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ORIGINAL RESEARCH

Measuring Healthy Lifestyle and Mental Health Indicators in South Asian Women Using the "Your Health: Quality of Life and Well-Being" Questionnaire

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Abstract

INTRODUCTION Health is a state of complete physical, mental, and social well-being and not merely the absence of disease or infirmity. A literature review has revealed that there is no specific questionnaire available to assess well-being within the community.

METHODS Fifty South Asian women were randomly selected to complete the "Your Health: Quality of Life and Well-being Questionnaire" assessing diet, lifestyle, and mental health among others. Data from the questionnaires was extracted and participants were categorised based on these findings.

RESULTS This tool has positively identified a number of key risk factors for poor health, symptoms associated with mental illness, and the burden of comorbidities within the assessed cohort. Sixty-three percent of the women had an unhealthy body mass index (BMI), over half did not know the maximum limit of salt per day, and almost one-fourth had multiple health conditions.

CONCLUSIONS This questionnaire is an effective tool to use within the community. There is a significant burden of obesity, complicated by poor lifestyle habits and significant mood and anxiety symptoms within the studied South Asian population.

KEY WORDS diet, health promotion, lifestyle risk factors, mental health, public health, questionnaire, well-being.

INTRODUCTION

Health care provision in the United Kingdom is changing from mainly hospital-based care to care in the community; the number of hospital beds in Great Britain peaked in the 1960s and has been in decline over the last 50 years.[1] Initiatives by NHS England are focusing on a greater emphasis on prevention of disease, which currently only receives 4% of the entire health care budget,[2] with a similar emphasis seen in the budget for health care in the United States of America.[3]

The concept of well-being was incorporated into the definition of health by the World Health Organization in 1946, as follows: "Health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity."[4]

Implying that this construct applies to all people, irrespective of physiological state, over time, the concept of well-being has been dissected and expanded. In 1978, Shin and Johnson defined well-being as a "global assessment of a person's quality of life according to his/her own chosen criteria."[5] Emerson in 1985 and Felce & Pery in 1995 believed that well-being stems from individuals' perceptions of their current situation and their aspirations.[6] Diener and Suh,[7] in 1997, stated that subjective well-being consists of three interrelated

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components: life satisfaction, pleasure effect, and unpleasant effect. Effects refer to pleasant and unpleasant moods and emotions, whereas life satisfaction refers to a cognitive sense of satisfaction with life.[7]

In some circles, this concept is used interchangeably with quality of life; however, this is defined by the World Health Organization as follows:

> "an individual's perception of their position in life in the context of the culture and values systems in which they live and in relation to their goals, expectations, standards and concerns. It is a broad ranging concept effected in a complex way by the person's physical health, psychological state, personal belief, social relationship and their relationship to salient features of their environment."[8]

Quality-of-life assessments have been manipulated to produce quality-of-life tools for specific disease entities (eg, sinonasal disease[9]) and as the conceptual health-related quality of life, whose role in the Centre of Disease Control and Prevention is to "[allow] health agencies to legitimately address broader areas of healthy public policy around a common theme in collaboration with a wider circle of health partners, including social service agencies, community planners, and business groups."[10]

These definitions clarify how quality of life can be considered a distinct aspect of well-being.

The aims of the study were as follows:

1. Identify unhealthy life activities that may have subsequent health-related consequences, in either short, medium, or long term.
2. Identify the burden of chronic disease in the target population.
3. Identify the prevalence of mood symptoms in the target populations.
4. Gage overall well-being of target population using well-being and quality-of-life indicators.[11]

Combining these aims with the aforementioned concepts, the questionnaire took the form of "Your Health: Quality of Life and Well-being Questionnaire" (Supplementary Appendix 1). Questions were developed based on their roles in completing the core aims; a few of the rationales are explained in Table 1.[11-30]

METHOD

The aforementioned questionnaire was used at a national educational convention run by the Ahmadiyya Muslim Community in October 2015. This was a female-only event due to religious reasons and was attended by a large number of South Asian members who were at the event being held in Hampshire, United Kingdom. The questionnaire was completed by 50 randomly selected women who were in attendance. Data were collated and then analyzed.

RESULTS

Fifty female attendees were given the questionnaire, of which all of them were analyzable.

The majority of participants were <44 years old (Fig. 1, yellow fill). Body mass index (kg/m^2) grading was used to assess weight status; <18 = underweight, 19-24.9 = healthy weight, >25-30 = overweight, >30 = obese. Half of all those surveyed were over the healthy weight for their height, with just under 1 in 10 classed as obese. Thirteen percent of the women were underweight.

Fifty-two percent classed themselves as housewives, and 1 in 10 attendees were students. Those who were employed held careers as doctors, teachers, civil servants, and members of the police force.

Of all surveyed, 60% of the women had never counted how many calories they had per day, and 1 in 20 had last counted calories a year or more ago. Twenty-six percent had counted their caloric intake that day or the day before.

Regarding knowledge of fat types, saturated fats are considered in lay terms to be "bad" fats because they are linked to heart attacks and strokes, a concept significantly pushed by public health authorities. Almost 30% of the women did not know which type was considered unhealthy.

The following questions looked at lifestyle habits and activities that can have negative health complications. Regarding fizzy drinks, 4% of the women drank a can of fizzy drink per day, and over a quarter of all surveyed had 3 or more cans per day (Fig. 2). The maximum cans one woman drank per day was 8.

To contextualize this, one small can of a fizzy drink can contain up to 36 g of sugar; the maximum recommended intake of sugar per day for women is 30 g.

Only 1 in 5 women have 5 portions of fruit and vegetables per day, with 54% managing 2-3 portions weekly. Ten percent of the women had either one or no pieces of fruit per week.

The majority of the women (72%) had 2 or more portions of fish per week, and 25% had at least one portion per week (minimum recommendation is 2 portions per week). One in 20 women had no fish at all per week.