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**Health Promotion at the Local Level Sports Clubs: Applying Health Promoting
Sports Club Standards in the Netherlands**

University of Jyväskylä
Department of Sport Sciences
Master's Thesis
Social Sciences of Sport
Spring 2014

Department of Sport Sciences/Faculty of Sport and Health Sciences

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ABSTRACT

Master's thesis, 43 pages and 1 appendix
Social Sciences of Sport
2014

This study explores health promotion activity of Dutch sports clubs by using the Health Promoting Sports Clubs (HPSC) standards, which are developed in Finland and here applied to the Dutch sports context. The standards consist of 23 items which cover different perspectives on health promotion. The standards form an overall HPSC index, which is used to create health promotion profiles for the sports clubs. 17 sports clubs from the municipality of 's-Hertogenbosch participated in this study, of which 42 club officials (1-6 per club) evaluated their own club on all HPSC standards on a five-point Likert scale. Per club, the average score on each standard was calculated. The average on the HPSC index was 9.00 ± 4.36 (range 0-23). This suggests that the participating sports clubs are positively oriented to health promotion. However, there is much room for improvement within the clubs. More research is needed to be able to generalize the results to different types of clubs, and to explore practical implications of the results.

Keywords

Setting based health promotion, sports clubs, HPSC standards

PREFACE

In the process of writing my master's thesis, it was decided by me and my supervisors that I would write an alternative type of thesis. Instead of writing a longer academic paper, I aimed for publishing a paper in a peer-reviewed journal. That work was complemented by an extended literature review on the topic. Therefore, I hereby present this complementary document with extra background information and an extended explanation of the methods that I have used for my study.

CONTENTS

ABSTRACT	2
PREFACE	3
INTRODUCTION	6
1. HEALTH PROMOTION	7
1.1 Definition of Health	7
1.2 Setting Based Health Promotion	8
2. SPORTS IN THE NETHERLANDS	10
2.1 Structure of the Sports Sector in the Netherlands	10
2.2 Sports Participation in the Netherlands	12
2.3 Health Promotion in Dutch Sports Clubs	13
3. HEALTH PROMOTION IN THE SETTING OF SPORTS	15
3.1 Health Promotion in the Field of Sports	15
3.2 Sports Clubs as a Setting for Health Promotion	16
3.3 Health Promoting Sports Clubs Standards	17
4. PURPOSE OF THIS STUDY	18
5. METHODOLOGY	19
5.1 Translation of the Health Promoting Sports Club Standards	20
5.2 Evaluation of Suitability and Applicability of the Health Promoting Sports Club Standards to the Dutch Context	20
5.2.1 Selection of Subjects	22
5.2.2 The Process of the Delphi Study	23
5.2.3 Quantitative and Qualitative Analysis	24
5.3 Assessing the Health Promotion of Dutch Sports Clubs	24
5.3.1 Respondents	25
5.3.2 Data Collection	26
5.3.3 Analysis	27
6. RESULTS	29
6.1 The Output of the Delphi Study: 23 HPSC Standards for the Dutch Context	29
6.2 The Outcome of the Survey: Current Health Promotion Orientation of Dutch Sports Clubs	30

	5
7. DISCUSSION	37
7.1 Limitations of the study	39
8. CONCLUSIONS AND IMPLICATIONS	40
REFERENCES	41

INTRODUCTION

Sports clubs have an important role in the Dutch society as they reach a large part of the Dutch population. This suggests that sports clubs in the Netherlands have a good opportunity to be a setting for health promotion. A clear picture of the current orientation of the Dutch sports clubs towards health promotion is missing. However, this orientation can be assessed by the Health Promoting Sports club (Health Promoting Sports clubs) Standards, as developed by Kokko and colleagues (Kokko et al., 2006). Based on these standards, an index was developed to describe the health promotion profiles of youth sports clubs in Finland. At first sight it appears that the sports structure in the Netherlands and Finland have many factors in common, for example high levels of sport participation, the importance of sports clubs in the society, and the prominent role of volunteers within those sports clubs. For this reason, the concept of HPSCs as developed in Finland might be also applicable to the Netherlands. National applications, however, have to be taken into account.

Health promotion within sports clubs, a social and informal environment, can lead to reaching many people. With the assessment of the orientation towards health promotion in Dutch sports clubs and the current role they fulfil, opportunities can be uncovered. The social function of the sports clubs can be developed by using these opportunities. Furthermore, this assessment and the awareness it creates among participating sports clubs and others will be a step towards a better intersectoral health policy.

1. HEALTH PROMOTION

1.1 Definition of Health

Health is a state of well-being, where well-being is a subjective concept. Everyone evaluates his or her own health based on subjective norms. This makes it difficult, if not impossible, to determine what health exactly is. Furthermore, health includes both a physical, mental and social aspect, which makes the concept even broader and more complicated. In 1948, the World Health Organisation (WHO) defined health as: “a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity” (WHO, 1948). This is generally the most accepted and used definition of health so far. However, different arguments of critique can be found on this definition. In 2011, a conference on defining health was organized in the Netherlands. Based on the outcomes of this conference, Huber et al. (2011) defined three points of critique on the current WHO definition that were discussed during this conference by 38 international experts. The first point is that complete well-being is absolute, while this is not attainable for most people. Another critique on the WHO definition of health is that the emphasis has moved since 1948 from acute to chronic diseases. The capacity to cope with the challenges of a chronic disease or disability has been given a minimal role in the current definition. Finally, the concept of complete well-being is not measurable, which makes the definition ‘impractical’. (Huber et al., 2011, p. 236.)

Antonovsky introduced the concept of salutogenesis, which defines the focus on what people can do to create health with their resources and capacities, instead of the dominant focus risks and diseases (Antonovsky, 1996). In other words, the emphasis of health and health promotion should be on the cause of health instead of the cause of disease (Lindström & Eriksson, 2005; Lindström & Eriksson, 2006). This vision focuses on what people can do, rather than constantly being disappointed or trying to achieve impossible outcomes. In this sense, again, health is seen as a subjective perception of well-being.

Besides the focus on individual level, health can also be defined as a precondition for a functioning society. The welfare and well-being of an individual is increased with good health, but also the welfare and well-being of the society. (VWS, 2013.) Over the past century, a paradox can be identified in the Western world. Despite the increasing welfare and with that also the growing body of knowledge concerning health, the prevalence of chronic diseases has increased enormously. (Mackenbach & Van der Maas, 2004.) Unhealthy lifestyle, such as smoking tobacco, abuse of alcohol, consuming unhealthy diets and physical inactivity, causes non-communicable diseases (Lim et al., 2012). Unhealthy lifestyles and non-communicable diseases can be addressed by health promotion (Brug & Van Assema, 2007).

In line with the paradigm of positive health as proposed by Antonovsky is the definition of health promotion as stated by Nutbeam in 1985: ‘The process of enabling people to increase control over the determinants of health and thereby improve their health’ (Nutbeam, 1998). It is not possible to force a person into a healthy lifestyle or to decide for people that they have to create a healthy environment to live in. Suggesting, teaching, supporting and providing are strategies that can, and should, be used to make the healthy option the most obvious one. This however, cannot be done only by organizations that have health promotion as their main business. Every individual and every organization of whatever type has the responsibility to pursue a healthy environment and society.

