PHYSICAL ACTIVITY ALLIANCE

The Importance of Equity, Diversity, Inclusion and Belonging in Promoting Physical Activity

The Physical Activity Alliance supports inclusive and equitable access to physical activity opportunities and spaces across all sectors of the National Physical Activity Plan, including healthcare, workplace, community, education, schools, parks and recreation, public health infrastructure, the military, and transportation. The Alliance demonstrates a commitment to equity, diversity, inclusion and belonging¹ in its work to harness all voices to inspire innovation, and collectively address the profound and persistent inequities in order to promote safe, inclusive, and convenient opportunities for everyone to be physically active.

A healthy population is essential for fostering economic prosperity; for developing a strong, productive, globally competitive workforce; and for ensuring all individuals can achieve their full potential. However, striking disparities in health exist across race, ethnicity, income, geography, and education due in large part to structural racism and other unjust policies that concentrate power among privileged groups while denying others the opportunity to survive and thrive.^{2, 3} While engagement in physical activity is crucial to the health and wellbeing of all people, opportunities for physical activity are not equitably afforded to all. In fact, policies -- many of which are still in place today-- were developed to deprive individuals from marginalized* communities the resources necessary to live an active lifestyle.^{4,5,6,7}

Regardless of the inequitable treatment of marginalized individuals, patients and clients across the United States are advised by health care professionals and trainers to be physically active. The goal of all Americans should be to meet or exceed the Physical Activity Guidelines for Americans of 150 minutes per week of moderate intensity for adults and 60 minutes per day for children. Physical activity is powerful medicine that can prevent and treat chronic diseases of the body and mind, yet too many of our citizens have no sidewalks, safe streets, or recreational spaces to traverse to be physically active and lack childcare, resources for equipment, or sufficient time off from work to engage in moderate to vigorous physical activity as advised by the Physical Activity Guidelines for Americans.

Low physical activity and fitness pose immediate and long-term threats to our nation's safety and security and may limit young people's opportunity to pursue a military career. Currently, 71 percent of Americans ages 17-24 fail to meet core eligibility requirements for entrance into the military, creating a serious recruiting deficit. Among those who do meet basic requirements for service, musculoskeletal injuries associated with low fitness levels cost the Department of Defense hundreds of millions of dollars and have been identified as the most significant medical impediment to military readiness. This becomes a more challenging problem to address when we unveil the inequities that disproportionately affect young people from historically under-resourced communities and where military service can be an important and viable career path.

To assure equitable access to regular inclusion of physical activity for all people of all abilities in the United States, the PAA supports and recommends policies that support:

- affordable, accessible, and adequate healthcare coverage;
- sufficient funding for sustained implementation of physical education and physical activity for all educational settings, including children in pre-school and grades K-12;
- community infrastructure conducive to safe, multi-modal mobility and connectivity;
- financial, physical and people resources to sustain a thriving community;
- adequate and safe housing;^{14,15,16}
- a focus on decreasing and eliminating health disparities.

^{*&}quot;Marginalized communities are those excluded from mainstream social, economic, educational, and/or cultural life."²

References:

¹ Schnabel, RB., Benjamin, EJ. Diversity 4.0 in the cardiovascular health-care workforce. *Nature Reviews. Cardiology.* 2020. www.nature.com/nrcardio.

² Churchwell K, Elkind MSV, Benjamin RM, Carson AP, Chang EK, Lawrence W, Mills A, Odom TM, Rodriguez CJ, Rodriguez F, Sanchez E, Sharrief AZ, Sims M, Williams O; on behalf of the American Heart Association. Call to action: structural racism as a fundamental driver of health disparities: a presidential advisory from the American Heart Association [published online ahead of print November 10, 2020]. *Circulation*.

³ Sevelius JM, Gutierrez-Mock L, Zamudio-Haas S, et al. Research with Marginalized Communities: Challenges to Continuity During the COVID-19 Pandemic. *AIDS Behav.* 2020;24(7):2009-2012. doi:10.1007/s10461-020-02920-3

⁴ Moore LV, Diez Roux AV, Evenson KR, McGinn AP, Brines SJ. Availability of recreational resources in minority and low socioeconomic status areas. *Am J Prev Med*. 2008;34:16-22.

⁵ Powell LM, Slater S, Chaloupka FJ, Harper D. Availability of physical activity-related facilities and neighborhood demographic and socioeconomic characteristics: a national study. *Am J Public Health*. 2006;96:1676-80.

⁶ Lindstrom M, Hanson BS, Ostergren PO. Socioeconomic differences in leisure-time physical activity: the role of social participation and social capital in shaping health related behaviour. Soc Sci Med. 2001;52:441-51.

⁷ Budds, D. How urban design perpetuates racial inequality – and what we can do about it. Accessed online February 15, 2021 at https://www.fastcompany.com/3061873/how-urban-design-perpetuates-racial-inequality-and -what-we-can-do.

⁸ US Department of Health and Human Services. Physical Activity Guidelines for Americans. 2nd edition. 2018. Washington, DC.

⁹ US Department of Health and Human Services. Physical Activity Guidelines for Americans. 2nd edition. 2018. Washington, DC.

¹⁰ Bornstein, DB., Grieve, GL., Clennin, MN., McLain, AC., Whitsel, LP., Beets, MW., Hauret, KG., Jones, BH., Sarzynski, MA. Which US states pose the greatest threats to military readiness and public health? Public health policy implications for a cross-sectional investigation of cardiorespiratory fitness, body mass index, and injuries among US Army recruits. *Journal of Public Health Management and Practice*. Jan/Feb 2019; 25(1):36-44.

¹¹ U.S. Department of Defense, Joint Advertising Market Research and Studies. (2016). The target population for military recruitment: youth eligible to enlist without a waiver. https://dacowits.defense.gov/Portals/48/Documents/General%20Documents/RFI%20Docs/Sept2016/JAMRS%20RFI%2014. pdf?ver=2016-09-09-164855-510.

¹² Hauret KG, Jones BH, Bullock SH, Canham-Chervak M, Canada S. Musculoskeletal injuries description of an under-recognized injury problem among military personnel. *AmJ Prev Med*. Jan 2010; 38(1)(suppl):S61–S70.

¹³ Bulzacchelli M, Sulsky S, Zhu L, Brandt S, Barenberg A. The cost of basic combat training injuries in the U.S. Army: injury-related medical care and risk factors. In: Military Performance Division, U.S. Army Research Institute of Environmental Medicine. Edited by Natick MA, March 2017.

¹⁴ Wong, M. S., Roberts, E. T., Arnold, C. M., & Pollack, C. E. (2018). HUD Housing Assistance and Levels of Physical Activity Among Low-Income Adults. *Preventing Chronic Disease*, *15*(E94). https://doi.org/http://dx.doi.org/10.5888/pcd15.170517

¹⁵ Bowen, D. J., Quintiliani, L. M., Bhosrekar, S. G., Goodman, R., & Smith, E. (2018). Changing the housing environment to reduce obesity in public housing residents: A cluster randomized trial. *BMC Public Health*, *18*(1). https://doi.org/10.1186/s12889-018-5777-y ¹⁶ Hood, E. (2005). Dwelling disparities: How poor housing leads to poor health. *Environmental Health Perspectives*, *113*(5). https://doi.org/10.1289/ehp.113-a310