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A REVIEW OF SETTINGS-BASED HEALTH PROMOTION WITH APPLICATIONS TO SPORTS CLUBS

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Running title: Settings approaches applied to sports clubs

SUMMARY
Sports clubs have a long and traditional history in many countries, yet they remain underdeveloped and underutilized settings for health promotion. Leisure time settings, in general, have been in minor role among settings-based health promotion initiatives. Current health concerns in western countries, such as sedentary lifestyles and obesity, have aroused a need to expand health promotion to include also settings with greater potential to reach and engage children and adolescents in more vigorous activity. To develop these alternative, most often non-institutional, settings to the level of the established ones, it is important to review what has been done, what has been accepted, and what is known from research, theory and practice to have contributed to health. Given that settings approaches have been implemented with diverse scope and without close cooperation between different initiatives, the first aim of this paper is, on the basis of a review of commonly used theories and practices, to propose a mutual definition for the settings approach to health promotion. The second is to examine the applicability of the theoretical basis to youth sports club settings. Sports clubs are used as a reflective setting when reviewing the traditional ones.

Key words: Health Promoting Sports Club; Review; Settings approach; Ecological models

INTRODUCTION
This paper seeks to examine the applicability of settings-based health promotion approaches to youth sports clubs. This is achieved by reviewing the fundamentals of the settings approach and current concepts and practices of the traditional initiatives, and by considering the fit of these with sports clubs. Some critical notions and targets for development are highlighted for the application of the settings approach to health promotion with sports clubs.

Central to health promotion, the concept of setting[1] delineates boundaries conceptually for the understanding of context. Context, in turn, is central to ecological approaches in health promotion and public health, where peoples' health-related opportunities and behaviors can be supported through organizational policies and environmental changes (Golden & Earp, 2012; Kok et al, 2008; Richard et al., 2011). Settings also represent a fundamental aspect of practice, recognizing the particular needs and

[1] We have sought to update a previous book chapter of Green, Poland and Rootman "The Settings Approach to Health Promotion" (Green et al., 2000) without repeating it. Readers are referred there for the pre-2000 citations. This paper also reflects parts of the doctoral dissertation of Sami Kokko "Health Promoting Sports Club – Youth sports clubs' health promotion profiles, guidance, and associated coaching practice, in Finland" (Kokko, 2010).

living (working, schooling, recreational) circumstances of a program's or policy's potential beneficiaries (Green et al. 2000). Settings define the audience of intervention (individually, collectively and organizationally), and the channels for predisposing, enabling and reinforcing their health-related behavior. Settings also define the position of health promotion relative to the core-business of the setting in question, which shapes the incentives required to assure the cooperation of the setting (Kokko 2010). The setting itself, in most cases, is also framed as a target of intervention, and community-wide programs usually involve multiple and varied settings (Poland et al. 2009). Most health promotion activity is bounded in space and time within settings that provide the social structure and context, i.e., setting-specific features for planning, implementing and evaluating health promotion. Community-wide health promotion programs and policies usually require the coordination of multiple settings within and across sectors.

The settings approach, therefore, has become one of the fundamental international foundations of health promotion. It had earlier national and local precedents in the organization of health promotion staffing in regional, federal, state and local health department offices, with school health (Green and Iverson, 1982; Loureiro, 2004), worksite health (Joint Committee of the Health Enhancement Research Organization, American College of Occupational and Environmental Medicine, American Cancer Society et al., 2012), and community health sections or units (Green, 1978, 1979; Green, McGinnis, Phillips et al., 1981). Such setting-based initiatives have diffused across countries, continents or even worldwide (WHO, 2012) and several new ones, like beauty salons (Linnan and Ferguson, 2007), farms (Thurston and Blundell-Gosselin, 2005), sports clubs (Dobbinson and Hayman, 2002; Dobbinson et al., 2006; Kelly et al., 2010, 2011; Kokko, 2005, 2010; Kokko et al., 2006; 2009, 2011) and/or organizations (Casey, 2011; Casey et al., 2009; Geidne, 2012; Geidne et al., 2013), sports arena/stadia (Drygas et al., 2011; Ratinckx and Crabb, 2005) have been established. The very development of "a competency-based pan-European Accreditation Framework for Health Promotion" has involved a "consultation process…grounded in the current practice context" (Battle-Kirk et al., 2012, p.675).

With the proliferation of settings initiatives, the search accelerates for commonalities across settings to produce a conceptual understanding of the settings approach. Yet, from the latest reviews of various applications of ecological approaches in settings initiatives (Kok et al., 2008; Richard et al., 2011; Golden and Earp, 2012) and commentaries by Mark Dooris based on reviews and interviews of a selected group of individuals who led the development of settings concepts, programs and polices in health promotion (Dooris, 2006a; 2013), it appears that the health promotion field still lacks a common understanding of the settings approach. Wide variation in the delineation of the concept of health promoting setting precludes an all-embracing definition that suits the full range of settings. Thus, the paper aims, first, to propose a mutual conceptualization for the settings-based health promotion approach, based on a review of commonly used theories and practices; and second, to examine the applicability of the theoretical basis of the approach to sports club setting. Through this reflection some critical issues and improvement targets are suggested.

SETTINGS-BASED HEALTH PROMOTION FROM PAST TO PRESENT

Even before the broad use of the term health promotion and its development as a field within public health, the idea of health promotion had many precedents (Green and Ottoson, 1999, pp.7-18). Winslow (Winslow, 1920) characterized early 20th century community health practice as the "science and art of preventing disease, prolonging life, and promoting health and well-being through organized community effort…" [and] "…the development of the social machinery to assure everyone a standard of living adequate for the maintenance or improvement of health." Thus, community health practice

was seen to encompass health promotion along with health services and environmental protection, but it was setting-focused with community as the setting.

