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IMPACTS OF OBESITY ON MARRIED WOMAN IN SHAHZAD TOWN ISLAMABAD



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2015

**IMPACTS OF OBESITY ON MARRIED WOMAN
IN SHAHZAD TOWN ISLAMABAD**



**Thesis submitted to the Department of Sociology, Quaid-i-Azam
University, Islamabad, for the partial fulfillment of the requirement of
degree of Master of Science in Sociology.**

By

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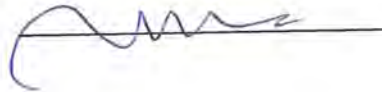
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FINAL APPROVAL OF THESIS

This is to certify that we have read the thesis submitted by Ms. Sonia Ashraf Khan, it is our judgment that this thesis is of sufficient standard to warrant its acceptance by the Quaid-i-Azam University, Islamabad for the award of the Degree of "M.Sc in Sociology".

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Abstract

Obesity in Pakistan is a health issue that has engrossed only in the past few years. This study highlights the current literature on the causes, contributing factors, assessment and diagnosis, co-morbid conditions associated with, and current treatments for overweight and obesity. This study will outline current tools used to assess and identify those who are or are at risk for overweight and obesity. The current gold standard for assessing and diagnosing overweight and obesity is the body mass index (BMI). Current treatment options include lifestyle modification and social impacts are discussed. The counseling of patients and weight issues are also mentioned in literature. Health Belief Model is also described. The study aims to find the entire impacts of obesity upon married women's health and what are the ways and modes by which they cope themselves. Also the diseases and the morbid conditions they face. There are many health disparities that are caused by and related to overweight and obesity. This study also examines current recommendations for preventing, and treating overweight married women. The universe of the present research was Shahzad Town situated in Islamabad. Women living in this area are mostly housewives and are obese due to various factors. In the present research, women who had been suffering from obesity for last few years were targeted population. The purposive sampling technique was used in the present study because the targeted population was only those people who had been suffering from obesity. As the sampling frame was not available for the researcher, that's how keeping in view the sample size in prior researches, the researcher has drawn a sample of 100 respondents. Most of the women were less educated, they couldn't understand the English language, biological terms and somehow the nature of the research. To conduct research in town, the interview schedule was taken as a tool for data collection.

Chapter No. 1

INTRODUCTION

CHAPTER 1

INTRODUCTION

Background

Obesity in Pakistan is a health issue that has engrossed only in the past few years. Urbanization and an unhealthy, energy-dense diet, the high presence of oil and fats in Pakistani cooking, as well as change among the lifestyles are the root causes contributing to obesity in the country. According to a list of the world's fattest countries published on Forbes, Pakistan is ranked 165 (out of 194 countries) in terms of its overweight population, with 22.2% of individuals over the age of 15 crossing the threshold of obesity. This ratio generally corresponds with other studies, which state one-in-four Pakistani adults as being overweight, so as women after marriage.

Research shows that people living in large cities in Pakistan are more exposed to the risks of obesity as compared to those in the rural countryside. Women also naturally have higher rates of obesity as compared to men. Pakistan also has the highest percentage of people with diabetes in South Asia, which is one of the reasons of overweight.

According to one study, fat is more risky for South Asians than for other people because the fat tends to adhere organs like the liver instead of the skin.

Problems of overweight and obesity are caused by a chronic imbalance between energy intake and actual energy needs of the body. The metabolic factors concerned include a low metabolic rate, low insulin sensitivity and high respiratory quotient. In addition, various socio-demographic factors such as smoking habits, dietary habits, socioeconomic situation, and education level (Bray, 1999).

In many developing countries, with growing urbanization, mechanization of jobs and transportation, availability of processed and fast foods, and dependence on television for leisure, people are fast adopting less physically active lifestyles and consuming more energy-dense, nutrient-poor diets (Bell, Drewnowski and Popkin, 1997 , Ge and Popkin, 2002; Popkin, 2002, 2001, 1998, WHO, 2003).

Humans have evolved as a species from hominids that were well-appointed to survive and reproduce in environments that give up an unsteady supply of readily available foods. The more the availability of food, the more it is taken, that result into over weighing of a person or to become an obese person.

Obesity is defined as a condition in which a glut of body fat is accumulated. As a matter of fact the definition of obesity is based on the Body Mass Index BMI; weight (kg)/height (m²). It is generally agreed that a BMI of greater than 30 is indicative of obesity, while a BMI of 25.0 to 29.9 is suggestive of overweight in an individual. BMI between 18.5 to 24.99 indicates normal BMI.

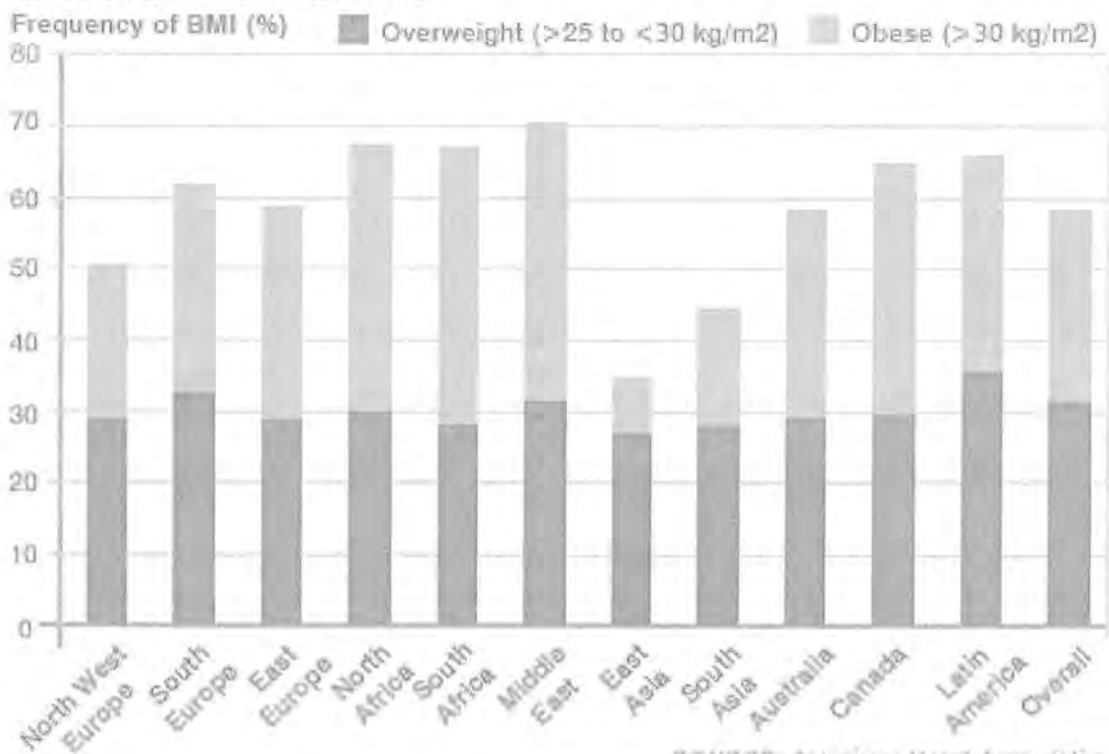
Rapidly changing diets and lifestyles are fueling the global obesity epidemic (WHO, 2003).

According to recent estimates, there are more than one billion overweight people worldwide and some 300 million of these are estimated to be clinically obese (WHO, 2002). Once considered a

problem related to prosperity, obesity is now fast growing in many developing countries and in poor neighborhoods of the developed countries (WHO, 2003; WHO, IASO, & IOTF, 2000). Even in countries like Pakistan, which are typically known for high prevalence of under nutrition, significant proportions of overweight and obese now coexist with the undernourished (Popkin, 2002).

Many overweight and obese patients report that they have not been counseled to lose weight by their primary care provider. Although the diagnosis at times is clear just by looking at the patient, there are useful tools available to clinicians to assess body weight in terms of risk of co-morbid conditions associated with obesity, such as heart disease, hypertension, diabetes, cancer, depression, reproductive disorders, joint and bone pain, among many others. Obesity has also been shown to lead to premature death. Women are more affected by obesity than men, and women tend to have more health complications associated with obesity than men.

GLOBAL OBESITY - WOMEN



Evolution of Obesity

Humans have evolved as a species from hominids that were well-appointed to survive and reproduce in environments that give up an unsteady supply of readily available foods. Survival and reproduction were dependent on energy stores of the individual and the species. For evolutionary reasons, human physiology is predisposed to conserve and store weight, not to shed excess amounts. However, in the modern industrial environment that provides easy access to calorically-dense foods and encourages a sedentary lifestyle, the metabolic consequences of these genes are maladaptive (Lieber and Rosenbaum, 1998). The rapid increase in the prevalence of obesity emphasizes the role of environmental factors, because genetic changes could not occur at this rate.

This increasing prevalence of obesity in the United States apparently represents the interaction of genes with an environment that encourages a sedentary lifestyle and consumption of calories.

The current relative adiposity is a product of the interaction between genetic predisposition with regard to the storage of body fat and an environment (low physical activity, high availability of calorically-dense foods) that is increasingly permissive to the expression of that genetic tendency. Although there are clearly strong genetic influences on openness to obesity, large changes in the prevalence of obesity over such a short time must reflect major changes in non-genetic factors, providing unspoken evidence that some aspects of obesity must be responsive to, or preventable by, manipulation of the environment (e.g., diet, physical activity).

In most humans, body fatness is a constant quantitative trait reflecting the interaction of development and environment with genotype (Lieber and Rosenbaum, 1998). Studies in twins, adoptees, and families indicate that as much as 80% of the variance in BMI is attributable to

genetic factors. Genetic influences on body weight are as strong as those on height. Heritability of adipose tissue distribution, physical activity, resting metabolic rate, changes in energy expenditure that occur in response to over-feeding, certain aspect of feeding behavior, food preferences, lipoprotein lipase activity, maximal insulin-stimulated acylglyceride synthesis, and basal rates of lipolysis are estimated to be as high as 40% (Lieber and Rosenbaum, 1998, p. 529).

According to Lieber and Rosenbaum (1998), there is substantial evidence that body weight is regulated by complex signaling systems that provide afferent signals, including glucostatic, lipostatic, and aminostatic signals to the CNS about the nutritional state of the organism, which are translated into efferent signals that affect energy intake and expenditure (p. 529).

Pathophysiology of Obesity

The following information regarding the pathophysiology of obesity was found in Abbas, Fausto and Kumar (2005). Energy intake from food and energy expenditure from cellular metabolism and exercise are precisely matched over long intervals in healthy adults resulting in stable body fat stores. Energy is continuously expended, and the rate of expenditure varies among persons. The brain and the liver are efficient at controlling nutrient levels based on need. Following ingestion of food, nutrient levels move from the gut into tissues for immediate use or storage. Under homeostatic conditions, the supply of energy in the blood does not decrease to below threshold levels and cause the brain to trigger eating. Even though full energy is generally voluntarily available, animals and humans still start meals.

Other events also predict the process of meals intake, such as an increase in body temperature, past experiences of meal initiation, such as the time of day, social factors, and others. According to this evidence, individuals do not initiate meals because there is a lack of available energy, but

rather the individual eats when it is accustomed to eating. The timing of meals is dictated by the individual's lifestyle, convenience, and opportunity. The timing and frequency of meals are motivated more by lifestyle than by need.

Hormonal Regulation of Appetite

The central regulation of caloric intake and energy expenditure that give energy balance involves interactions between the peripheral hormonal and neural pathways. Peripheral signals of hunger and satiety are interpreted in the hypothalamus and distributed to the periphery by the sympathetic nervous system. A positive energy balance or satiety is mediated by increased intestinal distention and other mechanical-chemical changes that induce neural impulses carried by the nerve and by augmentation in the circulating concentrations of glucose.

