

International journal for intersectional feminist studies

The Journal of Project Monma Research Centre

Volume 1, September 2015

ISSN 2463-2945



To cite this article

Aisha Bhatti & Rabia Ali, Lifestyle of working women in modern organization: Implications on health, *International journal for intersectional feminist studies*, 1, pp. 5-28

Lifestyle of Working Women in Modern Organizations: Implications on Health

Aisha Bhatti & Dr. Rabia Ali

Abstract

The relationship between the lifestyle of professional women and their health has been researched across the globe, including in developing countries. However, the area remains under-published in the context of Pakistan. The present study was conducted in 2013 to explore the effects of lifestyle on women's health in public and private organizations in Pakistan. The study was quantitative in nature and a sample of 330 professional women was selected by adopting a purposive sampling technique. A self-designed, close-ended questionnaire was used to collect the data. The results of the study highlight that health is strongly related with the lifestyle choices of the participants in modern organizations. Clearly, transformation and reproduction of gender roles have provided a space for women to enter the public arena to meet the demands of the globalizing world. Yet unfavorable working conditions and excessive work at the workplace coupled with traditional household responsibilities put immense pressure on women. As a consequence of this double pressure along with socio-cultural constraints arising from the existing power structure, professional women do not exercise, skip meals and consume junk food. This in turn leads to stress and health issues such as obesity and cardiovascular diseases among professional women. It is imperative that women realize the importance of maintaining a healthy lifestyle through personal efforts and a change in health behavior.

Keywords: Lifestyle, health, professional women, modern organizations, diet, exercise, sleep, obesity, heart problems, Pakistan

Introduction

Health is not merely the absence of disease but a condition in which an individual feels complete physical, mental, and social fitness. There are various elements that influence the health of an individual. These may include an individual's socio-economic background, physical atmosphere, lifestyle and behavior (WHO, 2009). Scholarship across the world highlights that the healthy lifestyle choices of people play an important role in improving and maintaining the health of people in societies (Brisson et al., 2000; Willett, 2000; Toobert et al., 2001).

Research indicates that the rate of women's employment has amplified globally due to the acknowledgment of women's high level of educational achievement and women's increased

desire for liberation and social recognition. In particular, globalization has brought great freedom to women, especially those living in traditionally conservative countries. In countries like Indonesia and Thailand women have been able to be economically independent and to have at least some choices in their personal lives (Mandle, 2001). In the modern globalized world the public space is rapidly expanding for women. However, demand for efficiency has laid great pressure on women to adapt to the needs of the capitalist market. This in turn has resulted in increasing changes in lifestyle of women across the world, where they get to spend minimum time on physical exercise and their eating and sleeping habits have changed too. These changes have been reported to affect their health adversely (Mozaffarian et al., 2011).

The effects of the changing lifestyle of women on their health behavior have been researched across the globe including in the developing countries (Katalin, 2008; Brisson et al., 2000). Studies have shown that the lifestyle of females of all age groups is shaped by a series of factors including demographic, epidemiological, social, cultural, economic and environmental (Denton, 2004; Katalin, 2008). These same factors also affect the lives of males but not as much as they affect girls and women (Ross & Bird, 1994; WHO, 2009).

Studies across the world have found that problems associated with an individual's lifestyle and behavior include lack of exercise, improper dieting and sleep (Appel, 2005; Autenrieth et al., 2011; Johanna & Jachens, 2004). Globally, an increasing number of women have been reported to be associated with cardiovascular complaints, obesity, diabetes, cancer, and excessive body weight which could be prevented through healthy lifestyle choices (Katalin, 2008; Laaksonen, 2001).

The President's Council on Fitness, Sports and Nutrition (2009) indicates that having increased body fat is a major threat for women's health. For professional working women this is largely because of the long working hours followed by a commitment to household chores and child rearing at home with limited opportunities to exercise and get engaged in leisure activities (Caruso et al, 2004; Denton, 2004; Artazcoz et al., 2007). Health administrators across the world have argued that lack of physical activity is one of the most persistent health issues of modern times. Most adults, especially women, do not undertake the recommended amount of regular exercise and are involved in sedentary activities (Centre of Disease Control, 2013). According to the World Health Organization (2004), lack of physical activity contributes to approximately

12% of falls in the elderly, 17% of diabetes and heart disease and ten percent of breast cancer and colon cancer. Specialists recommend that people should perform some kind of aerobic activities at least three times during the week.

In the context of Pakistan, technological advancements such as computers, elevators and personal vehicles have reduced physical activities of people at home and at the workplace. Due to social insecurity and worse law and order situations, people, especially women, avoid walking and utilize public or private transportation in daily life (Samir, et al., 2011; Sherin, 2013; WHO, 2004). Consequently, unhealthy behaviors such as unbalanced dietary habits and lack of physical activity have been reported to be the main contributing factors for the increased prevalence of coronary heart disease and obesity in the country (Samir et al., 2011; WHO, 2004).

Besides physical exercise, maintaining the required amount of sleep is also important to stay healthy and fit. Johanna and Jachens (2004) have argued that in industrialized nations many women report some kind of sleep problem. Sleep disorders are not actually the illness but the symptoms of multiple physiological, psychological, and spiritual deficiencies. Frank (2005) stated that one of the reasons for mood disorder is lack of sleep or too much sleep. It is important to maintain a regular schedule of sleep, whenever it is possible.