The rise of modern health promotion as an organized, distinct field in public health practice can be traced to many of the community-oriented efforts of public health education in the U.S. and some other countries (Green and Allegrante, 2012), but it took momentum in 1974 from the Lalonde report[2] (Glanz et al., 2002; Tones and Green, 2004). Marc Lalonde (Lalonde, 1974), the Canadian Minister of Health and Welfare, released a monograph titled *A New Perspective on the Health of Canadians*. The report was the first national government policy document that identified health promotion as a key strategy for improving the health of a population. This report also had an extensive international influence, including the passage in 1976 in the United States of the Health Information and Health Promotion Act (Viseltear,1976) and similar later initiatives in other countries such as Australia (Commonwealth Department of Health, Housing, and Community Services, 1993), and the international Ottawa Charter for Health Promotion (WHO, 1986). Despite the Lalonde report's emphasis on peoples' lifestyle factors, it set seeds for a shift from traditional biomedical-epidemiological illness-centered perspective towards wider recognition of social and environmental determinants of health inherent in settings (Kickbush, 2003; Tones and Green, 2004).

In addition to these pragmatic aspects of the focus on settings, and the legitimating rhetoric of the Ottawa Charter, a key factor behind the increased theoretical and strategic interest in the settings approach has been the ecological perspective of health promotion, demanding that individuals not to be treated in isolation from the larger social units in which they lived, worked, and played. The 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. The ecological perspective gained respectability and voice in health promotion, where it had been viewed largely with intellectual interest in earlier generations of health professionals addressing similarly complex problems with social and environmental determinants (Green, Richard and Potvin, 1996).

Health promotion is relatively young; ecology is not. Ecological perspectives have influenced health promotion through several streams of thought and action, and influenced public health education and, public health before that. These disciplines converged with various social and behavioral sciences and other professional perspectives to form the ecological and behavioral foundations of health promotion (Green, Richard and Potvin, 1996). These, in turn, form the foundation of the settings approach to health promotion practice (Poland et al., 2000).

Another important fundamental in modern health promotion alongside the settings approach has been the increased awareness of the health-end of the health-disease continuum i.e. salutogenic approach (Kickbusch, 2003; Lindström and Eriksson 2006). Peoples' health-related resources, rather than risk-factors for certain disease, have arisen in focus. This, in turn, has stressed peoples' empowerment and sense of coherence (SOC) (Lindström and Eriksson 2010). The latter represent resources and their utilization beyond oneself, "…to change or cope with the environment" as the Ottawa Charter (WHO, 1986, p.1) defined them and introduced the settings approach at the beginning of the document.

[2] This is commonly and respectfully referred to as the "Lalonde Report," although it was based conceptually on the Health Field concept introduced a year earlier by Lalonde's deputy, Laframboise (Laframboise, 1973).

The Ottawa Charter identified "creating supportive environments" as one of five key strategies for health promotion (WHO, 1986). The rationale given for this and other strategies directed at environments in which health is (and lifestyles are) created and sustained, provided support for the settings approach. The argument for "healthy public policies," for example, arose from the realization that many of the settings-based determinants of health need support beyond the health sector. Policy makers from other sectors are needed to reach people in the variety of settings in which their health is influenced. Thus, efforts with the line of this have been conducted, Health in All Policies in Europe, as an example (Ståhl et al., 2006).

Several charters or statements on health promotion have followed from successive international conferences on health promotion, though the Ottawa Charter has remained the touchstone, the others refining its details (de Leeuw et al., 2006; 2011). Today, it seems evident, that the position of the settings approach has strengthened. The International Union for Health Promotion and Education together with Canadian Consortium of Health Promotion Research released their statement at the end of their Vancouver 2007 global conference, stating that:

> "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" (IUHPE and CCHPR, 2007 p.3).

At the same time they argued, "…the reach of settings-based health promotion should be greatly expanded." (IUHPE and CCHPR, 2007 p.4)

The statement elevates settings-based thinking about the contexts in which health promotion should target its actions. Health promotion's diminished focus on individuals does not mean that individuals are ignored; individuals' behaviors and decision-making processes remain ultimate factors concerning their health, but the emphasis is clearly on settings and ecological factors that shape, limit or enhance those behaviors and decisions.

STUDY DESIGN AND METHODS

The need for this review arose when a health promoting sports club concept was constructed (starting in 2004, see more from Kokko 2005). The previous models did not appear in the sports club setting. To find parallels or opportunities for sports club applications, it was necessary to review other initiatives as well as overall fundamentals of the settings approach. When various settings initiatives were explored, it became clear that the most of the academic papers concentrated on one particular setting and the literature offered few cross-setting conceptualizations. Therefore, this reflective review attempts to propose a mutual conceptualization for the settings approach to health promotion, based on a review of commonly used theories and practices. In addition, the applicability of the theoretical basis of the settings approach to the sports club was examined.

More specific questions for this review are: (i) What are the determinants shaping the settings-based health promotion approach? ii) Are there shared characteristics among settings initiatives and could a mutual understanding of the concepts under the settings approach be found? (iii) What is the relationship between settings? (iv) Given the growing importance of obesity and physical activity, we have selected sports clubs as a case to ask prospectively how might an emerging setting for health

promotion build on the experience from other settings. Sports club setting is used as a reflective setting under the questions i-iii.

