Lessons from the field for working in Healthy Stadia: Physical activity practitioners reflect on 'sport'.

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ABSTRACT:

Drawing on four areas of our ongoing work, each with its own distinctive relevance to the Healthy Stadia agenda, this paper addresses the tension inherent to programmes aiming to promote physical activity through sport. Our experiences highlight often unresolved, but certainly resolvable, tensions between the aspirations of the respective agendas. These are not small matters; better Public Health is a powerful driver of the Healthy Stadia agenda. In particular, we notice that the desire for sporting, over health, improvement can be an important challenge point. In the hard-to-reach groups we work with, sport often has strong - and only occasionally positive - connotations. Equally, the importance of generating powerful social experiences is seen in the PA 'camp' as being an imperative for encouraging the involvement of hard-to-reach groups. In contrast, in sport-oriented programmes this is more likely to be seen as a happy bi-product of a good sport experience.

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Introduction

In this paper, physical activity (PA) specialists from academia gathered to discuss the role that sport plays in one of the key areas of Healthy Stadia activity. Sport, in particularly football is now well evidenced in preventing and treating non-communicable diseases.[1] Professional sport clubs play an increasingly acknowledged role in enhancing Public Health.[2] This health promoting activity is delivered through the community engagement programmes of professional sport clubs and through their stadia (or settings-based) activity.

Professional sport clubs through their community engagement initiatives tackle a breadth of health-oriented interventions. This covers a wide spectrum of the lifespan; including children;[3] men;[4] women[5] and older adults.[6] The evidence is growing for this settings-based approach, which offers a potentially attractive vehicle for policy makers and practitioners alike to attend to Public Health – including those working on and towards the Healthy Stadia agenda.

The Healthy Stadia agenda places the emphasis on supporting, exploring and understanding the potential of sport venues. Three cross cutting themes underpin this work: healthy stadium environments for fans and non-match day visitors, e.g. healthier food options; active travel options; healthy club workforces, e.g. annual health checks; PA programmes; and healthy populations in local communities, e.g. men's weight loss programmes; PA interventions.[7] It has been the latter of which that has received the most attention from policy makers, practitioners and researchers in recent times.

One fundamental underpinning philosophy of this approach is that funding sport is a trustworthy and credible approach for making PA consumable for individuals and community populations. This article seeks to articulate the challenges we experience with integrating sport into PA promotion, which is where much of the main funding currently lies in the UK. We also discuss issues emerging from on-going work in four communities with complex needs. The paper draws on our research with four groups; Looked After Children, Adult Diabetes, Older Adults and Low Socio-Economic Status communities across a variety of community sport and professional sport club-based settings.

Collectively, these contributions highlight our experiences of the principle and prominent challenges associated with pursuing sport to deliver PA-oriented interventions. This is particularly important for putting flesh on the bones of what the Healthy Stadia focus means on a day-to-day basis, especially in terms of engaging the local community. We have learned that, in their own right, stadia offer very little that is meaningful in behavior change terms. More important are the things that people experience while in those stadia and how these community outreach from stadia can facilitate positive health changes in local communities. That reality requires an increased focus of attention on the actions of the people who commission services, work in delivering programmes or develop policy surrounding community-based interventions focused on the Healthy Stadia agenda.

Looked After Children (LAC)

Even though sport is often seen as a panacea for addressing a host of social ills,[8] the beneficial link between sport and PA is unclear for marginalized young people, including LAC. LAC include those who have been removed from their family and placed in state care and their number is increasing. Of the 68,840 LAC in England in 2014,[9] many suffer poor physical and mental health, have difficulties with social and emotional wellbeing and lack stable relationships. All this produces problems with attachment and individual resilience.[10]

UK policy calls for all LAC children to engage in sport and PA 'equal to their peers' to overcome earlier disadvantage and enhance their physical and psychological well-being.[11] Yet, recent evidence highlighted that sport is rarely a central feature of their daily lives, with most of their sport experience being confined to school-based PE.[12] LAC often experience multiple placements, making their initial sporting experiences disrupted and limited. This lack of regular experience is only likely to contribute to their low self-competence and self-confidence in sport.