Balance between work and life is essential for working women to maintain good physical and mental health, but the multiple responsibilities of women as homemaker and worker have caused various health problems for them (Frazier, 2010). The health of women is imperative for the productivity of organizations and for the family and society at large, in which they play dynamic and multiple roles. To be able to perform well women need to have a balanced life.

In Pakistan, health is one of the major problems for the population. The issues related to health lead to a financial burden on the already struggling economy of the country (Wang et al., 2010). Women in the context of Pakistan constitute a significant proportion of the population of the society. Recently women's labor force participation rates have increased steadily. Globalization is believed to have contributed to women's development. Foreign direct investment and the private sector are reported to have positively influenced the status of women in the country (Bashir & Fida, 2012). However, as women's traditional roles have been transformed with increasing participation in public space, they have encountered new health risks which affect their existing professional exposure. Women have to follow the socially constructed model of

femininity, which limits their abilities to make independent decisions. This societal expectation also forces them to abide by the norms that restrict their activities and exclude them from the larger society, of which they are a significant part. Therefore, health and socio-cultural reforms are necessary for women's socio-economic development (Subbarao & Raney, 1995). Nevertheless, to start with, it is imperative to understand the issues related to women's health from the personal experiences of women.

Taking this as a point of departure, this study aims to explore the lifestyle of professional women in contemporary work organizations of Pakistan and its influence on women's health. The study is significant since it will provide a space to explore the health status of qualified women in the context of Pakistan, which is an under-researched area.

Methods and measurements

The quantitative study was undertaken in Islamabad and Rawalpindi, Pakistan, in the year 2013. A sample of 330 women was selected by adopting a convenient sampling technique. This technique was chosen due to the unavailability of a sampling frame. The sample represented the entire universe of the study. The sample was selected from banks and telecom organizations only because the study wanted to focus on modern organizations. Written, signed, informed consents were taken from all the selected respondents. The data was stripped of personal identifiers before release to the public. Therefore, this study was exempted from Institutional Review Board consideration.

Instrument

A self-designed, close-ended questionnaire was developed to evaluate the impact of lifestyle on the health of professional women. The contents of the questionnaire were developed through an extensive review of relevant literature. It was designed to measure different dimensions of lifestyle and health. It had two parts. Part-A consisted of three subscales of lifestyle to assess diet, physical activities and sleeping routines of participants. Part-B consisted of two subscales of health to assess their heart problems and obesity. Each scale consisted of a list of questions and the responses were measured by using the five points Likert scale. Responses included very often (1), often (2), rare (3), very rare (4) and never (5).

The instrument was designed to obtain information relevant to the objectives of the study and to collect the information with maximal reliability and validity. The validity of the questionnaire was checked before data collection. It was ensured that it accurately measures what it aims to do, regardless of who responds, when they respond, and to whom they respond or when self-administered.

The instrument was compared against the available “Gold standard”. The methods used for the validation of the instrument were face validation, content validation and construct validation. At the first stage of the validation, the questionnaire was given to the specialists for the face validation. They were requested to determine if the instrument seems to measure the target variables. The experts assessed whether the test "looks valid" in term of appropriateness of the instrument to examine the lifestyle and health of professional women. In the second stage, experts’ judgments were used to check out the validation of the contents. They determined whether the contents are representing all the facets of lifestyle and health. In the third step, construct validation was used to determine the reliability of the instrument. The instrument was finalized for the data collection after the reliability test of each index of lifestyle and health. To estimate the reliability of the instrument, researchers did a pilot study and interviewed 60 working women. The test of Cronbach’s Alpha was used for this purpose. An Alpha coefficient was obtained of the lifestyle and health index. It was altered and rephrased in this process.

Variables

Lifestyle: It was the independent variable for this study. It was measured through constructing three subscales: diet (dieting habits and refreshment at workplace), physical activity (exercise and household activity) and sleeping habits. The participants were asked to respond to questions in each subscale. Diet was measured by two separate list of questions. Questions about dieting habits included items: bread, cereals, vegetables, fruits, milk, meat/beef/chicken/fish, food containing fats and drinks containing sugar. The responses were measured by using the Likert scale. Responses of this index ranged from very often (1) to never (5). The reliability (Cronbach’s Alpha) of this index was 0.788. Refreshment of participants at their workplace was measured through asking them about items: burger, *samosa (local pastry)*, *chat (local dish)*, *dahibry (local dish)*, fries, rice, meal items, *salan (curry)*, *nan (bread)*, drinks or juices, and tea. The Cronbach’s Alpha of this index was .833.

Physical exercise was the second subscale. It was measured through questions about exercise — regular walking, jogging, bicycling, dancing, badminton and table tennis — and household activities — cleaning, washing clothes, dish washing, ironing and cooking. The reliability of this index was 0.800 and 0.766 respectively.

Sleeping routines were measured by asking about the frequency of difficulty of getting up, taking a nap, waking up at night, sleepiness or low energy in day and un-refreshing sleep. The reliability (Cronbach's Alpha) of this index was .776.

Health: It was the dependent variable and primary area of interest for the study. Two subscales, heart problems and obesity, were developed to study the health problems of the respondents. The scale of heart problems included questions about relevant symptoms: palpitation or irregular heartbeats, fast heart beat, weakness or dizziness, loss of consciousness, discomfort, heaviness, or pain in the chest, arm, or below the breastbone and discomfort radiating to the back, jaw, throat, or arm. The obesity scale consisted of questions about sweating, snoring, difficulty in doing daily physical activities, feeling very tired every day, back and joint pains and increased weight. The reliability of these indexes was 0.838 and 0.826 respectively.

