Leisure Activities and Recreation Facilities in Nigeria: Implications for Wholesome Community Health

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1 Introduction: Overview of Community Health and Health Inequity

Community health has gained prominence as a critical field of public health in recent times. Having its emphasis on the study of the health characteristics of people who live or reside in a given geographical area, it seeks to improve health indices of those people of such municipal localities. The aim of community health, therefore, is to draw on the concerted efforts of individual and corporate members of such a community to tackle self-identified challenges that question optimum health status for every member of that particular community. Creating solutions that could positively affect community health has become a subject of research for relevant stakeholders in recent years (Maraccini et al. 2017).

Health inequities are a common phenomenon in Nigeria (Kusimo 2015). Several communities have huge disparities among the inhabitants due to a myriad of reasons that are chiefly social, economic and cultural in nature and outside the circle of the health system itself. These health inequities have exposed the country to numerous unpleasant health indices such as a high maternal mortality rate, low life expectancy, rising prevalence of non-communicable diseases (NCDs) and endemicity of many infectious diseases. Adewole and Osungbade (2016), Anekoson (2013), Muhammad et al. (2017) and Ibama et al. (2015) are among various researchers that provide evidence of less than impressive health indicators in Nigeria. For the past three decades, Nigerian communities have adopted the approach of taking care of its members through the constitutions of community health committees (CHCs) that uphold and support government interventions in health structures at the local level (Abimbola et al. 2016). These CHCs focus mainly on the healthcare delivery system by engaging government agencies frequently to ensure functional primary health care
facilities are provided and maintained within their communities. The measures taken by these CHCs have, nevertheless, proved inadequate, because sufficient consideration is not being given to the social determinants of health (SDoH). As critical factors that impact health inequities of communities, the SDoH constitute an important missing link for wholesome community health. The arguments of Ichoku et al. (2013) on the subject shows that the influence of the SDoH on health inequities among and within communities runs very deep in Sub-Saharan Africa and accounts for the present-day inequities that we see.

According to the United States Office of Disease Prevention and Health Promotion (cited in Friedman 2020), the SDoH refer to ‘conditions in the environments in which people are born, live, learn, work, play, worship, and age that affect a wide range of health, functioning, and quality-of-life outcomes and risks’. Studies show that the SDoH are responsible for over 80% of preventable death. Thus, improving access to SDoH is crucial for the attainment of wholesome community health. Several studies have buttressed the role of neighbourhood conditions as a major contributor to the SDoH of communities. When communities are equipped with social amenities that engender communal interactions and recreational outdoor exercises and leisure activities, a solid avenue for the promotion of the health status of members is established (Friedman 2020; Jennings et al. 2016). SDoH have been linked to the state of health and well-being of a people. At the inception of the World Health Organisation (WHO) in 1946, the first drafters of its constitution acknowledged that health problems had social backgrounds (Commission on Social Determinants of Health 2005). Since then, the organisation has gradually stepped up actions to influence nations to prioritise those determinants. Researchers have begun to underline the huge potential in using SDoH to predict health (Ancker et al. 2018). Numerous SDoH have been identified in this regard, but this paper is focused on recreation, one of those social factors identified by WHO at the beginning as essential to human health. This paper seeks to find the basis for leisure activities and recreation facilities in Nigerian communities, identify opportunities for the promotion of such facilities, and draw potential implications as a result.

2 Conceptual Framework

In conceptualising the idea of wholesome community health, it is a given that certain thresholds are meant to be reached. Identifying those thresholds and attaining healthy societies require an understanding of all the terminologies that are the key constructs of this paper. First, what does the word ‘community’ mean? As Kravetz (2017, p. 8) put it, it is a commonly used word that we easily assume we know. Running through the literature, the word ‘community’ has been defined from various standpoints and, thus, fallen short of any universally acceptable definition. Green and Ottoson (1999, cited in Goodman et al. 2014) saw community as a group of inhabitants living in a somewhat localised area under the same general regulations and having common
norms, values, and organisations. It is given by this definition that every community may have evolved some encompassing rules and principles to which members subscribe to guide their co-habitation. By extension, the authors may be insinuating some form of distinction among communities. In essence, some form of psychological or mental delineation from other communities is created as a result. In the findings of Walton (2018), each neighbourhood tends to have a degree of sense of community (SOC) irrespective of the background of the constituent members of such a community. It is this SOC that fosters communal relationships. It can be deduced, therefore, that SOC is a critical construct of the concept ‘community’. Sarason (1974 cited in Sakip et al. 2013) was the first researcher to emphasise the concept of SOC, stressing its role in ensuring optimum functionality of any community. Kim and Kaplan (2004) identified four domains of SOC, namely, community attachment, community identity, social interaction and pedestrianism; he associated good communities with positive outcomes in each of the domains. Any neighbourhood where the SOC is missing opens itself to anarchy. According to Sakip et al. (2013) and Walton (2018), this state of anarchy has in itself the potential to bring social and mental distress to the people.