This reflective review is based on two previous publications of the authors (Green et al. 2000 and Kokko 2010). To update the materials of preceding papers a search for recent academic papers on settings-based health promotion (years 2002-2012) was conducted in April-May 2012 from databases of Medline (Ovid), Medic, PubMed (Medline), Springer Link, Science Direct (Elsevier) and Electronic Journals Service (EBSCO). Each database was searched with the following key words: healthy setting, health promoting setting, and in combination with approach, setting (and settings) and health promotion. This is not a systematic review. Instead, from a wide number of papers found, researchers selected the most relevant ones discretionarily. These papers were fully examined and are used in combination with the references in initial papers in the finding of this paper.

FINDINGS

Determinants of the settings-based health promotion

The statement from the Vancouver conference highlighted people's cultural, social, economic and environmental living conditions as main determinants of health. But what are these determinants within settings, or when considering settings-based work? We offer an example of the settings-based factors among cultural, social, economic and environmental factors from a study of sports club setting (Figure 1). This has analogy to the framework of Poland et al. (Poland et al., 2009) for intervention planning and implementation. The individual-based factors that create the ecological reciprocity between behavior and environment within a setting are dependent on the setting in question, because each setting is unique by construction and history in a particular time and place.

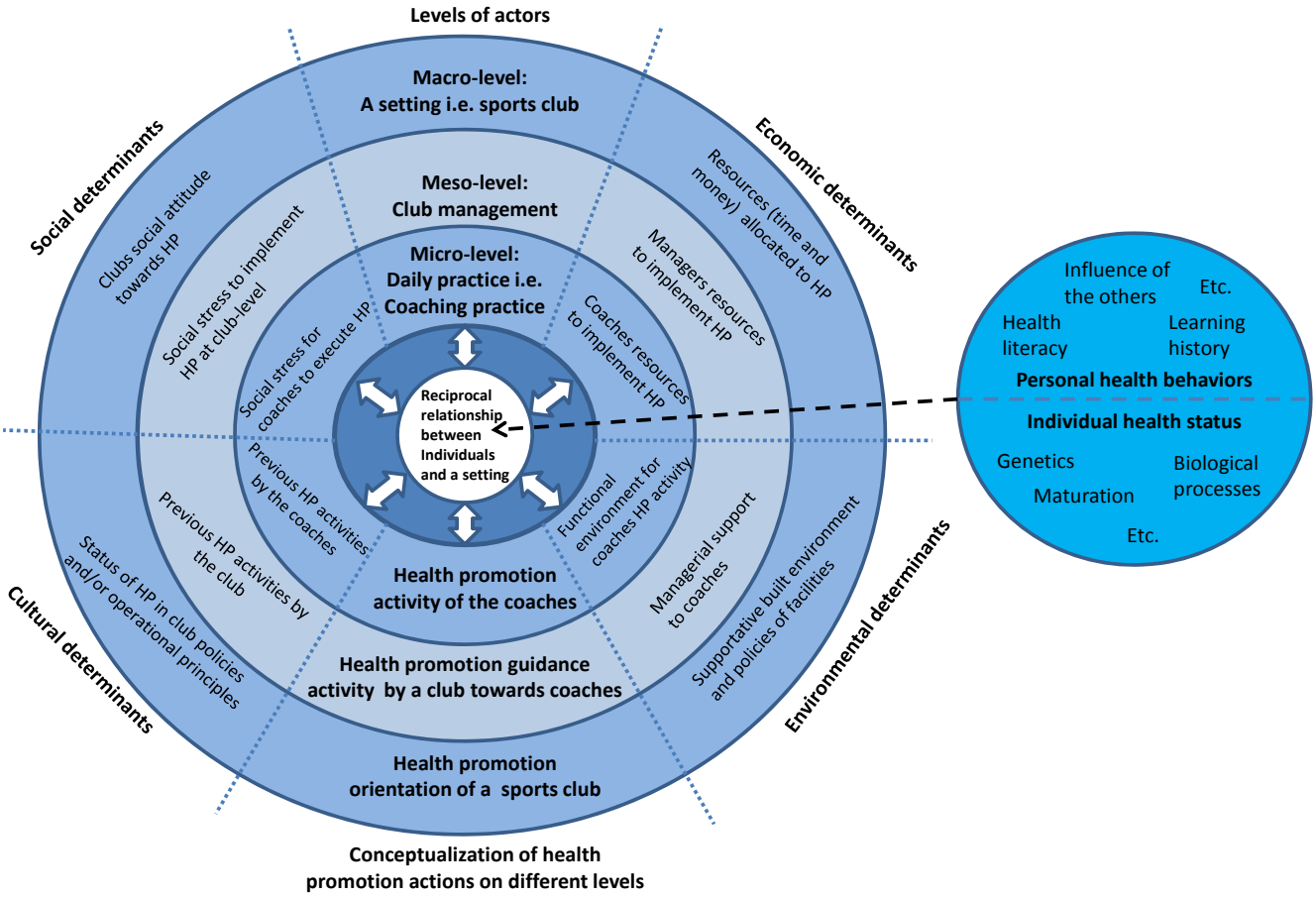

Figure 1 Determinants of settings-based health promotion and reciprocal interaction of setting- and individual-based factors within a sports club setting.

The activities of any organizational setting can be seen at three levels – macro, meso and micro. For a sports club setting, for example, the macro level encompasses the overall policies and orientation of activities of a club. Meso level relates to the activities managed by the leading persons in a club, namely club officials. These activities are many times designed to guide, alter or support the micro-level actors. Micro level refers to corresponding activities by the practitioners, namely coaches, in guiding, altering or supporting the actions of the club members. Health promotion activities appear at each level and mutually reinforce each other through policies and reward systems.