Their lack of stable placements often results in a disrupted schooling and Physical Education (PE) experiences; this runs counter to the narrative that youth sport offers a universally positive social experience. Combined with an uncritical and/unrefined promotion of sport within PE, this compounds the problems LAC face in making and

maintaining friendships. LAC have reported being picked last for teams, explaining this socially; they didn't know anyone in their PE lessons.

Arguably, limited experiences within and beyond school will impact on the development of physical capital ('ability'), potentially building a negative cycle of sport experiences. As such, sport – however it is encountered - highlights differences and alienates these individuals even further. Sport clearly has its benefits but by delivering competitive sport through PE in a wholly uncritical way, it is likely to have a negative impact on LAC's engagement in lifelong PA. While research evidence constantly suggests that regular engagement in PA may produce a variety of benefits that help some of the most marginalized and disadvantaged groups of young people in particular, we know little about how this group of young people view, access and experience PA.

So far, the LAC experience of sport has been underwhelming, but visionary clubs, like West Bromwich Albion and Tottenham Hotspur (and funding agencies like the British Academy) are making positive strides in redressing these shortcomings. These clubs offer LAC-specific programmes that aim to improve educational attainment, develop skills and, importantly, promote healthy active lifestyles. The 'wow' factor of the club helps to attract LAC but the attraction of doing sport rarely matters to them. Instead, it is the experience of positive, supportive, social environments that ensures their engagement. Once that's in place, many then opt for do more PA, mainly because they expect it to be similarly positive, supportive and social. Although some – mostly boys – do eventually adopt sport, few are as positive about what that might offer them.

Adult Diabetes

There are 3.9 million people in the UK with undiagnosed diabetes;[13] a further 2.9 million are diagnosed.[14] Numbers are expected to increase to 5 million by 2025, which makes its management a major Public Health priority.[15] Assuming that recruitment into any Healthy Stadia programme will reflect this prevalence, at least 1 in 16 attendees will have diabetes, whether diagnosed or not.

Although most health systems aim to treat diabetes locally, using medication, evidence increasingly confirms the value of PA-based approaches.[16] However, this means that the strategies mostly used to promote PA can focus on the single message of 'sport equals PA'. For some people with diabetes this may be inappropriate and ill-advised. This undifferentiated message can be promoted when staff are ill-informed and/or under-trained. As a result, these staff may also ignore prior health status and/or, misunderstand the secondary complications associated with diabetes. Equally, important issues may go unaddressed regarding individuals' knowledge of their own diabetes. Further, focusing on sport needs to be understood against the common personal histories of many clients with diabetes; this includes low self-efficacy and motivation resulting from negative experiences associated with earlier involvement in sport.[17]

Yet, PA promotion also requires care. For those who have diabetes and who do not engage in recommended levels of PA, there is often a fear of hypoglycemia, compounded by the perception that to be active invariably requires engagement in sport.[18] Equally, diabetes has two main forms with distinctive PA issues. Those with type 1 diabetes need to know how to control their diabetes *before* they participate in sport; this requires sophisticated self-management skills.[19] The variability of exercise intensity generates additional complications and when this is not handled properly it can end with emergency admission to hospital. For those with type 2 diabetes, regular participation in sport can help with metabolic control, but equally may be unfavorably compared to the ease of dietary change and taking medications.[20]

Many newly diagnosed individuals are surprised to learn that only a small increase in light intensity, day-to-day activity, equivalent to casual walking, will improve their metabolic control.[21] Therefore, for the least active people in the diabetes community, the promotion of PA as 'everyday activity' is usually a more useful strategy than the promotion of PA as 'sport and fitness'. Indeed, from a Public Health perspective, recommending individuals to lead a more active lifestyle, rather than encouraging them to participate in sport, is more achievable for most inactive individuals. Given the negative connotations of sport held by some individuals with diabetes, this factor alone may act as a disincentive for engaging in any form of PA.[22] Public health messages that reflect this understanding may be more successful in sustaining long-term behavior change, which is central to improving health status in people with diabetes.

