

THE PREVALENCE OF PARTICIPATION AND ENGAGEMENT IN FITNESS GYMS IN TIRANA

Rando KUKELI¹, Andi SPAHI²

Sport University of Tirana, Faculty of Physical Activity and Recreation. Tirana, Albania

Sport University of Tirana, Faculty of Movement Sciences. Tirana, Albania

Abstract

Participation in physical activities is universally accepted in the scientific environment as a health good for life. In this study, several fitness gyms in the city of Tirana were taken into consideration, where, through a questionnaire, we recorded factual data on the gyms participation in fitness. The data was processed with the SPSS 26 package where we analysed the percentage and frequency of participation in these gyms. This is a very significant indication of the effectiveness of these gyms. Also, the data from this study highlights that there is a considerable number of gyms that employ more than one instructor; gyms with 1 instructor and up to 4 employed instructors. The data are described as minimum, maximum and average. Data from the questionnaire on the gender distribution of instructors in gyms with 1 instructor, where male instructors predominate N=25 and female N=4. These data are very necessary for a continuous monitoring of the population and especially for the monitoring of health parameters.

Keywords: fitness, exerciser, gym, training

1. Introduction

Physical Activity (PA) is a key concept in public health and exercise because reduced PA is a well-documented risk factor for many chronic diseases (Harkel, Lee, Powell, Blair, Franklin., Macera, & Herath, 2007) especially with sedentary lifestyle becoming common around the world (WHO, 2004; Sarpong. Apaak & Dominic, 2015). The increasing drive towards physical exercise and fitness among the Albanian populace, which resulted from awareness and education, has led many people to embracing regular physical activity. Many elites now register at fitness centres springing up in order to meet their exercise needs for improving health, fitness, prevention and control of hypokinetic diseases. Consequently, this has led to proliferation of fitness centres and gyms across Albania. The fitness centre is a health, recreational and social facility geared towards exercise, sports and other physical activities. It may be a non-profit commercial facility or a community or institutionally supported centre (Mion, 2014). Awosika (1982) in Elias and Solomon (2010) espoused that the level of success of most sports and fitness programmes is greatly dependent on the degree of availability and care of up-to-date equipment, facilities and qualified manpower as these form the backbone around which such programme revolves. Moin (2014) added that a successful fitness facility would accommodate both the serious and the casual recreational user. Elias et al. (2010) highlighted that adequacy, skilled personnel and maintenance of facilities and equipment are very

crucial to realizing the set objective of any sports programme and other related fields. The implementation of the fitness programme therefore requires careful selection of location, facilities, equipment, programmes, personnel and strict adherence to standards and guidelines (Eleso, 2005). Igbanugo (1999) as reported by Elias and Solomon (2010), highlighted that basic guiding principles should include the following: *Involvement of professionals in the planning, building, administration and maintenance of the facilities and equipment*: Only certified professionals should be recruited for the fitness centres; Technical information including guidelines, standards, professional practice from professional bodies, literatures and manuals; and Careful selection of location that can accommodate expansion in the future when the need arises. These basic principles are imperative because the growth of the fitness industry has not come without some problems and its share of ups and downs. Some of these problems have been related to public and media perceptions as to the qualifications of some of those employed in the industry (David, 2002; Fitness Australia, 2012).

In order to curtail these and other challenges, various organizations within the fitness industry responded to the foregoing problems with the development and publication of standards and guidelines so as to set benchmark behaviours for service delivery by those in the industry (ACSM, 2012). Since 1975, various organizations within the fitness industry began to develop and publish numerous standards and guidelines for application to industry practices. Standard statements from at least 10 prominent professional organizations have been developed and published. However, no such standards have been enacted for use in the fitness industry in Albania.

Guideline and Standards for Fitness Centre

In furtherance to the above guidelines and standards, American College of Sports Medicine and American Heart Association's (2006) recommendations for fitness facilities/equipment are classified into three broad categories; cardiovascular screening, professional qualification and emergency policies. In addition to cardiovascular screening of prospective clients, the recommendations include information on risk stratification, the qualifications of personnel in health/fitness facilities, the emergency policies needed in fitness facilities and general considerations for selecting a health/fitness facility.