Cultural, social, economic and other environmental determinants of health promotion can be situated on each level. Cultural determinants relate to values associated with the position of health promotion within a sports club setting and in the club's policies and operational principles. At meso and micro levels the attitudes and actions of the management and coaches towards health promotion vary with whether they see it as central or peripheral to their mission. Is health promotion (beyond sports activity itself) socially accepted form of activity and what kind of signals do various actors send on different levels? In sports, especially in particular disciplines, the risk-taking and physical contact may create contradictions between sport and health (Robertson, 2003). In addition, Koski (Koski, 2005) found that girls participating in sports clubs have a higher level of health literacy than their male counterparts.

Economic determinants link the financial resources with practical (time and knowhow) resources to realize health promotion at each level. Do coaches have proper health-related knowledge and skills to execute substance-use prevention, for example? Other environmental determinants relate here to physical and social environmental conditions in which the daily activities take place. Are the facilities safe, cordial, joyful and health promoting? Health promoting refers here to an environment that provides possibilities to obtain a nutritious meal or snack, and to participate in youth activities in a smoke- and alcohol-free environment, as examples.

All of these determinants need to be recognized and addressed setting-specifically to create the best possible conditions for individuals to take control over their health. On the other hand, often forgotten in a settings-based work is the reciprocal determinism between a setting and behavior of the people involved (Figure 1). Reciprocal determinism refers here to environments setting limits on the possible behavioral forms (and by changing the environments it is possible to modify these behaviors or actions), but at the same time behaviors or actions of people also influencing the setting (Green et al., 1996; Green & Kreuter, 2005, p. 160). This is why the Ottawa Charter and other health promotion documents seek to give people greater participation in and control over the determinants of their health. Ideally, this would provide for people to be able to adjust their behavior to changing environments or adjust the environments to their changing needs (de Leeuw, 2011).

Much of this depends on recognition of a) the determinants that should be targeted and b) possibilities and ways that an individual or groups of individuals can have influence over these factors. For example, it may be that it is more complex in a community setting for an individual to identify possible health-related determinants. But also, at a worksite where this recognition might be clearer, but a hierarchical management structure may at the same time make it difficult to have access to these factors.

Conceptualizing settings-based health promotion

Among the several dimensions of health promotion – theory, policy, practice and evidence – practice often has a dominant role in everyday functioning. The same multidimensionality, but also dominance is present in the settings approach where the emphasis has generally been practice-led. Mark Dooris (Dooris 2006a), for example, argued that both Health Promoting and "Healthy-setting"[3] concepts have been used interchangeably without distinguishing semantic and real differences. Wenzel (Wenzel, 1997) had pointed out that to *execute* health promotion in the settings it is not the same as to plan and develop health promoting settings or settings-based practice. The former refers mostly to *exploiting* settings to reach target groups through a specific setting, which Whitelaw et al. (Whitelaw et al., 2001) classified as a passive model in their typology of settings-based health promotion.

The recent upswing of variously labeled "Health Promoting" or "Healthy" setting initiatives calls for an examination of the intended difference between these two concepts. Dooris (Dooris, 2006a) suggests the Health Promoting setting conceptually has a more straightforward focus on people, with an emphasis on the potential health effects of a setting. Grammatically, a "Healthy" setting implies that a setting can be healthy. This distinction emphasizes concepts more than existing practices. Conceptualization as reflected in terminology, however, has consequences for theory, policy and practice; and even evidence.

[3] We place the term "Healthy" in quotation marks where it has been used as an adjective for nouns that are not living things, such as settings, which at best can be healthful or health promoting, but not healthy.

A concept of “Healthy” setting, suggests the possibility of a static or ideal setting, with manners and workings statically healthful and the role of the setting relatively passive. No such settings exist that would, or even could, be permanently or continuously healthful by their structure and operations. Circumstances change, decisions on trade-offs between maximum health protection or promotion and economic productivity must be made, and in competition with other values. Organizations or settings could have continuous surveillance and processes of decision making that would optimize health. However, some compromise or trade-off between the primary purpose of the organization and the health of the people who inhabit the organization would be inevitable.

Healthfulness is always relative to the history and culture of the setting. Prisons would not presume to be as healthful environments as schools or recreational settings, for example, because inmates have far fewer freedoms than students, and students fewer than participants in a recreational setting. The concept “Healthy,” applied statically to whatever setting, might cause a conflict between health promotion and the core-business of the setting in question. Health promotion might be felt to threaten the core-business of the setting. The concept of “Healthy” might suit in referring to the people in the setting if the implication of absolute and universally applicable health were ignored, to profile individual-based rather than setting-based health promotion - a healthy child, a healthy inmate or a healthy athlete for example (cf. challenge to the WHO definition of health by Huber et al., 2011).

Health Promoting [gerund applied to a setting] as a concept, on the contrary, invokes the dynamic and conditional nature of health promotion activities and conditions and the *process* of making them healthful. In other words, it sets focus on the processes for continuously adapting the setting towards more health promoting circumstances, not assuming some universal, absolute or permanently healthy state of its varied and changing occupants. There is more room for variation to the extent that a setting will maintain processes and procedures to pursue and adapt health promotion. The ultimate goal is to change a setting to optimize and execute a comprehensive set of health promotion activities at several levels. Considering the many dimensions of health promotion, maximizing one in a specific setting might sometimes compromise another, and not all dimensions can be maximized simultaneously. For example, if the managers of a setting have not recognized health promotion at all, they can be encouraged to start do something with small steps. They can, as they should, then decide themselves with their employees or constituents or both, to what extent they have the interest and the resources to execute health promotion, and which aspects of health promotion should have priority. The example noted earlier in relation to sports clubs suggests that maximizing participation in a sport that has high expenditure of energy might also increase the risk of injury—two competing health promotion objectives.

