

Contents

<i>Foreword, David F. Seedhouse</i>	viii
<i>Acknowledgements</i>	x
<i>Notes on Contributors</i>	xi
<i>List of Figures</i>	xvii
<i>List of Tables</i>	xviii
<i>List of Boxes</i>	xix
<i>List of Abbreviations</i>	xx
Introduction	1
<i>Barbara L. Griffin, Jacqueline Merchant and Anne Charnock</i>	
PART I	
INTRODUCTION TO HEALTH PROMOTION, AND SPORT AND PHYSICAL ACTIVITY	9
1 Definitions, Values, Models and Approaches in Health Promotion	11
<i>Barbara L. Griffin and David F. Seedhouse</i>	
2 Definitions, Models and Development Issues in Sport	21
<i>Zofia Pawlaczek</i>	
3 Planning and Project Management	35
<i>Barbara L. Griffin and Alyson Learmonth</i>	
4 Research and Evaluation	45
<i>Barbara L. Griffin and Alyson Learmonth</i>	
PART II	
HEALTH OF THE INDIVIDUAL	61
5 Health Benefits of Physical Activity across the Lifespan	63
<i>David Blackwell</i>	

6	Drug Use in Sport	83
	<i>Alison McInnes, Ralph Heron and Mark Harrison</i>	
7	Culture, Lifestyle and Identity: Constructing the Healthy You	95
	<i>Nigel Watson</i>	
8	Health Promotion and Healthy Lifestyles: Motivating Individuals to Become Physically Active	103
	<i>István Soós, Jarmo Liukkonen and Rex W. Thomson</i>	
9	Psychology and Home Exercise Prescription	118
	<i>Sandra Darkings and Anne Charnock</i>	

PART III

	HEALTH OF COMMUNITIES	131
10	Physical Activity across the Lifespan: Establishing Community-Based Classes for the Older Person	133
	<i>Lorraine Hughes</i>	
11	How Understanding Community Development Will Help Your Career	145
	<i>Mark Burns and Barbara L. Griffin</i>	
12	From ‘Personal Exercise on Prescription’ to ‘HELP’: Evolution of an Exercise on Referral System	157
	<i>Sue Collins and George Goodson</i>	
13	Ethnicity and Health Promotion	174
	<i>Rex W. Thomson and István Soós</i>	
14	Gender and Sport: Promoting/Preventing Health in Our Schools	186
	<i>Kate M. Russell</i>	
15	Disability, Sport and Exercise	203
	<i>Hayley Fitzgerald and Di Bass</i>	

PART IV

	HEALTH OF SOCIETY	221
16	Social Inequalities, Social Exclusion and Health	223
	<i>Jacqueline Merchant</i>	
17	Getting Evidence about Physical Activity into Practice: Inequalities in Health and their Reduction	248
	<i>Michael P. Kelly and Hugo Crombie</i>	

<i>Contents</i>	vii
18 Global Health Promotion: Issues, Principles and Practice <i>Chris Llewellyn</i>	262
19 Australian Government Policy on Sport and Health Promotion: A Look at ‘Active Australia’ <i>Trent D. Brown</i>	282
<i>Index</i>	297

PART I

INTRODUCTION TO HEALTH PROMOTION, AND SPORT AND PHYSICAL ACTIVITY

CHAPTER 1

Definitions, Values, Models and Approaches in Health Promotion

BARBARA L. GRIFFIN AND DAVID F. SEEDHOUSE

Introduction

The aim of the chapter is to encourage a critical approach to the role of health promotion in relation to sport and physical activity. The authors decided to write this chapter as a dialogue and this means that there are comments to follow each part in order to facilitate a critical perspective on the concepts of values, definitions, models and approaches in health promotion.

In this chapter, the proposal offered by Barbara Griffin is that health promotion facilitates the process of engaging individuals or communities in increasing their uptake of sport and physical activity. The argument draws on current scientific evidence that regular engagement in physical activity reduces the risk of coronary heart disease (The European Heart Network, 1999). Nevertheless, this proposal requires further examination because of difficulties in defining the concepts that exist within it such as what is regular engagement in physical activity. Encouragement of physical activity to the general population is part of a lifestyle modification approach whereby the health experts recommend a change in behaviour to an individual's lifestyle.

Learmonth and Watson (1999) argue that lifestyle education is the cornerstone of United Kingdom health policy since the 1970s. In addition, because of the changes in employment, in that work is less physical, the lifestyle changes include how people spend their leisure time. For instance, participating in physical activity might mean spending time walking, jogging or cycling as part of a leisure routine. Nevertheless, the decision to support increasing levels of physical activity in the general population is an evaluative statement that draws on a person's or a society's values. In this context values mean something that a person or persons' believes to be important. Therefore, I intend to explore the underpinning values in the next section.