Older Adults

Older adults (OA) represent a core priority group for PA and Public Health policy.[23] As a result, significant interest is placed on how to optimize adherence to interventions promoting these approaches.[24] Sport, specifically football – and more specifically, professional football clubs - has featured in many approaches to tackle Public Health priorities in this group.[25]

For example, Extra Time (ET) is a national programme of PA interventions delivered in professional football clubs for OA aged 55+ years. In ET each club took its own approach to addressing the complex health needs of this target group. While the results and outcomes associated with ET have already been reported,[26] OA also offered their perspective on what 'worked' for them. The key design characteristic of ET that the OA endorsed included the 2 hour-long weekly classes, no admission costs and a broad menu of physical and social activities, delivered within and external to the football stadia. ET offered exercise to music, indoor bowls, cricket, new age curling, walking football, alongside traditional board games, bingo, table tennis, Zumba and skittles. This content matches that of other football-led health improvement interventions for OA.[27]

From 985 recruits, over 400 provided useable questionnaires detailing their responses to ET. From these people, 80.2% reported that the link to the professional football club made ET more appealing. Yet, semi-structured interviews with regular attenders identified that the appeal of the football club was only important in initial recruitment. Importantly, for programmers, relatively few recruits ever took up the opportunity to play football, and almost always these were men with histories of involvement with football. For the majority, adherence to ET was more strongly linked to participating in enjoyable activities and enriching social opportunities, than to any sport offering. These two features were inseparable, whereas sport, particularly football, was mostly seen as offering neither. Indeed, most sports-based options were met with widespread disinterest, with obvious implications for ET staff, most of whom had strongly sporting backgrounds.

Once alternative activities were offered OA willingly flocked to participate in - and continued to prefer – them. These activities involved light-to-moderate intensity

exertion, with modest skill demands (but with a significant opportunity to acquire competence), delivered alongside social activities. It took a while for some club staff to register this need, but once they did, more successful engagement followed.

Inactive low Socio-Economic Status communities

Leeds is one of the most active big cities in the UK.[28] Despite this, over 40% of Leeds' residents engage in no sport, and ≥60% fail to meet current PA recommendations.[29] To address this, 'Leeds Let's Get Active' (LLGA) was developed as part of Sport England's 'Get Healthy, Get into Sport' funding stream. LLGA aimed to recruit inactive participants from low SES neighborhoods to 'do something'. LLGA participants had free access to around 150 hours of gym and swim sessions at 17 leisure centers across the city. This has strong resonance with the Healthy Stadia agenda because it links local people to local resources to focus on improving health behavior. Our evidence gives powerful insights into issues affecting recruitment, retention and overall programme success.

In two years, more than 64,000 participants registered, presenting a wide range of baseline PA.[30] This reach is testament to the potential impact of carefully targeted recruitment. However, and notwithstanding its already impressive scale, this reach will only be optimized when interventions can be promoted with relevant messages about sport and PA. The LLGA communities we spoke to held divergent – and often contradictory - views about these respective elements of programme content.[31] Indeed, while there were 64,000 recruits, less than 50% activated their registration by attending a first session. This gives an important lesson; neither local reputation nor attractiveness will ensure attendance.

Equally, LLGA delivery staff were initially uncertain of the interests and capacities of their 'non-regular' clients; the assumption was that motivation for both sport and PA behavior was universal. The most effective LLGA deliverers adopted a proactive approach to recruitment to ensure that inactive people felt confident in taking the first steps across the thresholds of these venues. The implication here - for Healthy Stadia – is that it is not sufficient to rely on assumptions about the 'power' of the stadium; more is needed to engage potential beneficiaries of programmes. Equally, once participants

actually attend, any power linked to the stadium is quickly forgotten; recruits expect to experience something that meets their direct needs.

