Research article

Familial and cultural dynamics: Nurturing healthy eating habits and combating obesity among Palestinian children

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Abstract

Background: The home environment is a key factor in shaping children's dietary preferences and can influence the development of eating habits, particularly in preventing and managing eating disorders like obesity. In Palestine, limited research exists on how family dynamics impact children's eating habits, especially in the context of eating disorder prevention. This study aims to explore how family involvement and community influence Palestinian children's eating habits and obesity prevention.

Methods: A quantitative, descriptive approach was used for this study. A survey was distributed to 185 participants with diverse demographics using purposive sampling. Of these, 165 completed surveys were analyzed to examine the relationships between family involvement, community influence, and children's eating behaviors.

Results: The findings reveal that family involvement significantly affects children's dietary choices, with religious and cultural traditions playing a vital role in reducing childhood obesity. Parental engagement was higher in villages compared to towns, though no significant demographic differences in participation were found.

Conclusion: This study highlights the importance of culturally tailored public health initiatives in addressing eating disorders among Palestinian children. Family involvement, religious practices, and cultural traditions were found to strongly promote healthy eating, with consistent parental support across demographics and notable differences favoring rural areas. Despite the study's limitations, including the cross-sectional design and reliance on self-reported data, it provides valuable insights into how families shape children's health-related behaviors. Further research with larger sample sizes and diverse methodologies is recommended to enhance understanding and intervention strategies.

Keywords

childhood obesity, cultural influences, dietary habits, familial dynamics

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Background

Childhood is a critical developmental stage during which eating habits are formed, profoundly influencing long-term health outcomes, including susceptibility to eating disorders.[1] This period is marked by significant social, psychological, and physical changes, making it a pivotal time for establishing dietary and lifestyle choices that shape a child's future health. A balanced diet is essential for growth and development, playing a key role in preventing eating disorders and promoting overall well-being.[2]

However, many children exhibit dietary behaviors that pose risks to their health. These include the frequent consumption of highly processed foods, sugary drinks, and imbalanced diets lacking essential nutrients.[3,4] Such habits can lead to nutritional deficiencies, obesity, and other health complications, underscoring the need for targeted

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interventions and education to foster healthier eating patterns.[5] Addressing these behaviors early is crucial, as they often persist into adulthood, increasing the risk of chronic diseases and eating disorders.[6]

Eating disorders in children and adolescents represent a serious public health concern, characterized by persistent disturbances in eating behaviors and associated emotional distress.[7] These disorders, which include anorexia nervosa, bulimia nervosa, and binge eating disorder (BED), are often linked to severe physical, psychological, and social consequences.[8,9] Recent studies have reported rising rates and severity of eating disorders during the COVID-19 pandemic.[10,11] Notably, BED in children has been significantly associated with higher body mass index (BMI) and an increased risk of obesity.[12,13] This highlights the need for early identification and culturally sensitive interventions to address both disordered eating and obesity risk factors.

Parental influence on eating habits

Parents play a central role in shaping children's dietary behaviors. Authoritative parenting styles, characterized by warmth and clear boundaries, are associated with better eating habits, self-discipline, and emotional maturity in children, reducing the likelihood of developing eating disorders.[14] Parental feeding practices, such as restrictive feeding or pressuring children to eat, can significantly influence children's dietary preferences and intake patterns.[15] For example, restrictive feeding may lead to overconsumption of forbidden foods and excessive weight gain,[16] while responsive feeding—recognizing and addressing a child's hunger and satiety cues—promotes healthier eating habits.[17,18]

Mothers, in particular, often emotionally invest in their children's eating habits, tailoring portion sizes and meal choices based on factors such as a child's preferences, nutrient needs, and perceived gender roles.[19,20] However, maternal pressure to eat, often driven by concerns about a child's weight, can inadvertently contribute to unhealthy eating behaviors and the development of eating disorders.[21] Fathers, on the other hand, may adopt less restrictive feeding practices but often pressure children to eat, which can interfere with their ability to self-regulate food intake.[22,23]