Ibama et al. (2015) had another perspective to the definition of community. They viewed it as a group of people living within a common geographical boundary that may not necessarily be of the same origin as in language, culture and practices but are often of the spirit of joint ownership of issues of common interest and advancement. Ibama et al. (2015) introduced the notion of the existence of variety or assortment of community members to the definition, which ranged from race to ethnicity, social class and other demographic and psychographic characteristics. Walton (2018) opined that communal strain existed in certain neighbourhoods of America where racial and ethnic diversity was high. In contrast, Sakip et al. (2013) found a high degree of SOC—or what they otherwise referred to as community ties—in ethnically homogenous communities in Malaysia where middle-income earners lived. Even though demographic factors such as age and gender did not impact the SOC, they reported that social factors did. In recent times, anthropologists went further to demonstrate that a community might have broken its geographical boundaries with the advancement of communication and transportation technology. They argued that the world itself had become a global community with the creation of ‘social space’ for people to interact (Matsumoto 1993). Nevertheless, the focus of this paper is to point out the constructs of relevance in discussing wholesome community health and health inequity. For every community, we expect members to embrace common regulations and values, welcome diversity of composition and promote a SOC.

The word “health” is another terminology that requires conceptualisation. WHO set the tone in 1946 when it established that health is a state of complete physical, mental, and social well-being and not merely the absence of disease of infirmity (World Health Organisation, n. d.). It is apparent that the definition emphasised that no form of disease must be found in the human body, in addition to advocating for wholeness in all ramifications. It also views health as a static commodity that has a pedestal to attain and maintain. Even though WHO called on the nations of the world to take steps to ensure that people enjoy this state of health, the unmistakable
tone of the definition is the call to every individual to take responsibility for his or her health. In recent times, many researchers and practitioners have challenged the continued validity of the definition in today’s world. In 2008, two professors at the Centre for Global eHealth Innovation, University of Toronto, Jadad and O’Grady, posted a blog to spark conversations on the subject. Between then and now, there have been over a thousand reactions generated from it. A cursory scan revealed that the majority called for a new definition from WHO. In their own publication, Fallon and Karlawish (2019) posited that the seventy-year-old definition no longer addressed current realities. Feyzabadi et al. (2018) listed ambiguity, ideality, limitlessness, lack of comprehensiveness, lack of weighting to aspects of health, being non-operational, reductionism, and lack of a precise definition of the normal condition and disease as major drawbacks of the definition. Charlier et al. (2017) and Huber et al. (2011) thought that by going with such an idealistic definition, much of the whole world could be said to be unhealthy at one time or the other. This is because the global burden of disease and health inequity today is enormous without excluding people on the basis of race, wealth, demography or location (Roser and Ritchie 2020). Even the United States, despite having the highest per capita expenditure on health, is nowhere near being the healthiest nation (Bradley et al. 2018). It is on these bases that a review of the ‘health’ definition is called for. If eminent researchers have come to a consensus of questioning the utopian and unrealistic stance of the definition by WHO, what is the acceptable position for this paper to go on?

