHS Choices produced a bespoke webpage about mental well-being with links to an assessment tool and further information. Feedback from NHS Choices was that this was very successful:

> there have been 104 visits to the RLC page so far. On first glance this might sound a little disappointing, [but] that is above average for the time period involved. It should also be looked at in the context of the length of time people spent on the page (208 seconds)—this is significantly above average and would suggest (as it's a fairly short page) that people are taking the time to read it and, perhaps, use the wellbeing assessment on that page. The majority of people coming to this page are likely to have come directly to the site after seeing the URL on the various forms of marketing.

On behalf of RLC, Leeds Metropolitan University surveyed fans at one match about the acceptability of Rugby League promoting mental well-being. Key findings are set out below.

In response to statement 1 (The sport of Rugby League has a role in promoting mental well-being) 91 % agreed to some extent, with the largest proportion (58 %) agreeing strongly. Only 2 % expressed any degree of disagreement.

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In response to statement 2 (It is a good idea to use a Rugby League match day for promoting mental well-being) a very large proportion of respondents (95 %) expressed agreement with this statement, with most (66 %) agreeing strongly. Less than 2 % expressed any degree of disagreement and no one strongly disagreed.

There was little difference between sexes and different age groups. No one who initially expressed willingness to complete the survey subsequently declined on learning it was about mental well-being. Several described their own issues with mental health and how important it was that it was being talked about. It showed that RLC and Foundations can take key messages, build partnerships and deliver the messages effectively in ways that have meaning for fans—even in a very short space of time and with limited resources.

Cultural Change and Greater Capacity within Foundations and Clubs

All Foundations and Clubs undertook some training, including running sessions for younger players, coaches and those in community clubs based on 'mental health first aid' [10] which increased understanding and experience. Several Foundation staff also undertook additional training as Older People's Champions with Age UK. Staff reported that gaining confidence that they were doing 'the right thing' was one of the most important benefits, and building links with local mental health providers made it easier to know where to signpost people for support. This was particularly important as the sessions generally led to participants wanting to talk about themselves or someone close to them.

Building Links Between Clubs and Communities

All Foundations made links to their communities, engaging thousands of people through awareness and information programmes for the general public, and through a wide range of targeted activities for at-risk groups: including young people, older people, those with mental health issues and those who were isolated.

Partnerships

Although Foundations had a number of strong local connections, these projects enabled them to identify and collaborate with new partners, particularly mental health NHS trusts and specialist charities. A total of 64 external partners were involved from several different sectors: health (primary, mental, public), education, employment, housing, social care, justice, children's services, arts, media and

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charities supporting older people, young people, carers and those with specific mental well-being needs.

Partners provided valuable expert input, including refining programmes, managing referrals, recruitment and publicity. Most also came to events, sometimes playing a significant role in delivery and investing many hours of staff time.

Evaluation

To generate learning, all Foundations are evaluating their individual projects. In addition, RLC commissioned Professor Alan White at the Institute for Health and Wellbeing, Leeds Metropolitan University to carry out an independent review of the process to give RLC some insight into what additional support Foundations would like to receive [11]. The evaluation included a focus group (to establish key areas) followed up by one-to-one telephone interviews with the lead from each project.

Knowledge and Lessons

Feedback from Trusts and independent process evaluation by Leeds Metropolitan University have generated new learning and case studies which can be shared more widely, including about the value of partnerships with statutory and non-statutory bodies; how to engage different populations (such as the value of using local radio to reach out and target carers and working through specialist partners for those with mental health problems); the value of using the Club ground (such as St. Helens); and the success of Foundations in engaging with target populations. More details are below.

Lessons Learnt

- The importance of Sport Relief's funding and support: without the resource from Sport Relief, none of these projects would have been developed. Foundations generally have very small numbers of staff. Having funds to bring to the table enabled Foundations to gain the attention—and then the contribution—of partners who reported that they contributed their own time and resources because it was clear that 'something' was feasible.
- Foundations are able to design and deliver programmes, building local partnerships and engaging a range of at-risk groups: key successes include successfully identifying appropriate participants and partners, tailoring activities and effective communications and recruitment.

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- Foundations and Clubs are very valuable partners because people are attracted by the brand, interested in what the Club and players say, and feel comfortable engaging with the Club—particularly at its own facilities—even about very sensitive issues. Most partners cited this as a key reason behind their decision to become involved. Most appear interested in continuing or expanding the programmes.
- Fans welcome mental health initiatives. To some extent, stigma can be reduced by the public involvement of Foundations and players being open about the issues.
- Partnerships are very valuable in terms of quality, recruitment, signposting and follow-up.
- Statutory and charitable bodies recognise the value of working with Foundations because their brand and reputation mean they can attract and influence those considered 'hard to reach'.
- Projects show the value of partnership with Foundations bringing brand, attractive and accessible venues and expertise in sport, education and social inclusion, and partners bringing expertise in mental well-being, employment, housing and training.
- Partners helped to identify appropriate participants and, likewise, Clubs identified and referred on participants in need of specialist support who were not currently in the healthcare system.

Future Work

In the second year of this 2-year project, there will be a focus on identifying how to achieve future sustainability when Sport Relief funding ends, given that all of the Foundations feel strongly that Foundations and Clubs have a significant role to play in engaging people in need and promoting better mental well-being among some of the most disadvantaged in society.

Acknowledgments RLC is very grateful to Sport Relief for their grant funding, to the Foundations and Clubs and all of the partners and participants, and to Leeds Metropolitan University for their evaluation and support.

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Chapter 16
Slum Soccer: Female Empowerment Through Football

Vikrem Vybav, V.G. Raghvendran, Marisa Schlenker, and Abhijeet Barse

Background

India is the second most populous nation in the world, home to over a billion people. Two hundred and sixty million people in India (a group almost equal to the entire population of the United States) earn less than Rs 50 a day and 170 million of these people live on the streets with no place to call home. A sizeable portion of these 170 million people are women and children; and they are denied even the most basic right of survival and protection.

A surprisingly large proportion of Indian society believes a woman ought to be subservient and deferential to men, with the concept of gender equality sometimes almost nonexistent. In India's underprivileged communities, women endure physical and sexual abuse on an almost daily basis. Children of commercial sex workers in all probability will follow their mothers into the flesh trade. One of the many indelible scars that this unrelenting exploitation leaves on them is a significant trust issue. An offer to secure them a place of residence is in all probability likely to be met with suspicious refusal, thus perpetuating homelessness.

UN's Gender Inequality Index [1] shows that India is ranked 132 among 148 countries in terms of gender equality. Only 29 % of the women in India work, compared to 81 % of men. Furthermore, 22 % of women against 35 % of men in India have completed 10+ years of education; and only 1 % of the women in the lowest income level have completed 10+ years of education [2].

Fifty-five percent of the women in India have suffered some form of domestic abuse, and women in the underprivileged communities are twice as likely to be

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abused compared to those in higher income group communities. Girls whose mothers have faced domestic violence are about three times more likely to face the same [2].

What is more alarming is the fact that the current generation of adolescents in the country think that spousal abuse is justified. UNICEF's Global Report Card on Adolescents 2012 [3] suggests that 57 % of the boys and 53 % of the girls in India think that spousal abuse in the form of husbands beating their wives is justified.

Men in India who drink are reported to be 4.5 times more likely to abuse their wives [2]. Alcohol abuse is prevalent among cases of domestic abuse globally, while treatment for alcohol use disorders has been shown to lead to a reduction in domestic violence [4].

Aims of the Project

Slum Soccer addresses three main areas of concern:

1. Gender equality and women empowerment.
2. Development of three life skills—communication, leadership, problem solving.
3. Health and wellness.

Slum Soccer functions with the ultimate aim of reaching out to the Indian homeless using football as a tool for social improvement and empowerment. In addition to homeless youth, the larger demography that Slum Soccer works with include slum dwellers, recovering alcoholics and drug addicts, children of commercial sex workers, people living in extreme poverty, etc. In adopting the principle of "football for all," the organization does not discriminate people based on gender, age, religion, caste or creed.

Through a soccer-based approach, Slum Soccer attempts to support females to become self-reliant. Based on our experiences, we have found it an extremely effective measure to first encourage females to participate in our events and from there we are then able to work with them and get them involved in our different programs.

All we ask in the beginning is for our participants to kick a ball. Providing the chance to play in a designated safe space is a simple act that also aims to be therapeutic for our female participants. The inanimate football can be the outlet through which frustrations and disappointments that participants endure can be channelled out. The prospect of an evening kick about could possibly be something, if not the only thing, that they have to look forward to. They come to realize that our football pitches aren't a place where they are victimized or preyed upon, and can for some time let their guard down. As a first step, we give them an opportunity to play, as well as attempting to give them hope.

Football incorporates a lot of values and skill sets that can be taught as vital lifeskills. Female participants who have participated in our programs transform into individuals who have the ability to work with a team and in this process they learn to trust their team mates. Slum Soccer aims to bridge the gender divide by offering

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training and fielding of mixed gender teams, enabling men and women to compete on an equal footing together. We use this approach because we have found that it leads to greater confidence and self-esteem among the participants. Furthermore, the male players learn to respect women and value their contribution.

While the positive psychological impacts that Slum Soccer aims to have on its participants are latent and often take time to fully manifest, one objective that is immediately realized is the marked improvement in physical fitness levels. Care is taken to ensure that our players receive adequate nourishment and nutritional supplements while more importantly addressing their alcohol and drug-related problems with counselling and rehabilitation wherever applicable.

Even though substance abuse is more prevalent among the male participants in Slum Soccer, it often results in physical and mental abuse of females. We believe our objective in this regard directly impacts the young men by assisting them in their recoveries while indirectly impacting the women by pre-emptively preventing their future abuse.

How the Project Was Set Up

The journey of Slum Soccer in the field of women empowerment through sport started with the inception of the organization in 2001 when Prof Vijay Barse saw a bunch of boys and girls kicking a broken bucket around a slushy ground, blissfully unaware of the pelting rain in the midst of a sudden downpour. As time progressed, the physical education professor realized that the young people not only had improved football skills and fitness levels but also had better communication skills, leadership qualities and, more importantly, the divide between the genders was less obvious on the pitch.

Slum Soccer was then registered as a Non Governmental Public Charitable Trust Organization governed by the Public Trust Act of the state of Maharashtra in 2002 under a board of directors. The organization is subject to periodic financial audit by law.

The project was funded for the first few years by the founder of the organization, Prof Vijay Barse.

Delivery of the Project

Slum Soccer runs its women empowerment programs using the curriculum devised with the help of its partners—Coaches Across Continents, streetfootballworld and Homeless World Cup Foundation. The curriculum is tweaked to address specific concerns faced by females in underprivileged communities. Almost all centers have males and females training together, thus the work towards gender equality starts from day 1. In the initial stages, female participants are often uncomfortable when

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put on the same stage as men. To overcome this, there is an exclusive session for young women every week which gives them a platform to express their opinions and concerns without fearing rebuke.

Slum Soccer's curriculum is divided into weekly sessions based on the availability of the participants in each center and, in most cases, there are 3–4 sessions in a week with each session running for about 2 h. The sessions are delivered on the field in the form of football activities and games with each activity focusing on one football skill and one life skill (Figs. 16.1, 16.2, 16.3, and 16.4). At the end of each session, the coaches review the lessons for the day and obtain feedback from the participants.

On identifying the communities it decides to work with, Slum Soccer establishes centers based on ease of access for participants and ensures that such centers are a safe space for all participants to come and play.

Slum Soccer always establishes centers for the participants in their neighbourhood, within reach for their parents/guardians. Since the coaches are mostly from their own communities, this gives the parents the assurance that the girls and young women are in the care of people they are familiar with. We ensure that there are sufficient numbers of coaches to cater for the young people (ratio 1:5) in these sessions, which ensures that there is individual attention within controlled boundaries.

At present, Slum Soccer has 30 Community coaches running programs, with each coach dealing with around 20–30 young people per session. Each coach is also responsible for following monitoring and evaluation guidelines to then assess the impact of the programs. Ten senior coaches and leaders work to develop the curriculum for new communities and to introduce new games/activities based on feedback received from each of the centers. In addition to this, there are 15 volunteers supporting in the administration, marketing, and fundraising departments.

At the end of the 24-week program, a majority of the participants who have graduated from the program continue to work with Slum Soccer, participating in various tournaments or workshops. Participants who have demonstrated leadership skills and a willingness to improve their communities are identified as young leaders and guided through Slum Soccer's Young Leader Program. They are developed to be leaders and are given responsibilities at their respective centers. The skill set of such leaders is identified and they are also put in various administrative departments of Slum Soccer.

This self-sustainable model of developing our own community coaches and staff from within the pool of participants is one of the organization's priorities because the coaches know exactly what the community needs and how to work with the next generation of youth. They also serve as role models and inspire the young people in their community to take part in Slum Soccer's program.

A small proportion of the participants have gone on to become professional footballers, both playing at club level and representing their respective districts and states. Two footballers, Yashashree and Akansha, have represented Maharashtra in national tournaments.

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Fig. 16.1 Slum Soccer sessions being delivered

Fig. 16.2 Slum Soccer sessions being delivered



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Fig. 16.3 Slum Soccer sessions being delivered



Fig. 16.4 Slum Soccer sessions being delivered

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Outcomes and Evaluation

Outcomes

Through its full fledged football coaching camps, educational and healthcare workshops and societal development programs, Slum Soccer has brought about a positive influence to the lives of nearly 30,000 female participants in over 63 districts all around the country (overall outreach including men is 100,000).

We have found that the female participants feel more empowered and grow in confidence, enabling them to move in positive directions towards reaching their potential. The fact that some of the major achievements of the organization have been due to our female participants is no coincidence. In our experience, female participants of the project have been much more confident and equipped with a relevant skill set to succeed in male-dominated fields.

Slum Soccer Women's team were awarded the Fair Play award in the 2010 Homeless World Cup tournament at Rio de Janeiro which signifies that the program has not only helped these participants with their football skills but has also taught them important life skills which they exhibited on and off the field.

In the 2013 Homeless World Cup tournament in Poland, for the first time Slum Soccer fielded a mixed team with young men and women playing side by side on the same team against all male teams as well as other mixed teams. India finished with its highest ever position at the HWC, ranked 29th overall. This is a great testament to the work of Slum Soccer indicating that the performance of the team had only improved with the inclusion of women participants. The team was highlighted at the tournament because it was evident that the Slum Soccer organization valued both its male and female participants equally and that they all worked together as a unit. The success at the tournament can also be attributed to two factors—improvement in the confidence levels of the female participants (women empowerment) and how well the male participants have integrated them into the team (gender equality).

Recognition and Awards

Although there has been no formal evaluation of Slum Soccer, recognition and awards that the organization has received as listed below are yardsticks to gauge the effectiveness of its programs.

International

- Slum Soccer's curriculum has been certified by Coaches Across Continents.
- Slum Soccer has been the Indian National Partner of the Homeless World Cup since 2007.
- Slum Soccer is part of FIFA's Football for Hope program.

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- Slum Soccer is a network member with streetfootballworld. Also, Slum Soccer CEO Dr. Abhijeet Barse was elected its board member for the Asian Region in 2012.
- Slum Soccer was part of the Discover Football's International Women's Football Tournament conducted in Berlin in 2011. Out of 38 international organizations which applied for one of the seven sports on offer, Slum Soccer's application was viewed favorably by an eminent jury panel chaired by Dr. Theo Zwanziger, President, German F.A.

Domestic

- Slum Soccer was also named the Best Organization in the field of 'Sports for Development' by the Federation of Indian Chambers of Commerce and Industry in the year 2012.

Future Work

Slum Soccer is constantly expanding across the country, reaching out to new communities and geographical regions. Projects in the pipeline include using sport as a tool for people with disabilities and running workshops and events in areas where they do not have established community centers. Slum Soccer has identified another major area of concern for the country—environmental awareness. The organization is already working with its partners to evolve the curriculum to include modules for raising environmental awareness.

As one of the leaders in the field of sport for development, Slum Soccer also reaches out to other organizations that work using sport as a vehicle for social development to form strategic partnerships. With over a decade of experience and qualified coach trainers, Slum Soccer trains coaches from other organizations and supports them to run their own programs. Slum Soccer also aims to ensure that best practices and technical expertise are shared amongst organizations working towards common social goals.

Lessons Learnt

The concept of sports for development is still at its nascent stages in India and more so for women empowerment. For many years, Slum Soccer had struggled to convince many communities of its ideology, as formal education is still considered to be the only way of raising the social and economic status of women. This lack of understanding also created problems in fundraising and generating awareness of our work among corporate bodies, donors and the government. The success of the program and its impact on the participants in the last few years has helped the organization overcome such struggles and convince such stakeholders to get involved.

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Due to cultural and religious influences, women in underprivileged communities are discouraged from playing sports by their families. Slum Soccer has overcome this challenge by helping such families understand the concepts of women empowerment and gender equality. The first thing that our coaches/staff worked on was to gain the trust of the girls and their parents/guardians in matters of safety through interactions/workshops/awareness campaigns/tournaments. This helped us broaden their views on safety of the girls in sports and, when they were assured that the girls were safe in our programs, they were open to allowing them to attend our programs.

The success of various women participants of Slum Soccer like Disha, Shehnaz and Rubina, to name a few, had a rippling effect which encouraged many young girls from their communities to follow in their footsteps.

Whilst Slum Soccer's curriculum has been largely relevant among various communities and backgrounds, it has been recognized that it is important for the curriculum to continue to evolve to achieve the desired results of the program.

The work can definitely be tailored to address different issues, different audiences or even deployed using different sports. What is important is that the exercises should always be fun and engage the children and young people, because if they lose interest in the exercises, they would fail to understand the social messages or life skills that are an intrinsic part of the games.

Acknowledgment Photos courtesy of Kevin O'Donovan.

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Chapter 17
Fighting for Peace: From the Favelas of Rio de Janeiro and Beyond

Luke Dowdney and Alice Sampson

Background[1]

Fight for Peace (FFP) is an international voluntary organisation aiming to overcome divisions and violence and promote the potential of young people who live in disadvantaged communities by using boxing and martial arts combined with education and personal development.

FFP, or Luta pela Paz (LPP) in Portuguese, was founded by the first author (LD) in the Complexo da Maré, Rio de Janeiro, Brazil, in 2000. LD subsequently founded FFP in the UK via opening a second Academy in the London Borough of Newham in 2007, and Fight for Peace International in 2010 to expand FPP's methodology internationally.

The origins of FFP arise from research on the problem of youth involvement in violence, gangs and crime in Brazil and across four continents [1, 2]. Figure 17.1 summarises social and economic features of areas prone to violence and identifies social, cultural, political and economic problems that arise from these circumstances:

This analysis portrays children and young people both as victims and perpetrators of violence, living in a high state of anxiety and generators of fear, and experiencing stress and frustrations associated with living in poverty. As a consequence, young people's opportunities to fully participate in mainstream institutions, such as school,

[1] Much of the information in this chapter is drawn from an evaluation of the FFP Academies led by Alice Sampson, Centre for Social Justice and Change, Department of Law and Social Sciences, University of East London with Maria Rita Vilellaa [6].

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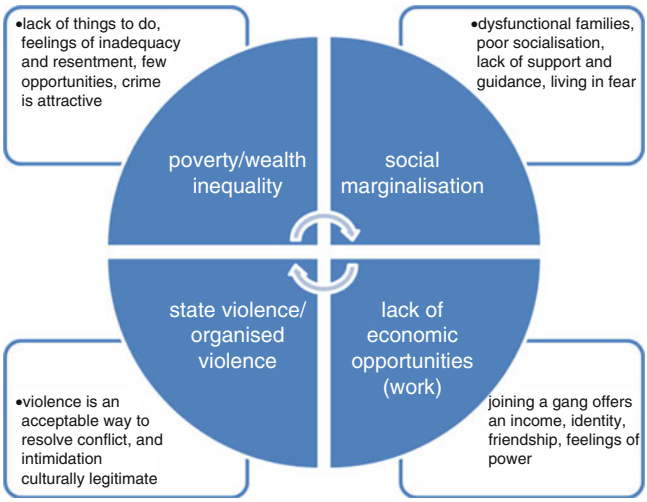


Fig. 17.1 Dowdney's conceptualisation of violence prone areas

college, apprenticeships and formal employment become very limited and they seek alternative lifestyles for economic gain and social status. In these situations their 'world' becomes their neighbourhood and they know of little else, and violence and poverty are reproduced from one generation to the next within the same communities. Recognition is also given to the contribution state agencies make to marginalising young people and failing to respond to their needs. Furthermore, structural and state sponsored violence, such as militarised public security policies in Rio de Janeiro's favelas carried out by the *Policia Militar* (Military Police) and other state security agencies, serves to reinforce the 'status quo' and an 'acceptable' level of day-to-day violence within poor communities. This further fuels a culture of violence where force is seen as the preferred method for dispute resolution and the maintenance of status. Community-based organisations (CBOs) are perceived by LD as a part of the solution; they are in a position to understand and be responsive to young people by being non-judgemental, flexible, and sensitive to cultures and histories, and to shifting community relations. It is these beliefs that inform and shape the work of the FFP Academies.

Aims of the Project

The aims of the FFP Academies are to overcome division and violence and to promote the potential of young people. To achieve these aims FFP has a clear set of values and principles and a holistic Five Pillars model of intervention (Fig. 17.2).

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Fig. 17.2 Five-Pillar model

At the heart of FFP are five values which express the organisation's commitment to young people:

- *Embracing*: to accept everyone without judgement
- *Solidarity* between staff and young people
- *Champion*: aim to be the best in all we do
- *Inspiring*: aim to inspire and to be inspired
- *Fearless*: stand up for peace

The five values are well-publicised within the organisation, integral to the delivery of services and incorporated into youth participation. These values offer an alternative *modus operandi* to violence, conflict and crime as a way of life, encourage young people to participate in education, training and employment, and promote an ethos of striving to do one's best.

The values inform how FFP delivers services and they are integrated into each of the Five Pillars that provide young people with opportunities to influence their life course by participating in boxing and martial arts; education; access to work; support services; and youth leadership. These activities offer a set of solutions to problems that are typically experienced by young people living in areas of poverty and conflict. They offer emotional and practical solutions within a framework of striving for excellence (Box 17.1).

FFP is inclusive. It engages with young people who are committed to becoming professional boxers or Muay Thai fighters, those who would like to lead a better

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Box 17.1 Description of the Five Pillars

Boxing and martial arts: attracts young people, provides role models, channels aggression, builds confidence and self-discipline, responsibility and identity.

Education: numeracy and literacy classes, qualifications for those who left school without qualifications, personal development and life-skills classes.

Employability: access to formal employment opportunities through job skills training, partnerships with companies providing internships and employment, and careers advice.

Youth support services: mentoring, case work, targeted support, home visits and community outreach.

Youth leadership: accredited courses, youth council participation in programme strategy and development.

lifestyle and to be fit and healthy, those who have become de-motivated, withdrawn and are not in education, employment or training (NEET), and those with a criminal record. FFP welcomes, and works with, all these young people.

The FFP model is intended to be internationally relevant. The programme is therefore designed to take into account working with young people across cultures and living in different societies.

The Academies are intended to benefit young people up to the age of 25 years in the UK, and 29 in Rio de Janeiro, who live in the neighbourhoods within which the Academies are situated. Early evening sports sessions are open to those under 16 years, followed by sessions for the older age group. Attendance is free and voluntary but regularly attending personal development (PD) is compulsory and non-attendance means that young people are unable to participate in the boxing and martial arts classes until they attend the PD sessions. In the UK some young people are referred by schools, pupil referral units and Youth Offending Teams and these young people are expected to attend. The intention is, however, that the coaching and training is open to all young people willing to participate.

How the Project Was Set Up

FFP originated as a project initiated by LD within Viva Rio, a Brazilian NGO. LD then established the project as an independent not-for-profit organisation in 2000. Several factors came together at one point in time to motivate LD to set up his own organisation: an injury that ended his own boxing career, a fascination with Brazilian

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favelas and 10 years experience of working in them, an observation that CBOs were sometimes frightened of engaging with young armed drug traffickers, and visits from international organisations who were prepared to offer funding but only on their terms and whose projects had limited effects. This latter observation is borne out by a review of the academic literature on urban violence and poverty which found few examples of successful interventions, as well as few well-evidenced initiatives [3], and a review of World Bank-funded community-based schemes which found that they had little discernible influence on enhancing community cohesion, overcoming corruption or reducing poverty [4].