Screening Prospective Members

According to ACSM (2012), cardiovascular screening at health/fitness facilities is becoming increasingly important because of the trend in cardiac rehabilitation to refer low- risk, stable patients to community facilities instead of specialized and costly cardiac programmes. For this reason, the number of clients with a history of cardiovascular disease will likely increase at health/fitness facilities. Therefore, all facilities that offer such exercise equipment or services should perform cardiovascular screening of new members. Pre-participation screening should identify both persons who are known to be at risk of a cardiac event during exercise and persons without risk factors. Fitness standards advocate the use of a self-administered questionnaire, completed by prospective clients, to elicit information about cardiovascular incidence. It is also essential that efforts should be made to educate all prospective members about the importance of obtaining a health appraisal and, if indicated, a medical evaluation before beginning exercise training (ACSM, 2012). Persons with known cardiovascular disease who fail to complete the questionnaire or who fail to obtain a recommended medical evaluation are expected to be prohibited from participating in

activities at the fitness facility; to the extent permitted by the law in order to avoid injuries. In addition, persons without known cardiovascular disease who do not obtain a medical evaluation as recommended may be permitted to participate if they sign a release or waiver.

Staffing and Emergency Policies

The report of ACSM describes five levels of health/fitness facilities. The Level 1 facilities have only an unsupervised exercise room and no personnel. Level 2 facilities have a single exercise leader to supervise the exercise room. Level 3 facilities are commonly called fitness centres, and are intended for healthy clients. Staff at level 3 facilities may include a general manager, a health fitness instructor and an exercise leader. Level 4 facilities serve clinical populations, and level 5 facilities provide medically supervised exercise programmes (ACSM, 2012). Professional standards according to Australia Fitness Code of Conduct (2015) includes competence and its boundaries (job description) providing services and interventions for which they are qualified for training and experience to prevent exposing clients to risk and injury. Other professional standards include keeping records of clients, referral and must not discriminate. ACSM standards (2012) recommend that personnel at health/fitness facilities must meet the professional standards as stipulated by ACSM. Staff at levels 3, 4 and 5 facilities may include the general manager of the facility, the medical liaison, the fitness instructor and the exercise leader. The medical liaison may be a physician, a registered nurse trained in advanced cardiac life support or an emergency medical technician. Medical liaisons are recommended for facilities that are levels 2, 3, 4 and 5 and are very key in reducing exposure of those who are predisposed to risk factors of cardiovascular diseases. However, this may not be obtainable in commercial oriented fitness centres where profit is the primary objective. ACSM recommends that all health/fitness facilities must have emergency policies and procedures, and such procedures must be reviewed and practiced regularly. In addition, staffs who supervise exercise activities should be skilled in basic life support. Emergency drills are recommended once every three months or more; often if staff turnover mandates it. The recommendations state that staff training and preparedness for emergencies are especially important at facilities that serve persons with medical conditions such as cardiovascular disease. An emergency plan is recommended for all types of health fitness facilities. Emergency equipment ranges from a telephone and "what- to-do-in-case-of-an-emergency" signs in exercise rooms at level 1 facilities to resuscitation equipment at level 5 facilities. Levels 2, 3 and 4 facilities should have a telephone, in-case-of-emergency signs, a blood pressure kit and a stethoscope available. In addition to this equipment, level 5 facilities (supervised cardiac rehabilitation) should also have a defibrillator, oxygen and a crash cart.

Implication of Non-conformity for Exercise Guidelines

Despite all of the physical and psychological benefits associated with exercise, working out does involve a risk of injury. Typical exercise- related injuries include pulled muscles, sprains, strains, breaks, fractures and dislocations. Clients may be more likely to be injured while exercising if they are out of shape, fail to wear protective gear, perform exercise moves improperly or use exercise equipment incorrectly. Predominantly, accidents have been too attributed to human error and seen as a failure of planning. In order to reduce client's risk of being injured while exercising, performing exercises that are beyond clients' or patients' physical abilities should be avoided. Clients/patients should always wear necessary safety gear,

including supportive shoes, helmets and kneepads. They should also ensure to use exercise equipment correctly by following the instructions provided by the manufacturer. However, it is the responsibility of the fitness instructor to ensure that the clients conform to these rules in order to prevent emergencies, which could lead to serious and irreparable consequences. It is the duty of fitness professionals to screen participants for exercise programmes, evaluate various fitness components, prescribe exercise to improve these components, and may also help people with specific or chronic conditions (Howley). Fitness trainers and instructors are expected to lead, instruct, and motivate individuals or groups in exercise activities, including cardiovascular exercise (exercises for the heart and blood system), strength training, and stretching. They are expected to work with people of all ages and skill levels (Truity Psychometrics LLC, 2016; David, 2002). Dekker's summary of the approach to occupational safety are three fundamental tenets: firstly, human error as a system of something deeper such as personality or work design; secondly, system safety is not inherent and thirdly, human error can be systematically connected to futures of people, tools, tasks and operating environments. This places great burdens on managers, users and owners of fitness facilities. Safety therefore, by people, put health risks and injury risks into consideration; thereby, making setting of standards and principles imperative.

