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Body Image and Obesity among Arab American Women: A Qualitative Descriptive Study of Cultural and Religious Influences

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Abstract. Obesity is a multifactorial chronic disease with significant physical, psychological, and economic consequences. Arab American women (AAW) remain an understudied population whose experiences of body image and obesity are shaped by the intersection of cultural traditions, religious beliefs, family expectations, and Western acculturation pressures, yet limited research addresses these unique influences. Aim: This study aimed to explore the perceived factors influencing body weight and body image among AAW, with attention to daily routines, eating behaviors, and cultural and spiritual practices. Method: A qualitative descriptive design guided by Colaizzi's phenomenological method was used. Fourteen AAW aged 20 and older, residing in Southern California, were recruited via snowball sampling. Semi-structured interviews were conducted via videoconferencing, transcribed, and analyzed through statement-by-statement coding until thematic saturation was achieved. Results: Seven themes emerged: cultural and religious influences on daily routine, eating attitudes and behaviors, healthy body image perspectives, body image concerns, influences on body image, balancing tradition with personal choice and self-care, and holistic well-being. Findings revealed that family obligations, religious practices, community expectations, and exposure to Western beauty ideals collectively shaped participants' perceptions of health, weight, and appearance, often creating tension between traditional and acculturated identities. Conclusion and Implications for Practice: Obesity and body image among AAW cannot be addressed through standardized weight-management approaches alone. Healthcare providers should adopt culturally responsive, patient-centered assessments that incorporate religious and family context, while healthcare systems and policy should promote clinician cultural competence training and improved ethnic data collection to reduce disparities in this underserved population.

Keywords: *Qualitative research, Arab American, women, obesity, body image*

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1. Introduction

Obesity has gained global recognition as a dominant determinant of health, and its complications contribute significantly to individual and public health outcomes worldwide [1,2,3]. The World Health Organization defines adult obesity as a body mass index (BMI) of 30 or greater [4], reflecting a caloric imbalance that produces "abnormal or excessive fat accumulation that may impair health" [1,5]. Clinically, obesity contributes to the development and progression of cardiovascular disease, including hypertension, coronary artery disease, and heart failure, type II diabetes mellitus, chronic kidney disease, and related disability and mortality [2,3,5].

Obesity also carries a considerable economic burden. Ward and colleagues found that in the United States, obesity accounted for over $1,800 in annual per-person medical costs in 2021, nearly doubling to approximately $3,000 for severe obesity [6], and globally, the World Obesity Federation projects that the combined direct and indirect costs of overweight and obesity across 161 countries, expressed in constant 2019 US dollars, will reach nearly $3 trillion by 2030 and $18 trillion by 2060 [7]. Prevalence trends mirror this trajectory: one national projection anticipated continued increases in obesity and severe obesity across nearly all U.S. subgroups, with persistent disparities by race/ethnicity and sex, including higher rates among racial/ethnic minorities relative to non-Hispanic White populations and among women relative to men across ethnic groups [8].

These disparities reflect obesity's standing as a chronic disease with multifactorial causes, including metabolic disease, medication side effects, nutritional imbalance within an obesogenic environment, and inadequate health education [5]. Minority and immigrant populations have been disproportionately affected, driven by physical and

non-physical barriers to healthcare access, racial discrimination, and cultural disparities in care [9,10]. These same factors not only promote obesity's development but also exacerbate psychosocial challenges and body image perceptions, both of which are shaped by distinct cultural norms and traditions [11].

Sex and gender-related disparities follow a similar pattern, with obesity and severe obesity consistently more prevalent among women than men across nearly all racial/ethnic groups [8,12]. Women face distinct risk factors linked to estrogen and progesterone fluctuations across pregnancy and menopause, which increase variability in fat distribution and appetite regulation and further contribute to caloric imbalance, while men face separate risks tied to testosterone changes [12,13]. Although men show greater risk for metabolic comorbidities, women appear more vulnerable to the psychological consequences of obesity, particularly under the influence of sociocultural factors and cultural beauty standards [12,14].

Arab Americans

The Arab American community remains a historically understudied minority group, underrepresented in health literature largely due to the absence of a distinct racial identifier in the U.S. Census, such as a Middle Eastern and North African (MENA) category, and due to barriers stemming from xenophobic discrimination amid a shifting social and political climate [15,16]. This has produced concentrated, targeted racialization that compounds existing health disparities while further undermining the community's visibility [16,17].