What then is enough for a setting to be called health promoting? Many of the settings initiatives have established policies, standards or guidelines to represent their requirements and/or definitions and sometimes the processes by which they should be decided and reconciled at the most local or decentralized level of the organization. Still, for many the criteria for settings to be considered health promoting are set by the health professionals or managers, not the people within that setting. Thus, it is the process not an absolute and static condition that needs to be considered more in future development of the health promoting setting concept, as an example.

Many of the present settings-based health promotion initiatives use the term “Healthy” setting in the way we have outlined as Health Promoting setting. There exist both so-called “Healthy” settings with

comprehensive aims and dynamic means as well as Health Promoting settings with limited aims and static, centralized means. We rationalized above that the concept of Health Promoting setting is (or needs to be) more dynamic, and people-in-the-setting-sensitive than a “Healthy” setting, recognizing more the origins of the ecological perspective to the settings approach. We, therefore, propose that a concept of Health Promoting setting, rather than “Healthy” setting should be used for the most of the settings initiatives.

A question of whether a concept of setting also describes adequately the environment and/or the context and/or surroundings also arises. Geographers, and the journal *Health and Place*, for example, discuss “place” when examining environmental factors. Sometimes also “portal” is used when interventions have been directed towards these factors (e.g., Katz et al., 2011). Overall we consider the concept of setting to encompass place, or to represent one kind of place; and there is no need to change the concept. Still, it remains important to define the concept of setting and its coverage.

Shared and setting-specific characteristics of settings models

The growing number of settings-based health promotion initiatives has produced an array in which they have been realized in various ways and with diverse scope. To find whether there are some collective characteristics, Kokko (Kokko, 2010) reviewed the settings-based practices in the health promotion literature, namely city, school, university, hospital, workplace, and prison, and reflected on how these might apply to a sports club setting. This enabled him to map out some shared characteristics and setting-specific factors, summarized in Table 1.

Table 1 Shared and settings-specific features of health promoting settings described in the health promotion literature, with a sports club addition (Kokko 2010).

		Setting						
		City[4]	**School**[5]	**University**[6]	**Hospital**[7]	**Workplace**[8]	**Prison**[9]	**Sports club**[10]
Setting-specific factors	**Launch year of the concept**	1986	1986/87	1998	1991	Late 1990's under a label of settings work	1995	2004
	Target group	Citizens	Primary students. Secondary, staff	Primary, students. Secondary, staff	Primary patients. Secondary, personnel and visitors	Working age adults	Primary, inmates, Secondary, custodians	Primary, participating youth. Secondary adults
	Implementation	Global	Global	No wider network	Global, but waiting for a breakthrough	Global, but settings-based work recently started	Mainly European countries	Finland and Australia
	Main activities	To get health on the agenda in the decision-making process, changes in community culture	Inclusive processes (teaching) and structural changes (management)	Similar to school	Organizational development to integrate health promotion into the curative care	To integrate health into daily management and activity	Through healthcare, changes in policies	Changes in club policies, development of daily culture e.g. coaching
	Range of the settings work	All the citizens, but distant in nature	School participating youth, i.e. almost all from a single age-cohort	University students, i.e. minority of young adults	Specific target group, i.e., unhealthy people	Employed people	Inmates	Youth participating in sports club activities, e.g. about 40% in Finland
	Quality of evidence	Relatively good on impact, weak on effectiveness because of the complexity	Strong on both impact and effectiveness	Some evidence on impact, none on effectiveness	Relatively good on impact, some on effectiveness	Strong on previous work, not much on the basis of settings work	No competent research	Tentative
Shared characteristics		• Complex entities • Grounded in the Ottawa Charter • Emphasis on environmental factors • Primary targeting on organizational change, secondary on individual behaviours • Key actions determined as standards or alike • Expansion after a link between settings-based health promotion and core-business of a setting in question recognised • Impact and effectiveness evaluation challenging and so far only partly successfully developed						

Several common factors among particular traditional settings and a sports club setting were found. First, the Ottawa Charter and its five action areas have provided the frame for all the settings-based models and laid out the grounds for practical actions. Second, in all the cases, the settings are wide and complex entities, which emphasize a need for multi-level actions. Third, the focus is primarily on organizational change and settings-based factors that can generate this change. Fourth, key actions are recognized as standards. Fifth, a breakthrough in distribution has been the moment when a link between settings-based health promotion and core-business of a setting in question has been realised.

[4] e.g. Awofeso 2003; Baum et al. 2006; de Leeuw 200; Hancock 1993
[5] e.g. Lee et al. 2008; Lynagh et al. 1997; Michaud 2003
[6] e.g. Dooris 2001; Tsouros et al. 1998; Xiangyang et al. 2003
[7] e.g. Groene et al. 2005; Johnson 2000; Pelikan et al. 2001; Whitehead 2004
[8] e.g. Chu et al. 2000; Engbers et al. 2005; WHO 2003b
[9] e.g. Department of Health 2002; Squires 1996; WHO 2003a
[10] e.g. Dobbinson et al. 2006; Kokko 2010; Kokko et al., 2009

Sixth, the main challenge in these models is on the difficulties in evaluation of their effectiveness and impact.

There were also many distinguishing features among these settings in their year of establishment, target groups, implementation particulars, main activities, range of the settings work, and the quality of evidence. For example, whereas those settings established early have been developed for almost three decades, newer ones have had only a decade or less of development. This has produced vast differences in the amount and quality of evidence and practical experience in these settings. Also different settings address different populations, which then define and limit the range of potential activities, processes and effects of the settings, but also enable population-tailored implementation.