Thus, key to understanding the success of FFP is the way in which it is implemented. In Rio and London a careful analysis of the problem was conducted using statistical data and ethnographic research and focus groups with young people to understand their lives, their challenges and to learn from them. LD described his approach, which he first tried out in a Brazilian favela:

> And I was there to learn and fascinated by the place. So I think that the mentality of just going in as an equal… because obviously I was, I certainly wasn't coming in with some crazy fancy degree and a whole load of theories about how we should be working with these kids—we didn't really know, we were just starting through this dialogue process.[2]

As a former amateur boxer, using boxing as a means to engage those who were deeply involved in the drugs trade was described by LD as 'instinctive'. However he recognised that its physicality, the discipline, and the close relationship boxers form with their coaches satisfied the desires of young people to become strong and improve their body shape, and provided opportunities for talking and developing relationships through the medium of boxing.

LD started the project in a shared community space within the Residents Association of the favela of Parque União, within the Complexo da Mare, with a total of 10 young people. As the project grew, he rented the second floor of a building in a nearby busy shopping street within the community. FFP started with a two-pillar model, boxing and *cidadania* or 'citizenship' which is now called 'personal development'. A grant from a multi-national company with a local presence enabled boxing equipment to be bought. LD coached three times a week and a paid member of staff had discussions with young people once a week. Such was the enthusiasm of these young people that, unknown to LD, they took his keys and had their own cut so that they could practice 'out of hours'. This infectious enthusiasm propelled the steady growth of FFP and with further funding in 2005 a distinctive sports and education centre was built in Maré, now as the Fight for Peace Academy, increasing its capacity to 500 young people a year and enabling the Five Pillars model to be implemented. In 2010, a third floor was built on the Academy and two satellite projects were established in rival gang territory within the favela as part of a project called Mare United which was supported by Comic Relief and Petrobras and works to break down the forced territorialisation of the favela by rival drug factions. This has increased capacity to over 2000 participants per year.

[2] Interview by Alice Sampson with Luke Dowdney, July 2012.

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In 2006 the United Nations Development Programme (UNDP) paid for an external evaluation which concluded that FFP was a successful prevention and rehabilitation project [5] and this gave LD confidence that the FFP model was sound and worthwhile developing. During this period LD also completed further research and found that young people's experiences of violence and crime were similar across several continents, and hypothesised that the FFP model could work in diverse cultures [2]. Similarities between the favelas in Rio and stories about the poverty, serious knife crime and use of guns by gangs in London provided LD with a suitable place to assess the viability of transferring the Five Pillars model to a different culture and social and political context. Drawing on statistical data on poverty, violent crime and community tensions, Tower Hamlets and Newham were identified as possible places. LD contacted a large high-profile multi-purpose community organisation in Newham, Community Links, and they used their close local political contacts to facilitate the rent-free use of an old building next door to a disused secondary school in the south of the borough. In 2007 a consultation process with 38 young people further shaped decision-making, a gap in the provision of opportunities for marginalised young people was identified and successful funding applications made to Esmee Faribairn, Laureaus Sport for Good Foundation and Credit Suisse. The second FFP Academy opened in October 2007 with the implementation of boxing and martial arts, a youth council and personal development classes. By the end of 2008 there was sufficient funding to put all Five Pillars in place.

Delivery of the Project

Research undertaken for an evaluation of FFP (see below) gives some insights into the challenges of delivering programmes for children and young people in areas where there are significant levels of violence [6]. In Complexo da Maré, for example, there was coercion and control by drug traffickers who sometimes used brutal punishments to act as a warning to others, killing of children and young people by the police, family violence in the home, interrupted schooling due to shootings, children 'acting out' violence, and young people so traumatised that they had neurological problems, short attention spans and mental health difficulties. In Newham increasing anger, family conflict and depression, as well as financial problems, were found to be common among young people. Living with 'trauma' makes it challenging for young people to attend regularly and to fully participate; nevertheless, both FFP Academies are popular and staff are working with large numbers of young people.

At the London Academy in 2012 a total of 1031 young people attended, of whom 82 % were young men and 18 % young women, typically aged 17–25 years old. In Rio 1725 young people attended, of whom 67 % were boys and young men and 33 % girls and young women aged between 15 and 17 years, with some under 10 years and a notable number of young adults over 20 years in addition. The overwhelming majority of young people hear about FFP from FFP members through word-of-mouth and social media, illustrating how young people hold FFP in high regard.

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The delivery of the Five-Pillar model in Rio and London is similar, but adapted to be culturally and locally sensitive; for example, an education pathways programme is run for 12 weeks in London while in Rio the course lasts a year, and in Rio a lawyer and two psychologists are full-time staff, but there are no such formal arrangements in London. Some outreach work is undertaken by staff and young people but both Academies are full to capacity. In 2012 there were 58 staff at FFP in Rio; 33 were male and 25 female. The project is currently managed by a woman and women staff are highly regarded, reflecting the strong equal opportunities ethos of FFP which sets an example in a male-dominated society. Similarly, in Newham women staff have a strong presence and a woman manager and, in 2012, 28 members of staff, nine of whom were women and 19 men. In both Academies, staff include those who live in the local area and bring with them local knowledge and understanding which FFP makes use of in the delivery and shaping of its activities.

Both Academies close for a month—London during August and Rio in December—to enable staff to take holidays, attend training and to plan for the following year. The education classes typically have terms, whilst the boxing and martial arts coaching is a rolling programme that incorporates new members, whatever their standard. Thus, the programmes are ongoing and their sustainability subject to securing funding, although in 2011 a Luta sports clothing range introduced a social enterprise element to FFP with half the proceeds from sales contributing to the cost of running the Academies.

The boxing and martial arts act as the 'hook' to attract young people to the Academies. They also provide a platform for learning about discipline, self-control, perseverance, respect and humility, as well as helping young people to get fit and build self-esteem through learning and mastering new skills. In keeping with the FFP values, the standard of coaching is professional and each discipline delivered several times a week. A key feature of the delivery of the Five-Pillar model is that it offers a holistic approach to meet the multi-faceted needs of young people and many young people participate in each of the pillars in addition to sport. The activities in each of the pillars and personal development interact and are mutually supporting. Thus, coaches do not simply train young people to box and educational workers do not just deliver a curriculum or course—youth workers train with young people and coaches respond to young people's personal 'crises', for example. All staff are involved in reinforcing the values of FFP and contribute to different pillars.

Young people emphasise the importance of having staff to talk to. One 22-year-old man explained the central role of strong relationships between the staff and young people when he said: 'It is with the staff that we talk about our issues. They are our pivot'. When young people join FFP they are classified according to three levels, based on their needs. The most vulnerable young people have intensive support and weekly meetings are held to discuss any young people who are a 'cause for concern'. In Rio seven members of staff made 622 home visits to make contact with parents/carers and to understand more about a young person's circumstances, an average of almost 89 visits per member of staff, during 2012. As a result of these visits, 97 young people received intensive casework. Six mentors, who are youth workers, are available to talk to young people confidentially in one-to-one sessions.

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A total of 334 young people were mentored during 2012. The mentoring programme is illustrative of the caring approach at FFP, for which it has an excellent reputation.

Young people who join education classes often have no formal educational qualifications and low levels of numeracy and literacy. The programmes are designed to assist these young people who may have been excluded from school and who have, or previously had, poor school experiences. In Rio, where the education system demands that young people pass examinations at 15 years old before they are allowed to continue receiving free education, classes are also designed to give additional assistance to young people who find their school work difficult in order to enable them to continue at school. During 2012 a total of 334 young people attended the education New Pathways programme and 131 young people attended literacy classes, of whom 62 % were young women. In London short intensive education courses are typically attended by young people 17 years and over who are NEET, male and Black. Each course has approximately 15 participants and there are two levels—Module 1 and Module 2. The one-to-one mentoring sessions, the sport, and conversations with the education staff all contribute to motivating young people to learn.

The education courses in Rio include vocational training and courses such as learning about administration, telemarketing, reception duties and leadership. The knowledge gained from these courses and career guidance link directly to the 'access to jobs' pillar. During 2012, 130 received career guidance; this advice enables young people to be better informed about what types of employment are possible and introduces them to new possibilities. At FFP young people are able to learn what it means to work and to study; one young man explained:

> What contributes most to change are the people who serve as examples and show that there are opportunities to work and study. (Male, 22)

During 2012 an apprenticeship partnership between a company and FFP benefited 11 young people who worked at the company and attended weekly classes at FFP, introducing them to the 'world of work' and offering them some real opportunities to gain practical experience. Similarly, in Newham considerable efforts are made to find work placements and employees at an international bank run courses to show young people how to write CVs, to interview for a job and talk about working cultures. In the first 6 months of 2012, 71 young people attended these courses.

The youth leadership pillar is underpinned by the FFP values that emphasise how young people are capable and have potential to lead and inspire others. Young people have the opportunity to become youth council members for 2 years. During this time they are trained and their programme includes project management, community organisation, public speaking and conflict mediation. Youth councillors are the public face of FFP and host visitors who include internationally acclaimed boxers and martial arts specialists, ambassadors and dignitaries, as well as funders. Youth council members are also a key link between young people and staff and enable the Academies to retain their responsiveness to young people. Over time they have increased their responsibilities and are now trained as mentors, delivering some personal development sessions from 2014. Within the youth leadership pillar there are also opportunities to volunteer as coaches, support staff and to gain qualifications, with a few young people going on to become members of staff.

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Integral to the Five-Pillar model are compulsory personal development classes. These citizenship classes include sessions on use of violence and its effects, meanings of citizenship, intimate relationships, sexuality, transgender, illicit drug-taking and criminal behaviour, as well as learning about how to contribute to society. Young people explained how discussions during personal development classes changed their attitudes and how they have become more understanding and tolerant of 'difference'. One young boy explained:

> Before, I did not use to care for others, today I have become more of a humanist. The PD [personal development] classes are good for they stimulate conversation about drugs, about life, about homophobia. They help understand the differences and not have prejudice. (Male, 13)

Regular newsletters on young people's achievements, photographs of famous visitors and programme developments are circulated electronically to partners. They are well-received, motivate partners to continue working closely with FFP and are integral to maintaining its good reputation.

Outcomes and Evaluation

Funding independent evaluations is integral to FFP's philosophy of self-improvement and checking that young people remain at the centre of their work. The most recent evaluation, completed for both Academies in 2013, was conducted by the University of East London (UEL) and employed a realist methodology [6]. The realist approach to evaluation produces evidence on what works, for whom and under what conditions, and is underpinned by the following principles:

- Interventions are considered to be theories about how to make a difference to identified problems. These theories of change may be non-linear, can be inconsistent and are causal only when they are active. Theories arise from how problems are characterised by programmes and strong theories are those which are able to modify problems that a programme is designed to alleviate [7]. Thus, successful programmes are those which conceptualise problems in ways that reflect the social realities of their intended participants.
- The identification and 'testing' of theories that underpin programmes negate the need for control groups, as mechanisms of change are surfaced and assessed as they link activities to outcomes [8].
- Identifying generative causal mechanisms is also integral to the research design because they are the principles that explain the effects of an intervention and it is these principles, rather than practices, which are transferred if a programme is to be successful in different settings [9–11].
- The effectiveness of interventions is sensitive to the context within which they are implemented. The context can be the organisation that delivers a programme as well as local economic and social conditions and community factors, all of which influence the anticipated causal mechanisms.

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- Interventions typically evolve and change as different decisions are made and an evaluation takes this 'life course' of an initiative into account when assessing its progress.

For the 2013 evaluation the following research activities were completed:

- Review of the academic literature on: youth transitions; the effects of sports, youth work, education and employment, and personal development on the lives of young people; and evaluations
- Monitoring data from FFP Academies
- Young people's self-completion questionnaires (London 2011: Open Access $n=118$; Intensive group (pathways and twilight programmes) $n=70$. Rio 2012: Open Access $n=86$; Intensive new pathways education programme $n=83$)[3]
- Youth Council self-completion questionnaires (Rio $n=11$; London $n=11$)
- Staff self-completion questionnaires (Rio $n=37$; London $n=16$)
- Face-to-face interviews with young people (21 in Rio and 37 in London)
- Face-to-face interviews with partner agencies (13 in Rio and 11 in London)
- Interviews with staff (4 in Rio and 3 in London)
- Observations of sports sessions in both Academies
- Three interviews with LD completed in 2007, 2008 and 2012

Key findings have been selected to explain how the FFP model works—the generative causal mechanisms—and to describe its effectiveness. A core theory of change is identified that shows how the FFP model contributes to young people making alternative life course choices, and examples of how this is achieved are described to illustrate how violence and division are reduced and how young people strive to reach their potential.

Firstly, and importantly, FFP has a strong and robust delivery structure in place in London and Rio. As a result of the following practical actions the implementation of the FFP model is rigorous: the articulation of the Five-Pillar model in all annual reports, on the website and on large posters displayed in the Academies; the use of videos describing the history of FFP for the induction of young people and at personal development sessions; discussions of the FFP model during the induction of new youth council members, staff induction and training sessions, and at meetings within each Academy and across the Academies. The routine analysis of monitoring data for performance purposes by a member of staff located in each Academy responsible for monitoring and evaluation, annual self-evaluations and staff supervisions are all activities which ensure the delivery of the FFP model.

Findings from staff self-completion surveys show that staff are very supportive of the Five-Pillar model, with 100 % of the staff in London and 92 % of the staff in Rio committed to the model. Staff are confident in their work and clear about what changes in young people FFP aims to achieve; 100 % in London and 97 % in Rio.

[3] In this chapter the questionnaires completed by those on intensive education courses and case work are identified and all other references made to completed questionnaires are the Open Access questionnaires.

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It is notable that there is a low staff turnover which gives continuity to young people, builds an in-depth knowledge of local areas and indicates high levels of satisfaction.

The youth councils in London and Rio have a key role to play in the implementation of the FFP model. All the council members say that they are clear on their roles and responsibilities (100 %). In Rio all youth council members say that they can influence how FFP is managed and 90 % in London feel that they can influence the direction of FFP. In Rio and London all council members say that issues raised by young people at meetings are taken seriously all or some of the time.

The successful implementation of the FFP model means that:

- Young people are offered the activities and support that they are promised.
- Partners, including community organisations, schools, social services, youth offending teams, can expect the young people they refer to receive the services they are promised by FFP and for the activities to be delivered to a high standard.
- Funders can be certain that their investments will be spent as specified in funding applications and young people will receive a high quality service.
- There is greater certainty that the FFP programme is a cause that has an effect and the FFP model can be rigorously 'tested' by evaluation research.

A key assumption of the FFP model is that boxing and martial arts are attractive to young people and the research found that boxing and martial arts, as well as use of a gym, are powerful 'hooks'. For the sessions which are open to all young people:

- Over 90 % in Rio and 85 % in London said that they joined FFP for the boxing and martial arts
- Over half the young people in Rio and over three quarters of those in London joined to get fit

Young people also find attractive the values that inform how FFP staff work and factors related to FFP as an organisation, including:

- The symbolic significance of FFP buildings as safe places
- Free training and education classes making it possible for young people to attend
- The friendliness, warmth, and approachability of staff
- Use of professional coaches and high standard of training

Some young people join FFP and then find that they are not really motivated to make the effort required to make changes to their lives and whilst they quit almost immediately, some rejoin several months later and attend regularly. Other young people with severe mental health problems, such as psychotic behaviour, are not suited to the FFP programme and are referred to other organisations.

The UEL study found that the FFP Five-Pillar model works effectively with active members. Research findings from interviews with staff and young people show how FFP supports young people both emotionally and practically through two key processes, surfacing and articulating doubts about their current lifestyle and by giving young people opportunities to learn how to make changes to their lives.

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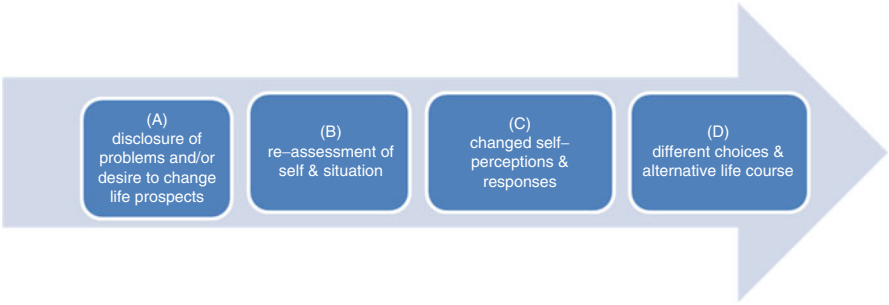


Fig. 17.3 Core theory of change: how FFP makes a difference to the lives of young people

This is the starting point for the core theory of change to take effect, and all of the pillars of the Five-Pillar model interact to enable young people to 'move from one state of affairs to another' to change the logic of their situation that alters their attitudes, thinking and decision-making. The core theory of change is presented in Fig. 17.3 and explains how FFP achieves its aims.

Staff and young people work together through each of the stages, A, B, C & D. This is an ongoing process; new concerns emerge and young people adapt and modify their self-perceptions leading to a different 'mindset' and behaviours. One of the strengths of the FFP model is that it allows for staff and young people to work together 'for as long as it takes'. Moving away from a lifestyle that involves crime or drug trafficking or prostitution creates new problems, and this flexibility and patience are a key reason for the success of FFP. For many young people this can involve revisiting A, B, and C several times, and some revise their goals (D).

The FFP theory of change assumes that improvements in behaviour, choices young people make and changes in their situation are connected to their self-perception, relationships with others and their thinking about their future. The research findings described below provide examples of how this theory works in practice.

FFP provides young people with a safe place to train where they can escape from feelings of fear associated with living in a violence prone area and the everyday pressures of living in poverty. They train in a positive, friendly and supportive atmosphere at the FFP Academies and this environment enhances their commitment to learning the 'discipline'.

At FFP physical exercise is rigorous and typically changes young people's body shape in a short period of time. These changes in body definition demonstrate to young people that they can make a difference to how they look when they make an effort. Since society places a high value on physical appearance young people soon feel that their body shape is more attractive and this is often confirmed by peer approval which they find encouraging and motivating. Young women and men also emphasised their pride in being stronger. This sense of achievement is reinforced through FFP values and enables young people to feel more positive about themselves, and to be more self-accepting.

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Young people talked about their new friends and how they have made a significant contribution to improving their lives. The overwhelming majority of young people said that they find it easier to make friends since joining FFP—87 % in Rio and 86 % in London.

Findings from the in-depth interviews with young people revealed that friendships at FFP affect their self-perceptions and motivations to achieve, and enable them to have positive relationships. These friendships are emotionally supportive, foster mutually respectful behaviour and enable young people to make better judgements about who to make friends with; thus, they are an important aspect of making alternative life choices.

The overwhelming majority of young people felt more positive about themselves since joining FFP—86 % in Rio and 87 % in London. FFP's values and ethos of friendliness and equality of treatment were found to contribute to how young people felt about themselves. One young person explained how through these processes FFP affected her thinking and actions, opening up new horizons that increased her potential:

> I'm 17. I think that FFP is good for me, it makes me think of life differently, it makes me think that there's more choices after just secondary school and it feels like it's given me more confidence to do different things. (Female, 17)

Another young person made links between the motivation he gained from learning Muay Thai and setting more ambitious life goals:

> Yeah, the Muay Thai has a big effect 'cause it teaches you that discipline, motivation to push on, the coaches and the staff members help you to push on and reach a goal not only in the sport but in your life, so it's quite <pause> without Muay Thai my life wouldn't be what it is right now. (Male, 21)

Young women talked about how FFP broadens their perspective about 'what is possible' for them. One young woman learning Muay Thai, like others, emphasised how they were able to participate in 'men's sport' and had learnt that exercise improves how they felt about themselves 'inside':

> Yes, normally we girls in East London, we just care about beauty and clothes and go out and, for us, exercise is just for men, but they show it's different, not just for men. Because exercise is not just for being a nice body, I think inside is the most important, and the exercise can help the inside to feel better. (Female, 25)

We also found some evidence that self-control gained from learning the discipline of boxing and martial arts and taking greater responsibility for oneself by learning to maintain and protect one's body sometimes included sexual responsibility. One young woman explained how some of the young men at FFP have stopped perceiving young women as sex objects and have learnt to control themselves:

> … they just want the same thing, which is mostly sex,… some of them they used to be like that, but they've changed, they've changed their ways… they've sort of realised here you get disciplined … you've got how to control yourself, like if you're in a fight or whatever, how to control yourself, how to protect yourself, how to deal with situations. (Female, 15)

These changes were one way in which attending FFP altered gender relations. This young woman explained that the discipline teaches 'how to protect yourself,

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how to deal with situations', and these skills enable young women to protect their own boundaries and space [12]. Feelings of self-worth and self-belief that arise from a sense of achievement from learning boxing and martial arts techniques were reinforced in discussions with youth workers, giving young women a 'can do' attitude. These factors—independence, self-acceptance, ability to defend oneself and ambition—all contribute to young women feeling better able to protect their boundaries on their own terms. The extent to which these young women can protect themselves from predatory male sexuality was, however, not explored in this study. Nevertheless, the research findings suggest that more respectful relationships amongst FFP members are negotiated between young women and men.

Alternative Life Course Outcomes

From the research findings it is possible to identify six indicators that represent alternative life courses chosen by young people. Key findings from each are summarised below.

1. Sports-related: to compete, work towards becoming a professional sports person, and/or a coach
   One defining characteristic of the FFP model is that young people are encouraged to 'aim to be the best in all we do', with some choosing to compete in boxing and martial arts. To realise this 'aim high' quality coaches are employed who are, or have been, champions themselves—this inspires young people and makes them feel valued.

   The high standard of coaching affects the reputation of FFP, encourages young people to excel and makes young people proud to be associated with an organisation that produces champions. Young competitors show other FFP members what can be achieved through hard work and commitment.

   In Rio, 90 young people took part in competitions—one at international level and four at national (Brasileiro) level, and the others at state and local tournaments. In London, there were 16 amateur boxing competitors—12 amateur and 3 semi-professional Muay Thai competitors, and one mixed martial arts amateur competitor. Young people took coaching qualifications and assisted coaches in training sessions, and in this capacity act as role models for others—in particular those who are new members.
2. Health-related: become healthier through improved fitness and making healthy lifestyle choices
   Of the young people who participated, 82 % in Rio and 96 % in London said that they were fitter, while 56 % in Rio and 67 % in London felt differently about their health.

   The dual approach of doing sport and promoting healthier lifestyles appears to be effective. Young people train hard and this relieves stress and anger, and the adrenaline rush from exercising makes them feel better. One young woman explained how boxing relieves her stress and anger:

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> if you have a lot of stress or if you have a lot of anger, boxing is a great way to get rid of that excess stress and anger. (Female, 17)

Young people also commented on how boxing and Muay Thai not just relieves stress but also makes them feel good about themselves. One young man explained how Muay Thai made him stronger and this gave him confidence. This self-assurance meant that he tried to do more things. He felt better about himself and this improved his mental health:

> … when you get stronger, you feel more confident, like you can do more things. It helps your moods, if you're feeling depressed, it just makes you feel great really. … No, no, I don't fight out in the street or anything, it's not about being strong enough to actually have fights or anything, it's just about feeling good about yourself in general. (Male, 17)

Through conversations and personal development sessions, young people learn about the importance of a healthy diet for their fitness and performance. This information is relevant to their sporting aspirations and is therefore meaningful and relevant to them.

In interviews, young people talked about giving up Coca Cola, cutting down on sweets, stopping smoking cigarettes and taking illegal drugs, and eating regularly. They make these choices to change their lifestyles not so much because their habits are 'unhealthy' or 'wrong' but rather because they want to get fit and to be good at what they do. It is possible that choosing healthy options for positive reasons will have a longer lasting effect.

3. Education and employment-related: an appreciation of the value of education and employment, and motivation to gain qualifications and to find work
   Implementing the education and access to jobs pillars is particularly challenging as young people are typically not motivated to learn within formal settings and have little prior knowledge about what it means to work, and the routines, expectations and need to comply with instructions. Improvements in young people's attitudes towards learning and obtaining qualifications are important 'first steps'. In assessing the achievements of the young people the following issues may be considered: it seems likely that without FFP in their areas they would still be NEET as there were no other opportunities in their neighbourhood to learn basic numeracy and literacy, and in Rio many of the young people would have been forced to leave school at 15 years old because they had failed their examinations.

   Pass rates were high for a group who started courses as reluctant learners and were mostly NEET. In Rio the pass rate was 70 % and almost two thirds (64 %) continued in education or joined a training course, and 50 young people (41 %) found employment at the end of the course. In London the pass rate for literacy was 76 and 73 % for numeracy, and there was a 73 % reduction in NEETs at the end of the courses. Six months after completing a higher level education course 10 young people had found work (60 %).
4. Peace-making and conflict resolution skills, reducing aggressive behaviour and preventing crime

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Particularly impressive were changes in the characteristics of young people's relationships towards a more conciliatory and empathetic approach, and a reduction in the use of their anger. The overwhelming majority of young people said that they improved their ability to negotiate and diffuse tensions in difficult situations. These changes imply a reduction in the use of violence and an improvement in the quality of their social relationships.

