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Original research

Identifying important and feasible policies and actions for health at community sports clubs: A consensus-generating approach

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ABSTRACT

Objectives: Children's high participation in organised sport in Australia makes sport an ideal setting for health promotion. This study aimed to generate consensus on priority health promotion objectives for community sports clubs, based on informed expert judgements.
Design: Delphi survey using three structured questionnaires.
Methods: Forty-six health promotion, nutrition, physical activity and sport management/delivery professionals were approached to participate in the survey. Questionnaires used an iterative process to determine aspects of sports clubs deemed necessary for developing healthy sporting environments for children. Initially, participants were provided with a list of potential standards for a range of health promotion areas and asked to rate standards based on their importance and feasibility, and any barriers to implementation. Subsequently, participants were provided with information that summarised ratings for each standard to indicate convergence of the group, and asked to review and potentially revise their responses where they diverged. In a third round, participants ranked confirmed standards by priority.
Results: 26 professionals completed round 1, 21 completed round 2, and 18 completed round 3. The highest ranked standards related to responsible alcohol practices, availability of healthy food and drinks at sports canteens, smoke-free club facilities, restricting the sale and consumption of alcohol during junior sporting activities, and restricting unhealthy food and beverage company sponsorship.
Conclusions: Identifying and prioritising health promotion areas that are relevant to children's sports clubs assists in focusing public health efforts and may guide future engagement of sports clubs. Approaches for providing informational and financial support to clubs to operationalise these standards are proposed.

1. Introduction

The Ottawa Charter emphasises the importance of settings in the delivery of health promotion interventions, as a way of embedding health into everyday activities.[1] Settings offer practical opportunities for the implementation of comprehensive strategies,[2] providing access to greater numbers of people within the target population and allowing broader changes to the physical or organisational environment. Community sports clubs have wide reach and appeal in Australia, with 1.7 million children, or 63% of children, participating in at least one organised sport outside of school hours, for an average of approximately 2.5 h per week.[3] As well as providing opportunities for the broader promotion of health to children, the creation of healthy sports clubs may have implications for the engagement of children in sport. Previous research indicates that the development of healthy and welcoming club environments is perceived by sporting officials to facilitate increased sports participation.[4]

However, research indicates that the availability of written policies to guide healthy practices at sports clubs in Australia is low, at both the peak sporting body[5] (which represent the sport at the regional, state and national level) and sports club level.[6] In a survey of 108 sports club officials, 58% of clubs reported that they had a written policy to prevent smoking within the club area, 12% had a policy on sun protection and only 3% had a policy on healthy eating.[6] While it can be argued that children who participate in organised sport may be more likely to engage in health-promoting behaviours than their non-participating peers, this may not be the case. Research has indicated that sports participants were more likely to engage in poor sun protection practices

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than non-participants, and were just as likely to consume inadequate fruit and vegetables.[7] As well, despite the high participation rates in organised sport, only 32% of 9–16 year old Australian children met the recommendations for physical activity participation on all four survey days in the most recent national survey of children's nutrition and physical activity in 2007.[8]

Identifying and prioritising key health promotion areas that are relevant to children's sports clubs would assist in focusing public health efforts and may guide future dialogue with, and engagement of, sports clubs. The aim of this study was to conduct a Delphi survey to collate informed judgments from experts spanning a range of relevant disciplines from the health and sports sectors, on aspects of community sports clubs that are necessary to promote good health to children and potential barriers to implementing initiatives in these areas.

2. Methods

Professionals in health promotion ($n = 18$), sports management/delivery ($n = 15$), nutrition ($n = 8$) and physical activity ($n = 5$) in Australia were identified and contacted by email to participate in the survey. These professionals worked in government health and sport agencies/departments ($n = 20$), academic institutions ($n = 13$) and non-government organisations ($n = 13$), and were purposively sampled based on the research team's knowledge of experts working in these fields, including those who had a strong publication record in the survey areas and/or were leaders/managers in related fields within their organisations. An explanation of the Delphi procedure and the purpose of the study were provided. Identified participants were asked to nominate any other potentially relevant experts, as part of the first round of the survey. A total of 46 health and sports professionals were approached.

