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Attitude and Awareness towards Impact of Nutrition and Physical Activities on Health; Related to Obesity among Men in Kashmir

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ABSTRACT

The impact of nutrition and physical activity on health cannot be underestimated. A healthy diet and regular physical activity can help people:

- **Reach and maintain a healthy weight**
- **Reduce the risk of heart disease and stroke**
- **Reduce the risk of certain cancers**
- **Strengthens muscles, bones and joints**
- **Improve mood and energy levels**

The main benefit of a healthy diet and physical exercise is to reduce the risk of obesity. Obesity is the main risk factor for several of today's most serious health conditions and chronic diseases (including high blood pressure, high cholesterol, diabetes, heart disease and stroke, and osteoarthritis). Obesity is also associated with various forms of cancer. The present study is an attempt to assess the attitude and awareness towards impact of nutrition and physical activities on health, related to obesity among common men in Kashmir and to take the study further in this regard.

Key words: physical activity, Kashmir, nutrition, Attitude

INTRODUCTION

Obesity refers to diseases that have accumulated abnormal or excessive fat in the human body and have a negative impact on health. For individuals, obesity is usually the result of an imbalance between calorie consumption and calorie expansion. Increasing the consumption of high-calorie foods without equivalent exercise can lead to weight gain. Lower physical activity levels will also lead to energy imbalances and weight gain.

Once considered a problem in high-income countries, today, overweight and obesity problems are increasing in low- and middle-income countries, especially in urban areas. Since 1980, obesity has doubled globally. In 2014, more than 1.9 billion adults (18 years and older) and 41 million children under five were overweight. In 2014, nearly half of overweight or obese children under five lived in Asia.

According to the National Family Health Survey India-3 (NFHS-3), in 2005-06, 13% of women (15-49 years old) and 9% of men (15-49 years old) were overweight or obese. The prevalence of overweight is higher in urban areas than in rural areas, while the prevalence of overweight is lower in people engaged in agriculture or manual labour.

The World Health Organization (WHO) defines overweight and obesity as abnormal or excessive fat accumulation that poses a threat to health. A simple method commonly used to classify adult overweight and obesity is body mass index (BMI). BMI is defined as a person's weight (kg) divided by his height in meters (kg / m2). When BMI is greater than or equal to 25, WHO determines overweight; when BMI is greater than or equal to 30, it is obese; in Asians, due to risk factors and morbidity, overweight (≥23.0kg / m2) and obesity (≥25.0kg / m2) The critical value is lower than the WHO standard.

Compared with underweight, overweight and obesity cause more deaths and are the cause of non-communicable diseases, such as cardiovascular disease (heart disease and stroke), diabetes, skeletal muscle disease (osteoarthritis), and certain cancers (including Breast cancer, ovarian cancer, prostate cancer, liver cancer, gallbladder, kidney and colon). Obesity in childhood can also lead to increased breathing difficulties, fractures, high blood pressure and psychological effects. In later life, the odds of obesity, cardiovascular disease, and diabetes are high, which may lead to disability and premature death.

Overweight, obesity and related non-communicable diseases are preventable. By choosing healthier foods and regular physical exercise, you can prevent overweight and obesity.

Symptoms

Weight gain usually occurs over time. Most people know when to gain weight. Some signs of being overweight or obese include:

• Clothes feel tight and require a larger size.
• Weight gain compared to previous measurements
• Excess fat in the waist.
• Above normal body mass index (a person's weight (kg) divided by his height in meters (kg / m2)) and waist circumference.

Other symptoms may be:

•Difficulty breathing
• Sweating
• Back and joint pain
• Feel tired even in daily activities
• Unable to cope with sudden physical exercise
• Psychological problems, such as low self-esteem and low self-confidence

Causes

Obesity does not happen overnight. When the energy balance is disturbed, it will gradually develop over time. Energy balance means "absorbing energy" through food intake and "absorbing energy" through physical activity. Eating high-fat foods, excessive calories in sugar, and not or almost no daily physical exercise for a long time will cause weight gain. The cause of the imbalance between calorie intake and energy expenditure may vary from person to person.

