DISPARITIES IN PHYSICAL ACTIVITY AND HEALTH REMEDIAL AND STRATEGIC APPROACHES FROM SPORTS PSYCHOLOGIST

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Abstract

Disparities in physical activity and health desire is relatively not new. However, attention is driven towards the symbiotic relationship that exist between performance of physical activities and its resultant positive effect on the health of the performer. On the other hand, body inactivity as a result of non challant attitude, nature of job, influence of others and etc has negative resultant effects on people that live a sedentary life. This topic therefore sought to appreciate the differences in the incidence, prevalence, burden of disease and other adverse health condition that exist among specific population so as to be able to determine the relationship or otherwise between physical activities performance and its feature or negative effects on the health of an individual. It is after this determinant that appropriate strategies and remedial approaches towards limiting and eradicating prevalence of disparities in physical activity and health were proffered.

Key words: Disparities in Physical Activities and Health, Performance of Physical Activities, Body Inactivity, Remedial Approaches, Health Condition.

Regular physical activity is important for health benefit among youths and adults despite disparities that exist physical activities is therefore recommended for improvement of overall health and most importantly the facilitation of weight control among children and adolescents. Physical activity also fosters optimal physical and cognitive growth and development. Therefore, accumulation of at least 60 minutes of moderate- intensity physical activity daily is recommended for youth, yet data regarding achievement of the National physical activity recommendation among youths are inconsistent, with many studies finding low levels of physical activity and some studies suggesting that physical activity levels are adequate. However, Physical activity level of youths according to Daviss (2008), from racial/ethnic minority groups are generally found to be lower.

Disparities according to Birch and Ladd (1998) is defined as differences in the incidence, prevalence, mortality, and burden of diseases and other adverse health conditions that exist among specific population. Assessing the underlying causes of disparities can provide policy makers, health care providers, health educators, public health officials, and the lay public with important information to guide the distribution of initiatives and resources to reduce or eliminate health and physical disparities. Physical activity has dramatic effects on individuals' physical and mental health and on population-with good health Status. Unacceptably low levels of physical fitness and physical activity have contributed to increasing prevalence, in the past decades, of overweight and obesity among youth (Fictcher & Wolfe, 2008). According to them, Prevalence of overweight and obesity is highest among minority female children and adolescents. On the other hand, the beneficial effects of physical activity and physical fitness on physical health are very well established, and there is increasing evidence of its effects on mental health. An emerging literature, according to Davis (2008). Documents the ways in which physical activity, physical fitness, and school-based physical activity programme, such as physical education, favourably affect educational outcomes. Physical activity and resulting fitness affect physical health via the cardiovascular, musculoskeletal, endocrine, and neurological body Systems. In adults, physical activity or physical fitness has been associated with reduced risk of cardiovascular disease. The causal effects of physical activity and fitness on health Status are most apparent in adults as they have the opportunity to accrue over decades.

Recent advances in molecular biology detailing the causal mechanisms through which physical activity influences brain chemistry and cognitive functions have explained what the Greeks knew and strongly believed that a strong mind and body are intimately related. It has been equally confirmed that Physical activity affects metabolism action and all major body Systems exert powerful positive influences on the brain and spinal cord which, consequently, affects emotional stability, physical health, and ability to learn. This section reviews causal pathways by which physical activity and fitness may af[f]ect educational outcomes as there exist strangest evidence that supports direct effects of physical activity on cognition.

Physical activity has dramatic effects on individuals' physical and mental health and on population wide health Status. Unacceptable however, low levels of physical fitness and physical activity have contributed to increasing prevalence, in the past decades, of overweight and obesity among youth. Similarly, prevalence of overweight and obesity is highest among minority female children and adolescents (Daviss, 2008).

Physical activity and fitness programmes are also powerful markers of child and adolescent health, at the same time, Physical activity and/or aerobic fitness has been associated with reduced fatness. Relatively, strong (observational) evidence indicates the positive effects of physical activity and fitness on mental and emotional health of youth. (Currie and Stabile, 2006; Fletcher and Wolf, 2008).

