

Physical Activity Among Muslim Women in Majority and Minority Settings: A Systematic Review of Barriers and Facilitators

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Abstract

Purpose

Physical activity (PA) is central to health and wellbeing, yet the physical activity participation of Muslim women remains understudied in the global public health literature. This mixed-methods systematic review aimed to assess the perceived barriers and facilitators to PA among Muslim women in Muslim-majority and Muslim-minority settings.

Methods

A systematic search of EBSCO, PubMed, and Google Scholar identified qualitative and quantitative studies (2000–2024) involving Muslim women aged 18 years and older, quality-appraised using the Critical Appraisal Skills Programme (CASP) for qualitative designs and the Mixed Methods Appraisal Tool (MMAT) for quantitative studies. Qualitative findings were analysed thematically and mapped onto the five levels of the Socioecological Model (SEM) to examine cross-level interactions; quantitative results were synthesised narratively.

Results

Eleven studies (nine qualitative, two quantitative; N = 816 women aged 18–55) across eight countries were included. Three themes were identified: modesty, visibility, and the absence of safe space; gatekeeping by family and community; and infrastructure, climate, and policy neglect, operating through compounding SEM-level mechanisms. Facilitators included religious motivation, health awareness, family support, and culturally tailored programming; barrier-facilitator configurations varied between Muslim-majority and Muslim-minority contexts.

Conclusions

A context-sensitive, multi-level, tailored approach is essential to promote physical activity among Muslim women. Faith-sensitive, gender-segregated initiatives that simultaneously address structural, organisational, and community factors offer the most promising pathway for equitable participation and wellbeing.

Introduction

Physical activity (PA) is a central determinant of population health, reducing the risk of major non-communicable diseases such as cardiovascular disease, type 2 diabetes, several cancers, dementia, and stroke. Global estimates from the World Health Organization indicate that approximately 1.8 billion adults (31%) are insufficiently active, with inactivity projected to rise to 35% by 2030 if current trends

continue [1]. Women remain consistently less active than men (34% vs 29% inactive) [1], and these disparities intersect with ethnicity, migration status, and religion: women from ethnic minority and migrant backgrounds in high-income countries experience disproportionately low PA due to sociocultural, structural, and environmental constraints [2, 3].

Within this broader landscape, Muslim women represent a population of particular concern. Muslims comprise approximately 26% of the global population, making Islam the second-largest religion worldwide [4]. Muslim women and girls account for around 12% of the global population, residing across 45 Muslim-majority countries and more than 30 nations with significant Muslim minority populations [5, 6]. Despite the theoretical and cultural significance attributed to health and physical wellbeing within Islamic scholarship [7], Muslim women continue to face unique and compounding challenges in engaging with PA. Earlier work by Babakus and Thompson [8] offered foundational insight into cultural and behavioural influences on PA among Muslim women but lacked methodological rigour and did not address the intersection of religion, gender, and structural factors. More recent evidence highlights persistent disparities, particularly in Western minority contexts, where Muslim women navigate dual pressures: cultural expectations within their communities and structural barriers in wider society [9–11]. This, with their underrepresentation in PA research, underscores the need for a systematic synthesis of global evidence.

To contextualise the complex factors influencing PA among Muslim women, this review draws on the Socioecological Model (SEM) as its guiding theoretical framework. The SEM recognises that health behaviours are shaped by multiple, interacting layers of influence, from individual beliefs and motivations to interpersonal relationships, organisational structures, community norms, and broader policy environments [12–14]. Here, the SEM is used analytically, to examine how influences across levels interact, compound, or contradict one another, rather than simply as a tool for sorting findings into categories [14].

Methods

Design

A systematic review of qualitative and quantitative studies was conducted following a protocol registered prospectively with PROSPERO (CRD42025641522; 28 January 2025) and is reported in accordance with the PRISMA 2020 statement [15].

Search Strategy

A systematic search was conducted across EBSCO, PubMed, and Google Scholar to identify studies published between January 2000 and December 2024, using combinations of 'barriers,' 'facilitators,' 'physical activity,' 'Muslim women,' and 'health' with Boolean operators (full search strategy in Online Resource 1). Duplicates were removed and titles/abstracts screened against predefined eligibility criteria, with full texts reviewed in accordance with PRISMA guidelines [15]. The number of records

identified, screened, excluded, and included at each stage is reported in the PRISMA flow diagram (Fig. 1).