1.2 Setting Based Health Promotion

With the introduction of the model developed by Marc Lalonde in 1974, the stress on health as an individual and medical issue shifted towards a more structural viewpoint with an important role for the social and cultural environment (Lalonde, 1974). The importance of the system was acknowledged by more and more researchers, which also led to a change in the concept of health promotion. During the first international conference on health promotion, held in Ottawa in 1986, health promotion was defined as *“the process of enabling people to increase control over, and to improve, their health”*. Five health promotion strategies were identified to provide for a basis on which interventions, policies and implications could be built: (1) build health public policy; (2) create supportive

environments; (3) strengthen community action; (4) develop personal skills; and (5) reorient health services. These strategies were developed with regard to the fact that the responsibility for health goes beyond the health sector. (WHO, 1986.)

In line with the Ottawa Charter, the change from the approach in which individuals are held responsible for their health and where health is considered as a biological issue, to a more environmental-oriented approach led to the development of a new concept within health promotion: setting based health promotion. Dooris (2004) identified three factors in this approach:

- Creating supportive and healthy working and living environments;
- Integrating health promotion into the daily activities of the setting; and
- Developing links with other settings and with the wider community. (Dooris, 2004.)

The settings approach is based on the belief that investment in the social settings instead of focus on individuals is necessary to promote health effectively. These social settings consist of multiple actors on different levels in both organization and practice, which asks for co-operation between these actors. Furthermore, since health is relevant to all sectors, health promotion requires an intersectoral approach. Finally, the society as one system consists of many settings, for example municipalities, schools, sports and recreational clubs, hospitals, etcetera, which requires work within, across and between the various sectors. (Dooris, 2004; Jackson, 2006; Whitelaw, 2001.)

2. SPORTS IN THE NETHERLANDS

2.1 Structure of the Sports Sector in the Netherlands

The sport and physical activity sector has an important impact on health; physical activity can benefit physical, mental and social health. Increasing sports participation can lead to a healthier population, with the condition that the physical activity is performed under healthy circumstances (WHO, 2010). In the Netherlands, current sport policy is based on three pillars: (1) to move, (2) to participate, and (3) to perform. The first aim is to provide for a healthy possibility to participate (without overloading or sports injuries) in physical activities, which should facilitate citizens to make the choice for a healthy and active lifestyle themselves. The second objective is to get people to meet each other through sport, and to get them participating in public activities. Finally, a professional climate for elite sports should be created, with the protection of both the health of the participants in sports and physical activity, and the image of sports. Furthermore, (the social image of) the organization of events in the Netherlands is aspired. Facilitating circumstances to be physically active will enable people to increase control over and improve their mental, social and physical health. (VWS, 2005.)

Within these ambitions of the Dutch government to increase participation in physical activity and in (public) activities, the broad concept of health has a prominent place. Moreover, the national political departments of public health, welfare and sport form one ministry (Dutch ministry of Health, Welfare and Sport). The ministry is currently starting a National Program Prevention to develop the health policy. In this program, emphasis is placed on prevention in the health care system, the promotion of health and the maintenance of the health protection. (VWS, 2013.) Therefore, the important links between these fields have a political base, which seems to be an example for practical collaborations.

In 2013, Poel and Pulles aimed to describe the infrastructure of the sports sector in the Netherlands. They stated that the national government in the Netherlands appears to have

the responsibilities for the sports policy in a broader perspective, whereas the local governments, the municipalities, have a more facilitating role in the local sports activities, organizations and facilities. The municipalities are closely linked to sports clubs as a provider of both financial support and support in the form of maintenance of the facilities. Furthermore, the Dutch sports sector is, especially on the local level, strongly relying on volunteers and voluntary organizations (Poel & Pulles, 2013). The organization of sports events, the maintenance of facilities, and particularly the organization of sports clubs is highly depending on the volunteers.

The Netherlands has approximately 27 000 sports clubs, 800 public swimming pools, 2 000 providers in the fitness branch and more than 10 000 other sport organisations, like organisations that provide for playgrounds and courts. In 2011, more than 5.2 million people were member of a sports club in The Netherlands. This accounts for more than 30% of the population, which seems to be a stable figure. (Van Kalmthout & De Jong, 2009; Schmink & Van Veldhoven, 2012; NOC*NSF, 2013; Tiessen-Raaphorst & van den Dool, 2012.) The largest sport federations are respectively soccer, tennis, golf, gymnastics and field hockey, which account for over 52% of the total amount of members (Smink & van Veldhoven, 2012).

81% of the sports clubs offer 1 type of sports, 14% offers 2 types and 4% offers more than 2 types of sports. The sports clubs have a good reputation among 47% of the non-participants, 60% of the sport participants and 79% of the sports club members. The non-participants generally think that the sports clubs are too competitive, that they should focus more on beginners and/or there are too many obligations within a sports club. 80% of the sports clubs think that they have a social responsibility, for example that they should pay explicit attention to fair play and respect, they should stimulate people to be more physically active, they should provide for prevention of sports injury, or even that they should counteract against obesity. (NOC*NSF, 2013.)

18% of the Dutch respondents to the Eurobarometer 2013 says to engage in voluntary work that supports sporting activities, which is far above the European average (European

Commission, 2014). National figures confirm this high rate. 14-16% of the Dutch population says to be engaged in voluntary work that supports sport activities. On average the sports clubs have 40 volunteers and 2.5 persons as paid staff. 73% of the clubs have one or more certificated trainer/coach, and per club 63% of the trainers are certificated. More than half of the sports clubs pay the volunteers with some kind of financial compensation. (Van Kalmthout & De Jong, 2009; NOC*NSF, 2013.)

Furthermore, 88% of the sports clubs have some form of collaboration with other organisations, like local governments, other sports clubs, schools, and sport federations. The main purpose of these collaborations is to exchange experiences, sharing training and competition, and sharing the accommodation . 43% of the clubs participates in one or more projects to promote sports. (NOC*NSF, 2013.)

2.2 Sports Participation in the Netherlands

The Netherlands has a population of approximately 17 million people, of whom 14.8 million are between 5 and 80 year olds. 50.1% of the population is female, 49.9% male. (NOC*NSF, 2013.) In The Netherlands, the physical activity levels are amongst the highest in Europe (European Commission, 2010). Four different norms are mainly used to measure the physical activity, the fitness and the sport participation in the Netherlands: the Dutch norm for healthy physical activity, the fitnorm, the combinorm and the sportnorm. In table 1 these norms are described.

Table 1. Norms used in the Netherlands to evaluate physical activity and sport participation.

Norm	Content
Dutch norm for healthy physical activity	To maintain a good health one needs to be vigorously physically active at least five days a week, 30 minutes per time. For children, youth and obese people it is to be vigorously physically active also at least five days a week, but at least 60 minutes per time.
Fitnorm	To improve health, one should do intensive physical activity at least three times a week, for at least 20 minutes per time.
Combinorm	One meets the combi norm if one meets the Dutch norm for healthy physical activity, or the fit norm, or both.
Sportnorm	To participate in sports at least 12 times year.

According to the Netherlands Olympic Committee*Dutch Sport Federation (NOC*NSF), in 2012 69% of 5-80 year olds participates in sports at least 12 times a year. Furthermore, 61% of the population meets the combinorm. In total 14% of the Dutch does not meet both the sportnorm and the combinorm. (NOC*NSF, 2013.)

The main motivations to be physically active are to improve health, to have fun, to improve fitness or to relax. The importance of these moments seems to have grown over the last few years (European Commission, 2014). Time seems to be the biggest restriction to participate in sports or be physically active (European Commission, 2010). About 26% of the 4.6 million Dutch that don't participate in sports enough to meet the sportnorm wants to increase their sports participation in the future. Their main restriction seems to be the intrinsic opportunity, in other words the priority they give to participate in sports. (NOC*NSF, 2013.)

