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The Impact of Community-Based Physical Activity Programs on Mental Health and Social Wellbeing Among Socially Marginalized Adults: A Cross-National Study

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ABSTRACT
This study investigates the effects of community-based physical activity (CBPA) programs on mental health (anxiety, depression, self-esteem) and social wellbeing (social connection, community belonging) among socially marginalized adults (low-income groups, ethnic minorities, persons with mild disabilities). A cross-sectional survey of 2,847 participants across five countries (USA, Australia, UK, Chile, and South Africa) was conducted between 2021–2023. Participants in CBPA programs (n=1,423) reported significantly lower anxiety (β=-0.32, p<0.001) and depression scores (β=-0.28, p<0.001), higher self-esteem (β=0.41, p<0.001), stronger social connection (β=0.38, p<0.001), and greater community belonging (β=0.35, p<0.001) compared to non-participants (n=1,424). Program characteristics—including group-based sessions, culturally tailored activities, and trained peer leaders—moderated these effects. Findings highlight CBPA programs as cost-effective interventions to address mental health disparities and enhance social cohesion among marginalized populations, offering actionable insights for public health policymakers and community organizations.

Keywords: Community-Based Physical Activity; Mental Health; Social Wellbeing; Marginalized Adults; Health Disparities; Social Connection; Public Health Interventions

1. Introduction

Physical inactivity is a leading modifiable risk factor for global morbidity and mortality, with disproportionate impacts on socially marginalized populations—including low-income groups, ethnic minorities, and persons with disabilities (World Health Organization [WHO], 2022). Beyond physical health consequences, inactivity is strongly linked to poor mental health outcomes such as anxiety, depression, and low self-esteem, as well as reduced social connection and community alienation (Centers for Disease Control and Prevention [CDC], 2023). Socially marginalized adults face unique barriers to physical activity, including limited access to affordable fitness facilities, financial constraints, cultural and linguistic barriers, and lack of programs tailored to their needs (Bull et al., 2021). These barriers exacerbate existing health disparities, creating a cycle of marginalization and poor health outcomes that public health interventions have struggled to address.

Community-based physical activity (CBPA) programs—defined as structured, accessible, and contextually adapted physical activity initiatives delivered in local settings (e.g., community centers, parks, religious institutions)—have emerged as a promising strategy to promote physical activity among marginalized populations (Pate et al., 2022). Unlike traditional fitness programs, CBPA initiatives prioritize accessibility, cultural relevance, and social support, addressing the structural and contextual barriers that prevent marginalized adults from engaging in regular physical activity (Rhodes et al., 2023). Previous research has demonstrated that CBPA programs can increase physical activity levels, improve cardiovascular health, and reduce chronic disease risk among marginalized groups (Okonkwo et al., 2022). However, fewer studies have systematically examined the effects of these programs on mental health and social wellbeing—key dimensions of holistic health that are often overlooked in physical activity research (Sullivan et al., 2023).

Mental health disparities among socially marginalized populations are well-documented: low-income adults are 2.5 times more likely to experience depression than higher-income groups (Substance Abuse and Mental Health Services Administration [SAMHSA], 2022), ethnic minorities face higher rates of anxiety due to systemic racism and discrimination (American Psychological Association [APA], 2023), and persons with disabilities report elevated levels of psychological distress compared to the general population (WHO, 2023). Social wellbeing—encompassing social connection, community belonging, and mutual support—is similarly compromised among marginalized groups, with social isolation contributing to poor mental and physical health outcomes (Holt-Lunstad et al., 2022). CBPA programs have the potential to address both mental health and social wellbeing by providing opportunities for social interaction, skill development, and collective empowerment, yet the mechanisms through which these programs exert their effects remain understudied.

Existing research on CBPA programs and mental health has been limited by several factors. First, most studies have focused on single-country or single-program samples, limiting the generalizability of findings across diverse cultural, economic, and social contexts (Chen et al., 2021). Second, few studies have examined the specific program characteristics (e.g., group size, activity type, peer leadership) that moderate the relationship between CBPA participation and mental health outcomes (Torres et al., 2022). Third, research has often failed to disaggregate outcomes by marginalized subgroup, masking important differences in program effectiveness among low-income groups, ethnic minorities, and persons with disabilities (Márquez et al., 2023). Addressing these gaps is critical to developing evidence-based CBPA programs that effectively promote mental health and social wellbeing among all socially marginalized adults.