• Genetics may play a role in converting food into energy and how the body burns calories during exercise. Genes may affect the amount of fat storage and fat distribution in the body.
• Family history-If one or both parents are obese, a person is more likely to be obese. Overweight and obesity often occur not only in the family due to genetics, but family members tend to share similar diet and activity habits. Children's choices, diet and physical exercise habits will be affected by the surrounding environment.
• Unhealthy diet-The diet contains a lot of calories (fast food), high-calorie drinks, excessive food, bad eating habits (eating between meals, preference for sweets, refined foods and fats), and a diet lacking fruits and vegetables ; All these factors can cause weight gain.
• Sedentary lifestyle-Sedentary lifestyles, such as sedentary occupations and inactive entertainment (watching TV), store more calories in the body each day than calories consumed by exercise. Therefore, a sedentary lifestyle promotes weight gain. If there are any related medical problems, such as arthritis, it may result in decreased activity; it helps to gain weight.
• Health conditions-Due to hormonal disorders, such as hypothyroidism, Cushing's syndrome and polycystic ovary syndrome (PCOS), certain medical conditions may cause overweight and obesity.
• In hypothyroidism, lack of thyroid hormones slows down metabolism and leads to weight gain.
• PCOS is a disease that affects women of childbearing age. Due to high levels of androgens, it is usually associated with obesity.
• In Cushing's syndrome, the production of adrenal cortisol hormones increases.
• Medications-Certain corticosteroids, antidepressants and seizure control drugs may cause weight gain.
• Emotional factors-For some people, eating habits will be affected by emotions such as sadness, stress, boredom, or anger, and they will respond by eating too much.
• Smoking-Quitting smoking is usually associated with weight gain. However, smoking is a serious health risk, and quitting smoking is more important than gaining weight.
• Age-Obesity can occur at any age, even young children. Overweight babies have an increased chance of becoming obese in later life. With age, muscle mass tends to decline, and some hormonal changes will occur. These factors and a less active lifestyle will increase the risk of obesity in the elderly.
• Gender-Men have more muscle mass and more calories than women (even at rest). Therefore, women are more likely to gain weight than men who consume the same calories. However, women's middle-age weight gain is mainly due to aging and lifestyle, but in menopause, hormonal changes also play a role in weight gain.
• Pregnancy-Women gain weight during pregnancy, and some women find it difficult to lose weight after the child is born.
• Insufficient sleep-Insufficient sleep or excessive sleep can cause hormone changes, which increase appetite and cravings for high-calorie and carbohydrate foods, which may lead to weight gain.
• Environment-If the environment does not support a healthy lifestyle, it will contribute to obesity. Some reasons include-

o Lack of sidewalks, parks and safe entertainment venues can prevent people from exercising.
o People who work long hours and commute long have insufficient time for physical exercise.
o Unable to obtain healthy foods, such as fresh fruits and vegetables, or for some people, the prices of these healthy foods are too high.
o Lack of knowledge about healthy eating and healthy cooking habits.
o High-calorie, high-fat snacks and food advertisements for sugary drinks prompt people to buy.

There are two different types of body fat distribution.
• Excess body fat spread around the waist (apple-shaped body, belly fat);
• Excess body fat is distributed on the hips and thighs (pear-shaped body, there is fat under the skin)
Fat collected in the waist (apple-shaped) increases the risk of health problems related to obesity.

DIAGNOSIS

a) Obesity assessment
Height and weight are the simplest and most commonly used measures. Overweight and obesity can be diagnosed by calculating the individual's body mass index (BMI). BMI is usually associated with fat accumulation, although sometimes it may incorrectly classify the body 's total fat content, such as muscled athletes, who have a higher BMI due to muscle heavier than fat and even if they are not fat, their BMI will be overweight Within range. Since the BMI threshold for adults is still increasing, it is not suitable for them.
BMI is defined as a person's weight (kg) divided by his height in meters (kg / m2). BMI (metric formula) = kg weight / m2 height.