In this study, several fitness gyms in the city of Tirana were taken into consideration, where, through a questionnaire, we recorded factual data on the exercisers' participation in fitness.

2. Body of Manuscript

2.1 Methods

Questionnaire were distributed in 30 fitness gyms in three cities. Each responsible of fitness gyms answers the question and gave to the project team manager. For each questionnaire were taken approval from the head of the fitness gyms

2.2 Statistics analysis

The data was processed with the SPSS 26 package where we analyzed the percentage and frequency of participation in these gyms.

2.3 Results

The data from table no. 1 show the size and height of the gyms of the fitness centers, which is directly related to the space dedicated to exercise in these centers.

On average, the size of the fitness gyms is 610 m², where the smallest gym is 80 m² and the largest has a space of 1200 m².

Also, the height of these gyms is on average 3.37 m, where the gym with the smallest height is 2.2 m and the biggest gym is 5 m in height.

Table 6
Descriptive Statistics

	N	Minimum	Maximum	Mean	Std. Deviation
Size_m2_FitnessGym	30	80.0	1200.0	610.667	258.2425
Height_m_FitnessGym	30	2.2	5.0	3.370	.5566
Valid N (listwise)	30				

Table no. 2 shows data on the size and height of these gymnasiums of fitness centers, but divided according to the respective cities. From the data in the table, the minimum, maximum and average values for the size and height of these gyms can be seen.

Table 7
Descriptive Statistics

City		N	Minimum	Maximum	Mean	Std. Deviation
Durrës	Size_m2_FitnessGym	4	600.0	800.0	650.000	100.0000
	Height_m_FitnessGym	4	3.0	4.0	3.350	.4726
	Valid N (listwise)	4				
Tirana	Size_m2_FitnessGym	25	80.0	1200.0	616.800	273.8874
	Height_m_FitnessGym	25	2.2	5.0	3.388	.5833
	Valid N (listwise)	25				
Vlorë	Size_m2_FitnessGym	1	300.0	300.0	300.000	.
	Height_m_FitnessGym	1	3.0	3.0	3.000	.
	Valid N (listwise)	1				

The data from table no. 3 show the number of instructors in these fitness gyms according to employment; gyms with 1 instructor and up to 4 employed instructors. The data are described as minimum, maximum and average.

Table 8
Descriptive Statistics

	N	Minimum	Maximum	Mean	Std. Deviation
Age_No_1_Fitness_Instructors	30	22.0	58.0	38.300	10.8855
Age_No_2_Fitness_Instructors	25	20.0	53.0	32.440	7.4503
Age_No_3_Fitness_Instructors	15	21.0	39.0	27.867	5.2762
Age_No_4_Fitness_Instructors	9	23.0	50.0	34.222	9.3378
Valid N (listwise)	9				

Table no. 4 shows the data on the gender distribution of instructors in gyms with 1 instructor, where male instructors predominate N= 25 and female N=4.

Table 9

Gender_No_1_Fitness_Instructors		N
Male	No_Fitness_Instructors	25
	Valid N (listwise)	25
Female	No_Fitness_Instructors	4
	Valid N (listwise)	4

Table no. 5 shows the data on the gender distribution of instructors in gyms with 1 instructor, where male instructors predominate N= 15 and female N=10.

Table 10

Gender_No_2_Fitness_Instructors		N
Male	No_Fitness_Instructors	15
	Valid N (listwise)	15
Female	No_Fitness_Instructors	10
	Valid N (listwise)	10

Table no. 6 shows the data on the gender distribution of instructors in gyms with 1 instructor, where male instructors N= 7 and female N=7.

Table 11

Gender_No_3_Fitness_Instructors		N
Male	No_Fitness_Instructors	7
	Valid N (listwise)	7
Female	No_Fitness_Instructors	7
	Valid N (listwise)	7

Table no. 7 shows the data on the gender distribution of instructors in gyms with 1 instructor, where male instructors N= 4 and female N=4.

Table 12
Descriptive Statistics

Gender_No_4_Fitness_Instructors		N	Minimum	Maximum	Mean	Std. Deviation
Male	No_Fitness_Instructors	4	4	4	4.00	.000
	Valid N (listwise)	4				
Female	No_Fitness_Instructors	4	4	4	4.00	.000
	Valid N (listwise)	4				

Table no. 8 shows the profile of gyms where one gym has a male-only profile, one gym has a female-only profile, and 28 gyms are mixed and attended by men and women.