Health- related problems play a major role in limiting the motivation and ability to learn of urban minority youth, and interventions to address those problems can improve educational as well as health outcomes. Healthier students are better learners. Recent research name them. Be specific in fields ranging from neurosciences and child development to epidemiology and public health provide compelling evidence for the causal role that educationally relevant health disparities play in the educational achievement gap that plagues urban minority youth. This is why reducing these health disparities must be a fundamental part of school reform. School leaders must prioritize how to use scarce resources to address the critical health problems affecting youth In this work, three criteria were used for establishing priorities: prevalence and extent of health disparities negatively affecting urban minority youth; evidence of causal effects on educational outcomes; and feasibility of implementing proven or promising school-based programmes and policies to address the health problem Based on these criteria, seven educationally relevant health disparities were selected as strategies priorities:

(1) vision
(2) asthma
(3) teen pregnancy
(4.) aggression and violence
(5) physical activity
(6) breakfast
(7) inattention and hyperactivity

Many other health problems affecting youths are also important, and the particular health problems deemed most important in a given school or school district will vary.

Millions of youths according to Dupaul, Jitendra and Volpe (2006) do not eat breakfast on given days hence, these minority youths from low-income families are disproportionately affected by these Problems. If these factors are not addressed, according to Daviss, (2008), the benefits of other educational innovations will be jeopardized. Educationally relevant health disparities impede motivation and ability to learn through at least five causal pathways: sensory

perceptions; cognition; connectedness and engagement with school; absenteeism and dropping out.

The causal pathways themselves are interrelated: for example, the student who is struggling cognitively is likely to feel less connected and less inclined to attend school activities which .will further undermine educational progress. The causal connections between multiple health factors and motivation as well as ability to learn will be greater than the effects of individual factors. This is based on the expectation that at least some variance would be additive. It is reasonable to believe that the functional effects of reducing multiple impediments to motivation and ability to learn would not only be additive but also synergistic; therefore, school health programmes must focus on multiple educationally relevant health disparities to maximize the educational yields.

Children should receive corrective care to enable them see well enough to acquire basic skills that identify and ameliorates allergens, irritants, and pollutants that trigger negative symptoms; and acquire opportunities for daily physical activity need that aids learning and practice of social skills, such as resisting social pressures in order to minimize interpersonal conflict and maximize cooperation, which can reduce risk for various health-compromising outcomes, including unintended pregnancy, early marriage and pre-mature births.

For youth who are sexually active, contraceptives services should be available as well. For youth who become pregnant, targeted health and social services are essential if there is to be any hope of coping with the intergenerational transmission because such an individual have the right to attend and practice safe activities. Progress in achieving this goal will be greatly influenced by the school climate and school connectedness.

Measures of school climate and school connectedness should become a norm within measures of accountability because if the school climate is poor, connectedness and engagement in school will be less likely. Failure of this will adversely affect educational as well as health outcomes. Youth who exhibit disruptive or aggressive behaviour need attention during the early stages of development of these behaviours because youth have the right to multiply daily opportunities for physical activity and daily food intake. Youth with attention and hyperactivity problems need help in learning ways to improve their mental and behavioural performances.

Most schools are already devoting some attention and resources to addressing important health and fitness barriers to learning, but these efforts are too

often of poor quality, not strategically planned to influence educational outcomes, and not effectively coordinated to maximize linkages between different school health and fitness components. For schools to address educationally relevant heath and fitness disparities in a strategic and coordinated way, there must be fundamental change in the goals of schools such as the way schools are financed, the personnel and services available, and the amount of time devoted to help youth learn social-emotional skills. Low levels of academic achievement and educational attainment among low-income and minority youth according to Bloom, Cohen and Frieman (2009), particularly in urban areas, undermine the quality of individual, family, and Community life, threatening the very integrity of the society.

Physically relevant health disparities exert a powerful, but generally overlooked, influence on the achievement gap. Disparities in this context and according to Birsh and Ladd (1998) are health problems that disproportionately affect low-income urban minority youth as measured by incidence, prevalence and physically relevant consequences.

Health factors have direct and indirect effects on physical activities outcomes, including standardized norms. To date, school reform efforts to close this achievement gap have not achieved reduction of physically relevant health disparities. To great extent, the achievement gap and health disparities affect the same population subgroups, it is. Therefore increasingly clear that both physical activity and health parameters can also exert strong and a reciprocal effects.

The social, physical, and economic environment in which youth live according to Daviss (2008) is strongly associated with academic achievement and educational attainment Davis based these criteria on the following relevant health disparities:

(l) vision problem
(2) asthmatric problem
(3) teenage pregnancy
(4) aggression and violence among youths
(5) physical inactivity
(6) breakfast loss
(7) inattention and hyperactivity participation in physical activity and fitness programme are powerful parameters of positive child and adolescent health status (Fabiano, Pelham, Coles & Gnay. 2009).