WHO defines BMI greater than or equal to 25.0kg / m2 and is overweight; when BMI is greater than or equal to 30.0kg / m2, it is obese. In Asians, due to risk factors and morbidity, the cut-off values for overweight (≥23.0kg / m2) and obesity (≥25.0kg / m2) are lower than WHO standards.

Waist: measured at the midpoint between the lower border of the rib cage and the. Men's waist circumference ≥102cm and women's waist circumference ≥88cm are associated with an increased risk of metabolic complications.
Waist: Hip ratio (WHR): High WHR (male> 1.0, female> 0.85) indicates abdominal fat accumulation.

(B) Obese persons should undergo a comprehensive medical evaluation, including routine evaluation of comorbidities (such as diabetes, hypertension, and dyslipidemia). People over the age of 40 or those with a history of heart disease need to have a cardiovascular examination.

(C) Various laboratory tests can be conducted to assess comorbidities —
• Fasting blood lipids
• Liver function test
• Thyroid function test
• Fasting blood glucose and hemoglobinA1c (HBA1c)

Management
For most people who are overweight or obese, weight loss is the safest and most effective way to set goals through lifestyle changes, such as reducing calorie intake and exercising. If lifestyle changes are not enough, you can only choose drugs and bariatric surgery. If you have any comorbidities, such as diabetes, high blood pressure, cardiovascular disease, osteoarthritis, please consult a doctor before you start to change your lifestyle.
Set realistic goals:

• The best way to lose weight is to slowly lose weight. It is safe to lose 1 to 2 pounds per week, which will give you time to adopt a new and healthy lifestyle. Therefore, you can lose 5-10% of your current weight within a six-month period.
• If the child in the family is overweight or obese, the focus should be on encouraging his healthy eating habits and physical activity; if there are any health conditions related to being overweight or obese, a paediatrician should be consulted.

(A) Lifestyle changes:
Lifestyle changes include healthy eating habits and physical exercise.
(I) Healthy eating habits can provide sufficient nutrition for the body to maintain good health, but the number is not so large that the weight gains. Healthy eating includes:

• Limit energy intake in total fat, and change fat consumption from saturated fat to unsaturated fat, and eliminate trans fatty acids. This can be achieved in the following ways:
o Eat low-fat, low-fat dairy products such as low-fat yogurt, cheese, and milk

o Avoid whole milk, whole cheese, cream, butter and ice cream
o Avoid foods containing solid fats (Vanaspati ghee, lard, coconut oil and palm oil), such as fried snacks
o Restrict the use of partially hydrogenated foods (doughnuts, cookies, biscuits, muffins, pies and cakes)
o Restrict use of ground beef, sausages and processed meat
• Eat whole grain foods (whole wheat bread and pancakes, oatmeal and brown rice), beans and nuts
• Increase consumption of fruits and vegetables
• Limit intake of free sugar
• Limit consumption of salt (sodium) from all sources and ensure that salt is iodized.

Serving size: Reducing the serving size is a good way to reduce calorie intake. Avoid oversized parts. Use smaller plates, bowls and glasses.

Food weight: In a certain amount of food, eat foods with low calorie and fat content; for example; replace full-fat foods weighing 2 ounces with low-fat foods of equal weight. Another useful approach is to eat foods that contain a lot of water, such as vegetables, fruits, and soups.
Low-calorie diet (VLCD): The calorie intake per day is less than 800 calories. Although these diets cause rapid weight loss, they are not a safe method for everyone. VLCD is recommended only when obesity-related complications require rapid weight loss.

(Ii) Physical exercise-this is an important part of the weight loss plan. Regular physical exercise is essential to increase energy consumption. A few important suggestions are-
• Consult a doctor before starting physical exercise, especially those with obesity and other medical problems.
• Start physical exercise slowly and gradually increase the intensity and duration over time. Medium and low intensity is sufficient. There is no need to participate in hard activities.
• Choose activities that you like and are suitable for your daily life.
• Start activities by doing more daily activities, such as climbing stairs instead of elevators and doing housework.
• The next step is to start a slow walk, ride a bicycle or swim, and increase exercise time, or gradually increase exercise intensity. (Bright walking, dancing, gardening, and water aerobics are moderate-intensity physical exercises).