Key mechanisms that explain improvements in co-operation, peace-making and conflict resolution skills were identified from the 2012 self-completion questionnaires. The responses were:

- More likely to listen to others: 86 %
- More likely to think before act: 86 %
- Feel calm more often: 72 %
- Feel more able to say how they feel: 69 %

The findings also indicate a changing set of values that inform young people's revised attitudes and behaviour that includes greater self-respect and 'taking responsibility', that can be traced to the FFP ethos and activities. Some of these findings are highlighted from the group worked with intensively in Rio. Their responses were:

- 89 % feel more able to cooperate with others
- 87 % are more able to accept those who are different and have more respect for others
- 86 % are more likely to listen to others and defend their opinions and attitudes

These findings demonstrate a greater willingness to listen and cooperate, a more tolerant and respectful attitude, and an improved ability to articulate their point of view, which is often a source of frustration for young people.

5. Overcoming divisions and creating positive relationships in local communities
Some very courageous young people were identified in the research, particularly in Rio where young people were prepared to 'cross the line' into areas that are patrolled by different drug factions. In Rio, of those who completed a questionnaire, 79 % said that they felt safer in other communities.

Wearing an FFP t-shirt allows young people to move back and forth between favelas within the Complexo da Maré, and participating in training sessions and competitions enabled them to visit other communities without running the risk of being punished. Wearing the project's t-shirt is described as a 'free-pass' and 'holy shirt' which, according to one young person, 'serves as a bullet-proof vest'.

There are indications that the FFP model has enabled divisive community values, imposed by drug factions, to be questioned and challenged by young people who wish to live 'free from violence'. Due to its excellent reputation and because it offers young people a safe place and an alternative way of life, drug traffickers are tolerant of young people who wear FFP t-shirts and who walk across drug faction 'lines'. This tolerance explains how changes in community norms are coming about led by young people who have altered their views about making friends across divided communities. One young man explained:

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you begin to realize that only because he lives in a place that has a different drug faction does not mean that you can't become friends. (Male, 15)

6. Reducing and preventing criminality
The information on desisting from criminal activity is limited and likely to be underreported, but the indicators are that a high proportion of young people turn away from crime. In London 78 % of offenders known to the criminal justice system (21 young people) stopped offending after attending intensive casework sessions and seven young people ceased to be affiliated to gangs, whilst two people joined.

Findings from the self-completion questionnaires identify changes in attitudes and behaviour that explain how reductions in 'troublesome' behaviour and criminality can occur. For example, in London the group worked with intensively reported:

- Feeling calmer more often (62 %)
- More likely to listen to others (74 %)
- More respectful of others (73 %), more tolerant of difference (73 %)
- More often think before taking action (71 %), and more respectful of rules (70 %)
- Find it easier to do things on own (63 %)
- Feel safer (67 %)

These changes in feelings and attitudes are interlinked to the skills young people learn at FFP. The following comments by young people illustrate how young people are less likely to resort to using violence. A young man who was a street fighter explains how learning Muay Thai has changed his self-perception, his thinking, and actions:

I grew up, like a man, as well, because I used to think that I could fight anyone or I could do anything I want,… When I came into Thai boxing, it made me grow more, to think before I act, that kind of stuff. (Male, 21)

Another young man's comments were typical of others; young people liked their improved body shape, their strength, and remarked how they had learnt self-control and how through boxing had learnt to be less aggressive and had found an alternative way to behave:

I was a rough fighter I would say, in a street fight before, I could defend that time as well—boxing, though I have a better body image and I'm more stronger than before, boxing doesn't teach you to go up and beat people if someone looks at you wrong or if he swears at you, it just tells you how to control your anger. The routine that you go through is phenomenal, it teaches you how to behave. (Male, 20)

During interviews young people talked about how they have made several lifestyle changes that explained their distance from criminal activities. Figure 17.4 and Box 17.2 illustrate how the Five-Pillar model impacts on young people's lives and how support from family and friends, as well as FFP staff, contributes to young people leaving a lifestyle that is defined by illegal activities as it becomes replaced by a different set of values, new attributes and experiences, as well as skills.

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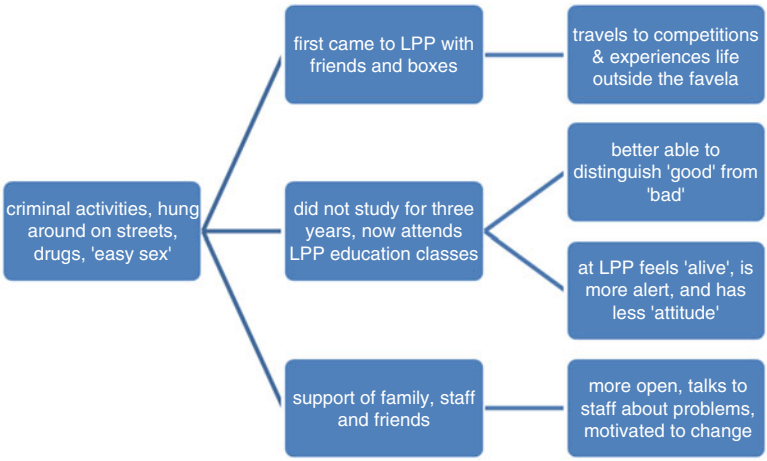


Fig. 17.4 Five-Pillar model and routes out of criminal lifestyles in Rio

Box 17.2 A Young Person's Experience of FPP

George (not his real name) joined FFP after spending time in a Young Offenders Institution. He is supported by his family and friends and coming to FFP has enabled him to stop offending for a year:

> It makes a difference because before I used to do nothing, I used to just cause trouble down the roads and that… Yeah talking makes a difference… I've come here a couple of times angry but I take it out on the boxing bag. … Yeah it makes me feel better than hitting someone and avoiding getting arrested for it…

He also talked about how using the gym has brought about improvements in his life and how these changes motivate him to lead a healthier lifestyle:

> I used to smoke as well and now I don't, ever since I came to the gym, I stopped smoking… I prefer it though now. I can run further, before I couldn't… I've cut down on sweets, sugary stuff, I've started eating more because before when you smoke, you forget to eat, but now I eat more. I eat vegetables now, before I didn't like vegetables, I'm starting to eat fruits again..

He went on to add, with a sense of achievement:

> I've stopped [offending], I haven't done nothing for a year now (male, 17)

Future Work

The FFP Academies in Rio and London will continue to ensure that high quality work will assist young people to reach their potential and reduce violence and division within local communities, using the Five-Pillar model. In addition, a new UK

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Alumni Programme (UKAP) aims to build the capability of boxing clubs and youth organisations across the country to deliver more than just boxing. The FFP London Academy will include a Training Centre and over a 2-year period 15 clubs from different UK cities will be trained.

FFP also has an international programme, Fight for Peace International (FFPI), which is delivering the Global Alumni Programme (GAP) to 120 CBOs for 3 years (2012–2015). The aim of this programme is to build the capacity and capability of CBOs in communities across the world affected by violence, and to support the organisations to adapt and use the FFP methodology. As part of the GAP, FFPI is establishing a network of trained CBOs. FFPI will transition from primarily providing training to coordinating and supporting this network, using the global group as a platform for data gathering, innovation and advocacy for alternative approaches to youth violence.

Lessons Learnt

Many lessons have been learnt over the past 13 years, and there is still much to learn, but the overarching lesson is probably patience, persistence, taking a long view and ongoing learning through on-the-ground practice as well as via more elaborate research and evaluation.

An initial research and planning phase, that may take years rather than months, provides the space to develop an intervention that has a clear purpose and organisational structure. Through reflective practice, this purpose and structure is clarified in the light of experience, learning from mistakes and debate, and it can take 4 years or more of fine-tuning before their effectiveness is apparent. The DNA of FFP includes the FFP Five-Pillar model, newsletter, and T-shirts worn by all young people and is a place where: the rules and expectations offer young people a secure place to prosper; the CBO delivering the Five-Pillar model, FFP, has a clear identity within its local area; and it is a brand that is understood by partners and funding bodies. The dynamic interaction between these three factors creates, fosters and maintains an excellent reputation, and a good reputation feeds back into, and reinforces the attractiveness of the organisation for young people and quality work by staff, and also enhances a track record that appeals to funders.

Maintaining a good reputation rests on the ongoing rigorous implementation of the brand and investing in staff, some of whom will live in the same area as the young people, is a key consideration. The UEL research found that staff are very committed to the values and ethos of FFP and to delivering the Five-Pillar model. This commitment is recognised and valued by young people who in turn, respect, listen, and take advice from staff. [6] Staff are responsive to young people and when they express a concern, they arrange meetings and have discussions with them, and staff are prepared to make different decisions having heard the opinions of the young people.

(continued)

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Finally, in recognition that social, economic, and political dynamics within communities are always changing and remaining responsive to this shifting terrain is essential for retaining the relevance of an intervention for its intended beneficiaries, monitoring and self-evaluation are core tasks and lie at the heart of FFP. The annual collection and collation of data from staff, young people and partners, using self-completion questionnaires, is used to assess performance and to highlight areas for improvement. Success may be achieved but it is often fragile, slippery and temporal, and the FFP approach fosters an ethos of taking stock, review, addressing difficult issues and striving to 'do ones best', and this explains its continuing adaption, relevance and growth.

LD has now founded a social sportswear brand called LUTA (www.luta.co.uk) with private equity funding. 50 % of profits from the company are donated to FFP annually, yet the aim of the brand is more than a new income stream for the charity. LD believes that part of FFP's success is that it exists as a youth brand—a lifestyle and identity that has a coherent vision across all its actions. LUTA is a way to celebrate this lifestyle and include people who may not live in communities affected by crime and violence, but who, in their own way, show the determination and strength to face any challenge head-on and never quit no matter what.

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Chapter 18
Millwall FC Medical Service: 'No One Likes Us, We Do Care'—Working Together for Better Health in South London

Nick Hart and Alison Leary

Background

Millwall Athletic Football Club ('the Lions') is a professional football club founded in 1885 which currently plays in the Championship of the Football League—just one tier below the English Premier League.

Having originated in the tough and insular Isle of Dogs, in the heart of Victorian London's docklands, the club is currently located on the borders of the London boroughs of Lewisham and Southwark which have a combined population of approximately half a million people. These London boroughs rank below the national England average on health in several areas. In Lewisham, deprivation is higher than average and about 18,300 children live in poverty. Life expectancy for both men and women is lower than the England average by 6.8 years. 24.4 % of children in Year 6 (age 10–11) are classified as obese. People in this area are more likely to die an early death through cancer, heart disease or smoking-related diseases [1]. Southwark is a borough of diverse fortune, consisting of areas of affluence and severe deprivation. There is a life expectancy difference of 10 years in men between the most and least affluent areas and higher-than-average rates of smoking-related disease and death. Like Lewisham, Southwark has high levels of childhood obesity [1].

In the 1970s, the name of Millwall FC became ever more reinforced in the public mind with inner-city decline, hooliganism and extremist politics. The events at the 1985 FA Cup quarter-final versus Luton Town reinforced the public perception that Millwall

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was a 'trouble club'—provoking a famous description by the Sunday Times newspaper of football as 'a slum sport played in slum stadiums watched by slum people' [2].

Attempts to change this perception of the club began in the mid-1970s, with some of the first community events within football. A regular Sunday market began at the club's ground, the Den, along with local sports events on the pitch and, in the 1980s, a match-day crèche to encourage more female support. The ground-breaking Millwall Community Scheme founded in 1985 was one of the first to seriously address the wider role of a football club within the community, as well as to tackle issues such as racism, health, education and crime through sport and social inclusion activities.

In 1993, the construction of the 'new' Den at Zampa Road saw the first brand new stadium built in the capital for 80 years. Built entirely in line with the recommendations of the Taylor Report [3], the new stadium provided far more modern facilities for a club keen to shed the burdens of the past.

The association in the public mind with hooliganism continues, however, with major disturbances at the ground in 1993 and again in 2002. Despite these knocks, efforts to turn around the image of the club remain ongoing. Yet, as the brand image of the sport has moved toward a trouble-free, clean family product, Millwall remains a bastion of old-fashioned raw-edged football. As the fans anthem has it—'no-one likes us, we don't care'.

The Millwall Medical Service

Like all league clubs in England, Millwall has an on-site medical service for spectators. The provision of crowd medical services in the UK was revolutionised after the Hillsborough stadium disaster in 1989, in which 96 Liverpool fans died. Subsequent investigations concluded that more people could have been saved if there had been a co-ordinated emergency response [4]. As a result of an enquiry led by Lord Justice Taylor, it was recommended [3] that there should be on-site medical cover at football stadia.

Over the years, this has become guidance which is now overseen by the Sports Ground Safety Authority (SGSA). One of the main factors in the Hillsborough disaster was thought to be the overcrowding and surging of a standing crowd against a rigid surface [4] causing crush injuries and subsequent cerebral oedema in many who had died [3]. This threat of specific injury has to a large extent been designed out of stadia. As stated above, Millwall's current ground was built in 1993 as part of the post-Taylor initiative [5]. The design of the ground reflects this as an 'all-seater' stadium with a capacity of 20,146 and no high fences.

English league football is an activity that attracts many spectators throughout the football league season. Like any mass participation event there is some inherent risk. Since the beginning of the twentieth century there have been 306 deaths amongst football spectators in the UK and over 3500 serious injuries with approximately 1.2

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billion attendances in the post-war years [5]. Although there is a growing body of literature examining medical consultations at mass gatherings [6–11] there is little literature in the area of English league football.

The original service at Millwall was typical of most match-day medical services in that it was prepared to provide first aid and emergency incident management. The recommendations of the Taylor Report reflected a time before all-seater stadia and a very different industry culture. The roots of the game in the United Kingdom were very much based on the idea of professional sport being a recreation designed to entertain a primarily male and working-class audience. Social and economic changes since 1945—and especially since the pivotal 1996 European Championships staged in England—have seen a distinct move away from these traditional roots, towards a far more middle-class and female-friendly support base.

Since 2001, the match-day medical team have collected data on usage of the service, how many people present, when, the reasons for doing so, if they present for a pre-existing condition, who treats them and what the outcome was (for example went home, stayed in ground, GP referral or went to hospital). After collecting these data for five football seasons (2001/2002 to 2005/2006) the team looked to see if there were any trends or areas in which the service could be improved. The activity analysis of these five seasons of presentations [12] revealed that the majority of usage (97 %) was for both minor accidental injuries (often occurring in previous days) and exacerbations of chronic disease such as asthma, epilepsy, chronic pain and advice—the mainstay of primary care. This finding supported the anecdotal experience of those working in the service and this situation has also been found in other clubs' spectator services [7].

Although the demographic of spectators in football has changed to include more women and children, the majority of spectators presenting to the medical service at Millwall FC is still predominantly male (approximately 70 %) and of working age—a group who typically do not engage with primary care.

After the evaluation, the medical team decided to reconfigure the service to allow open-door access to health professionals, to engage with the fans and local services to run health promotion events/projects and, through user involvement, to reconfigure the service to make it more responsive to the needs of those using it.

Aims of the Project

Through audit and data analysis it was clear that the service configuration that was being offered was not responsive to the needs of the people using it. The service was focused on emergency response whereas demand was for primary care. It was becoming outdated and was designed to be reactionary. Although there was a necessary focus on the management of major incidents and medical emergencies, such emergencies made up less than 3 % of the work overall. Running the service as an emergency service when the majority of presentations were for primary care issues

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and minor injuries meant that a new approach was necessary. This included thinking about what was really needed to meet the needs of people using the service, what had to be provided in case of a major incident and how best to do that. To change the nature of the service meant that a review of the skill mix would also be necessary.

The service was defaulting to sending spectators to accident and emergency for manageable conditions that needed some immediate management and longer term care that could be done in general practice. It was also clear that some people using the service were finding it difficult to access primary care. The service was increasingly accessed for advice on newly diagnosed problems like diabetes and cancer.

After looking at the service and working with the supporters on different projects in the past the aim then became to reconfigure the service to better meet the needs of the population including a more responsive and flexible match-day service and a wider spectrum of health promotion/health awareness events of each football season in partnership with the supporters.

How the Project Was Set Up

After the data analysis of the 2005/2006 season, the review of the match-day service began. With support from the stadium management, the service more formally operated a policy of open-door access to healthcare advice for anyone attending the Den. The service also sought service representation from the supporters, and in the 2007–2008 season a number of one-off health promotion events were organised with the local public health organisation (a Primary Care Trust) to see if there would be interest.

Short interventions were offered on match days prior to kick-off in conjunction with the local public health and men's health promotion team in Southwark. These activities showed the depth of the issue. In one pre-match event, 70 people presented in the 90 min before the game for various health checks, such as testing for hypertension or diabetes. At this one event alone, two people were referred to their general practitioners for probable type-2 diabetes, seven were referred for hypertension and one person presented with emergent symptoms of stroke and was transferred to hospital.

The uptake at these health promotion events, in addition to the changing demands of the service, caused the team to reflect on the need to run longer term partnership projects in addition to the regular match-day service.

In 2009, the team were approached by members of the supporters club who wanted to run a 'Fit Club'. This idea involved a group of volunteers who wanted to improve their health and raise money for charity. The supporters wanted to do this by building a team mentality and wanted help to design a programme that would help them lose weight, improve fitness and change poor dietary habits. The group ran for some 6 months, under the medical guidance of the Millwall match-day medical service. The medical team estimated that it could support ten participants, but

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over 80 people applied to take part. The people who could not be accommodated were signposted to other local services. Results were mixed, in that some took the Fit Club concept initially more seriously than others, but the idea of tying the need for improved health amongst male fans to their support of Millwall Football Club was integral to the initiative. An evaluation in 2013 showed that 6 of the 10 participants in the first group maintained healthy weight, reduced alcohol consumption and exercised regularly, even after 4 years. This is an idea which may well be replicated more widely with similar levels of support from the football authorities.

After reviewing the various interventions it was clear that it would be necessary to develop a collaborative relationship with local health providers, the local community schemes and charities in order to deliver health promotion events and work with the supporters on a larger scale. By their very nature, Millwall fans tend to be suspicious of authority of any kind; [13] indeed, conventional attempts to press healthcare messages will almost certainly fall upon deaf ears. The role of fans' groups, however, has proven to be an interesting one in so far as we have been able to work with the club on such ideas as the Fit Club and also in promoting an annual five-a-side football competition in support of local charities, 'The Lions Trust Cup', with the final played at The Den. The collaborative approach with the club and the Millwall match-day staff has ensured that these events have been well-run and very popular.

Once a new strategic medical plan had been drawn up to accommodate the various desired activities, changes in the workforce had to be initiated. The emphasis on emergency care meant that the roles defined in previous guidance had to be reviewed; for example, it was necessary to change the staffing to include those trained in both initial emergency management and primary care. This allowed a more responsive service and the ability and expertise to deal with more presentations in the ground, signpost to other services or advise certain users—many of whom were men, self-employed or on zero hours contracts—that a GP visit was necessary.

Delivery of the Project

Due to the degree of risk that such changes to the service might involve, they were introduced over a number of football seasons. This included changes in workforce, running specific and finite projects such as Fit Club or one-off events, such as men's health, smoking cessation and cardiovascular focused events on match days. Much of this approach was to ensure that the emergency response side of the service would not be compromised and that the ground would remain safe.

Changes in the way that healthcare is organised in England have recently impacted on running these events. At the time of writing (2013), local public health in England is undergoing reform and this has meant that the infrastructure that has supported the health promotion events has disappeared. To overcome this challenge we have started to build a collaborative relationship with the charitable sector.

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Fig. 18.1 Prostate cancer awareness raising event. Courtesy of Ben Spencer Photography

In the 2012/2013 season, the service worked with Prostate Cancer UK, a charity raising awareness of prostate cancer and matched to the demographic of league football supporters—a group who are typically reluctant to seek health advice [14]. Working with Prostate Cancer UK involved delivering awareness and information events during the season (Fig. 18.1), the club donating shirt sponsorship for the season and various other fund raising activities in 2013/2014.

The medical service offers an open-door service and is now staffed on match days by primary care and emergency care staff (such as senior GPs with incident management training and emergency aspects of care provided by nurse practitioners with expertise in emergency care and resuscitation) in addition to the already established first aid volunteer workforce from St John Ambulance, a voluntary service agency/charity.

The service has also started to take medical and nursing students from local universities so that they might see a different way of delivering healthcare and working in partnership with the people who use the service.

In the 2012/2013 season, the team, supporters and players worked together on a health application called V-football (Fig. 18.2). This allowed the download of an app which supplied public health advice and health awareness activity, allowing participants to chart their progress in terms of healthy living activity (e.g. exercise and alcohol intake). The first team players gave consent for their performance to be public through the app. This allowed participants to watch the progress of players as well as their own individual progress.

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Fig. 18.2 Promoting the V-football app. Courtesy of Ben Spencer Photography

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Outcomes and Evaluation

Outcomes

The project has seen a transformation of working practices, closer working relationships with outside agencies, improved satisfaction and access to healthcare services, reduced referral to emergency care, more responsive service and has started to introduce a culture of co-design with the supporters.

Feedback from the various activities has been very positive. One of the responses to the prostate awareness day was from the son of a man who had stopped by to talk to one of the nurses and later posted on one of the message boards:

> I got my dad to see the prostate people today. I've been really worried about him he had some of the symptoms and wouldn't go to the doctor's—they were really good with him—he is going to the doctor's on Monday.

Another of the supporters reported how his brother had some of the signs of prostate cancer and, following the awareness day, went to see his GP:

> Luckily he didn't have prostate cancer but turns out he was p***ing all the time 'cos he has got diabetes—it's bad apparently and they say he is lucky they caught it now or he would have got really ill. I'm really glad he saw them at the Leeds game—he wouldn't have gone to his doctor otherwise.

Evaluation

The project is ongoing and evaluation continues into different activities. The project overall was to transform the team and the services we offered so that they were more responsive to need. The team now have 6 years' worth of data that it is currently being analysed in addition to the 'before' data (2001–2005) and so a more formal evaluation is underway along with a more strategic approach to delivering the activities.

The open-door service has been delivered with excellent user feedback and lower rates of referral to emergency department care.

Individual health promotion activities have been evaluated. The events have a high rate of participation and feedback is positive. The open-door policy has seen use of the service increase but the need to send spectators to hospital decrease.

Future Work

At the time of writing, the match-day medical service is still well used for both emergency care and advice. Other projects are ongoing. Capacity restricts the activity but now there are more health awareness projects which are run in conjunction with the local press and other local organisations/national charities. It is likely that this reach will be the most effective use of the club as a focus for change in terms of awareness and health behaviours.

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In 2013/2014, the service began collecting default destination data (asking those who use the service what they would have done if the service had not been available, how many prescriptions were issued, etc). About 40 % of presentations to the service were minor injury or illness where self-care would have been appropriate. Promoting self-care is a possible area for a peer-to-peer support programme and the service is looking at providing sessions on topics such as basic first aid with the local voluntary service agency.

Lessons Learnt

The medical team, supporters and club have all worked very hard to achieve a transformational culture and approach to health promotion. The medical team is a multidisciplinary, multi-agency group of healthcare professionals and first aid volunteers. After reviewing the data from the activity analysis it was necessary to review the workforce and skills required; for example, bringing in more primary care expertise as well as emergency expertise. The change to the service also necessitated acting against the guidance of the time that was informed by the original Taylor Report [3] which focused only on emergency provision and major incident management. This presented a challenge and required robust data to justify reconfiguration in such a way. This guidance issued by the then Football Licencing Authority (now SGSA) has been updated to reflect the changing needs of clubs and spectator care, but in 2006 it was necessary to negotiate this change with the local authority Safety Advisory Group which issue the ground safety licence and the local service providers (London Ambulance Service and St John Ambulance) who initially had some concerns.

In retrospect, it would have been wiser to have taken a more strategic approach to the projects instead of treating each activity as a separate project. This particularly applied to resourcing, as demand was underestimated (e.g. the demand for Fit Club was very high).

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Chapter 19
Sport as a Post-Disaster Psychosocial Intervention for Children in Bam, Iran

David Conrad

Background

As well as their potential to cause physical injuries and fatalities, and to destroy homes and infrastructure, natural disasters can have a huge impact on the mental wellbeing of those who survive [3]. Psychological trauma can occur when an individual exposed to a life-threatening event experiences a sense of 'intense horror, fear and/or helplessness' [4]. Recovery from psychological trauma depends on the victim's coping mechanisms and resilience, including levels of support available through family and social networks, as well as individual characteristics [5].

Psychosocial interventions have emerged as a means of supporting process of psychological rehabilitation in post-disaster situations. Rejecting the classic medical model directed at the individual, these types of interventions are focussed on empowering communities to support each other, often making them more responsive to the local context [6].