The definition offered by Oleribe et al. (2018) is apt. In summarising views from sociological, environmental, societal and economic perspectives, they postulated that health is a satisfactory and acceptable state of physical (biological), mental (intellectual), emotional (psychological),economic (financial), and social (societal)wellbeing. They recognised that an absolute perfect state of health is a mirage by accommodating the dynamic nature of our health. Humans are exposed daily to different physical, emotional and social stressors and must find the resilience to handle them and maintain wellness of body, spirit and soul. In the words of Huber et al. (2011), this is the ability to adapt and to self-manage. It is this dynamic state of health that Bradley et al. (2018) referred to as fullness of life. Health is not an isolated object picked off the shelf of a supermarket; it enjoys inputs from our total wellbeing to produce in us the fullness of life. Rather than aggregating so much into the definition of health as WHO did, we can see what health actually is—fullness of life—and distinguish it from those factors that affect health. Realistically, nobody is in a complete state of well-being because stressors are always with us (Misselbrook 2014; Huber et al. 2011). Everyone is responsible for his health, but no one is in complete control of the external stressors. Numerous epidemiological studies have revealed to us how sociocultural, political, economic and environmental factors positively or negatively affect health (Balog 2017). It is on this premise that Shilton et al. (2011) advocated for meaningful and positive contribution from the public in the promotion of health. Health cannot be separated from the influence of external factors. The public has a major role to play to promote, support and uplift our collective health status. Bates et al. (2019) took a step further by backing the call of previous prominent scholars on adopting the culture-centred approach (CCA) to
defining health. They argued that what health meant could differ from community to community depending on their respective needs, realities and perspectives. While Bates et al. (2019) were able to validate their approach in community experiments, this paper regards that a somewhat universal definition, such as the one put forward by Oleribe et al. (2018) could serve as the starting point for CCA.

In canvassing for wholesome community health, therefore, the essential items for consideration are that we identify every neighbourhood as hosting people who are bound by a SOC and are in an acceptable and satisfactory state of well-being, bearing in mind that positive stressors should be generated from the locality. Or perhaps, it is not that simple. Goodman et al. (2014) acknowledged how difficult defining community health could be, following a comprehensive literature review and the practical analyses they carried out. For instance, according to Alakija (2000) and Ibama et al. (2015), community health is concerned with the health of the whole population [of the community], …identifies the root causes of diseases and health problems, [deploys] community resources principally in solving their problems [in addition to] the resources from government and private sector… [with the aim of] giving the highest level of health for all people in the community and such level includes that of physical, mental, moral, social and spiritual health. The definition provided by Alakija (2000) recognises that every community could have peculiar health challenges, which necessitate a community-based approach to tackling them. It is apparent that factors affecting health differ from one community to another. Consequently, health needs will also differ. For instance, Dannefer et al. (2020) observed a huge disparity in the health status of many communities of New York in spite of the tremendous wealth the city enjoys. In other words, all stakeholders have to uncover the characteristic health needs of every community and work with community leaders to address communal health challenges. Pierre et al. (2020) reported that the place-based model of intervening in community health in some communities in New York City has yielded some desirable improvements. Abimbola et al. (2016) also recounted a degree of progress with the introduction of CHCs in some communities in parts of Nigeria. Goodman et al. (2014) provided a workable definition for this paper: a multi-sector and multi-disciplinary collaborative enterprise that uses public health science, evidence-based strategies, and other approaches to engage and work with communities, in a culturally appropriate manner, to optimize the health and quality of life of all persons who live, work, or are otherwise active in a defined community or communities. From the foregoing, consequently, wholesome community health is multifactorial. An aggregate of the SDoH are critical to its sustenance.

Scholars have subjected the word ‘leisure’ to diverse interpretations by from time immemorial. A long chronicle exists in the literature from the times of the Greek philosopher, Aristotle, showing the multidimensional portrait of the word (Hemingway and Parr 2000; Beville 2010; Suleiman 2016; Cordes 2013, p. 1). ‘Leisure’ will continue to connote and evoke assorted inferences depending on the discipline and angle from which the discussants evaluate the subject. In contemporaneous time, Henderson et al. (2004) linked early attempts to social philosophers who barely explained the word with conjectures in the 1960s similar to the ancient
philosophers. More recent reviews have identified three main domains in ‘leisure’. First, leisure is associated with free time (Ogunwuyi 1998, cited in Suleiman 2016). Cordes (2013, p. 2) argued contrarily, referring to the vast amount of free time available to prisoners but who cannot claim to have leisure. It is, therefore, reasonable to state that while free time does not always translate into leisure, it remains an important resource for leisure. Second, it is believed that all activities in which we engage that are not related to work and chores can be classified as leisure activities (Cordes 2013, p. 3). Here, activities are classified based on whether participants are physically active or inactive. One could sit down with the internet during his leisure time or one could take a brisk walk up and down the street. While the former is a physically inactive engagement, the latter demands a lot physically in terms of energy expenditure. Stakeholders have weighed both and found the latter to be more worthwhile (Suleiman 2016; Omodior and Ramos 2019). In today’s world, information technology has given formal work the opportunity to invade homes. The internet has brought tremendous disruption to the way we work (Leung and Lee 2005). The recent COVID-19 pandemic has worsened the dynamics, potentially bringing more physical inactivity to people (Meister 2020). Meanwhile, physical inactivity has had the reputation of being a major risk factor for global ill health and mortality (Akarolo-Anthony and Adebamowo 2014). On the other hand, leisure time physical activity (LTPA) is strongly correlated to health and a health-related quality of life (Omodior and Ramos 2019; Akarolo-Anthony and Adebamowo 2014). In fact, WHO has made awareness about physical activity one of its global cardinal goals by formulating a draft action plan on the matter and circulating it to member states at the 71st World Health Assembly in Geneva (World Health Organisation 2018). LTPA is no longer being viewed as a personal matter but as a fundamental and prioritised social issue for the community to deal with (Biernat and Piatkowska 2020). Thus, the emphasis is on physical activity.