(Iii) Behaviour changes-Changes in behaviours or habits related to food and sports activities are important for weight loss, such as:
• Change habits that promote weight gain, such as watching TV for long periods of time.
• Record your weight loss.
• Seek help or encouragement from friends, family and healthcare providers.
• Rewards for successfully achieving weight loss goals.

(B) Anti-obesity drugs for weight loss may be a dietary and exercise aid for obese adults who cannot achieve weight loss through diet and exercise. The medicine is prescribed only when the BMI is 28 kg / m 2 or higher and has other weight-related conditions or the BMI is 30 kg / m 2 or higher.

(C) Bariatric surgery (also called bariatric surgery) is sometimes used to treat severely obese people (BMI is 35 kg / m 2 coexisting or BMI exceeds 40 kg / m 2). Common bariatric surgery includes:
• Gastric bypass surgery
• Laparoscopic adjustable gastric band (LAGB)
• Biliary and pancreatic metastasis with duodenal switch
• Stomach cover

(D) Vagal block is another treatment for obesity. It involves implanting a device under the skin of the abdomen, which sends intermittent electrical impulses to the abdominal vagus nerve, telling the brain when the stomach feels empty or full. This new technology is for adults who are unable to lose weight through weight loss programs and have a BMI of 35-45 kg / m 2 and have at least one obesity-related disease (such as type 2 diabetes)

Complication
Obesity increases the risk of many health conditions-
• Type 2 diabetes
• High blood pressure (hypertension)
• Coronary heart disease and stroke
• Metabolic syndrome (combined with diabetes, hypertension and obesity)
• Cancer-colon cancer, breast cancer in postmenopausal women, endometrial cancer
• Gallstones (Gallbladder stones)
• Gastroesophageal Reflux Disease (GORD)-(Situation of acid reflux to the esophagus)

•asthma
• Osteoarthritis-joint pain and stiffness
• Low back pain
• Fertility decline
• Sleep apnea (breath interruption during sleep)
• Liver disease
• Kidney disease
• Pregnancy complications, such as gestational diabetes, preeclampsia, fetal defects
• The severity of obesity will shorten its average life expectancy by 3 to 10 years

Prevention

It can be seen that the increase in the incidence of obesity is largely due to the obesity environment rather than individual medical and genetic problems. Therefore, the goal of preventing overweight and obesity should be to create an environment that encourages changes in diet and physical activity.

These efforts must not only focus on the prevention of obesity (primary prevention) for those who are not already obese, but also must prevent those who are already obese from gaining weight and promoting weight loss before the onset of obesity. (Secondary prevention).
It has been suggested that breastfeeding is a potential protective factor against children's weight gain, which is important because overweight children and adolescents are at risk of becoming overweight adults.
At the individual level, people can follow:

Healthy diet helps prevent obesity-
• Limit total fat intake, change fat consumption from saturated fat to unsaturated fat, and eliminate trans-fat.
• Increase consumption of fruits, vegetables, beans, whole grains, beans and nuts
• Limit sugar and salt intake

Regular physical exercise helps maintain a healthy weight-
People should exercise properly (60 minutes per day for children and 150 minutes per day for adults). On most days, at least 30 minutes of regular moderate-intensity physical exercise can reduce the risk of obesity and comorbidities.

WHO recommends that the food industry can play an important role in promoting a healthy diet in the following ways:
• Decrease the fat, sugar and salt content of processed foods;
• Ensure that all consumers are provided with affordable and healthy choices;
• Restrict sales of foods high in sugar, salt and fat, especially foods for children and adolescents; and
• Make sure to provide healthy food choices and support regular physical exercise in the workplace.