Aid organisations and other NGOs are increasingly using sport-based post-disaster psychosocial interventions, particularly when targeting children and young people. Such interventions can help to build community cohesion and encourage mutual support while providing a structured, safe and non-confrontational environment in which to help children and young people express their problems and feelings, build resilience and overcome the trauma which they have suffered [7].

This chapter has been based on Valeria Kunz's original assessment report on the intervention for SAD and subsequent paper published in the journal *Sport in Society: Cultures, Commerce, Media, Politics* [1, 2]. Further details of the intervention and the results of the assessment can be found in these documents.

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The Bam Earthquake

On 26 December 2003 a devastating earthquake, with a magnitude of 6.6, struck the historic city of Bam, Iran and its surrounding area, killing approximately 30,000 people and orphaning around 6500 children. Most of the city's buildings, which were made of mud bricks, were destroyed, making over 75,000 people homeless.

National and international humanitarian aid organisations responded to a worldwide appeal for helping the Iranian government and the United Nations, and refugee camps were set up to house the homeless. Children who had survived the earthquake, and who all had family members and friends among the fatalities, found themselves living in the unfamiliar environment of the camps, where the living conditions were precarious and they had nothing to do. In response to this situation, the 'Sport and play for traumatised children and youth project was set up.

Aims of the Project

The purpose of the project was to use sport and games to provide the children with structured activities which would:

- Provide an emotional outlet.
- Improve mental and physical wellbeing.
- Encourage mutual support and social cohesion through promoting values of teamwork and fair play.
- Promote norms and behaviours important for coping with daily life.
- Provide a platform for health promotion.

It was also intended that the project would provide parents with some relief from childcare and build capacity by empowering local coaches and project staff.

How the Project Was Set Up

The project was set up by the Swiss Academy for Development (SAD),[1] a practice-oriented research institute, founded in 1991, that promotes development opportunities for children and young people experiencing rapid and often conflictual change. SAD has long been involved in the field of sport and development, exploring the use of sport as a tool to address various issues, such as overcoming trauma of civil war or natural disasters; integrating marginalised groups; fostering education and gender equity; and promoting peace and conflict transformation.

[1] http://www.sad.ch/.

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Funding for the project was received from the Swiss Agency for Development and Cooperation (SDC)[2] and a number of other funders and corporate donors.

In August 2004, a Memorandum of Understanding was signed with the Iranian dedicated authority, the Bam affected area Task Force, agreeing the establishment of two centres for delivering sports activities in the Amir Kabir and Shahid Rajaie refugee camps (both of which entirely lacked psychosocial support for children and young people). The village of Baravat, 10 km from Bam and similarly lacking support for psychosocial rehabilitation, was chosen as a third location. A protected warehouse in each of the two refugee camps was allocated for delivering the activities and kitted out with sports equipment, including football goals, table tennis tables and mats for gymnastics, while the sport federation in Baravat allowed the local sports stadium to be used as a venue for activities in the village.

Sport and play activities were initially delivered through the Czech organisation People in Need (PIN) during a pilot phase which ran until May 2005. Experienced professional sports coaches were recruited from the local population to lead the activities and a young Iranian woman was recruited as a local project manager.

The project was promoted in local schools in the Bam area and activities began being delivered at all three of the project's locations by the end of October 2004.

Delivery of the Project

The coaches provided a range of sports activities, including football, volleyball, basketball, gymnastics, karate and table tennis, in 12 different classes comprising an average of around 20 children and young people. A monitoring system was put in place to identify which classes were most and least popular, allowing the programme of activities to be adjusted several times in keeping with demand. Participants often requested additional activities, resulting in several trips, picnics and competitions being organised in addition to the scheduled classes. Sponsors provided sports shoes and clothing for the participants.

The range of activities was expanded over the course of 2005 to include health education and conflict management and violence prevention programmes. Workshops were also provided for the coaches to provide them with further training in sport didactics and psychosocial issues.

At the end of the pilot phase, there was clear enthusiasm from the participants, parents and the coaches to continue with the intervention and it was decided that the SAD would continue to run the project directly through the local project manager.

In August 2005, the administrators of one of the camps claimed back the warehouse in which the sports activities were being delivered. There was additional space in the warehouse at other camp, however, which allowed the activities to continue, with a minibus organised to regularly transport the participants between their home camp and the new venue.

[2] http://www.sdc.admin.ch/.

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In order to achieve equal participation from boys and girls, it was necessary to ensure that the project was compatible with the conservative values and gender norms which prevailed among the population. It was not considered socially acceptable for women to practice sports in public, so activities were run indoors with curtains over the windows. Separate classes were run for boys and girls, with the venues reserved for one or the other at specific times, and the girls' classes led exclusively by female coaches. It was also important to ensure the safety of the girls in getting to and from the class, which was a common concern for parents.

From December 2005, the refugees gradually left the camps and returned to Bam and its surrounding villages. Rather than bringing the project to a close, it was transferred into local structures in 2006. A local team—consisting mainly of the original coaches—continued to manage and deliver the intervention, with support from the authorities and donors allowing a new sports centre to be opened in Bam in which the activities could be held.

Outcomes and Evaluation

The importance of building evaluation into the intervention was recognised from the outset. In light of the complex, long-term process of post-disaster rehabilitation and the innovative nature of the project and limited evidence-base in the field of sports-based disaster response work, it was decided to conduct an impact evaluation with ongoing monitoring of the project. This integrated and participatory approach allowed for the format and goals of the project to evolve as it developed and lessons were learnt about what was and what wasn't working well. The local project manager was also able to shape the monitoring system over time in order to ensure that it remained fit for purpose and use insights from the monitoring process to inform the ongoing development of the project.

Data Sources

Data for the evaluation were gathered from weekly reports submitted by the coaches and interviews with the children's family members. The findings from these data sources were triangulated with the results of a gender questionnaire survey which had been undertaken prior to the intervention.

Initially reports were made daily by the coaches but it quickly became apparent that this was too demanding and after 6 weeks a switch was made to weekly reporting in the form of a structured interview conducted by the project manager. The interviews comprised open questions covering issues such as the relationship between the coach and the children, group dynamics and the children's behaviour. A table was also completed to collect basic quantitative data, such as number and age of participants and injury counts. Rather than the coaches simply submitting written reports, this format allowed a more dynamic feedback process in which the project manager could discuss particular issues in more depth directly with the coaches.

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Structured interviews with a sample of participants' family members were conducted by the project manager in March 2005. The project manager selected five family members to interview at each of the project's three locations, focussing on the families of children who were perceived as traumatised or having difficulties at home. The interviews gathered qualitative data on family members' attitudes towards the project and the perceptions of its impact on the children.

As part of a separate research project conducted by the SAD on gender, sport and development [8], additional data were collected from questionnaires completed by the coaches, parents and children involved in the project. The data from these questionnaires provided further information on the project activities, although they comprised mostly closed questions and were focussed on gender-specific issues, rather than the physical and mental wellbeing of the children.

Attendance

From the outset of the project the number of participants grew everyday until it reached a consistent average of around 300 in each of the three project locations and around 20 in every individual class. The children and young people ranged in age from 6 to 18 years old, with girls representing over half of the participants. There was no requirement or expectation regarding the number of sessions that participants should attend, with freedom to join or quit a class at any time. As participation at individual level was not recorded, it was therefore not possible to quantify the duration of participants' exposure to the intervention. The coaches' reports, however, suggested that most of the participants attended on a regular basis except for events such as holidays or school exams.

There was a high level of enthusiasm for the project among the children and young people from the outset, to the extent that coaches sometimes had difficulty bringing classes to a close because of the participants' eagerness to continue. The levels of enthusiasm varied considerably across the range of activities on offer, however. While gymnastics for girls and football classes for boys were very popular, some classes were cancelled after a few weeks due to low attendance. The tendency for the boys to prefer football over other sports particularly led to the boys' volleyball, basketball and table tennis classes all being cancelled.

Impact on Participants' Wellbeing

Although the main aim of the project was to improve the physical and mental wellbeing of the participants, scientific measurement of its impact in this regard was lacking and instead the evaluation relied on the reported observations of the coaches and the sample of family members who took part in the interviews. Data from both of these sources showed that participants were regarded as generally very nervous at the beginning of the project. Coaches described an initially hostile atmosphere in classes, with both boys and girls commonly displaying physical and verbal

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aggression towards each other and weaker participants being made fun of, to the extent that it was difficult to control the classes sufficiently to conduct some of the activities. This behaviour corresponded to the typical reactions exhibited by school-age children who have experienced traumatic events [3].

The coaches' reports and interviews with family members both provided anecdotal evidence of changes improvements in participants' wellbeing over time and a beneficial effect of the intervention, describing examples of improvements in participants' self-confidence, depression and hostility. It is important to exercise caution in drawing conclusions from these reports, however, due to: (1) the absence of reliable data on the participants pre- and post-earthquake wellbeing and behaviour with which to make a comparison and judge the impact of the event on the children; (2) the lack of a control group in the study to provide an indication of the extent to which positive changes might be attributable specifically to the intervention itself, rather than being things which might have occurred over the same period of time anyway; (3) the reliance on second-hand anecdotal evidence relating to a non-random sample of the participants and the substantial associated potential for bias.

Social Cohesion and Social Integration

The reports of the coaches frequently portrayed an atmosphere of hostility in the groups which betrayed a lack of social cohesion. Physical, as well as verbal, aggression was commonly reported, which the coaches attributed not to the trauma of the earthquake but factors such as upbringing, lack of attention and longstanding hostilities between families. This was said to also reflect the atmosphere in the refugee camps, where social cohesion was lacking as a result of families from different areas living together in difficult conditions.

Over time, the coaches reported improvements in the participants' attitudes and behaviour towards each other, with less aggression, increased sense of fairness and a greater willingness to support each other. Extra activities, such as competitions with other teams and a picnic in the countryside particularly appeared to help build a sense of team spirit. The boys' football classes in the two warehouse locations remained the most challenging—although respect for the coach and some sense of fair play did emerge, with friendships building which extended beyond the context of the project and some participants forming study groups to prepare for school exams.

The Role of the Coaches

Out of the 50 participants surveyed, 49 fully agreed with the statement 'My coach is like a friend to me'. Three quarters of respondents fully agreed with the statement 'I usually share my private problems with my coach'. Overall, respondents most commonly selected 'understanding and caring about people' when asked to indicate

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the characteristics which they felt were the most important for a coach; girls were more likely to give this answer than boys, while boys were more likely than girls to select 'respected and setting strict rules' as the most important characteristics (possibly reflecting the apparent need for these attributes in the generally less-disciplined male classes).

The extent to which coaches were accepted as trusted confidantes and sources of support varied, with relationships of trust and mutual support between coaches and participants being much more quickly established in the classes based in the village, where social cohesion was notably greater than it was in the refugee camps. The coaches were proactive in talking to participants who appeared to be experiencing problems. The dominant construct of masculinity presented a barrier to boys approaching the coaches to discuss feelings and problems, but other boys would often alert the coach if they felt someone else in the group had a problem, allowing the coach to initiate a conversation with the individual concerned.

Participants commonly looked to the coaches for advice and mentorship, particularly regarding problems with parents. The hardships faced by families—with almost all having lost members in the earthquake, poverty, the prevalence of physical disability and mental suffering, the difficult conditions in the camps and high rates of drug consumption—were frequent sources of tension in day-to-day life. Parents generally welcomed the support which the classes and coaches provided to their children and respected their role as mediators, reinforced by the coaches' willingness to engage with parents to achieve buy-in by explaining the wider benefits of the project on their children's wellbeing and development.

Lessons Learnt

One of the most interesting findings from the data collection was that the majority of the participants themselves regarded the serious aspects of the intervention to be more important than the simple enjoyment of taking part in the sport activities—over half of 50 participants surveyed did not agree with the statement *'The main thing is to have fun'*. This suggests that when establishing other similar interventions, it would be wrong to assume that promoting the enjoyment aspect should form the sole basis for recruiting and achieving buy-in among young people.

- Recruiting the coaches from the local population, rather than bringing them in from outside the community, proved to be a major advantage in establishing relationships with participants and parents. As locals, the coaches already had a level of trust and respect on which to build, which was crucial for achieving support early on for the project and being regarded as legitimate mediators by both participants and their parents.

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- There were pros and cons to the open manner in which the project was organised, with newcomers able to come along and join activities as and when they wished rather than having a more formal membership or allowing newcomers to join only at certain times. This approach meant that the intervention was always accessible to its target audience, rather than reaching only those who had joined at the outset of the project or those who were prepared to commit to regular attendance right away. The downside, however, was that newcomers were frequently perceived as a source of disruption—causing trouble and disrupting the cohesion and discipline which had been built up over previous sessions with the regular participants.
- Coaches found that the disruption caused by newcomers could sometimes be prevented by separating the class into smaller groups or allocating some of the regular participants to be responsible for the induction of newcomers. In some cases, however, it was necessary to exclude disruptive newcomers from the class as the only effective solution.
- The need to ensure the provision of adequate resources for sports activities, or at least to be prepared for the potential for problems where this is not possible, was highlighted by the frequency with which fighting over limited equipment was a source of conflict and hostility among participants.
- In some of the classes the atmosphere of verbal and physical aggression among the participants, particularly in the early sessions, meant that weaker or less confident children were often victimised by the others. This presented a challenge for coaches in tackling this behaviour and ensuring that participation in the project had a positive impact on the weaker participants rather than simply being a fresh source of difficulties for them. One of the techniques which proved effective was to give weaker participants specific tasks which would ensure their inclusion in the activities or to appoint them as 'coaching assistants' in order to boost their self-confidence and help them to be accepted by the rest of the group.

Future Work

The refugee camps began to be gradually dissolved from December 2005, as most families moved back to Bam or nearby villages. Rather than bring the project to an end, it was transferred into local structures to be managed independently and continued over the long term. The management capacity of the local team was developed over a transitional period during 2006 before the project was completely handed over to them to run. With the support of local authorities, one of the warehouses was donated to the project and a plot of land in a poor district of Bam was secured to which the warehouse could be relocated. Donations from Nestlé Iran, ensured that the running costs of the project would be covered for some time to

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come and the new centre was opened on June 11, 2006 in a ceremony attended by the city mayor, state representatives, the Bam sports federation and the media.

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Chapter 20
Football Fans in Training: A Weight Management and Healthy Living Programme for Men Delivered via Scotland's Premier Football Clubs

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Background

The prevalence of obesity in UK men is amongst the highest in Europe [1]. On current trends, nearly 50 % of UK men will be obese by 2030 [2], and already more than three quarters of men are overweight or obese in Scotland [3], putting them at increased risk of cardiovascular disease, diabetes and cancer. Obesity also poses an increasing burden on health services and a challenge to public health [2, 4–7], and can prevent men from fully taking part in day-to-day activities which they themselves value.

However, there are real challenges in supporting weight management in men who wish to lose weight. Men often view dieting as 'feminine' [8, 9] and they are much less likely to use existing commercial and NHS weight loss programmes [10–14]. As obesity rates are increasing more quickly in men than in women, the development of weight management strategies which are appealing and acceptable to men is a public health priority [15]. These are likely to work best when they are designed to work with, not against, dominant cultural ideals of masculinity and valued aspects of men's identities [16] and delivered in settings in which men feel comfortable [15, 17, 18]. Furthermore, because the evidence base on what works in

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weight loss *for men* is relatively sparse (given men's underrepresentation in weight loss trials) [19] it is important that new interventions are rigorously evaluated. In this chapter we describe the Football Fans in Training (FFIT) programme [20] which has been delivered via professional football clubs in Scotland and evaluated using the world's first randomised controlled trial in a professional sports club setting [21].

Aims of the Project

The FFIT programme was designed as a weight management and healthy living programme for men aged 35–65 years with a body mass index (BMI) of at least 28 kg/m^2. The programme has been gender-sensitised in context, content and style of delivery [20], and hence is intended to provide men with support in adopting healthy behaviours in ways which are consistent with, rather than counter to, prevailing cultures of masculinity. The development and history of the FFIT programme is described in detail elsewhere [20].

How the Project Was Set Up

FFIT exploits the traditionally male environment of football clubs [22], existing loyalty to football teams and the opportunity to participate in men-only groups to maximise men's engagement [17]. The programme built on evidence on what works best in group-based weight management programmes and on an evaluation of a programme developed specifically for men and delivered via a men's health clinic in central Scotland [17]. Three members of the FFIT research team (KH, SW and CG) initially approached the Scottish Premier League Trust (SPL Trust), now in 2010 to ask whether they would be willing to collaborate in developing an evidence-based, gender-sensitised weight management programme for delivery by community coaches to overweight men. We also indicated from the outset our desire to evaluate the programme using the 'gold standard' methodology of the randomised controlled trial (RCT). We then worked with the SPL Trust to secure funding from the Scottish Government and the Football Pools for the deliveries, whilst simultaneously applying for research funding to evaluate the effectiveness of the programme, first to the Chief Scientist Office (for funding for a feasibility pilot study) and then to UK National Institute for Health Research Public Health Research Programme (for funding for a randomised controlled trial of effectiveness of the programme, a process evaluation and a health economic analysis of cost-effectiveness). We conducted feasibility work which used qualitative methods and observations of pilot deliveries of FFIT in autumn 2010, and subsequent discussion of these findings with the community coaches, to optimise the FFIT programme for the full-scale randomised controlled trial. The feasibility research also tested the acceptability of the methods and measures proposed for the full-scale trial and provided an indication of the likely benefits of taking part in FFIT [20, 23].

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Delivery of the Project

FFIT is a men-only, evidence-based [24, 25], 12-session, weight management, lifestyle and physical activity group programme, with subsequent minimal-contact weight loss maintenance support via occasional emails from club coaches, and a 9-month reunion session. It is delivered free of charge at Scottish Professional Football League (SPFL) football clubs by community coaches trained in diet, nutrition, physical activity and behaviour change techniques to a standard protocol to ensure that key elements of FFIT are delivered. FFIT is gender-sensitised in context, content and style through its delivery at professional football stadia by club community coaches who encourage participative learning, a practical focus through shared experiences of progression towards behaviour change and a light-hearted atmosphere ('banter') which supports men in discussing potentially difficult issues. In addition to advice on diet, alcohol and sustainable behaviour change strategies, each of the weekly sessions of FFIT focus on physical activity through an incremental pedometer-based walking programme to encourage greater activity in daily life [16] and pitch-side sessions led by club coaches. The mapping of these key elements onto behaviour change techniques which are effective in weight management [26] (e.g. self-monitoring of weight and physical activity, intention formation, goal setting and review) is described elsewhere [20].

Outcomes and Evaluation

The results of a feasibility study demonstrated that FFIT had the potential to help men to lose weight and that an evaluation using a randomised design was possible [23]. Early qualitative work using observations of deliveries, focus group discussions, and semi-structured interviews with participants and coaches also demonstrated FFIT's popularity with men [16, 23].

A full-scale RCT, powered to assess whether participation in FFIT helps overweight/obese men to lose at least 5 % of their body weight 12 months after baseline (pre-programme) measurement, has been completed—the first RCT of a behavioural intervention in a professional sports setting [21]. In June–September 2011, sufficient men were recruited to fill all available places on FFIT (at that time funding was available from the UK's Football Pools and Scottish Government for deliveries at 13 professional football clubs in August–December 2011, February–April 2012 and August–December 2012). At baseline measurement sessions in August–September 2011, objective measurements of body composition were taken and self-completed questionnaires were administered to gather information on men's health and physical and social characteristics (see Table 20.1 for a description of measures included). After assessment of eligibility (age 35–65, BMI $\geq$ 28), 374 men were randomly allocated to undertake FFIT immediately (trial intervention group) and 374 to undertake FFIT 12 months later (waitlist comparison group; 1 man subsequently withdrew). Men who were unable to attend baseline measurement sessions were placed on a waiting list and offered a place on the February 2012

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Table 20.1 Measures collected at baseline, 12 weeks (post-programme) and 12 months in the FFIT RCT

	T_0	T_1	T_2
Objectively measured by fieldwork staff	✓	✓	✓
Height (T_0 only), weight, body mass index, waist circumference, body composition (% fat)			
Health and well-being	✓	✓	✓
Self-assessed health and fitness; self-esteem; positive and negative affect; health service and medication use			
Joint pain; past and recent injuries affecting ability to do physical activity			✓
Health behaviours	✓	✓	✓
Diet; physical activity; alcohol consumption; smoking			
Social and other characteristics	✓	✓	✓
Marital status; employment status; education			
Ethnicity; quintile of deprivation of area of residence; housing tenure; orientation to masculine norms	✓		
Football	✓	✓	✓
Frequency of attending matches at home and away games; frequency of viewing football at home and in the pub; football-associated alcohol consumption			

T_0—baseline measurement sessions at club stadia conducted prior to randomisation of men to different programme deliveries
T_1—'12-week' measurement sessions at club stadia conducted in November–December 2011, after men in the intervention group had completed the 12 week FFIT programme
T_2—'12-month' measurement sessions at club stadia conducted in August–September 2012, before men in the waitlist comparison group had started their 12 week FFIT programme

delivery of FFIT ('non-trial' group) if any places remained after prior allocation to men who had attended the measurement sessions. Ethical approval for the study was granted by the College of Social Sciences Ethics Committee, University of Glasgow.

All objective baseline physical measures (weight, height, waist circumference, blood pressure, percentage body fat) were taken in the clubs by fieldworkers trained to standard protocols (see Hunt et al. [21, 27] for more details). As part of the process evaluation of FFIT, men who had attended at least six sessions in August–December 2011 (85 % of intervention group) were invited to a discussion about their experiences of FFIT at the end of the 12 weekly FFIT sessions; 63 men participated in 13 focus groups. These discussions were audio-recorded with consent, transcribed verbatim, and transcripts checked for accuracy against recordings. Men were asked about their experience of taking part both in the FFIT programme and in the research evaluating its effectiveness. We were able to achieve very high levels of follow-up of the participants in the trial at both 12 weeks (88 % intervention group, 93 % of waitlist comparison group) and 12 months (89 % intervention group, 95 % of waitlist comparison group).

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The results of the RCT are reported in detail elsewhere and have shown that participation in FFIT enables men to lose weight (the primary outcome of the trial was the difference in weight loss between the intervention and comparison groups 12 months after baseline) and gain other benefits to their health and well-being, and that the programme provides a cost-effective use of resources [21]. In brief, the trial succeeded in attracting high-risk men from a range of socioeconomic backgrounds; at baseline 92 % were classed as 'obese', mean body-mass index was 35.3 kg/m^2, and over 90 % were at very high or extremely high risk of future ill-health on the basis of their combined BMI and waist circumference. Men who had done the FFIT programme weighed, on average, 5.6 kg less 12 months after baseline (compared with 0.6 kg in the waitlist comparison group). Put another way, 12 months after starting the programme, FFIT participants had lost over nine times more weight than men who had not done the programme. There were significant differences in the changes in the secondary outcomes post-programme (weight loss at 12 weeks, waist circumference, BMI, percent body fat, systolic and diastolic blood pressure, total MET-minutes/week expended in physical activity, fatty food score, fruit and vegetable score, sugary food score, amount of alcohol consumed, self-esteem, positive affect and negative affect), all of which showed greater health improvements in the intervention than the waitlist comparison group. At 12 months, these differences were still apparent, although sometimes the differences between the two groups had lessened.

The health economic assessment showed that FFIT was relatively inexpensive to deliver (including the cost of club-branded t-shirts, programme materials for coaches and participants, a pedometer for each man, club community coaches' time for training and for delivering the sessions), and was judged to be cost-effective (for a cost-effectiveness threshold of £20,000 per quality-adjusted life year gained (QALY), the probability that FFIT is cost-effective compared to no intervention is 0.72, and this probability rises to 0.89 for a cost-effectiveness threshold of £30,000) [21].

Our qualitative research has demonstrated the popularity of FFIT with its participants [16, 20, 23].

Future Work

Further funding for the FFIT programme has been provided by the Scottish Government for deliveries in the football seasons 2013–2014, and 2014–2015. The coordination of these deliveries is provided by SPFL Trust. Further projects have developed from FFIT, including a feasibility study of delivery of a similar programme in the rugby clubs setting (RUFIT), a study of using a FFIT-based programme to address inactivity and sedentary behaviour in professional football clubs in four European countries (EuroFIT), and work testing the use of the football metaphor and form in other settings, including prisons.