Statement of the Problem

Obesity in Pakistan is a health issue that has engrossed only in the past few years. Urbanization and an unhealthy, energy-dense diet, the high presence of oil and fats in Pakistani cooking, as well as change among the lifestyles are the root causes contributing to obesity in the country.

The study aims to find the entire impacts of obesity upon married women's health and what are the ways and modes by which they cope themselves. Also the diseases and the morbid conditions they face. There are many health disparities that are caused by and related to overweight and

obesity. This study also examines current recommendations for preventing, and treating overweight married women.

Objectives

The purpose of this study is to review the current literature on overweight and obesity, with particular emphasis on the impact it has on married women's health issues. The importance of healthcare providers for preventing overweight, obesity, and related co-morbid conditions is stressed in it.

1. To find out the socio-economic profile;
 - Education.
 - Occupation.
 - Religion.
2. To assess the genetic relation if any.
3. To explore the dietary patterns including;
 - Daily consumption of food items.
 - Weekly consumption of fatty items.
4. To explore the impacts upon married woman on;
 - Performance of domestic course.
 - Their self-esteem; stigmatization, mental health concerns.
5. To find out the health problems.
 - Joint problems.
 - Diabetes.
 - High cholesterol.

- Asthma.
- Back pack.
- Swelling of hands and feet.

6. In presence of varies;

- Social roles,
- Presence in public gathering.
- Participation on rituals.

7. To see the relation with husbands.

- Distraction or any other factors.

Significance of the Study

Many recommendations have been made about the occurrence and quality of weight showing which has exposed, the impacts of obesity on married woman's health, including the proper counseling for decreasing their weight which made them caught in several morbid conditions. Also the practitioners who do not routinely address weight issues with their clients. Obesity causes several diseases due to irregular dietary patterns. It decreases performance of varies; social roles, presence in public gathering, participation on rituals.

Overweight and obesity are health imbalances that not only affect patients but also health care providers as well. From a nursing standpoint, nursing duties are more difficult and sometimes impossible with overweight and obese clients.

It has been seen that people are particularly vulnerable to the consequences of obesity and excessive weight gain. Obese people experience chronic diseases more frequently than non-obese individuals. As a result, obese people pay more during their lifetime for medical care related to chronic diseases than their non-obese counterparts.

There are many health disparities that are caused by and related to overweight and obesity.

Chapter No. 2

REVIEW OF THE RELEVANT LITERATURE

CHAPTER 2

LITERATURE REVIEW

Assessing Body Fat

Ideal weight:

Body weight is not an only sensitive indicator for defining obesity (Atkinson, 1993). Age, sex, height, lean muscle mass and body fat percentage are all unaccounted for when using weight alone to measure healthy body weight on an individual level. A simple way to calculate ideal body weight for women is as follows: 100 lbs for the first 60 in (5 ft) + 5 lbs for every additional inch (Davis and Sherer, 1994, p.292).

Percentage of Excess Body Weight:

Height for weight charts are not predictive of medical conditions associated with increased weight. They can best be used as a screening tool in a nutritional assessment. Deviations from the ideal body weight (IBW) indicate the degree of depletion or overweight. Percentage of excess body weight is calculated by $(\text{actual weight} / \text{IBW}) \times 100 = \% \text{ IBW}$. This number is the percentage of IBW. Obesity, by this measurement, is defined as 20% above ideal.

Analysis:

Factors such as age, sex, height, lean muscle mass and body fat percentage are all unaccounted for when using weight alone to measure healthy body weight on an individual level. Thus, weight alone should be avoided as a standard for assessing a person's relative risk for overweight and obesity. Ideal body weight is an unscientific measure, and can provide only an estimate of appropriate weight.

Body Mass Index;

In adults, overweight and obesity are defined as BMI levels at which adverse health risks increase (Lyznicki et al., 2001). Healthcare providers should screen for obesity using the body mass index.

The U.S. Preventative Services Task Force found good evidence that body mass index (BMI) is reliable and valid for identifying adults at increased risk for mortality and morbidity due to overweight and obesity (Calonge, 2004). Those with a BMI between 25 and 29.9 are considered overweight and those with a BMI above 30 are considered obese. The BMI is a desirable measurement of the tendency towards obesity.

Analysis

BMI is easy to determine, correlates fairly well with body fat and consequent morbidity and mortality. It is therefore thought to be the most desirable clinical measure of obesity's short measuring body composition.

The BMI is an accurate alternative to more expensive and invasive tools to evaluate body fatness. The BMI is a desirable measurement of the tendency towards obesity, and helps to identify those at risk for overweight and obesity.

Problems faced by nursing of obese woman:

In recent times, obesity has been largely unrecognized by physicians as a condition that requires medical intervention, and patients have been regarded as having "no will-power" or as gluttons (Aronne and Klauer, 2001).

Research shows that healthcare providers, like others in society, describe overweight individuals as repulsive, disgusting, weak, and lacking self-discipline (Golden, Greenwald and Rogge, 2004).

Overweight and obesity are health disparities that not only affect patients, but also health care providers as well. From a nursing viewpoint, nursing duties are more difficult and sometimes impossible with overweight and obese clients. For example, instruments used for health screening typically used by nursing staff are all too often insufficient to meet the needs of overweight patients. Scales many times do not read weights over 300 pounds, thereby making weight measurements unreliable. Blood pressure cuffs do not fit properly, thereby making it impossible to obtain accurate readings.

Analysis:

There have been many amendments in the delivery of healthcare for obese patients, but there are still far more health care issues that have not been able to be solved in recent years.

Clinicians may find that diagnostic reasoning is greatly impaired due to limitations placed on them and the patient because of large body size, increased adiposity, and limited mobility of overweight patients. Many assessment tools such as radiography, CT scanning, MRIs and sonography are often difficult or impossible to perform and interpret due to excessive adiposity and larger body sizes.

Counsel to decrease body weight:

Nurse practitioners are in a wonderful position to educate patients regarding diet and exercise, as well as help with the maintenance of appropriate weight and identification of those at risk for overweight and obesity (Holcomb, 2004).

Patient interest and readiness to change ultimately determine whether or not any management strategy will result in weight loss (Lyznicki, 2001).

Further barriers on the part of the health care provider may prevent finest assessment and treatment of overweight and obese patients. Provider characteristics take account of lack of recognition of obesity as a chronic condition that is difficult to treat, and one that requires continuous and long-term management, and that also has high rates of disheartening a patient. Negative and unsympathetic perceptions that obesity represents a lack of patient discipline, self-control or will power, rather than a chronic disease, may prevent the provider from adequately assessing and treating the patient. Another barrier involves poor training for primary care providers in the medical management of obesity, which ultimately leads to inadequate assessment and management of overweight or obese patients.

Analysis;

Each clinician needs to build up self-awareness clearly among obese patients about their weight, their weight loss efforts, and especially their weight control failures. Other providing characteristics take account of lack of recognition of obesity as a chronic condition that is difficult to treat which requires continuous and proper and apposite management, and that also has high rates of disheartening a patient.

Health problems and chronic diseases:

A team of Stanford University researchers has calculated that every excess pound of body fat on US citizens drains approximately \$25 from the American health care system annually (Peterson, 2005).

Obese people experience chronic diseases more frequently than non-obese individuals. As a result, obese people pay more during their lifetime for medical care related to chronic diseases than their non-obese counterparts.

Analysis;

People victimized by obesity face more chronic disease as compared to the normal weighing people. Obese people have less stamina and less resistance to overcome diseases by which they are more prone to chronic diseases.

Amount of food intake:

According to Clegg and Woods (2004) when CCK is administered to animals or humans prior to a meal, meal size is reduced dose-dependently (p. 971).

The amount of food intake is regulated by signals generated as food is eaten. Cholecystokinin (CCK) is secreted in the intestine in response to ingested food and stretch receptors in the gut. CCK acts to reduce meal size.

Analysis;

Obesity is greatly dependent upon how much of food is taken. The availability of meal-generated, pre-absorptive negative feedback signals such as CCK to reduce meal size depends upon estrogen levels. Estrogen increases the satiating action of CCK. Hence, females generally eat less food, assuming normal circulating plasma concentrations.

Over consumption of calories

Food is in abundance and portion sizes have increased. Moreover, a large proportion of total caloric intake came from fat and added sugar, accounting for more than 46% of the total calories (Brett, Cruz, Luke, Lun, Philpot, Prasad and Zetaruk, 2004, p.265).

Another trend in nutrition that have attributed to the overconsumption in calories are the increased consumption of soda and juice. (Luke, 2004).

Americans live in an environment that promotes obesity, food is present in abundance and hence takes as more, as compared to Pakistani people. Especially the trend of fast foods has increased in pakistani people and so as the consumption of more calories, and consumption of juice and soda.

Analysis;

The poor dietary habits are followed by children into adolescence and adulthood, leading to overweight and obese adults. Food is taken in abundance and portion sizes have increased. Trend of taking fast foods and fried foods are increasing day by day with a large ratio. Also a large proportion of total caloric intake came from fat and added sugar, and hence became a core factor of increasing obesity.

Economy effects:

It is estimated that obesity results yearly in the loss of 39 million workdays. The cost of obesity to U.S. companies amounts to more than \$13 billion annually in decreased productivity and increased medical fees. Lower salaries are yet another way in which obesity can negatively impact an individual. Economists have noted that there is a negative relationship between weight

and wages. However, the cause and nature of this relationship is not well understood. For women, wages are lower for those with higher BMI and body weight (Couzelis, 2005).

These figures do not convey the fact that everyone, not just obese people, will be affected by the epidemic. The obesity epidemic will increase health care costs, and employers and government agencies will pass on at least some of these increases to consumers. Increased health care costs could influence people to only seek out suggestive care while neglecting to stay current with indicated preventative services and failure to control disease risk factors, which can only result in a twist of unnecessary illnesses, health care costs and disability. These economic and health factors will increase poverty and disability rates (Hoffman, Kottke and Wu, 2003).

Analysis;

More the money is more will be consumption of food. Economists have noted that there is a relationship between weight and wages. Increased health care costs could influence people to only seek out suggestive care while neglecting to stay current with indicated preventative services and failure to control disease risk factors, which can only result unnecessary illnesses, health care costs and disability.

Genetics of Obesity:

Obesity is a disorder with a multifactorial etiology. According to the literature, only rarely a case is a result from a single gene disorder (Kumar, 2005, p. 464).

In recent years, many "obesity" genes have been identified; genes that encode molecular components of the neuroendocrine system that regulates energy balance. (Abbas, Fausto and Kumar, 2005).

Obesity is may due to genetically disease, that mostly came from maternal side, it is a disorder with a multifactorial etiology. The genes of obesity have been identified that encode molecular components of the neuroendocrine system that regulates energy balance

Analysis;

According to them obesity is a disorder with a multiple reasons regarding health in which one of them is genetics or the heredity obesity. Cause of genetically obesity is the imbalance of molecular components of neuroendocrine systems. In these patients abundant fat stores are accumulated resulting into overweight.

Decreased Physical Activity:

The proliferation of modern technology, mobile phones and computers, the increase in number of hours people watch television, and our tendency to convenience all of them to our sedentary lifestyles (Spence-Jones, 2003).

According to the US Surgeon General, approximately 25% of American women are completely sedentary (Lyznicki, 2001).

Around all over the world 70% of women are not regularly physically active and fail to meet the minimal modest amount of exercise associated with disease prevention. The introduction of modern technology, mobile phones, computers, the increase in number of hours people watch television, make the lives of people more sedentary.

Analysis;

Caloric consumption has steadily increased and daily physical activity has significantly declined for several reasons. First, there has been an increased reliance on motor vehicles for transportation, second the increase in modern technology, mobile phones, computers and the

number of hours people watch television. Women are totally sedentary, not physically active, don't even exercise and thus are more prone to victimized by diseases.

Societal Influences:

Fashion designers and clothing manufacturers, as well as advertising agencies, promote and ideal, often wasted, body image (Golden, Greewald and Rogge, 2004).