Third, leisure requires the right state of mind (Cordes 2013, p. 5; Suleiman 2016). Leisure should instil a sense of freedom and control for the subject in question; it should not be of compulsion. It is when the motivation to engage in leisure activities is intrinsic that optimal satisfaction is derivable. Thus, it is the state of mind that determines leisure, not the activity itself. An athlete who spends an extra hour for exercises after team training cannot be said to be engaged in leisure. This is because it is an exercise coming from extrinsic motivation—his goal to be better and increase his chance of success at tournaments. On the other hand, a banker, who after returning home from his paid employment does the same exercises, is driven by intrinsic motivation—physical fitness and social interaction. This banker is not obligated to the same routine, because options are available to him unlike the athlete who has to master his art in order to get better at it. While the athlete may get more exhausted by his extra work, the banker is likely going to feel rejuvenated. In summary, putting the construct of ‘leisure’ in context, we expect an availability of free time to engage in physical activities that are driven by intrinsic motivation.

The definition of the term ‘recreation’ has followed a trajectory similar to ‘leisure’—no universally accepted definition (Cordes 2013, p. 7; Suleiman 2016). Recreation involves all activities in which a person or group of persons engage for...
pleasure at times of leisure. This could take place indoors or outdoors depending on what is found more suitable. Giddens (1964) explained that recreation to adults is essentially what play is to children: non-economic unstructured pleasurable exercises. Suleiman (2016) listed eight criteria to be fulfilled before an activity could be regarded as recreational. This paper finds some of them debatable but highlights acceptable conditions that are relevant to it. First, recreation has to be a voluntary action. A person must be deliberate about his intention without external compulsion or urge. Second, recreation involves leisure time and activities. Cordes (2013, p. 7) posited that recreation was a subset of leisure that involved active participation, which may include social interaction with other people. Kelly and Godbey (1992, cited in Beville 2010) identified ‘social cohesion’ with neighbours as an important impetus for recreation. Third, the subject is fully aware of his involvement in leisure activities and is capable of deriving explicit satisfaction and enjoyment. For instance, a mentally deranged individual cannot be associated with recreational activities no matter what he is doing. Fourth, measurable positive health outcomes are produced. This may be physical, psychological, social or a combination of two or more health outcomes. Oftentimes, people find partners for their recreational activities. Thus, communities should enable the process by making recreation facilities available and the built environment conducive for pleasurable exercises (Bird et al. 2018). As WHO pursues its goal of reducing the global prevalence of physical inactivity by 15% in ten years’ time, communities are charged to come to the party with actionable steps. Promoting the culture and practice of recreation in the community is hinged on a SOC that breeds healthy social interactions and an environment with facilities that make engagement in LTPA appealing. Both factors work in tandem to make recreation a pleasure (Xu et al. 2019; Bird et al. 2018). Herein lies the context of and influence on the community and community health of the SDoH in recreation and leisure.

3 Operationalisation of Research Construct into Variables

To engender wholesome community health, the variables at play are community, health, leisure time and recreation facilities. Consequently, the effectiveness of strategies to achieve our aim depends largely on the configuration of these variables and the alignment of the community’s orientation towards sustainability, such that the equation of exchange is written as:

\[ y = f(x) \]

where:
- \( y \) = wholesome community health (dependent construct)
- \( x \) = environment (independent construct).