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Lessons Learnt

- The football club setting proved very successful in attracting high-risk men from a wide range of social backgrounds to a weight management and healthy living programme
  Professional sports clubs, and specifically professional football clubs in the United Kingdom, are increasingly seen as settings that can attract men to health-promoting activities [28, 29]; Pringle and colleagues suggest that 'the product (i.e. football/EPL [English Premier League]) … , the place (club stadia and facilities), people (players and management) and processes (including communication, marketing and the product delivery infrastructure)' all contribute to their appeal [29, p. 412]. The mean weight of the participants in the FFIT RCT was 109.5 kg (sd 17.3) and mean BMI was 35.3 kg/m^2 (sd 4.9). Over 90 % of participants had a BMI > 30; 44 % were classed as 'mildly obese', 31 % as 'moderately obese', and 17 % as 'extremely obese'. Over 95 % were classed as at 'extremely high' or 'very high' risk of developing Type-2 diabetes, hypertension and cardiovascular disease on the basis of their objectively measured body mass index and waist. The qualitative data revealed the powerful 'draw' of the football club setting in attracting men who were otherwise reluctant to attend existing weight management programmes [27]. The opportunity to undertake the FFIT programme in circumstances that enhanced physical and symbolic proximity to something they valued highly, i.e. the football club, was crucial in overcoming other apprehensions about enrolling in a group-based weight management programme. Although these men were sufficiently concerned about their weight to enrol for FFIT, less than 4 % had attended a commercial or NHS weight loss programme or clinic in the previous 3 months. Many of the men appreciated being able to work together in a male-only group, with 'men like them' (both in terms of shared interests and perceived similarities in body shape and fitness). The feeling that FFIT was 'right' for them was reinforced by what men said that FFIT was not: i.e. FFIT was not for women, not Weight Watchers or Scottish Slimmers, not a diet club and so on [27].

  Participants' 'insider' experiences of the club, i.e. the greater physical and symbolic proximity to the club that they felt they gained whilst on the programme, fostered a strong and supportive group identity which encouraged men in achieving their individual weight loss and other goals.
- The FFIT programme can be delivered in other football club settings
  FFIT was being designed to be generalised to other football club settings at relatively low cost. If the FFIT programme is delivered in other clubs, using the FFIT coach and participants' materials and following appropriate training for delivery, weight loss and other positive health changes can be expected.
- It is possible to conduct 'gold standard' research, such as randomised controlled trials, in sports-based settings in partnership with community organisations

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(continued)

- The FFIT evaluation demonstrates that, despite the many challenges in conducting this type of evaluative research in community settings such as professional football clubs [30], it is possible to obtain objective measures and use 'gold standard' evaluative designs (such as a RCT). Building a strong evidence base on what works and for whom for interventions in community-based sports settings is only possible through the establishment of strong working partnerships with the organisations that deliver and fund novel interventions and requires considerable investment in relationships with all parties. Working with coaches and clubs in a competitive league environment to deliver a programme to a standardised protocol was facilitated by the coordination of the SPFL and the commitment of community coaches to their club's fans.
- Men will change
- Assertions that men undertake 'risky' behaviours (such as smoking and drinking excessively) and avoid health-protective behaviours (such as help-seeking) to prove their status as 'real' men are commonplace [31], and reinforced in popular media and day-to-day interactions. Some have argued that 'the very state of manhood' is 'a precarious social status that is hard won and easily lost [requiring], continual public demonstrations of proof' [32, p. 101]. Findings from FFIT reinforce earlier evidence [16] that FFIT is valued by men who want to lose weight, is enjoyable and engaging, and enables men to undertake positive care of themselves and their health whilst 'bolstering' their masculine capital through their association with football clubs, symbolically and physically, and their participation and association with other men like them. The men's own evaluations of the usefulness of various elements of the FFIT programme (see Table 20.2) show how they valued learning about diet, physical activity and how to sustain behaviour changes in a group setting with other men.

As we have argued elsewhere, the professional football club setting appears to have provided these men with a physical and social opportunity which matches well with their own identities/values as men:

'The fact that FFIT attracted like-minded men with similar physiques and levels of fitness ("people like them") contributed to the appeal of the group format. In relation to the COM-B model [of health behavioural change], men's accounts suggested they wanted to, and were motivated to, lose weight for whatever reason and that the FFIT programme was an ideal opportunity. Our attempts to "gender sensitise" FFIT in context (professional football stadia), content (e.g. specific sessions on alcohol and weight, "branding" with club insignia on programmes and club-based t-shirts), and style of delivery (participative, peer-supported learning which encouraged male "banter") appears to have worked in terms of engagement' [27, p. 8].

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Table 20.2 Men's rating of various aspects of the FFIT programme

How useful was/were the … (*n* providing data)	Very useful (%)	Quite useful (%)	Slightly/ not useful (%)	NA/don't remember (%)
… pedometer (308)	82	12	6	1
… advice on increasing walking (308)	80	17	3	<1
… activity sessions (308)	78	13	7	2
… information about diet (307)	76	21	2	–
… information on food portion sizes	77	20	2	<1
… information on eating regular meals	69	25	5	<1
… information on food labels	67	25	7	<1
… information about daily calories and eating plans	68	25	7	<1
… SMART goal setting	43	44	11	2
… tips on overcoming setbacks	50	38	10	2
… it to know your 5–10 % weight loss target	64	27	6	3
… being given physical evidence of weight loss	62	18	8	12
… information on the role of alcohol in weight gain	61	14	11	2
… information on the role of fizzy juice drinks in weight gain	65	25	8	2
… to hear how other men were getting on	72	18	8	2
… meeting up with other men between or after FFIT sessions	58	15	16	11
… get support from family in doing more exercise	56	27	14	2
… get support from family to change eating and drinking habits	57	26	16	1
… emails and letter from the club post-FFIT	46	33	14	6
… 9-month reunion	49	18	7	25

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Chapter 21
The Stanford Sports to Prevent Obesity Randomized Trial (SPORT)

David Conrad

Background

Childhood obesity is regarded as one of the most serious public health challenges of the twenty-first century [2, 3]. The issue is global, steadily affecting many low- and middle-income countries, particularly in urban settings [2]. Childhood obesity constitutes something of a public health time bomb, with overweight or obese preschoolers are five times as likely to become overweight or obese adults, compared with their normal-weight peers [4]. Reflecting its status as the world's second most obese populous country [5], the United States has high rates of obesity among preschool children—approximately one child in eight aged 2–5 years is obese, with particularly high rates in the State of California [4]. Tackling childhood obesity requires a broad range of population-level actions, including the adoption of community-based interventions [6], and there is a need to build the evidence-base around engaging overweight children in cost-efficient, feasible, and effective ways.

Increasing participation in team sports may have a role to play in achieving positive lifestyle changes among this target group, as there is evidence that children who take part in team sports are generally more physically active and have greater levels of physical fitness compared with children who do not [7–10]. Barriers to obese children accessing team sports activities can include parents' concerns about the safety of outdoor play [11] and the influence of children's perceptions of their own competence on participation [12]. Also, it is has been shown that children who are

This chapter is based on Weintraub et al.'s original research paper published in the *Journal Archives of Pediatrics & Adolescent Medicine* [1], where further details of the project and the results of the trial can be found.

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overweight perceive more barriers to participating in physical activity compared with normal-weight children [13, 14]. Increasing team sports participation among overweight children, therefore, requires an approach which can successfully address these issues.

Aims of the Project

The purpose of the project was to design an organized after-school team sports intervention for low-income overweight children and test its effectiveness against a "control" intervention using standard health promotion materials and activities produced by federal health agencies and national nongovernmental health organizations.

The intervention was designed to create a supportive environment, with the aims of reducing weight gain, increasing physical activity and improving psychological health.

How the Project Was Set Up

Researchers and physicians at Lucile Packard Children's Hospital and the Stanford University School of Medicine in California, USA devised the Stanford Sports to Prevent Obesity Randomized Trial, or SPORT, after noticing increasing numbers of obese, physically inactive children attending their clinics. It became apparent that simply promoting the benefits of exercise was insufficient to achieve meaningful behavior. While the children and their families tended to recognize the importance of exercise for controlling weight gain, they were unsuccessful in finding ways to routinely incorporate sufficient increased physical activity into their lives. In response to this problem, the SPORT project was conceived, involving designing an after-school physical activity intervention specifically for overweight and obese children and conducting a pilot study to test its efficacy against a traditional nutrition and health education intervention.

Through a combination of feedback from overweight children attending local clinics, school district personnel and staff from other community youth programs, and previous clinical work with children in the community, it was ascertained that soccer was the most popular sport among children in the community. As soccer was also felt to be easy to teach to children with varying levels of skill and experience, it was decided to use co-ed soccer as the basis for designing the intervention. The study was approved by the Stanford University Panel on Protection of Human Subjects in Medical Research and implemented in local schools in collaboration with school district personnel. Initially, a 3-month feasibility study was undertaken with 13 children to establish that it was acceptable to the target group, practical to deliver, and showed promise in slowing BMI gain and improving psychological outcomes before commencing the main pilot study.

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Delivery of the Project

The recruitment of participants, delivery of the intervention, and follow-up took place between April 2005, and February 2006.

To be eligible for inclusion, children had to have a body mass index (BMI) score at or above the 85th percentile for age and sex,[1] and be in grades 4 and 5 (ages 9–11) in a low-income community in northern California. Children were excluded from the study if their growth was affected either by a medical condition or any medication they were taking, or if they had a medical condition which would limit their ability to participate in the intervention or the assessments. Children were also required to be given medical clearance to take part in the sport activity by a primary care professional.

Eligible participants were recruited through primary care, schools, and community centers where children were sent home with leaflets describing the study and inviting parents to telephone the study coordinator if they were interested in their child becoming a participant. Recruitment also took place through physician referrals, with doctors issued with "prescription pads" for the study which served as both a referral and medical clearance.

Baseline assessments were completed for all participants before they were randomly allocated either to the after-school soccer intervention or to a traditional nutrition and health education program which served as a control. Twenty-one children were enrolled in the study in total, of whom 14 had never previously participated on a sports team. Nine children were allocated to the treatment intervention and 12 to the control group.

Both the intervention and the control programs were delivered after-school by undergraduate and medical students from Stanford University, under the guidance of the investigators leading the study. All the students underwent appropriate training, including certification in the Protection of Human Research Subjects and training in youth development, group management, and the soccer curriculum for the program.

The control program consisted of 25 weekly information-based sessions using materials and activities produced by federal health agencies and national nongovernmental health organizations to promote healthy eating and physical exercise.

The soccer intervention was delivered 3 days per week initially, but in response to requests from participants and parents this was later extended to 4 days per week. A soccer game was played 1 day per week, with other days set aside for practice. Matches involving the children, their parents, and the coaches were held quarterly. Each session was 2¼ h long in total, including a homework period followed by 75 min of activity. Every player was provided with a water bottle, shin guards, and uniform. The trained students acted as both coaches and homework tutors. The activity period would start with a supportive, teambuilding check-in which was followed by 15 min of warm-up and stretching exercises. The remainder of the time in the practice sessions was involved using fun exercises to teach soccer skills, with a scrimmage to conclude the session.

[1] On the 2000 Centers for Disease Control and Prevention BMI charts (http://www.cdc.gov/growthcharts).

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The practice sessions were designed to promote respect for self and others, inclusion and teamwork, with a celebratory cheer and recognition of teamwork and each player's individual efforts at the end. When the program concluded, all the children received medals and certificates of accomplishment.

Outcomes and Evaluation

Outcome Measures

As the whole project was designed as a research trial, evaluation was built in to the intervention from the outset.

The following primary outcomes were measured at baseline (before participants were randomly allocated to the intervention or control group) and then again 3 and 6 months later:

- Body Mass Index (BMI)
- Physical activity (measured using accelerometers)
- Self-reported screen time (television, video viewing, and video gaming)
- Self-esteem (using the 10-item Rosenberg Self-esteem Scale)
- Depressive symptoms (using the 10-item Children's Depression; Inventory), and weight concerns (using the Weight and Shape subscale of the McKnight Risk Factor Survey)

Basic demographic data for the sample were recorded at baseline. Injuries and adverse events were recorded, and participation and attendance rates were used to assess the acceptability of the intervention, along with participant satisfaction scores.

Participant Characteristics

The mean age of the children in the soccer intervention group was 9.50 years while the mean age of those in the control group was 10.34 years.

In the soccer intervention group, two children had a BMI at or above the 85th to the 94th percentile, while seven had a BMI at or above the 95th percentile. All of the children in the control group had a BMI at or above the 95th percentile.

The ethnicities of the participants (self-reported) were 8 Hispanic/Latino and 1 black or African American in the soccer intervention group and 10 Hispanic/Latino, 1 black or African American and 1 Native Hawaiian or other Pacific Islander in the control group.

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Attendance and Sample Retention

Attendance rates for the soccer intervention ranged from 14 to 86 %, with a mean of 42 %. Mean attendance was higher in the first 3 months (53 %) than in the latter half of the intervention (35 %).

Attendance rates for the control intervention ranged from 3 to 94 %, with a mean of 46 %. Mean attendance of 45 % in the first 3 months and 49 % in the latter half of the intervention.

None of the children were lost to follow-up (i.e., all 21 completed the study).

Weight Loss, Physical Activity, and Screen Time

After both 3 and 6 months, the soccer intervention was found to have medium to large beneficial effects on BMI, BMI z score, total daily physical activity, moderate physical activity, and vigorous physical activity, in comparison with the control intervention.

All of the children who received the soccer intervention and 5 of the children (42%) who received the control intervention had lower BMI *z* scores[2] at the 3- and 6-month follow-up points. The soccer intervention had the greatest effect in comparison with the control intervention on those children who had lower BMI z scores at the start of the study.

At the 6-month follow-up, 8 of the 9 children in the soccer intervention group stated that they wished to continue to playing on a soccer team.

The results were inconclusive regarding the impact of the soccer intervention on the amount of time children spent on watching television and other screen-based activities.

Depressive Symptoms, Overweight Concerns, and Self-Esteem

The soccer intervention was not shown to have any beneficial impact over the control intervention regarding the psychological factors which were studied, with inconsistent results for depressive symptoms and no differences between the groups regarding self-esteem or concerns about overweight.

Adverse Events

There were no adverse events attributable to participation in the study in either the intervention or the control group.

[2] A BMI *z* score or standard deviation score indicates how many units (of the standard deviation) a child's BMI is above or below the average BMI value for their age group and sex. http://www.noo.org.uk/uploads/doc/vid_11601_A_simple_guide_to_classifying_BMI_in_children.pdf.

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Lessons Learnt

- The effect sizes shown for some of the outcomes studied suggest that studies with larger sample sizes and greater statistical power may be required for establishing the effectiveness of this kind of intervention. Also, as the children with lower BMI z scores achieved the best results from the intervention, the sample size should ideally be large enough to allow stratification according to different degrees of overweight at the baseline measurement while still having sufficient statistical power.
- Although as a pilot study there are limitations on the conclusions which can be drawn from its findings, the project demonstrates the potential for delivering sports-based health interventions for overweight children in a school setting. Both the soccer intervention and control had high attendance rates, suggesting that offering interventions specifically for overweight children may help to overcome access barriers. Although the intervention was held in public view, there were no reports of the children having experienced any negative effects from participation, such as teasing or bullying.
- The children reported that they enjoyed the opportunity to be part of a team, make friends and have fun while exercising and learning about health. Parents typically reported that their children felt more comfortable in a group with others of a similar weight and that the project had increased their confidence and self-esteem while improving their eating habits and raising their levels of physical activity. It was reported that some children who had participated in the soccer intervention went on to get involved in other school-based sports teams.
- Although the physicians who had been approached to help with recruitment were enthusiastic about the study, most of the referrals came from schools. It is not known whether the low level of recruitment via physicians reflected limited appropriate opportunities for them to issue "prescriptions" for the study, other reasons for low prescribing rates, or low prescription-to-participation conversion rates.
- While there was no formal healthy eating education element to the soccer intervention (in order to be able to assess the impact of the sports team activity in isolation), discussions about healthy eating arose spontaneously with participants throughout the course of the intervention. Those leading similar sports interventions should therefore be appropriately trained to provide basic health promotion around diet, even if this is not intended to be part of the program.
- The overall lesson from study is that overweight children who have had negative experiences of team sports or have never previously participated in team sports can be successfully targeted through a sports-based intervention which is tailored specifically for them and in some cases go on to develop enthusiasm for team sport beyond their participation in the project.

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Future Work

Further research is required to test out the findings of this pilot study with a larger sample and over a long follow-up period. Additional studies would also be useful to establish the optimum design for such interventions (e.g., comparing the effectiveness of single-sex versus mixed-sex groups) and to explore the potential for using the same approach with other sports.

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Chapter 22
It's a Goal: A Football-Based Mental Health Programme

Pete Sayers and Helen Spandler

Background

The It's a Goal (IAG) project sought to address the problems of male depression and suicide. Following some alarming figures which surfaced in 2003/2004 from the UK Government and the World Health Organisation (WHO), and which stated that 1 in 4 of all suicides involved men between the ages of 16 and 35, IAG determined to find out the reasons for this, and what (if any) facilities, mainstream or otherwise, were in place working with men of this age as a distinct group.

Aims of the Project

Initially, the aim of the project was to deliver a service that would encourage at-risk young men to confront and deal with their issues and act as an alternative to potentially suicidal behaviour. IAG targeted young men aged 16–35 and attempted to engage them in group-run sessions held in an arena in which they felt comfortable and relaxed enough to address their issues.

These sessions were held in football stadia, for reasons to be explained shortly, and a secondary aim soon became a desire to place the project in as many football grounds up and down the country as possible.

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How the Project Was Set Up

Laureus, a large European-based charitable organisation, runs projects all over the world that encourage social change through sporting activity. A number of these projects are in third-world countries and, at that time, there were no such projects in the United Kingdom. Laureus made an amount of money available to Malcolm MacClean, a social entrepreneur based in the north west of England, to set up a 3-year project and he quickly identified the need for something in the mental health field that addressed the problems of suicide and depression that many young men appeared to be facing with little or no specialist help. Given that football is the number one sport in the country, Macclesfield Town FC were invited to get involved which they were happy to do, and a seminar was organised at the club creating a focus group from interested local professionals. This was a fairly diverse group, consisting of a range of professions, which carried out an extensive feasibility study on whether football could be a factor in helping these young men.

From this group, it became clear that a football ground might be the perfect place for young men to go to do this kind of work. It has been well documented how men in general find it difficult to talk about their emotions at the best of times, and the project set out to create an arena that was both welcoming and relaxing, with a non-clinical (clinical settings being an instant turn off to most men) and non-stigmatising feel (men are often terrified about who may see them at the doctor's) in a place where men routinely let their emotions out. Whilst it was realised that of course not all young men like football, the curiosity element was relied on to draw in people who may not have accessed mainstream services as well as those who wanted to come to their local football club.

The work of the focus group moved forward and it became clear that the project was going to need a full-time manager. The requirements for the post included having a professional qualification in either psychiatric nursing or social work, being self-motivated, having the ability to work on one's own, having good local knowledge of both health politics and the demographics of the area, possessing good local contacts within the health and social service fields and having an interest in football. The first author (PS) was appointed to the post, on an initial 18 months secondment basis.

The football club had agreed to allow the project use of part of their stadium for office purposes and project delivery. It was therefore decided to develop a number of sessions that were therapeutically based but used football as a metaphor or an analogy. It was recognised that, every weekend, the stadium would experience extremes of emotion ranging from joy to despair, anger to ecstasy, frustration through to satisfaction, yet none of these were exclusively football emotions. They were human emotions that everyone would have felt at some point in their lives, and it was planned to use this experience to help clients identify with their own feelings and situations.

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It was also recognised that, quite often, men are intimidated by the use of 'clinical language' and a decision was therefore made, as project manager, to avoid the use of health professional jargon as far as possible, and, to adopt the title of 'coach', wearing a Macclesfield Town polo shirt, tracksuit pants and trainers for session delivery. For most of the time the club allowed use of their corporate room, an excellent facility that stretched along the whole of the new stand, and this soon became known as the 'home ground'. It was decided that sessions would be known as 'matches' and that initially there would be six of these (soon extended to 11 as a result of feedback) in what would be known as the 'season'. The clients themselves were to be termed 'players' and the groups they made up would be 'teams'.

The 'matches' used content similar to that used with patients suffering from mild to moderate mental health problems. This ranged from topics such as assertiveness, problem solving, stress-busting and anxiety and anger management to looking at the facts about depression and suicide whilst learning techniques and skills to deal with the symptoms (such as relaxation and posture). Emphasis was placed on the use of football analogies, particularly those relating to Macclesfield Town, as it was felt that 'players' would identify better with issues that were happening locally.

A major problem in the early days was getting the message out, particularly to people who might well be isolated, but also to potential referrers. With that in mind, Malcolm MacClean organised a project launch at the club and Laureus sent along three of its more high-profile ambassadors to help bring the crowds in: Sir Ian Botham, Sir Bobby Charlton and Dame Tanni Grey-Thompson. This resulted in an excellent turnout as well as good media coverage, ensuring that people knew what the project was about and the type of referral that was being looked for.

Despite the high-profile launch, however, reaching and engaging directly with the target group of men proved difficult at the beginning, particularly in the case of those men who lived in their bedrooms, had little social contact or contact with services and were clearly prime candidates for harming themselves. Posters and leaflets were designed, using a striking image of an ordinary man in everyday clothes celebrating like modern footballers are often seen doing, by running with his jersey over his head, and these began to appear all over town, including fast-food shops, laundries, bus and train waiting rooms and pub toilets. In addition, talks were given at doctors' surgeries, social service departments, community psychiatric nurse meetings, probation services and the like, promoting IAG. It was this promotion of the project to local professionals that resulted in initial referrals.

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Delivery of the Project

The concept of engaging men in therapy via football metaphor was tested out before the first 'team' of referrals was recruited. A 'trial team' of six young volunteers from a local youth employment agency was set up, initially taking part in a 2 h 'match' with a 15 min half-time break at the ground.

These members of the 'trial team' all bought into the concept and were very keen on using the football language throughout. It was decided to use round tables and name badges on which the 'team' members were asked to write their first names only plus the name of the team they supported. This, not unnaturally, led to a lot of initial banter and helped to create a relaxed atmosphere. The idea of using a contract system as would any footballer signing up to a new team was also tried out. The 'contracts' themselves were quite basic and contained items on confidentiality, respect for others, the place and themselves, not attending under the influence of drink or drugs, punctuality, being active in the matches (not sitting in corners saying nothing) and permission for the 'coach' to pass on a written report to their referrer that they could look at if they wished. The concept of using metaphor seemed to work really well and encouraged the quieter 'team' members to come out of their shell. Five of the six volunteers finished the 'season' and gave good constructive feedback about what they felt worked and what was a little weak or needed polishing up a little. The results of the feedback were used to refine the sessions for the first 'team' of actual referrals, which commenced 1 week later.

To make up the first 'team' of referrals, 12 men were interviewed before the first 'match' and assured that they were all joining a new set up as most were worried that the 'team' was already established and they would be the odd one out. All said that they would participate, but, in fact, only six attended, although experience proved that six was actually the maximum size of 'team' that could be coped with successfully.

All of the 'matches' were based around a goal-setting theme which fitted perfectly into the football metaphor. An IAG 'season' was likened to that of a real football team which may start the season looking to win the league as the long-term goal, but to win as many matches along the way (short-term goals) to achieve that result. Of course, not every team can win the league. Some may fall just short, others may know they have no realistic chance and will set their long-term goal to fit with that. The intention was that 'players' should have an idea of where they want to go and would leave the programme having achieved that aim or, if not, at least knowing how to, and be in the process of actively moving towards it. The mantra was 'to be the best you can be' as the aim was for all of the 'players' at the end of their respective 'seasons' to say they felt they had given it everything they had got.

On deciding, subsequently, to lengthen the 'season', the 'matches' were split into a football formation of 4-4-2. The first 'match' was entitled 'the goalkeeper' with four 'defensive' 'matches' in front of him, then four 'midfield' and finally two

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'strikers'. The 'goalkeeper' 'match' was very much a getting-to-know-you exercise with the main objective of getting the 'players' back for the second 'match'. Everyone signed the 'contract' to join the 'team' and everyone made a verbal contribution. As a warm up, the 'players' were paired up and asked to talk a little about themselves to their partner. After 5 min they reversed roles, and finally handed back to the rest of the 'team' what they had found out about each other. This was completely non-threatening as they were talking about each other not themselves and, without realising it, were confronting one of their shared fears, that of talking in front of everyone. After being given a brief introduction to the philosophy of the 'team' and the 'season', 'players' were encouraged to come up with some short- and long-term goals that they intended to work on through the 'season' (To prepare them for this, goal setting had been discussed in their individual interviews and they had been asked to have some potential goals ready for the first 'match').