Women are disproportionately stigmatized by the disease, given society's premium of female physical attractiveness (Aronne and Klauer, 2002).

Societal influence is greatly upon women, as the trends of latest fashioned dresses make them depressed and superiority complexes. Because fashion designers and clothing manufacturers promote their products by advertising them on females. This makes women more dress conscious regarding latest fashioned.

Analysis;

An emerging economic explanation for obesity is that the increase in BMI among people may be attributable to technological advances that have reduced job difficulty and increased consumption of mass-produced foods. The overall decrease in occupational physical activity, as well as other changes in the ways we use our time, have contributed to the trend toward a higher BMI. Advancing food technology may have accelerated the rate of BMI increase by making it easier for people to consume more high-calorie, prepackaged and snack foods. Although technologic advances have enriched our lives and made things much easier, it has become almost impossible to get a decent amount of exercise.

Family Influences:

(Shepard, 2004), Risk factors associated with childhood and adolescent overweight and obesity include high birth weight, maternal diabetes, and a family history of obesity. If one parent is obese, there is a three-fold increase for the child to become obese in adulthood. If both parents are obese, the risk is ten times greater.

Factors associated with childhood and adolescent overweight and obesity include high birth weight, maternal diabetes, and a family history of obesity. Before age 3, parental weight is more of a risk factor for developing obesity than the child's actual weight. Low income, low education, absence of family meals, and sedentary behavior are also linked with the development of overweight and obesity in children.

Analysis;

According to Shepard family influence has much manipulation upon an obese person. It depends upon high birth weight, maternal diabetes, and a family history of obesity. If one parent is obese, there is a three-fold increase for the child to become obese in adulthood. If both parents are obese, the risk is ten times greater. Low income, low education, absence of family meals, and sedentary behavior are also associated with the development of overweight and obesity.

Co-morbid Conditions Associated with Obesity:

Obesity is regarded as the most avertable causes of morbidity and mortality, primarily because of the links to hypertension, coronary artery disease, stroke and diabetes (Rogge, 2004).

Studies suggest that people who are more than 20% overweight have prevalences of hyperlipidemia, hypertension, and diabetes that are between 1.5 and 3.5 times higher than those people whose weight is normal (Mulrow, 1998).

People who are more victimized by obesity are more prone co-morbid conditions. Other complications associated with obesity include osteoarthritis, joint pain, gall bladder disease, sleep apnea, respiratory impairment, diminished mobility and psychosocial distress.

Analysis;

Obesity is a risk factor for major causes of death, including cardiovascular disease, numerous types of cancer, and diabetes. It is also linked with markedly diminished life expectancy. Other complications coupled with obesity include osteoarthritis, joint pain, gall bladder disease, sleep apnea, respiratory impairment, diminished mobility and psychosocial distress. All of the problems are faced by the people having over weight.

Premature Mortality:

The centers for disease control estimate that obesity and related lifestyle issues caused 300,000 deaths in 2002 (Aronne and Klauer, 2002, p.1080).

More than 400,000 deaths and one in five cancer deaths can be credited to obesity annually (Peterson, 2005, p. 44).

(Barendregt, Bonneaux, Mackenbach, Mamun, Peeters, and Willenkens, 2003). In a study to predict years lost due to obesity, the results showed that as compared to a group of normal weight participants, the overweight group had 4 to 5 more deaths per 100 people, and the obese group had 10-11 more deaths than the normal weight group per 100 people. This represents a 115% (women) and 81% (men) increased risk for death in the obese group. The decreases in life expectancy were reflected in increased probabilities of premature death (defined as death before the age of 70 years).

The probability of death increased with each higher category of BMI group (i.e. normal weight, overweight, and obese). Among 40-year-old nonsmokers without previously diagnosed cardiovascular disease, overweight was associated with a 3-year decrease in life expectancy and obesity was associated with a 7-year decrease in life expectancy for women and a 6-year life expectancy decrease in men

Analysis;

Obesity relates to premature mortality to a great extent, but unfortunately it is being most neglected matter. The decreases in life expectancy were reflected in increased probabilities of premature death which is defined as death before the age of 70 years. The probability of death increased with each higher category of BMI group i.e. normal weight, overweight, and obese. Overweight was associated with a three year decrease in life expectancy and obesity was associated with a seven year decrease in life expectancy for women and a six year life expectancy decrease in men.

Heart Disease:

The American Heart Association has cited obesity as a foremost flexible risk factor for coronary heart disease. Compared with their lean counterparts, obese women have an increased mortality risk that rises in proportion to the degree of obesity (Aronne and Klauer, 2002).

The risk of developing coronary heart disease is increased three times in women with a BMI greater than 29 compared to BMI less than 21. Obese persons are likely to have a low HDL cholesterol values, and these factors may increase the risk of coronary artery disease.

The association between obesity and heart disease is complicated and the linkage may be related to the associated hypertension and diabetes rather than to weight. Observational studies have

established a clear association between overweight and hypercholesterolemia and suggest an independent relationship between overweight and coronary artery disease.

Analysis;

Obesity is associated with insulin resistance and hyperinsulinemia which leads to heart diseases and heart attacks. Its important feature is diabetes mellitus. It has been speculated that excess insulin, in turn may play a role in the, expansion of blood volume and smooth muscle propagation that are the hallmarks of hypertension. The prevalence of diabetes and hypertension is three times higher in overweight adults than in those of normal weight. Obese persons are likely to have a low cholesterol values, and these factors may increase the risk of coronary artery disease. The linkage between obesity and heart disease is complicated and this may be related to the associated hypertension and diabetes rather than to weight.

Osteoarthritis and Degenerative Joint Disease:

Obesity has been identified as the main preventable risk factor for developing osteoarthritis (Cicuttini, Powell, Teichtahl, and Wluka, 2004).

It has been speculated that obesity increases bony stiffness, making bones less adept at coping with impact loads.

Also, studies have shown that obese women are at a higher risk of osteoarthritis of the hand than women who are thinner. This suggests that the effect of obesity on osteoarthritis is mediated not only by excess loading on the joints, but also by metabolic or inflammatory factors that may go with obesity. These metabolic factors may have harmful effects on the joint (Felson, 2004).

Arthritis, which typically appears in older persons, is attributed in large to the cumulative effects of wear and tear on the joints. It is reasonable to assume that the greater the body burdens of fat, the greater the disturbance to the joints with passage of time.

Analysis;

People who are obese have a higher prevalence of osteoarthritis of knee than those who are not. The relation of osteoarthritis of the knee to obesity is stronger in women than in men for reasons that are unknown. The effect of obesity on osteoarthritis is mediated not only by excess loading on the joints, but also by metabolic or inflammatory factors that may go with obesity. Arthritis, which normally appears in older persons, is known as largely effective in wear and tear on the joints. It is reasonable to assume that the greater the body burdens of fat, the greater the disturbance to the joints with passage of time. Obesity has also been associated with certain cancers, including those of the rectum, gallbladder, breast and ovary.

Reproductive Disorders:

Obesity may represent a condition of leptin resistance. Leptin acts directly on the ovary, in particular on the follicular cells, including the granulosa, thecal and interstitial cells. Leptin may exert a direct inhibitory effect on ovarian function. (Pasquali,2003).

Major links are seen in reproductive endocrinology between excess body fat and irregular menstrual cycles, reduced spontaneous and induced fertility, increased risk for miscarriage and hormone-sensitive carcinomas.

It is also known that the presence of anovulatory cycles either separately or in association, were significantly higher in obese than in normal-weight women.

Obesity may interfere with many neuroendocrine and ovarian functions, thus reducing fertility rates in otherwise healthy women. Obesity is associated with increased risk of hyperandrogenism and anovulation in women of reproductive age as supported by the strong association between obesity and the polycystic ovarian syndrome (PCOS). Approximately 50% of women with PCOS are overweight.

Analysis;

Reproductive disorders are mainly due to the abnormality in the excess body fat and irregular menstrual cycles, reduced spontaneous and induced fertility, increased risk for miscarriage and hormone-sensitive carcinomas. It is also known that the presence of anovulatory cycles either separately or in association, were significantly higher in obese than in normal-weight women.

Psychological and Social influences:

Obesity is associated with body image dissatisfaction across gender and ethnic groups. Women are more dissatisfied with their body weight and shape than men (Aronne and Klauer 2002).

“Historically, being overweight has been associated with gluttony and sloth, which represent overindulgent behaviors. Obesity represents the outward manifestation of self-indulgence and spiritual imperfection, exemplifying the biblical admonition “the spirit is willing but the flesh is weak (Matthew 26:41)” (Rogge, 2004, p. 305).

Obese young people, between the ages of 16 and 24 were less likely to be married and had lower household incomes than did those who were not overweight. These findings were more pronounced among women than among men (Rogge, 2004).

Several studies have indicated that obesity is even more common among those seeking important care services than it is among the general population because of the increased morbidity brought on by obesity. Unfortunately, obese patients are often unwanted in medical settings, where they meet negative attitudes, discriminatory behavior, and a challenging physical environment.

Analysis;

Obesity is highly linked with body image dissatisfaction across gender, it is found more in females than in males. Women are more discontented with their body weight and shape than men. It also represents the outward manifestation of self-indulgence and spiritual imperfection.

Obese people are less likely to be married with due to bulk of the reasons and problems which are highly concerned by male members.

Also, obese patients are often unwanted in medical settings, where they meet negative attitudes, discriminatory behavior, and a challenging physical environment. These negative experiences may explain why obese patients are more likely to delay clinical check-ups associated with obesity.

Diet:

Low calorie diets with 1,000-1,500 calories per day have been shown to provide approximately an 8% weight reduction in obese individuals over 3-12 months when compliance is good (Aronne and Klauer, 2002). Very low calorie diets, including liquid formula diets, provide 400-800 calories per day, and should be reserved for obese people.

Low fat diets (20-30% of calories) have not been shown to significantly reduce weight without a reduction of calories. However, low-fat diets coupled with caloric restriction are a useful and healthy way to lose weight (Aronne and Klauer, 2002).

If calories are reduced to 1,200 kcal per day, a wide variety of nutrients can be incorporated while still allowing for weight loss. With a balanced, reduced-calorie diet, weight loss should be at a rate of about one to two pounds per week. Basic treatment of obesity is reduction in the number of calories consumed.

Analysis ;

The foremost factor to increase in weight is imbalance diet. An overall decrease in the number of calories is essential for weight loss to occur, with emphasis on consumption of raw fruits and vegetables, protein, fiber, and also should be sufficient in nutrients and vitamins. Decreasing intake of processed foods, sugars, salts, fats, oils, and nutritionally-dense foods should be encouraged. The specific diet is best developed in consultation with a registered dietician.

Calculating daily caloric requirements can help the health care provider in counseling patients about caloric needs to maintain weight.

Exercise:

The benefits of regular exercise have positive effects on mind, bone, risk for cancer, glucose tolerance and insulin sensitivity, and quality of life. The Nurse's Health Study documented a lower incidence of cardiovascular disease, including both coronary heart disease and stroke (Aronne and Klauer,2002, p.1084).

Daily physical exercise is necessary for health. Even a moderate-intensity exercise such as walking is associated with a lower risk of disease. The recommendation for aerobic activity is thirty minutes on most, if not all, days of the week. This is the minimum recommendation; those wishing to lose weight should aim to exceed this

Analysis ;

For a normal health person it is necessary to exercise daily, it maintains the body weight, metabolic rate and over all structure of the body. The benefits of regular exercise have positive effects on mind, bone, risk for cancer, glucose tolerance and insulin sensitivity, and quality of life. The patient should be advised to gradually increase her energy expenditure through changes to her daily routine for instance climbing stairs rather than riding the elevator, parking farther from a destination if safe and the inclusion of regular exercise likely to be continued over the long-term.

Other Salient Causes:

Storage of excess calories as fat must eventually result from a net positive energy balance (energy intake is greater than energy expenditure) over time (Lieber and Rosenbaum, 1998).