Furthermore, the Dutch population uses sports clubs most often for sport and physical activity, compared to other countries of the European Union. According to the Eurobarometer from 2013, 19% of the Dutch population is member of a health or fitness club. Moreover, the majority of the population (27%), says to be physically active in sports clubs, which is the highest proportion of the participating countries (European Commission, 2014). National research confirms this relatively high number. The NOC*NSF reported in 2012 that 45% of the Dutch is member of a sports club or other commercial sport provider, such as fitness centres (30% of sports club, 20% of commercial sport provider) (NOC*NSF, 2013).

94% of the Dutch respondents to the Eurobarometer 2013 state that the sports clubs offer many opportunities to be physically active.

2.3 Health Promotion in Dutch Sports Clubs

In the Netherlands, two studies related to health promotion in sports clubs have been conducted. In 2012, an exploratory study (commissioned by the ministry of Health, Welfare and Sport) was undertaken by Van Kalmthout (2012) to investigate the situation of healthy

products in the range of products in sport cafeterias. The main outcomes stated that on average only 28% of the range of the products offered was defined as healthy (for example diet sodas, mineral water, juices, milk, salads, sandwiches, pasta, soup, fruit, yoghurt). Moreover, the respondents (who were board members of their sports club) indicated that customers barely demand for (more) healthy products. (Van Kalmthout, 2012.)

Pluim et al. (2013) identified four themes that were mentioned by board members to be associated with healthy tennis clubs: (1) provision of healthy foods, (2) injury prevention and treatment, (3) social health, and (4) safety around the club. To achieve the status of a healthy (tennis) club, possible interventions can be identified according to an ecological model on macro-, meso- and micro-level. Based on this model and the four themes, a rather specific multilevel intervention framework was proposed for the Royal Netherlands Lawn Tennis Association (KNLTB). In the first theme the support of club management, kitchen-related problems, and legislation and policies (about hygiene, alcohol, and smoking) were included. Injury prevention and treatment (amongst others: fair play, sexual harassment, child protection and participation by the disadvantaged) included support of club management and coach education. The third theme included support of club management, central and local support, infrastructure and materials. Finally, safety around the club consisted of support of club management, central and local support, legislation and policies, and infrastructure and materials. (Pluim et al., 2013.)

3. HEALTH PROMOTION IN THE SETTING OF SPORTS

3.1 Health Promotion in the Field of Sports

In several settings, projects were initiated to promote health within this holistic approach; including cities, schools, universities, workplace, hospital and prisons (Dooris, 2004; Poland et al., 2000). Recently, also the field of sports has been studied and used as a setting for health promotion. In England, Australia, Norway, France, Sweden and Finland research has been conducted on stadia (Drygas, 2011), sporting organizations (Casey et al., 2012), and (youth) sports clubs (Kokko et al., 2006; Skille, 2008, Geidne et al., 2013, VanHoye et al., 2014). In the Netherlands no such research has been done yet. Moreover, the effectiveness of policy interventions implemented through sporting organizations has not yet been evaluated in research (Priest et al., 2008).

Drygas et al. (2011) identified sports stadia as significant settings for public health strategies, because of the great reach of the community. However, health promoting strategies are often opposed to the marketing strategies of the main sponsors, who often represent the gambling, alcohol and (unhealthy) food industry. Promoting physical activity, mental health and protection against exposure to UV in sunlight are not in conflict with other goals. Therefore stadia can be used as a setting for health promotion. The research conducted by Casey et al. investigated the factors affecting the sustainability of health promotion within sport and recreation organizations and the readiness and capacity building strategies of these organizations to promote health. They concluded that to achieve sustainability of health promotion within sports organizations, organizational processes, structures, resources and commitment should be secured to support the practices for the long-term. The size and the organizational capacity influence the dependency on the funding: mainly the smaller organizations, which work mostly with volunteers, are dependent on the funding. (Casey et al. 2009; 2012.) Furthermore, Dobbins et al. (2006) conclude that designating the policy development to a given individual enhances the prevalence of health policies in clubs. Also connections and cooperation with health

agencies are proved to be important when developing a health promoting orientation in sports clubs.

3.2 Sports Clubs as a Setting for Health Promotion

Skille (2008) identifies sports clubs as settings for sport policy implementation. He concludes that the active import, interpretation and implementation of central policy on local level occur at the local context. Furthermore, the prominence of volunteers within these sports clubs also affects the way that policies are implemented in this setting. The structure of voluntary sports clubs influences the power, professional competence and well-grounded decision making (Thiel & Mayer, 2009). This has to be taken into account when starting setting based health promotion within sports clubs. Furthermore, Geidne et al. (2013) concluded that the potential of youth sports clubs to become a health promoting setting, the sports clubs should take on a comprehensive approach and develop their aims, purposes and activities.

Kokko (2010) argues that youth sports clubs are suitable as a setting for health promotion, based on four arguments. The first argument is that sports club activities reach many people. Secondly, sports clubs have an informal educational nature. Thirdly, coaches have an important influence on their pupils, especially on children and adolescents. Finally, health promotion is beneficial for performance. Even though Kokko et al. have limited their research to youth sports clubs, adults could also be reached through this way. (Kokko et al., 2010.) Not only members of a sports club could benefit from health promoting sports clubs. As a healthy and welcoming environment, sports clubs can increase participant membership in their sports (Eime et al., 2008). This implies that the reach of HPSCs could even increase once they are developed. The increase in sports participation can contribute to the global action against physical inactivity, the fourth major cause of non-communicable diseases (Kohl 3rd, 2012).

3.3 Health Promoting Sports Clubs Standards

To examine the health promotion of orientation of youth sports clubs in Finland, 22 health promoting sports clubs standards were developed based on suggestions of experts in health promotion as well as sports club activity and on the five strategies on health promotion as defined in the Ottawa Charter. The list of standards as currently used can be found in the appendix. Based on the developed standards, a health promoting sports club index (HPSC Index) was developed. (Kokko et al., 2006.) This index is divided into four sub-indices, namely a policy index, an ideology index, a practice index and an environment index. The HPSC Index has been validated in a Finnish study, but was also recommended to be applicable to sports clubs in other countries (Kokko et al., 2009). Recently Van Hoye et al. (2014) have used the HPSC standards to assess the perceptions of French coaches on the aims and the actual activities on health promotion in their sport clubs, and they confirmed the findings in Finland.

In the Netherlands, sport and sports clubs in particular have an important role within society, which is comparable to Finnish sports clubs (Kokko, 2010). Furthermore, sport participation in Finland and the Netherlands are amongst the highest rates within Europe and sports clubs in both countries are mainly organized based on volunteers (European Commission, 2010). Therefore, the concept of the health promoting sports club could be transferred to the Netherlands.

4. PURPOSE OF THIS STUDY

The aim of this master's thesis is to carry out a first assessment on the health promotion orientation of the Dutch sports clubs, using the HPSC Standards. To do so, these standards first have to be translated from English into Dutch, and the applicability of the HPSC Index for the Dutch context should be investigated. The final list of standards will then be used to assess the health promotion orientation of a sample of Dutch sports clubs in the city of 's-Hertogenbosch. Therefore, the following research questions are formulated in order of procedure:

1. To what extent do Dutch experts on Health Promotion and/or the Dutch sports system think that the HPSC Standards are applicable to the Dutch context?
2. To what extent are sports clubs in 's-Hertogenbosch oriented to health promotion, when measured by the HPSC Standards?