It was found that long-term goals varied somewhat between 'teams', but in the main were centred on such things as wanting to get a job, wanting more esteem and confidence, wanting to reduce dependence on alcohol or drugs or wanting to feel less stressed or anxious. Some had very defined goals like wanting to regain contact with children and one 'player' used the goal system to come off prescription drugs. The idea was for the 'players' to make short-term goals that they could achieve in the week until the next 'match', on their road to making their long-term goal(s). It was stressed that it was important that their goals were reachable as some 'players', in their excitement, often made goals for themselves that were totally unrealistic. In this respect, the response of the 'coach' was key. 'Players' were encouraged to set goals for themselves that they valued, not ones they thought would look or sound good to the 'coach'. In addition, the 'coach' was completely non-judgemental about the goals themselves, or if 'players' had failed to achieve them that week. It was made clear that the important thing was for them to understand why they had not achieved and work on that in the future. The 'players' were also asked to score their problems on a scale of 1–10 so that as the weeks passed, and they achieved more of their short-term goals, they could see, by scoring every week, how much progress they were making, rather like their own personal league table.

The four 'defensive matches' included topics like the concept of change, teamwork, feelings, roles and self-esteem. These also included a backtrack 'match' in which it was made sure that all the 'players' had understood everything that had been talked about previously and were given a chance to ask questions if anything had bothered them or if they had not quite taken something on board.

The 'midfield matches' concentrated a little more on communication and looked at the physical self and how that is or can be portrayed, posture, assertiveness and language, including again a recap 'match'.

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The two 'striker matches' focused on taking opportunities that are presented and worked on topics such as repetition of helpful behaviour patterns, practice, objectivity and luck. These included the final 'match' which was an opportunity to review the 'season' as a whole. As often as possible, it was arranged for someone from the football club to present the 'players' with a certificate of attendance and a few well-chosen words. This generally turned out to be the chairman or the CEO, but occasionally players from the club would attend and this was always exciting for the IAG 'players'.

As some 'players' felt that they needed more support and help, a drop-in group was set up at the stadium (entitled the 'Supporters Club'), and this ran successfully alongside the regular 'seasons' that were ongoing. The rules were slightly different for this group in that there was little or no structure, 'players' could talk about anything, but often took the opportunity however to re-evaluate their goals or to ask for clarification of something they had not understood or had forgotten from the 'season'.

A wish to recruit volunteers to support the delivery of IAG from among the 'players' resulted in one 'player', Jerry, offering his services as someone who could welcome new 'players', make cups of tea and coffee and empathise with the 'team' as someone who had 'already been there'. Jerry subsequently intimated that he would like to get more involved, so in the next 18 months he trained in order to run IAG 'matches' himself which he eventually did successfully at a number of other clubs.

Laureus funded the project for a total of almost 6 years, but the intention was that IAG should become self-supporting. Malcolm MacClean and PS therefore created the It's a Goal! Foundation, a non-profit-making social enterprise that would attempt to sell the programme along with supervision, support and expertise to other mental health trusts around the country. Sir Bobby Charlton, a Laureus ambassador, showed a particular interest in the project, and was instrumental in helping set it up at Manchester United's Old Trafford stadium. The same rules applied despite having moved from probably the smallest league club in the country to arguably one of the largest football clubs in the world. Referrals were obtained from around Manchester and Salford, and the project ran successfully there for several years. Other projects followed at Stoke City, Plymouth Argyle, Burnley, Chester City, Stockport County, Preston North End, Oldham, Blackpool and Rochdale. The project even ran at a number of rugby grounds in the Scottish Borders for a spell.

Interestingly, the focus of referral also began to change as IAG was extended to other clubs and, instead of interviewing men who had been sent by their referrers on grounds of depression, other conditions were raised. Men who suffered from anxiety, stress, anger problems and relationship difficulties began to come into the mix. A small number of women 'players' were also accepted as referrals.

Outcomes and Evaluation

Two external independent evaluations have been carried out which have helped to validate the ideas underpinning IAG. An early evaluation of the project was undertaken by the University of Nottingham. By collecting feedback and personal

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stories from men who had used the programme, this study identified a range of self-reported benefits and outcomes, including increased understanding and awareness of mental health and threats to maintaining good mental health [1–3]. This clearly demonstrated the positive value of the programme to those who participated.

A second and more extensive evaluation was carried out by a team at the University of Central Lancashire. This involved evaluation of the project as it was delivered by a third-sector organisation in 7 Football clubs (in association with 7 Primary Care Trusts) in the North West of England [4, 5]. It was concluded that those who completed the *It's a Goal*! programme experienced significant mental health benefits, especially in relation to confidence, self-esteem and communication skills (i.e. talking about problems rather than 'bottling it up', and asking for help from others). Using a 'before and after' validated measure of psychological well-being, it was shown that 'players' started the programme with below average well-being scores and, upon completing the programme, their well-being scores had risen to close to the population average [4, 5]. It was suggested that these benefits were likely to increase resilience, prevent deterioration of mental health problems (including the likelihood of self-harm and suicide), and decrease problems associated with violence/aggression, and/or drug and alcohol use.

In addition, although *It's a Goal*! was initially set up for young men, this evaluation also suggested that a broader age range could successfully participate and benefit [4, 5]. Given the concern about male suicide rates *across the life span* [6], it is significant that this evaluation suggested projects like IAG could be an important intervention for men across the age range. Like the previous evaluation, this study also suggested that the small numbers of women who completed the programme had similar benefits to the men, although numbers were too low to generalise from this. This evaluation also confirmed that 'players' really valued the non-clinical setting and informal atmosphere of the programme.

Research published in 2014 illustrated in some detail how football metaphor was a particularly useful tool to engage men in therapeutic support [7]. This showed how the use of football metaphor and analogies in the project helped to support men's therapeutic change by: aiding initial engagement; facilitating mutual support; enabling self-understanding; and helping to motivate changes.

Future Work

Despite these positive evaluations, future and continued funding of the programme remains uncertain. IAG is now owned by Unlimited Potential, a Salford-based Social Enterprise.

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Lessons Learnt

The main lesson learnt from the IAG project is that it has shown quite clearly that men can and do talk about their issues and difficulties particularly at an emotional level given the right situation and encouragement. From the feedback received, it seemed clear that a large number of men who passed through IAG had felt rather 'feminised' when visiting health service premises and many said they were unwilling to talk to female counsellors or doctors about their problems, who they felt would not understand.

Also, a number said there was an issue for them about being stigmatised, something that did not happen when they visited the football club. Similarly they spoke about language and how often health professionals would confuse them by using jargon and words they did not understand. It seemed they appreciated working in a relaxed atmosphere among other men, being understood and understanding others.

PS' goal of wanting to be just known as 'Pete from the football club' also appears to have been achieved. Of all the 'players' who passed through IAG only one or two made any mention of PS' status, qualifications, background etc. Virtually all found this irrelevant and just wanted to be there for themselves in order to best solve their own problems.

The advice for anyone setting up a similar project would be to have confidence in the approach, but also to be patient, as things can take a while to get established. It is important also to recognise that, although a football—or other—club may welcome the project, this will not be their highest priority. It will be necessary to be flexible and responsive to the requirements of the club, avoiding interference with their main objective, that of getting a winning team out on the park at the weekend. Good relationships with everyone who works at the club help greatly and experience suggests that the less that is asked for, the more that tends to be provided, for example meeting players, tours of the ground, match tickets etc.

There would seem to be no reason why this project could not work in other countries, even where football is not the number one sport. Why, for instance, could this not work with cricket, rugby, American football, Aussie rules, basketball or ice hockey? All of these sports have their own stories and legends, and are central in a lot of people's lives. The sport involved would need to be a team event, but how many countries' national sport is an individual affair? In addition, it is also felt that the project could certainly be tailored to fit different audiences with differing problems. What makes it work is the magic of sport and how that touches people and encourages them to use it to address their own particular difficulties.

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Chapter 23
Promoting Healthy Physical Activity and Nutrition in a Low Socioeconomic Status Community: A University-Australian Rules Football Collaborative Model

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Background

Each of the authors of this chapter has been, or is currently, lecturing in the area of sport and society to undergraduate Sport Science or Health and Physical Education students. At some point, usually early on the course, we have asked these students to reflect on the meaning of sport in contemporary society. The responses have been many and varied. The majority of undergraduate students recognise sport as a vehicle for engagement in physical activity and competition. Some see it from a functionalist perspective [1], in which sport provides positive opportunities for people to enjoy themselves whilst engaging in activities that will enhance skill development, fitness and health. Further, these students perceive sports as providing the opportunity to develop positive attitudes and behaviours around morals, ethics and team orientation. While these are certainly potential outcomes from sporting involvement, it is clear that sport has the capacity to be far more than a vehicle for physical activity and competition. Indeed, much of what is often perceived as being a positive aspect of sport is somewhat individualistic. We claim, and have evidence to indicate, that sport offers a significant opportunity to develop community engagement, particularly in marginalised, low socioeconomic status (SES) communities. We also contend that it is this community orientation that provides the potential for long-term positive behaviour change around health.

In this chapter we will outline a 9-week project that was conducted in a very low SES community in the southern metropolitan region of Adelaide, South Australia. The project was known as the Flinders-Panthers Be Your Best project. The name came about as a result of a union between Flinders University, which is a premier Australian University in the Southern suburbs of Adelaide, and the South Adelaide Football Club, colloquially known as 'The Panthers'.

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Aims of the Project

The aim of the Flinders-Panthers Be Your Best project was to develop and evaluate an in-school health promotion programme for primary school children—based on evidence and established good practice, and capitalising on the potential of the football club as a vehicle for community engagement—for the purpose of achieving positive dietary and physical activity behaviour change.

How the Project Was Set Up

The South Adelaide Football Club is an Australian rules football club located in the heart of a low SES community. The football club plays a significant role in the identity of the community and *The Panthers*, and its players, are viewed positively. The club had previously run a healthy lifestyle programme for children in local primary schools (Panthers Be Your Best), but this involved relatively limited engagement with the schools concerned (often, just once or twice a year). Upon discussion between Flinders University and the South Adelaide Football Club management, it was decided that a 9-week project based on healthy physical activity and nutrition would be implemented in two local primary schools, given the significant evidence to indicate that children in low SES communities are more likely to go on to practice unhealthy behaviours in adulthood compared to children growing up in more affluent communities. Growing up in a disadvantaged household may also limit one's health literacy throughout the lifespan [2], and, additionally, compromise health in adult life through overweight, particularly with respect to lifestyle diseases such as cardiovascular disease and diabetes [3]. Enhancing physical activity and dietary behaviours in childhood is important, given the epidemiological evidence over the past few decades indicating that a lack of physical activity and poor nutrition is a significant modifiable risk factor in reducing mortality and morbidity associated with many chronic, non-communicable and potentially preventable diseases in subsequent adult life [4–6]. This represents a significant personal and financial cost to the Australian community [5, 7].

It should be noted that there are particular health concerns for the population residing in the location in which this programme is situated: the City of Onkaparinga. According to data obtained from the South Australian Department of Health 2009–2010, residents of the City of Onkaparinga face such chronic conditions as diabetes (8.1 %), cardiovascular disease (7.4 %), arthritis (20.1 %) and mental health conditions (15.5 %). Additionally, this demographic faces a number of risk factors which can impact their health, including BMI overweight (36.6 %), BMI obese (22.4 %), smoking (21.2 %), insufficient exercise (48.4 %), insufficient vegetable intake (87.1 %), and insufficient fruit intake (56.5 %). It should also be noted that the specific area within the Onkaparinga region that this project was located in has double the amount of unemployment (10.7 %), compared with the South Australian state

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average (5.1 %). We also know that unemployment and education are closely aligned, therefore it is possible to argue that health literacy, which is heavily dependent upon education, will likely be affected in a negative way. Hence, it is clear from these statistics that such a locality would potentially benefit from positive intervention around physical activity and nutrition.

The project was funded by a Commonwealth sourced Knowledge Exchange Grant. This funding scheme emphasises the need for strong community collaboration to create ongoing and sustained benefits for both the University and the community partners.

Delivery of the Project

The original 'Panthers Be Your Best' programme was based on a system whereby several *Panthers* footballers would visit schools in the local area and generally discuss the importance of healthy physical activity and diet. As stated above, this was, however, frequently restricted to just one or possibly two visits throughout the year. While these visits were popular with children, given they would meet local *Panthers* 'heroes', there was little ongoing sustainability associated with the messages being presented. Therefore it could be argued that much of what the *Panthers* had been doing in the previous iteration of this project was based around goodwill more than community engagement and health promotion. The basis of the current project was to engage with schools on a weekly basis for an entire 9-week term and access every child for at least 40–50 min each week, alternating between physical activity 1 week and nutrition the next. There was a project officer from Flinders University onsite throughout, together with a range of third and fourth year undergraduate Physical Education students to assist each session. Additionally there were a number of senior *Panthers* footballers in attendance to provide football skills development and engage with the students on issues associated with fitness and training. The programme was systematic and fundamentally underpinned by sound evidence and good pedagogical practice due to the affiliation with Flinders University and its expertise in health and physical education.

Each session with the children was designed to be a new and rewarding health-based experience with a view to developing skills and knowledge to be used beyond the school environment. The children were exposed to new ball-based activities and inclusive movement-centred games. They were also exposed to new types of fruits and vegetables as well as alternative methods of food presentation for the more traditional and accessible foods. It was important that physical activity and nutrition classes were separated into alternating weeks in order to emphasise the significance of each as being singularly important to health. However, at all times, discussion with the children revolved around the way in which both physical activity and nutrition were clearly linked in terms of health outcomes and performance associated with sports and physical activity. The basis of each session was centred on fun and experiential learning.

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Early in the implementation stage of the project, the team made contact with Foodbank SA, which is a not for profit organisation that has its core business centred on reducing hunger through the delivery of free and cost effective food to individuals and communities that are in need. This organisation was able to provide the programme with very low cost or free fruits and vegetables, which assisted the budget significantly. It also offered the children at the two schools the opportunity to access new foods that they had not previously consumed. It was clear that the children were excited and enthusiastic about eating a range of new fruits and vegetables, as well as yoghurts, each week.

The project team spent one entire school day a week at each school and were therefore able to access every child in the school on each occasion. This was above and beyond the children's existing sport, health and physical education lessons already scheduled. In the final week of the programme, a physical activity and food expo was conducted, which received favourable comments from the students. Foodbank SA provided most of the food for the event, with many *Panthers* footballers and Flinders University Health and Physical Education students in attendance. A number of free items were provided to the children from South Adelaide Football Club and Flinders University (for example footballs, pens and rulers), as a way in which the programme team could thank the children for being involved, and as a reminder of the programme when the team had gone.

Outcomes and Evaluation

Like all good health promotion initiatives, it was imperative that the programme was appropriately evaluated to ascertain its merits and understand process, impact and potential outcomes. While it was difficult to evaluate for long-term outcomes, it was possible to focus on the processes that took place and the impact that the project had on the children, the teachers and the school. The two specific evaluation objectives were to:

1. Ascertain whether the processes that were implemented were appropriate.
2. Understand what type of impact the programme had on the participants.

Therefore, immediately upon completion of the project, the team undertook a number of focus group interviews with children across all year levels as well as individual interviews with teachers and the two Principals of the schools. Focus groups are ideal in attaining high-quality descriptive information in a systematic manner [8]. All of the interviews were audiotaped and transcribed verbatim. They were then thematically analysed to identify dominant themes [9]. The Flinders University Ethics Committee approved the evaluation. Each of the child participants involved in the interviews provided signed consent by their parents. The teachers and Principals provided their own signed consent. All participants were free to leave the interviews at any point without prejudice in which case their data would not be used.

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The data obtained from the children were, understandably, different in some respects from the responses of the teachers and the Principals, particularly as the latter were able to compare the project with the previous, more limited, interventions delivered to the schools over the years. However, it should be stressed that the children's opinions were given no less weight than those of the adults [10–12]. Indeed the voices of the children provided a crucial perspective through which we could understand the nuances of the programme and the way in which was implemented.

The major themes to emerge from the immediate post-project interviews were:

1. The importance of health-based programmes in low SES communities.
2. The significance of role models.
3. University students as models of aspiration.

The Importance of Health-Based Programmes in Low SES Communities

Low SES communities have been the focus of a number of well-meaning health-based initiatives by governments and philanthropic groups specifically designed to reduce obesity among this demographic. However, many of these initiatives are based around short-term solutions and do not address the notion of sustainability. Importantly, there is evidence to indicate that programmes and initiatives that are based on sustained input, particularly in relation to frequent and consistent engagement with the participants, have a greater likelihood of a successful outcome. This was certainly the case with the Flinders-Panthers Be Your Best Project, which was conducted over a 9-week period with every child across two schools. It was this continued involvement which, in turn, made the team members of the project, including the university students and the *Panthers* footballers, feel as if they were part of the school and therefore the 'buy in' from the school community was heightened. As one Principal identified:

> It's been a very positive involvement from everyone's perspective. Teachers have loved it, kids have loved it, and we've even had comments from parents. So that enthusiasm is there from the kids and it rubs off. Teachers have been really happy because of the program and the way it's delivered and the number of students that have been supportive. The kids have enjoyed that more youthful involvement and of course it's reinforcing the messages that the kids have been getting. So that's a quick nutshell of how I've seen it from afar.

Another factor identified by the teachers and Principals was the fact that this programme did not espouse anything radical or provide information contrary to what had been previously taught through the school curriculum. The role of the programme was to reinforce health messages and provide a new way of articulating them to the children through the university students and the footballers. Another Principal stated:

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> Look, I think it's definitely promoted healthy eating and healthy lifestyles for most kids. It's worked out quite well because last year we started the 'Crunch and Sip Program' as well, where the kids bring healthy food to school and eat that at the same time. Each class eats their fruit at the same time every day, and drink their water. So I think this just kind of consolidates the message that we're all trying to get across for healthy living and healthy lifestyles. And I think the program has been really good because it's been an ongoing program in a sense that it's not just something that's been done once and then just left and forgotten about. It's something that's happened every week. It's been predictable which is important for these kids. They know on a Wednesday that you guys have been coming, which is something they've been looking forward to. And it's just been promoting, yeah, getting that message across as well as the 'Crunch and Sip' and whatever the teachers talk about in the class and the health lessons they do, like the garden with the fruit and veg we've got now. Just all those things together, I think, help get the message across. And hopefully it has left a bit of a lasting legacy and message with the kids.

Similarly, one of the teachers reiterated the perspective of the Principal when he claimed:

> I think things like the program are great for our guys because it means that you're reinforcing what we're saying in health about healthy eating and about the 'Crunch and Sip'. It's like the stuff that we've said is real. So we've tried to have a healthy eating focus for the last few years and when people come in and combine that with a sporting activity, because a lot of our kids as you know are not really involved with sport outside of school, then it just kind of reinforces what we keep saying. So with somebody else saying it and other young people saying it—because they'd see the guys from the uni as young people, rather than us oldies—they kind of get the idea that it's not just a parent or an older teacher thing. Young kids are saying it's good to think about what you're eating, and it's good to go out and do activities. So it just reinforces on different levels the stuff that we're trying to teach them.

The Significance of Role Models

The interview data indicated that the manner in which the project was delivered played a key role in its ultimate success. It was clear when interviewing the children that they perceived the *Panthers* footballers as being a significant factor in the entire process and as a consequence many viewed these footballers as role models. The teachers also recognised this factor and identified the significance of the footballers within the successful context of the project. As one teacher stated:

> I thought it was very successful. I thought it engaged the students really, really well. I thought it was good to have someone coming in from outside who had expertise in a particular area of sport. I think most primary school teachers may have played their own particular sport during their own younger days. And I did. I used to do athletics and baseball. I was never a football player so it was really good to have someone who actually had that depth of skill base to come in to show my kids how to do stuff that I actually would not be able to show them, because I wasn't aware of some of the processes that they use. You know, for holding the ball and kicking and all those sort of things. So I thought that was really good. I thought it was really positive having the younger players from the Panthers to

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> come out because I felt that really engaged the kids and made the kids feel that it was something that was more significant and more worthwhile. I mean the kids took it a little bit more seriously. It wasn't just a whole bunch of academics, older people coming out telling the kids what they were going to do. It was actually some people who they could relate to I think, on more of an equal sort of level because they weren't much older than the kids. And they also didn't have the attitude that a lot of teachers, that we need to have, where a lot of it is about teaching and disciplining the children.

The importance of the *Panthers* footballers attending on a committed, regular basis was seen by all as a crucial element of the success of this project. Indeed, as one of the teachers pointed out, this aspect of the project had a positive impact on truancy rates among boys, which had been particularly high in these schools. As a result of the *Panthers* players being present at the school each week, some of these boys were themselves motivated to come to school on a regular basis.

> There's been one kid in particular, a year five boy. And obviously I won't mention his name, but he's been a severe behaviour problem for a number of years. And he was on a restricted time at school. He usually went home around 12.30 in the afternoon, so after that time he was missing out. Once he heard the buzz around it (the project), he likes footy and he plays football for a local footy team in the juniors. And he actually asked if he could do it and it was a real incentive for him to stay at school, just to be a part of that program. So that's one example that springs to mind. I mean it was that incentive he needed. It gave him that extra reason to stay at school. Yeah, I suppose something that's relevant and important to him. He loves his footy.

University Students as Models of Aspiration

In addition to the involvement of the *Panthers* footballers being shown to be crucial to the success of the project, the interviews also demonstrated the significance of the contribution of the university students who inadvertently provided important aspirational value for the children. This was particularly evident amongst the older children in years 6 and 7 as some of them began to reflect on life after school. Having the third and fourth year Flinders University Undergraduate Health and Physical Education students teach a good deal of the intellectual content allowed the school students to engage with them on a regular basis. It also provided the opportunity for these school students to ask about a life as a university student and inquire in a non-threatening manner with respect to post-school pathways. It should be noted that university had not been perceived as a real pathway for many of these school students given that most of the children (as usual in low SES communities) had not had family members, including parents, previously attend a tertiary institution. The significance of the university students as aspirational models was recognised by teachers, one of whom stated:

> …especially the year 7s. They see people around them that are just like them, although they're going to uni and they started off somewhere. And when they (the Flinders students)

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> gave their experiences and their stories it showed them that they were just like them. Some of them never even thought about "what would I be doing when I grow up", you know. And so they realised that "oh it's not difficult. I can move up". Some of them want to give up after year 7 over here; they didn't want to continue with year 8 some of them, but now ….

Several of the university students also grew up in the area, which meant that some of the school students were able to specifically identify with them and develop an affinity with them based on similar upbringing. Another teacher claimed:

> It was good when some of the uni students said that they came from an area like this. Because it's kind of like sometimes these kids don't see that they actually have a positive future, whether it's family circumstances or they're just not feeling good about themselves. For these Flinders students to actually share those positive stories about this and what they've done, and this is what they want to do or something like that, is really good for those kids as well.

12 Months Later

An unrelated qualitative research project on nutrition literacy, in which the two project schools were part of the cohort studied, enabled us to reflect on the significance of the programme 12 months later, particularly in terms of what the children had learnt and the type of information they had retained, as well as how they had used it in their lives. This research also allowed us to ascertain whether behaviours that may have changed early in the period after completing the programme were still maintained 12 months on.

It was clear that the children had taken a good deal away from the programme and continued to use it in their lives. As some of the children claimed:

A1: 'When the Flinders University people were here, we learnt about lots of foods'.
A2: 'Yeah it was really fun when we got to do the football'.
A1: 'And we talk about it in PE sometimes'.

Nutrition was arguably the biggest component that impacted the children and continued to influence them, given that food is such an integral part of both individuals' and families' lives. It is somewhat different from physical activity, whereby engagement is often based around a conscious decision-making process. A group of boys began talking about certain nutrition principles and reflected positively on how the Flinders-Panthers Be Your Best programme had instilled these into them, as shown in the following dialogue:

Q: 'What do the numbers mean?'
A2: 'It's as much is in the food'.
Q: 'If it said 10g?'
A2: 'That would still be a fair bit of sugar but it wouldn't be it wouldn't be that unhealthy'.

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Q: 'How about 20?'
A1: 'A bit unhealthier'.
Q: 'And 5?'
A2: 'Five would be enough'.
Q: 'So what's high then?'
A2: 'About 30'.
Q: 'Where did you learn about those numbers?'
A2: 'Last year we learned with Sam when Flinders University came here'.
A3: 'And you're looking for the sodium too'.

A group of girls identified something similar:

A3: 'We got told by Flinders the 5 & 20 rule. So to look for something between 5 and 20 grams for the sugar and fat. Five is healthy and 20 is not as healthy'.
Q: 'So if something had 12 grams of sugar?'
A3: 'Well it would be closer to 20'.
A4: 'It's still healthy but not as healthy'.
A2: 'It's not healthy, but it's more healthy than some other things'.