Absurdly obesity often coexists with a substantial level of malnutrition (Peterson, 2005).

The rise of global obesity is thought to be a by-product of environmental and behavioral changes linked to economic development, modernization, and urbanization. Absurdly obesity often coexists with a substantial level of malnutrition.

Obesity is not a simple problem of will power or self-control, but a complex disorder involving appetite regulation and energy metabolism that is associated with a variety of co-morbid conditions.

Analysis;

Increasing evidence suggests that obesity is not a simple problem of will power or self-control, but a complex disorder involving appetite regulation and energy metabolism that is associated with a variety of co-morbid conditions. Although its etiology is not clearly established, genetic, cultural and psychosocial factors contribute to obesity. In most cases, the increasing prevalence of overweight and obesity reflects changes in society and behaviors over the past 20-30 years.

Assumptions

1. Obesity is defined as a condition in which a glut of body fat is accumulated. It is due to various factors such as age, sex, height, lean muscle mass and body fat percentage are all unaccounted for when using weight alone to measure healthy body weight on an individual level.
2. The BMI is an accurate alternative to more expensive and invasive tools to evaluate body fatness. The BMI is a desirable measurement of the tendency towards obesity, and helps to identify those at risk for overweight and obesity.
3. There have been many amendments in the delivery of healthcare for obese patients, but there are still far more health care issues that have not been able to be solved in recent years.
4. Each clinician needs to build up self-awareness clearly among obese patients about their weight, their weight loss efforts, and especially their weight control failures.

5. People victimized by obesity face more chronic disease as compared to the normal weighing people. Obese people have less stamina and less resistance to overcome diseases by which they are more prone to chronic diseases.
6. Obesity is greatly dependent upon how much of food is taken. The availability of meal-generated and pre-absorptive negative feedback signals.
7. The poor dietary habits are followed by children into adolescence and adulthood, leading to overweight and obese adults. Trend of taking fast foods and fried foods are increasing day by day with a large ratio.
8. More the money is more will be consumption of food. Economists have noted that there is a relationship between weight and wages.
9. Obesity is a disorder with multiple reasons in which one of them is genetics or the heredity obesity. Cause of genetically obesity is the imbalance of molecular components of neuroendocrine systems.
10. Obesity is a risk factor for major causes of death, including cardiovascular disease, numerous types of cancer, and diabetes. People who are obese have a higher prevalence of osteoarthritis of knee than those who are not.
11. Reproductive disorders are mainly due to the abnormality in the excess body fat and irregular menstrual cycles, reduced spontaneous and induced fertility, and increased risk for miscarriage.
12. Obesity is highly linked with body image dissatisfaction it is found more in females than in males. Women are more discontented with their body weight and shape than men.
13. Lack of exercise leads to obesity because it maintains the body weight, metabolic rate and over all structure of the body.

14. Obesity is not a simple problem of will power or self-control, but a complex disorder of appetite regulation and energy metabolism. The increasing prevalence of obesity reflects changes in society and behaviors over the past 20-30 years.

Chapter No. 3

THEORETICAL FRAMEWORK

CHAPTER 3

Theoretical Framework

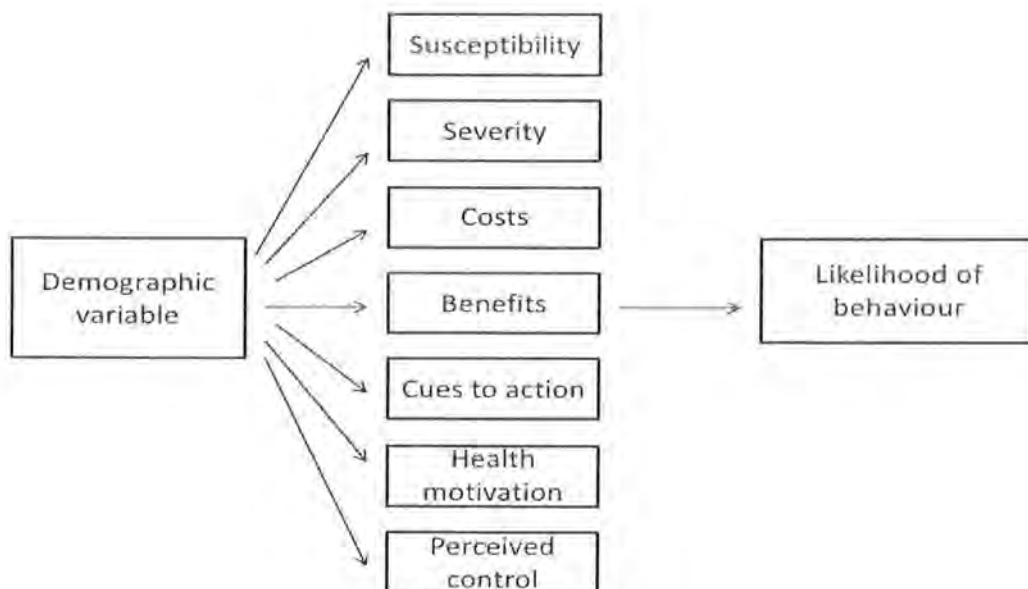
The framework for illuminating and explaining health behavior is the Health Belief Model (HBM). The HBM addresses a person's perceptions of the threat of a health problem and the accompanying appraisal of a recommended behavior for preventing or managing a problem (Kish and Robison, 2001). Its focal point is the behavior related to the prevention of disease, and seeks to explain why people do or do not engage in preventive health action in response to a specific disease threat. The following are factors that determine a person takes the recommended health actions or not ; the person's perceptions of their own weakness or perceived threat of the disease; the degree of severity of consequences perceived; the health action's potential benefits in preventing susceptibility; and the physical, psychological, financial and other barriers related to the behavior. Demographic, social-physiological, and structural variables are included in the theory as potential modifying factors that influence both individual perceptions and the perceived benefits of the preventative actions.

APNSs (Advance Practice Nurse) use this model will plan care with motivation as their central focus. The APN must educate patients about potential health threats, convince them to take preventative action by heightening perceived susceptibility of a health problem, enhance perceived benefits of health actions, offer help in identifying barriers, give encouragement and incentives, and help in making preventive health care choices. "The most promising application for this model is to serve as a guide for APNs to develop messages that are likely to persuade individuals to make healthy decisions" (Kish and Robinson,2001, p.574).

Implementation

This theoretical framework is relevant to the obesity epidemic because much of our society equates overweight and obesity to only an aesthetic issue. Patients may not completely understand the health implications of being overweight, making it necessary that the subject of weight be out in the open and not ignored in the health care setting. Prevention is difficult unless the patient understands his or her own personal risk for the co-morbid conditions associated with obesity. That is why every health care practitioner who encounters women who are, or are at risk for becoming overweight or obese should provide a thorough assessment for obesity and its co-morbid conditions, and offer individualized counseling and treatment to either prevent or reverse the progression of overweight and obesity.

Health Belief Model



Propositions;

1. The Health Belief Model is a standard pattern used to evaluate or influence an individual's behavioral changes in regard to a particular health condition.
2. The model suggests that the likelihood that an individual will take action concerning a health condition is determined by the person's desire to take action and by the perceived benefits of the action weighed against the perceived costs of barriers.
3. The model also evaluates how an individual estimates their susceptibility to a condition and the benefits of detection and treatment for that particular illness.
4. Health Belief Model is a solid and effective humanistic theory because; it is comprised of multiple truths because it applies to different situations and individuals in various ways. The knowledge gained is interpretive in nature.
5. This also relies heavily on free will because the actions involved are determined by each individual.
6. This theory is value-laden because beliefs and values play a huge role in the ideology of this theory.

Chapter No. 4

CONCEPTUALIZATION AND OPERATIONALIZATION

CHAPTER 4

CONCEPTUALIZATION AND OPERATIONALIZATION

Conceptualization refers to defining the variables in a holistic way, and the variables that includes are impacts of obesity upon married women's health, feeling of women being non satisfied, dependency upon others including their family members, morbid conditions they face, diseases which they have, their participation in daily household chores. As it is mentioned previously that primary data is collected on the specified mentioned variables. Structured questionnaire is used to collect the information. In the following section the concepts are defined.

Marriage;

1. Marriage, also called matrimony or wedlock, is a socially or ritually recognized union or legal contract between spouses that establishes rights and obligations between them. (Pratt and Patricia, 2012)
2. A contract made in due form of law, by which a free man and a free woman reciprocally engage to live with each other. (William C. Burton, 2007)

Woman;

1. A woman is a female human. The term woman is usually reserved for an adult, with the term girl being the usual term for a female child or adolescent. (Onions, Oxford, 1966, p. 1011)
2. Woman is the noun referring to adult human beings who are biologically female that is capable of bearing offspring. (Random House Kernerman Webster's College Dictionary, 1997)

Obesity:

1. Obesity is a medical condition in which excess body fat has accumulated to the extent that it may have a negative effect on health, leading to reduced life expectancy and/or increased health problems.(WHO 2000,p.6)
2. Obesity is a complex disorder involving an excessive amount of body fat. Obesity isn't just a cosmetic concern. It increases your risk of diseases and health problems such as heart disease, diabetes and high blood pressure. (Mayo Foundation for Medical Education and Research, 1998-2005)

Operationalization

Operationalization refers to measuring the variables in the respective tool for data collection.

In this study the variables are operationalized in the interview schedule as under.

Marriage

Marriage, also called matrimony or wedlock, is a socially or ritually recognized union or legal contract between spouses that establishes rights and obligations between them. This variable was asked in the interview schedule as;

Q.1 what is your age?

Q.2 What is your qualification?

Q.9 Do you think married women take more dense foods, as they are no more figure conscious?

a) Yes

b) No

c) Don't know

Q.10 Do you ever face husband distraction from you due to obesity? If yes then what was your response?

- a) Get dishearten
- b) Go for exercise
- c) Any Other

Q.11 Do you face social stigmas upon you?

- a) From husband
- b) From in-laws
- c) From other family members

Q.27 How much of your involvement is in daily household chores?

- a) To great extent
- b) To some extent
- c) Not at all

Q.29 Are you dependent upon your maid for;

	Yes	No
Massaging		
Food serving		

Q.31 Amount of sugar and salt is a core factor of obesity, how much do you use on daily basis?

	1 time	3 times	more
Sugar			
Salt			

Q.32 Which of the food items are included in your weekly dietary patterns;

	Daily	Once	Twice	Never
Pulses				
Vegetables				
Fried foods				
Sweets				
Cold drinks				
Ice creams				
Fast foods				

Q.33 What is your weekly average consumption of specific fatty items i-e Oil, ghee, butter, milk

	Less than 1kg	Less than 2kg	Less than 5kg	No usage
Oil				
Ghee				
Butter				
Milk (liters)				

Woman

A woman is a female human. The term woman is usually reserved for an adult, with the term girl being the usual term for a female child or adolescent. This variable was asked in the interview schedule as:

Q.1 How do you perceive your physical appearance?

- a) Satisfied
- b) Depressed
- c) Non-satisfied

Q.2 Do you intend to change your physique?

- a) Yes
- b) No

Q.11 Do you face social stigmas upon you from society?

- a) Yes
- b) No
- c) Sometimes

Q.13 Do you face tog-up problems regarding latest fashion dresses?

- a) Yes
- b) No

Q.14 Do you think you are genetically an obese woman?

- a) Yes
- b) No
- c) Don't know

Q.15 Have you faced reproduction complications?

- a) Yes
- b) No

Q.16 Do you ever counseled to lose weight?

- a) Yes
- b) No

Q.17 Do you think you have less stamina?

- a) Yes
- b) No

Q.20 Do you think your mobility decreases due to obesity?

- a. Yes
- b. No

Q.21 Do you know about the high mortality rate of obese women?