5. METHODOLOGY

The first research question, how health promotion-oriented Dutch sports clubs are, could be answered by using the HPSC Standards as developed by Kokko and his colleagues (Kokko et al., 2006). However, to do so the standards first had to be translated, reviewed and evaluated on their applicability on the context of Dutch sports clubs. To answer the second research question on what Dutch experts on health promotion and/or the sports system in the Netherlands think about the applicability of the HPSC Standards to the Dutch context, two types of data were needed. Firstly, the translated HPSC Standards were evaluated on their relevance by the selected experts. Secondly, possible missing themes or topics that could complement the current index were traced, formulated and evaluated. The results of the evaluation, e.g. the standards as an outcome of this part, formed a valid instrument to assess the current status on orientation towards health promotion within Dutch sports clubs. This instrument was then used on a sample of sports clubs in the city of 's-Hertogenbosch.

In conclusion, the research tasks of this study were divided in three parts (as displayed in figure 1). First the Health Promoting Sports club standards were translated into Dutch using the back-translation method. Secondly, the translated standards were verified by a panel of experts, following a conventional Delphi technique. Finally, the developed questionnaire was used to assess the current health promoting status of Dutch sports clubs.

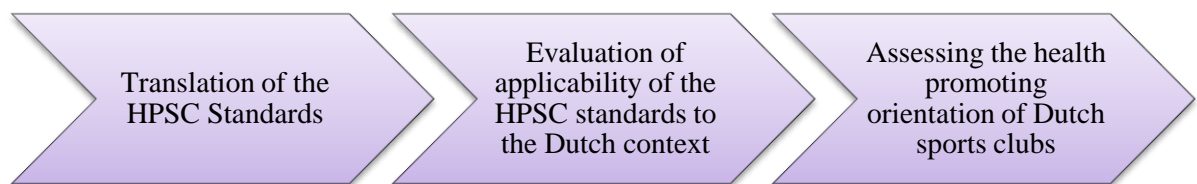


FIGURE 1 Research tasks.

5.1 Translation of the Health Promoting Sports Club Standards

In order to correctly translate an instrument in another language, both the meaning and function should be preserved (Griffie, 2001; Su & Parham, 2002). For this reason, the back-translation method was used to translate the HPSC Index from the source version (English) to the target version (Dutch). Firstly, the HPSC Standards were translated from English into Dutch by a translator who is a native speaker of the target language and has a sufficient level of the source language. Secondly, a second translator, who is a native speaker of the source language and is fluent in the target language, had translated the Dutch translation as proposed by the first translator back to English. The second translator did not have access to the original HPSC Index prior to her task. Therefore, the researcher could compare the product to the original version. In the evaluation of the product, a few differences were noticed compared to the original version. This could have been caused by linguistic or cultural differences between the two translators (Su & Parham, 2002). Therefore, the researcher discussed the differences with both translators slightly modified the translation.

5.2 Evaluation of Suitability and Applicability of the Health Promoting Sports Club Standards to the Dutch Context

After translation of the questionnaire, the standards were evaluated and possibly adapted to fit the Dutch context. Dutch experts on both health promotion and the sports structure and sports clubs in the Netherlands were consulted using the Delphi technique. Via this method, a valid evaluation could be obtained to develop the HPSC Index into an applicable instrument. Figure 2 displays the distinctive steps that were taken to get to the final HPSC standards that would eventually be used to assess the health promotion orientation of sports clubs in the Netherlands.

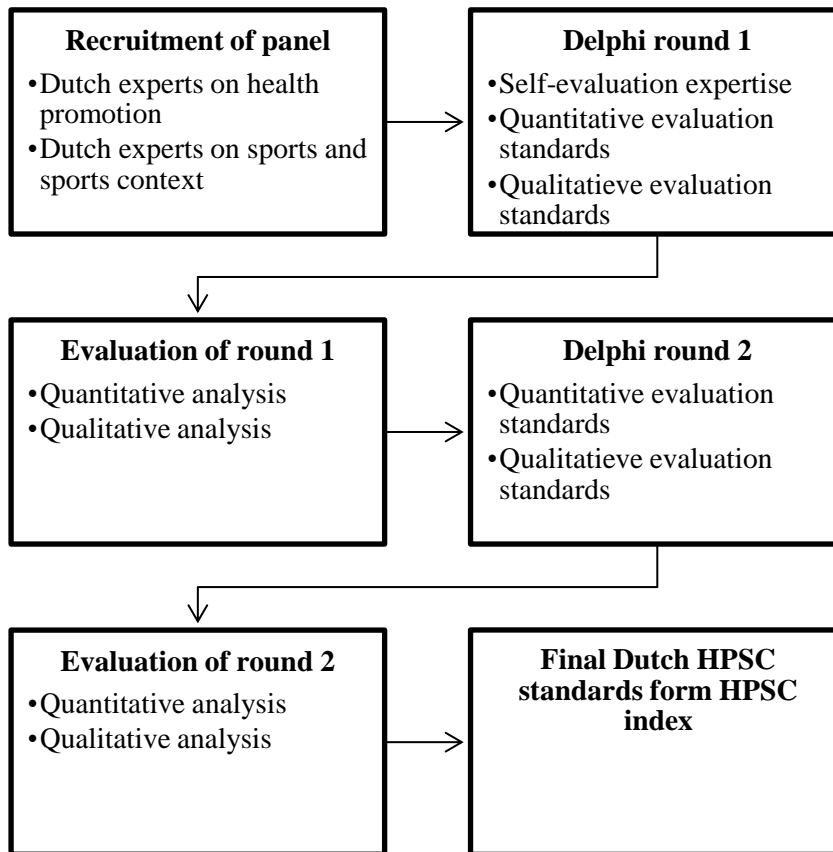


Figure 2. Design of Delphi study.

In order to get insights in the perspectives of both the field of health promotion and the field of sport (clubs), this evaluation included the perspectives of experts on both fields. A Delphi study is a suitable method, since it allows included experts to evaluate and re-evaluate the questionnaire and come to a consensus (Hsu & Sandford, 2007). Using the conventional Delphi-technique allows the experts to anonymously express their opinions and suggestions, without being influenced by other experts. The advantage of the conventional Delphi technique is that multiple interactions are possible with multiple experts and without the need to travel. Furthermore, compared to a real-time Delphi method, the researcher has the flexibility to adjust the process if the circumstances demand this. (Linstone & Turoff, 1975.)

Hsu and Sandford (2007) identified several challenges that come with using the Delphi technique. First of all, the commitment of the experts and a high response rate has to be warranted. This will be aspired from the moment of recruitment by phone and during every round by an e-mail and a reminder. Secondly, molding of opinions might occur when some experts might express their opinions in strong words. Even though reaching consensus is the goal of the Delphi technique, receiving suggestions from all perspectives is important. This can be achieved by selecting qualified experts and by guaranteeing them anonymousness. Finally, there will be a variation between the knowledge and experience of the participants. This also can be managed by a deliberate selection of the experts in the panel. (Hsu & Sandford, 2007; Linstone & Turoff, 1975.)

Using the Delphi study implies that the subjects should be chosen consciously. Furthermore, the method should be carried out in a structured and controlled way. In advance, it was not determined how many rounds were going to be done in this research. However, all rounds started with a questionnaire for the subjects, followed by an evaluation of the responses and finally feedback to the subjects about the results and ideas.

