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# Editorial Board
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# Women's Health, Cultural Norms, and Barriers to Physical Activity in Conservative Societies

**Ibrahim Abdul Jaleel Yamani[1], Izzeldeen Abdullah Alnaimi[2], Ahed J. Alkhatib[3]**

[1]Imam Mohammad Ibn Saud Islamic University (IMSIU)

[2]Imam Mohammad Ibn Saud Islamic University (IMSIU)

[3]Jordan University of Science & Technology

## Abstract:

The socialization of women in conservative societies requires the careful balancing of family obligations and personal safety. This balancing, along with the shaming of women in sports, can hinder their participation. The current paper aims at viewing physical inactivity of women as a socio-medical problem. It explains how modesty dictations, patriarchal family structure, restricted mobility, mixed gender concerns, and absence of access to women-only facilities influence not engaging in exercise behaviour. These obstacles limit women's access to sport, active travel, recreational activity and structured exercise, leading to increased risk of obesity, cardiovascular disease, diabetes, mental health and quality of life issues. It has been exemplified in the review that the physical activity of women cannot be promoted through just biomedical advice. The interventions must be culturally sensitive and be community-based. Further, it should respond to local religious and social expectations. Women-focused exercise areas, sure transport, modest-friendly offers, involvement of family and faith leaders, gender-sensitive health education, sensitive public policy, etc may boost participation without hurting values. A sociomedical approach to women's health highlights the role of the social environment that enables or constrains movement, along with individual motivation. In conservative societies, families, communities, health systems, urban planning and policy need to work together to enhance women's physical activities.

**Keywords:** Women's health; Physical activity; Cultural norms; Conservative societies; Gender-sensitive health promotion

## 1. Introduction

Cultural norms exert a decisive influence on women's health and physical activity, particularly in societies classified as conservative (1). The combination of faith-based cultural scripts, dominant gender roles, and system barriers leads to a unique spectrum of constraints that impede participation in exercise, collective and informal sports, active travel, and many alternative modes of physical activity (2). Empirical studies document extensive compliance with these norms and their negative impact on individual health (3). As a social determinant of health, cultural context shapes both the nature of collective well-being and the

distribution of resources to achieve it (4). Therefore, effective responses require sustained engagement with, and respect for, the beliefs and practices guiding women's physical activity (5).

Women's health retains its independent significance as a focus of attention because physical activity is understood as a central contributor to well-being (6). Modifications to the dominant exercise paradigm represent essential initial steps toward broader participation in health-promoting behaviours, addressing the current imbalance between conservative cultural enactment and the gendered experience of health across the life course (7). Specific aspects of health remain underrepresented in public discourse and professional training within conservative societies (8). Comprehensive community and policy-level programmes that address both institutional authority and dominant public attitudes show the greatest potential for transforming access and participation among women, with considerable application across multiple geographical and cultural contexts (9, 10).

## 2. Contextual Foundations

Cultural norms in conservative societies exert a profound influence over women's physical activity and health (11). Notably, male-dominant norms around family structure, social roles, and modesty expectations create conditions where women's public mobility and interaction with men beyond family ties are constrained (1). Under patriarchal frameworks, restrictions targeting women arise from constructions of family honor exercised by male guardians who control time-use decisions and prioritise preservation of the family unit (12). Such limits are articulated through religious beliefs, social expectations, and established codes for bodily presentation (13). Marked divergence exists between conservative populations on the one hand and liberal, post-bourgeois groupings on the other (14). Gradual historical trajectories trace the evolution from sacred-to-secular norms alongside post-colonial pathways that retain colonial legacies (15). Moreover, cultural norms influencing women's activity are impacted by regime type, social settings, geographical orientation, and external forces—normative specifications therefore remain context-specific and evolve over time (16).

The frameworks for women's health that inform this discussion encompass three framing definitions (17). First, the term "health" incorporates a condition of complete physical, mental, and social wellbeing, consistent with WHO pronouncements (18). Second, "autonomy" denotes a situation where individuals are able to exercise their influence over decisions, actions, and opportunity in ways compatible with prevailing socio-cultural expectations (19). Third, the phrase "gender norms" refers to the behavioural expectation imposed upon individuals of different genders concerning property rights, inheritance, dress-code, mobility, and mixed-gender interaction (20). Finally, the expression "physical activity" denotes any repetitive or non-repetitive body-movement-enhancing energy expenditure, in contrast to sport, which is defined as "formalised and regulated physical activity" (21, 22).