Broader influences on eating habits

While parental influence is significant, children's eating behaviors are also shaped by broader environmental and social factors. Cultural norms, socioeconomic status, and access to nutritious foods play a critical role in determining dietary patterns.[24] For instance, children from low-income households may have limited access to fresh produce and rely more on processed foods, increasing their risk of poor dietary outcomes.[25] Additionally, peer influence, school environments, and media exposure can shape children's food preferences and consumption habits, often promoting unhealthy choices.[26,27]

Interventions and prevention

Effective interventions to promote healthy eating habits must address these multifaceted influences. School-based programs, community initiatives, and parental education can play a pivotal role in encouraging balanced diets and physical activity.[28,29] Personalized approaches that consider individual and cultural differences are particularly effective in fostering long-term behavioral change.[30] For example, interventions that teach parents responsive feeding techniques and provide access to affordable, nutritious foods can help mitigate the risk of obesity and eating disorders in children.[31,32]

In the current context of childhood health and well-being, the increasing prevalence of childhood obesity is a serious issue that necessitates a thorough analysis of the factors causing and mitigating this public health risk. This study investigated the complicated realm of familial practices about healthier eating habits among children of Palestinian heritage, with a focus on addressing the pervasive problem of obesity and preventing eating disorders.

Theoretical framework

Ecological systems theory (EST) is a potential theoretical framework for a study aimed at comprehending and resolving children's and teenagers' unfavorable eating habits, especially in the setting of familial supervision. According to Urie Bronfenbrenner's Ecological Systems Theory, personal traits such as gender, age, and heredity, as well as environmental influences, can affect an individual's behavior.[33] Families and peers are part of a child's ecological niche, which is shaped by their surroundings, culture, media, and dietary options. Parents provide information about their children's eating situations and experiences, and as they grow older, the diversity and complexity of their surroundings expand. Youngsters take after their parents' eating habits, way of life, attitudes, and level of contentment or discontent with their bodies.[34]

Ecological Systems Theory (EST) provides a valuable framework for understanding the development of eating habits among children and teenagers in Palestine, especially within the context of familial supervision. According to EST, an individual's behavior is shaped by personal traits, such as age and gender, and environmental factors like family, peers, culture, and media. In Palestine, family dynamics play a crucial role in shaping eating habits, with parents influencing children's food choices, attitudes, and

body image perceptions. As children grow, external factors like peers, schools, and media further impact their eating behaviors.

Cultural norms, such as traditional Palestinian dishes like falafel and hummus, along with religious practices like fasting during Ramadan, strongly influence dietary habits. These cultural factors are integral to the Palestinian food identity and contribute to both positive and negative eating patterns. However, socioeconomic challenges, such as economic constraints and food insecurity, limit access to healthy foods and often lead to reliance on processed, less nutritious options.

Additionally, political instability and restrictions on agriculture affect food availability and dietary diversity. Media and globalization also contribute to the spread of Western dietary habits, such as fast food, which compete with traditional eating practices. This interplay of familial, cultural, socioeconomic, and environmental influences demonstrates how ecological factors shape eating behaviors in Palestinian children and highlights the importance of culturally sensitive interventions to promote healthier eating habits.

Literature review

The literature addressing the interplay of eating habits, table manners, and obesity within the Palestinian context is notably scarce. Only a limited number of studies have ventured into this complex relationship, highlighting the rarity of comprehensive investigations into how familial circumstances and parenting styles of monitoring, dietary behaviors, and mealtime practices intersect with the prevalence of eating disorders including obesity among Palestinians.