This study aims to fill these gaps by conducting a cross-national investigation of the effects of CBPA programs on mental health and social wellbeing among socially marginalized adults. The research addresses three core questions: (1) Do participants in CBPA programs report better mental health (lower anxiety and depression, higher self-esteem) and social wellbeing (stronger social connection, greater community belonging) compared to non-participants? (2) Which program characteristics (group-based sessions, cultural tailoring, peer leadership) moderate the effects of CBPA participation on mental health and social wellbeing? (3) Do the effects of CBPA programs vary across marginalized subgroups (low-income groups, ethnic minorities, persons with mild disabilities)? By answering these questions, this study provides valuable insights for public health policymakers, community organizations, and researchers seeking to design and implement effective CBPA programs for marginalized populations.

2. Literature Review

2.1 Social Marginalization, Physical Inactivity, and Health Disparities

Social marginalization is a complex, multidimensional construct characterized by exclusion from social, economic, and political resources due to factors such as poverty, ethnicity, race, disability, and gender (Braveman et al., 2022). Marginalized populations face a range of structural barriers to physical activity, including limited access to safe and affordable recreational facilities, lack of transportation, financial constraints, and cultural norms that discourage physical activity (Rhodes et al., 2021). For example, low-income neighborhoods are often characterized by inadequate park space and high crime rates, making outdoor physical activity unsafe (CDC, 2022). Ethnic minorities may face linguistic barriers to accessing fitness programs, as well as a lack of culturally relevant activities that reflect their preferences and traditions (Okonkwo et al., 2021). Persons with mild disabilities often struggle to find physical activity programs that are accessible and adaptable to their needs (WHO, 2021).

These barriers contribute to high rates of physical inactivity among marginalized populations: in the USA, only 23% of low-income adults meet the WHO's physical activity guidelines, compared to 41% of high-income adults (CDC, 2023). In Australia, ethnic minority groups are 30% less likely to engage in regular physical activity than the general population (Australian Bureau of Statistics [ABS], 2022). In Chile, persons with mild disabilities report physical activity levels that are 40% lower than those without disabilities (Márquez et al., 2022). Physical inactivity, in turn, contributes to a range of health disparities, including higher rates of obesity, diabetes, cardiovascular disease, and mental health disorders among marginalized groups (Bull et al., 2022).

2.2 CBPA Programs: Key Characteristics and Theoretical Foundations

CBPA programs are grounded in the social ecological model of health, which recognizes that individual behavior is shaped by interactions between intrapersonal, interpersonal, organizational, community, and policy factors (Sallis et al., 2021). These programs address multiple levels of influence by providing accessible physical activity opportunities (community level), fostering social support (interpersonal level), and building individual skills and self-efficacy (intrapersonal level) (Pate et al., 2021). Key characteristics of effective CBPA programs include:

Accessibility: Programs are delivered in convenient, local settings (e.g., community centers, parks, churches) and are affordable or free of charge, reducing financial and transportation barriers (Rhodes et al., 2022).

Cultural tailoring: Activities are adapted to reflect the cultural values, preferences, and traditions of the target population, increasing engagement and adherence (Okonkwo et al., 2023). For example, a CBPA program for Latino communities might include salsa dancing or traditional folk games, while a program for Indigenous populations might incorporate land-based activities such as hiking or fishing.

Group-based sessions: Programs emphasize group participation, fostering social connection and mutual support among participants (Chen et al., 2022). Group settings provide opportunities for peer encouragement, accountability, and the development of social networks, which are critical for sustained physical activity engagement.

Peer leadership: Programs are led by trained peer leaders from the target population, who serve as role models and provide culturally relevant support and guidance (Torres et al., 2023). Peer leaders have a unique understanding of the barriers and challenges faced by marginalized adults, making them more

effective at engaging and motivating participants than external facilitators.

The theoretical mechanisms through which CBPA programs influence mental health and social wellbeing are multifaceted. First, physical activity itself has well-documented effects on mental health, including the release of endorphins, reduction of stress hormones, and improvement of brain function (Biddle et al., 2021). Second, group-based physical activity fosters social connection, which reduces social isolation and loneliness—key risk factors for anxiety and depression (Holt-Lunstad et al., 2023). Third, CBPA programs promote self-esteem and self-efficacy by providing opportunities for skill development, goal achievement, and positive feedback from peers and leaders (Sullivan et al., 2022). Fourth, participation in community-based programs enhances community belonging by connecting individuals to local resources and fostering a sense of collective identity (Márquez et al., 2021).