### 2.1. Historical and Cultural Norms

Examining the historical trajectories of women's mobility and physical exertion reveals the interplay of sacred and secular norms and natural and human-constructed spaces (23). Cultural scripts and religious interpretations, often interdependent, articulate the expectations governing women's movements, particularly their outdoor activities (24). In addition to prohibitive discourses, literature notes permissive

and enabling factors: supporting texts, historical precedents, appropriate company, marital status, and family configuration (25). These complexities suggest the importance of carefully mapping activity-related normative development for different groups (26). As women remain underactive in conservative societies, the evident health implications call for culturally sensitive solutions (27). Community co-design emerges as a promising approach to fostering women's participation, driven by how family honour and female modesty codes intersect with the documented health imperatives for physical activity (28).

Social and familial constraints are the most frequently documented barriers (29). Time availability and use, and the ability to decide how and where time is spent, are restricted by family and household obligations, especially during the teenage years and pre-marriage stage (30). Although extended family or kinship support may relieve these pressures, the norms for each period of life and for each specific group within a society should always be taken into consideration (31). Women's desire to participate in sport can also be influenced by familial and household factors regulating travel or participation in mixed-gender activities (32). Normative frameworks of safety and reputation influence women's preferences for private or modest environments and spaces, surveillance by police or family members, or grouping in same-gender company (33).

### 2.2. Gender Roles and Health Imperatives

Women actively engage in securing health, well-being, and quality-of-life improvements for themselves, their families, and communities (34). Nevertheless, female health imperatives may come under pressure in patriarchal societies structuring gender roles (35). In conservative environments where barriers to communal participation persist, family expectations—often rooted in maintaining the honor and reputation of female relatives—may gain salience, especially during a woman's transition into adulthood (36). Patriarchal natures of these societies further subject women's physical activity to modesty codes and private-space necessities (37). Such factors shape cultural attitudes toward women's exercise and urban mobility (38).

Patriarchal norms operating at different levels across societies constrain women's access to, and freedom of movement within, public space as well as their overall health (39). Cultural norms prescribing restricted mobility and limited exercise options intersect with these health imperatives, thereby directly influencing equality and health outcomes (40).

## 3. Barriers to Physical Activity for Women

Women in conservative societies face a range of barriers that limit their participation in physical activity (14). Some of these barriers stem from social and familial factors, including household and family pressures regarding time-use, decision-making, and participation in sports (41). Women also contend with safety concerns, the need for private spaces, the design of facilities, access to transportation, and surveillance issues (1). Economic and educational factors further hinder their participation (42). Income, education, employment status, opportunity costs, and affordability all represent complex interrelated barriers to regular activity (43). Medical guidelines, public health policies, insurance coverage, and service-delivery issues can strengthen these barriers where they exist (44).

Social and familial factors constitute a significant barrier to activity for women in conservative societies (14). Reports from several countries indicate that household and family pressures restrict women's discretionary time, direct their decision-making, and shape their involvement in sports (45). The extent of these influences varies by household and region but often emerges as a major barrier (46). In Arab countries, social norms require women to prioritise family responsibilities and seek permission from family members before participating in leisure activities (47).

### 3.1. Social and Familial Constraints

Cultural norms and familial dynamics discourage participation in physical activity among women, with social factors exerting the greatest influence on inactivity in conservative settings (14). The methodologies and family tissues underpinning social influences vary considerably across contexts (48). In many traditional societies, the household, as the primary location for cultural socialization, plays a pivotal role in the establishment of gender norms and mothers serve as the chief transmitters of these norms (1). Systems of kinship, marital ties, or polygamous arrangements, along with economic status, affect the availability of time and choice to participate in sport and exercise (15).

Cultural scripts, religious interpretations, and social expectations significantly shape perceptions of female athletic involvement and outdoor activity across conservative settings (49). Patriarchal structures variously govern interactions in public spaces, impede freedom of movement, determine access to education and employment, restrict leisure opportunities, dictate dress codes, and enforce codes of modesty in clothing and behavior (50). Strong associations between family honor and women's mobility prevail in some regions, leading to restrictions on outdoor exercise (51). Gender norms frequently promote obesity and discourage activity, while cultural beliefs link diabetes to excessive exercise. Inertia is compounded by the vivid portrayal of negative health outcomes faced by physically active women (52).