Despite a growing body of literature, a scoping review found that understanding of Arab American wellness varies considerably by study, yielding mixed and inconsistent findings attributable to sociodemographic variation and limited research, underscoring a persistent lack of disaggregated data and research attention [18]. Focused studies nonetheless reveal distinct patterns, including higher prevalence of cardiovascular disease, metabolic disorders such as diabetes mellitus, and depression and anxiety among Arab Americans [19,20,21,22,23]. A related theme is reduced engagement in preventive care, attributable to cultural and linguistic barriers, experiences of discrimination, mistrust of providers and the healthcare system, and limited health literacy and acculturation [16,18].

Cultural norms, faith-based practices, and immigration patterns emerge as major influences on the development and management of these conditions. An integrative review of physical activity among AAW found that adherence to traditional norms of female modesty can limit participation in health-promoting behaviors, increasing cardiovascular risk [24]. Similarly, a systematic review of diabetes self-management among Arabic-speaking immigrants found that cultural stigma, dietary habits, and religious beliefs about illness substantially deter effective health behaviors [25]. In mental health, cross-sectional studies show that Arab refugees and immigrants who resettle after political violence or religious persecution experience poorer mental health outcomes, including higher depression and anxiety, than their U.S.-born counterparts [23,26].

Women, Culture, and Body Image

These intersecting sociodemographic factors extend predictably into the psychosocial domains of obesity and body image. As noted above, cultural norms and traditions shape health behaviors in ways that carry weight for AAW, who navigate distinct tension between traditional Arab cultural norms and Western ideals.

Cultural Conceptions of Body Image

Arab culture is rooted in conservatism and collectivism, with modesty and the well-being of the group, rather than the individual, central to societal and personal expectations [27]. In practice, this often reinforces patriarchal norms and defined gender roles [28], alongside a strong orientation toward family and community, whose perceptions carry significant weight over individual body image and beauty standards [29,30]. Arab female beauty ideals traditionally associate plumpness and a curvier body type with femininity and fertility [27,31]; exposure to the thinner Western beauty standard therefore creates an abrupt clash in ideals that can undermine AAW's self-esteem and body satisfaction [27,30].

Impact of Western Ideals and Acculturation

As globalization extends Western ideals into non-Western cultures, greater exposure to and reduced "cultural distance" from Western beauty standards are associated with increased body dissatisfaction and diminished body appreciation [27,30,32]. This dynamic is especially salient for AAW in the U.S., who navigate acculturation, defined as the process of cultural transition experienced by immigrant groups [33], within a multicultural environment that requires balancing the diametrically opposed curvy and thin body ideals. Conflicts between personal identity and societal expectation further compound this dissonance, with consequences that extend into physical and psychosocial health and well-being [27,31,34].

Arab American Women and Obesity

Together, these factors present a multidimensional picture of obesity's implications for AAW. Beyond physical complications, obesity is linked to adverse mental health outcomes, including lower self-esteem and greater body dissatisfaction [14,35]. Layered onto existing gender norms and weight-based stigma [36,37], these psychosocial consequences intensify, both contributing to and resulting from poor eating behaviors [31] and disengagement from health-promoting lifestyle behaviors [38]. Given these interwoven complexities, this study aimed to deepen understanding of the specific factors shaping AAW's perceptions of obesity and body image.

2. Materials and Methods

2.1. Study Design

This study used a qualitative descriptive design to explore Arab American women's (AAW) perceived factors affecting body weight and body image, focusing on their daily life activities and perceptions of obesity and body image. This approach was well suited to examining AAW's everyday lived experience of routine as shaped by cultural and spiritual practice, given the limited existing understanding of the topic and the broader paucity of literature on Arab American (AA) health generally and

AAW specifically. The study followed the 32-item Consolidated Criteria for Reporting Qualitative Research (COREQ) checklist to enhance transparency in reporting findings [39].

2.2. Participants

Fourteen participants were recruited through snowball sampling and word-of-mouth, and all agreed to participate. Participants were purposively sampled to include AAW aged 20 years and older residing in Southern California. The principal investigators (PIs) selected this broad age range to capture diverse information about AAW eating practices and body image concerns. Exclusion criteria included women outside Arab American culture, pregnant, or having any active eating disorders.