Data analysis

The data was analyzed by SPSS version 17. Descriptive statistics included frequency, percentage, mean and standard deviation. The Pearson Bivariate Correlation Model was used to determine the strength of the relationship between lifestyle and health of the participants. The modifying variables were developed by SPSS version 17 for analyzing the correlation between lifestyle and health.

Results

The mean age of respondents in the current study was 28 years with SD of four years. The respondents aged between 20 to 29 years were 77%, between 30 to 39 years were 18%, and above 39 years were 5%. In the study 54% of respondents' income was ranged from Rs. 20,000/- to Rs. 40,000/-, whereas 25% were earning below Rs. 20,000/- and 21% of respondents' income was above Rs. 40,000/-. Unmarried respondents were 60%, whereas married were 36%, divorced were three percent and separated were only one percent. The results will be discussed in the light

of the research aim, i.e., to investigate the lifestyle of the respondents and explore how lifestyle affects their health.

First is the question of lifestyle. It is well-known that a balanced diet is essential for a healthy life (US Food Standard Agency, 2001). It has been reported in previous studies that the concept of a healthy diet in Pakistan is changing rapidly. People in contemporary Pakistan prefer to eat an “energy-dense” diet. It is rich in saturated fats, trans-fatty acids and sugar. In celebration of special events, meat, sweets, oil and sugared fizzy drinks are frequently used. Inflation is also on the rise in Pakistani society so people use cheaper sources of energy such as fats and sugar. Fast food and junk food are also very popular among people in urban areas (Sherin, 2013).

To determine the health of the respondents, it was important to study their diet patterns. This was measured by using two subscales including meals and snacks consumed by respondents at the workplace. Table 1 presents the information about the meals consumed by respondents. The data shows that the eating patterns of the respondents varied. For example, only 22% women often consumed cereals while 26% reported that they rarely ate cereals. Fruits, milk, vegetables and meat were often consumed by 41%, 28%, 46% and 48% of respondents respectively. On the other hand, 37% of the respondents reported to consume fatty food and drinks containing sugar. The quantity of fats in the food was high because it was reported to have been ordered from restaurants due to long working hours. The data shows that though a good number of respondents consumed healthy food, there were many who had unhealthy habits due to time constraint, work pressure and related causes at work. Previous research across the world reveals that unhealthy food including fats can lead to numerous health issues in people such as obesity and cardiovascular disease (Appel et al., 2005).

Snacking at the workplace was reported to be a common practice by a large number of women. This was largely due to time constraints due to long working hours and work pressure. Most of these snack items are usually taken from restaurants and contain many fats and unhealthy elements. These include burgers, *samosa* (local pastry), fries and *Chat* (local dish made of yogurt). The results of the study show that 22% women reported to eat burgers, 29% reported to eat *samosa* (local pastry), 22% reported to eat fries and 24% reported to eat *chat* at their workplace. The intake of tea was also reported to be high among the women as reported by 48%. One woman reported that she took tea four to five times at her workplace. Drinks that contain

sugar were reported to be taken by 38% of women in contrast to 11% of women, who drank them very rarely (see Table 2).

Physical activities are also important to sustain or enhance physical well-being and health. These are also helpful for strengthening the muscles and the cardiac system, losing weight and receiving enjoyment (Autenrieth et al., 2011; Reiner, 2011). In the present study physical exercise was measured by two subscales that included exercise and household activities. Table 3 shows the evidence of the exercise routine of the respondents. The results highlight that the majority of the women do not get involved in regular physical activities. The data reveals that the only rigorous exercise undertaken by the respondents was walking as reported by 25% of respondents. Other kinds of aerobic exercises were performed by very few working women. Results showed that jogging, bicycling and dancing were quite uncommon as shown by 54%, 70% and 59% of respondents respectively. Similarly, badminton and table tennis were reported to never have been played by 59% and 69% of respondents respectively. It was found that the majority of the women recognized the importance of exercise for good health, but they reported that they were unable to spare time for exercise due to their hectic work routine. One woman reported that she had to manage the dual responsibilities of home and workplace; therefore, she could not spare time for physical exercise.

A large number of women were of the view that socio-cultural values such as modesty restricted them from participating in aerobic exercises such as jogging, dancing and riding a bicycle. Furthermore, they were not allowed to perform the exercises in the presence of men. Similar findings were reported by Begum (2002) who found in her study that women were expected to conform to certain codes in Pakistani society. The need to restrict women's mobility arises from the customs of the "honor and shame" of the family. The Muslim custom of '*Purdah*' (veil) also limits the physical activities of women.

Table 4 represents household activities of the respondents. It contains clear evidence of the kind of burden and double-edged pressure faced by women at work and at home. Research into the social determinants of women's health has been dominated by the role framework in which women's primary role is as housewives and mothers, and paid employment is an adjunct (Artazcoz et al., 2007; Borrell et al., 2004). Household maintenance is one of the primary responsibilities of all women in Pakistani society.

The results of this study show that despite the work load at the workplace, the majority of the women also performed their household activities. This pattern, which is also evident in the context of other South Asian countries including India and Bangladesh, shows that the burden on women has actually increased as they are expected to contribute financially within their households. However, it does not change the socio-cultural expectation from them to look after their families. Hence, changes in gender roles are evident in terms of only men being the key bread earner, but not much change has been seen in the traditional gender roles of women being the primary care-taker.