2.3 CBPA Programs and Mental Health Outcomes

Existing research has provided preliminary evidence that CBPA programs can improve mental health outcomes among marginalized populations. A systematic review by Chen et al. (2021) found that CBPA programs were associated with significant reductions in depression and anxiety symptoms among low-income adults, with effect sizes ranging from small to moderate. A study by Okonkwo et al. (2022) of a culturally tailored CBPA program for African American women found that participants reported significant improvements in self-esteem and reductions in depressive symptoms after 12 weeks of participation. Similarly, Torres et al. (2022) found that a CBPA program for persons with mild disabilities was associated with lower anxiety scores and higher self-efficacy compared to a waitlist control group.

However, the evidence is not consistent across all studies. Some research has found no significant effects of CBPA programs on mental health outcomes, highlighting the importance of program characteristics in determining effectiveness (Rhodes et al., 2023). For example, a study by Sullivan et al. (2023) found that CBPA programs with group-based sessions were more effective at reducing depression than individual-based programs, while programs with culturally tailored activities had greater effects on self-esteem than generic programs. These findings suggest that the design of CBPA programs plays a critical role in their ability to improve mental health outcomes among marginalized populations.

2.4 CBPA Programs and Social Wellbeing Outcomes

Social wellbeing is a key component of holistic health, encompassing social connection, community belonging, and mutual support (Keyes, 2021). Marginalized populations often experience social isolation and disconnection due to structural barriers such as poverty, discrimination, and lack of access to social resources (Braveman et al., 2023). CBPA programs have the potential to address these issues by providing opportunities for social interaction and community engagement.

Research has shown that CBPA programs can enhance social connection among marginalized adults. A study by Márquez et al. (2023) of a CBPA program for low-income families in Chile found that participants reported stronger social networks and more frequent social interactions after six months of participation. Similarly, Chen et al. (2022) found that a CBPA program for ethnic minority seniors in Australia was associated with increased social participation and reduced loneliness. CBPA programs also promote community belonging by connecting individuals to local organizations and fostering a sense of collective purpose (Okonkwo et al., 2021). For example, a study by Torres et al. (2021) found that participants in a community garden-based physical activity program reported greater attachment to their neighborhood and a stronger sense of community belonging compared to non-participants.

2.5 Gaps in the Literature

Despite the growing body of research on CBPA programs, several key gaps remain. First, most studies have focused on single-country or single-program samples, limiting the generalizability of findings across diverse contexts (Rhodes et al., 2021). Cross-national studies are needed to determine whether CBPA programs have consistent effects on mental health and social wellbeing among marginalized populations in different cultural, economic, and social settings. Second, few studies have examined the specific program characteristics that moderate the relationship between CBPA participation and health outcomes (Chen et al., 2023). Understanding which features of CBPA programs (e.g., group size, activity type, peer leadership) are most effective can help optimize program design. Third, research has often failed to disaggregate outcomes by marginalized subgroup, masking important differences in program effectiveness among low-income groups, ethnic minorities, and persons with disabilities (Okonkwo et al., 2023). Finally, few studies have used rigorous quantitative methods to examine the causal effects of CBPA programs, relying instead on pre-post designs or cross-sectional data with small sample sizes (Sullivan et al., 2021). This study addresses these gaps by conducting a large-scale, cross-national survey of CBPA program participants and non-participants across five countries, using regression analysis to examine program effects and moderating factors.

3. Methodology

3.1 Study Design and Sample

This cross-sectional study was conducted between January 2021 and December 2023, involving participants from five countries: USA, Australia, UK, Chile, and South Africa. The target population was socially marginalized adults aged 18–65 years, defined as individuals belonging to one or more of the following groups: low-income (household income below the national poverty line), ethnic minority (non-dominant ethnic or racial group in the country of residence), or person with mild disabilities (e.g., mobility impairments, visual or auditory impairments that do not require intensive support).

Participants were recruited through two channels: (1) CBPA program participants were recruited from 50 community-based programs across the five countries, including programs delivered by community organizations, local governments, and non-profit agencies; (2) non-participants were recruited from the same communities as program participants, using convenience sampling methods (e.g., flyers, social media, community events) to ensure comparability between groups. A total of 2,847 participants were included in the final sample, including 1,423 CBPA program participants and 1,424 non-participants.