After collecting the responses of all experts, these were evaluated and summarized and the general judgment of the group is assessed by the researcher. Accordingly these first conclusions were sent back to the subjects. This way the panel of experts had the possibility to review each other's opinions and suggestions, and comment on each other. This process could be repeated over as many rounds as needed to reach consensus concerning the standards. For this study two rounds were necessary to come to a final decision on the list of standards.

5.2.1 Selection of Subjects

The literature shows different numbers of a minimum amount of participants in a Delphi study, varying between five and fifty (Linstone and Turoff, 1975). In this study, two fields of expertise are involved: the field of health promotion and the sports sector. Five experts from the field of health promotion and six experts from the sports sector were recruited to form a panel for the Delphi method. Researchers from several organizations, research

institutes and universities were selected, representing different perspectives in the panel. Moreover, three club officials were selected to represent the more practical perspective. The fields of expertise and the relatedness to sport (clubs) and/or health promotion were evaluated before selecting the experts. Furthermore, in the first questionnaire the participants were asked to evaluate their own expertise on health promotion and the sports sector.

During the first round, ten subjects filled out the questionnaire (four sport experts, four health promotion experts and two sports club experts). Of these ten respondents, one dropped out before the second round, but one of the invited experts who was not able to join the first round, filled out the second questionnaire. Therefore, again ten subjects responded (four sport experts, three health promotion experts and three sports club experts). The Delphi panel can be described as a group of higher educated experts, most of whom are a member of a sports club themselves. The majority of the group is female, and the experts are equally spread over the fields of expertise (according to self-evaluation). The average score of the self-rate on expertise, in the range of 1 (none) to 5 (very much), on health promotion was 3.45, whereas the self-rated expertise on sports clubs in the same range was scaled a little lower with an average of 3.36. Table 3 displays the descriptive statistics of the participating experts.

5.2.2 The Process of the Delphi Study

During the first round of the Delphi technique, a questionnaire was sent to all experts to gather their opinion and suggestions about the instrument as translated from the original HPSC Index. The questionnaire was distributed by the software program of MrInterview and it consisted of three parts. In the first part of the questionnaire, general information about the respondents was collected. The second part included the items of the instrument as translated from the HPSC Index in the first part of this thesis project. The items were evaluated on relevance by use of a five-point Likert scale (1: not relevant at all – 5: extremely relevant). After each standard, a possibility was given to explain or comment on the thoughts concerning the standard and the given rating. The last part of the questionnaire consisted open-ended questions. Specifically, the experts were asked to formulate

additional standards that in their opinion should be added to the existing list. Also an opportunity to give general opinions and ideas was given in this part of the questionnaire.

The responses to this first questionnaire were evaluated and summarized by the researcher, after which a second questionnaire was distributed among the experts. This time the (re)defined items and considerations were proposed. The experts were asked to review the summary about the responses of the first round, again by using the five-point Likert scale. Again there was room for comments and suggestions in this round, specifically after each item and in general in a second, open-ended part of the questionnaire.

The analysis of the second round consisted of the evaluation of the agreement and disagreement among the experts on the previously defined items. Based on this analysis, it was concluded that no third round was needed. A final decision was made on modifications of the instruments and the experts were notified that the Delphi study was finished.

5.2.3 Quantitative and Qualitative Analysis

After both rounds, the answers were evaluated by means of mixed methods. The first round provided with an evaluation of the translated instrument using the Likert scale, which was quantitatively analysed with SPSS by the mean and standard deviation of distribution. Furthermore, the suggestions and opinions of the experts were qualitatively evaluated and clustered. After the second round the level of consensus was be determined again by statistical analysis of the Likert scale. Furthermore, the differences between the evaluation of the standards during the first and the second round were analysed.

5.3 Assessing the Health Promotion of Dutch Sports Clubs

Finally, the standards were used to investigate the current orientation of Dutch sports clubs towards health promotion. Therefore, an HPSC Index was developed, containing the standards and additional questions to investigate actual regulations, interventions and other actions that are taken in practice of the investigated sports clubs. The data was obtained from multiple respondents per club, to reflect a realistic view.

To assess the health promotion orientation within Dutch sports clubs, a survey was carried out in cooperation with the municipality of the city 's-Hertogenbosch. This city is with 143.500 inhabitants the 18th largest city in the Netherlands, and has 250 registered sports clubs. The municipality of 's-Hertogenbosch is very much sports oriented, and leading in the development of sport and recreation in the city, and therefore is a good partner for this research. The city got rewarded as Elite Sport City of the Year in 2007, National Sport City of the Year in 2010, European City of Sports in 2011 and The European Capital of Sports 2012. Furthermore, the city of 's-Hertogenbosch has a large population of a diversity of sports clubs that can be evaluated on their current health promotion orientation.

Before the actual survey, a pilot was held among three sports clubs. The respondents of this pilot evaluated whether the survey is clear to them and user-friendly. After the pilot, some small adaptations were made before starting the survey.

5.3.1 Respondents

Of the 250 sports clubs in the data base of the department of Sport and Recreation from the local government of 's-Hertogenbosch, 160 sports clubs in the city of 's-Hertogenbosch were approached to participate in this part of the study. The selected clubs were considered to be active in cooperation with and involvement in the local sports sector (e.g. the municipality, other sports clubs or other organizations). The invitation was developed in cooperation with the municipality of 's-Hertogenbosch in the form of an email, and was written in an accessible and informal way that had a low threshold for sport clubs to react and sign up. In the invitation the purpose of the study was described, as well as the procedure of participation. After two weeks, a reminder was sent to the contact persons, and during other activities some of the clubs were approached in person.

After a recruitment period of 8 weeks, 24 sports clubs had applied for participation. One of these was a private Fitness and Wellness Club, which was profit-seeking and not based on voluntarism, and therefore excluded from the study. One other club withdrew from participation. The contact persons of the other 22 sports clubs were sent a general questionnaire on background information of the club, and asked for details of the

representatives of the club that would fill out the main questionnaire. Of the 22 contacted clubs, 17 clubs were represented by respondents in the assessment of the health promotion orientation and were included in the study.

Because a realistic overview of the current situation within the sports clubs was desired, both club officials and coaches or trainers from each participating sports club were asked to fill out the questionnaire. The club officials were defined as being officially assigned to responsibilities of the development of policy or the practical execution of policies. Both the club officials and coaches should have been working for the club for at least two years. Of the 17 participating clubs a total of 45 respondents filled out the questionnaire, of whom 3 were coaches/trainers. Because they were such a small number, they were excluded from the study to secure a more homogenous respondent group of 42 club officials (1-6 per club).

5.3.2 Data Collection

Three different questionnaires were developed: for the contact person of the clubs, for club officials and for trainers/coaches. The questionnaire for the contact persons consisted of two parts. The first part contained general questions to identify characteristics about the sports club in question, such as the size, amount of volunteers, the membership of an umbrella organization, the sport discipline(s), the accommodation and the cafeteria. The second part investigated the need for support from the municipality (this part is of interest for the department of Sport and Recreation, not for this research). The questionnaires for both the club officials and the trainers/coaches consisted of a part on the characteristics of the respondents, like gender, age, education, position in the club and duration of membership. The second part consisted on questions about their perceptions on to what extend the HPSC standards describe their club in the current season. The third part had items on their perceptions on the need of their club for support on several topics. Finally, the club officials were asked to rate the importance of their sports club to devote attention to health promotion on a scale from 1 (not important at all) to 10 (extremely important). The recruited participants were asked to fill out the questionnaire in the autumn of 2013.