Eligibility Criteria

Studies were included if they focused on Muslim women aged 18 years or older (Population), explored perceived barriers or facilitators to PA participation (Interest), and were conducted in any geographical or cultural context (Context). Empirical qualitative, quantitative, or mixed-methods studies were eligible; only peer-reviewed English-language publications were included. Full eligibility criteria are presented in Online Resource 2.

Data Extraction and Quality Assessment

Studies were screened sequentially by title and abstract, then full-text review, with reasons for exclusion documented at each stage. Included studies were assessed for methodological quality using the Mixed Methods Appraisal Tool (MMAT) [16] for quantitative studies and the Critical Appraisal Skills Programme (CASP) [17] for qualitative studies. Quality ratings are presented in Online Resources 3 and 4.

Data Synthesis

A mixed-methods narrative synthesis was employed, guided by published guidance on integrating qualitative and quantitative evidence [18, 19]. Quantitative results were synthesised narratively, comparing indicators of PA levels, barriers, and self-efficacy across studies. Qualitative findings were synthesised using Braun and Clarke's [20] six-phase thematic analysis: familiarisation with the full dataset; inductive coding of semantic and latent meanings; collating codes into candidate themes; reviewing themes for internal coherence, with unsupported themes merged or discarded; refining and naming each theme; and producing the report by selecting illustrative extracts and embedding the analytic narrative within the wider synthesis.

Each theme was then mapped analytically onto the SEM [12], which conceptualises health behaviour as shaped by five nested levels: intrapersonal (knowledge, attitudes, self-efficacy, beliefs), interpersonal (family, spousal, peer relationships), organisational (policies and environment of institutions and facilities), community (norms, networks, expectations), and public policy/environmental (laws, infrastructure, governmental provision) [13, 14]. For each theme, the analysis identified which level(s) were implicated and how influences interacted, compounded, or counteracted one another, used analytically rather than as a classificatory grid. Variation across Muslim-majority and Muslim-minority contexts was examined throughout.

Results

Study Characteristics

A total of eleven studies met the inclusion criteria: nine qualitative and two quantitative. Table 1 summarises all included studies by location, design, and population. The qualitative studies [21–29] explored Muslim women's PA experiences across eight countries spanning Muslim-majority and Muslim-minority settings. Across the included studies, 816 Muslim women participated, with individual study sample sizes ranging from 6 to 100 participants aged 18 to 55 years, representing Arab, South Asian, Middle Eastern, North African, Turkish, Somali, and Emirati backgrounds, using methods ranging from semi-structured interviews and focus groups to participant observation, photography, and community-based participatory approaches. The two quantitative studies [30, 31] used cross-sectional surveys to assess PA levels, perceived barriers, self-efficacy, and religious influences among Muslim women in Saudi Arabia and the United States. Detailed characteristics are presented in Online Resources 5 and 6.

Table 1
Characteristics of included studies (N = 11)

Study (Author, Year)	Country	Design / Method	Population	Sample size (n)
Alqout and Reynolds [21]	Saudi Arabia	Qualitative	Saudi Arabian women	7
Soltani [22]	New Zealand	Qualitative	Muslim women engaging in aquatic leisure activity	20
Harkness [23]	Qatar	Qualitative	Women and stakeholders in female sport participation	30
Donnelly et al. [24]	Qatar	Qualitative	Qatari women living with cardiovascular disease	50
Murray et al. [25]	United States	Qualitative (PhotoVoice)	Somali women, San Diego	8
Miles and Benn [26]	United Kingdom	Qualitative	University-based Muslim women	34
Al Bakri [27]	Oman	Qualitative	Female university students	6
Berger and Peerson [28]	United Arab Emirates	Qualitative (participatory action research)	Young Emirati women	20
Koca et al. [29]	Turkey	Qualitative	Turkish women	100
Samara et al. [30]	Saudi Arabia	Quantitative (cross-sectional survey)	Female university students	94
Eldoumi and Gates [31]	United States	Quantitative (cross-sectional survey)	Arab Muslim mothers of children < 5 years	447

Total N = 816 (541 quantitative, 275 qualitative). Full study-level detail is presented in Online Resources 5 and 6 (Supplementary Tables 5 and 6).