3.2 Measures

3.2.1 Demographic Variables

Participants completed a demographic questionnaire collecting information on age, gender, country of residence, marginalized subgroup (low-income, ethnic minority, person with mild disability), education level, and employment status.

3.2.2 CBPA Program Participation and Characteristics

Program participants were asked to report details about their CBPA program, including: type of activities (e.g., walking groups, dance classes, sports), frequency and duration of participation (hours per week), group size, whether the program was culturally tailored (yes/no), and whether the program was

led by peer leaders (yes/no). Non-participants were asked to report reasons for not participating in CBPA programs (e.g., lack of time, financial constraints, no accessible programs).

3.2.3 Mental Health Outcomes

Anxiety: Measured using the 7-item Generalized Anxiety Disorder (GAD-7) scale, which assesses the frequency of anxiety symptoms over the past two weeks (Spitzer et al., 2006). Scores range from 0–21, with higher scores indicating greater anxiety severity. Cronbach's alpha for the current sample was 0.89.

Depression: Measured using the 9-item Patient Health Questionnaire (PHQ-9), which assesses the frequency of depressive symptoms over the past two weeks (Kroenke et al., 2001). Scores range from 0–27, with higher scores indicating greater depression severity. Cronbach's alpha for the current sample was 0.91.

Self-esteem: Measured using the 10-item Rosenberg Self-Esteem Scale (RSES), which assesses global self-esteem (Rosenberg, 1965). Scores range from 10–40, with higher scores indicating higher self-esteem. Cronbach's alpha for the current sample was 0.87.

3.2.4 Social Wellbeing Outcomes

Social connection: Measured using the 8-item Social Connection Scale (SCS), which assesses the strength of social relationships and feelings of connectedness (Lee et al., 2020). Scores range from 8–40, with higher scores indicating stronger social connection. Cronbach's alpha for the current sample was 0.88.

Community belonging: Measured using the 6-item Psychological Sense of Community (PSOC) scale, which assesses feelings of belonging to a community (McMillan & Chavis, 1986). Scores range from 6–30, with higher scores indicating greater community belonging. Cronbach's alpha for the current sample was 0.85.

3.3 Data Collection

Data were collected using an online survey platform (Qualtrics) and paper-based surveys for participants with limited digital access. Surveys were translated into the primary languages of each country (English, Spanish, and Afrikaans) and back-translated to ensure accuracy. Participants were provided with a small incentive (e.g., gift card, grocery voucher) to complete the survey, valued at approximately $10 USD. Data collection protocols were approved by the institutional review boards of each participating university.

3.4 Data Analysis

Data were analyzed using SPSS 28.0 and R 4.2.0. Descriptive statistics (means, standard deviations, frequencies) were used to characterize the sample and compare demographic characteristics between program participants and non-participants. Bivariate analyses (t-tests, chi-square tests) were conducted to examine unadjusted differences in mental health and social wellbeing outcomes between groups.

Multiple linear regression analyses were used to examine the effects of CBPA program participation on mental health (anxiety, depression, self-esteem) and social wellbeing (social connection, community belonging) outcomes, adjusting for demographic variables (age, gender, education, employment status) and country of residence. Moderation analyses were conducted to examine the effects of program characteristics (group-based sessions, cultural tailoring, peer leadership) on the relationship between CBPA participation and outcomes. Subgroup analyses were performed to examine program effects across marginalized subgroups (low-income, ethnic minority, persons with mild disabilities). Statistical significance was set at $p<0.05$.

4. Results

4.1 Sample Characteristics

The final sample included 2,847 participants, with a mean age of 42.3 years (SD=11.2). The sample was evenly split between males (n=1,412, 49.6%) and females (n=1,435, 50.4%). Marginalized subgroups included low-income adults (n=1,139, 40.0%), ethnic minorities (n=1,006, 35.3%), and persons with mild disabilities (n=702, 24.7%). Country representation was as follows: USA (n=712, 25.0%), Australia (n=569, 20.0%), UK (n=569, 20.0%), Chile (n=569, 20.0%), and South Africa (n=428, 15.0%).

CBPA program participants and non-participants were comparable in terms of age, gender, and country of residence ($p>0.05$). However, program participants were more likely to be employed (58.3% vs. 41.7%, $p<0.001$) and have higher education levels (42.1% with college degree vs. 28.5%, $p<0.001$) than non-participants. The most common reasons for non-participation were lack of time (32.1%), financial constraints (24.3%), and no accessible programs (18.7%).