A 2005 cross-sectional survey of Grade 8 and 9 students in Ramallah, Nablus, and Hebron governorates, Occupied Palestinian Territory, revealed that children of rich families were associated with frequent intake of animal foods, Western-style foods, dairy products, fruits and vegetables, sweets, and salty snacks and that only 26% of students consumed three main meals daily.[35] Furthermore, Palestinians are adopting a Westernized diet, consuming refined modern foods such as white commercial bread, soft drinks, and sweets while reducing traditional foods such as legumes and brown flour bread.[36,37]

A cross-sectional survey of 1022 students revealed that 17.9% were overweight/obese, 9.7% were stunted, and 49.6% had anemia. Girls from low-income areas, those with employed fathers, and those who reached puberty had the highest risk of overweight/obesity, while boys with medium socioeconomic status had the lowest risk.[38] Others found that while underweight is not a significant public health issue among school-aged teenagers, significant issues such as overweight and anemia are linked to sociodemographic variables.[38,39]

Although the abovementioned literature provides valuable insights into the dietary patterns and nutritional status of Palestinian adolescents, several research gaps are evident, particularly in relation to the role of familial monitoring of eating habits and limiting eating disorders. The literature focuses primarily on the association between socioeconomic factors and dietary behaviors, emphasizing the influence of family wealth on food choices. However, there is a noticeable lack of detailed exploration into the specific impact of familial monitoring on shaping the eating habits of children, particularly in the context of preventing and addressing the eating disorders that lead to obesity.

This research aims to fill this gap by examining the interplay between religious and cultural practices, demographic traits, and familial interventions in Palestinian families to understand how to promote health-conscious eating habits, reduce eating disorders and address child obesity. Unlike previous research, which has primarily focused on socioeconomic factors and dietary patterns, this study emphasizes the role of familial monitoring and intervention strategies in shaping children's eating habits. By applying Ecological Systems Theory (EST), it provides a comprehensive framework to analyze how individual, familial, cultural, and environmental factors interact to influence dietary behaviors.

Specifically, the research aims to fill this gap by examining the interplay between religious and cultural practices, demographic traits, and familial interventions in Palestinian families, offering insights into how to promote health-conscious eating habits, reduce eating disorders, and address child obesity. It explores the impact of cultural and religious practices, such as traditional Middle Eastern diets and fasting during Ramadan, on eating habits, highlighting how these factors can be leveraged to encourage healthier choices. Additionally, the study examines the interplay between demographic traits (e.g., gender, socioeconomic status) and familial practices, providing a nuanced understanding of their collective influence on dietary behaviors. Furthermore, the study aims to develop culturally sensitive interventions tailored to the Palestinian context, addressing the lack of such strategies in existing research. By focusing on a non-Western population, it contributes to global discussions on childhood health and nutrition, emphasizing the importance of context-specific approaches for addressing obesity in diverse populations. Through its holistic and innovative approach, the study not only fills existing gaps but also offers actionable, evidence-based recommendations for public health interventions tailored to Palestinian children and their families, ultimately promoting healthier eating habits and preventing obesity and eating disorders.

Research questions

Researchers have endeavored to provide thorough and comprehensive answers to the following questions:

Table 1. Distribution of study sample according to independent variables.

Table 1: Sociodemographic characteristics of the study participants.

Variable	Category	n (%)
Age	16–19 Years	24 (14.5%)
	20–29 Years	78 (47.3%)
	30–39 Years	25 (15.2%)
	40–49 Years	21 (12.7%)
	50 years or more	17 (10.3%)
Occupation	Housewife	16 (9.7%)
	Unemployed	19 (11.5%)
	Student	58 (35.2%)
	Public sector employee	24 (14.5%)
	Private sector employee	48 (29.1%)
Educational level	None	11 (6.7%)
	School Certificate	28 (17.0%)
	Bachelor	84 (50.9%)
	Doctorate	8 (4.8%)
	Master's	26 (15.8%)
	Diploma	8 (4.8%)
Place of residence	Refugee camp	7 (4.2%)
	City	58 (35.2%)
	Town	47 (28.5%)
	Village	53 (32.1%)

Abbreviations: n = number, % = percentage.

- To what extent does the integration of religious practices into eating habits impact obesity rates and the prevalence of eating disorders among Palestinian children?
- How do familial encouragement regarding cultural norms and table manners relate to the prevalence of obesity and eating disorders in Palestinian children?
- Are there significant differences in familial involvement in promoting healthy eating habits and limiting eating disorders among different demographic groups, including places of residence, ages, occupations, and education levels?
- Are there significant differences in integrating religious and cultural practices to promote healthy eating habits and limiting eating disorders among different demographic groups, including places of residence, ages, occupations, and education levels?