Before you do that Barbara, let me stop you for a moment, so that I might begin to explain why we have to be so careful about definition. There are many different types of definition, and each of these ultimately has an ethical ramification, dependent on how a definer chooses to use it. For example, there is a very significant difference between defining a tree by pointing at it and saying 'tree', and defining a person by pointing at her and saying 'healthy'. It is easy enough for people to agree about the difference between a tree and vegetable. Once this way of talking about trees and vegetables becomes conventional there is usually little reason to change it, unless technical developments (say in genetics) mean that it makes sense to refine plant taxonomy. Nonetheless, defining people as healthy and unhealthy is much more problematic. People are complex – which parts of them are we pointing at as we define 'healthy'? Why do we think some parts of them are healthy? Is it the way they look? The way they function? The way the person uses the parts as she lives her life? In other words, we always need to be careful about which sort of definition we make, and we always need to examine why we have chosen to use that sort of definition rather than an alternative.

With definitions in mind, health promotion workers, in the area of sport and physical activity such as sport development officers, who in their daily work have a responsibility to promote health, need to analyse their definition of health. Arguably sport, exercise and physical activity students draw on definitions of health operating within a scientific paradigm such as the medical model. The medical model follows a causal pathway of identifying a problem, locating a solution and measuring the outcome.

Yes. Another way of putting this is to point out that the primary reason the nature and meaning of health is contested is because health is not 'out there' to point at like trees are. Presumably a tree looks and feels the same to everyone who notices it, and responds in replicable ways to laboratory tests, but this is not the case with health. You can walk into the woods and find countless trees, and everyone will agree that they are trees. You cannot walk onto a city street and find countless healthy people (or lifestyles, or attitudes, or exercise regimes) that everyone will agree are healthy since health is not an idea you can define ostensively, (i.e. just by pointing).

Many people involved in very practical, physical health promotion do not fully appreciate this point. They believe that the fact they can measure – say – improved respiration and blood pressure levels in an individual following a programme of 'healthy' exercise and nutrition, means that they can measure an objective improvement in that person's health. This is a serious philosophical error – one which has potentially severe ethical and practical consequences.

Health is not an objective idea – it is an evaluative idea. What we think of as healthy and unhealthy depends upon our values and preferences: I may consider a defiant cancer patient as extremely healthy; her doctor may see her as profoundly unhealthy. A physically activity health promoter may see a previously overweight person who now goes to the gym daily as much more healthy than she was, while her husband may be wondering why she is beginning to pay less attention to him

and their children as a result of her new-found interest in her physical appearance. Our different assessments of health have very little to do with the bits of people and people's behaviour that we can point at and measure; but they have everything to do with the extent to which we approve of them.

Therefore, it is worth noting that bio-medical explanations of health tend to reduce complex issues to single problems such as reducing coronary heart disease by recommending an increase in physical activity (The European Heart Network, 1999). Following on from the medical link between coronary heart disease and physical activity, the current scientific medical literature, which suggests that the maintenance for adults of 30 minutes physical activity that make the individual warm and slightly out of breath, 3–4 times a week, is beneficial for reducing the risk of coronary heart disease (The European Heart Network, 1999).

This may be statistically true for groups of individuals, though presumably the research evidence is not decisive (it hardly ever is). Nevertheless, it does not necessarily apply to any given single individual, since the causes of coronary heart disease are multifactorial and by no means all to do with exercise (see Wilkinson, below, for example). If people are encouraged to do something (exercise) which they don't like to do on the ground that it is certainly good for them, then there is clearly some cause for ethical concern (for example, if it makes them feel tired and means they can spend less time on activities they like better).

Given that medical experts argue that physical activity helps reduce the incidence of coronary heart disease, diabetes, and obesity there appears to be a mismatch between the medically defined problem of the consequences of people's low physical activity levels and people's willingness or desire to change their behaviour in relation to increasing their physical activity level. One explanation of this mismatch could be that health promoters assume that people can and want to change their behaviour. In addition, Wilkinson (1996) argues that poverty, poor nutrition, inadequate housing and unemployment also contribute to the high levels of coronary heart disease in the United Kingdom.

And genetic predisposition.

Therefore, one can conclude that taking a single medical perspective on a health issue only provides ONE perspective. It is essential to recognize other factors play a part. So why is physical activity given such a high profile?

In my opinion, because:

- *It is relatively easy to promote.*
- *It produces aesthetic changes to the body that are also enthusiastically promoted by a wide range of commercial interests (the diet, fashion and lifestyle industries to name but three).*

- *It is supported by the medical profession who see it as a direct way to reduce the incidence and severity of disease.*
- *It doesn't require much thought.*
- *It doesn't require significant social change, for example, in work patterns, income distribution, equity, living conditions and so on.*
- *It is perceived as helping to keep people 'out of mischief' – if they are exercising then they are not doing something else that might be bad for them.*

Following on from these points the promotion of physical activity tends to oversimplify the issue. For example, to illustrate this point I intend analysing a quotation from the United Kingdom, Ministry of Culture, Sport and Media website (2003) 'Sport is very powerful both in the pursuit of excellence and helping to tackle social and health problems'.