The data highlights that household chores like cleaning, dish washing, ironing of clothes and cooking were most frequently done by 31%, 34%, 56% and 34% of respondents respectively as compared to 10%, 8%, 8% and 6% of respondents who performed these activities very rarely. Many women reported that managing the household was one of their primary responsibilities. In particular, married women reported to have no escape from any of these activities, and they received little help from their male counterparts in performing these chores.

Besides diet and exercise, adequate sleep is essential for the well-being of a person. Previous research shows that inadequate sleep for a long duration of time or attaining poor quality sleep increases the risk of having heart disease, hypertension, obesity, stress and depression (Ram et al., 2010). In this research the majority of the respondents reported that they were unable to get good sleep due to their busy routine in life and increasing responsibilities. Consequently, they reported to feel sleepy and to have low energy throughout the day.

The findings also show that the majority had difficulty in falling asleep and waking up in the morning. Data indicates that 30% of respondents reported to feel difficulty getting up in morning, while 26% reported to feel difficulty falling sleep at night. Another 33% of respondents reported that they felt sleepy or had low energy during the day. Of respondents, 28% reported to wake up frequently at night, 26% reported interrupted sleep and 19% said that they often took a nap. One of the women stated that her sleeping routine was disturbed due to the long working hours. She said she often had to work overtime and was unable to get refreshing sleep. A number of women reported that they had experienced tensions and depressions due to work pressures. Consequently, they experienced interrupted sleep (see Table 5).

Having discussed the lifestyle of the respondents, the remainder of this paper will focus on the influence of lifestyle on the health of respondents. The study found that the unhealthy lifestyle of the respondents had led to a number of issues related to their health. Previous research literature indicates that the lifestyle of a person influences the health of that person. Studies across the globe show that individuals who are less involved in exercise and do not eat a balanced diet face a number of health problems including obesity, cardiovascular disease, diabetes, stress and depression (Appel, 2005; Mozaffarian, 2011). The results of this study indicate the prevalence of different symptoms of heart problems among professional women (see Table 6). Respondents reported that they often experienced the symptoms of cardiovascular disease. Data indicates that respondents often felt weakness or dizziness (30%), shortness of breath (18%) and fast heartbeat (17%). Data also shows that 13% of respondents reported that they frequently experienced palpitations (irregular heartbeats or a "flip-flop" feeling in chest). One participant reported that a tough schedule at work made it hard to get involved in physical activities and consuming a healthy diet. Consequently, she often experienced these symptoms.

Loss of consciousness was reported by 9% of respondents. Only 16% reported discomfort, pressure, heaviness, or pain in the chest, arm, or below the breastbone while 25% sometimes felt this problem. Of respondents, 12% reported to feel discomfort radiating to the back, jaw, throat, or arm as compared to 30% of respondents who rarely reported to feel it (Table 6). Similar findings have been reported in previous studies. Scholarship illustrates that there are a number of risk factors for women that increase the risk of Coronary Heart Disease (CHD) among women, comprised of an inactive way of life, high-cholesterol diet and social segregation (Herman, 2007; Mozaffarian et al., 2011). Studies indicate that it is important to recognize that multiple risk factors are necessary to address CHD because no single factor can address the complex relations between health behavior, the social setting, and maintenance of health (Willett, 2000).

Above, it was discussed that the unhealthy lifestyle of the respondents affected their sleeping patterns and energy level. . Similarly, the effect of an unhealthy lifestyle can be reflected in the physical appearance of individuals and obesity is one example of this. Obesity negatively impacts the health of women in many ways. Being overweight or obese increases the relative risk of diabetes and coronary artery disease in women. Working women in contemporary work organizations feel tired and they also feel pain in back and joints frequently due to continuously

sitting in the office. Data shows that they are less engaged in physical activities and consume fatty foods.

Table 7 indicates the symptoms of obesity among respondents. It shows that 31% felt very tired every day, 26% reported back and joint pains and 22% reported increased weight. Another 18% reported breathlessness and 17% sweat a lot. Of respondents, 15% had difficulty in doing daily physical activities and only six percent of participants reported snoring. Many women said that their body weight had increased after they had started employment. They attributed this to their intake of food, including having high-cholesterol food at work, and the inability to spare time for exercise due to long working hours.

The results of the study highlight that lifestyle including diet, physical activities and sleeping routines have a significant relationship with indicators of health: heart problems and obesity. The fact that it is significant is evidence that there is a systematic co-relation between the health indicators mentioned above and lifestyle. Heart problems have positively correlated with the lifestyle of professional women and their Pearson Correlation is 0.307, whereas the Pearson correlation of obesity is 0.248. Results indicated that correlations of both heart disease and obesity are significant at 0.01 levels (see Table 8).

Discussion

The present study intended to explore the impact of lifestyle on the health of women working in contemporary organizations of Pakistan. The study highlighted that the burden on women has increased as they are expected to contribute financially within their households, but it has not changed the socio-cultural expectations such as looking after their families. It is clear that changes in gender roles are evident in terms of only men being the key bread earner, but not many changes in traditional gender roles of women are observed, like being the primary care-taker. This is one of the major challenges for them in maintaining their healthy lifestyle.

The study demonstrated that the responsibilities of women at the workplace and at home have affected their health negatively. The findings of the study have clearly established that the nature of work and the double burden (household and job) do not allow women to consume a balanced diet, and they often rely on junk food during office hours. Similar findings have been reported in previous research where consumption of junk food and drinks containing sugar has been reported

to affect the health of individuals. For example, in the US according to the US Food Standards Agency (2001), the Balance of Good Health is based on the Government's Eight Guidelines for a Healthy Diet. Two of them are that one should not eat too many foods containing a lot of fat and avoid consuming sugary foods and drinks too often.