With these unifying and separating elements in settings models, it is surprising how seldom different settings initiatives have worked together or drawn on lessons one from another. Lessons learned in one setting could support the development of another. A need for more active cooperation between settings gains more weight when the interaction between settings is highlighted (next).

REFLECTIONS ON FINDINGS

Layers and types of settings

Different setting initiatives are usually reviewed within or between each other, but usually as equal and independent actors. This is reasonable when considering that an individual moves from one setting to another many times per day and thus it would be optimal if these equal level settings, like school, workplace and sports club, would have parallel and mutually reinforcing actions and messages. Another perspective, however much less discussed, is that settings act on different levels *and* settings have interaction between each other at the same level of settings, *and also* have interaction and reciprocal relationships between different levels of settings (Figure 2).

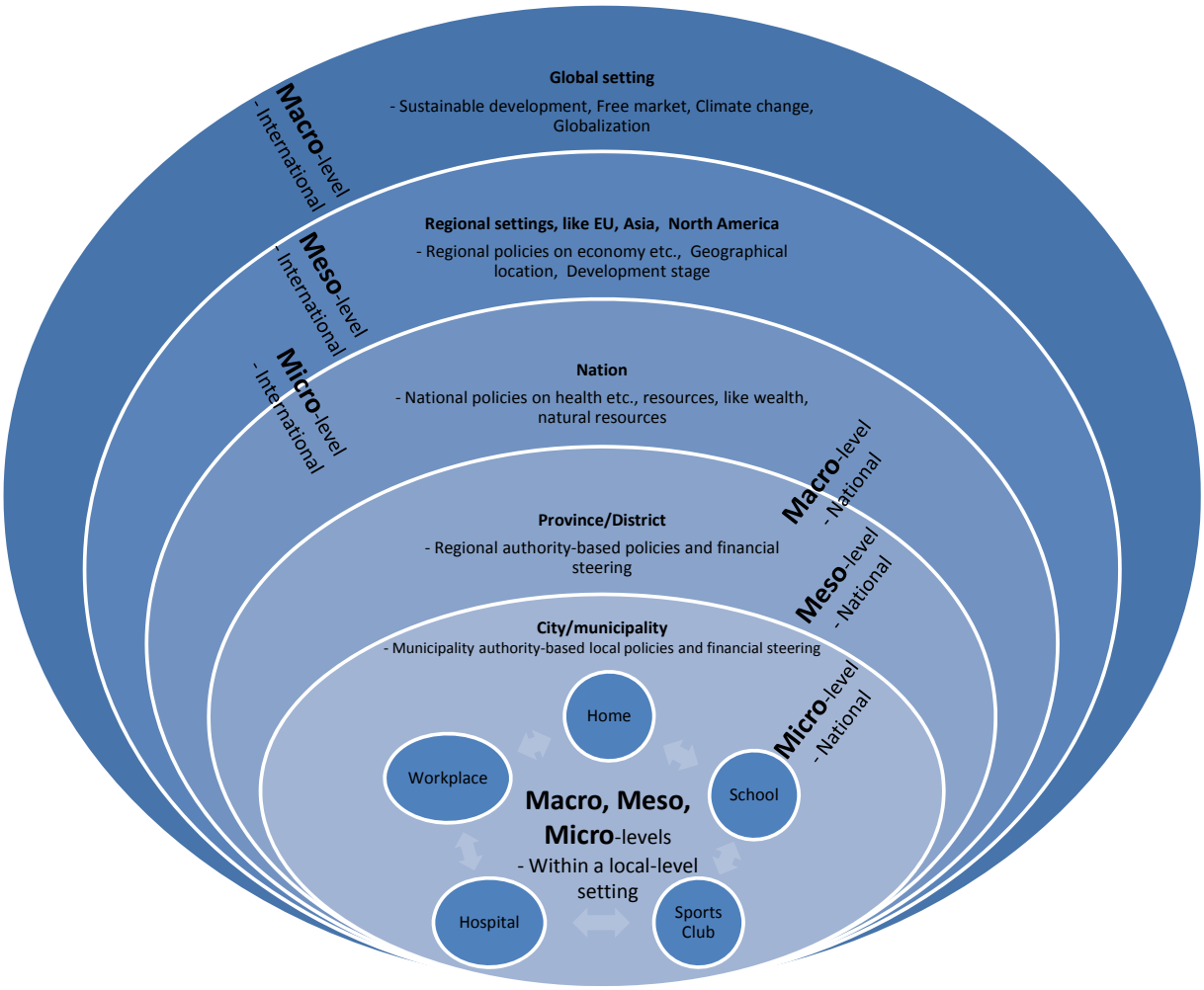

Figure 2 Layers of settings: interaction between settings.

From a global starting point, the planet as a setting for health promotion, one can find factors, movements even, that have a fundamental effect on life circumstances everywhere. Global issues are fundamental for settings-based health promotion as well; climate change, peak oil and environmental degradation are concerns of everyone. Poland and Dooris (Poland and Dooris, 2010, p. 292-293) argue that "…helping midwife the emergence of a new post-carbon society is perhaps the most important health promotion project of modern human history." Regional settings have gained more weight during recent years, especially in Europe, thanks to the European Union (EU). Regional actors make their policies and guidelines in physical activity for example. These documents have a guiding effect on national policies, as in the EU. Nations create boundaries for national actors to act within. National policies guide the work done at regions and at local levels. The prevailing public management ideology devolves decision-making power to the local governments, but often without the devolution of resources to implement them. National guidance also has continued force and meaning.