The questionnaires were web-based and sent to the participants using the software of MrInterview. The data was directly collected in SPSS, which is linked to MrInterview.

5.3.3 Analysis

The data was analysed by the means of SPSS. For the characteristics on both the respondents and clubs, descriptive analysis was used, including the means and standard deviations. Furthermore, for the sample size of this study was too small to do an exploratory factor analysis on this data, the reliability of the sub-indices as determined by Kokko et al. (2009) was statistically tested to determine the division of the modified and added standards. Thereafter, the responses of the 42 respondents were converted into mean scores per club. These averages were then reduced to a two-point scale, in order to deduce the index to a score ranging from 0 to 23. For this scale, clubs that scored higher than 3 (describes my club fairly) on an item were considered enough oriented to this standard, and were therefore given a one, whereas scores of 3 and lower were converted to a zero. These values were then used to determine the scores of the clubs on the separate standards, as well as on the sub-indices and the HPSC index. The range of the HPSC index is therefore 0-23.00, the policy sub-index 0-8.00, the environment index 0-6.00, the practice index 0-7.00, and the ideology index 0-2.00.

The clubs were divided into three categories of health promoting orientation, based on the categorization by Kokko et al. (2009). They were considered highly oriented towards health promotion on the HPSC index or the sub-indices at a score higher than 16.68. Clubs that scored from 11.50 to 16.68 were considered fairly oriented towards health promotion, whereas scores below 11.50 were considered low oriented towards health promotion. Table 2 displays the categories of health promoting orientation with the corresponding values for the main index as well as the sub-indices.

Table 2. Categories of health promotion orientation.

Index	Scores for low health promotion orientation	Scores for fair health promotion orientation	Scores for high health promotion orientation
Policy Index	Score < 4.18	$4.18 \leq \text{Score} \leq 5.75$	Score > 5.75
Environment Index	Score < 2.61	$2.61 \leq \text{Score} \leq 3.66$	Score > 3.66
Practice Index	Score < 3.66	$3.66 \leq \text{Score} \leq 4.76$	Score > 4.76
Ideology Index	Score < 1.05	$1.05 \leq \text{Score} \leq 1.57$	Score > 1.57
HPSC Index	Score < 11.50	$11.50 \leq \text{Score} \leq 16.68$	Score > 16.68

6. RESULTS

6.1 The Output of the Delphi Study: 23 HPSC Standards for the Dutch Context

During the first round the standards were evaluated on their relevance varying from 2.70 to 4.3, with an average of 3.67. The qualitative suggestions and opinions of the experts were evaluated and twelve standards were adapted based on the conclusions. Furthermore, one standard was added to the original list. After the second questionnaire, which included the 23 reformulated standards, all items had a score on relevance from 3.0 to 4.6 with an average of 3.83. Only the second standard showed a significant increase in relevance after reformulating it. Furthermore, the added standard scored 4.20, which confirmed the relevance of this item. The quantitative evaluation of the standards is displayed in table 4.

The 23 listed standards formed the Health Promoting Sports Club Index in the Dutch context. After the classification of Kokko et al. (2009), the standards were divided in four sub-indices: policy, environment, practice and ideology. The added standard concerns the availability of healthy alternatives in the sports cafeteria, which should be placed in the sub-index of environment according to qualitative evaluation. Moreover, the reliability analysis confirms this conclusion quantitatively (see table 3).

Table 3. Quantitative allocation of the added standard

(Sub)Index	Cronbach's alfa without standard 23	Cronbach's alfa with standard 23
Policy	0.792	0.778
Environment	0.404	0.467
Ideology	0.629	0.371
Practice	0.834	0.766
HPSC	0.879	0.871

Table 4. Quantitative evaluation of the relevance of the translated standards by the Delphi panel.

Standard	Round 1 (n=10)*		Round 2 (n=10)*		Absolute differences in mean
	Mean (1-5)	SD	Mean (1-5)	SD	
1	3.70	1.160	3.60	0.843	-.10
2	3.30	1.494	4.20	0.789	.90**
3	4.00	1.054	3.70	0.823	-.30
4	4.20	1.317	3.70	1.059	-.50
5	3.80	1.229	3.70	0.949	-.10
6	4.00	1.155	3.70	1.059	-.30
7	4.00	0.943	4.00	0.943	.00
8	4.30	0.823	3.90	1.287	-.40
9	4.70	0.483	4.50	0.707	-.20
10	3.10	1.197	3.30	0.949	.20
11	3.80	1.033	3.70	1.059	-.10
12	4.10	0.994	4.60	0.516	.50
13	3.30	1.059	4.20	0.789	.90
14	3.00	0.943	3.30	1.337	.30
15	3.40	1.265	3.80	1.135	.40
16	3.40	0.699	3.20	1.135	-.20
17	3.10	1.101	3.40	1.174	.30
18	3.40	1.578	3.80	1.033	.40
19	4.10	1.287	3.60	1.265	-.50
20	3.90	1.370	4.50	0.707	.60
21	3.50	0.707	3.80	1.033	.30
22	2.70	1.252	3.00	1.155	.30
23			4.20	1.317	

*During the first round the number of participants was 10; one expert didn't fill out the questionnaire. During the second round, one expert has dropped out, but the missing participant did answer the questionnaire this time.

**The mean score on relevance of this standard was significantly higher during the second round than during of the first round.

6.2 The Outcome of the Survey: Current Health Promotion Orientation of Dutch Sports Clubs

The clubs were represented by 42 club officials (1-6 per club), of whom the characteristics are described in table 5. Amongst these officials, 24 were board members, eight had a role in a committee and ten respondents were acting as another kind of coordinator, responsible for, for example, youth coordination or competition coordination. 83% of the respondents were male, and 71% had a high educational degree, from a university of applied sciences or a university. Furthermore, almost 75% of the respondents had the role of club official for over 4 years.

Table 5. Characteristics of the respondents of the Delphi study and the club survey.

Delphi panel			Club officials		
	n	%		n	%
Gender			Gender		
Male	4	36	Male	35	83
Female	7	63	Female	7	17
Education			Education		
Lower General Secondary Education	0	0	Lower General Secondary Education	1	2
Higher general Secondary Education/Vocational Education	0	0	Higher general Secondary Education/Vocational Education	11	26
Polytechnic/University	11	100	Polytechnic/University	30	71
Member of sports club			Member of sports club		
Yes	9	82	0-5 years	8	19
No	1	9	5-10 years	8	19
Not anymore	1	9	More than 10 years	26	62
Expertise			Function		
Health or health promotion	4	36	Boardmember	24	57
Sports and sports clubs	4	36	Member of committee	8	19
Both	3	27	Other	10	24

Of the seventeen included sports clubs, sixteen filled out the questionnaires concerning the background information on the clubs. This background information is summarized in table 6. Of these sixteen, 75% offer only one discipline and are so-called specialized sports clubs. In this study, thirteen of the clubs are considered to be large clubs with more than 250 members, one club is small with less than 100 members, and two clubs are of average size with 100-250 members. Six of the clubs are an indoor club, whereas nine clubs offer outdoor sports, and one club has both indoor and outdoor sports to offer. Also, eight clubs offer individual sports, whereas fifteen clubs offer team sport.

On an organizational note, all but one of the clubs have a significant amount of volunteers, varying from 25 to 500. Furthermore, fifteen clubs are member of a sport federation, and five are member of an umbrella organization. One of the sixteen clubs is no member of any kind of umbrella organization. Nine of the sixteen clubs have their own accommodation, one of which shares the accommodation with other sport club(s). Moreover, 75% of the

clubs have their own (shared) cafeteria, of which only two do not manage the cafeteria themselves.