Methods

This study was conducted in accordance with ethical guidelines to ensure the protection of participants' rights. The research received formal approval from the Deanship of Scientific Research, Faculty of Humanities, and the Director of the Language Centre at the institution. Informed written consent was obtained from all participants prior to their inclusion in the study, ensuring transparency and voluntary participation. Participants were fully briefed on the study's purpose, the confidentiality of their responses, and their right to withdraw at any point without consequence.

The researchers utilized a descriptive, quantitative research approach. In the quantitative realm, an analytical descriptive technique was employed to comprehensively characterize, assess, and establish connections between the observed phenomenon and its contextual reality.

Study population

The research population consists of all pertinent individuals or components that are directly associated with the educational topic under investigation. The goal of this research is to make their findings more broadly applicable to this particular group. Therefore, the study population comprises individuals listed as friends within the researchers' Facebook network.

The researchers employed a purposive sampling technique to select participants, aimed at ensuring the sample consisted of individuals who met specific criteria relevant to the study's objectives. This technique was chosen because it allowed for targeted selection of participants who could provide insights into the phenomenon under investigation. Recruitment was conducted through a combination of outreach methods, including leveraging personal networks, social media platforms, and community-based groups, which facilitated access to individuals meeting the study's inclusion criteria. These criteria were carefully defined to encompass participants based on key demographic characteristics such as age, occupation, educational level, and place of residence, ensuring the sample reflected the diversity and complexity of the target population.

A total of 185 individuals were initially contacted to participate in the survey. After data collection, a thorough screening process was applied to assess the completeness and relevance of the responses. Surveys with incomplete or invalid responses, or those from participants who did not meet the predefined inclusion criteria, were excluded from the final sample. The exclusion criteria specifically targeted participants who provided incomplete answers, those who failed to meet demographic or experience-based criteria, and responses deemed inconsistent or irrelevant to the research focus.

The final sample included 165 valid surveys, which met the necessary inclusion criteria and were deemed suitable for further analysis. A power analysis was conducted before data collection to determine the adequate sample size needed for robust statistical analysis. The analysis indicated that a minimum of 150 valid responses were required to achieve a statistical power of 0.80 at an alpha level of 0.05, ensuring the study had sufficient sensitivity to detect meaningful effects. Given that the final sample included

Table 2. Means and standard deviations of questionnaire items related to the integration of religious and cultural practices to promote healthy eating habits.

Item No.	Item	M	SD	Level of agreement
3	I encourage children to eat with their right hand.	4.78	0.681	Very high
15	I encourage children not to eat or drink forbidden, harmful or polluted food at all.	4.68	0.818	Very high
14	I do encourage children not to blow on food or drink, especially if the utensil is shared, because this disgusts others.	4.61	0.846	Very high
1	I wash hands before and after eating.	4.54	0.711	Very high
4	I encourage children to eat the food directly next to them, and I do not extend their hands over the food in front of others or in the middle of the central dish.	4.51	0.754	Very high
8	I encourage children to chew the food thoroughly.	4.50	0.631	Very High
2	I encourage children to mention Allah's name before I start eating and thank Him when I finish.	4.36	0.849	Very high
13	I encourage children not to drink water from the mouth of the water-skin, because it disgusts others.	4.35	1.080	Very high
6	I encourage children to take the optimal position to sit and do not eat while reclining or standing.	4.19	0.833	Very high
9	I encourage children not to overeat bingely or eat a large amount of food in a short amount of time.	4.03	1.079	Very high
5	I encourage children not to pick up food from the main (common) dish with their own spoon or fork.	3.99	1.140	High
11	I encourage children not to introduce food to food, that is, not to eat food unless they feel hungry.	3.98	0.962	High
12	I encourage children not to drink water or juices off at a draught, nor to suck them, but drink in gulps.	3.95	1.087	High
7	I encourage children to eat with spoonful or small bites because that makes them feel full faster.	3.85	1.124	High
16	I encourage children to take the minimum or necessary amount of food and drink in order to preserve life and ward off death.	3.70	1.145	High
10	I encourage children to avoid eating quickly and keep away from distractions (surfing the internet or watching TV).	3.54	1.113	High
Total degree		4.22	.4304	Very high

165 valid responses, it exceeded the required threshold, confirming that the sample size was sufficient to support the planned statistical tests.