4.2 CBPA Program Characteristics

Among program participants, the most common types of activities were walking groups (32.1%), dance classes (24.7%), and sports (18.3%). The average frequency of participation was 3.2 sessions per week (SD=1.1), with an average session duration of 65 minutes (SD=15.2). Most programs were group-based (92.3%), with an average group size of 18.4 participants (SD=7.6). Approximately 78.5% of programs were culturally tailored to the target population, and 67.2% were led by peer leaders.

4.3 Unadjusted Differences in Outcomes Between Groups

Bivariate analyses revealed significant differences in mental health and social wellbeing outcomes between CBPA program participants and non-participants (Table 1). Program participants reported significantly lower anxiety scores ($M=5.2$, $SD=3.1$ vs. $M=7.8$, $SD=3.8$, $p<0.001$), lower depression scores ($M=4.9$, $SD=3.3$ vs. $M=7.6$, $SD=3.9$, $p<0.001$), higher self-esteem scores ($M=32.4$, $SD=4.2$ vs. $M=27.6$, $SD=4.8$, $p<0.001$), stronger social connection ($M=31.2$, $SD=4.5$ vs. $M=25.3$, $SD=5.1$, $p<0.001$), and greater community belonging ($M=22.5$, $SD=3.8$ vs. $M=17.8$, $SD=4.3$, $p<0.001$) compared to non-participants.

4.4 Adjusted Effects of CBPA Program Participation on Outcomes

Multiple linear regression analyses, adjusting for demographic variables and country of residence, confirmed that CBPA program participation was significantly associated with better mental health and social wellbeing outcomes (Table 2). Specifically, program participation was associated with lower anxiety scores ($\beta=-0.32$, $p<0.001$), lower depression scores ($\beta=-0.28$, $p<0.001$), higher self-esteem scores ($\beta=0.41$, $p<0.001$), stronger social connection ($\beta=0.38$, $p<0.001$), and greater community belonging ($\beta=0.35$, $p<0.001$). These effects remained significant after controlling for all covariates, accounting for 12–18% of the variance in outcomes.

4.5 Moderation by Program Characteristics

Moderation analyses revealed that program characteristics significantly moderated the effects of CBPA participation on mental health and social wellbeing outcomes (Table 3). Group-based sessions were associated with stronger effects on social connection ($\beta=0.12$, $p<0.01$) and community belonging ($\beta=0.10$, $p<0.05$) compared to individual-based sessions. Culturally tailored programs had greater effects on self-esteem ($\beta=0.14$, $p<0.001$) and anxiety reduction ($\beta=-0.11$, $p<0.05$) than non-tailored programs. Programs

led by peer leaders were associated with stronger effects on depression reduction (β=-0.13, p<0.01) and social connection (β=0.15, p<0.001) compared to programs led by external facilitators.

4.6 Subgroup Analyses

Subgroup analyses revealed that CBPA program participation had positive effects across all marginalized subgroups, but the magnitude of effects varied (Table 4). For anxiety reduction, the strongest effects were observed among persons with mild disabilities (β=-0.38, p<0.001), followed by low-income adults (β=-0.33, p<0.001) and ethnic minorities (β=-0.27, p<0.001). For depression reduction, effects were strongest among ethnic minorities (β=-0.31, p<0.001), followed by low-income adults (β=-0.29, p<0.001) and persons with mild disabilities (β=-0.25, p<0.001). For self-esteem, social connection, and community belonging, the strongest effects were observed among low-income adults, followed by ethnic minorities and persons with mild disabilities.

5. Discussion

5.1 Key Findings

This cross-national study provides compelling evidence that CBPA programs have significant positive effects on mental health and social wellbeing among socially marginalized adults. Program participants reported lower levels of anxiety and depression, higher self-esteem, stronger social connection, and greater community belonging compared to non-participants, even after adjusting for demographic variables and country of residence. These findings are consistent with previous research highlighting the mental health benefits of physical activity and social support (Chen et al., 2022; Okonkwo et al., 2022) but extend this work by demonstrating the effectiveness of CBPA programs across diverse cultural, economic, and social contexts.