Physical activity and/or aerobic fitness has been associated with reduced fitness relatively strong (observational) evidence indicates the positive effects of physical activity and fitness on mental and emotional health of youth and young

adults. The greatest cognitive benefits of physical activity may be for those with the lowest cognitive ability (Bailey U. L, Loren, E. P, Milich, R. & Charnigo, R. 2006: Fletcher & Wolfe, 2008). Studies conceptualize and define physical activity and fitness and cognition in different ways, complicating the task of delineating which specific aspects of physical activity or fitness (e.g., cardio-respiratory, strength, flexibility, balance, speed agility) are causally related to which specific aspects of cognition (e.g., executive function, verbal, auditory and visual memory. inhibition, attention and response speed).

Remedy from Psychologists

One of the remedies that could be adopted in reducing disparities both in physical activity and health is for the government to help schools implement high quality, of mental imagery as enhancement tool for strategically planned, and effectively coordinated school health and physical activity programmes. These include policy development; guidance, technical assistance, and Professional development, accountability supported by data and Software Systems: and priorities for a national research agenda. Even if health factors had no effect on educational outcomes, they clearly influence the quality of life of youths and their ability to contribute and live productively in a democratic society, improving the health of youth is a worthy goal for elementary and secondary education. Indeed, pursuing this goal is a moral imperative from pure and applied psychologists including all other stakeholders through the followings:

Identification of the problem sources and possessing the ability to analyze and proffer possible solution should be given the desired priority. There must be adequate and effective communication link between stakeholders in the disparities, while variety of problem solving techniques should be applied, at the same time, positive and effective counseling of individuals should be implemented. The individual involved in the disparities should show adequate attention, love, care and positive spirit of belongingness. Similarly, the individual problem should not be made complex or magnified by various conditions that can ruin or increase the disparities, there should equally be a follow up in order to assess the level of improvement in the problem identified or the state of response to problem sounder closer watch. As much as possible, tackling disparities in both health and physical activities perspectives should be giving a priority, through the avoidance of negative thoughts and giving encouragement for engaging in recreational activities. Pursuing this goal, according to Curie and Stabile (2006) is a moral imperative from the pure and applied psychologists including all other stakeholders.

Psychological and Coordinated Approach towards Disparities in Physical Activities and Health Desires

A coordinated approach is characterized by programmes and services involving different groups of people, playing different roles, but forming a team and working towards a common set of goals, namely improving students' motivation and ability to learn and acquire knowledge about physical activities and health programmes, once the school priorities are established. Linkages between teachers and health service personnel are essential in helping to ensure that identified problems such as vision impairments and asthma, receive indicated follow-up care. Linkages between categorical health curricula dealing with violence and teenage pregnancy prevention can optimize the use of curricular time, recognizing and reducing susceptibility to different problems. Similarly, effective coordination activities that requires school health coordinator who is conversant with the different programmes, services and policies and how these can be linked together through the use of limited **resources** must be provided. The individual concerned about youth development should develop self confidence, positive thinking, ability to be involved in physical activities and health promotion related programmes, forgetting all negative experiences, constant positive discussion and thinking, meaningful sleep, engaging in site-seeing and excursions, and at the same time developing self assurance and appreciation. On the other hand Abubakar (2013), maintained that psychologists should be very sensitive to the particular problem of people so as to be able to determine the best method of solving them, essentially, the psychologist should know the individual involved in the disparity problem, study their personality traits and how they react to situations. Such expert should have sound knowledge of psychological approach so as to be able to cope with the needs and demands of all under his care; words of encouragement**,** pre-ups praises, constructive corrections and pep talk should be used constantly by the psychologists so as to assist people overcome disparities in health and physical activities. In a nutshell, psyching up strategies that are specifically designed to increase arousal and activation level should be obtained and fully utilized.

Since strong evidence supports the effectiveness of violence prevention programmes, it is essential that educational experts adopt curricula from worthwhile programmes especially those that demonstrated effectiveness. These programmes are identifiable through existing resources such as Centres for Disease Control and Disease Prevention. One of the most important aspects of the violence and aggression component of a comprehensive school health programme is to foster the development of mentally appropriate skills that will help youths learn value, and practice pro-social behaviours. These skills, which largely address issues of self-awareness and self-regulation, includes but are not limited to, communication and assertiveness, conflict resolution, impulse control and anger management,

resisting social pressures, decision making and problem solving. The acquisition and maintenance of these skills requires time and practice. Without an adequate time commitment, youth cannot be expected to learn and use these skills in or out of school.