2.3. Data Collection

Data were collected through semi-structured interviews conducted via a videoconferencing platform (Zoom) to gain a deeper understanding of participants' experiences around eating behaviors. The PIs developed a semi-structured interview guide grounded in current, relevant literature on eating attitudes and behaviors and their impact on body image, with a specific focus on AAW. The guide comprised ten questions addressing eating attitudes and behaviors and perceptions of body image (Table 1) and was reviewed by three content experts for content validity, with minor revisions made based on their recommendations.

Table 1. Semi-Structured Interview Guide Questions

Please describe what a typical day looks like for you.
Can you describe what body image means to you as an Arab American woman?
Can you talk about your concerns, if any, with your eating attitudes and behaviors?
What influences have you had in your life when it comes to eating behaviors?
What influences have you had in your life when it comes to your body image?
How would you describe healthy eating attitudes and behaviors?
How would you describe healthy body image?
Talk to me about what you view as important in defining your appearance.
Can you describe what influences how you view your appearance?
Can you describe what you view as important to your overall well-being?

Interviewers used supplementary probes as needed during individual interviews to clarify or elaborate on the questions asked. All interviews were digitally recorded and transcribed by a professional transcription service. A sociodemographic survey was administered to describe the sample and confirm that inclusion criteria were met, capturing age, weight, height, number of years in the United States, family annual income, availability of health insurance, and work status.

Videoconferencing via Zoom offered several advantages for this population. It allowed participants across Southern California to be interviewed without travel burden and to select a private location of their own choosing, which prior methodological research suggests can enhance comfort when discussing sensitive topics and supports interviewer–participant rapport to a degree comparable with in-person interviews [40]. This may have been particularly relevant for AAW, for whom modesty and family privacy are culturally salient, as remaining in a familiar home environment allowed participants to control their visibility and surroundings while discussing body image and eating behavior. At the same time, videoconferencing carries potential limitations for this population: participants interviewing from shared or multigenerational households may have experienced reduced privacy or hesitance to discuss sensitive topics with family members nearby, connectivity or technical barriers may have limited participation among less digitally literate participants, and the absence of in-person cues may constrain rapport-building relative to face-to-face interviews. Future research with AAW should consider offering multiple interview modalities, including audio-only or in-person options, to accommodate differing comfort levels with being on camera.

2.4. Data Analysis

Data collection and analysis occurred concurrently, in accordance with Colaizzi's phenomenological method. Using this method, two PIs independently conducted a statement-by-statement analysis of each transcript, separately evaluating and coding significant statements for meaning. The two coders then met to compare their independent coding, and any discrepancies in coding or interpretation were resolved through discussion until consensus was reached.

Following analysis of each interview, significant statements relevant to body image, eating behaviors, and daily routine were extracted verbatim from the transcripts. For each significant statement, the PIs formulated its underlying meaning by moving beyond the literal content of participants' words to articulate the more general meaning conveyed, while remaining closely grounded in and traceable back to the original statement, consistent with Colaizzi's method. These formulated meanings were then clustered into emerging themes and compared across participants to identify patterns of convergence and divergence. During the initial interviews, new categories and meanings were identified and incorporated into the developing thematic framework. By the tenth interview, the major thematic categories had been established, and subsequent interviews primarily reinforced previously identified meanings rather than introducing new conceptual categories. Thematic saturation was operationally defined as the point at which continued analysis of subsequent transcripts yielded no new codes or themes and existing categories were consistently and redundantly reflected across participants' accounts. Following analysis of the eleventh interview, no additional themes emerged and existing categories were fully redundant across accounts, indicating that thematic saturation had been achieved; interviews twelve through fourteen served to confirm, enrich, and validate the existing thematic framework. Data collection therefore concluded after fourteen interviews, as sufficient depth and redundancy had been reached to comprehensively describe the lived experience of AAW regarding the psychosocial factors influencing obesity and eating behaviors.

2.5. Ethical Considerations

The study was reviewed and deemed exempt by the Institutional Review Board (IRB) of California State University, Long Beach and adhered to the guidelines of the Declaration of Helsinki. All participants received a comprehensive description of the study and the nature of participation and were permitted to ask questions before providing informed consent. All recordings, transcripts, and study data were kept in password-protected storage accessible only to the research team. To protect confidentiality, participants themselves selected a pseudonym of their own choosing, rather than one assigned by the researchers, which was used throughout the interview to safeguard their identities. All interviews were conducted by a single researcher: a female professor who shared participants' cultural background. She was trained in qualitative interviewing techniques and applied bracketing, a method in which researchers explicitly identify, document, and temporarily set aside their own personal biases, beliefs, and assumptions to limit their influence on data collection and interpretation.