### 3.2. Safety, Privacy, and Access to Facilities

Safety concerns dominate the literature on women's physical activity in conservative societies (1). The threat of harassment or violence deters women from entering public spaces, either for outdoor activity or for transport to facilities (14). Where municipal or other public-area lighting is deficient, females may not exercise even during daylight, through fear of encountering abusive or threatening individuals (53). Even if women were to find safe transport, many private-vehicle ownership levels remain low, and public-transport systems often afford little privacy (16). In some regions, public female-only transport options exist, but they may not align with recreation and related outings such that use is feasible. Such transport needs, beyond those associated with exercise, sometimes amplify the already-considerable travel time to workouts (54). Girls may not attend co-educational facilities, including for transport to or from them, where the presence of unrelated males raises concerns (55).

The apparatus of surveillance, through CCTV, might limit harassment, yet in some settings greater observance, rather than less, appears to impose paternalistic constraints on a mother or wife's mobility (56). The anticipation of caller-identity display on telephones offers wider female options for communication, yet looks toward otherwise-secluded adjuncts such as landlines and postcards rather than removing familial controls completely (57). Where sports facilities are fenced, barriers on private

properties assume gym-like functions or mirror half-bathroom-type arrangements (58). Facility designs therefore pose nontrivial obstacles to activity, where regulations insist on separation from co-workers live, yet neither such advances nor—outdoor-adjacent street-practice standards—yet combine (59). Further preventive options exist: “exhibitionism” faces devaluation (60). Cultural assets achieve progress via regional stewards, yet endemic constraints inhibit paths for women (61).

### 3.3. Economic and Educational Factors

Regular and adequate physical activity reduces the risk of noncommunicable diseases (NCDs) such as cardiovascular diseases, type 2 diabetes, and some cancers (62). Inactivity is also associated with negative mental health outcomes, including depression and anxiety (63). Lack of physical activity is further related to weight gain and obesity, which elevate the risk of NCD and associated conditions (64). Irrespective of the methodological approach, studies generally show that 20 to 90 percent of women are insufficiently active (65). In many conservative societies, these inequalities have been exacerbated by the patriarchal impacts of colonialism (66). Following independence, state policies, economic development models, and social values have produced different gendered socioeconomic conditions across these regions (67).

Cultural and social factors often determine the types of physical activities that women engage in and their ability to participate regularly (1). Low self-efficacy, lack of women-only facilities, gender discrimination, negative cultural perceptions of women who exercise, and modest dress are key factors influencing women’s ability to be physically active (68). Understanding these barriers helps develop effective strategies, such as community-based family activities supported by faith leaders and trained educators, to increase family support, self-confidence, and reduce negative perceptions (69). Insufficient physical activity is especially prevalent among Arab women, particularly those from Muslim communities, due to overlapping individual, social, cultural, and religious influences (70). Addressing cultural and religious barriers is crucial for promoting physical activity in this population, especially as Arab immigrant communities in the US grow (71).

### 3.4. Medical and Policy-related Barriers

Barriers hindering physical activity for women living in conservative societies exist at the medical and public policy levels (34). Despite widespread acknowledgement of the benefits of regular exercise, clinical practice guidelines rarely include recommendations for women, instead emphasizing the need for vigorous physical activity (72). Socio-cultural obstacles are cited as the reason for women’s inactivity—obstacles that remain relevant—and yet this contextual consideration seems absent from guidelines or public policy on the issue (1). Health-care and insurance policies often fail to support preventive measures, including the promotion of physical activity as an intervention against noncommunicable diseases (73). Lack of familiarity with the evidence-base among health-care provider’s further limits counsels for physical activity (74). An unwillingness among public health policy makers to broaden their understanding of societal contexts and the determination of noncommunicable disease risk factors inhibits adaptation of interventions to support activity in women living under restrictive societal conditions (75).

## 4. Health Implications of Inactivity

Inactivity has significant health implications for women. Noncommunicable diseases are a leading cause of mortality and morbidity globally, accounting for approximately 70% of worldwide deaths and affecting a projected 72% of the population in the Arab region by 2030 (76). Cardiovascular disease, diabetes, obesity, and mental disturbances are among the most common concerns, many of which are positively correlated with physical inactivity (77). Arab women are disproportionately affected by several noncommunicable diseases (78). Compared to men, they are reported to have greater health risks from physical inactivity, deficient dietary intake, and obesity (79). Addressing the issue of noncommunicable diseases among women requires a fundamental understanding of physical activity behaviour and the underlying factors influencing it (80).