- a) Yes
- b) No
- c) Don't know

Q.22 Do you feel yourself embarrassed in public gathering?

a) Yes

b) No

Q.23 Do you feel ashamed in public gathering?

a) Yes

b) No

Q.24 Do you feel ridiculed in public gathering?

a) Yes

b) No

Q.31 What type of daily household chores you do?

	Yes	No
Sweeping		
Swabbing		
Dish washing		
Cooking		
Washing clothes		

Q.34 If you are a working lady what are your mental health concerns?

	Yes	No	Don't know
Self esteem			
Depression			

Q.35 How would you describe your general health in comparison to other women of your age?

- a) Is it same
- b) Poor than others
- c) Worst than others

Obesity;

Obesity is a medical condition in which excess body fat has accumulated to the extent that it may have a negative effect on health, leading to reduced life expectancy and/or increased health problems. The whole tool explores the different aspects of obesity. This variable was asked in the interview schedule as;

Q.3 Do you exercise?

- a) Daily
- b) Twice a week
- c) Once in a week
- d) Not at all

Q.4 Do you take any medicine/having any treatment to overcome obesity?

- a) Yes
- b) No

Q.5 Do you ever feel yourself handicapped/dependent upon others?

- a) Yes
- b) No
- c) Sometimes

Q.6 Do you feel you are a problem for your family members most of the time?

- a) Yes
- b) No
- c) Sometimes

Q.7 Do you agree that literate people have less ratio of obesity?

- a) Yes
- b) No
- c) Don't know

Q.8 Does high income in household results in increasing obesity?

- a) Yes
- b) No
- c) Somehow

Q.13 Do you face tog-up problems regarding latest fashion dresses?

a) Yes

b) No

Q.15 Have you faced reproduction complications?

a) Yes

b) No

Q.16 Do you ever counseled to lose weight?

a) Yes

b) No

Q.17 Do you think you have less stamina?

a) Yes

b) No

Q.18 Do you know that you are more prone to many of the ordinary diseases like;

	Yes	No
Diabetes		
Blood pressure		
Gall stones		
Kidney problems		
High cholesterol		
Arthritis		

Q.19 Do you face any morbid conditions like;

	To great extent	To some extent	Not at all
Asthma			
Back pain			
Swelling of hands			
Swelling of feet			
Cholesterol level			
Breathlessness while talking			

Q.26 Do you face problems while;

	Yes	No	Sometimes
Sitting			
Lying			
Walking			

Q.27 How much time you give to television for leisure?

- a) 3 hours
- b) 6 hours
- c) More

Q.29 Does your size easily available in markets for;

	Yes	No
Shoes		
Undergarments		

Q.18 Do you face any morbid conditions like;

	To great extent	To some extent	Not at all
Asthma			
Back pain			
Swelling of hands			
Swelling of feet			
Cholesterol level			
Breathlessness while talking			

Q.19 Do you know that you are more prone to many of the ordinary diseases like;

	Yes	No
Diabetes		
Blood pressure		
Gall stones		
Kidney problems		
High cholesterol		
Arthritis		

Chapter No. 5

RESEARCH METHODOLOGY

CHAPTER 5

RESEARCH METHODOLOGY

In research methodology the researcher selected the method and techniques used in the study for data collection and analytical techniques that are to be used in the literature survey a model of questionnaire about impacts of obesity on married women. In the present research, the interview schedule was adapted after discussion with the research advisor.

Universe of the Research

The universe of the present research was Shahzad Town situated in Islamabad. Women living in this area are mostly housewives and are obese due to various factors.

Target Population

In the present research, women who had been suffering from obesity for last few years were targeted population.

Sampling Technique

The purposive sampling technique was used in the present study because the targeted population was only those people who had been suffering from obesity.

Sample Size

As the sampling frame was not available for the researcher, that's how keeping in view the sample size in prior researches, the researcher has drawn a sample of 100 respondents.

Tools of Data Collection

Most of the women were less educated, they couldn't understand the English language, biological terms and somehow the nature of the research. To conduct research in town, the interview schedule was taken as a tool for data collection.

Technique for Data Collection

Non probability sampling techniques for data collection were used because of the nature of research.

Pre Testing

Pre testing is a tool in which a researcher tests his research before the collection of data. It becomes necessary for the verification of significance of the study. The interview schedule was pretested from 10 respondents. Hence the pre-testing assisted the researcher in this scenario.

Data Analysis

This is the main tool for drawing a conclusion of the conducted research. After collection of the data, the researcher coded the interview schedule in SPSS. After coding, data was coded in SPSS software.

In order to analyze the data, statistical tests were applied, frequencies were drawn. Chi-square test was applied. Then conclusion was drawn.

Opportunities and Limitations of the Study

The concept of impacts upon married women's health of obesity is quite new for them. Not all but a large number of women were obese but they felt hesitate to give personal information regarding health in context with social behavior. It was not difficult for the researcher to manage due to the small specified area. The main focus of the research was to explore the impacts of obesity on married women.

In this research, purposive sampling is for the reason that targeted people were only married women who are suffering from obesity for last few years.

Ethical Concerns

The targeted population was married women who were suffering from obesity for last few years hence the researcher did not face any of the ethical issues during research. Women were willing to give information as well as desire to know the other factors that make them obese. Less educated women hesitated to give information about their age and personal information regarding health issues. Majority of the respondents served researcher tea and drinks during the interview.

Chapter No. 6

RESULTS

CHAPTER 6

RESULTS

In this chapter data analysis and findings are presented. After the collection of actual data, it is edited, coded and computerized. Analysis is done with the help of Statistical Package for Social Sciences (SPSS 20).

This chapter is further divided into two parts.

1. Descriptive analysis
2. Hypothesis testing.

Frequency Tables

Distribution of Age

Categories	Frequency	Percent
20-40	48	48.0
40-60	43	43.0
60-80	9	9.0
Total	100	100.0

This table shows the age of the respondents. The data represents that 48% belong to age group 20-40, 43% belong to age group 40-60, and 9% belong to age group 60-80.

It is concluded that majority of the respondents were of young age.

1. Perception of physical appearance

Categories	Frequency	Percent
satisfied	62	62.0
depressed	12	12.0
non satisfied	26	26.0
Total	100	100.0

Table no.1 shows the perception of the respondent's physique. The data shows that 62% of the respondents are satisfied with their physique, 12% are depressed, 26% are non-satisfied. It is concluded that majority of the respondents are satisfied with their physique.

2. Intention to change physique

Categories	Frequency	Percent
yes	50	50.0
no	50	50.0
Total	100	100.0

Table no.2 shows that Do the respondents intend to change their physique? The data shows that 50% of the respondents intend to change their physique and 50% do not want to change it, it is concluded that respondents want to remain same as they are.

3. Probability of exercise

Categories	Frequency	Percent
daily	8	8.0
twice a week	6	6.0
once in a week	28	28.0
never	58	58.0
Total	100	100.0

Table no.3 shows the data about exercise, the data represents that 8% of the respondents exercise daily, 6% exercise twice a week, 26% exercise once in a week, and 58% of them do not exercise at all. It is concluded that majority of the respondents do not exercise at all.

4. Probability of taking medicines/having any treatment.

Categories	Frequency	Percent
yes	25	25.0
no	75	75.0
Total	100	100.0

Tableno.4 shows that do respondents take any medicine/having any treatment to overcome obesity? The data reflects that 25% of the respondents take medicine/having treatment to overcome obesity, and 75% do not take any medicine or having any treatment. It is concluded that majority of the respondents do not take any medicine or having any treatment to overcome obesity.

5. Feeling of being handicapped/dependent upon others

Categories	Frequency	Percent
yes	37	37.0
no	62	62.0
sometimes	1	1.0
Total	100	100.0

Table no.5 shows the respondents feeling of being handicapped/dependent upon others. The data shows that 37% of the respondents feel themselves handicapped/dependent upon others, and 62% of them do not feel handicapped/dependent upon others. Hence, it is concluded that majority of the respondents do not feel themselves to be handicapped or dependent upon others.

6. Feeling of being a problem for family members

Categories	Frequency	Percent
yes	16	16.0
no	36	36.0
sometimes	48	48.0
Total	100	100.0

Table no.6 represents the respondent's feeling of being a problem for family members most of the time? The data shows that 16% of the respondents feel they are a problem for their family members, 36% of them feel that they are not a problem for their family members, and 48% of them feel that sometimes they are a problem for their family members. It is concluded that majority of the respondents sometimes feel themselves a problem for their family members.

7. Literate people's less ratio of obesity

Categories	Frequency	Percent
yes	43	43.0
no	38	38.0
Don't know	19	19.0
Total	100	100.0

Table no.7 represents that how much of the respondents agree that literate people have less ratio of obesity? The data shows that 43% of the respondents agree that literate people have less ratio of obesity. 38% of them do not agree, and 19% said that they don't know about the ratio level of obese people. It is concluded that majority of the respondents agree that there literate people have less ratio of obesity.

8. Effect of high income in household increase in obesity

Categories	Frequency	Percent
yes	41	41.0
no	22	22.0
somehow	37	37.0
Total	100	100.0

Table no.8 reflects that does high income in household results in increasing obesity? The data shows that 41% of the respondents said yes, high income in household results in increasing obesity. 22% of them said no, and 37% of them said they somehow high income results in increasing obesity. Hence, it is concluded that majority of the respondents said Yes, high income results is increasing obesity.

9. Ratio of married women that take more dense foods, as they are no more figure conscious.

Categories	Frequency	Percent
yes	55	55.0
no	33	33.0
Don't know	12	12.0
Total	100	100.0

Table no.9 reflects that what does a respondent think? Married woman take more dense food as they are no more figure conscious. The data shows that 55% of the respondents said Yes, married woman take more dense food as they are no more figure conscious, 33% of them said No, and 12% of them said they don't know whether married woman take more dense food or not. It is thus concluded that majority of the respondents think that married woman take more dense food as they are no more figure conscious.

10. Response of husband's distraction due to obesity

Categories	Frequency	Percent
get dishearten	12	12.0
go for exercise	40	40.0
any other	48	48.0
Total	100	100.0

Table no.10 shows what the respondent's response was when her husband distracted from her due to obesity. The data reflects that 12% of the respondents got dishearten, 40% of them said they go for exercise and 48% of them said that they took other remedies to overcome their obese look. Thus it is concluded that majority of the respondents took other remedies to overcome their obese look.

11. Probability of facing social stigmas

Categories	Frequency	Percent
from husbands	13	13.0
from in-laws	50	50.0
from other family members	37	37.0
Total	100	100.0

Table no.11 represents that do the respondents face social stigmas? The data shows that 13% of the respondents have faced stigmas upon them by their husbands, 50% of them have faced by their in-laws, and 37% of them have faced by the other family members. It is concluded that majority of the respondents have faced social stigmas by their in-laws.

12. Probability of facing social stigmas from society

Categories	Frequency	Percent
yes	41	41.0
no	46	46.0
sometimes	13	13.0
Total	100	100.0

Table no.12 reflects the responses of facing social stigmatization by society. The data shows that 41% of the respondents said yes, they have faced social stigmatization by the society, 46% of them said No, and 13% of them said sometimes. It is concluded that majority of the respondents do not face social stigmatization by the society.

13. Probability of facing tog-up problems regarding latest fashion dresses

Categories	Frequency	Percent
yes	58	58.0
no	42	42.0
Total	100	100.0

Table no.13 represents that do the respondents face tog-up problems regarding latest fashion dresses? The data shows that 58% of the respondents face tog-up problems, and 42% of them do not face such problem. It is concluded that majority of the respondents face tog-up problems regarding latest fashion dresses.

14. Ratio of genetically an obese woman

Categories	Frequency	Percent
yes	24	24.0
no	54	54.0
Don't know	22	22.0
Total	100	100.0

Tableno.14 represents that does the respondent think that she is genetically an obese woman? The data shows that 24% of the respondents said that Yes, they are genetically obese, 54% of them said that they are not, and 22% of them said that they don't know whether they are genetically obese or not.