We concentrate here on local level interaction between a city/municipality and a sports club and give an example in physical activity (PA). A city/municipality is the unit (setting) that creates and provides

pre-conditions for its sub-settings, like schools or sports clubs, to enhance and for citizens to execute PA. The sub-settings actually rely on the PA-related definition of policies of the city/municipality in question, like whether a city/municipality has a PA strategy or has PA as a part of wider policy, how PA possibilities for commuting and the built environment are recognized in urban planning or what kind of PA facilities exist.

Some attempts have been made to situate different levels of settings into a typology. Galea et al. (Galea et al., 2000) divided settings into elemental and contextual settings. Elemental settings refer to the ones invisible for the purpose of health promotion, but having existing social, cultural, economic, psychological and administrative or organizational idiosyncrasies. These settings are usually small units, so that its members feel communality. Contextual settings are larger units that hold these smaller elemental ones. This typing has some analogy to our example under the city/municipality and its sub-settings. Dooris (Dooris, 2009) has thereafter argued for a need to revise the work of Galea et al. and to explore how these elemental and contextual settings function at various levels. Dooris (Dooris, 2006b) himself has stated that settings are unpredictable complex systems, with inputs, throughputs, outputs and impact (System Thinking), and open systems that interact with the other settings and the wider environment. Furthermore, Dooris (Dooris, 2009) states that settings should work both upwards and outwards, where upwards refers to efforts within a setting to generate an organizational change; outwards means effort toward addressing political, economic and social factors beyond the work setting. We would add here that a most fundamental capability for a setting to operate in health promotion is whether the setting is under the public, private or voluntary sector. This, for example, determines, whether the relationship to health promotion the people have is formal or informal. In a sports club setting the voluntary participation of the youth, as an example, creates an informal health promotional nature, which can then be exploited by justifying health issues through development in sports (see more in Kokko, 2010).

Position of a setting in settings-based health promotion: Application to sports clubs

One key question in the success of settings-based health promotion is how strongly the setting in question is involved in its development. The typology introduced by Whitelaw et al. (Whitelaw et al., 2001) more than ten years ago, is still relevant. It points out, that to achieve best possible results the health promoters should act as transform agents to stimulate the people within a setting to start changing the setting. The setting can be, and perhaps at early stage needs to be, used as a strategic route to the key stakeholders. Still, when considering settings-based health promotion, the usage of it as a passive channel of communication should be only a first step. We next adapt the typology of Whitelaw et al. (Whitelaw et al., 2001) to a sports club setting. In the sports club application the original five-part typology (passive, active, vehicle, organic and comprehensive) was reduced to three, because the last two (top-end) models were considered too complex for sports clubs at this point in their history (Table 2). The sports club construct was initially represented by Kokko and Vuori (Kokko and Vuori, 2004).

Table 2 Characteristics of settings-based models adapted to youth sports club activities (Kokko 2010; cf. Whitelaw et al. 2001; Kokko and Vuori 2004).

	Passive education model	**Club-based education model**	**Club society development model**
Position of the setting	Passive, providing access to the target group desired	Somewhat active, carries out supportive actions	Main focus on organizational change i.e. culture and ethos
Characteristics of the model	Health education oriented, specific risk behaviour,	Individuals as primary focus, measures of support by the	Primary goal (long-term) on changes in the club operations,

	individual targeted and external expert	club	secondary goal (short-term) on individual health behaviours, emphasis of activity on environmental factors
Examples of activity	Specific health education lessons, use of leaflets and other health education materials	Individual-level; support on behavioural change Club-level; education of actors like coaches, guidelines for actions	From single health topic programs to changes in club policies, regulations and operational principles, both policy and practice level changes

The first model for sports clubs is called the passive education model, in which the sports club provides an existing channel to a specific audience and as a social environment for individual-centred health promotion. Health promotion here targets specific risk behaviour. Health promotion/education is realised by an external expert without particular association to sports. The second model, the club-based education model, requires more active role and engagement of the club. Individuals' health behaviours remain the primary focus, but the supportive role of a setting is recognised and realised. In practice these measures of support can be targeted to those participating in club activities (target group), but also to those carrying out health promotion, e.g., coaches (mediators). In the latter case, for example, coaches' knowledge and skill are improved via education organised by the club.

The third model, the club society development model, has as its primary goal (mid-term) to modify sports clubs through development in the setting to make them more health promoting. The secondary goal (short-term) is to change individuals' sentiments and general culture or norms toward health promotion. Contributions to individuals' health behaviours remain ultimate goals (long-term). Improvements in actions of a setting generate pre-conditions for individuals to achieve these behaviours. This means, in practice, that in the first stage, separate health promotion programs are seen as vehicles through which more profound goals are executed. For example, if the primary goal is to have substance-use prevention as a permanent element of the daily sport coaching, it is pursued at first stage by raising its importance for sporting youth. These actions primarily aim to change coaches' and club officials' attitudes, but meanwhile might arouse changes among athletes' behaviours. In the subsequent stages of this model, attempts are made to effect changes in sports clubs' structures and culture through changes in the operational principles, regulations, and/or established practices. More health promoting practices might then have the ultimate effect on individuals' behaviours.

DISCUSSION

Although the settings approach has become one of the central approaches to health promotion, there is little consensus on its conceptualization or theoretical basis. Indeed, as the approach has its roots in ecology, the current practices range in a vast variation, often representing something other than original ecological fundamentals. While a comprehensive review of each health-promoting setting initiative is beyond the scope of this paper and we recognize the limitations of the sports club setting, variation in reach between countries and amorphous formats compared to institutional settings like school, we aimed to introduce a sports club setting as a fresh application of the experience and concepts from traditional initiatives and in this way to highlight and reflect on some important conceptual aspects of the field, as well as the potential of new, most often non-institutional, settings.