The Delphi survey is a group facilitation technique, comprising an iterative multi-stage process, designed to transform opinion into group consensus.[9] A series of three structured questionnaires (rounds) was used to reach consensus. All rounds were completed between May and September 2011. Questionnaires were designed to address two research questions:

(i) What aspects of community sports clubs are important for developing healthy and supportive sporting environments for children?
(ii) Which of these aspects could be most feasibly implemented in community sports settings?

In round 1, participants were provided with a list of 21 potential standards for health-promoting sports clubs related to seven health-promoting themes of healthy eating, sponsorship and fundraising, alcohol management, smoke-free environments, sun protection and social inclusion. This list was based on previous surveys with sports clubs and peak sporting bodies in Australia, where sports officials were asked to nominated a range of initiatives that could be undertaken by clubs for improving the healthiness, inclusiveness and safety of sports.[10] Further, key health promotion areas to be considered were those assessed in systematic reviews of evidence on the effectiveness of health promotion in sports clubs,[11] and based on a previous survey in Finland of health promotion in sport.[12]

Participants were asked to rate each of these standards based on both their importance and feasibility on two separate four-point Likert scales (1 = 'Very important'/'Very feasible' to 4 = 'Unimportant'/'Definitely unfeasible'). These qualities are commonly used to identify priority intervention areas that are perceived as both necessary and amenable to change.[13] Participants were asked to provide comments on the standards, including their phrasing, scope and any potential implementation challenges. Participants were asked to nominate any additional important and feasible standards for the creation of health-promoting sports clubs. Open-ended responses were collated and duplicates removed.

Responses on the importance (I) and feasibility (F) scales were added ($I + F$) to give a total score for each standard from 2 ('Very important' and 'Definitely feasible') to 8 ('Unimportant' and 'Definitely unfeasible'). Standards that achieved an overall median score of 3 or less, with an interquartile range (IQR) of 2, were established as confirmed standards. For these standards, 75% or more of the sample perceived these to be at least important *and* feasible. Standards with a median score of 5 or more were excluded (half of the sample perceived these to be at least slightly unimportant or possibly unfeasible). Comments from the group on the phrasing/scope of the standards were also incorporated. This resulted in one original standard being split into two separate standards.

In round 2, for standards that achieved a median score greater than 3 but less than 5 in round 1, participants were provided with statistical information on the previous round's responses, indicating the extent of group convergence for each issue. This included measures of central tendency (median) and dispersion (IQR). Participants whose response was outside the median ± IQR were shown how their response compared to the group as a whole and given an opportunity to rate these elements again or to justify their response. Participants were provided with a list of additional standards that were nominated by participants in round 1 and asked to rate each of these aspects on their importance and feasibility, and again, were asked to indicate any potential challenges for implementation.

Finally, in round 3, the scoring procedure outlined above was applied to the additional standards nominated by participants. Participants were again provided with statistical information comparing their response to the group for the standards nominated by participants and given an opportunity to rate these elements again or to justify why they chose to maintain their rating, if their response was outside the median ± IQR. Finally, participants were asked to rank their overall top five priority standards from the list of confirmed standards for health-promoting sports clubs. A weighted ranking system was applied, so that standards that were rated as the highest priority were given a score of 5, while those given a rating as the fifth highest priority received a score of 1. Standards were prioritised based on their total score.

All questionnaires were sent to participants via email and one email reminder was sent at the completion of each survey round for participants who had not yet responded. Ethics approval was obtained from the University of Sydney Human Ethics Committee in July 2011. Consent to participate was indicated by returning the completed questionnaire.

3. Results

A total of 26 professionals (57%) approached agreed to participate and completed round 1. Twenty-one professionals subsequently completed round 2 (81%) and 18 (69%) completed round 3. The final sample completing all three rounds of the survey comprised eight experts in health promotion, six sports management/delivery professionals, three experts in physical activity and one expert in nutrition from four Australian states and territories. The number of people who were employed at academic, government and non-government organisations was similar between responders and non-responders. For those who completed at least one of the survey rounds, the ratio of people working in these different organisations was 7:11:8, compared to 6:9:5