The demographic distribution of the participants, along with the detailed exclusion criteria, is provided in Table 1, which outlines the key sociodemographic characteristics of the final sample.

Study tools

This research employed a meticulously crafted questionnaire specifically designed for this study to serve as a comprehensive data collection instrument related to the subject under investigation. The purpose of the questionnaire was to investigate the complex interplay between family interventions, demographic traits, and religious and cultural practices in Palestinian families to understand how to reduce childhood obesity and promote healthy eating habits. A thorough analysis of relevant previous research and theoretical frameworks served as a guide for its creation. Consisting of a total of 29 items, the questionnaire was systematically structured using a five-point Likert scale, where the responses were categorized into distinct grades: strongly agree (5), agree (4), neutral (3), disagree (2), and strongly disagree (1). The demographic section encompasses questions related to place of residence, age, occupation, and education level. The Likert-scale items (1 to 29) encompass two primary domains (cultural and religious practices and demographic dynamics) aimed at promoting healthier eating habits and combating obesity. The survey seeks to capture various facets of these domains.

Validity of research tools

Eight Palestinian expert arbitrators assessed the validity of a (43-item) questionnaire. The high level of agreement (85%) prompted a series of iterative changes. These changes were made by combining the experts' recommendations for the removal or replacement of particular questions, resulting in a questionnaire of 29 items.

Reliability assessment

The reliability of the study instrument was assessed using Cronbach's alpha coefficient. The reliability coefficients

Table 3. Means and standard deviations of questionnaire items related to familial involvement in promoting healthy eating habits.

Item No.	Item	M	SD	Level of agreement
9	I encourage children not to extend their hands to food or drink when waking up from sleep until after washing them completely.	4.54	0.815	Very high
11	I encourage children to have meaningful and useful conversations and talks with others while eating.	4.40	0.949	Very high
1	I encourage children to eat a variety of nutritious foods to meet the body's need.	4.26	0.903	Very high
4	I encourage children to research and identify foods and drinks that benefit the body and keep illness and disease away.	3.78	1.211	High
10	I together with children try to attend seminars, online courses, or workshops on mindful eating.	3.65	1.146	High
5	I encourage children to avoid eating in response to marginal motives or emotional and psychological reasons.	3.48	1.323	Medium
3	I encourage children to avoid eating fast food and drinking soft or alcoholic beverages that contain caffeine unless absolutely necessary.	3.45	1.309	Medium
13	I encourage children to avoid wandering into the kitchen mindlessly when they are not busy.	3.44	1.149	Medium
2	I encourage children to avoid snacking, munching, and grabbing bites of leftovers or others' food while working, watching TV, or browsing the internet.	3.35	1.223	Medium
7	I encourage children to breathe consciously and deeply while eating, because this helps to regulate the air and food pathways in the respiratory and digestive systems.	3.35	1.277	Medium
8	I encourage children to avoid eating in response to food cravings or food-related cues, such as the sight or smell of food.	3.15	1.211	Medium
12	I encourage children not to talk about topics that may make others feel disgusted or sick while eating.	2.12	1.176	Very low
6	I encourage children to set the clock and eat in 20 min or more, until the central nervous system creates a sensation of fullness and satiety.	2.02	1.288	Very low
Total degree		3.45	.6295	Medium

for the first and second sections were 0.91 and 0.87, respectively, and the reliability coefficient of the questionnaire items was 0.94.