The ***first reflection*** highlights the wide variation of different activities executed under the rubric of settings approach. Currently, these practices are bundled under the settings label, even when they might

be limited to individual-based health promotion activities merely delivered or executed in a certain setting as the channel or portal of an external initiative. A settings approach emphasizes setting-related factors: the health determinants and decision processes of a setting (e.g., active participation), among others. The determinants of settings-based health promotion, namely cultural, social, economic and environmental factors, are the primary focus. These determinants need more attention to understand the pre-conditions for implementing health promotion in a certain setting. Each setting has its particulars and represents a given set of people in a certain time and place.

History is another determinant of a setting's receptivity to health promotion. A setting may have some historically established health-related activities, whereas another might be without any previous experience. These pre-assessments of historical and other determinants reveal leverage points to start the work of health promotion (see Green & Kreuter, 2005; Poland et al., 2009). In the first case it might be somewhat easier to start, but depending on the previous work, it might also be difficult to get further if the previous activities have failed. In the latter case the start might be more difficult with more resistance, but if the advantages of health promotion are properly presented and resistance overcome, the work can begin with a fresh start. Understanding all of these determinants helps tailor the plans and activities to current reality of a setting in question. It also shows the capacities a setting has for health promotion work. If, for example, the setting has not committed any resources to health promotion, this should become an initial issue to address.

The vast variation in the activities of settings work produces wide variability in the concepts used. Thus, our ***second reflection*** is on terminology. The field would be clearer if those initiatives targeted primarily towards individual determinants rather than environments would identify themselves by the type of healthy people they seek to produce, e.g., healthy athletes, workers, students, or prisoners; and those with an emphasis on settings-based factors as "health-promoting" (e.g., school). The field also needs to determine what common meaning these concepts have in both research and practice. We would suggest that these determinations for research could include factors similar to what we represented for a sports club setting in Figure 1. This way the settings-based factors are recognized as variables. In research it is also crucial to understand that when measuring the settings factors through questionnaires or key-informant interviews, a single individual opinion does not usually reflect the whole truth. Thus, it is important to have multiple respondents to evaluate the situation in a setting. Kokko et al. (Kokko et al., 2009) used mean values of several respondents when evaluating Finnish youth sports clubs' health promotion orientations, for example.

The ***third reflection*** concerns the levels of settings-based work. A macro level in a single setting refers to overall orientation of a setting towards health promotion. The macro level ideally would be the level at which health promotion is initiated. This way, the actual interest of a setting to join-up in the health promotion work can be served, and policy-level interventions in relation to determinants will more likely have organizational support. Meso level thereafter concerns the relationship of key stakeholders at various levels to health promotion. If the managing persons of a corporation do not value health promotion, it is very difficult to proceed in a settings-based way. Key stakeholders can also be so-called informal influentials whose opinions are valued by others. In any case, at this level it is a question of activity level of the stakeholders in health promotion. The macro and meso levels determine which kinds of pre-conditions are available to execute health promotion in a particular setting. The micro level conducts the daily implementation. At the micro level in a sports club setting, for example, the practitioners are mainly the coaches. For successful implementations, coaches' attitudes, knowledge and skills are crucial. Of course, there are better possibilities for success when the club-based pre-

conditions are supportive for coaches. The positive orientations of macro and meso club-level activity have a positive effect on coaches' health promotion activities (Kokko, 2010). Ultimately, if not primarily, the workers, students, members, or other beneficiaries of the organizational setting's health promotion efforts should be engaged or represented in each of the other stakeholders' decision making.

The ***fourth reflection*** is on the observation of Whitelaw et al. (Whitelaw et al., 2001) that if a setting is passive or leadership only somewhat active, it actually is not yet settings-based work. This does not mean that the work could not become a settings approach to health promotion; indeed it is often that the settings-based health promotion needs to be started without strong support from the setting leadership. The support might and should increase when the work proceeds and the first signals of the positive influences can be seen. Actual settings-based work starts when the setting starts to participate actively. Thus, the settings-based work means that instead of health professionals coming outside the setting and trying to conduct external programs, it is a question of getting the people in the setting collectively changing the setting, with a help of health professionals.

Our ***fifth reflection*** is that various settings initiatives should cooperate more. Indeed, there are many shared origins and characteristics between different settings, but at the same time with many setting-specific factors. Shared factors offer possibilities for more active cooperation in which different setting initiatives can learn from each other. Some initiatives are more advanced in their work and have solved some problems that some others are still struggling with, but also traditional initiatives could learn from the fresh ideas of the new setting initiatives. One of the most important development needs, namely evaluation, could benefit also from closer cooperation and discussion of the methodology or at least shared data and standardization of some key indicators and outcome variables. Setting-specific factors create a need for setting-specific applications, and these might prove to have complementary value to other cooperating settings.

Finally, in our ***sixth reflection***, we note, that under the settings approach there are always multiple level interactions between various settings. Galea et al. (Galea et al., 2000) represented a duality of elemental and contextual settings, which formed a good start. In response to the suggestion of Dooris (Dooris, 2009) that settings should always work both upwards and outwards, we have offered some elements for this typology. Different levels of settings are dependent on each other and there are power relationships among them – between a city/municipality and sports club, for example. The sports club or any other setting need not await or depend on initiative and support from the municipality, but might advocate and stimulate action from the municipality. This highlights the need for comprehensive pre-assessment of the settings-based determinants and their interaction with determinants beyond the setting before going into action in settings. Overall, layers of settings exist with many perspectives: from global to local, from public to voluntary via commercial, from umbrella settings to sub-settings and with policies, resources and practices influencing.

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