This quotation contains what could be conflicting concepts and requires further examination. First, the notion that sport can embrace excellence and secondly, that sport can combat social and health problems. Sporting excellence can achieve reward, for instance England's success in the rugby World Cup on 22 November 2003. Pursuing the goal of sporting excellence necessitates the exclusion of those people who cannot achieve success. Conceivably, the values that underpin sporting excellence relate to national status, cultural identity and competition. Sport at a national level has the potential for being high risk and means that sportsmen and women are often in sport rehabilitation for periods of their sporting career. Arguably, this quotation expresses a shared value about the role of sporting excellence in society. For instance, in relation to competitive sport, Hendry et al. (1993) argue that young men who are fans of competitive teams are more likely to engage in physical activity than those young men who are not fans of competitive teams.

The second element of the quotation is that sport and physical activity contribute to combating health and social problems. Therefore, I intend illuminating the values that could underpin physical activity that relate to tackling social and health issues. Increasing levels of physical activity in a population requires participation particularly by those people who do not usually engage in physical activity, such as women and ethnic minorities (The European Heart Network, 1999).

Is this true? My everyday observation in New Zealand of aerobics classes, swimming pool use, netball games, tennis play and so on reveals a female representation of at least 50 per cent, probably more.

One conclusion to the above point might be that there are differences between cultures and social class in relation to women's participation in sport. The European Heart Network (1999) and Mulvihill et al. (2000) suggest that women participate less in sport. The value of increasing levels of physical activity in a population means that the emphasis is upon engagement rather than excellence. Nevertheless, the recommendation to engage in physical activity is normative meaning that experts drawing on scientific evidence believe that low levels of activity damage people's health. Engagement here means participating in either a sport or physical

activity in order to improve or maintain one's health rather than participating to achieve sporting excellence. The reference to social issues could mean that engaging in purposeful physical activity maybe an alternative to participating in unsocial behaviour. Possibly, in a social sense the goal of engagement connects to aspects of social exclusion.

Therefore, the values that underpin sporting excellence and participation in physical activity are different. For instance, I mean a person who is an international swimming coach has different goals to a person who is a community physical activity officer. In support of sensitivity to a person's role Learmonth and Watson (1999) argue that health promoters need to be aware of the theoretical basis of their work. This means that the task of defining concepts is important otherwise there is an assumption that there are shared definitions in relation to health. Health promotion is a complex area because the core concept of health is difficult to define. What are you trying to promote? Arguably, to be able to establish a working definition it is critical that health promoters examine their values in order to avoid misunderstandings in relation to how different people define health (Seedhouse, 1997; Raphael, 2000).

There can be no argument about this. Unless health is explicitly defined by health promoters the health promoters' values will be at least partially hidden. Given the widespread but mistaken belief that health is an objective notion, many health promotion recipients will experience the effects of those values under the impression that they are objective – but values are never objective.

This point cannot be overstated. At the very least we need to be clear about:

- a) *Which health obstacles we should remove – should we remove all and any health obstacles or only some of them?*
- b) *If we can't remove them all at once, or can't afford to remove them all at once, which obstacles we should remove first?*
- c) *What we do if we as health promoters select different obstacles from those selected by our health promotion clients? Are we always right? Are our values always best?*

Let's flesh this out a little more. In order for me to be healthy (in my view), at this moment (1.41 p.m. NZ time on Friday January 23rd 2004), I feel I need, among other things:

- a) *A customer for my software business.*
- b) *NZ\$100,000 to build the level of product I need.*
- c) *A letter from a playwrights' agency telling me they like my latest play.*
- d) *More close friends.*
- e) *A good night's sleep.*

Should I go to my local health promotion office and ask them to help me with these things? I don't suppose I'd get very far with any of them except e). The trouble is

that without these things I definitely do not feel that I am as healthy as I can be, and to some extent the lack of them does provoke anxiety.

Would the health promoter be right to focus on the sleep issue? If so, why? Is it more of a health issue than the others? If so, why? What if the health promoter decided that the chief obstacle is that I'm overworking? What if I took the view that the health promoter didn't have a clue? Which of us would be right? Who would understand health best?

Normative health messages such as 'take more physical activity' focuses on one issue rather than taking into account the problems that people face in their daily lives. For example, if cost was a factor in why people do not participate in more physical activity then there could be collective initiatives in workplaces to encourage people to participate in physical activity, such as reduced fees at sport centres. Conceivably, this argument assumes that physical fitness is of prime importance for health; however, how does one decide how much physical activity is beneficial for health? An elite sportswoman might not consider her health as the prime goal, but rather achieving sporting excellence in a particular sport. It could be the case someone who does achieve sporting excellence might say that they have achieved fulfilment in their lives through their success. Clearly, the concept of health in relation to sport and physical activity is a contested area that requires scrutiny and debate because individuals and groups define health in different ways.