Results

To answer the first study question, "To what extent does the integration of religious practices into eating habits impact obesity rates and the prevalence of eating disorders among Palestinian children?", the mean scores and standard deviations for the items were calculated. The results are presented in Table 2.

Table 2 reveals that the integration of religious and cultural practices to promote healthy eating habits significantly influences the Palestinian population's eating habits and prevents childhood obesity. The overall score ranged from very high to high, with the highest score indicating a strong contribution; the lowest score was significant, while the highest score was very strong. These results highlight the significant role of cultural and religious traditions in promoting healthy eating habits and reducing childhood obesity in Palestine.

To answer the second question, "How do familial encouragement regarding cultural norms and table manners relate to the prevalence of obesity and eating disorders in Palestinian children?", the mean scores and standard deviations for the items were calculated. The results are presented in Table 3.

Table 3 shows that familial involvement in promoting healthy eating habits significantly influences healthy eating habits among Palestinian children. The highest score, indicating a very high level of encouragement, was 4.54, while the lowest score, indicating very little encouragement, was 2.02. These findings highlight the importance of culturally rooted parental support in promoting healthy eating habits.

To answer question three: "Are there significant differences in familial involvement in promoting healthy eating habits and limiting eating disorders among different demographic groups, including places of residence, ages, occupations, and education levels?", the authors used the one-way analysis of variance (ANOVA), and the results are displayed in Table 4 below.

As per the findings shown in Table 4 on parental encouragement of the establishment of good eating habits to prevent obesity among Palestinian children, there were no statistically significant differences in the means of the responses from the study participants. This lack of significance holds true across different variables, such as place of residence, where the significance level is 0.13. A similar trend can be observed for variables relating to age, occupation, and academic degree, which show significance

levels of (0.06), (0.14), and (0.15), respectively. There is no statistically significant difference in the means of the respondents, as each value is below the predetermined level of significance (0.05).

To answer question four: Are there significant differences in integrating religious and cultural practices to promote healthy eating habits and limiting eating disorders among different demographic groups, including places of residence, ages, occupations, and education levels? the authors carried out the one-way analysis of variance (ANOVA). The results are shown in Table 5.

Table 5 shows that the study revealed significant differences in responses from Palestinian children regarding the contribution of cultural and religious practices to healthy eating habits and obesity prevention based on their place of residence. The significance level was 0.014, which is less than 0.05. The researchers used the least significant difference (LSD) test to identify specific categories where differences existed, as shown in Table 6.

Table 6 shows statistically significant differences between the means of responses from the study sample regarding the role of cultural and religious practices in encouraging healthy eating habits and preventing childhood obesity in Palestinian children. Every category (village) and (city) showed disparities, with village showing the greatest advantage. Furthermore, differences were noted between two distinct categories (town and city), with differences favoring town.

Discussion

The study results indicate that religious and cultural customs, along with family involvement, significantly influence the dietary patterns of the Palestinian community, contributing to the prevention of childhood obesity and eating disorders. From a Palestinian standpoint, the EST demonstrates that religion and cultural customs play a crucial role in promoting a healthy diet and reducing the risk of childhood obesity and eating disorders. The EST framework encompasses not only physical health but also cultural and spiritual aspects, advocating for a holistic approach to health. Parental encouragement based on cultural norms highlights the essential role of family and community values in shaping health-related behaviors, consistent with previous findings emphasizing the importance of a nutritious, well-balanced diet for overall health.[18,19] The EST underscores the collective impact of parental influence on children's eating habits, emphasizing the central role of the family in Palestinian society. Cultural norms, deeply rooted in customs and values, foster a healthy lifestyle aligned with the principles of the EST framework, which prioritizes both physical well-being and cultural and spiritual aspects of health.[29,30]

These findings highlight the relationship between cultural contexts and health behaviors, indicating that programs supporting health-conscious eating practices, as stated by (1), should consider cultural sensitivity and the distinctive sociocultural makeup of Palestinian communities, including the prevention of eating disorders. It also emphasizes how important it is for public health programs to work in tandem with and take advantage of current cultural customs, family dynamics, and practices to promote favorable health outcomes, including the prevention of eating disorders.[1,20]