In LGGA the most successful staff acknowledged that many potential clients assumed that the centers were 'home' to intimidating people who were 'nothing like me'; they were thin, attractive, popular, skilled and competitively successful. Each of these notions, let alone their combination, can be sufficient to prevent many inactive people from taking the first steps to involvement, even though the buildings were well established locations within the community.

Baseline LLGA data also signal that recruits into programmes have widely variable PA backgrounds. For example, just over half (55%) of participants who were identified as 'sufficiently active for health' (≥150 minutes of MVPA per week) in their baseline questionnaires reported involvement in sport at least once each week. Among participants who were 'inactive' at baseline (<30 of minutes of MVPA per week) sport was less prominent; 15%.[32] Therefore, to help increase PA levels, it is important that community providers move beyond the assumption that active=sporty and the equally ill-founded corollary that inactive=non-sporty. Further, talking to recruits confirmed their highly variable physical activity and sporting histories; many had periods that featured (in) activity and others characterized by (non) sporty behavior.

By responding to these, and many other similar ideas, LLGA generated over 135,000 gym and swim sessions in inactive participants. This is important; it shows that inactive people can be effectively integrated into conventional venues. Overall, an additional 799 MET-minutes/week were reported by participants at follow-up. However, within this figure, sport participation increased by only 5 minutes. Worse, only 28% of recruits achieved an additional 30+ minutes of sport each week at follow-up; twice as many (55%) achieved similar or greater increases through PA.[33] These findings question the efficacy and effectiveness of using sport to deliver on the implicit social contract underpinning Public Health to reduce illness and preventable death and to improve quality of life.[34]

Among these participants, PA seemed better suited than sport for improving activity and health profiles. Moreover, our experience suggests that health professionals

working with similarly inactive clients are likely to achieve better results by placing PA, rather than sport, at the heart of the intervention to deliver on the Healthy Stadia agenda.

Summary

These accounts, and our subsequent reflections on them, underline the fractious relationship that prevails around using 'sport' to promote PA. Clearly, inactive people hold strong and varied notions about (i) sport-based venues, (ii) sport and (iii) their relevance to personal needs. Overall, in three of these communities – excluding LACs - the notion of sport appeals, and continues to be made appealing, to a sizeable minority. They are predominantly males and they are (usually) in the minority.

While sport is often understood ambiguously, so too were sport-oriented venues. On the one hand, sports venues can be very appealing. Yet, inactive adults in LLGA recognized the presence of local recreational centers but felt that the traditional sport that went on there was too physically demanding for them. This dissuades some from joining and others from sustaining involvement; the low uptake in LLGA is ample evidence that any reliance on ideas linked to the 'build it and they will come' mentality (in LLGA that link might be expressed as 'It's there so they will come'), is unlikely to be effective in client groups who are as suspicious of sports venues as they are of sport-based programmes.

On the other hand, for other people, sport provides a meaningful and valuable challenge. Thus, sport is a double-edged sword; what is powerfully engaging for some is overwhelmingly counterproductive for others. Sport seems most acceptable to inactive people when it is used to prioritize and meet their social needs. At this point, for many 'traditionalists', that form of sport has lost much of its 'real' meaning.

Achieving the potential benefits associated with playing sport relies on the flexibility and variability that it affords. Yet, deliverers of sport are often under-prepared, and sometimes unwilling, to offer what works best for inactive people. These clients can be confused by the contradictions around high level sport; we regularly see inactive people, drawn in by the allure of elite level sport, but who are rarely able or willing to participate in those sports. What is more, when participation is PA-oriented, some

sports advocates regard it as diluted and not 'the real deal'. For these individuals, sport engagement is the single yardstick of programme effectiveness. However, when so few inactive people achieve these goals - as seen in our ongoing work – it can be enormously dispiriting for programme staff.