The dependent construct (\( y \)) can further be disaggregated into the following variables:
\[ y_1, y_2, y_3, y_4, \ldots, y_n \]

where:
\[ y_1 = \text{Sense of community} \]
\[ y_2 = \text{Fullness of life} \]
\[ y_3 = \text{Common values and regulations} \]
\[ y_n = \text{Unspecified variable.} \]

The independent construct (x) can be disaggregated into the following variables:

\[ x_1, x_2, x_3, x_4, \ldots, x_n \]

where:
\[ x_1 = \text{Leisure Time Physical Activity (LPTA)} \]
\[ x_2 = \text{Recreation facilities} \]
\[ x_3 = \text{Built environment} \]
\[ x_n = \text{Unspecified variable.} \]

The operationalisation of the construct can be summarized in this model:

| Factors for community health (Y) | Environment (X) |
|---------------------------------|-----------------|
| \( y_1 = \text{Sense of community} \) | \( x_1 = \text{Leisure time physical activity} \) |
| \( y_2 = \text{Fullness of life} \) | \( x_2 = \text{Recreation facilities} \) |
| \( y_3 = \text{Health equity} \) | \( x_3 = \text{Built environment} \) |

4 Theoretical Background

A number of theories have been postulated and models have been proposed to discuss leisure and recreation in practice (Henderson et al. 2004). ‘Play’, as the denominator that brings the two terms ‘leisure’ and ‘recreation’ together, has been theorised for ages. Even though the three words have been used interchangeably in some literature, they are not the same (Caldwell and Witt 2011). Play remains the foundation upon which leisure and recreation is built. Giddens (1964) established the relationship between play and leisure and reviewed various theories of play including The Recreation Theory. Lazarus (1883, cited in Giddens 1964) propounded the Recreation Theory, which emphasised that mental and physical recuperation was the hallmark of recreation after people had been exposed to work-related stress. In this manner, it is evident that play (through recreational activities) constitutes a social determinant of health today. Eberle (2014) stated that much of the pleasure we derive from play is social in nature, and play strengthens our social skills. Evidently, play provides the platform for sound health to thrive on both the individual and communal level. There are other theories and models that point to the usefulness and relevance of leisure and recreation to health. For instance, applying the Theory of Planned Behaviour (TPB)
to measure willingness to engage in leisure activities, Ajzen and Driver (1991) found that consequential positive impact on health behaviour is a major reason for people to recreate. In 2019, applying the same TPB but on a different sample population, Li, Hsu and Lin also reported a similar outcome from their research. Laird et al. (2018) proved that the social support theory could show that participation in physical activities improved overall physical and mental performance of participants. From the perspective of preventive health, researchers have been able to use some theories to predict people’s willingness to participate in LTPA (Beville 2010). The Health Belief Model developed by Becker in 1974 was based on using probability and the consequence grid to predict health-promoting behaviours of humans (Corcoran 2007, p. 15–17). However, the efficacy of the model to predict and influence physical activity behaviour has been queried (Hosseini et al. 2017; Sas-Nowosielski et al. 2013).

From the perspective of cognitive behaviour, the Social Cognitive Theory has been found to be useful. Lee et al. (2018) demonstrated the usefulness of the theory to implement effective physical activity programmes, while Winters et al. (2003) and White et al. (2012) measured and explained physical activity behaviour successfully using the theory’s framework. Beville (2010) noted that health behaviour theories and models would continue to provide veritable frameworks for the study of LTPA. Social Cognitive Theory has been applied in built environment literature too. Built environment refers to the part of the environment that is made or developed by man. In a community, this will cover the house and road designs, lay-bys and walkways, gardens and green parks, streetlights, drainage system, and leisure and recreation facilities. The summation of findings is that the built environment influences the health-promoting behaviour (National Institute of Health 2008). Yu et al. (2020) and Gomes et al. (2016) provided significant scientific evidence that strongly correlated built environment with LTPA. Ashraf et al. (2017), guided by Kim and Kaplan’s theory of 2004, established that the SOC was linked to the built environment in communities with residents apparently more willing to uphold common values. Similarly, Farahani and Lozanovska (2014) proved the strong relationship between the built environment and the SOC and showed that a buoyant social life was an added benefit. Evidently, the built environment impacts on many domestic choices made daily, including the degree of physical activities in which people engage in the community and the level of community ties that is experienced. Clearly, there are attendant community health implications for the built environment.