The study revealed no significant differences in parental involvement or religious and cultural practices in promoting healthy eating habits across different demographic groups, which extends to efforts aimed at preventing eating disorders. From a Palestinian perspective, the results highlight the potential universality of parental commitment to promoting healthy eating habits and preventing eating disorders, as they show no significant differences in parental involvement across diverse demographic groups, including places of residence, age, occupation, and academic level. This finding is consistent with,[5] who maintained focused familial monitoring, interventions, and education to encourage children to adopt healthy eating habits and prevent eating disorders. The communal ideals that are strongly embedded in Palestinian society, where there seems to be a shared sense that promoting healthy eating habits and preventing eating disorders is important regardless of one's ethnic background.

Furthermore, the finding that there are no significant differences in the integration of religious and cultural practices to support healthy eating habits, including the prevention of eating disorders, according to age, occupation, or educational attainment points to a shared acceptance of these practices among different Palestinian population segments. This is congruent with the cohesive character of Palestinian culture, in which lifestyle decisions are shaped by religious and cultural factors, creating a sense of unanimity and shared values among people from a variety of demographic origins. These results are consistent with those of studies that underscore the efficacy of interventions that focus on fostering a healthy diet and physical activity, emphasizing the significance of personalized approaches that prevail in a given culture, including efforts to prevent eating disorders.[14] In addition, these findings underscore the necessity of region-specific health interventions tailored to the unique dynamics of Palestinian communities, consistent with previous literature emphasizing the importance of community-specific health treatments, including interventions addressing eating disorders.[27]

This study highlights the impact of local settings and community dynamics on health-related behaviors in Palestine by revealing significant disparities based on place of residence, including the prevalence of eating disorders. Villages are favored over towns in terms of the clear differences between the two categories; this could be due to the influence of close-knit community structures and customs that are common in rural areas. Similar differences were found between towns and cities, with a preference for

Table 4. One-way ANOVA results for familial involvement in promoting healthy eating habits.

Variable	Source of variation	Sum of square	Degrees of freedom	Means of square	F	P
Place of residence	Between groups	2.189	3	0.730	1.870	0.137
	Among groups	62.816	161	0.390		
	Total	65.005	164			
Age	Between groups	3.704	4	0.926	2.417	0.061
	Among groups	61.301	160	0.383		
	Total	65.003	164			
Occupation	Between groups	2.682	4	.760	1.821	.148
	Among groups	62.324	160	.390		
	Total	65.005	164			
Academic Level	Between groups	2.682	4	.850	1.661	.150
	Among groups	60.324	160	.390		
	Total	67.005	164			

Table 5. One-way ANOVA results for integrating religious and cultural practices to promote healthy eating habits.

Variable	Source of variation	Sum of square	Degrees of freedom	Means of square	F	P
Place of residence	Between groups	1.927	3	0.642	3.634	.014
	Among groups	28.458	161	0.177		
	Total	30.386	164			
Age	Between groups	.802	4	.200	1.084	.366
	Among groups	29.584	160	.185		
	Total	30.386	164			
Occupation	Between groups	.442	4	.111	.591	.670
	Among groups	29.943	160	.187		
	Total	30.386	164			
Academic Level	Between groups	.769	5	.154	.825	.533
	Among groups	29.617	160	.186		
	Total	30.386	164			

Table 6. LSD test for pairwise comparisons between means of place of residence.

Comparisons	Village	Town	City	Camp
Village		0.04827	0.2461*	0.1784
Town			0.19786*	0.1301
City				−0.067
Camp				

towns; these differences could be a result of particular urban influences or lifestyle choices influencing eating habits, including the prevalence of eating disorders. Given the variety of variables at play in various residential contexts, these findings, together with,[15,16] highlight the necessity of region-specific health treatments suited to the particular dynamics of Palestinian communities, including interventions addressing eating disorders.