Table 13

FitnessGym_Profile_Practitioner		N
Male	No_Fitness_Instructors	1
	Valid N (listwise)	1
Female	No_Fitness_Instructors	1
	Valid N (listwise)	1
Mix= Male+ Female	No_Fitness_Instructors	28
	Valid N (listwise)	28

3. Conclusions

From the descriptive data of this study, it emerges that these fitness centers considered have enough space for the exercisers, the average size of the fitness gyms is 610 m², where the smallest gym is 80 m² and the largest has a space of 1200 m². Also, the height of these gyms is on average 3.37 m, where the gym with the smallest height is 2.2 m and the biggest gym is 5 m in height.

This is a very significant indication of the effectiveness of these gyms. Also, the data from this study highlights that there is a considerable number of gyms that employ more than one instructor; gyms with 1 instructor and up to 4 employed instructors. The data are described as minimum, maximum and average.

Data from the questionnaire on the gender distribution of instructors in gyms with 1 instructor, where male instructors predominate N=25 and female N=4.

The profile of the gyms is also important, where one gym has a male-only profile, one gym has a female-only profile, and 28 gyms are mixed and attended by men and women.

References

- [1]. ACSM (2012). Cardiovascular screening at health/fitness facilities in becoming increasingly important because of the trend in cardiac rehabilitation to refer low- risk.
- [2]. Ahmed, Y. A. (2009). Settlements Pattern and Functional Distribution in an emerging communities - A case study of a Local Government in Kwara State, Nigeria. *The Social Science* 4 (3), 256-263.
- [3]. Ajibade, LT, Fatoba, P.O, Raheem, U. A., and Odunuga, B. A. (2004). Ethnomedicine and Primary Healthcare in Nigeria. *Indian Journal of Traditional Knowledge*. 4(2), 150-158.
- [4]. Akinsanmi, T. (1995). Maintenance of sports facilities and equipment: The experience of Nigeria Colleges of Education in Nigeria. *Journal of Nigeria Academy of Sports Administration* (1 &2), 64-65.
- [5]. American Fitness Society (2006) Equipnre M recommendation for fitness clinics. Retrieved October 16th, 2009 from www.afs/fcrec.org.
- [6]. American Heart Association/ American College of Sports Medicine (2006).Recommendations for Health/Fitness Facilities. Retrieved March 21, 2009 from <http://www.circ.ahajournals.org>.
- [7]. Australia Fitness Code of Conduct (2015) Professional to includes competence and its boundaries (job description) providing services and interventions for which they are qualified for training and experience to prevent exposing clients to risk and injury
- [8]. Awosika, B.Y. (1982). Intramural programme in some selected Nigerian Universities. Unpublished Doctoral Thesis, University of Ibadan, Ibadan.
- [9]. David I. H. (2002). Standards and Guidelines for Fitness Facilities: Sword or Shield?(4" ed.) PRC Publishing. Retrieved on 1 3/ 06/ 2 016 http://recmanagement.com/feature_print.php?fid=200609GCO3
- [10]. Eleso, T. (2005).Ensuring the availability of sporting facilities and equipment for the success of the Universal Basic Education Programme: Issues and challenges. *Journal of Nigerian Association for Physical, Health Education, Recreation Sports and Dance*, 2 (1), 186-193.
- [11]. Harkel, Lee, Powell, Blair, Franklin., Macera, & Herath, (2007). Physical Activity (PA) is a key concept in public health and exercise because reduced PA is a well-documented risk factor for many chronic diseases.
- [12]. Igbunugo (1999) Eleso, (2005). The implementation of the fitness programme therefore requires careful selection of location, facilities, equipment, programmes, personnel and strict adherence to standards and guidelines.
- [13]. Grantham, W.C.; Patton, R.W.; York, TD. & Winick, M.L. (1998). Health fitness management. USA: Human Kinetics.
- [14]. (Mion, 2014). Awosika (1982) in Elias and Solomon (2010). It may be a non- profit commercial facility or a community or institutionally supported centre.
- [15]. Truity Psychometrics LLC (2016). Fitness trainer or Instructor. Retrieved from <http://www.truity.com/career-profile/fitness-trainer-or-instructor> 15/06/2016.
- [16]. WHO, 2004; Sarpong. Apaak & Dominic, 2015. Especially with sedentary lifestyle becoming common around the world.