15. Facing reproduction complications

Categories	Frequency	Percent
yes	31	31.0
no	69	69.0
Total	100	100.0

Table no. 15 reflects that have the respondents faced reproduction complications? The data shows that 31% of them said that they have face reproduction complications, and 69% of them said they haven't face. It is concludes that majority of the respondents do not face reproduction complications.

16. counseling to lose weight

Categories	Frequency	Percent
yes	45	45.0
no	55	55.0
Total	100	100.0

Table no.16 represents that have the respondents ever counseled to lose weight? The data reflects the result that 45% of the respondents are counseled to lose weight, 55% are not. Thus it is concluded that majority of the respondents are not counseled to lose weight.

17. Having less stamina

Categories	Frequency	Percent
yes	55	55.0
no	45	45.0
Total	100	100.0

Table no. 17 represents the response of having less stamina of the respondent. The data shows that 55% of the respondent said yes, they have less stamina, and 45% of them said they don't have less stamina. It is concluded thus that majority of the respondents have less stamina.

18. Probability of more prone to diabetes

Categories	Frequency	Percent
yes	60	60.0
no	40	40.0
Total	100	100.0

Table no. 18 shows that do the respondent know that she is more prone to diabetes? The data shows that 60% of the respondent said yes, they know they are more prone to diabetes, and 40% of them said no, they don't know. Hence it is concluded that majority of the respondents know that they are more prone to diabetes.

19. Probability of prone to blood pressure

Categories	Frequency	Percent
yes	48	48.0
no	52	52.0
Total	100	100.0

Table no. 19 shows that do the respondent know that she is more prone to blood pressure? The data reflects the results that 48% of the respondents know they are more prone to diabetes, and 52% of them said no, they don't know. Hence it is concluded that majority of the respondents do not know that they are more prone to blood pressure.

20. Probability of prone to gall stones

Categories	Frequency	Percent
yes	42	42.0
no	58	58.0
Total	100	100.0

Table no. 20 shows that do the respondent know that she is more prone to gall stones? The data reflects the results that 42% of the respondents know they are more prone to gall stones, and 58% of them said no, they don't know. Hence it is concluded that majority of the respondents do not know that they are more prone to gall stones.

21. Probability of prone to kidney problems

Categories	Frequency	Percent
yes	48	48.0
no	52	52.0
Total	100	100.0

Table no. 21 shows that do the respondent know that she is more prone to kidney problems? The data reflects the results that 48% of the respondents know they are more prone to kidney problems, and 52% of them said no, they don't know. Hence it is concluded that majority of the respondents do not know that they are more prone to kidney problems.

22. Probability of prone to high cholesterol problem

Categories	Frequency	Percent
yes	59	59.0
no	41	41.0
Total	100	100.0

Table no. 22 shows that do the respondent know that she is more prone to high cholesterol? The data reflects the results that 59% of the respondents know they are more prone to high cholesterol, and 41% of them said no, they don't know. Hence it is concluded that majority of the respondents know that they are more prone to high cholesterol.

23. Probability of prone to Asthma

Categories	Frequency	Percent
yes	23	23.0
no	77	77.0
Total	100	100.0

Table no. 23 shows that do the respondent know that she is more prone to arthritis? The data reflects the results that 23% of the respondents know they are more prone to diabetes, and 77% of them said no, they don't know. Hence it is concluded that majority of the respondents do not know that they are more prone to arthritis.

24. Facing Asthma

Categories	Frequency	Percent
to great extent	27	27.0
to some extent	18	18.0
not at all	55	55.0
Total	100	100.0

Table no. 24 represents that do the respondent face asthma? The data reflects that 27% of the respondents face asthma to great extent, and 18% of them face to some extent, and 55% of them do not face at all. Hence, it is concluded that majority of the respondents do not face asthma.

25. Facing back pain

Categories	Frequency	Percent
to great extent	33	33.0
to some extent	49	49.0
not at all	18	18.0
Total	100	100.0

Table no. 25 represents that do the respondent face back pain? The data reflects that 33% of the respondents face back pain to great extent, and 49% of them face to some extent, and 18% of them do not face at all. Hence, it is concluded that majority of the respondents face back pain to some extent.

26. Facing Swelling of Hands

Categories	Frequency	Percent
to great extent	19	19.0
to some extent	31	31.0
not at all	50	50.0
Total	100	100.0

Table no. 26 represents that do the respondent face swelling of hands? The data reflects that 19% of the respondents face swelling of hands to great extent, and 31% of them face to some extent, and 50% of them do not face at all. Hence, it is concluded that majority of the respondents do not face asthma.

27. Facing Swelling of feet

Categories	Frequency	Percent
to great extent	35	35.0
to some extent	33	33.0
not at all	32	32.0
Total	100	100.0

Table no. 27 represents that do the respondent face swelling of feet? The data reflects that 35% of the respondents face swelling of feet to great extent, and 33% of them face to some extent, and 32% of them do not face at all. Hence, it is concluded that majority of the respondents face swelling of feet.

28. Facing High Cholesterol level

Categories	Frequency	Percent
to great extent	46	46.0
to some extent	22	22.0
not at all	32	32.0
Total	100	100.0

Table no. 28 represents that do the respondent face high cholesterol level? The data reflects that 46% of the respondents face high cholesterol level to great extent, and 22% of them face to some extent, and 32% of them do not face at all. Hence, it is concluded that majority of the respondents face high cholesterol level.

29. Facing breathlessness while talking

Categories	Frequency	Percent
to great extent	33	33.0
to some extent	35	35.0
not at all	32	32.0
Total	100	100.0

Table no. 29 represents that do the respondent face breathlessness while talking? The data reflects that 33% of the respondents face breathlessness while talking to great extent, and 35% of

them face to some extent, and 32% of them do not face at all. Hence, it is concluded that majority of the respondents face breathlessness while talking to some extent.

30. Do you think your mobility decreases due to obesity?

	Frequency	Percent
yes	70	70.0
no	30	30.0
Total	100	100.0

Table no.30 represents that do the respondent's mobility decreases due to obesity? The data shows that 70% of the respondents said yes, their mobility decreases due to obesity, and 30% of them said no. It is concluded that mobility of the respondent decreases due to obesity.

31. Probability of knowing high mortality rate of obese women

Categories	Frequency	Percent
yes	21	21.0
no	43	43.0
Don't know	36	36.0
Total	100	100.0

Table no.31 represents that does the respondent know about the high mortality rate of obese woman? The data shows that 21% of the respondents said yes, they know about the high mortality rate of obese woman, 43% of them said no, and 36% of them said that they don't know. It is concluded that majority of the respondents do not know about the high mortality rate of obese woman.

32. Feeling of embarrassment in public gathering

Categories	Frequency	Percent
yes	20	20.0
no	80	80.0
Total	100	100.0

Table no.32 represents that does the respondent feel embarrassment in public gathering? The data shows that 20% of the respondents said that they do not embarrass in public gathering, and 80% of them said they do not embarrass in public gathering. It is concluded that majority of the respondents do not embarrass in public gathering.

33. Feeling of being ashamed in public gathering

Categories	Frequency	Percent
yes	16	16.0
no	84	84.0
Total	100	100.0

Table no.33 represents that does the respondent feel ashamed in public gathering? The data shows that 16% of the respondents said that they do not feel ashamed in public gathering, and 84% of them said they do not feel ashamed in public gathering. It is concluded that majority of the respondents do not feel ashamed for going in public gathering.

34. Feeling of being ridiculed in public gathering

Categories	Frequency	Percent
yes	20	20.0
no	80	80.0
Total	100	100.0

Table no.32 represents that does the respondent ever ridiculed in public gathering? The data shows that 20% of the respondents said that they ridiculed in public gathering, and 80% of them said they do not ridiculed ever in public gathering. It is concluded that majority of the respondents do not ridiculed in public gathering.

35. Facing problems while sitting

Categories	Frequency	Percent
yes	22	22.0
no	61	61.0
sometimes	17	17.0
Total	100	100.0

Table no.35 represents that does the respondent face problems while sitting? The data shows that 22% of the respondents said yes, they face problems while sitting, 61% of them said they do not, and 17% of them said that sometimes they face problem while sitting. It is concluded that majority of the respondents do not face problems while sitting.



36. Facing problems while Lying

Categories	Frequency	Percent
yes	59	59.0
no	39	39.0
sometimes	2	2.0
Total	100	100.0

Table no.36 represents that does the respondent face problems while lying? The data shows that 59% of the respondents said yes, they face problems while lying, 39% of them said they do not, and 2% of them said that sometimes they face problem while sitting. It is concluded that majority of the respondents face problems while lying.

37. Facing problems while walking

Categories	Frequency	Percent
yes	50	50.0
no	38	38.0
sometimes	12	12.0
Total	100	100.0

Table no.37 represents that does the respondent face problems while walking? The data shows that 50% of the respondents said yes, they face problems while walking, 38% of them said they do not, and 12% of them said that sometimes they face problem while walking. It is concluded that majority of the respondents face problems while walking.

38. Time give to television for leisure

Categories	Frequency	Percent
3 hours	83	83.0
6 hours	10	10.0
more	7	7.0
Total	100	100.0

Table no. 38 represents that how much time respondent gives to television for leisure? The data shows that 83% of the respondents give time 3 hours to television for leisure, 10% said that they give 6hours, and 7% of them said that they give more time to television in leisure. Hence it is concluded that majority of the respondents give 3hours to television for leisure.

39. Involvement in daily household chores

Categories	Frequency	Percent
to great extent	58	58.0
to some extent	30	30.0
not at all	12	12.0
Total	100	100.0

Table no.39 represents that how much of respondent's involvement in daily household chores? The data shows that 58% of the respondents have involvement in daily household chores, 30% of them said to some extent, and 12% of them said that their involvement is not at all in household chores. It is concluded that to a great extent majority of the respondents have involvement in daily household chores.

40. Easy availability of Shoe size in markets

Categories	Frequency	Percent
yes	85	85.0
no	15	15.0
Total	100	100.0

Table 40 represents that does respondent's size easily available for shoes in markets? The data shows that 85% said yes their size is easily available in markets for shoes and 15% of them said no. it is concluded that majority of the respondents get their shoe size easily in markets.

41. Easy availability of undergarments in markets

Categories	Frequency	Percent
yes	73	73.0
no	27	27.0
Total	100	100.0

Table 41 represents that does respondent's size easily available for undergarments in markets? The data shows that 73% said yes their size is easily available in markets for undergarments and 27% of them said no. it is concluded that majority of the respondents get their undergarments size easily in markets.

42. Dependency upon maid for messaging

Categories	Frequency	Percent
yes	38	38.0
no	62	62.0
Total	100	100.0

Table no. 42 represents that does the respondent depend upon her maid for messaging? The data shows that 38% of the respondents said yes, they are dependent upon maid for messaging, and 62% of them said that they are not dependent upon maid. Hence it is concluded that majority of the respondents aren't dependent upon their maid for messaging.

43. Dependency upon maid for food serving

Categories	Frequency	Percent
yes	37	37.0
no	63	63.0
Total	100	100.0

Table no. 43 represents that does the respondent depend upon her maid for food serving? The data shows that 37% of the respondents said yes, they are dependent upon maid for messaging, and 63% of them said that they are not dependent upon maid. Hence it is concluded that majority of the respondents aren't dependent upon their maid for food serving.

44. Sweeping in their home

	Frequency	Percent
yes	23	23.0
no	77	77.0
Total	100	100.0

Table no. 44 represents that does the respondent sweep her home? The data shows that 23% of the respondents said that yes, they sweep their home, and 77% of them said no, they don't. Hence it is concluded that majority of the respondents do not sweep their home.

45. Swabing in their home

Categories	Frequency	Percent
yes	12	12.0
no	88	88.0
Total	100	100.0

Table no.45 represents that does the respondent swab in her home? The data shows that 12% of the respondents said that yes, they sweep their home, and 88% of them said no, they don't. Hence it is concluded that majority of the respondents do not swab in their home.