Quality Assessment

Samara et al. [30] received a high MMAT rating and Eldoumi and Gates [31] a moderate rating, reflecting reliance on self-reported data. The nine qualitative studies were of moderate-to-high CASP quality overall, with clear thematic development and credible interpretation; the main limitations were incomplete reporting of participant characteristics [22], limited transferability [24], small samples [25, 27], and reliance on self-report [28]. Full ratings and judgement criteria are reported in Online Resources 3 and 4.

Quantitative Findings

Quantitative findings from Samara et al. [30] and Eldoumi and Gates [31] consistently showed that positive attitudes toward PA coexisted with low activity levels, and that structural and psychosocial factors, rather than religious or family opposition, were the primary drivers of inactivity. Among 94 Saudi university students [30], 56% met the WHO threshold of 600 MET-minutes/week of moderate PA, while 44% remained inactive. Self-efficacy was low overall and significantly lower among inactive than active students ($P = 0.02$). The dominant barrier was inadequate provision: 75% agreed there were too few places to exercise and 52% that locations were too far away. Sociocultural factors were comparatively minor: only 19% selected family and 15% the Islamic community as a hindrance, compared with 32% who selected the university timetable, the only setting a plurality identified as a hindrance, and most disagreed that family (66%) or embarrassment (71%) were barriers. Despite low activity levels, PA was viewed positively overall, and 98% agreed it was important for women to have a fit and healthy body; students exercised predominantly at home (92%) and alone (80%), motivated by health (72%) and weight management (50%).

Among 447 Arab Muslim mothers in the United States with children under five [31], 76% reported no strenuous PA in the past week and approximately 40% reported no moderate or mild leisure exercise. Despite near-universal recognition of PA's importance (95%), only 34% felt confident in their ability to maintain an active lifestyle. Factor analysis of 19 barrier items identified three clusters: dress code and negative perception (24% of variance), with 83% reporting discomfort wearing gym clothes and 60% embarrassed to exercise in public; lack of motivation and stress (10% of variance); and family responsibilities (9% of variance). Multiple regression explained 21% of the variance in weekly leisure activity ($P < .001$): lack of motivation and stress, family responsibilities, and self-efficacy were all significant predictors, while neither religious faith nor acculturation reached significance, indicating low PA was driven by psychosocial and structural factors rather than religious adherence per se.

Environmental and institutional barriers were the most consistently reported obstacles across both studies, particularly the lack of accessible, culturally appropriate women-only facilities. Self-efficacy emerged as a significant facilitator, with higher confidence associated with greater PA levels, while competing responsibilities and limited motivation were frequently cited barriers, particularly among mothers of young children [31].

Qualitative Findings: Thematic Analysis

Thematic analysis of the nine qualitative studies generated three analytic themes: (1) modesty, visibility, and the absence of safe space; (2) gatekeeping by family and community; and (3) infrastructure, climate, and policy neglect. Each theme is presented below with supporting quotations and a critical interpretation of which SEM level(s) are implicated and how influences across levels interacted.

Theme 1: Modesty, Visibility, and the Absence of Safe Space

The first and most pervasive theme concerned the compounding effect of limited self-efficacy and the absence of gender-appropriate physical spaces. Low self-efficacy, the most consistently reported individual-level barrier, was rarely a standalone psychological state; rather, it reflected the structural and social environments women inhabited [21, 24]. Across multiple studies, the absence of women-only spaces and gender-segregated facilities was identified as the decisive barrier preventing PA, even among highly motivated women [22, 23, 26].

'We cannot run and jog because of a lack of any places for women that will enable them to carry out these activities ... The authorities must work to make girls active with body fitness as it is applied in the boys' schools.' (Salma, aged 42) [21]

Modesty requirements interacted directly with this lack of provision. Where facilities did not accommodate Islamic dress (for example, requiring swimwear in mixed-sex pools), women's religious values became a practical barrier not because of faith itself, but because organisational environments failed to design for it [22].

'I used to [go to] the swimming pool with my husband and my sons. I wore a swimming suit with scarf... Every time, they [guards] looked at me and then asked, "Why you are wearing things like that" ... people they stared at me... So, now, I stop going to swimming there.' (Najmeh, University researcher) [22]

Interpreted through the SEM, this theme reflects a self-reinforcing interaction between the intrapersonal and organisational levels: the absence of organisational provision reduced opportunities for PA, which in turn limited confidence and habituation, further eroding self-efficacy [21, 24]. What appears an intrapersonal or religious barrier is therefore frequently an organisational failure of provision, with direct implications for where intervention should be targeted. This dynamic was further amplified by community-level stigma, discussed under Theme 2.