To explain possible definitions of health in relation to sport and physical activity, I plan to introduce quotations about health from the Stockport Certificate in Health Education course (Stockport Health Promotion, 1993). In a preliminary exercise to define health, the participants complete the sentence '*I feel healthy when . . .*' What follows in the exercise are examples of quotations that cover elements of physical health such as having all the parts of your body in working order, being the ideal weight for your height. Additionally there are quotations about social health such as feeling healthy when with family and friends, or mental health such as coping with everyday stresses. Nevertheless, when I have used this exercise in groups of students there is a sense of shared meaning at one level because the concepts of physical, social and mental health appear in the World Health Organization (1946) quotation:

Health is a state of complete physical, mental and social well-being, not merely the absence of disease and infirmity.

(WHO, 1946)

In this definition, health appears to be a separate state and Buetow and Kerse (2001) suggest that well-being replaces the word health. Arguably, the definition of well-being is problematic.

Of course it is, and for just the same reasons that defining health is problematic. People disagree about the nature and importance of well-being.

Nevertheless, if the terms remain vague, in health promotion practice there is scope for different practitioners from agencies to misunderstand the problems and the resolution of those problems. For instance, health promoters in Sedgfield District Council have put together a successful proposal (see Chapter 3 of this book) in order to increase the levels of physical activity in adolescent girls in two local schools because from the current evidence (Mulivill et al., 2000) adolescent girls do not participate in levels of physical activity that is beneficial to their long-term health.

Has anybody asked the girls what they think? Has anybody asked the girls what they think health is?

The health promoters will be asking the girls, which physical activity they want to undertake rather than what they think about health? Nevertheless, health promotion practitioners can make assumptions that can easily ignore important ethical issues. For example, the scientific argument that physical activity is good for you therefore you should do it ignores people's thoughts and feelings about physical activity in particular, and generally about what are their priorities. For example, if a young female is more interested in relationships with friends and listening to music than taking daily physical activity may not be her number one priority.

Exactly.

Another assumption is that despite the acknowledgement of different interpretations of health there is still an underlying pull towards health from a positivist perspective, meaning, that health promoters of physical activity measure and observe health. The positivist perspective sees health as 'out there' in the same way as illness and disease are 'out there' rather than interpretation of what one sees. Therefore, explanations about health are an interpretation of evidence. In a physical activity context, for example someone who has battled all their adult lives with an injury from a car accident that occurred in their late teens might be considered to be healthy because of their 'fighting spirit' or considered to be ill because of the complications from their car accident. Therefore, health is an evaluative judgement of evidence not a specific object and health promotion practice requires caution and there needs to be priorities, but who decides on the priorities?

Exactly.

A second issue in accepting that physical activity is beneficial tends to draw on a medically orientated definition of health. In a sport and physical activity context, the definition of health tends to focus on the maintenance of physical health and the prevention of disease. One understanding of the medically orientated definition of health might be that if people do not engage in 30 minutes of physical activity 3–4 times a week they are not healthy. In other words according to this definition very few of us are healthy and interventions that prevent disease become desirable.

Caplan (1964) argues that the prevention of disease takes place at different levels. To illustrate this typography I will use physical activity examples to illustrate each level:

- Primary prevention meaning the interventions that reduce the onset of disease, for example young people (5–18) should aim to take one hour accumulated moderate-intensity activity to promote optimal growth, and development and help to foster appropriate activity patterns into adulthood. The inclusion of physical activity in the school curriculum contributes to encouraging young people to remain active; however, adolescent females do not continue to participate. Therefore, the health promotion intervention needs to take into account the preferences and priorities of the adolescents.
- Secondary prevention means preventing a recurrence of an illness or disease in its early stages and treatment. For instance, the Department of Health (2000) coronary heart disease National Service Framework outlines 12 standards for the reduction of coronary heart disease. In the first two standards, there is reference to the prevention of coronary heart disease in high-risk patients. I understand this to mean that nurses or doctors will screen for patients in a primary care or hospital setting who experts identify as high-risk or who have had a heart attack. One response to identify people who are at high risk might be to recommend information about the benefits of engaging in physical activity.
- Tertiary prevention means restricting the disease in terms of recurrence and complications. Referring back to the United Kingdom, coronary heart disease National Service Framework standards the final standard refers to the rehabilitation of coronary heart disease patients. In a physical activity context this means physical rehabilitation as exemplified by my colleague Zofia Pawlaczek's (Chapter 3 this book) definition:

Physical Rehabilitation is the use of physical movement to support or improve rehabilitation in the human body and or mind (as mental health can be improved through physical movement). The type of activity selected by the professional or individual (self-administering) is normally congruent with the rehabilitation goal. Professionals undergo training that enables them to respond appositely to a disease and or condition in relation to the general medical consensus. A presiding body does not govern the lay-referral system, however certain lay-beliefs will influence choice of activity, for example, for weight-loss the health and fitness industry has overtaken as the body responsible for disseminating advice on such issues (as opposed to GP's in the past). Physical rehabilitation can include sporting activities, physical games, exercise, and any physical movement.