3. Results

Interviews addressed sociodemographic characteristics, daily routines, perceptions of and concerns about body image, influences on body image, healthy eating attitudes and behaviors, personal eating habits, general appearance, and factors affecting overall well-being. Analysis of participants' responses yielded seven main themes, presented below following a summary of participant characteristics.

3.1. Participants' Sociodemographic Characteristics

Table 2. Participant Sociodemographic Characteristics (N = 14)

Variable	N	M (SD)	Range
Age (years)	14	37 (14.3)	20–60
Years residing in the United States	14	12.07 (8.60)	2–30
Height (cm)	14	163 (9.6)	145–177
Weight (lb.)	14	153 (17)	123–185
BMI	14	25 (7)	17.8–34.4
Socioeconomic Status	N		
Lower class	2		
Lower middle class	5		
Middle class	4		
Upper class	3		

All 14 participants were proficient in English and self-identified as Arab American women. All participants reported having health insurance. Table 2 summarizes participant age, height, weight, BMI, and self-identified socioeconomic status.

3.2. Main Emerging Themes

Seven themes emerged from the data: (1) cultural and religious influences on daily routine, (2) eating attitudes and behaviors, (3) healthy body image perspectives, (4) body image concerns, (5) influences on body image, (6) balancing tradition, personal choices, and self-care, and (7) well-being, happiness, mental health, and appearance. Each theme is described below with supporting participant evidence.

3.2.1. Cultural and Religious Influences on Daily Routine

Cultural and religious values strongly shaped participants' daily routines. Traditional Arab culture placed high importance on family, community, and marriage, and married women often prioritized hosting guests and maintaining social relationships, with traditional Arab food central to gatherings and celebrations. Participants described a sense of responsibility for parenting, caregiving, nurturing, and cooking for immediate and extended family, and married women with children structured their daily routines around family and community.

Amy: "I quit my job for my kids." ... "I clean my house, I do my prayers, fix my kids' breakfast... help my husband with his business. We have a big family, so we often attend gatherings or social activities on weekends. I'm always busy, I'm always active, I have no time to be lazy."

3.2.2. Eating Attitudes and Behaviors

Participants shared a priority on healthy eating, including organic foods, a Mediterranean diet, and moderation and balance. Cultural and religious values shaped dietary habits, particularly cooking for family, gatherings, and special events.

Ana: "My culture influences 80% of the cooking that I do at home, which involves the bread, the rice, and a lot of the stews."

Hazel: "Social media... is the biggest influence on my eating habits. I'm always following health food accounts or healthy food alternatives, and I'm interested in finding ways to substitute bad cookies with better ones."

3.2.3. Healthy Body Image Perspectives

Participants defined healthy body image in varied ways: some associated it with physical fitness and appearance, while others balanced physical health, mental well-being, and comfort. Cultural and community norms informed these perceptions, and participants recognized healthy body image as subjective and individualized, with personal criteria for feeling healthy, confident, and content.

Hudhud: "Body image is the health, and it's the power of the woman. If the woman looks good, she's healthy."

Lulu: "I like to have a fit body, as I'm coming from a Middle Eastern country, where they think that skinny people are healthier and more beautiful. That's why I go to the gym; I try to lose some weight around my hips and my stomach."

3.2.4. Body Image Concerns

All participants expressed body image concerns, though focus varied by age. Older participants focused on aging-related changes, including stomach size after childbirth and the effects of decreased metabolism and menopause, while younger participants focused on specific features such as height and weight and on societal standards

affecting different body types.

Zanoba: "When we are aging, our body tends to change, as our metabolism rate slows down... Now it takes longer, and I need to be more mindful of what I eat."

3.2.5. Influences on Body Image

Participants described their body image as shaped by both societal expectations, including standards, cultural expectations, and media portrayals, and personal experiences involving family, community, and religious values. Many emphasized the impact of others' comments and expectations on their body image.

Sara: "In the social aspects, like you see on TV, how the image has to be skinny, to have curves... it's like all around."