5 Addressing the Nigeria Situation

The SDoH receive little attention from policy-makers in Nigeria (Rispel et al. 2009, cited by Kusimo 2015). Unfortunately, the Nigeria situation is worsened by the deplorable health indices and the high health inequity it has. Adewole and Osungbade (2016), Anekoson (2013), Muhammad et al. (2017), and Ibama et al. (2015) have all painted the gloomy picture of the current state of health. Hence, attainment of
wholesome community health in Nigeria requires a multidisciplinary approach and significant investment from all stakeholders, not only in the health institutions but also in the SDoH (Braveman 2002, cited in Kusimo 2015).

Access to leisure activities and recreational facilities has been established as one of the viable means of promoting community health. Leung and Lee (2005) found that a major determinant of life quality in a community is the volume of leisure activities taking place. Omodior and Ramos (2019) pointed out that engagement in recreational activities by members of a community enhanced their health-related quality of life. The provision of parks in communities, coupled with ease of accessibility and use, significantly improves the leisure-time physical activity (LTPA) of members. Higgerson et al. (2018) recommended the creation and provision of accessible and free recreation parks and leisure facilities to support increased community levels of physical activity. Jennings et al. (2016) cautioned, however, that accessibility of recreation centres ought to be backed by evidence of social accessibility before optimal engagement of leisure facilities by community members can be more certain. Social accessibility is a function of community ties or a SOC, because we feel safer in a neighbourhood where everyone cares for and protect one another. Humans are social beings and do not tolerate isolation for long; humans are wired for regular social interactions. If a person perceives that his use of outdoor recreation facilities in the community exposes him to some form of danger or discriminatory treatment, he will most likely back off. On the other hand, such leisure facilities potentially provide avenues to develop a deeper SOC among community members. In essence, leisure facilities for recreation and physical activities contribute to wholesome community health due to inherent physical, mental and social benefits (Friedman 2020).

Nigerians have gradually embraced that leisure activities and outdoor exercises are contributory factors to health and good quality of life. Perception about recreation services is positive. Following his survey carried out in some communities of Kwara State, Nigeria, Asagba (2007) established that leisure activities were viewed by community members as important indicators of their present and future health status. Lawal and Bilesanmi (2013) discovered that two of every three persons surveyed in South West Nigeria saw outdoor recreation as an important tonic for health living; only less than 10% of respondents claimed that no correlation existed between recreation and health. Olaitan et al. (2012), Bakare (2013) and Dantata (2014) are other researchers who reported similar findings. Nevertheless, Adedotun et al. (2019) discovered that Nigerian adults loved frequent outdoor recreation, but the interest in sedentary activities such as drinking and chatting was higher than in physical activities such as jogging, swimming and football. It is apparent that a lot of awareness campaigns need to be done by stakeholders to promote routine and regular LTPA among Nigerian adults. The emphasis of WHO is on getting communities engaged in physical activities because of associated diverse health benefits and redressing health equity imbalance (World Health Organisation 2018). Vincent-Onabajo and Blasu (2016) opined that health benefits were derivable from leisure participation as part of the post-management regimen of cases of stroke. About 90% of the study group participated in communal leisure activities, even though more social interactions and less physical exercises were involved. This gives an insight
to the fact that communities could come up with event centres for recreation activities for their members to rehabilitate and make the built environment conducive for LTPA. Faerstein et al. (2018) claimed that only limited evidence was found in his study linking natural and built environment with physical activity in low and middle-income countries such as Nigeria. Conversely, Oyeyemi et al. (2018) found from their study that the neighbourhood’s built environmental factors provided great impetus for recreational and health-related physical activities among Nigerian adults.

6 Conclusion and Recommendation

This paper has underscored the invaluable importance of three constructs—built environment, leisure activities and recreation facilities—in the promotion of wholesome community health and reduction of health inequity challenges. It has argued for the identification of leisure activities and recreation facilities as critical variables for the SDoH framework. A strong conceptual and theoretical basis for advocating leisure activities and recreation facilities was provided to stimulate stakeholders—governments at all levels, communities and individuals—to take the necessary steps in that regard.

Peculiar challenges facing communities in Nigeria were highlighted. A community approach similar to the place-based model discussed by Dannefer et al. (2020) or CCA by Bates et al. (2019) could offer veritable opportunities to address health inequities and SDoH issues in Nigeria. More targeted community studies are needed in Nigeria.

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