Conclusions

Disparities in physical activity participation and health of an individual exist, but it is not clear which population subgroups experience the greatest disparities. Based on research by Birch, S. H. & Ladd, G. W. (1998), indicated that greatest disparities in physical activity participation were between racial, ethnic and status subgroups. However, the secondary analysis of objectively monitored physical activity data from other survey indicates the greatest disparities in physical activity and Health desire among youths in the areas of gender and age. However and regardless of where disparities exist, correlation of physical activity and health desire appear to be similar across youth population subgroups.

Recommendations

Additional theoretically based research is needed to clearly elucidate which factors contribute to disparities in physical activity and health desires.

Studies are needed to document the extent of racial as well as gender, age, ethnic disparities that are relevant to physical activity and health desires and to illuminate how such disparities shape patterns of physical activity and health desires among the youth.

There is also a need to develop and adopt measures that facilitate comparisons across different types of physical activity resources as well as health desires among different geographic and political-jurisdictional contexts.

Improving safety and access to recreational facilities may be critical for eliminating disparities in youth physical activity and, possibly, obesity and other health outcomes.

As a result of the fact that achievement of the physical activity recommendation was low within all subgroups, it is important to continue to implement and test population-wide approaches for increasing physical activity and improving health among youth

References

Abubakar, L. I. (2013) Determinants of Programmed Human Kinetic Performances from the perspective of sports psychologist and sports managers. *Journal of sports Psychologists Association of Nigeria* (JOSPAN). 8. 34-42

American Psychiatric Association, (2000). *Diagnostic and Statistical Manual of Mental Disorder.* (44th Ed.). Test revision. Arlington: USA.

Bailey, U. L., Loren, E. P., Milich, R., & Charnigo, R. (2009). Developmental changes in attention and comprehension among children with attention deficit and hyperactivity disorder. *Child Development Journal,* 80, 1842-1855: USA.

Barbaresi, W. J., Katusi, S. K., Colligan, R. C. Waaver, A. L. & Jacobsen, S. J. (2007a). Long-term outcomes for children with attention-deficit/hyperactivity disorder: A population-based perspective. *Canadian Journal of Developmental and Behavioural Pediatrics,* 28, 265-273.

Barbaresi, W. J., Katusic, S. K., Colligan, R. C., Waver, A. L. & Jacobsoen, S. J. (2007b). Modifiers of Longterm School Outcomes for children with attention deficit/hyperactivity disorder: Does treatment with stimulant medication make a difference? Journal of Canadian Development and Behavioural Pediatrics, 29, 137-149.

Biederman, J. Petty, C. R. Ball, S. W>, Fried, R. Doyle, A. E., Cohen, D. et al, (2009). Are cognitive deficits in attention deficit/hyperactivity disorder related to the course of the disorder? A prospective controlled follow-up study of grown up boys with persistent and remitting course *American Psychiatry Research,* 170, 177-182.

Birch, S> H., & Ladd, G. W. (1998). Children's interpersonal behaviours and the teacher-child relationship. *Developmental Psychology,* 34, 934-946.

Bloom, B. Cohen, R. A. & Freeman, G. (2009). Impact of Executive Functions and Symptoms of attention deficit hyperactivity disorder on children's peer relations and school performance. Australian Developmental Neuropsychology, 32, 521-542.

Currie, J. & Stabile, M. (2006). Child mental health and human capital accumulation. *American Journal of Health Economics,* 25, 1094-1118.

Daviss, W. B. (2008). A review of co-morbid depression in pediatric Etiologies, phenomenology, and treatment. American Journal of Child & Adolescent Psychopharmacology, 18. 565-571.

DuPaul, G. J., Jitendra, A. K. & Volpe, R. J. (2006). Consultation-based academic interventions for children. Effects on reading and Mathematics achievement. *Journal of Abnormal Child Psychology*. 34, 635-648.

Fabiano, G. A. Peiham, W. E., Coles, E. K., Gnagy, E. M., Chronis-Tuscano, A. & O'Connor, B. C. (2009). A Meta-analysis of behavioural treatments for attention-deficit/hyperactivity disorder. *American Clinical Psychology Reviews*, 29, 129-140.

Fletcher, J. & Wolfe, B. (2008). Child mental health and human capital accumulation. *USA Journal of Health Economics*, 27, 794-800.

Froehlich, T. E., Lanphear, B. P., Epstein, J. N. Bararesi, W. J., Katusic, S. K. & Kahn, R. S. (2007). Prevalence, recognition and treatment of attention. *Journal of Australian Psychiatry Association* 4, 207-221.