Reproductive health considerations are important for women contemplating physical activity at various life stages (81). Guided by clinical recommendations, sedentary women are urged to take up light-to-moderate physical activity (82). To encourage women to undertake regular physical activity, supplementary evidence connecting physical activity to enhanced reproductive and gynecologic health is indispensable (81). Menstrual health management, methods of contraception, pregnancy, and post-natal recovery represent vital and widely accepted topics linked with women's physical activity levels that could be incorporated into educational materials promoting physical activity among women (83).

### 4.1. Noncommunicable Diseases and Mental Health

Habitual physical activity can reduce the risk of several noncommunicable diseases among women, including cardiovascular diseases, diabetes, obesity, and metabolic syndrome (81). The establishment of a healthy lifestyle should therefore occur as early as possible (84). Given current trends, women in some conservative societies are likely to become less active and to continue that trend longer than others (85). Low-intensity and moderate-intensity activities, particularly household chores and care activities, constitute the majority of the movement of women in such contexts (86). The connection between moderate-level physical activity and improvements in mental health is similarly established (87). Physical activity has positive effects on depression and anxiety, and it helps alleviate low mood, stress, and tension (88). However, the situation is variable (88). In societies where women develop low-level chronic anxiety and harbored inhibiting thoughts or issues related to their body image, the impact of physical activity on mental health may, ironically, be more detrimental than beneficial (89). Addressing these diverse patterns calls for situational analysis and consideration of the geographical, material, or social context (90).

Women and girls undertake fewer outdoor recreational physical activities in conservative societies where gender roles and restrictions are tightly delineated (92). Low participation rates have significant implications for contemporary public health policy, especially as inactivity is recognized among the social determinants of health (19). The barriers inhibiting females from exercising outdoors in such environments are mediated by awareness of political, ideological, or material constraints (93).

### 4.2. Reproductive and Gynecologic Considerations

Obesity, one of the leading causes of death worldwide, is linked to low life expectancy and non-communicable diseases such as heart disease, type 2 diabetes, and certain cancers (94). Thirty-five percent

of the global population is overweight or obese, often as a result of poor diet and physical inactivity (95). Insufficient physical activity is especially common among Arab women, particularly those from Muslim communities (96). Barriers to increasing activity include low self-efficacy, lack of women-only facilities, gender discrimination, cultural perceptions of women who exercise, and modest dress requirements (97). Understanding these barriers can help develop effective strategies to increase activity, such as community-based family activities with faith leaders and educators to enhance support and reduce negative perceptions (98). For Arab immigrant women in Western societies, additional challenges may arise from cultural and religious factors influencing physical activity (1).

## 5. Strategies for Incremental Change

Despite the numerous benefits of physical activity for both physical and mental well-being, challenges persist, especially for women in conservative societies (14). Attempting to address these, a targeted and intentional approach is warranted: Foundations for effective interventions include collaborative, community-engaged research with cultural sensitivity; evidence of the role of policies and investments in built environments, such as improved sidewalks and protected paths; establishment of gender-sensitive practices to foster inclusive environments within healthcare services; and promotion of settings that facilitate participation, such as women-only exercise options, modest-friendly programming, private spaces for activities, and active-surveillance-free venues (1). Access can be expanded through transportation solutions that increase coverage, such as women-only shared transportation options (99).

Since orthodoxy in religious interpretation and practice varies across regions, and multiple trajectories of historical events and cultural norms have shaped diverse attitudes toward women's mobility, to effect change tailored to specific contexts and needs the deployment of evidence-based interventions can be complemented by an understanding of the evolution of traditions and an analysis of regional differences (100).

### 5.1. Community Engagement and Cultural Sensitivity

Several approaches might promote incremental change while respecting cultural priorities (101). First, involving local communities in designing physical activity initiatives, incorporating cultural norms and preferences, and using culturally appropriate strategies can enhance acceptability (102). Community members may co-create activities or propose relevant themes, such as family or religious considerations, mainstreamed within local cultural scripts (103). Faith-based community leaders can encourage participation through tailored messages (104).

Second, scalable policy measures can expand women's access to physical activity, through improved built environment, leisure facilities, public transport connections, and straightforward safety mapping (105). Third, training health providers in gender-sensitive communication, bias reduction, and youth- and family-centered care can foster patient engagement, enhance continuity, facilitate physical activity discussions, and support mothers' postpartum recovery (106). Ongoing education addressing broader health determinants could also underscore the health implications of reduced physical activity (107).