46. Dish washing in their home

Categories	Frequency	Percent
yes	63	63.0
no	37	37.0
Total	100	100.0

Table no.45 represents that does the respondent wash dishes in her home? The data shows that 63% of the respondents said that yes, they wash dishes in their home, and 37% of them said no, they don't. Hence it is concluded that majority of the respondents do not wash dishes in their home.

47. Cooking in their home

Categories	Frequency	Percent
yes	78	78.0
no	22	22.0
Total	100	100.0

Table no.47 represents that does the respondent cook food in her home? The data shows that 78% of the respondents said that yes, they cook food in their home, and 22% of them said no, they don't. Hence it is concluded that majority of the respondents cook food in their home.

48. Washing clothes in their home

Categories	Frequency	Percent
yes	42	42.0
no	58	58.0
Total	100	100.0

Table no.48 represents that does the respondent wash clothes in her home? The data shows that 42% of the respondents said that yes, they wash clothes in their home, and 58% of them said no, they don't. Hence it is concluded that majority of the respondents do not wash clothes in their home.

49. Usage of Salt on daily basis

Categories	Frequency	Percent
one time	55	55.0
3 times	24	24.0
more	21	21.0
Total	100	100.0

Table no. 49 reflects that how much salt does respondent use on daily basis? The data shows that 55% of the respondents use salt 1 time daily, and 24% of them use 3 times daily. Hence it is concludes that majority of the respondents use salt 1 time daily.

50. Usage of sugar on daily basis

Categories	Frequency	Percent
one time	45	45.0
3 times	27	27.0
more	28	28.0
Total	100	100.0

Table no. 50 reflects that how much sugar does respondent use on daily basis? The data shows that 45% of the respondents use salt 1 time daily, and 27% of them use 3 times daily. Hence it is concluded that majority of the respondents use sugar 1 time daily.

51. Usage of pulses in weekly dietary patterns

Categories	Frequency	Percent
daily	20	20.0
once	46	46.0
twice	18	18.0
never	16	16.0
Total	100	100.0

Table no.51 represents that does pulses include in respondent's weekly dietary patterns? The data shows that 20% of the respondents use pulses daily, 46% of them use once in a week, 18% of

them use twice in a week, and 16% of them never use. Hence it is concluded that majority of the respondents take pulses once in a week.

52. Usage of Vegetables in weekly dietary patterns

Categories	Frequency	Percent
daily	46	46.0
once	15	15.0
twice	33	33.0
never	6	6.0
Total	100	100.0

Table no.52 represents that does vegetables include in respondent’s weekly dietary patterns? The data shows that 46% of the respondents use vegetables daily, 15% of them use once in a week, 33% of them use twice in a week, and 6% of them never use. Hence it is concluded that majority of the respondents take vegetables daily.

53. Usage of fried foods in weekly dietary patterns

Categories	Frequency	Percent
daily	21	21.0
once	48	48.0
twice	20	20.0
never	11	11.0
Total	100	100.0

Table no.53 represents that does fried food include in respondent's weekly dietary patterns? The data shows that 21% of the respondents use fried foods daily, 48% of them use once in a week, 20% of them use twice in a week, and 11% of them never use. Hence it is concluded that majority of the respondents take fried foods once in a week.

54. Usage of Sweets in weekly dietary patterns

Categories	Frequency	Percent
daily	22	22.0
once	56	56.0
twice	21	21.0
never	1	1.0
Total	100	100.0

Table no.54 represents that do sweets include in respondent's weekly dietary patterns? The data shows that 22% of the respondents take sweets daily, 56% of them take once in a week, 21% of them take twice in a week, and 16% of them never use. Hence it is concluded that majority of the respondents take sweets once in a week.

55. Usage of Ice-creams in weekly dietary patterns

Categories	Frequency	Percent
daily	15	15.0
once	40	40.0
twice	26	26.0
never	19	19.0
Total	100	100.0

Table no.55 represents that does ice-cream include in respondent's weekly dietary patterns? The data shows that 15% of the respondents take ice-creams daily, 40% of them take once in a week, 26% of them use twice in a week, and 19% of them take never. Hence it is concluded that majority of the respondents take ice-creams once in a week.

56. Usage of Fast foods in weekly dietary patterns

Categories	Frequency	Percent
daily	16	16.0
once	31	31.0
twice	17	17.0
never	36	36.0
Total	100	100.0

Table no.55 represents that does fast food include in respondent's weekly dietary patterns? The data shows that 16% of the respondents take fast food daily, 31% of them take once in a week, 17% of them use twice in a week, and 36% of them take never. Hence it is concluded that majority of the respondents take fried foods not even once in a week.

57. weekly average consumption of oil

Categories	Frequency	Percent
less than 1kg	30	30.0
less than 2kg	35	35.0
less than 5kg	6	6.0
no usage	29	29.0
Total	100	100.0

Table no.57 represents that what is respondent's weekly consumption of oil? The data reflects that 30% of the respondents consume less than 1kg oil, 35% of the respondents consume less

than 2kg, 6% of them consume less than 5 kg, and 29% of them do not use oil. Hence it is concluded that majority of the respondents consume less than 1kg oil in a week.

58. weekly average consumption of ghee

Categories	Frequency	Percent
less than 1kg	33	33.0
less than 2kg	44	44.0
less than 5kg	10	10.0
no usage	13	13.0
Total	100	100.0

Table no.58 represents that what is respondent's weekly consumption of ghee? The data reflects that 33% of the respondents consume less than 1kg oil, 44% of the respondents consume less than 2kg, 10% of them consume less than 5 kg, and 13% of them do not use oil. Hence it is concluded that majority of the respondents consume less than 2kg ghee in a week.

59. weekly average consumption of butter

Categories	Frequency	Percent
less than 1kg	36	36.0
less than 2kg	39	39.0
less than 5kg	7	7.0
no usage	18	18.0
Total	100	100.0

Table no.59 represents that what is respondent's weekly consumption of butter? The data reflects that 36% of the respondents consume less than 1kg butter, 39% of the respondents consume less than 2kg, 7% of them consume less than 5 kg, and 18% of them do not use ghee. Hence it is concluded that majority of the respondents consume less than 2kg butter in a week.

60. weekly average consumption of milk

Categories	Frequency	Percent
less than 1litre	23	23.0
less than 2liters	33	33.0
less than 5liters	38	38.0
no usage	6	6.0
Total	100	100.0

Table no.60 represents that what is respondent's weekly consumption of milk? The data reflects that 23% of the respondents consume less than 1litre milk, 33% of the respondents consume less than 2liters, 38% of them consume less than 5liters, and 6% of them do not take milk. Hence it is concluded that majority of the respondents consume less than 5liters milk in a week.

61. Mental health concerns regarding self esteem

Categories	Frequency	Percent
yes	58	58.0
no	28	28.0
Don't know	14	14.0
Total	100	100.0

Table no.61 represents that what is the mental health concern of respondent regarding self esteem? The data shows that 58% of the respondents have self esteem, 28% of them do not have self esteem, and 14% of them said they don't know about their self esteem. Hence it is concluded that majority of the respondents have their strong self esteem.

62. mental health concerns regarding depression

Categories	Frequency	Percent
yes	41	41.0
no	45	45.0
Don't know	14	14.0
Total	100	100.0

Table no.62 represents that what is the mental health concern of respondent regarding depression? The data shows that 41% of the respondents have self esteem, 45% of them do not depress, and 14% of them said they don't know about being depressed. Hence it is concluded that majority of the respondents do not depress by their personality.

63. Description of general health in comparison to other women

Categories	Frequency	Percent
it is same	38	39.0
poor than others	39	38.0
worst than others	23	23.0
Total	100	100.0

Table no. 63 represents that how would respondent describe her general health in comparison with other women? The data shows that 38% of the respondents described that it is same, 39%

described that it is poor than others, and 23% describes that it is worst than other women. It is concluded that majority of the respondents described their general health poor in comparison with other women.

6.2 Hypothesis testing:

6.2.1. Hypothesis 1

H_1 = There is a significant relation between dense food intake and figure consciousness.

H_0 = There is no relationship between intake of food and figure consciousness.

Level of Significance:

$\alpha = 0.05$

Computation:

Table no.1 Cross Tabulation

Married women take more dense foods, as they are no more figure conscious and weekly usage of fried food in dietary patterns

		Does fried food include in your weekly dietary patterns?			
		daily	once	twice	never
Married women take more dense foods, as they are no more figure conscious?	yes	16	19	10	10
	no	3	29	0	1
	Don't know	2	0	10	0
Total		21	48	20	11

Chi-Square Tests

	Value	df	Asymp. Sig. (2-sided)
Pearson Chi-Square	59.380 ^a	6	.000
Likelihood Ratio	61.166	6	.000
Linear-by-Linear Association	.232	1	.630
N of Valid Cases	100		

a. 4 cells (33.3%) have expected count less than 5. The minimum expected count is 1.32.

Conclusion

The Pearson Chi-square value is .000 which is less than $\alpha = 0.05$. This shows that the data is highly significant. Hence, the researcher approved the alternative hypothesis and rejects the null hypothesis. Results show that married women take more fried foods as they are no more figure conscious.

Table no.2 Cross Tabulation

Married women take more dense foods, as they are no more figure conscious and weekly average consumption of oil

Count

		Weekly average consumption of oil?			
		less than 1kg	less than 2kg	less than 5kg	no usage
married women take more dense foods, as they are no more figure conscious?	yes	3	32	6	14
	no	25	3	0	5
	Don't know	2	0	0	10
Total		30	35	6	29

Chi-Square Tests

	Value	df	Asymp. Sig.
Pearson Chi-Square	73.307 ^a	6	.000
Likelihood Ratio	76.317	6	.000
Linear-by-Linear Association	.038	1	.845
N of Valid Cases	100		

a. 6 cells (50.0%) have expected count less than 5. The minimum expected count is .72.

Conclusion

The Pearson Chi-square value is .000 which is less than $\alpha = 0.05$. This shows that the data is highly significant. Hence, the researcher approved the alternative hypothesis and rejects the null hypothesis. Results show that married women consume more oil as they are no more figure conscious.

Table no.3 Cross tabulation

Married women take more dense foods, as they are no more figure conscious and Daily usage of Sugar

	Usage of Sugar on daily basis			Total	
	one time	3 times	more		
Married women take more dense foods, as they are no more figure conscious?	yes	16	16	23	55
	no	19	9	5	33
	Don't know	10	2	0	12
Total		45	27	28	100

Chi-Square Tests

	Value	df	Asymp. Sig. (2-sided)
Pearson Chi-Square	17.793 ^a	4	.001
Likelihood Ratio	20.678	4	.000
Linear-by-Linear Association	17.203	1	.000
N of Valid Cases	100		

a. 2 cells (22.2%) have expected count less than 5. The minimum expected count is 3.24.

Conclusion

The Pearson Chi-square value is .000 which is less than $\alpha = 0.05$. This shows that the data is highly significant. Hence, the researcher approved the alternative hypothesis and rejects the null hypothesis. Results show that married women use more sugar on daily basis as they are no more figures conscious.

6.2.2 Hypothesis 2

H1=There is a significant relationship between Obesity and less involvement in daily household chores.

H0=There is no relationship between Obesity and involvement in daily household chores.

Table no.1 Cross Tabulation

Description of married women's general health in comparison to other women and act of Sweeping in their home

		Do you sweep in your home?		Total
		yes	no	
Description of married women's general health in comparison to other women	it is same	7	32	39
	poor than others	5	33	38
	worst than others	11	12	23
Total		23	77	100

Chi-Square Tests

	Value	df	Asymp. Sig. (2-sided)
Pearson Chi-Square	10.645 ^a	2	.003
Likelihood Ratio	9.713	2	.008
Linear-by-Linear Association	5.547	1	.019
N of Valid Cases	100		

a. 0 cells (0.0%) have expected count less than 5. The minimum expected count is 5.29.