Theme 2: Gatekeeping Through Family Permission and Community Surveillance

The second theme captured how family authority and community surveillance jointly regulated women's freedom of movement and bodily visibility. Family dynamics, particularly the authority of male guardians, spouses, and in-laws, operated in close relationship with community-level gender norms, such that interpersonal restrictions typically reflected and reinforced wider expectations of appropriate femininity [21, 24, 29]. In several Muslim-majority contexts, women described domestic responsibilities and male

family members' expectations as directly constraining participation, legitimated by community norms around gender segregation and female mobility [21, 23].

'My family does not allow me to go out and they did not allow me to complete my university studies. They never allow me to go the sports club.' (Asma, aged 26) [21]

Cultural stigma toward women's public exercise added a further layer of constraint, interacting with both diminished self-efficacy and inadequate facilities (Theme 1) to create a compounding dynamic that individually targeted interventions alone cannot address [21, 29].

'My mother- and father-in-law are against my physical activity. Actually, they don't know that I am exercising. They are living in the village. You know they are conservative. If I tell them, they will think that I am going to a bad place. They think that sport is not a good thing for a woman.' (Gonca) [29]

Conversely, family support operated as a powerful facilitator precisely because it counteracted, rather than reflected, community-level norms. Miles and Benn [26] found that explicit encouragement from spouses and peers enabled participation among Muslim women at a UK university by buffering against community stigma and providing relational permission to prioritise PA.

'I just think it's my family because we're all really competitive and really love sports. So I think that's the reason.' (Zena) [26]

'My mother and family really encourage sport. I mean my dad sits there teaching me how to do these special back exercises.' (Fatima) [26]

Interpreted through the SEM, this theme illustrates a bidirectional interaction between the interpersonal and community levels: family restriction was legitimated by community norms, while family support drew its protective power from actively resisting those norms. This interaction was configured differently in Muslim-majority and Muslim-minority settings, as the cross-cutting analysis below shows.

Theme 3: Infrastructure, Climate, and Policy Neglect

The third theme concerned the physical and policy environment within which PA took place: infrastructure, transport, climate, and government investment, analytically distinct from the space provision addressed in Theme 1. In Gulf contexts (Qatar, UAE, Saudi Arabia), extreme heat restricted PA to indoor, air-conditioned spaces, making the scarcity of women-only indoor facilities especially consequential [23, 24, 27].

'The weather in Oman, as we have eight months of summer with temperatures above 35 degrees, it is challenging to have any outdoor physical activity; moreover the urban planning infrastructure in Oman is not built for outdoor physical activity; we do not have pedestrian paths for people to walk.' (Student participant) [27]

In Western minority contexts, urban safety concerns, transport barriers, and cost of access combined with time pressures from paid and domestic labour to create multilevel constraints particularly acute for low-income women [25, 31]. Policy-level neglect of women's PA infrastructure compounded these barriers; women identified safe urban design, climate-appropriate indoor facilities, culturally sensitive programming, and government investment as the enablers most needed. This reflects a compounding interaction between the organisational and policy/environmental SEM levels, producing severely restricted options for women whose opportunities were already limited by the space constraints of Theme 1.

Cross-Cutting Pattern: Variation Across Muslim-Majority and Muslim-Minority Contexts

A pattern cutting across all three themes was systematic variation between Muslim-majority and Muslim-minority settings. In majority contexts (Saudi Arabia, Qatar, Oman, UAE), institutional barriers, particularly the absence of gender-segregated facilities and restrictions on female sport (Themes 1 and 3), were the primary constraint, alongside interpersonal barriers of family permission and guardian approval (Theme 2) [21, 23, 27, 30]; the Islamic framework was more consistently cited as a motivational facilitator here.

In Muslim-minority contexts (UK, USA, New Zealand), women additionally navigated a dual set of pressures not present in majority settings: expectations from within their own faith communities alongside those of a secular mainstream fitness culture often unwelcoming or discriminatory toward visibly Muslim women [22, 25, 29, 31].