With these levels of prevention in mind, I would argue that defining people as healthy or unhealthy in relation to coronary heart disease reduces the definition of health to one that is medically orientated. Arguably the medical definition of health is dominant and as Katz et al. (2000: 29) argue it is, 'the most powerful and influential discourse about health and, as we have seen, one which defines health quite narrowly'.

Exactly.

So far, I have tried to suggest that in a sport and physical activity context the dominant arguments draw on a medically orientated definition of health. In relation to reducing the incidence of illness and disease, the disciplines that support the promotion of physical activity for health are physiology, medicine, psychology, sociology and education. If we limit health promotion and physical activity to the dominant argument, that is, the medical arguments then we reduce the approaches that are mainly the physical measurements that constitute a healthy person. Arguably, the medical perspective relates to the way people look perhaps in terms of their weight and their participation in physical activity. For example, the recent United Kingdom government targets for reducing obesity as well as increasing levels of activity (Department of Health, 2000). This means ordinary people's lives become the object of scrutiny in relation to how they live their everyday lives (Bercovitz, 2000). As stated earlier, recent United Kingdom government policies promote altering lifestyles such as reducing intake of alcohol, smoking cessation, reducing weight and increasing activity levels. To avoid a dogmatic approach a health promoter needs to consider their own values, the values of their organizations and the values of the people they aim to help. This requires a scrutiny of health promotion practice rather than scrutiny of whether people are physically active or not.

In order to offset the limitations of the medical model, I suggest that sport and physical activity experts adopt a broader definition of health. This would facilitate broader health promoting possibilities such as engaging people in the planning and management of sport and physical activity projects. To explain this point further I want to return to my original aim of the book. I have taught health promotion to sport scientists and sport, exercise and development students for ten years. The students' main criticism of health promotion is that it is not relevant to their course. This is despite the employment of sport, exercise and development graduates in health promotion departments (James and Johnston, 2004). The role of health promotion to sport and physical activity is the way health promotion works or the processes health promotion employs. For instance, using communication strategies to raise awareness on an issue, professional training in project management, health education development in the curriculum in schools, including the hidden curriculum and community development approaches to help people identify their health needs.

Conclusion

A main component of health promotion is values, as all other activities follow on from an understanding of the importance of values in making judgements about what are the definitions of health, the problems and what actions to take. Health promoters need to examine their own values in relation to why they might prefer certain definitions of health, as opposed to others, and why certain

interventions are taken in preference to others. The values a health promoter has might be individual value or one that society shares. Nevertheless, it is important to note that not everyone will share the same values and definitions of health. Health is a contested subject and there are different definitions of health. Health promoters need to define what they are doing in order to avoid confusion and misunderstanding.

References

- Bercovitz, K. L. (2000) A critical analysis of Canada's Active Living: science or politics?, *Critical Public Health*, 10, 1, 19–39.
- Buetow, S. A. and Kerse, N. M. (2001) Does reported health promotion activity neglect people with ill-health?, *Health Promotion International*, 16, 1, 73–78.
- Caplan, G. (1964) *Principles of Preventive Psychiatry*. New York: Basic Books.
- Department of Health (2000) National Service Framework for Coronary Heart Disease. London: HMSO.
- The European Heart Network (1999) Physical Activity and Cardiovascular Disease Prevention in the European Union. [www.ehnheart.org/Visited 26-01-04](http://www.ehnheart.org/Visited%2026-01-04).
- Hendry, L. B., Shucksmith, J., Love, J. G. and Glendenning, A. (1993) *Young People's Leisure and Lifestyles*. London: Routledge.
- James, A. D. and Johnston, L. H. (2004) The emerging role of the physical activity promoter within health promotion, *Health Education*, 104, 2, 77–89.
- Katz, J., Peberdy, A. and Douglas, J. Eds. (2000) 2nd edition *Promoting Health Knowledge and Practice*. Milton Keynes: Open University and Macmillan Press.
- Learmonth, A. M. and Watson, N. J. (1999) Constructing evidence-based health promotion perspectives from the field, *Critical Public Health*, 9, 4, 317–333.
- Ministry of Culture, Sport and Media (2003) <http://www.culture.gov.uk/sport/default.htm> Visited 17-07-04.
- Mulvihill, C., Rivers, K. and Aggleton, P. (2000) Views of young people towards physical activity: determinants and barriers to involvement, *Health Education*, 100, 5, 190–199.
- Raphael, D. (2000) The question of evidence in health promotion, *Health Promotion International*, 15, 4, 355–367.
- Seedhouse, D. (1997) *Health Promotion Philosophy, Prejudice and Practice*. Chichester: Wiley.
- Stockport Health Promotion (1993) *Certificate in Health Education Course*. Stockport: Stockport Health Promotion.
- WHO (World Health Organization) (1946) *Preamble of the Constitution of the World Health Organization*. Geneva: WHO.
- Wilkinson, R. G. (1996) *Unhealthy Societies*. London: Routledge.