Table 6. Descriptives of the sports clubs (n=17, 1 missing).

	n	%
Disciplines		
One sports discipline	12	71
Multiple sports disciplines	4	24
Indoor or outdoor sports		
Indoor	6	35
Outdoor	9	53
Indoor and outdoor	1	6
Indoor and outdoor sports	1	6
Individual, duo or team sport		
Individual	8	47
Duo	2	12
Team	15	88
Size		
Large club (>250)	13	77
Medium club (100-249)	2	12
Small club (<100)	1	6
Member of umbrella organization and or sports federation		
Umbrella organization	1	6
Sports federation	11	65
Umbrella organization and sports federation	4	24
Facilities		
Own facilities	8	47
Own facilities shared with other sport club(s)	1	6
No own facilities	7	41
Cafeteria		
Own cafeteria	11	65
Own cafeteria shared with other sport club(s)	1	6
No own cafeteria	4	24
• Own management of cafeteria	10	59

Table 7 displays the average scores of the seventeen participating sports clubs on the 23 individual standards, the HPSC index and the four sub-indices. The clubs scored an average HPSC score of 9.00 ± 4.36 (39% of the maximum score of 23.00). The average score on the policy index was 2.59 ± 2.03 , which is 32% of the maximum of 8, on the environment index the average was 2.53 ± 1.33 out of (42% of the scale 0-6), and on the practice index the clubs scored an average of 1.94 ± 1.71 (club scored 28% of the maximum range to 7).

Table 7. Index scores (n=17).

Standard and Index	Mean	StdDev
1. The sports club's regulations include a written section on well-being and/or health promotion and / or health education and / or healthy lifestyle.	0.06	0.24
2. The sports club's regulations include a written section on substance abuse.	0.24	0.44
3. Health and well-being viewpoints are observed in the sports club's decision-making process.	0.71	0.47
4. The sports club supervises the implementation and functionality of its regulations.	0.59	0.51
5. The sports club's health promotion activities and / or state of well-being are evaluated in the annual report.	0.06	0.24
6. The sports club collaborates with other sports clubs and / or health professionals on health issues such as nutrition, education or injury prevention.	0.12	0.33
10. The sports club assures that its sub-groups have agreed regulations and practices.	0.53	0.51
13. Health promotion is part of the coaching practice.	0.29	0.47
<i>Policy Index (0-8)</i>	<i>2.59</i>	<i>2.03</i>
7. The sports club assumes its share of responsibility for a safe sports environment, e.g., reviews the sports environment yearly (in co-operation with the proprietor).	0.41	0.51
8. The sports club provides a sports environment that is free of intoxicants during junior activities (the facility that is mainly used).	0.35	0.49
9. Coaches and other officials give a good example through their own behaviour to children and adolescents.	0.77	0.44
12. Possible conflicts (e.g., bullying) are monitored, solved and dealt with.	0.82	0.39
14. In coaching, there is a health promoting element also beyond sports performance (within the sports club's activities).	0.12	0.33
23. The sports club offers healthy alternatives in the range of products in the sports cafeteria.	0.06	0.24
<i>Environment Index (0-6)</i>	<i>2.53</i>	<i>1.33</i>
19. The sports club promotes the 'everyone plays' ideology and the 'everybody can participate' ideology (in other words: everybody who wants to join the clubs is allowed / welcome).	0.94	0.24
20. The sports club promotes the 'fair play' ideology (among others: other people and the regulations of the sport are respected and violence is prevented).	1.00	0.00
<i>Ideology Index (0-2)</i>	<i>1.94</i>	<i>0.24</i>

11. The sports club discusses its regulations with the Executive Committee, coaches and parents at regular intervals (at least once a year).	0.35	0.49
15. The sports club pays particular attention to coaches' / instructors' interaction skills.	0.35	0.49
16. The sports club provides education on health issues (such as nutrition or substance use prevention) or makes provisions for its members to receive such education.	0.06	0.24
17. The sports club assures that health education (education of youth towards a sporty lifestyle) is carried out.	0.00	0.00
18. The sports club promotes individual growth and development.	0.53	0.51
21. Sports injuries are comprehensively prevented and dealt with (including, e.g., the psychological effect of an injury on an adolescent). In other words: done so that together with offering support on the physical injury also mental and social support is offered (injured youth is asked to join the activities during rehabilitation time).	0.41	0.51
22. The sports club reviews and communicates the treatment policies in case of a sports injury.	0.24	0.44
<i>Practice Index (0-7)</i>	<i>1.94</i>	<i>1.71</i>
HPSC Index (0-23)	9.00	4.36

The score on the ideology index was high with an average score of 1.94 ± 0.24 (97% of the maximum score of 2). The scores of the clubs on the HPSC index and the sub-indices are visualized in figure 3. As displayed in table 8, eleven clubs were categorized as low orientated to health promotion, whereas four clubs scored fairly and two clubs scored high on the overall index. On all sub-indices but the ideology index, the majority of the clubs scored low as well: sixteen clubs were categorized as highly oriented to ideology index.

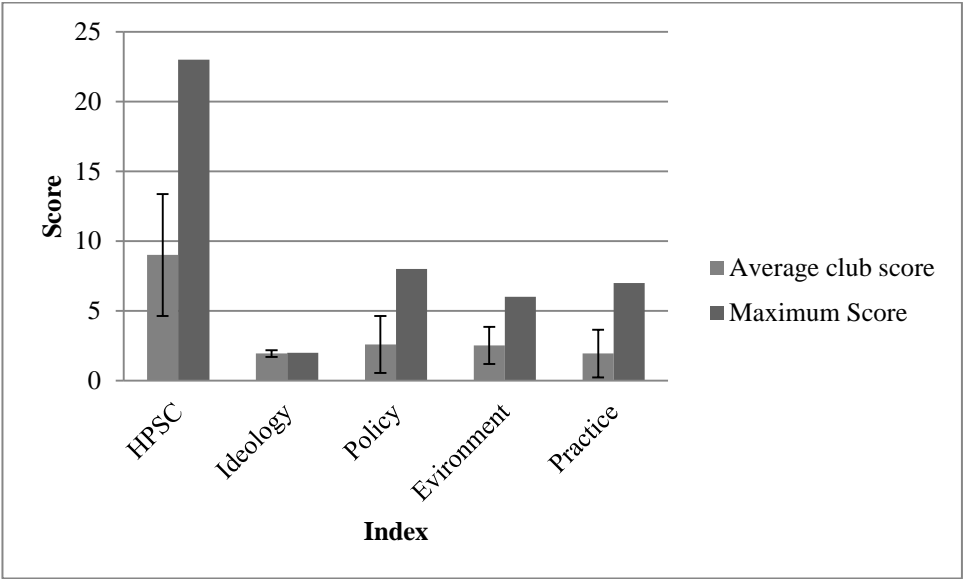


Figure 3. Average scores on HPSC index and sub-indices.

Table 8. Categorization of the clubs as low, fair and high oriented to health promotion.

Index	Low health promotion orientation	Fair health promotion orientation	High health promotion orientation
Policy	15	1	1
Environment	10	3	4
Practice	14	2	1
Ideology	0	1	16
HPSC	11	4	2

Furthermore, the opinion of the club officials on the relevance of their clubs’ role in health promotion was asked. 38 of the 42 respondents have rated the importance of their sports club to pay attention to health promotion on a scale from 1 (completely unimportant) to 10

(very important). The average score was 7.08 ± 1.50 , with 89.5% of the respondents rating the importance a 6 or higher.