The moderation analyses revealed that program characteristics play a critical role in determining the effectiveness of CBPA programs. Group-based sessions were associated with stronger social wellbeing outcomes, which aligns with the social ecological model's emphasis on interpersonal and community-level factors (Sallis et al., 2021). Culturally tailored programs had greater effects on self-esteem and anxiety reduction, highlighting the importance of adapting programs to the unique needs and preferences of marginalized populations (Okonkwo et al., 2023). Programs led by peer leaders were more effective at reducing depression and enhancing social connection, as peer leaders can provide culturally relevant support and serve as role models for participants (Torres et al., 2023). These findings suggest that CBPA programs should prioritize group-based, culturally tailored activities led by peer leaders to maximize their mental health and social wellbeing benefits.

Subgroup analyses revealed that CBPA programs are effective across all marginalized subgroups, but the magnitude of effects varies. Persons with mild disabilities experienced the strongest anxiety reduction, which may be due to the fact that CBPA programs provide accessible physical activity opportunities that reduce feelings of helplessness and improve physical function (WHO, 2023). Ethnic minorities reported the strongest depression reduction, potentially because culturally tailored programs address the unique stressors faced by these groups, such as systemic racism and discrimination (APA, 2023). Low-income adults experienced the strongest improvements in self-esteem, social connection, and community belonging, which may be attributed to the social support and skill development opportunities provided by CBPA programs (Sullivan et al., 2023). These findings highlight the need for targeted program design that

addresses the specific needs of each marginalized subgroup.

5.2 Theoretical Implications

This study contributes to the literature on physical activity and health by providing empirical support for the social ecological model of health (Sallis et al., 2021). The findings demonstrate that CBPA programs, which address multiple levels of influence (intrapersonal, interpersonal, community), are effective at improving mental health and social wellbeing among marginalized populations. The study also extends the literature on social determinants of health by highlighting the role of community-based interventions in addressing health disparities (Braveman et al., 2022). By providing accessible, culturally relevant physical activity opportunities, CBPA programs can help reduce the health gap between marginalized and non-marginalized populations.

5.3 Practical Implications

The findings of this study have important practical implications for public health policymakers and community organizations. First, policymakers should invest in the expansion of CBPA programs, particularly those that are group-based, culturally tailored, and led by peer leaders. This could include providing funding for community organizations to develop and implement such programs, as well as integrating CBPA programs into national public health strategies. Second, community organizations should prioritize the recruitment of peer leaders from marginalized populations and provide training to ensure they have the skills to effectively lead and motivate participants. Third, programs should be designed to address the specific needs of different marginalized subgroups, such as accessible facilities for persons with disabilities, culturally relevant activities for ethnic minorities, and low-cost or free programs for low-income adults.

5.4 Limitations

This study has several limitations that should be noted. First, the cross-sectional design prevents the establishment of causal relationships between CBPA program participation and outcomes. Future studies should use longitudinal or experimental designs to examine the long-term effects of CBPA programs and establish causality. Second, the sample was recruited using convenience sampling methods, which may limit the generalizability of findings. Future studies should use random sampling to ensure a more representative sample. Third, the study relied on self-reported measures of mental health and social wellbeing, which may be subject to social desirability bias. Future studies should incorporate objective measures, such as clinical assessments or physiological markers of stress, to validate self-reported outcomes. Fourth, the study did not collect data on the duration of program participation, which may influence outcomes. Future studies should examine the dose-response relationship between CBPA program participation and mental health and social wellbeing outcomes.

6. Conclusion

This cross-national study demonstrates that CBPA programs are effective at improving mental health and social wellbeing among socially marginalized adults. Program participants reported lower anxiety and depression, higher self-esteem, stronger social connection, and greater community belonging compared to non-participants. The effectiveness of these programs is moderated by program characteristics, including group-based sessions, cultural tailoring, and peer leadership, and varies across marginalized subgroups. These findings highlight the potential of CBPA programs to address health disparities and enhance social

cohesion among marginalized populations.

Public health policymakers and community organizations should prioritize the expansion and optimization of CBPA programs to maximize their mental health and social wellbeing benefits. This includes investing in group-based, culturally tailored programs led by peer leaders, and designing targeted interventions for different marginalized subgroups. Future research should use longitudinal and experimental designs to examine the long-term effects of CBPA programs and identify the mechanisms through which these programs exert their effects. By promoting accessible, inclusive physical activity opportunities, we can improve the health and wellbeing of marginalized populations and build more equitable and resilient communities.

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