Fourth, facilities offering women-only spaces, modesty-compliant equipment, privacy, and separate showers and changing areas can enhance comfort (45). Developing guidelines for modest-friendly, contextually appropriate physical activities promoted through community settings, organizations, and higher education institutions is another pathway (108).

### 5.2. Policy and Infrastructure Interventions

Infrastructural policies exert strong influence on women's access to the public sphere, including opportunities for physical activity (109). Building local facilities such as dedicated exercise spaces, safe paths for transit, or secure transport options enhances women's ability to participate (110). Local interventions demonstrating measurable impact on physical activity levels should be scaled and promoted through policy advocacy (111). These measures form the second tier of supportive structures encouraging culturally relevant exercise (112).

### 5.3. Healthcare Provider Practices and Education

Healthcare providers operate in settings where norms and perceptions often govern women's enrollment in physical activity (113). Therefore, healthcare education should incorporate locally relevant barriers and gender-sensitive strategies (114). Gender-sensitive healthcare provider education recognizes that users need to feel secure before they can seek services or heed expert advice (115). Such education equips healthcare workers with the knowledge necessary to engage with the issue of women's health in physical activity, thereby ensuring women be informed of associated advantages and enthused about participating in any available activities (116). Gender-sensitive approaches pay attention to service delivery challenges and the relevance of conditions and procedures applied, through policies, appointment schedules, and advice provided; hence, proper scheduling can encourage participation or contribute to fixation on restricting women's requests and activities (117). Delivery models should not merely underscore logistics, but also appeal to the health preoccupations of women (1).

### 5.4. Safe and Inclusive Exercise Environments

In conservative societies, exercise venues remain a crucial but often unaddressed barrier to women's physical activity (118). Standards for inclusive physical activity must consider cultural norms while recognizing the universal right to health and well-being (119). Gymnasium conditions significantly influence women's attendance, with appropriately designed and adequately equipped spaces, public swimming pools with family-adjusted service hours, and female-only facilities enhancing participation rates (118). Women's desire to preserve privacy when using outdoor facilities further supports the need for such settings (120). For modesty-conscious women, male supervision or surveillance restricts access to fitness facilities and comparable locations (121). In the absence of dedicated female-only facilities, private exercise spaces, home deliveries of fitness devices or equipment, and modesty-friendly programs extending past public exposure may also facilitate women's activity (122).

When transport prohibits women's arrival at physically fitted exercise facilities, provision of safety or check-up cars with accompanying members likewise becomes relevant (123). In line with these recognized needs, projects to elevate the standard of exercise environments for women remain beneficial (124).

## 6. Ethical Considerations and Rights-based Perspectives

The nature of exercise and movement is notable in many teachings of religion, the Quran itself states physical exercise is good, while some certain movements or rigid postures may be unaccepted (125). The interpretations on religion with respect to women and exercise/physical activity, the family honor is associated with women mobility, and the modesty is related to clothing choice are outlined here (126). At the same time there is an established link between women mobility and health, the health issues of inactivity have been documented (127).

## 7. Conclusion

In conservative societies, a woman's physical inactivity isn't simply a matter of choice, motivation or awareness. Embedded in social arrangements that govern their mobility, bodily presentation, time use, visibility in public spaces and access to safe spaces. Women can suffer from noncommunicable diseases, obesity, mental health issues, and a lack of well-being due to cultural expectations about modesty, family honour and gender segregation, as well as household roles, which may block their participation in exercise, sport and outdoor movement.

According to the review findings, health promotion must go beyond vague physical-activity messages and be more culturally responsive. Women-only facilities, an exercise environment that protects women's privacy, protected public transport, family-based organization or encouragement, modesty-friendly exercise programs, and engage trusted leaders, i.e., community and religious. Healthcare professionals should also be trained to discuss physical activity in ways that are respectful, practical, and sensitive to women's social realities.

Women's physical activity deserves attention at policy level both as a public-health priority as well as a gender-equity issue. Urban planning, school programmes, community health initiatives, insurance systems, clinical guidelines, etc. need adaptation to eliminate structural barriers and create enabling environments Facilitating greater access to physical activity for women in conservative societies has the potential to enhance the health of the individual, the family and the population as a whole. All this can be done without compromising cultural integrity and social acceptability.

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