Conclusion

The Pearson Chi-square value is .003 which is less than $\alpha = 0.05$. This shows that the data is highly significant. Hence, the researcher approved the alternative hypothesis and rejects the null hypothesis. Results show that there is a significant relationship between Obesity and less involvement in daily household chores i-e sweeping in home.

Table no. 2 Cross Tabulation

Description of married women's general health in comparison to other women and act of Sweeping in their home

		Do you wash dishes in your home?		Total
		yes	no	
Description of married women's general health in comparison to other women and act of Sweeping in their home	it is same	10	29	39
	poor than others	30	8	38
	worst than others	23	0	23
Total		63	37	100

Chi-Square Tests

	Value	df	Asymp. Sig. (2-sided)
Pearson Chi-Square	41.005 ^a	2	.000
Likelihood Ratio	48.275	2	.000
Linear-by-Linear Association	38.061	1	.000
N of Valid Cases	100		

a. 0 cells (0.0%) have expected count less than 5. The minimum expected count is 8.51.

Conclusion

The Pearson Chi-square value is .003 which is less than $\alpha = 0.05$. This shows that the data is highly significant. Hence, the researcher approved the alternative hypothesis and rejects the null hypothesis. Results show that there is a significant relationship between Obesity and less involvement in daily household chores i-e washing dishes in home.

Table no.3 Cross Tabulation

Description of married women's general health in comparison to other women and washing clothes in their home

		48.do you wash clothes in your home?		Total
		yes	no	
Description of married women's general health in comparison to other women and washing clothes	it is same	16	23	39
	poor than others	14	24	38
	worst than others	12	11	23
Total		42	58	100

Chi-Square Tests

	Value	df	Asymp. Sig. (2-sided)
Pearson Chi-Square	1.407 ^a	2	.002
Likelihood Ratio	1.399	2	.013
Linear-by-Linear Association	.506	1	.019
N of Valid Cases	100		

a. 0 cells (0.0%) have expected count less than 5. The minimum expected count is 9.66.

Chapter No. 7

SUMMARY, CONCLUSION AND SUGGESTIONS

Conclusion

The Pearson Chi-square value is .002 which is less than $\alpha = 0.05$. This shows that the data is highly significant. Hence, the researcher approved the alternative hypothesis and rejects the null hypothesis. Results show that there is a significant relationship between Obesity and less involvement in daily household chores i.e. washing clothes in their home.

Results

The above statistical tests show that H_0 is rejected and H_1 is accepted. It is concluded that Hypothesis 1; There is a significant relation between dense food intake and figure consciousness. And Hypothesis 2; There is a significant relationship between Obesity and less involvement in daily household chores.

DISCUSSION, CONCLUSION and SUGGESTIONS

Discussion

The research is primarily targeted upon the married women who have been victimized by obesity for last few years. Humans have evolved as a species from hominids that were well-appointed to survive and reproduce in environments that give up an unsteady supply of readily available foods. The more the availability of food, the more it is taken, that result into over weighing of a person or to become an obese person.

Obesity in Pakistan is a health issue that has engrossed only in the past few years. Urbanization and an unhealthy, energy-dense diet, the high presence of oil and fats in Pakistani cooking, as well as change among the lifestyles are the root causes contributing to obesity in the country. According to a list of the world's fattest countries published on Forbes, Pakistan is ranked 165 (out of 194 countries) in terms of its overweight population. This ratio

generally corresponds with other studies, which state one-in-four Pakistani adults as being overweight, so as women after marriage.

Rapidly changing diets and lifestyles are fueling the global obesity epidemic (WHO, 2003). According to recent estimates, there are more than one billion overweight people worldwide and some 300 million of these are estimated to be clinically obese (WHO, 2002). Once considered a problem related to prosperity, obesity is now fast growing in many developing countries and in poor neighborhoods of the developed countries (WHO, 2003; WHO, IASO, & IOTF, 2000). Even in countries like Pakistan, which are typically known for high prevalence of under nutrition, significant proportions of overweight and obese now coexist with the undernourished (Popkin, 2002).

Many overweight and obese patients report that they have not been counseled to lose weight by their primary care provider. Although the diagnosis at times is clear just by looking at the patient, there are useful tools available to clinicians to assess body weight in terms of risk of co-morbid conditions associated with obesity, such as heart disease, hypertension, diabetes, cancer, depression, reproductive disorders, joint and bone pain, among many others. Obesity has also been shown to lead to premature death. Women are more affected by obesity than men, and women tend to have more health complications associated with obesity than men.

The researcher selected the area Shahzad town in Islamabad, because it is far away from the commercial areas of Islamabad. Women living here have relatively higher ratio of being obese. Because majority of them are included in high class which let them zero involvement in their house hold chores. Due to their higher living standards they hired maids and drivers which decrease their work burden. They do not walk, do not work at homes, and do not even cook, in their homes because of the maximum dependency upon maids.

Interview schedule was used for the interviewing; this was prepared with the help of indicators drawn from the literature review. Interview schedule consists of detailed questions, which have further categories. Purposive sampling was used for the data collection. Data was collected through face to face interview as it is the requirement of the interview schedule. After the data collection relationship of variable and statistical analysis was done through SPSS.

Major findings were the entire impacts of obesity on married woman, their self esteem, their mental health concerns and also what their perception of personality in comparison with normal weighing woman.

Researcher observed that majority of the women are satisfied with their physical appearance, they do not even intend to change their personalities, and rather they don't even exercise on daily basis.

It was also found that only 25% of the respondents take medicine/having treatment to overcome obesity.

Researcher observes that only 24% know that they are genetically obese, and 22% of them said that they don't even know whether they are genetically obese or not.

Researcher observes that women do not have any idea of getting more prone to diseases as compared to the ordinary weighing women, for instance, high blood pressure, diabetes, kidney problems, high cholesterol etc.

Majority of them are facing back problems, swelling of hands and feet and high blood pressure.

While some of them are facing breathlessness while talking and asthma.

Fast foods, fried foods, ice-creams, and sweets are vigorously used by them, without any hesitation, without caring their harmful queries.

Conclusion

This study offers current data on obesity. Included are definitions of obesity, clinical tools to assess patients for overweight and obesity. There is a review of the current literature that links obesity to many of the common illnesses and all the social as well as psychological impacts upon married obese woman. Also the chief complaints faced by practitioners at all levels. Important recommendations and emphasize to counsel patients is included in this study.

Sensitive care of obese patients involves self-esteem in the primary care setting. Encouraging compassionate care of obese patients will positively impact the health. This may occur through increased compliance with preventative screening, better attention to co-morbid conditions and more regular medical care. The person, not the obesity, should be the focus of treatment. All of these characteristics are part of world-view and theories of delivering compassionate, effective preventative services of health.

Recommendations

It is suggested by the researcher that people should check in routine about the quality of their diet, whether they have a consistent exercise practice that they enjoy, and their means of balancing and coping with the increasing demands of work and life. In addition counseling for prevention and using alternatives for weight loose should be done.

The researcher recommends that all patients, women in particular, should have weight, height, BMI, and waist circumference assessed regularly after every 3months. This recommendation extends to all health care providers in all settings. It has been observed that healthy adult patients may under-utilize health prevention services, and avail every opportunity to screen and educate women about the health implications of their weight status. They should be fully optimized all over the world in order to reduce the rates of obesity related complications and deaths.

Findings should be individualized and the patient should be counseled about health consequences of weight gain, and appropriate measures taken to ensure the patient adequate counseling on diet, exercise, and behavior modification techniques to improve quality of life.

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ANNEXURE

Interview Schedule

Impacts of Obesity on Married Women In Shahzad Town Islamabad.

Research Supervisor: Mr. Farhan Ahmad Faiz

This questionnaire will be used for academic purpose only and the privacy of the respondents will not be disclosed. Giving correct information will be highly appreciated and will be useful to reach the real facts.

Demographic Profile:

Age:

Occupation:

Qualification:

1. How do you perceive your physical appearance?
 - d) Satisfied
 - e) Depressed
 - f) Non-satisfied

2. Do you intend to change your physique?
 - a) Yes
 - b) No

3. Do you exercise?
 - a) Daily
 - b) Twice a week
 - c) Once in a week
 - d) Not at all

4. Do you take any medicine/having any treatment to overcome obesity?
 - a) Yes
 - b) No

5. Do you ever feel yourself handicapped/dependent upon others?
 - a) Yes
 - b) No
 - c) Sometimes
6. Do you feel you are a problem for your family members most of the time?
 - a) Yes
 - b) No
 - c) Sometimes
7. Do you agree that literate people have less ratio of obesity?
 - a) Yes
 - b) No
 - c) Don't know
8. Does high income in household results in increasing obesity?
 - a) Yes
 - b) No
 - c) Somehow
9. Do you think married women take more dense foods, as they are no more figure conscious?
 - a) Yes
 - b) No
 - c) Don't know
10. Do you ever face husband distraction from you due to obesity? If yes then what was your response?
 - a) Get dishearten
 - b) Go for exercise
 - c) Any Other
11. Do you face social stigmas upon you?
 - a) From husband
 - b) From in-laws
 - c) From other family members
12. Do you face social stigmas upon you from society?
 - a) Yes
 - b) No
 - c) Sometimes
13. Do you face tog-up problems regarding latest fashion dresses?
 - a) Yes
 - b) No

14. Do you think you are genetically an obese woman?

- a) Yes
- b) No
- c) Don't know

15. Have you faced reproduction complications?

- a) Yes
- b) No

16. Do you ever counseled to lose weight?

- a) Yes
- b) No

17. Do you think you have less stamina?

- a) Yes
- b) No

18. Do you know that you are more prone to many of the ordinary diseases like;

	Yes	No
Diabetes		
Blood pressure		
Gall stones		
Kidney problems		
High cholesterol		
Arthritis		

19. Do you face any morbid conditions like;

	To great extent	To some extent	Not at all
Asthma			
Back pain			
Swelling of hands			
Swelling of feet			
Cholesterol level			
Breathlessness while talking			

20. Do you think your mobility decreases due to obesity?
- a) Yes
 - b) No
21. Do you know about the high mortality rate of obese women?
- a) Yes
 - b) No
 - c) Don't know
22. Do you feel yourself embarrassed in public gathering?
- a) Yes
 - b) No
23. Do you feel ashamed in public gathering?
- a) Yes
 - b) No
24. Do you feel ridiculed in public gathering?
- a) Yes
 - b) No



25. Do you face problems while;

	Yes	No	Sometimes
Sitting			
Lying			
Walking			

26. How much time you give to television for leisure?
- a) 3 hours
 - b) 6 hours
 - c) More
27. How much of your involvement is in daily household chores?
- a) To great extent
 - b) To some extent
 - c) Not at all

28. Does your size easily available in markets for ;

	Yes	No
Shoes		
Undergarments		

29. Are you dependent upon your maid for;

	Yes	No
Massaging		
Food serving		

30. What type of daily household chores you do?

	Yes	No
Sweeping		
Swabbing		
Dish washing		
Cooking		
Washing clothes		

31. Amount of sugar and salt is a core factor of obesity, how much do you use on daily basis?

	1 time	3 times	more
Sugar			
Salt			

32. Which of the food items are included in your weekly dietary patterns;

	Daily	Once	Twice	Never
Pulses				
Vegetables				
Fried foods				
Sweets				
Cold drinks				
Ice creams				
Fast foods				

33. What is your weekly average consumption of specific fatty items i-e Oil, ghee, butter, milk

	Less than 1kg	Less than 2kg	Less than 5kg	No usage
Oil				
Ghee				
Butter				
Milk (liters)				

34. If you are a working lady what are your mental health concerns?

	Yes	No	Don't know
Self esteem			
Depression			

35. How would you describe your general health in comparison to other women of your age?

- a) Is it same
- b) Poor than others
- c) Worst than others

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