Zanoba: "I come from an Arabic culture; the body image has to look symmetrical."

3.2.6. Balancing Tradition and Personal Choices and Self-Care

Participants described the challenge of balancing cultural or traditional expectations with personal choices, including work, family, and self-care through exercise, healthy eating, skincare, and dress that aligned with cultural or personal values. Fashion, clothing, and grooming choices were often intertwined with cultural and societal expectations.

Amona: "One of the biggest concerns that I have right now is trying to get proper exercise, finding a gym or a trainer that I feel comfortable with. It's harder today to find places where someone who might be a little bit more modest... can find a comfortable place to be fit and active... people in our culture also find it somewhat amusing when they see someone being very proactive about their health. They don't prioritize it as much."

3.2.7. Well-being, Happiness, Mental Health, and Appearance

Beyond physical appearance, participants associated overall well-being with mental health, family relationships, religious practice, and community engagement. Cultural identity, religious beliefs, and societal norms contributed to their sense of well-being and appearance, and happiness was frequently linked to a holistic combination of family, community, faith, and personal satisfaction, extending well-being beyond the physical.

Hazel: "My mental health is the most important to me now. I'm focusing on this by doing a lot of journaling, self-reflecting, and reading more about self-development. Before, it was mostly physical, but now I try to think of it as physical and mental."

4. Discussion

This qualitative study of 14 Arab American women (AAW) illustrates that perceptions of health and body image are shaped by an interdependent web of cultural, religious, and personal factors rather than by diet and physical activity alone. Consistent with current conceptualizations of obesity as a multifactorial chronic disease, participants' accounts reflected the intersection of family expectations, religious beliefs, immigration and acculturation experiences, media exposure, and evolving gender norms [3,5]. These findings reinforce growing evidence that obesity prevention and management require culturally responsive approaches addressing social, psychological, and structural determinants of health, rather than relying exclusively on individual behavior change [3,9].

Cultural and religious values shaped nearly every dimension of participants' daily routines and eating behaviors. Traditional Arab culture, characterized by strong familial and communal ties, influenced behavior particularly among married women, who often prioritized familial duties and social obligations over personal health goals; traditional food, central to family gatherings and celebrations, reinforced cultural identity and community cohesion even as it complicated adherence to healthy eating and regular physical activity. Participants nonetheless drew on culturally rooted eating patterns—adherence to a Mediterranean-style diet, a preference for fresh and organic foods, and an emphasis on moderation and balance—as a foundation for healthy eating. Throughout, participants engaged in an ongoing negotiation between cultural expectation and personal autonomy, balancing work, family responsibility, and self-care; this negotiation, rather than a simple choice between tradition and health, illustrates the intersectionality of cultural identity, gender roles, and personal agency that health promotion interventions for AAW must account for. These patterns mirror findings among other Arab American and Middle Eastern populations, where food preparation, hospitality, and caregiving roles frequently compete with health-promoting behaviors [18,24], and suggest that culturally tailored nutrition interventions should build upon existing cultural strengths, such as Mediterranean dietary patterns, rather than replace them [24].

Participants' conceptions of healthy body image extended well beyond physical appearance to include confidence, emotional well-being, comfort, family relationships, and spiritual wellness, and these conceptions varied across the lifespan: older participants focused on age-related changes associated with childbirth, menopause, and slowing metabolism, while younger participants emphasized body size, weight, height, and societal beauty standards. Many participants, particularly younger women and those with greater exposure to Western culture, described mounting pressure to conform to the thinner body ideal promoted by Western and social media, a pattern consistent with cross-cultural research linking globalization and acculturation to body dissatisfaction, internalized appearance ideals, and psychological distress among women of Middle Eastern background [5,32]. Notably, however, a subset of participants appeared to resist this pattern, maintaining positive appraisals of body types traditionally associated with health, femininity, and fertility within Arab culture and grounding this appraisal in cultural pride rather than in comparison to Western ideals. This divergence suggests that acculturative pressure does not translate uniformly into body dissatisfaction among AAW and that cultural pride may function as a protective factor even amid competing appearance ideals—a nuance not well captured

in prior literature and one that merits further exploration. These patterns are consistent with evidence that positive body image is associated with better mental health, self-esteem, and healthier lifestyle behaviors independent of body mass index [14], and together they underscore the importance of tailoring interventions to life-stage-specific concerns rather than applying a single framework across age groups.