Finally, table 9 displays the percentages of the participating sports clubs that were interested in support from the local government on topics that were included in the questionnaire. All clubs showed interest in support on multiple topics, the main emphasis on development of coaches, volunteers, board members and parents. Education on health topics such as diet, injury prevention, healthy cafeteria and alcohol/drug abuse were selected a little less, but still the majority of the clubs are interested in help with this as well. Information on fair play was selected by one-third of the clubs, and one club suggested another topic for support: recruitment of members.

Table 9. Interest of clubs in support from local government.

Topic	Interested clubs
Positive coaching for trainers/coaches	88.24%
Talent development (potential) volunteers	82.35%
Administering the club	76.47%
Parental involvement/participation	76.47%
Sharing knowledge with other sports clubs	70.59%
Sporty diet/healthy lifestyle	70.59%
Injury prevention	64.71%
Involvement in the community/neighbourhood	64.71%
The healthy sports cafeteria	64.71%
Parents on the side-line	58.82%
Alcohol/drug abuse and the policy	52.94%
Fair play: respect & sportsmanship	35.29%
Other: recruitment of members	5.88%

7. DISCUSSION

In order to conduct this study, two tasks were fulfilled preceding the assessment of the health promoting orientation of Dutch sports clubs. Firstly, the translation of the HPSC standards into Dutch through the back-translation method was confirmed by the translators to be effective and resulted in a valid and unambiguous product. Secondly, the applicability of the HPSC standards to the Dutch context was successfully evaluated by using the Delphi study. The relevance of all the standards as developed by Kokko and colleagues was confirmed, and the translation was validated by the panel to be clear and unambiguous. Furthermore, an extra standard was added to the original list, concerning healthy products in the sports cafeteria. Later on in the process, this standard was evaluated to be highly relevant and therefore a good addition to the original list of standards. This is in line with previous research by Kelly et al. (2010), which suggested that healthy eating has an important role in the general health promotion in sports clubs and should be included in both policy and environmental organization of the sports club. This translated and validated list of standards could now be used to conduct an exploratory study among Dutch sports clubs.

In the analysis of the results based on the evaluation of the responses of the club officials, more than three-quarters of the participating sports clubs scored low on the HPSC index, and the average score was also considered to be low. However, the sports clubs score high on the ideology sub-index, suggesting that ideology of the clubs is highly oriented to high inclusion in participation and highly valued fair play. These results correspond with studies in Finland and France (Kokko et al., 2009; VanHoye et al., 2014), Both on the standard concerning 'fair play' ideology, on the ideology of the ability for everyone to play and participate the average club score was very high (1.00 and 0.94 respectively). However, the participating clubs scored low on the other sub-indices. The second highest scoring sub-index was, also conform the Finnish and French findings, the environmental conditions of the sports clubs. Yet the Dutch sports clubs still scored to be low on the environmental sub-index, whereas Finnish sports clubs were considered to be a fairly healthy environment (Kokko et al., 2009) and French clubs even highly positively oriented towards health promotion in terms of environment activities (VanHoye et al., 2014). Finally, again in line

with the Finnish and French sports clubs, the scores on the sub-indices of both practices and policies were considered to be low. Comparing the ideology sub-indices to the other sub-indices, it can be argued that there seems to be a gap between the ideology and the actual output of the clubs.

Furthermore, within the policy and environment index, the variation between the standards is large. In the policy index, especially the standards containing concrete and objective measures, such as an annual report or a written section score very poorly. The more subjectively measurable standards, containing verbs as to supervise or to observe, are rated significantly higher. Within the practice sub-index, all of the included standards were rated to be describing the participating sports clubs to a very low degree, resulting in the lowest score of the sub-indices.

It is noteworthy that the majority of the clubs also do not seem to need support on the theme of fair play, confirming the high score on the ideology sub-index, and that this theme is already well-developed within the clubs. These results are in correspondence with the evaluation of the original Finnish HPSC standards by Kokko et al. (2009). However, to increase the score on the general HPSC index and to be considered a highly health-promoting sports club, Dutch sports clubs still have plenty of room to improve on the other sub-indices. As concluded in the systematic review by Geidne et al. (2013), an all-around approach to the policies, strategies, environment and ideologies is needed to become a health-promoting setting. The score of 7.08 on the opinions of the respondents for their club to pay attention to health promotion suggests that the room for improvement in the clubs actually would be supported by the club officials, and therefore offers potential to develop the concept of health promoting sports clubs in the Netherlands. This conclusion corresponds to the research conducted by VanHoye et al. (2014) on the coaches' perspective of their clubs as a setting for health promotion, which concluded that health promotion is an aim for sport clubs.

The high interest of the sports clubs in support on positive coaching, injury prevention, healthy sports cafeterias and a sporty diet/healthy lifestyle confirms the willingness of club

officials for their clubs to play a role in health promotion. Furthermore, the wish to develop the potential of volunteers, to increase the parental involvement, to share knowledge with other sports clubs and to increase the involvement in the community/neighborhood suggests that this setting should be considered in the development of the inter-sectoral approach in health promotion.

7.1 Limitations of the study

The leading position of the city of 's-Hertogenbosch in the development of sports may misrepresent the average municipality in the Netherlands. This should be considered when interpreting these first results. Moreover, the exploratory nature of this study limited the amount of participating sports clubs. Therefore it is not possible to extrapolate the results to the Dutch sports clubs in general, or even to all clubs of the city of 's-Hertogenbosch. The limited amount of participating clubs also limited the possibility to draw conclusions on the relation between the club characteristics and the results. For example the size of the sports club, the nature of the sport (team or individual), the possession of or managing an own accommodation/cafeteria, or the membership of umbrella organization could influence the orientation of the club towards health promotion.

Another aspect that should be considered when interpreting the results of this study is the fact that the representatives of the clubs were all club officials, and had therefore all a similar perspective. For example the perspective of trainers/coaches, athletes, or parents could shine another light on the actual health promotion orientation of Dutch sports clubs. Kokko et al. found that the club officials rated the health promoting orientation of their clubs significantly higher than the trainers/coaches (Kokko et al., 2010). Possibly the Dutch club officials also sketched a not complete overview of the reality of their clubs. This suggests that considering multiple perspectives within a club will result in a more correct overview of the actual situation in the clubs.

8. CONCLUSIONS AND IMPLICATIONS

This exploratory study showed the applicability of the HPSC standards in the Dutch sports context on the grass-root level. Future research should be conducted to extend on the knowledge about the current situation and the development of the concept of health promoting sports clubs. Firstly, a larger study or research on specific sports can give more insight in the current situation. Moreover, valid generalizations can be made and used to expose strengths, weaknesses, opportunities and threats in the potential of Dutch sports clubs. Comparing the results of this research to the Finnish outcomes of a similar study using the HPSC standards is also restricted because of the limited amount of participating clubs. However, this also is an interesting implication for further research on the comparison between those and other countries which have a similar position and role for sports clubs on the grass-root level of sports.

Secondly, even though the participating club officials showed some orientation towards health promotion within their clubs, there is much room for improvement. To fulfil the potential of the Dutch sports clubs as a setting for health promotion, and with that contribute to the health behaviours of individuals, a practical tool can be developed based on the translated and adapted standards and on the already developed guidelines in Finland (Kokko, 2014). In the development of health promoting sports clubs in the Netherlands, the current gap between the ideology and the actual output of the clubs should be considered.

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