In addition, the data illustrates that women seldom took initiatives to undertake regular exercise — owing to professional burdens and socio-cultural expectations of maintaining modesty — which is an important part of health maintenance. The findings of this study show that the only exercise managed by the women was walking. The results indicate that most of the women were aware of the significance of regular exercise but they were unable to spare time for it in their busy lifestyle. This resonates with the Pakistani society where women are mostly restricted in performing aerobic exercises due to customary barriers and social insecurities. They often depend on male members to perform physical activities like walking, jogging and dancing due to the unavailability of culturally-sensitive facilities such as women parks and gyms. In addition, the double pressure at work and at home does not permit women to get engaged in physical exercises.

Several studies have highlighted that gender has influenced the habits of Asian populations to be able to engage in exercises. These studies found lower levels of physical activities among Asian women (Krishnan et al., 2008; Khueaja and Kadir, 2010). Chopra et al. (2013) have highlighted in their study that a majority of South Asian women spend their leisure time in household responsibilities and taking care of the extended family. It limits their time for participating in regular physical activities. They found that a lack of physical activities leads to a greater risk of obesity levels among Asian women. Similarly, Willett (2000) has noted that physical exercise is necessary to maintain physical fitness and overall health and well-being of people. Likewise, Herman (2007) found that regular physical exercise strengthens the immune system of a person and helps to prevent the "diseases of affluence" such as obesity, cardiovascular disease, heart disease and diabetes. Frans and Wacker (2005) also emphasized that increased physical activity helps to increase life expectancy, and in old age it helps to improve quality of life and the ability of a person to continue enjoying work and recreation.

The study also indicated that working women do not get proper sleep. It has been found in previous studies that the required amount of sleep is very important for a healthy life. Jetter and

Cassady (2006) have found that lack of sleep or too much sleep can worsen a person's moods. So, one should try to maintain a regular sleep schedule. Johanna (2004) stated that sleep disorders are a very common problem. In industrialized communities especially, many people suffer from some form of sleep disorder. He said that sleep disorders are not illnesses; rather, they are indications of a variety of physical and mental health issues.

The results of the present study show a significant relationship between lifestyle and health of professional women. The result of Pearson correlation analysis indicates that improper diet, exercise and sleeping habits of working women increase the symptoms of cardiovascular disease and obesity among them. Similarly, the findings of this study also highlight that due to an unhealthy lifestyle, extended working hours and work-related stress in meeting deadlines, the majority of the participants were found to be affected by diseases such as heart problems, hypertension and overweight.

There is enough evidence in previous research to support the argument that health behavior and lifestyle have an impact on health. Mukkhupadhah (1997) pointed out that two-thirds of Indian working women suffer from behavior disorders, and 53% of them skip meals and go for junk food due to work deadlines and pressure. The survey also indicated that 68% of working women in the age bracket of 21-52 years were found to be suffering from lifestyle illnesses such as obesity, chronic backache, diabetes and hypertension. As indicated by the Asian-specific BMI cutoff of 23 kg/m² one-fourth of the general population in Pakistan is overweight or obese (Jafar, Chaturvedi, & Pappas, 2006). Significant factors include gender, urbanization, high educational attainment and high socio-economic status of people (Bahadur et al., 2013). Obesity is prevalent in the majority of the Pakistani population in recent decades and needs prevention by taking proper measures. Genetic predilection, customs, sedentary lifestyle, sleeping habits and dietary behaviors are contributing factors to obesity (Sherin, 2013). According to Bonanno (2000), a number of behavior-related Coronary Heart Disease (CHD) risk factors have been identified for women, including sedentary lifestyle, high-fat diet, exaggerated stress responses and social isolation.

Limitations

Besides the broad significance, there are certain limitations of this study. First, the unavailability of a sampling frame of working women in selected sectors (bank and telecommunication) restricted researchers to utilizing a purposive sampling technique. Second, due to the cross-sectional design, a temporal relation between the selected variables was not possible to be assessed. Third, a self-designed questionnaire was used due to the unavailability of the standard scales for measuring selected variables. It might have resulted in misclassification of information and lack of comparability of results to those from studies that have used standard instruments. Lastly, this study was conducted only in the two cities of Pakistan (Rawalpindi and Islamabad); therefore, the findings cannot be generalized to the entire population of working women across Pakistan.

Conclusion

The current study attempted to analyze the impact of lifestyle on the health of professional women. The findings highlight that the context in which women live is of great importance to their health status and quality of life. It was evident that the reproduction and transformation of gender roles has actually over-burdened women. While they have begun to contribute to their family income, they continue to perform their traditional roles. This indicates that women's access to work does not change the socio-cultural expectations automatically. The paper argues that this remains one of the major challenges for women in maintaining their health. It can be concluded that health is maintained and improved through the efforts and behaviors of the individuals. It is important that women should understand this for their long term health.