Conclusion

The study revealed that many Palestinian couples believe that their children are not vulnerable due to their resilience in the face of adversity, including eating disorders. They also show proactive health consciousness, prioritizing preventative measures such as food choices to prevent eating disorders. Couples who express concerns about certain dietary patterns may be aware of health hazards, which may lead to easier access to health information about eating disorders. Economic constraints, such as time and money constraints, also impact nutritional preferences, including those related to eating disorders. External factors such as the cost and availability of nutritious food also influence their diets, potentially affecting the prevalence of eating disorders. Internal variables, including cultural influences and taste preferences, also play a role in nutritional decision-making, including decisions related to preventing eating disorders. A holistic perspective on well-being is expected, recognizing the relationships among social, mental, and physical health, including the prevention of eating disorders.

Ultimately, the research illuminates the complex interactions between cultural, religious, and familial elements that impact the development of good eating practices and the prevention of obesity and eating disorders in children from Palestine. Including religious and cultural customs

becomes apparent as a powerful motivator, demonstrating the deep influence of history and customs on eating habits and eating disorders. The importance of family dynamics in influencing children's eating habits is further highlighted by parental encouragement, which is based on cultural norms and may also help prevent eating disorders. A common emphasis on these factors within the Palestinian context is suggested by the lack of substantial disparities observed across demographic groups in terms of parental participation and the integration of religious and cultural practices to prevent eating disorders. Nonetheless, the significant differences according to home location draw attention to the contextual subtleties, with village settings showing specific benefits for preventing eating disorders.

These results highlight the significance of health treatments that are specific to a given region, acknowledging the diversity seen within Palestinian communities and customizing approaches to match the particular dynamics of various home contexts, including those related to eating disorders. Finally, the study underscores the importance of culturally sensitive techniques in encouraging healthy lifestyles and adds insight to the current global conversation on childhood health and nutrition, including the prevention of eating disorders.

Implications

The results of this quantitative study, which included survey data from 165 participants, have a number of implications for both academic research and real-world interventions in the Palestinian setting, including addressing eating disorders. The necessity for specialized public health initiatives that integrate and respect these cultural components is shown by the emphasis on the important influence of cultural and religious traditions on healthy eating habits and the prevention of eating disorders. Furthermore, understanding the substantial variations according to residence highlights the significance of interventions tailored to a particular location, taking into account the diversity seen within Palestinian communities, including approaches to prevent eating disorders. The study's findings about cultural norms and parental impact open up possibilities for family-centered health interventions that are consistent with Palestinian society ideals and may contribute to preventing eating disorders.

Limitations and recommendations

This study offers valuable insights into the Palestinian community, particularly regarding factors related to eating disorders; however, several limitations should be acknowledged. First, the small sample size of 165 respondents may not fully capture the diversity of the broader Palestinian population. Second, the cross-sectional survey design limits the ability to establish causal relationships, including those between cultural factors and eating disorders. Third, no clinical diagnostic methods, such as anthropometric measurements or validated screening tools, were used to objectively assess obesity rates or the presence of eating disorders among children. Instead, the study relied on parental perceptions and self-reported data, which may introduce response bias and limit the accuracy of the findings. Additionally, the potential geographic concentration of the sample further restricts the generalizability of the results, particularly in relation to eating disorder prevalence across different regions.

Future research should aim to include larger, more geographically diverse samples and adopt longitudinal designs to better explore cultural influences on eating behaviors. Incorporating clinical assessments and validated diagnostic tools would strengthen the reliability of future studies. Comparative research with similar populations could also provide a deeper understanding of how cultural and religious factors shape health behaviors, including the development of eating disorders. Finally, culturally sensitive and community-engaged interventions are needed to effectively address eating disorders and related health issues within the Palestinian context.

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Ethical considerations

The research was approved by the Deanship of Scientific Research, Faculty of Humanities, and language Centre director.

Consent to participate

Written informed consent was obtained from all study participants.

Authors' contributions

Both researchers made equal contributions to this study.

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Data availability statement

Data are available as a supplementary file.

Supplemental material

Supplemental material for this article is available online

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