Societal expectations and structural barriers further shaped participants' health behaviors. Beyond family and cultural norms, participants identified concrete obstacles to engaging in health-promoting behaviors: difficulty locating exercise environments that accommodated modesty and religious practice, limited social support for prioritizing self-care, and exercise routinely deprioritized relative to family obligations. These barriers echo broader evidence that environmental, organizational, and cultural factors substantially influence obesity prevention among racial and ethnic minority women [9,11], suggesting that healthcare systems should move beyond individual counseling toward culturally tailored community partnerships that expand access to acceptable physical activity and nutrition resources.

Finally, participants described well-being holistically, encompassing physical health, mental health, family relationships, faith, community engagement, and personal fulfillment, and identified body weight and appearance as sensitive topics shaped by family expectations, cultural identity, and prior healthcare experiences. Culturally responsive communication has been shown to improve patient trust, engagement, and adherence while reducing stigma and disparities in preventive care among Arab American populations [16,18]. These findings also underscore the continued classification gap facing Arab Americans in U.S. health research: the absence of a distinct MENA identifier limits accurate assessment of obesity, mental health, and chronic disease disparities, and constrains the development of evidence-based interventions and policy [16,19].

Study Limitations

This study's sample of 14 participants may not capture the full diversity of AAW experiences nationally. Because participants discussed sensitive topics, including body weight, appearance, and family dynamics, responses may have been subject to social desirability bias; this possibility may have been compounded by the shared cultural background between the principal investigator and participants, which could have shaped disclosure in either direction. The focus on Southern California means findings are best understood in terms of transferability rather than generalizability: readers should weigh the extent to which the cultural, religious, and structural context described here corresponds to their own setting before applying these findings elsewhere. Future research should test the applicability of these findings among AAW in other geographic regions and among more demographically diverse samples to clarify which findings reflect experiences broadly shared among AAW versus those specific to this regional and cultural context.

5. Conclusion and Implications

This study shows that AAW's perceptions of obesity and body image emerge from a dynamic interaction of cultural traditions, religious beliefs, family expectations, acculturation, and societal beauty standards, and that body image itself encompasses emotional well-being, cultural identity, family relationships, and overall quality of life. For clinicians, the clearest message is that obesity in this population must be approached as a complex biopsychosocial condition warranting culturally informed, patient-centered care rather than standardized weight-management strategies.

In practice, this means incorporating culturally sensitive assessment of patients' beliefs about body image, eating behavior, physical activity, family responsibility, and religious practice into routine care, and building interventions on existing strengths, such as traditional dietary patterns including the Mediterranean diet, rather than replacing them. Clinicians should use this understanding to foster supportive environments for body positivity and self-esteem and to help patients negotiate the balance between cultural expectation and personal autonomy in self-care. Healthcare organizations should expand cultural competence training addressing communication, implicit bias, health literacy, and the social determinants specific to Arab American communities, as such training improves trust, reduces stigma, and increases preventive care utilization [16, 18].

For policymakers, the priority is establishing a distinct Middle East and North Africa (MENA) identifier in public health surveillance to enable accurate assessment of obesity, mental health, and healthcare disparities in this population [19]. Advancing this goal requires concrete, coordinated action: sustained advocacy for the U.S. Census Bureau and Office of Management and Budget to finalize and implement a standalone MENA racial/ethnic category; partnerships with Arab American community organizations and health systems to collect MENA-specific data at the point of care in the interim; and the addition of supplementary MENA identifier questions to existing national and state health surveys (e.g., BRFSS, NHANES) so that obesity and mental health disparities in this population are not obscured by aggregation into the "White" category. Policymakers should also support training primary care providers to routinely discuss weight, nutrition, physical activity, and mental well-being with Arab American patients considering cultural, religious, and acculturation factors.

For researchers, future studies should draw on larger, geographically diverse samples and examine differences across generation, immigration history, socioeconomic status, religious affiliation, and acculturation, ideally through mixed-methods and longitudinal designs that track how cultural identity and social environment shape obesity risk and body image over time.

Taken together, these findings call for clinicians to individualize care around cultural context, policymakers

to prioritize MENA data visibility through the concrete steps outlined above, and researchers to expand and diversify the evidence base—collectively addressing the needs of a population that remains historically understudied and underserved.

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