TABLE 1 Meals of Respondents

Roti (bread)	232	77	14	5	2
	(70.3%)	(23.3%)	(4.2%)	(1.5%)	(0.6%)

¹ V Often = Very Often

² V Rare = Very Rare

Cereals	46 (13.9%)	73 (22.1%)	86 (26.1%)	70 (21.2%)	55 (16.7%)
Fruits	81 (24.5%)	138 (41.8%)	71 (21.5%)	30 (9.1%)	10 (3.0%)
Vegetables	111 (33.6%)	153 (46.4%)	38 (11.5%)	20 (6.1%)	8 (2.4%)
Milk	104 (31.5%)	93 (28.2%)	62 (18.8%)	37 (11.2%)	34 (10.3%)
Meat/beef/chicken/fish	109 (33.0%)	160 (48.5%)	37 (11.2%)	13 (3.9%)	11 (3.3%)
Food containing fats	41 (12.4%)	123 (37.3%)	97 (29.4%)	44 (13.3%)	25 (7.6%)
Meal Items	V Often	Often	Rare	V Rare	Never
Drinks containing sugar	50 (15.2%)	124 (37.6%)	81 (24.5%)	47 (14.2%)	28 (8.5%)

Source: Survey

TABLE 2 Snacks at Workplace

Burger	32 (9.7%)	73 (22.1%)	101 (30.6%)	60 (18.2%)	64 (19.4%)
<i>Samosa (local pastry)</i>	26 (7.9%)	96 (29.1%)	90 (27.3%)	75 (22.7%)	43 (13.0%)
<i>Chat (local dish)</i>	25 (7.6%)	81 (24.5%)	113 (34.2%)	69 (20.9%)	42 (12.7%)
<i>Dahibry (local dish)</i>	24	75	89	85	57

	(7.3%)	(22.7%)	(27.0%)	(25.8%)	(17.3%)
Fries	37 (11.2%)	107 (32.4%)	88 (26.7%)	50 (15.2%)	48 (14.5%)
Rice	68 (20.6%)	153 (46.4%)	48 (14.5%)	28 (8.5%)	33 (10.0%)
Meal Items	V Often	Often	Rare	V Rare	Never
<i>Salan (curry)</i>	90 (27.3%)	123 (37.3%)	44 (13.3%)	30 (9.1%)	43 (13.0%)
<i>Nan (Bread)</i>	75 (22.7%)	121 (36.7%)	60 (18.2%)	38 (11.5%)	36 (10.9%)
Drinks/Juices	84 (25.5%)	126 (38.2%)	62 (18.8%)	38 (11.5%)	20 (6.1%)
Tea	160 (48.5%)	86 (26.1%)	27 (8.2%)	31 (9.4%)	26 (7.9%)

Source: Survey

TABLE 3 Physical Activities

Regular walk	55 (16.7%)	84 (25.5%)	76 (23.0%)	69 (20.9%)	46 (13.9%)
Jogging	12 (3.6%)	32 (9.7%)	48 (14.5%)	57 (17.3%)	181 (54.8%)
Bicycling	7 (2.1%)	17 (5.2%)	28 (8.5%)	47 (14.2%)	231 (70.0%)
Dancing	11 (3.3%)	42 (12.7%)	27 (8.2%)	54 (16.4%)	196 (59.4%)
Badminton	6 (1.8%)	33 (10.0%)	49 (14.8%)	68 (20.6%)	174 (52.7%)
Table tennis	5 (1.5%)	19 (5.8%)	28 (8.5%)	48 (14.5%)	230 (69.7%)

Source: Survey

TABLE 4 Household Activities

Cleaning	104 (31.5%)	138 (41.8%)	46 (13.9%)	34 (10.3%)	8 (2.4%)
Washing clothes	75 (22.7%)	95 (28.8%)	67 (20.3%)	50 (15.2%)	43 (13.0%)
Dish washing	115 (34.8%)	103 (31.2%)	76 (23.0%)	28 (8.5%)	8 (2.4%)
Ironing	186	72	34	28	10

	(56.4%)	(21.8%)	(10.3%)	(8.5%)	(3.0%)
Cooking	115	106	69	21	19
	(34.8%)	(32.1%)	(20.9%)	(6.4%)	(5.8%)

Source: Survey

TABLE 5 Sleeping Routines

Difficulty falling sleep at night	26 (7.9%)	88 (26.7%)	99 (30.0%)	62 (18.8%)	55 (16.7%)
Difficulty getting up	73 (22.1%)	102 (30.9%)	80 (24.2%)	42 (12.7%)	33 (10.0%)
Take nap	29 (8.8%)	63 (19.1%)	101 (30.6%)	82 (24.8%)	55 (16.7%)
Wake frequently at night	26 (7.9%)	95 (28.8%)	88 (26.7%)	81 (24.5%)	40 (12.1%)
Sleepiness/low energy in day	41 (12.4%)	110 (33.3%)	96 (29.1%)	58 (17.6%)	25 (7.6%)
Un-refreshing sleep	31 (9.4%)	87 (26.4%)	110 (33.3%)	60 (18.2%)	42 (12.7%)

Source: Survey

TABLE 6 Symptoms of Heart Disease

Shortness of breath	24 (7.3%)	62 (18.8%)	76 (23.0%)	57 (17.3%)	111 (33.6%)
Palpitation/irregular heart beats	6 (1.8%)	46 (13.9%)	87 (26.4%)	55 (16.7%)	136 (41.2%)
Fast heart beat	17 (5.2%)	59 (17.9%)	90 (27.3%)	76 (23.0%)	88 (26.7%)
Weakness/dizziness	21 (6.4%)	101 (30.6%)	101 (30.6%)	52 (15.8%)	55 (16.7%)
Loss of consciousness	10 (3.0%)	31 (9.4%)	61 (18.5%)	77 (23.3%)	151 (45.8%)
Discomfort, heaviness, or pain in the chest, arm, or below the breastbone	7 (2.1%)	54 (16.4%)	84 (25.5%)	83 (25.2%)	102 (30.9%)
Discomfort radiating to the back, jaw, throat, or arm	11 (3.3%)	42 (12.7%)	100 (30.3%)	76 (23.0%)	101 (30.6%)