'In New Zealand, I like going to the beaches to play body boarding ... I take my headscarf off when I'm playing ... I don't want to wear [headscarf] because of wanting to play sport especially I don't want to wear a lots of stuffs. It doesn't fit [with Islamic teachings], I know.' (Elmira, dentist) [22]

This dual-pressure dynamic was not simply an additive burden but a distinct interactional pattern: women in minority settings negotiated the Theme 2 dynamics twice over, once toward their own faith community and once toward the host society, with visible markers of faith, notably the hijab, inviting scrutiny from both directions simultaneously.

Synthesis of Findings

Across the eleven included studies, Muslim women's PA was shaped by interconnected influences spanning all five SEM levels, with barriers rarely operating in isolation but combining across levels: between the intrapersonal and organisational levels (Theme 1), the interpersonal and community levels (Theme 2), and the organisational and policy/environmental levels (Theme 3). Facilitators were most effective when operating across multiple levels simultaneously, and both barriers and facilitators were configured differently in Muslim-majority versus Muslim-minority contexts; these patterns are summarised in Online Resources 7–9.

Discussion

This mixed-methods systematic review synthesised global evidence on the barriers and facilitators shaping PA among Muslim women across eleven studies in diverse cultural and geographical contexts. Our findings show participation is shaped by a complex, multilevel interplay of factors operating simultaneously through compounding mechanisms, with direct implications for intervention design.

Cross-Level Mechanisms and the Limits of Individual-Level Approaches

Our findings show that the most persistent barriers to PA among Muslim women operate through cross-level compounding mechanisms rather than as isolated individual factors. Low self-efficacy at the intrapersonal level was systematically reinforced by the absence of gender-segregated spaces at the organisational level and by community-level stigma (Theme 1), suggesting that programmes targeting self-efficacy alone are unlikely to produce sustained participation gains. This extends the foundational work of Babakus and Thompson [8], who documented cultural norms as mediators of Muslim women's PA, by identifying the mechanisms through which those norms interact with structural and organisational factors; recent studies similarly highlight the dual pressures Muslim women face, particularly in minority contexts, where Islamic community expectations and structural barriers both shape participation opportunities [9–11, 32, 33].

At the individual level, religious identity, particularly the hijab as an expression of modesty and faith, played a complex role in shaping engagement. Soltani [22] showed how modest dress requirements influenced Muslim women's aquatic-based participation in New Zealand, illustrating how religious expression can simultaneously motivate and constrain activity. Consistent with Kahan [11, 34], our findings indicate that culturally competent facilities are necessary but not sufficient: even well-designed women-only spaces may fail to enable participation if community stigma or family restrictions (Theme 2) are not simultaneously addressed.

Gender Roles, Marginalisation, and the Regulation of Women's Public Presence

The interpersonal and community-level barriers under Theme 2, particularly the requirement for male guardian or spousal approval before attending a sports club, cannot be fully understood without situating them within broader discourses of gender role expectation and the social regulation of women's bodies in public space. The demand for protected, gender-segregated PA space is not simply a matter of religious modesty; it intersects with wider patterns of cultural marginalisation and normative expectations about how women, and Muslim women with caregiving responsibilities in particular, are expected to conduct themselves in public [35]. The guardian-approval dynamics in Theme 2 illustrate how these gendered expectations operate at the interpersonal level: permission-seeking behaviours reflect assumptions about appropriate femininity shared, in different forms, across many patriarchal social structures [11]. This suggests that interventions addressing gender norms, not religious accommodation alone, may be necessary to shift participation, particularly where caregiving roles are used to justify restricting women's time, mobility, or autonomy outside the home.

The Structural Versus Cultural Interpretation: A Synthesised Position

A central tension in the literature concerns whether Muslim women's low PA participation primarily reflects cultural or religious factors, or structural and institutional failures. Samara et al. [30] and Eldoumi and Gates [31] both caution against overattributing barriers to religion or culture alone; our synthesis supports and extends this position. The included studies collectively show that what first appears a cultural or religious barrier frequently reflects a failure of structural provision: modesty requirements become a practical barrier only when organisational environments fail to accommodate them (Theme 1), whereas when facilities do provide appropriate changing rooms, covered pools, or female-only sessions, the same religious value becomes a motivator. As Al Busafi [36] emphasises, Islam provides a supportive theological framework for health and PA; constraints arise from the interaction of cultural interpretations with structural deficits, not from faith itself, and the relative weight of each varies by context: structural barriers appear more determinative in under-resourced majority settings, while dual community pressures create a more complex constraint profile in Muslim-minority Western settings.