Index

- 'Active for Life' programme 114
- accident prevention 103, 133–7, 143, 176, 252
- Active England Report 223, 229–30, 243–5, 250, 279
- action learning 35–44, 57
- Active Australia 282–94
- Active England 42, 45, 51, 57
- adolescence 50, 63, 69, 73–80, 180–6, 197
- adulthood 18, 63–79, 125, 187, 197–8, 211, 226, 236, 240
- advocacy 208–11, 265, 270–1
- ageing 35, 63–79, 104, 133–8, 143, 289, 294
- Ajzen, I. and Fishbein, M. 105, 110, 115, 121, 126
- Alma Ata 269
- anabolic steroids 83–4, 88–9, 91, 94
- anti-doping 84–5

- Bandura, A. 54, 57, 120–7
- BASE activity programme 114
- Beattie, A. 143
- behaviour 11–15, 36–9, 42, 46–8, 54–5, 58, 77, 80, 86, 90–3, 97, 101–17, 255, 257–8, 261, 271, 276, 292, 294
- Bercovitz, K. L. 19–20, 50–1, 57
- Biddle, S. 77–8, 104, 110–12, 115–17, 188, 294
- Black Report 225–30, 237, 242, 279–80
- Blaxter, M. 143
- blood born virus 83
- blood composition 68, 74, 76
- blood pressure 12, 67, 75, 79, 81, 112, 118–29, 136, 161, 165, 249
- bodies 25, 29, 49, 85, 95–102, 196
- body fat levels 166
- bone mineral density 69, 74, 78, 81, 135, 188, 249

- cardiovascular system 20, 46, 64–8, 71–5, 77, 80, 112, 119, 127, 176, 181–3, 187, 235, 240, 249–50, 277

- Cashmore, E. 98, 102
- childhood 78, 97, 226, 277
- childhood obesity 78
- children 13, 29–32, 40–1, 48–50, 59, 63–4, 69, 73–80, 95–6, 113–14, 116, 135, 138–44, 147–53, 176, 183, 186–98, 215–16, 225–8, 230, 235, 262–9, 288–93
- choosing health 1, 244
- coaching 30, 33, 197, 209–15, 257
- cognitive function 126, 255, 292
- community 15, 19, 23, 25, 29, 37, 40–3, 81, 83, 133–50, 158–73, 177–82, 210–13, 230–9, 253–7, 263–78, 284–9, 294
- community development 19, 97, 110, 150, 242
- community development theory 154
- consumption 66–7, 88, 97–100, 102, 276
- Cooke's house of sport 27–8
- coronary heart disease 11, 13, 18, 20, 129, 134–6, 157–72, 181, 227, 231, 249–50, 260–1
- cross-culture 104, 183
- culture 14, 21–5, 31–2, 42, 48, 50, 95–6, 100–2, 116, 119, 193–4, 198, 204, 223, 229, 253, 264–5, 271–4
- cycling 38, 46–8, 58, 72, 76, 115, 152, 195, 231, 256

- definitions 12, 21, 23
- Delphi study 46
- depression 112, 231, 235, 241, 248–9
- deprivation 35–6, 44, 182, 229–34, 238–9, 243, 259, 279
- diabetes 13, 64, 66, 71–2, 74, 112, 136, 176–84, 249–50, 268, 277
- disability 30, 112, 114, 135, 146, 155, 203–19, 235, 237, 250, 265
- disadvantage 116, 123, 176, 189, 192, 197, 240, 248, 264
- DISCUS 3, 83, 86–8, 90–3
- disengagement theory 143