Given this lack of agreement and understanding between practitioners apparently 'in the know', it's no surprise that inactive people so readily lump sport together with PA. They often describe both their experience and expectations with a single, negative, judgment. Yet, when we can get them to disaggregate their experiences, it is sport that draws the most bitter, and predominantly childhood-based, accounts. Rarely does walking, dancing or gardening draw such negativity, although cycling – and road accidents involving cyclists - sometimes does.

Crucially, the assumption that sport generates PA is as strongly endorsed by sport advocates as it continues to be rejected by PA advocates. Crucially, that rejection is often deeply held by the least active individuals. Even after all this time, we – those who variously represent either the sport or the PA constituencies - still seem to be sleeping in the same bed, but dreaming different dreams. For this reason, we suggest that it is essential for all those working within and around the Healthy Stadia agenda become fluent with these issues. Sport and PA represent inherently different behaviors, with distinctive challenges, incentives and meanings for every potential recruit. Responding to such diversity requires that practitioners deploy an equally diverse repertoire of skills to meet clients' preferences.

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Notes

[1] Hunt et al, 'Gender sensitized weight loss'; Krustrup and Bangsbo, 'Football to treat disease'
[2] Parnell and Richardson, 'Football and public health'; Pringle et al., 'Health benefits of football interventions'; Martin et al., 'Football for health improvement'
[3] Parnell et al., 'Effective interventions for children'; Parnell et al., 'Football and school sport'
[4] Pringle et al., 'Football interventions for men'; Curran et al., 'Engaging men with football in the community'
[5] Rutherford et al., 'Weigh loss programmes for older men'
[6] Pringle et al., 'Football interventions for older adults'; Parnell et al., 'Reaching older adults with football'
[7] Martin et al, 'Football and health improvement'
[8] Coalter, 'The social role of sport'
[9] Department foe Education, 'Children in looked after care'
[10] Simkiss, 'Looked after children and young people'
[11] Department for Education and Skill, 'Care matters'
[12] Quarmby, 'Physical activity and looked after children'
[13] Diabetes UK, 'The scale of diabetes in the UK'
[14] Diabetes UK, 'Prevalence of Diabetes'
[15] Diabetes UK, 'Cost of Diabetes'
[16] Avery et al,., 'Changing physical activity behaviour in type 2 diabetes'; Cuenca-Garcia et al., 'Physical activity and its influence on glycaemic control'
[17] Edmunds et al., 'Physical activity in children with diabetes'
[18] Brazeau, 'Physical activity and type 1 diabetes'; Lascar et al., 'Barriers to exercise for type 1 diabetics'
[19] American Diabetes Association, 'Physical activity and diabetes'
[20] (Loreto et al, 2003)
[21] Healy et al., 'Objectively measured sedentary time and physical activity'
[22] Blair et al, 'Physical activity and physical fitness for health'
[23] Department of Health, 'Start active stay active'
[24] Short et al., 'Physical activity intervention delivery'
[25] Bingham et al., 'Football for health'; Pringle et al., 'Football based interventions and health'
[26] Parnell et al., 'Physical activity for older people in football clubs'
[27] Pringle et al., ' Burton Albion case study'
[28] Robinson, 'Leeds activity levels'; Sport England, 'Active people survey'
[29] Sport England, 'Active people survey'
[30] Zwolinsky & McKenna, 'Leeds let's get actives reach'
[31] Zwolinsky & McKenna, 'Participant views of Leeds let's get active'
[32] Zwolinsky & McKenna, 'Leeds let's get active baseline data'
[33] Zwolinsky & McKenna, 'Outcomes from Leeds let's get active'
[34] Fineberg, 'Successful and sustainable health car systems'

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