The children also demonstrated health literacy competencies when it came to choosing foods. They argued that as a result of the programme they had greater capacity to make food selections based on sound evidence they learned from the University students in particular. One girl stated:

A1: 'When the university came it made me want to read labels because you could learn how much you could be eating that's really bad for you and things like that. I feel better. One example would be the different types of peanut butter; you could have the Kraft one or the normal one. So you would look for the sugar and the fat and the sodium'.
Q: 'And which one would you choose?'
A1: 'I'd pick the one with the less sugar and salt and the less fat'.

Similarly, another claimed:

> I look at the boxes, Flinders showed us that. You look for the fat total and how much sugar it has in it. I got WeetBix because it had less fat content in it.

These types of comments represent only a few statements made in relation to the Flinders-Panthers Be Your Best project. It was clear that it had a lasting impact on some of the children and had positively influenced many of their lives beyond the length of the program. Reading labels to select healthier foods comprised just one of the numerous health-related skills that these children were able to glean from the project and potentially maintain for life. There should also be recognition of the potential for children to bring such information back into the home environment and act as change agents within the family.

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Lessons Learnt

Sport offers immense opportunities to engage with the community in which it is located. This is particularly relevant where an identifiable sporting team has significant meaning to that community. The community in which the Flinders-Panthers Be Your Best project was located, like many other low SES communities in Adelaide, places significant emphasis on Australian football. Indeed, Australian football has its roots firmly located within working class origins, which has continued its strong association in contemporary times. This is despite the significant corporatisation of the elite Australian football competition established and run by the Australian Football League (AFL).

The state-level AFLs, which are viewed as pre-elite, also have professional players. However, they are paid far less and generally have to supplement their income through paid work. Noteworthy is that the clubs within these leagues tend to have close ties with their immediate local communities. As a consequence, the South Adelaide Panthers football team, which is closely aligned with its region, has a somewhat galvanising effect on the community. Therefore, utilising its players in child-based health promotion initiatives proved to be an important mechanism through which potential attitude and behaviour change around health could occur. The ongoing visibility of the players, and the team, was a constant reminder of the programme in which the players were involved and the positive messages they endorsed and promoted.

One of the issues that many sporting teams face when confronted with engaging in health promotion initiatives in schools is that many of these athletes are not entirely prepared to be conveyers of health promotion messages, given their lack of grounding in health education. Often these players become somewhat tokenistic in their roles as health educators. It is therefore arguable that to gain a sustainable grounding based on sound evidence and appropriate health education, sporting clubs and their athletes need to be closely aligned with current research and pedagogy around health promotion. The involvement of the Sport, Health and Physical Education (SHAPE) research centre at Flinders University and its third and fourth year undergraduate Health and Physical Educators working alongside the Panthers footballers provided an ideal mechanism through which health education could occur.

It is clear that there are many well-intentioned government and philanthropic organisations that set out to enhance and promote health among a range of individuals and communities including those which are marginalised and disadvantaged. Using sporting identities has been a strategy used by these organisations to enhance the popularity and potential uptake of the program. However, while these are seen as exciting and somewhat popular, what has often been lacking has been the long-term and sustainable aspect of the programme, which is likely to impact overall success. Many of these programmes

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tend to try and access as many individuals as possible at the expense of spending longer periods with the participants. Given that accessing high numbers of participants, rather than time spent with them, is often written as an aim of the programme, it is generally deemed a success.

The Flinders-Panthers Be Your Best project set out to access a smaller number of individuals in a demographic that is recognised as being very low SES and displaying significant health inequalities, particularly with respect to overweight and obesity. Therefore physical activity and nutrition were seen to be key elements within the context of enhancing health literacy. Additionally, it was argued that accessing children in this demographic would be crucial in developing long-term attitude and behaviour change, which in term would bode well for their future as well as generations to come.

Both the Flinders University and the South Adelaide Football Club are significant organisations in the region in which the programme was run. The South Adelaide Football Club plays a very important community role within the specific locality in which the schools were located. Therefore its role was seen as integral to the overall success of the program. The role of the University and its undergraduate Health and Physical Education staff was seen as crucial to the intellectual capacity of the project. It can be argued, based on the process and impact evaluation data collected upon the completion of the project, that the initiative was successful in developing positive attitudes and behaviours among children towards nutrition and physical activity. There is also evidence to indicate that there were positive unintended outcomes associated with education and lifelong learning. The importance of these effects cannot be understated, as they can ultimately enhance children's health literacy, which in turn is a valued asset in developing positive long-term health outcomes for all.

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Chapter 24
"Manning Up for Men's Health": Sports Radio and the INTEGRIS Men's Health University, Oklahoma, USA

Stephen D. Petty and Lyn Hester

Background

The US state of Oklahoma has a proud pioneer heritage which has served it well through at least two oil booms and busts, droughts, tornados and even a bombing in the heart of the capital city in 1995. Each time our citizens have regrouped, rebuilt and recovered. However, that same stubborn spirit has contributed to Oklahoma ranking at or near the bottom in almost every US health statistic. That "I am the master of my fate" attitude is one reason we smoke more, eat poorly (fried Twinkies are one of the mainstays at our annual State Fair), refuse to pass motorcycle helmet laws and the list goes on. Couple these issues with poverty (1 in 5 children is in poverty), poor access to health, high percentages of Oklahomans that are uninsured and low rates of physical activity and you have a state in crisis.

Historically, healthcare has had a "let them come to us" approach. Recognizing the limitations of this approach, not-for-profit corporation INTEGRIS Health formed a Community Health Improvement Department for the sole purpose of changing the health status of the people of Oklahoma. Many successful programs were launched but the health of our men continued to lag behind. We needed a creative program that would educate men on their unique health risks along with screenings and treatment. In 2004, the INTEGRIS Men's Health University (Men-U) was born, complete with logo and t-shirts.

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Aims of the Project

Our overall goal was to focus specifically on delivering health improvement for men in a non-threatening manner, partnering with traditionally male-friendly businesses and media and using humor to engage men with health issues. We adopted the approach of delivering health promotion events tied in with traditionally male-friendly activities such as car shows, grilling competitions and sports.

The specific aims of the project were:

- To create awareness of health issues in the male population by providing accessible services and information to men and their families.
- To offer health services and information to men through innovative practices and, when appropriate, away from traditional healthcare settings.
- To facilitate health-enhancing activities and improvement of health outcomes in the male population.
- To teach younger men and boys the importance of taking care of all aspects of their health.
- To communicate the importance of men's health and regular screenings to other members of the family.

How the Project Was Set Up

When it became apparent that men were not responding to traditional ways of delivering health information and screenings, a core group of men was brought together to think "out of the box" and brainstorm ideas for delivering male-friendly and male-focused health promotion. The INTEGRIS Men's Health University was created to put these ideas into practice, with an internal committee encompassing a wide range of departments, including our Heart Hospital, Cancer Center and Corporate Communications involved in delivering health events.

We recruited local nursing schools to help with the provision of health screenings and partnered with local colleges and malls to host health events.

Recognizing that the majority of men are interested in some type of sports, we contacted a local sports radio station, WWLS "The Sports Animal," to see if they would be interested in working with us to promote our events and help engage men with health issues. They had a large audience, a great sense of humor and were keen to join our endeavors.

Delivery of the Project

As part of our partnership with the radio station, we would purchase advertising on their station, while the DJs would talk about men's health on the air. The DJs would go above and beyond as our partners to get the word out about our events and how

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they were going to participate in the health screenings themselves. Listeners would call in and discuss health issues while the DJs would use humor to talk about topics such as prostate screening and checking themselves for testicular cancer. This approach captured the attention of listeners in a fun light-hearted manner, and raised awareness of the importance of regular checkups and where these could be accessed along with other health resources.

In partnership with the radio station, we developed our own loyalty card—the "ManCard"—in keeping with our goal to use humor to engage men. Card-holding men earn "ManPoints" by attending events sponsored by INTEGRIS Health and the radio station. Men receive 500 ManPoints for every event attended and can earn additional points by improving their health status at designated health screenings. ManPoints are redeemed for items such as sporting event tickets, tools and other traditionally "manly" prizes. The radio station has helped publicize and distribute the card and our website is updated frequently with events and prizes. The card has been a huge success, with over 5500 members to date.

Our first Men-U event was held at one of our larger hospitals with a vintage car show in the parking lot to attract attention. The event offered a range of screenings, including screening for prostate cancer, skin and oral cancer; glucose, cholesterol, and blood pressure testing; and a stroke assessment. At each of our health fairs, the sports radio station would be an active partner, broadcasting live at the event. The DJs would interview our physicians about the screenings, how easy it is to get checked and talk with listeners in person about sports teams, who won last night's game, etc. Having the chance to talk with local radio celebrities and get free give-aways from the sports station (T-shirts, sports tickets, etc.) was a big draw for the community. In addition, we would always host a free sports-themed tailgate party for lunch for all those who had attended a screening earlier in the day.

Although the focus of the events is men's health, men will often attend with their families, so we have never adopted a "men only" policy to the screening provision.

An important aspect of all screenings is that we follow-up with every participant who has an abnormal screening. We do this both in writing and by phone so that the screenings do more than merely give people current statistics but ensure that everyone has the opportunity to get a firm diagnosis and appropriate treatment regardless of ability to pay. Social workers, counselors and referral experts assist each person to access the healthcare services they need.

The worldwide celebration of "Movember" was another opportunity for us to use our sports radio partners, as well as our local hockey team, the Oklahoma City Barons, to promote men's health. Movember was started in Australia in 2003, encouraging men to grow a moustache during the month of November as a way to promote men's health and create awareness about the importance of men taking care of their health. Since that time, Movember has turned into a global health movement to raise awareness and funds for cancers that impact men. In Oklahoma, the Barons team and coaches promoted this event with special ticket discounts, promotions during the game, and a moustache contest at the end of November. This partnership has proven to be particularly effective, bringing us a variety of additional publicity from local television and print media—moustache contests were even televised.

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Other events have included "Pancakes & Prostates," a pancake breakfast and prostate screening held at our cancer center, which also utilized the sports radio station personalities and the OKC Barons at the event, free health lectures by physicians held throughout the year on a variety of health topics just for men, and our Men's Fit Club—"For Men Who Give A Fit." In keeping with our goal to have fun events away from healthcare settings we have also hosted Men's Healthy Grilling Lectures at local restaurants and a tailgate party of sorts to teach men how to make healthier meals. We realized a great way to get men's attention is through their stomachs and there is nothing more traditionally masculine than meat and a grill. Our goal was to show men how to make better food choices without sacrificing the taste—to still be "Masters of the Grill," just with less fat, sodium and cholesterol. Justin Sparkes M.D., a physician with the INTEGRIS Family Care Clinic in Edmond, and one of our Champions of Men's Health, spoke about the importance of men taking care of themselves and grilling with healthy foods as a great way to improve heart health and weight reduction. INTEGRIS Health Dieticians gave a healthy grilling demonstration using fish, chicken, moderate amounts of lean red meat and a lot of vegetables. This was not a boring meeting, but a "meating" equipped with good food, music, sports-talk and door prizes.

At the end of the year, we held a "Manquet" at a local restaurant and a Casino Night for all ManCard Holders in which they could redeem their ManPoints for tickets to use at casino games and for prizes. The member with the most ManPoints received a trip to Las Vegas. When the New Year started, we encouraged guys to join our "Resolution Revolution." Our goal was to help men renew their resolutions through weight-loss classes designed for men of all ages focusing on eating habits and increasing fitness levels. Promoted through our sports radio partners, men and their friends were challenged to join together. To further encourage male participation we waited until after the holidays and started our program the day after the Super Bowl.

Outcomes and Evaluation

Our partnership with "The Sports Animal" radio station and the generation of an enormous amount of other media coverage have led to consistently increasing levels of participation at the events. So far, we have screened more than 11,000 men and found just over 3000 abnormal results.

Evaluations are taken at the end of each event to determine how we can improve, get suggestions for increasing participation and give participants a chance to tell us what topics or screenings they are interested in for future events. Additionally, we survey men at other events throughout the year to determine areas of interest for future programs and activities.

As we began our focus on men's health, the Mayor of Oklahoma City began to raise awareness of the poor health status of our state and declared he was putting the city on a

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diet—challenging Oklahomans to lose a million pounds. This declaration garnered national attention along with a score of individuals, clubs and businesses (including INTEGRIS Health) joining in the challenge. In January of 2013 the city achieved its goal. In addition to the pounds lost, all of this attention to health has seen a real change in thinking. More people are walking, restaurants offer healthier choices and—as a result of an effort led by INTEGRIS Health—vending machines in schools offer healthy options.

All of these efforts, including increased education and awareness, have helped to move the ranking of our state's health status indicators from 49th in the United States to 43rd. Clearly we still have a long ways to go, but this is the first time in many years that Oklahoma has seen such a positive shift.

Future Work

Our plans for future development of the program include:

- Increasing the education of high school boys and college men about the importance of taking care of their health and avoiding risky behavior.
- Expanding our Men's Health Clinics through our current community clinic locations across the state.
- Establishing a Fatherhood Initiative that will focus on engaging fathers in all aspects of the pregnancy and birthing experience, parenting skills, healthy relationships and being a responsible father and role model.
- Working with our mental health department to coordinate more services and education directed towards anger and stress management, substance abuse, depression and suicide.

Also, we have been approached by other hospitals requesting our assistance in starting their own men's health programs.

Lessons Learnt

- Building partnerships and collaborations both within the hospital and with community agencies and businesses was vital to developing a robust and effective program. Partnership working is especially important for being able to deliver events outside of traditional health settings; for example, churches play an important role in Oklahoma, so we partnered with churches in high minority and low income areas of the city to deliver physician lectures and screenings.
- Sports themes and fitness challenges with an element of competition are effective ways to make health events fun and inviting. Partnering with other

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male interest groups to combine health events with other activities likely to appeal to a male audience, such as car/motor cycle shows, grilling competitions, tool and "do it yourself" shows, is also a good way to attract interest.

- If possible, have at least one physician who can act as a "champion of men's health." Having a medical professional available at community screenings who can knowledgably discuss men's health topics and present well in media interviews is an important asset.
- Listen to the public and try to give them the programs and services they ask for. Explain the reasons why when it's not possible to do.
- It is important to always have a community champion with whom your target community can relate. Our largest minorities are Hispanic and African Americans, so we identified champions in both communities to help us coordinate activities in their neighborhoods.
- Never underestimate the potential benefits of establishing a strong partnership with the media for raising awareness and generating interest. Working closely with the sports radio station and other local media gave us free advertising prior to our events and even some live coverage of the events themselves.

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Chapter 25
'Quit Smoking with Barça': An Initiative of the European Commission's 'Ex-Smokers Are Unstoppable' Campaign

Jordi Monés and Jan Teulingkx

Background

Tobacco is the single largest cause of avoidable death in the European Union (EU) accounting for almost 700,000 deaths each year [1]. A further 13 million people in the EU suffer from serious diseases caused by smoking [2], such as cardiovascular disease (CVD) and chronic obstructive pulmonary disease (COPD). One in four (26 %) of all deaths from cancer in the EU are caused by smoking, and smoking is responsible for 85 % of lung cancer deaths across the EU [3]. Even individuals who do not smoke can be affected by smoking and tobacco. It has been estimated that 79,000 non-smoking Europeans die each year as a result of exposure to second-hand smoke (passive smoking) [3].

Despite these figures, almost a third (28 %) of citizens across the EU currently smoke either cigarettes, cigars or a pipe, although one in every two smokers admits they would like to quit [1]. Socio-demographically, smokers are more likely to be male (32 %) than female (24 %), from lower social and economic groups and a younger demographic, with 28 million smokers falling within the 25–34-year-old age group [1].

Research shows that smokers who quit before the age of 35 have mortality rates similar to those who never smoked [1] and that 61 % of current smokers have tried to quit (58 % in the 25–39 age group) [2] but need support because they often struggle to stop completely.

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Aims of the Project

With these figures in mind, the European Commission (EC) sought to redress the overwhelming burden of tobacco consumption across member states, tasking Saatchi & Saatchi Brussels to develop a campaign to specifically target 25–34-year-olds, given both the increased incidence of smoking and the increased potential for reversal of damage caused by smoking in this age group.

Thus, 'Ex-Smokers are Unstoppable' ('Ex-Smokers') was created, a 3-year, pan-European campaign that had, at its heart, two integral elements:

1. The iCoach tool, a free, online health coach to support and guide smokers step-by-step through the quitting process.
2. Positive psychology embedded throughout all communications and educational materials, emphasising the multitude of benefits (financial, emotional and physical) of becoming an ex-smoker, rather than the negative health consequences of smoking—in short, the campaign asserted that becoming an ex-smoker was not about stopping something, but about starting something new.

The first year of the 'Ex-Smokers' campaign was a great success, driven in part by a range of partnerships with corporate, social and sporting bodies, particularly with an emphasis on the latter in marathons and other races. These partnerships amplified the messages and helped to surpass all targets and objectives set for engagement and uptake of the iCoach tool. However, it was clear that more could and must be done to engage this 'hard-to-reach' audience, particularly with an emphasis on young males, given the higher incidence of smoking amongst this demographic.

With the demonstrable benefits of delivering health messages through sports to effect behavioural change, and the particularly connecting, community and loyalty-building abilities of football, with millions-strong fanbases and motivational figures, this was quickly identified as the ideal platform for the 'Ex-Smokers' message.

The ambition was set to take the 'Ex-Smokers' initiative from a campaign to a true movement that was both interruptive and inspiring with the potential to drive change, supporting young people to take steps to manage their own health. The critical element was identifying the ideal partner.

Barça quickly emerged as a leading ally, with one of the largest fanbases and social media followings around the world via Facebook and Twitter (more than 58 million and approximately 22 million respectively), its appeal transcending country borders and attracting dedicated and avid followers everywhere. Of greater importance is the culture of the club. Barça pride themselves on being more than a club (their motto: més que un club), and they demonstrate this by encouraging and supporting their fans to be as passionate about their health as they are about their heroes on the pitch through many social- and health-focused initiatives.

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In January 2012, the Barça Board of Directors voted to implement a smoke-free stadium policy on their home ground, Camp Nou, under the banner, 'Camp Nou Sense Fum' (A smoke-free Camp Nou). Afterwards, the Assembly of Representatives of the club voted in favour and approved this initiative. In taking this pioneering step Barça became the first football club in all of Spain to address the issue of smoking directly with fans. The 'Sense Fum' initiative was a tangible demonstration of Barça's ongoing commitment and dedication to their fans and is now a fully integrated element of the club's ideology.

The aim in establishing a unique partnership between Barça and the EC was to harness the EC's heritage in health awareness programmes and the power of their award-winning 'Ex-Smokers are Unstoppable' campaign, and channel this to Barça's millions of fans. With 'Quit Smoking With Barça', there would be a platform to reach those who wish to quit smoking but lack motivation or guidance, and to help them gain that support from their football team. The decision of the club to make the Camp Nou stadium smoke-free was a pledge to help their fans live healthier lives, and 'Quit Smoking With Barça' aimed to convert the 90 min of smoke-free time when fans watch the game to the beginning of a smoke-free lifetime.

The creation of a partnership between one of the world's largest institutions, the EC, and one of the most globally supported and recognised football clubs, Barça, sought to drive the health message of smoking cessation right across Europe, inspiring other clubs, institutions and individuals to join the quit-smoking-for-life movement.

How the Project Was Set Up

The well-publicised 'Barça Sense Fum' initiative attracted the attention of the EC, who identified the club as the partner of choice for the 'Ex-Smokers' messages. The EC's position as a leader in health initiatives and Barça's commitment to the health of their fans united the partners in a shared goal of bettering the health of people across Europe and reducing the burden of tobacco-related disease and death.

Following a brief meeting between campaign organisers, Saatchi & Saatchi, Tonic Life Communications and Barça's Jordi Monés, a shared vision emerged to disseminate both health information and practical guidance in a motivational and non-judgemental manner. With a mutual aim of reaching the men and women of Europe and effecting a measurable change in the health of the region, a partnership was established and planning for the new campaign was soon underway.

The campaign 'Quit Smoking With Barça' aimed to reach out to Barça's own fanbase and fans of football more broadly with the message 'The whole club supports you'. It was integral both to the EC and Barça, however, to ensure this message was backed up at every stage with actual support, guidance and tips for smokers. Representatives of Barça would commit to helping fans to kick the habit from all levels of the club: from the groundskeeper to the marketing manager, players, coach and club president. With 'Quit Smoking with Barça', truly, the whole club was going to support you to quit.

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To achieve this ambition, the standard iCoach tool, a central component of the 'Ex-Smokers' campaign, needed to be adapted to integrate tailored messages, support, videos, tips and quotes from the staff and players of Barça.

In order to ensure the campaign was visible right across each country of the EU, it was necessary to support Barça's communications through a combination of audio-visual elements (videos, player testimonials, images), paid advertising waves (through pan-European print and online media), and international PR efforts (local agencies in each country of the EU pitching the story to national media with tailored news angles).

As a project of the wider 'Ex-Smokers' campaign, the partnership fell within the budgetary scope of the EC's 3-year anti-tobacco initiative and was further supplemented by Barça's marketing department. The 'Quit Smoking with Barça' campaign is not a commercial partnership and has at no point involved a financial exchange: it is a commitment on behalf of both parties to join forces and maximise the impact of their respective existing campaigns.

Delivery of the Project

The 'Quit Smoking With Barça' campaign was coordinated and communicated by marketing and communications representatives of Barça and the consortium responsible for the 'Ex-Smokers are Unstoppable' campaign: Saatchi & Saatchi Brussels, led by Karen Smessaert, Tonic Life Communications, led by Orla Barnewell, Zenith Optimedia, BrandNewHealth and ESN.

The campaign integrated the same two central elements of the original 'Ex-Smokers' initiative:

1. The new iCoach tool (adapted from the standard iCoach), that became known as the FCB iCoach.
2. Positive psychology embedded throughout all aspects of communications, emphasising the benefits of becoming an ex-smoker over the negative health consequences of smoking.

The FCB iCoach

The FCB iCoach, developed by BrandNewHealth, is a digital health coach (adapted from the standard iCoach www.exsmokers.eu, a component of the 'Ex-Smokers' campaign) aimed at smoking cessation and is available as an online tool and as a mobile app (Android, iOS). The FCB iCoach is strongly evidence-based and draws heavily on insights from the Transtheoretical Model of Behaviour Change [4], the Theory of Planned Behaviour [5] and the Self-Determination Theory [6]. It

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incorporates techniques from cognitive behaviour therapy [7] and motivational interviewing [8] and draws heavily on tailoring [9, 10].

On a step-by-step basis, the FCB iCoach increases ex-smokers' knowledge, motivation, and self-efficacy and, over time, changes users' behaviour for the better. The tool is low-threshold, not lecturing, and above all interesting, using interactive elements such as diaries, regular feedback reports, graphic overviews, trigger mails, etc. The FCB iCoach specifies problems, helps users gain insight into their individual behaviour and breaks down barriers. Consequently, modified health behaviour slowly builds up in accordance with a phased plan towards durable behaviour change.

Most importantly, the FCB iCoach uses a positive approach, emphasising the gains associated with smoking cessation. The digital health coaching process has four major aims:

1. To *motivate* people to reconsider their tobacco use by challenging common misconceptions and wrongful beliefs about tobacco.
2. To change users' *locus of control and self-efficacy* by emphasising that smoking is a behaviour they are in control of and—hence—something they *can* change.
3. To deliver a '*call to change*' encouraging users to grasp the strategies they are handed in the FCB iCoach and to take action to start to change their behaviour, and in the long run to be able to control their own behaviour.
4. To make changes *durable* and long-term, so that newly acquired behaviours are consolidated, are formed into new habits and become part of the 'rituals' that people perform in their everyday lives.

In contrast with other smoking cessation interventions, the FCB iCoach was explicitly developed to be relevant for smokers in any stage of the stop-smoking process: smokers who are reluctant to give up the habit, smokers who are ready to make a(nother) quitting attempt, even smokers who have already quit smoking. In particular, the latter characteristic is what makes the FCB iCoach unique: although frequent relapse is characteristic of smoking, few interventions provide long-term relapse prevention and follow-up.

What makes the FCB iCoach special? When a smoker or ex-smoker registers with 'Quit Smoking With Barça', he or she completes a short questionnaire for the FCB iCoach that determines the type of coaching needed to quit. Based on the answers, that individual receives personalised tips, information and motivation to their phone or email to suit their needs. What characterises the FCB iCoach and makes it distinct from the standard model is that the tips and advice users receive come directly from the hearts and mouths of Barça's staff and players. The club's four captains: Carles Puyol, Andres Iniesta, Victor Valdes and Xavi Hernàndez are among those offering advice as are former President Sandro Rosell, former coach Tito Villanova and former player Guillermo Amor. Each representative speaks to registered users from a position of knowledge and authority about health: physical, emotional and indeed, financial wellbeing.