- doping 83–6, 93–4
 drug use 3, 72, 83–95, 115, 151, 177–8,
 234, 284, 287
 Drugscope 86, 94
- education 11, 16, 19, 20, 23, 36–9,
 42–3, 49–50, 52, 103–16, 122–7,
 136, 148–52, 160, 176–84, 186–201,
 204, 206, 207–18, 224–43, 250–3,
 257, 260, 264–5, 269–71, 275,
 289–92
 effectance motivation theory 105
 employment 1, 11, 19, 36, 41–2, 135,
 151, 171, 206, 230
 ethnic minorities 14, 51, 98, 114, 146,
 149, 151, 174–84, 187, 204, 237,
 239, 251–3, 261
 ethnicity 108
 European Health Promotion Award 152
 European Heart Network 11, 13–14, 20,
 48
 evaluation 37–39, 43, 45–56, 111,
 154–5, 230, 256, 268, 274–5,
 293, 295
 exercise 12–13, 16, 18–19, 21–2, 24–5,
 29, 31, 40, 42–3, 46, 56–8, 72–81, 94,
 96, 98–100, 102–17, 136–7, 140, 146,
 150, 157–73, 176, 181, 203, 223–44,
 251–9, 279–86
 exercise behaviour model 108
 exercise prescription 118–29
- Featherstone, M. 97, 102
 ‘Fit for life’ programme 114
 football 147, 149–51, 153–4, 181–4, 191,
 194, 210, 290
 Foucault, M. 101
- gender 29–30, 33, 47–8, 59, 95–6, 102,
 140, 178, 186–201, 204, 237, 242,
 252, 264, 268, 288, 290
 Green, L. W. and Kreuter, M. 36, 43,
 107, 116, 136
- harm minimisation 83, 86–7, 90–1, 93
 health action zones 57
 Health Canada 52, 58
 health development 123, 238, 251, 254,
 257, 260, 268, 271–3
 health promotion (models) 11, 28, 36–7,
 39, 41, 81, 83, 86
 health psychology 109, 127–8
 Health Survey for England 33, 187, 236,
 251, 260
- ‘HELP’ 157–73
 ‘HEPA’ network 113
 hepatitis 83, 88–9
 HIV 83, 86, 252, 264–5
 house of sport 27–8
 hypertension 67–68, 74–5, 79, 92, 113,
 170, 227–8, 235
- identity 14, 23, 50, 95–7, 124, 151, 178,
 190, 195, 199, 210–11, 217, 232
 index of multiple deprivation 35
 international
 competition 27, 254
 conference on health promotion 270
 games 213
 monetary fund 279
 Olympic committee 83–4, 94, 96
 Paralympics 214
 Sport Conference 289
 swimming 15
- Kelly, M. 35, 252–61
 Kolb, D. A. 53, 58
- learned helplessness 105
 leisure 11, 20–1, 23, 27, 30–4, 42, 50–1,
 66, 81, 95–7, 99, 102, 113, 115–16,
 142, 158–71, 179, 236, 239–40, 284
 lifespan 63, 105, 133
 lifestyle 1, 11–13, 19–20, 25, 28–9, 32,
 36, 42–3, 66, 71–4, 95–7, 99–101,
 136, 158–71, 176–82, 187, 198,
 228–43, 257–9, 292
 Likert scale 47
 Liver Function Test (LFT) 88–9, 93
 locus of control 105–6, 109, 111, 126
 longevity 64–5, 72, 78, 80, 135
 Lupton, D. 98–100, 102
- medical model 1, 12, 19, 53, 55, 161,
 171, 205
 medicalisation 85, 101
 memory 71, 77
 mental health 16, 18, 74, 77–8, 81,
 103, 116, 134, 151, 158, 169, 238,
 242, 267
 Ministry of Culture, Sport and Media 14,
 20
 misuse of drugs 86, 91, 93–4, 252, 261
 models 11, 28, 36–7, 39, 41, 56, 103, 107,
 116, 120–1, 123, 126, 128, 133, 144,
 159, 171, 275
 morbidity 46, 71, 77, 80, 104, 112, 134,
 137, 223–4, 236, 248, 283