Source: Survey

TABLE 7 Symptoms of Obesity

Breathlessness	12 (3.6%)	62 (18.8%)	68 (20.6%)	57 (17.3%)	131 (39.7%)
Sweating a lot	15 (4.5%)	56 (17.0%)	99 (30.0%)	98 (29.7%)	62 (18.8%)
Snoring	5 (1.5%)	22 (6.7%)	56 (17.0%)	94 (28.5%)	153 (46.4%)
Difficulty in doing daily physical activities	7 (2.1%)	50 (15.2%)	91 (27.6%)	114 (34.5%)	68 (20.6%)
Feeling very tired every day	26 (7.8%)	104 (31.5%)	67 (20.3%)	76 (23.0%)	57 (17.3%)
Back and joint pains	33 (10.0%)	88 (26.7%)	70 (21.2%)	72 (21.8%)	67 (20.3%)
Increased weight	21 (6.4%)	74 (22.4%)	67 (20.3%)	71 (21.5%)	97 (29.4%)

Source: Survey

TABLE 8 Correlations between Health Behavior and Indicators of Health

Variables	R	p	n
Heart problem	.307**	.000	330
Obesity	.248**	.000	330

**. Correlation is significant at the 0.01 level (2-tailed).

References

- Appel, L., Sacks, F., & Carey, V. (2005). Effects of protein, monounsaturated fat, and carbohydrate intake on blood pressure and serum lipids: results of the Omni Heart randomized trial. *JAMA*, *294*, 2455-64.
- Artazcoz, L., Cortès, I., Borrell, C., Escribà-Agüir, V., & Cascant, L. (2007). Gender perspective in the analysis of the relationship between long work hours, health and health-related behavior. *Scand J Work Environ Health*, *33*, 344-50.
- Autenrieth, C. S., Baumert, J., Baumeister, S. E., et al., (2011). Association between domains of physical activity and all-cause, cardiovascular and cancer mortality. *European Journal of Epidemiology*, *26*, 91-99.
- Bahadur, S., Yousaf, M., Ayaz, H. M., Sohail, Z., Rehman, A. U., & Baloch, S. (2013). Self reporting of obesity, overweight and health risks among 1st year MBBS students of Rehman medical college, Peshawar. *Khyber Med University Journal*, *5*(2), 98-102.
- Bashir, M. Z. & Fida, A. (2012). Effects of globalization on women in Pakistan. *Humanomics*, *28*(3), 180-186.
- Dijkstra, A. G. & Hanmer, L. C. (2002). *Measuring Socio-Economic Gender Inequality: Towards an Alternative to the UNDP Gender-related Development Index*. Working Paper Series. Institute of Social Studies, The Hague, 1: 30.
- Borrell, C., Muntane, C., Benach, J., & Artazcoz, L. (2004). Social class and self-perceived health status among men and women: what is the role of work organization, household material standards and household labour. *Social Science Medicine*, *58*, 1869-87.
- Bonanno, P. (2000). Women: the emerging economic force. *Women Entrepreneurs in the Global Economy*. Retrieved June 15, 2013 from <http://www.cipe.org/programs/women/pdf/jalbert.pdf>.
- Brisson, C., Larocque, B., Moisan, J., Vezina, M., & Dagenais, G. R. (2000). Psychosocial factors at work, smoking, sedentary behavior, and body mass index: a prevalence study among 6995 white collar workers. *Journal of Occupational and Environmental Medicine*, *42*(1), 40-6.

- Caruso, C. C., Hitchcock, E. M., Dick, R. B., et al. (2004). *Overtime and extended work shifts: Recent findings on illnesses, injuries and health behaviors*. Cincinnati: US Centers for Disease Controls. National Institute for Occupational Safety and Health.
- Centers for Disease Control and Prevention. (2013). Retrieved from <http://www.cdc.gov/physicalactivity/everyone/guidelines/index.html>.
- Chopra, S. M., Misra, A., Gulati, S., & Gupta, R. (2013). Overweight, obesity and related non-communicable diseases in Asian Indian girls and women. *Eur J Clin Nutr*, 67(7), 688-696.
- Denton, M. (2004). Gender Differences in Health: A Canadian Study of the Psychosocial, Structural, and Behavioral Determinants of Health. *Social Science and Medicine*, 58, 2585-2600.
- Frans, J. T & Wackers, M.D. (1999). Exercise. In: *How to lower Your Heart Disease*. Yale Medical Library. Retrieved from <http://med.yale.edu/library/heartbk/7.pdf>.
- Frank, E. (2005). Healthy lifestyles: Improving and Maintaining the Quality of Your Life. *National Depressive and Manic Depressive Association*. Retrieved from <http://www.dbsalliance.org/pdfs/healthylifestyles1.pdf>.
- Frazier, M. (2010). The reality of Working Woman: Her Impact on the Female Target Beyond Consumption. Retrieved from http://adage.com/images/bin/pdf/aa_working_women_whitepaper_web.pdf.
- Herman, T. (2007). Health Benefits of Exercise. Retrieved from <http://www.bettyjung.net/201fs/herman.pdf>.
- Jafar, T. H., Chaturvedi, N., & Pappas, G. (2006). Prevalence of overweight and obesity and their association with hypertension and diabetes mellitus in an Indo-Asian population. *Canadian Med Assoc J*, 175, 1071-7.
- Jetter, K. M. & Cassady, D. L. (2006). The availability and cost of healthier food alternatives. Retrieved from http://www.aahf.info/test/pdf/youth_articles/PIIS0749379705003351.pdf.
- Johanna, C. & Jachens, B. (2004). Sleep Disturbances & Healthy Sleep. *AWSNA Publications. Waldorf Journal Project #3*. Retrieved from <http://waldorflibrary.org/.../SleepDisturbances.pdf>.
- Katalin, L. (2008). The relationship between pro-environmental behavior and health behavior. Retrieved from http://ganymedes.lib.unideb.hu:8080/dea/bitstream/2437/80889/6/tezis_angol.pdf.