Implications for Intervention and Policy

Our findings suggest effective interventions must be multilevel, contextually adapted, and informed by an intersectional understanding of how gender, religion, culture, and structural position interact. Gender-segregated spaces, female staff, cultural dress accommodation, and faith-sensitive programming consistently emerged as enabling structural features, most effective when accompanied by community-level factors such as visible role models and family encouragement that normalise participation. At the policy level, our review points to systemic underinvestment in women-friendly PA infrastructure as a determinant cutting across cultural and religious contexts; policymakers should prioritise investment in such spaces and develop monitoring frameworks tracking PA participation among Muslim women as a priority population.

Contextual Variation: Muslim-Majority Versus Muslim-Minority Settings

The contextual variation identified in our synthesis represents a contribution beyond earlier reviews: while Babakus and Thompson [8] documented cultural and behavioural influences, their review did not systematically examine how majority versus minority setting shapes the configuration of barriers and facilitators. In majority contexts, institutional and policy barriers (inadequate gender-segregated facilities, climate constraints, restrictions on female sport) were primary determinants; in minority Western contexts, dual community pressures, navigating expectations from Islamic and mainstream secular fitness cultures, created additional constraints not present in majority settings [22, 25, 31], consistent with Knez et al. [35], Miles and Benn [26], and Berger and Peerson [28], who similarly show women in both contexts negotiate constraints and draw on religious identity and social support as resources.

This majority/minority distinction is, we suggest, one of the most practically important contributions of this review: a single, universal model of 'Muslim women's PA barriers' risks obscuring two substantially

different policy problems. In majority settings, the challenge is primarily infrastructure and institutional investment in existing, culturally legitimate demand for gender-segregated PA; in minority settings, it is compounded by the need to navigate two distinct normative communities, neither of which may adequately accommodate Muslim women's needs alone. Interventions that fail to distinguish between these problem structures, such as exporting a Western 'inclusive gym' model into a majority context, are unlikely to be effective; future intervention design should begin by locating the target population within this distinction.

Strengths and Limitations

Strengths

A major strength of this review is its geographic and cultural breadth, drawing evidence from Muslim-majority settings (Saudi Arabia, Qatar, Oman, UAE) and minority Western contexts (US, UK, New Zealand), enabling analysis of contextual variation. The review employed rigorous quality appraisal using both MMAT and CASP, with the mixed-methods approach integrating quantitative and qualitative findings and the SEM used analytically to examine cross-level mechanisms within each theme.

Limitations

The restriction to English-language peer-reviewed publications will have excluded relevant studies in Arabic, Malay, Turkish, Urdu, and other languages common to Muslim-majority countries, potentially introducing selection bias toward Western and Anglophone research. The included studies span very different cultural, structural, and policy contexts, limiting comparability; several had small samples and relied on self-reported data. Only eleven studies met the inclusion criteria, reflecting the scarcity of high-quality research on this population.

Recommendations for Future Research

Gender-segregated and culturally safe spaces. Future research should determine how such spaces can best be designed, implemented, and sustained within non-Muslim-majority and OECD settings, including models for community-based women-only provision.

Intersectionality and diverse identities. Future research should recognise the diversity within 'Muslim women' as a category, including differences by ethnicity, migration status, age, disability, and religiosity, as intersectional designs would illuminate how overlapping identities shape PA opportunities.

Longitudinal and intervention studies. Longitudinal and experimental designs are needed to examine how PA participation changes over time and which intervention components are most effective.

Muslim-minority contexts. Muslim women in minority Western contexts remain under-represented in the evidence base; research addressing dual-culture navigation challenges would fill a significant gap.

Conclusion

The findings from this systematic review demonstrate that PA participation among Muslim women is determined by sociocultural, organisational, and structural factors operating through compounding mechanisms across multiple ecological levels. While Islam provides a supportive theological framework emphasising health, movement, and holistic wellbeing, Muslim women's actual participation is constrained by the interaction of cultural interpretations, gendered social norms, inadequate infrastructure, and systemic policy gaps, not by faith itself. Multi-level, coordinated approaches addressing infrastructure, policy, organisational practice, and community norms simultaneously are required. This review establishes an evidence base for culturally competent health-promotion strategies and for policy supporting equitable access to PA among Muslim women globally.