- mortality 42, 46, 66–7, 71, 77, 80, 104, 112, 134, 176–7, 223–45, 248–53, 260–4
- motivation 36, 38, 49, 57, 103–7, 111, 114, 116–29, 138, 163–73, 188, 194, 203, 290
- motivational systems theory 106
- Mulvihill, C. 14, 20, 48, 252, 260–1
- National Curriculum 190, 290
- National Physical Activity Guidelines for Australia 286
- National Service Framework 18, 143, 169, 172, 238, 289
- National Statistics 30, 33, 250, 261
- needle exchange 86–7
- obesity 33, 42, 64, 69, 74, 112, 170, 176, 186–8, 198, 228, 238, 248–9, 252–3, 261–2, 277–8, 288, 292
- older people 133–44, 147, 152, 169, 173, 237–8, 244, 249, 255, 259
- Olympic Games 22, 83–4, 84, 96, 203, 214, 265, 280, 284–5
- optimal experience theory 106
- Peckham Pulse 25, 32
- performance 22–3, 26–7, 33, 77, 84, 89, 94, 106, 116, 153, 193, 203, 213–17, 121, 126, 284–5, 287
- performance enhancing drugs 83–6
- physical education 21, 23, 26, 31–4, 49–50, 114, 144, 160, 172, 186–98, 207, 209, 211, 216, 264–5, 257, 282, 288–92
- Pikora, T. 38, 46–8, 58
- planning 19, 26, 30, 32, 35, 43, 50, 52, 56, 86, 107, 109–10, 120–1, 124, 126, 133–4, 136, 138, 140, 143–4, 148, 153, 155, 161, 213
- policy 11, 24, 27, 33, 36–8, 42–3, 48, 52, 84, 86–7, 94, 189, 196, 203–8, 218, 248–80
- preced-proceed 37, 107
- Prochaska, J. O. and DiClemente, C. C. 109–10, 116
- project management 19, 35, 155
- psychosocial 71, 86, 115, 128, 231, 234
- public health 20, 23, 44, 57–58, 86, 102–103, 112, 133, 136, 144–5, 181, 187, 229, 230, 244, 248, 250–7, 260–1, 267–8, 273–9
- Raphael, D. 15, 20, 45, 47, 53
- rehabilitation 14, 18, 25, 119, 122–3, 125, 127, 129, 206, 269, 282
- risk 11, 13–14, 18, 30–1, 66–7, 69–81, 85, 86, 90–1, 100, 108, 112, 114, 119, 122–3, 136–8, 143, 151, 159–71, 177, 182, 186–7, 192, 224–8, 231–5, 242–3, 248–50, 255, 260
- Sedgefield 35, 42, 51
- Seedhouse, D. 11, 15, 20
- self-determination theory 116
- self-worth theory 105
- skeleto-muscular system 69, 74, 76
- smoking 19, 66, 110, 113, 116–17, 159, 170, 250–3, 260–1
- social
- capital 233
 - change 14
 - class 14, 53, 98–9, 175, 223–48, 253
 - cohesion 23, 151, 232
 - construction 33, 48, 50, 95–8, 135, 174, 193, 203
 - deprivation 51, 279
 - exclusion 15, 33, 74, 101, 161, 223–47
 - groups 30, 102, 232
 - health 16
 - inclusion 23, 223, 230–1, 238, 242
 - inequalities 223–47
 - integration 210
 - issues 15, 28–9, 42, 46, 66, 90, 108, 134, 181, 292
 - marketing 114
 - model 203–6
 - problems 14, 37, 39, 83, 182
 - support 124–5, 139, 252, 257
- social-cognitive theory 114, 118, 120, 126–7
- socialisation 74, 97, 179, 210
- social-psychological commitment model 111
- socio-economic 98, 107, 146, 179, 183, 187, 204, 238, 267, 269, 273
- sociology 33, 58, 94, 102, 179
- socio-political 30, 141
- sport
- action zones 239
 - commitment model 211
 - continuum 26
 - development 25–8, 155, 207, 211, 285
 - injury 119, 122
 - models 21
 - policy 283, 292
 - psychology 117

- sport – *continued*
 Sport England 23, 27–9, 57, 207–15, 284
 students 36, 57
 stages of change model 109
 standardised mortality ratio 42
 stroke 67–8, 72, 74, 80, 249–50
 Sunderland 78
- Tannahill, A. 36, 44, 116
- theory 35, 53–4, 57, 64, 105–6, 110–11,
 114–16, 123, 143, 154, 157, 173,
 262, 278–9
 theory of planned behaviour 110, 123
 theory of reasoned action 105
 transport 46–7, 49, 67–8, 138, 140, 212,
 244, 277, 287
 transtheoretical model 110, 114, 128
 Turner, B. 101–2
- unemployment 13, 150–1, 161, 176, 206,
 224–5, 240
 UNICEF 232, 263, 269
- values 11–23, 28, 33, 37, 45, 52, 72,
 75, 84, 88–9, 97–101, 107–9, 116,
 120, 123, 126, 138, 141, 155,
 178–9, 190
- walking 11, 22–3, 29, 38, 44, 46–8,
 51, 58, 72–3, 81, 113, 115, 151–2,
 167, 170, 188, 236–7, 243, 250–8,
 287
 walking bus 32, 34
 weight control 12, 16, 18–19, 49, 66,
 68–9, 74, 81, 97, 113–14, 117,
 166, 170, 187, 249,
 252, 261
 weight loss 70, 75, 85, 101, 196, 249
 welfare dependency 51, 134
 well-being 16, 49, 63, 66, 70, 72, 74,
 77, 114, 127, 133–44, 162, 169, 182,
 266, 270
 Werner's Syndrome 64
 Wilkinson, R. 20, 232–4, 243–4
 World Anti-Doping Agency 84–5
 world class 28
 World Cup 14
 World Health Organization 16, 20, 29,
 34, 44, 59, 103, 113, 117, 129, 150,
 186, 202, 233, 235, 250, 261, 270,
 277, 281
- youth 30, 47, 49, 50, 58, 74, 80–1,
 114–17, 150, 154, 188–98, 208, 210,
 277, 288, 291–2