- Khuwaja, A. K., & Kadir, M. M. (2011). Gender differences and clustering pattern of behavioural risk factors for chronic non-communicable diseases: Community-based study from a developing country. *Chronic Illness*, 6(3),163-170.
- Krishnan, A., Shah, B., Lal, V., Shukla, D. K., Paul, E., & Kapoor, S. K. (2008). Prevalence of risk factors for non-communicable disease in a rural area of Faridabad district of Haryana. *Indian J Public Health*, 52(3), 117-124.
- Laaksonen M., Pra`tta`la,` R., & Karisto, A. (2001). Patterns of unhealthy behavior in Finland. *Eur J Public Health*, 11(3), 294-300.
- Mandle, J. R. (2001). Trading Up: Why Globalization Aids the Poor in Developing World. 11th ed., *McGraw-Hill*, New York, NY.
- Mozaffarian, D., Hao, T., Rimm, E. B., Willett, W.C., & Hu, F. B. (2011). Changes in diet and lifestyle and long-term weight gain in women and men. *N Engl J Med*, 364, 2392-2404.
- Mukkhupadhah, S. (1997). Working Status and Health: A study of middle class Calcutta Women. *The Indian Journal of Social Work*, 57(2), 327-336.
- President's Council on Fitness, Sports, and Nutrition. (2009). Retrieved from <https://www.presidentschallenge.org/informed/digest/docs/200909digest1.pdf>.
- Ram, S., Seirawan, H., Kumar, S. K. S., Clark, G. T. (2010). Prevalence and impact of sleep disorders and sleep habits in the United States. *Sleep Breath*, 14, 63-70.
- Reiner, M., Niermann, C., Jekauc, D., & Woll, A. (2013). Long-term health benefits of physical activity — a systematic review of longitudinal studies. *BMC Public Health*, 13, 813.
- Ross, C. E., Bird, C. E. (1994). Sex Stratification and Health Lifestyle: Consequences for Men's and Women's Perceived Health. *Journal of Health and Social Behavior*.35(5), 161 – 178.
- Samir, N., Mahmud, S., & Khuwaja, A. (2011). Prevalence of physical inactivity and barriers to physical activity among obese attendants at a community health-care center in Karachi, Pakistan. *BMC Research Notes*, 4(1), 174.
- Sherin, A. (2013). Obesity: how to prevent Pakistani people from getting heavier? *Khyber Medical University Journal*, 5(2), 59 – 60.
- Subbarao, K., & Raney, L. (1995). Social gains from female education: A cross national study. *Econ Dev Cultural Change*, 44(1), 105-128.

Toobert, D. J., Strycker, G., & Russell, E. (2001). *Enhancing support for health behavior change among women at risk for heart disease: the Mediterranean Lifestyle Trial*. Oregon Research Institute. Arizona State University.

US Food Standards Agency. (2001). *The Balance of Good Health*. Retrieved from <http://www.food.gov.uk/multimedia/pdfs/bghbooklet.pdf>.

Wang, H., Dwyer-Lindgren, L., Lofgren, K. T., Rajaratnam, J. K., Marcus, J. R., & Levin-Rektor, A. (2010). Age-specific and sex-specific mortality in 187 countries, 1970-2010: a systematic analysis for the Global Burden of Disease Study. *Lancet* 2012, 380(9859), 2071-94.

Willett, W. C. (2000). Primary Prevention of Coronary Heart Disease in Women through Diet and Lifestyle. *New England Journal of Medicine*, 343 (1), 16-22.

World Health Organization. (2004). *Global strategy on diet, physical activity and health*. *World Health Organization*. Retrieved from http://www.who.int/dietphysicalactivity/strategy/eb11344/strategy_english_web.pdf.

World Health Organization. (2009). *Milestones in Health Promotion: Statements from Global Conferences*. *World Health Organization*, New York, NY.

Aisha Bhatti works as Lecturer at the Department of Sociology, University of Wah, Wah Cantt, Pakistan. She is also a PhD scholar at the International Islamic University Islamabad, Pakistan. Her research interests include gender, health, and globalization. She can be contacted at aishauw@gmail.com

Dr. Rabia Ali works as Assistant Professor in the Department of Sociology at the International Islamic University Islamabad. She holds a PhD in Sociology from the University of New South Wales Australia. Her research interests include gender, globalization, ethnographies of development, peace and conflict, higher education and empowerment, gender justice. Some of the courses she teaches at PhD and MS level include "Globalization: Issues and Debates," "Gender and Discourse," and "Contemporary Sociological Theories." Rabia can be contacted at: rabi.ali@gmail.com



Aisha Bhatti & Rabia Ali, 2015

2015, by Aisha Bhatti & Rabia Ali. This work is licensed under the Creative Commons Attribution 4.0 International License. To view a copy of this license, visit <http://creativecommons.org/licenses/by/4.0/>.