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Positive Psychology

As with the 'Ex-Smokers' campaign, 'Quit Smoking With Barça' consistently emphasises the positive benefits of becoming an ex-smoker rather than focusing on the multitude of negative health consequences that have become, for many, white noise.

To engage and inspire the young audience, a series of films and videos were made featuring testimonials from Barça's club captains, president and other members of staff.[1] These videos, alongside creative advertisements and digital banners were disseminated via YouTube, press outreach, websites and social media channels and through Barça's own media channels. This enabled the campaign to reach the widest audience and drive men and women to log onto www.quitsmokingwithbarca.eu to start their journey towards a smoke-free life.

To create a sense of true celebration at launch, and to involve men and women from multiple countries across the EU in the campaign, a search was undertaken to select some of Barça's greatest fans with the desire to quit smoking. Fourteen men and women from countries across the EU were selected as the first to sign up to the FCB iCoach. Barça invited these men and women to fly to their stadium, Camp Nou, to receive VIP treatment involving tours of the stadia, meetings with players, and participation in a press briefing with the club President and representatives from the EC before attending a match that evening. The launch received significant EU-wide media attention, amplifying its impact.

The campaign was further driven by Tonic Life Communications-led PR agencies across 27 EU Member States to engage media, healthcare professionals, health ministries and NGO stakeholders with details of the initiative and its aims, establishing further support from the health community, coordinating local media interviews and driving greater uptake of the FCB iCoach tools.

Within Barça, the initiative was adopted throughout the entire club and across all areas of personnel with efforts made to communicate the campaign at every level from posting signage throughout the entire stadium to communicating via fan club newsletters, always with a positive angle and the central message: 'The whole club supports you'.

Outcomes and Evaluation

Objective: Create Awareness

The paid advertising element of the campaign obtained 1,986,489,661 media impressions, but thanks to intensive PR efforts in 27 countries, that number was nearly tripled by additional free publicity.

[1] https://www.youtube.com/user/unstoppableBarcelona.

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Press outreach yielded 1131 media articles across the EU, with 3,313,894,818 media impressions generated across Europe on broadcast, print and online media (the greatest coverage being achieved in Germany, Spain, Poland and the Netherlands). This represented a 55 % increase in media coverage compared with the previous 'Ex-Smokers' campaign.

Objective: Create Engagement

Amongst the core reasons for a partnership between Barça and the EC was the vision to amplify the volume of solid health information delivered from the EC to Barça's large number of fans and followers. Barça communicated the campaign messages and information throughout their own media: from Facebook and Twitter (combined reach of approximately 80 million) to their website and newsletter.

The high number of Facebook 'shares' of the campaign messages on Facebook shows the viral effect of the campaign. As an example, a 'Quit Smoking With Barça' Facebook post on September 18, 2012 generated 14,940 likes, 404 comments and 1376 shares. Furthermore, a selection of videos (testimonials, teaser movies, FCB iCoach demos) were filmed and aired on Barça's media, as well as supported by a paid advertising component. The paid media obtained a total of 1,110,436 video views, but a further 110,000 views were generated by Barça's own YouTube channel.

Objective: Consider Stopping

Ensuring the visibility or knowledge of the campaign was an important measure, but actually driving people to think about their smoking habit and consider stopping was another. The first step in the journey with 'Quit Smoking With Barça' is to visit the website or download the mobile application to find out what the campaign is about.

In the time between the launch of the FCB iCoach app in December 2012 until April 29, 2013 nearly 600,000 unique visitors were counted on the website and the app was downloaded 69,967 times (iOS: 19,068, Android: 50,899). It is clear that media efforts resulted in peaks on site visits (December and February/March).

Objective: Drive Registrations

Simply considering stopping is still, however, not enough. Once people had downloaded the mobile app or visited the website, we wanted them to effectively register on the FCB iCoach and start the behavioural process to stop smoking.

From the launch of the FCB iCoach on December 1, 2012, the conversion rate (% of visitors on the registration page who actually register) was extremely high at

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51.3 % (compared to the generic iCoach conversion rate of 40 %). This resulted in a total number of registrations on FCB iCoach of 71,507 (between December 1 and April 29), with media efforts and campaign moments clearly resulting in peaks in registration numbers. A breakdown of the registrations on FCB iCoach per EU Member State again clearly demonstrated that the campaign was effective throughout the EU.

Of great importance also, was that the campaign was reaching the target audience. When we looked at age, occupational status and gender of registrants we could see that engagement of the young, predominantly male audience with an emphasis on the lower socioeconomic demographic was achieved.

Evaluation

Analysis of the quit-rates for 'Quit Smoking with Barça' provided the following results:

via the standard web browser, the FCB iCoach reported that 37.2 % of smokers at baseline quit smoking at (minimum) 3 months follow-up; [11] via the mobile application, the FCB iCoach reported that 27.4 % of smokers at baseline quit smoking at (minimum) 3 months follow-up [12].

These findings were based on a self-reporting methodology whereby 3 months after registration (or after the last completed measurement) users were invited to fill in the follow-up measurement. If they did not fill in the measurement right away, they had the option of completing it later.

Data from the FCB iCoach were presented at the European Health Psychology Society Conference (EHPS) and European Respiratory Society (ERS) Conference in 2013, demonstrating the increased success of the iCoach health intervention run in partnership with Barça over the standard 'Ex-Smokers' iCoach. The FCB iCoach is demonstrated as being more attractive to young males than the original iCoach. Since launching in December 2012, 68 % of all iCoach registrations originated from the 'Quit Smoking With Barça' initiative.

With the FCB iCoach, more smokers with the following characteristics (at baseline) were reached than with the standard iCoach:

- Those less motivated to quit
- Those who felt quitting is less important
- Younger audiences
- Males
- Those with lower educational attainment

In 2013, 'Quit Smoking With Barça' was recognised with Gold, Silver and Bronze awards by the following bodies and organisations;

- EACA Care
- EuroEffie

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- European Excellence Awards
- European Lung Foundation Award
- Creative Club Belgium
- Media Week Award

Upon the presentation of the ELF award in September, 2013, Monica Fletcher, Chair of the European Respiratory Society and Head of Education for Health commented: 'As healthcare professionals we are really inspired by the "Quit Smoking With Barça" campaign and the incredible steps they have taken to de-normalise smoking across Europe. I am proud to present the campaign with the 2013 ELF Award and would like to extend my thanks and congratulations to all who have made this campaign a success.'

Future Work

The tools and health information for 'Quit Smoking With Barça' remain available for public use and consumption; however, this was a limited partnership within the wider context of the EC's 'Ex-Smokers' campaign that ran until October 2013. As such, while both the EC and Barça remain committed to supporting smoking cessation across Europe and ensuring continued provision of the FCB iCoach platform for the near future, 'Quit Smoking With Barça' is no longer actively promoted.

Lessons Learnt

The coming together of sporting club and political institution may on the face of it appear an unnatural partnership. However, the combined result of this pairing was a greater social and health impact than could have been achieved independently (as demonstrated by the respective results of 'Ex-Smokers are Unstoppable' and 'Sense Fum' when run independently). The sum total of the collective strengths of Barça and the EC, when brought together by a great creative idea and packaged as a communications campaign, achieved an impact that is still generating interest, reaction and requests from sports clubs and, most critically, is continuing to motivate people to take control of their own health.

When designing successful health interventions, the 'Quit Smoking With Barça' model can offer a very useful tool. The enhanced results of the 'Quit Smoking With Barça' campaign compared against the pre-existing 'Ex-Smokers' initiative could clearly be linked to the establishment of an alliance with the right partner. This is evident both in terms of quality (endorsement of messages

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by football players generated a greater degree of engagement) as well as quantity (enabled by Barça's use of their own communications channels).

A further important performance indicator is the interest the campaign generated amongst other organisations and brands which proactively sought to align themselves with the project. A wide and varied selection of partnership requests was received on behalf of national sports teams and associations eager to deliver the same health message and practical support to their fans and replicate Barça's success.

In particular, the campaign can serve as relevant learning when specifically addressing smoking in the youth audience. Young people are at greater risk of falling into the smoking category and so the campaign deals with a matter of great importance. It is critical that this audience receives valuable health messaging, in a resonant format. The clear benefit of embedding positive psychology in health messages should be considered. 'Quit Smoking With Barça' originated from the 'Ex-Smokers are Unstoppable' campaign's insight that quitting smoking is a challenge so great that when people finally overcome it they can feel a greater sense of psychological and emotional wellbeing. This enhanced wellbeing often leaves young people better prepared and more motivated to take control of, and proactively manage, their physical health.

The campaign has offered a number of lessons as to how to communicate health messages towards younger audiences, who are typically seen as 'hard to reach':

1. In basic strategy: integrating positive psychology into the messaging is a powerful and effective approach to promote uptake of health tools and support behavioural change.
2. In mechanics: the power of partnerships between institution and social / sporting groups has the potential to effect significant behavioural change; and the means by which the partnership is communicated (social media, audio-visual content, the use of digital tools) will mark the difference between valid and valuable engagement with the target audience, and simple 'awareness'.
3. In application to other health areas: the campaign model can be successfully applied to a wide range of health communications initiatives, particularly where behavioural interventions are a consideration: alcohol and nutrition, for example, offer clear parallels to tackling tobacco in that each represents an area of addiction proven susceptible to change and improvement via positive psychology and motivation, both at the prevention and treatment stages; also, there is strong evidence to support the association between poor mental health and addiction of this nature and the 'Quit Smoking With Barça' campaign can serve as a valuable reference point and source of data for these other health areas.

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Chapter 26
Conclusion: The Next Steps

David Conrad and Alan White

The global health challenges of the twenty-first century call for greater upstream, preventative action. To truly tackle major population health issues, such as obesity, the aging population and the spread of HIV, we need innovative ways to bring public health into the mainstream and effectively engage people with health messages and health interventions in their everyday lives. Bringing the worlds of sport and public health together is one such innovative approach, offering a wide range of opportunities to make population health interventions more accessible—whether that population is the football fans of a whole nation or a small community of people with a shared health need.

In this book we've looked at the well-evidenced benefits to physical and mental well-being of sports participation, we've discussed the myriad opportunities to work with sports partners and we've seen the variety of sports-based health interventions being undertaken across the spectrum of public health work. We've also discussed the unhealthy aspects of sport and the challenges and potential pitfalls of bringing the worlds of sport and public health together. Although certainly not a panacea for the world's public health problems, sport's huge popularity, breadth of reach and increasing accessibility give it powerful potential as a vehicle for targeting and engaging populations with health interventions.

While a whole host of interventions around the world are aimed at engaging people in sport for the primary purpose of increasing levels of physical activity, what we have showcased in this book are examples of sports-based interventions with

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wider public health aims. Many of these interventions have involved participation in sports activities (although never simply as an end in itself), while some have used sport as a theme for communicating health messages, and others have used sports venues and events as settings in which to deliver health interventions to a captive audience. Although sport-based interventions may not seem an obvious choice when seeking to increase vaccination uptake or respond to a natural disaster or terrorist atrocity, for example, the concepts which underpin such projects reflect familiar staples of public health theory, such as social marketing and the settings approach.

The use of sports-based interventions in public health work, other than simply as a means to increase physical exercise, however, is very much an emerging field. Evidence for the impact and cost-effectiveness of such interventions in achieving public health outcomes is currently limited and much of the work is experimental. There is a pressing need to grow the evidence base so that cost-effective interventions can be championed and potential funders and commissioners can have confidence that investment in rolling out these interventions will lead to improvements in public health outcomes. It is just as important that we understand what kinds of sport-based interventions aren't cost-effective, or in what contexts an intervention might be successful while in others it might be ineffective. Building a strong evidence base for public health interventions is always a challenge, however, particularly in emerging niche fields characterised by scattered, often small scale, projects of widely varied history, design, objectives and resources. Certainly, there is considerable variation in the extent and rigour of formal performance monitoring or evaluation accompanying the interventions featured in this book. These case studies are not intended as flawless illustrations of 'best practice', however, but rather have been chosen to reflect the variety of work being undertaken across the globe and the current state-of-the-art in the field.

As we set out in the Preface, our ultimate purpose in bringing these chapters together is to inspire further developments in the sport and health field by showing the exciting range of projects which have already been realised. To conclude this book, we're therefore going to focus on taking the reader through two practical overarching key messages which we believe will be crucial for the next generation of sport-based health interventions seeking to secure their place as a staple of mainstream public health work: firstly, *use the evidence base and build the evidence base* and secondly, *acknowledge the challenges and take a critical approach*.

Use the Evidence Base and Build the Evidence Base

One of the biggest challenges of sport and public health work is the limited amount of good-quality-published evidence in the field. When there is a lot of reliable evidence around a particular type of intervention it makes it much easier both to make a strong business case for why the intervention should be funded or commissioned

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and to design an intervention with confidence that it will be effective in achieving its objectives. With an emerging field such as this, where the evidence is limited both in quality and quantity and much territory remains unexplored, it's particularly important to design innovative interventions which have robust evaluation and performance monitoring at their core. One of the things that can hold back advancement in innovative areas of public health practice is the tendency for multiple separate small-scale projects to repeatedly spring up with little if any grounding in academic evidence but which themselves fail to generate good-quality evidence which could add to the academic literature.

Using the Evidence

The drive to set up a sports-based intervention may stem from a specific opportunity which has arisen (e.g. an important local sport club is keen to work with you to deliver health promotion or run a project in the community), or it may simply begin with a belief that sport offers a way to reach a particular target group. Whatever the impetus for setting up a sport-based health project, the starting point for designing any intervention should be a well-informed understanding of the health needs of the population, from which an overarching set of objectives is then derived. Once you have this you can search for evidence of specifically what works to achieve those objectives, ideally published in peer-reviewed academic journals. There may be little evidence available around using sport to achieve your particular objectives, but even where the sport element of the project is entirely innovative you should still strive to draw on evidence pertinent to other aspects of the project design. Remember that the quality of evidence varies widely even in peer-reviewed academic journals.

The following tips will help you to apply an evidence-based approach to your project design:

- Conduct a thorough literature search, including both published and grey literature—if you're not familiar with literature searching methods it's worth reading an introductory guide (several books on conducting literature reviews have been published—some specifically focussed on the field of health).
- Apply critical appraisal methods when assessing evidence—free tools such as CASP (www.casp-uk.net) will help you.
- Try to avoid applying a 'medical model' when assessing evidence of non-clinical interventions. Subtle contextual factors can make all the difference to the effectiveness of an intervention and what works in one set of circumstances may not work in another. You can find out more about this approach by reading about 'realist methodology' online or in books dedicated to the subject.

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Building the Evidence

In an emerging field with a limited evidence base such as this, a primary function of every intervention, whatever its scale, should be the generation and dissemination of good quality evidence through effective performance monitoring and rigorous evaluation, leading to publication in the academic literature. Small-scale innovative interventions particularly are often established by practitioners whose skills, knowledge and interest are focussed much more on the frontline delivery of hands-on work with the public than the academic side of public health. This can lead to evaluation and data collection becoming an afterthought rather than being built into the design of the intervention from the outset. Even where there is an appreciation of the need to generate evidence from the project and an enthusiasm for sharing that evidence, a good understanding of what constitutes quality evidence may be lacking. Considering the following tips will help to get your project on a good footing with regard to generating evidence (even if practical restraints mean that you can't implement all of them):

- Ideally, have someone on the project team or steering group who has at least a basic knowledge of research and evaluation methods and an understanding of the way that commissioners and potential funders assess the effectiveness of interventions.
- Understand the different types of evaluation (e.g. process vs. outcome evaluation) and which type(s) would be most appropriate for generating the evidence you need to take your project forward.
- Accept that qualitative evidence of effectiveness alone is likely to carry little weight with commissioners—qualitative evidence is very valuable for understanding how an intervention is working and for bringing quantitative outcome data to life, but without that quantitative outcome data it is very difficult to show that an intervention is cost-effective in any meaningful way.
- Appropriate statistical methods should be applied to any quantitative outcome data—for example, don't expect commissioners or academic journal editors to be impressed by figures showing that 80 % of those who received your weight loss intervention were slimmer at the end if you don't have any *p*-values or confidence intervals for those figures. Numbers can look impressive without being statistically significant. If you don't know what '*p*-values', 'confidence intervals' and 'statistical significance' are, make sure that your project is informed by someone who does and never commission someone to undertake your evaluation who doesn't know what they are either.
- Don't confuse output with outcomes—interventions are often labelled a success because they have impressive outputs (e.g. 'we engaged X hundred people with healthy eating advice' or 'we distributed X thousand condoms') but it's the ultimate outcome that tells you how effective an intervention is in meeting its public health objectives (e.g. how many of those people changed their diets as a result of the healthy eating advice they received and for how long; and how many of the condoms distributed were used and how many people carried on using condoms

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longer term?). Output data is always important for performance monitoring and showing the potential scale of an intervention, and in some types of intervention the output and outcome may be one and the same (e.g. providing vaccinations at a sport event, where the objective is simply to increase vaccination rates in the immediate term). Output data can't tell you about the effectiveness of interventions aimed at achieving long-term behaviour change, however; for this you'll need a robust study design with data collected at post-intervention follow-up intervals.

- Try to budget appropriately for evaluation at the outset—getting funding for new interventions can be hard, particularly for innovative work in a field with a limited evidence base, so the natural instinct can often be to assign as much of the money as possible for delivering the intervention itself, regarding evaluation as a luxury or a secondary concern, or even as simply a box-ticking exercise. The project will be far more useful, however, if it adds to the evidence base for sport-based health interventions as one of its primary functions, as well as simply delivering the intervention itself. Funders typically want to see that an innovative project will contribute to knowledge and advance the field—there is little point in funding a short-term intervention if at the end of it no one will really know how well it worked. Good quality evaluation costs money but skimping on it is a false economy because without hard evidence that your intervention is delivering on outcomes it will be much harder to secure ongoing funding to keep the project going long term or roll it out on a larger scale.
- Remember that all evaluation is not equal. Particularly for relatively small-scale projects, it's not uncommon to see glossy (and undoubtedly expensive) evaluation reports authored by self-styled 'consultants' which make bold claims as to the efficacy of an intervention unsupported by any genuine statistical analysis and sometimes based on eye-wateringly unrigorous research methods. It can be tempting to think that a glowing evaluation report from a third party espousing the virtues of the project and glossing over its limitations will offer the best chance of securing continued funding for the intervention. One-sided evaluation reports which merely present a sales pitch for the project based on spurious interpretations of weak evidence will not fool the initiated, however, and most importantly will not provide the knowledge needed to understand how the project is working and how it might be made more effective or rolled out further.
- If at all possible, get some expert input—if you can't afford to commission an experienced university-based team of researchers to undertake a rigorous evaluation, seek input and support from colleagues with experience of successfully undertaking evaluations or research studies (preferably both quantitative and qualitative) and publishing them in credible peer-reviewed academic journals.
- Disseminate the findings of your evaluation—aim to publish a condensed version of your evaluation report as a research paper in a peer-reviewed journal, as well as having the report available for download on your project or organisation's website. A literature search of academic journal databases, such as PubMed (www.ncbi.nlm.nih.gov/pubmed), will almost always be the first port of call for anyone seeking to understand the latest evidence and developments in the field

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of sport and health. Furthermore, the publication of your evaluation in a reputable peer-reviewed journal will give readers and potential funders confidence that the findings and conclusions have been subject to a degree of scrutiny and the evaluation conducted with a certain degree of rigour.

Acknowledge the Challenges and Take a Critical Approach

In seeking to capitalise on sport's potential to do good, it's important to keep a keen awareness of the ways in which sport can be a negative influence on health and well-being as well as being health-enhancing. Sport is not inherently good, and mixing the worlds of sport and public health is not an inherently good idea—context is everything.

It's also important to think about how others might take a critical perspective on your work. Could you face accusations of reinforcing gender stereotypes, compromising the values of public health by teaming up with commercial sports partners, or endorsing a violent sport, for example? How will you respond to these kinds of arguments? The issues which you could find yourself dealing with and the best ways to handle them will vary depending on the nature of individual projects and the organisational, cultural, economic and social contexts in which you find yourself operating. Playing devil's advocate in your project planning, however, will help you to prepare for dealing with sceptics and also help you to design an intervention in which the health-enhancing aspects of sport are optimised and its potential negative aspects minimised.

Passion drives innovation and a whole lot of energy and enthusiasm are needed to get a new project off the ground, particularly in an emerging field. The case studies in this book reflect incredible levels of determination and commitment among dedicated professionals around the world to develop the field of sport and health, to explore new ideas, find funding, build partnerships and reach out to communities in new ways. Successfully facing the challenges of undertaking experimental work relies on an ability to 'sell' the project to potential partners, funders and participants—often over a sustained period of time. Although not always easy, though, it's equally important to maintain a reflective and constructively critical perspective on our own endeavours in order to anticipate potential problems, understand the thinking of those who do not share or may even appear to be actively thwarting our own visions and to identify and explore new ways to improve or expand an intervention. As with any area of public health work, not all the projects and approaches which have been attempted in the sport and health field have proven successful, but by thinking critically about the project throughout its inception and subsequent delivery you can maximise the chances of the initial concept developing and shaping into something which delivers on public health outcomes in an evidenced, cost-effective way.

We've chosen to conclude this book with a set of questions (Box 26.1), based on the common lessons and recurring themes from the twenty case studies, as well as the discussion chapters in Part I, which hopefully readers will find useful as a mental checklist which can be applied in developing new sport-based health interventions.

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Box 26.1 Critical Questions When Designing, Delivering and Evaluating Sports-Based Health Interventions

- Does the intervention have clearly stated objectives which are S.M.A.R.T. (specific, measurable, achievable, realistic, time-bound)?
- Are these objectives derived from a robust assessment of the health needs of the target population in question?
- Is the intervention part of a broader programme of work designed to address these objectives or are all the eggs in this one basket?
- Does the intervention make optimum use of existing sport partners?
- Will new sport-health partnerships need to be formed to successfully deliver the intervention?
- How much is the intervention dependant on one or more particular partnership arrangement and how likely are these arrangements to remain in place in the short, medium and long term?
- What are the motivations and needs of sport partners involved in the project—how will these be met and how might they impact positively or negatively on the delivery, outcome and sustainability of the project?
- Is the design of the intervention based on a thorough search and understanding of the relevant literature?
- Has robust evaluation been built into the design of the intervention, informed by people with sound knowledge and experience of quantitative and qualitative evaluation?
- Will the evaluation and performance monitoring data once acquired provide the kind of evidence required to truly assess the efficacy and cost-effectiveness of the intervention?
- Has the cost of a robust evaluation been budgeted for and factored into the business case/funding bid for the project?
- What are the risks associated with the intervention, particularly with regard to the sport element? (see Chaps. 4 and 5 for ideas.)
- Will the intervention be piloted initially to iron out teething problems and get an idea of the scale of the demand?
- Is the project adequately resourced to meet with greater-than-expected demand or unexpected problems (e.g. a vital staff member going off work due to illness)?
- Will staff delivering the project on the frontline have adequate training to deal with health issues, respond to requests for advice from participants and signpost appropriately to other services?

The list in Box 26.1 is not intended to be exhaustive, but it should give a good kick-start in applying a critical reflective approach to the development of new sports-based health interventions and ensuring that they are built on key principles of evidence-based public health. You may never be able to tick all the boxes of a 'textbook' public health intervention, especially when operating in situations where

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resources are scarce—by necessity, most public health work is a triumph of pragmatism over idealism. Indeed, few of the projects featured in this book would have happened at all if their creators had been prisoners of the purest principles of public health practice. While the quest for perfection should never stand in the way of innovation, however, a clear understanding of the strengths and limitations of your own projects will always equip you to anticipate potential problems and set clear goals and ambitions for future development.

Our hope is that the ideas, discussions, lessons and advice shared in this book will provide both a guide and an inspiration for the development of new sports-based health interventions and a greater mainstreaming of what is currently a niche area in the field of public health. The case studies we've chosen to highlight cover a broad spectrum of applications of sport in public health work but there is still huge potential for further experiment and exploration—using sport to tackle even more of the range of public health outcomes; tailoring interventions to different target groups, including older people, people with disabilities and more work targeting women and girls; and, of course, using different sports to reach different audiences. A substantial proportion of the case studies in this book have featured soccer, reflecting the global popularity of the sport and its predominance in the sport and development field, but the principles of this work could be applied to a vast array of sports as long as they provide a means to engage a target audience. Sport is a ubiquitous but endlessly complex and multifaceted feature of our global social and cultural landscape. Certainly, sport is no 'one-size-fits-all' panacea for the public health challenges of the twenty-first century, but the signs are that it has the potential to make a very significant contribution to the cause. Only further innovation, experimentation, building and sharing of evidence—and, of course, funding—will show us how great that potential really is.

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