Abbreviations

CASP

Critical Appraisal Skills Programme

MMAT

Mixed Methods Appraisal Tool

PA

Physical Activity

PRISMA

Preferred Reporting Items for Systematic Reviews and Meta-Analyses

SEM

Socioecological Model.

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Figures

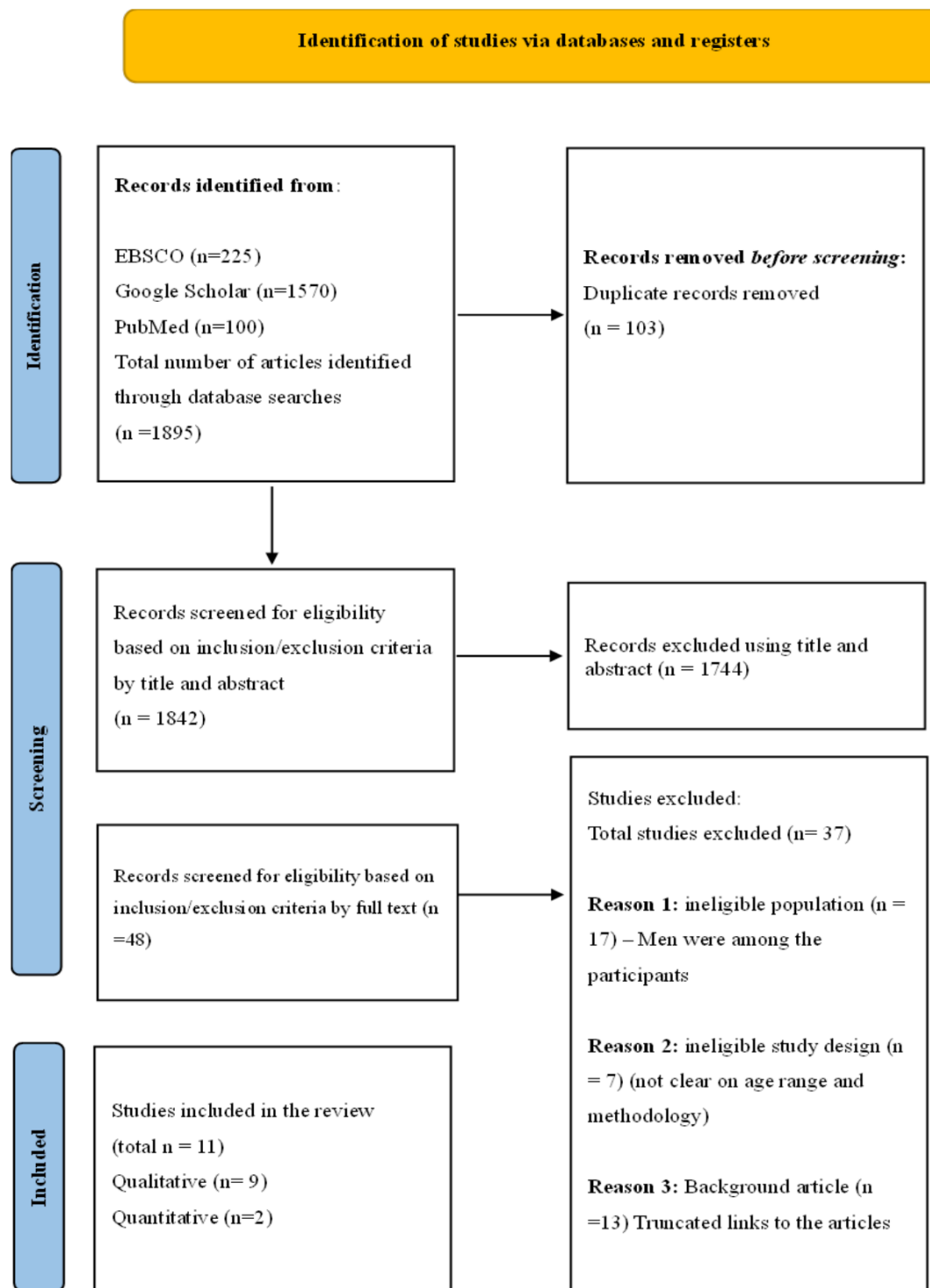


Figure 1

PRISMA flow diagram of study identification, screening, and inclusion for the systematic review of barriers and facilitators to PA among Muslim women

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