Objective

1. To study the attitude towards impact of nutrition and physical activities on health related to obesity in the age group 15-39 years and 40 years and above
2. To study the awareness towards impact of nutrition and physical activities on health related to obesity in the age group 15-39 years and 40 years and above
3. To study the relationship between attitude and awareness towards impact of nutrition and physical activities on health related to obesity

Hypotheses

1. There is no significant difference in the attitude towards impact of nutrition and physical activities on health related to obesity in the age group 15-39 years and 40 years and above
2. There is no significant difference in the awareness towards impact of nutrition and physical activities on health related to obesity in the age group 15-39 years and 40 years and above
3. There is a significant relationship between attitude and awareness towards impact of nutrition and physical activities on health related to obesity

Delimitations

1. The study was limited to Kashmir only.
2. The study was limited to men only.
3. The study was limited to 300 samples only.

REVIEW OF RELATED LITERATURE

https://www.omicsonline.org/scholarly/obesity-and-nutrition-journals-articles-ppts-list.php
Obesity is highly correlated with body nutrition and related factors. A person's healthy lifestyle will greatly affect his ability to overcome obesity. Human nutrition is the main factor that must be reflected when treating obesity and overweight.

Nutrition plays a major role in controlling individual obesity. Eating a healthy diet is very important to reduce obesity. There are several fat burning foods that should fight obesity. This means that healthy eating habits are an important factor that obese individuals should pay attention to. Fat-burning foods include red peppers, whole grains, low-fat dairy products, lean meat, green tea, etc.

https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5787353/ Jennifer M. Poti (2018); 'Intake of ultra-processed foods and obesity: what is truly healthy health-processing or nutrition content? ";

Purpose of review
The purpose of this narrative review is to summarize and criticize recent evidence that assesses the relationship between ultra-processed food intake and obesity.

Recent findings
Four of the five studies found that buying or eating ultra-processed foods is related to overweight / obesity. Other studies have reported the relationship between ultra-processed food intake and increased fasting blood glucose, metabolic syndrome, increased total and low-density lipoprotein cholesterol, and the risk of hypertension. Whether the association can be attributed to processing itself or the nutritional content of ultra-processed foods is unclear. Only three of the nine studies used a prospective design, and the possibility of residual confounding was high.

Summary
Recent research has provided fairly consistent support for the association of obesity and related cardiac metabolism results with the intake of ultra-processed foods. Obviously, further research is necessary, especially those using longitudinal design and sufficient control to confuse to potentially confirm these findings in different populations and determine whether the intake of ultra-processed foods is not related to obesity It has nothing to do with nutrition.

METHODOLOGY

Descriptive survey method was used for collection of samples in the present study.

LOCATION AND AREA OF THE STUDY
Until the middle of the 19th century, the term "Kashmir" only meant the Kashmir valley between the Greater Himalayas and Panjar Mountains. Today, the term covers larger areas, including Indian-ruled Jammu, Kashmir and Ladakh, Pakistan-ruled Azad Kashmir and Gilgit-Baltistani territories, Chinese-ruled Aksai Chin and Anti-Kerala territory.

In the first half of the first millennium, Kashmir became an important center for Hinduism and later Buddhism; later, in the ninth century, Kashmir Schevism was born. In 1339, Shah Mir became the founder of the Salatin-i-Kashmir or Shah Mir dynasty and became the first Muslim ruler of Kashmir. Kashmir was part of the Mughal Empire from 1586 to 1751, and until 1820 it was part of the Duranj Empire in Afghanistan. That year, Sikhs under Ranjit Singh annexed Kashmir. In 1846, Sikhs failed in the first Anglo-Sikh war. After purchasing the area from Britain under the Treaty of Amritsar, Gulab Singh, the prince of Jammu, became the new ruler of Kashmir. The rule of his descendants continued until the supreme rule of the British royal family, until the division of India in 1947, when the former monarch of the British Indian Empire was made into a disputed territory, now managed by three countries: India, Pakistan and China.

Demographic
In the 1901 British Indian Census, the population of Kashmir and Jammu was 2,905,578. Among them, Muslims are 2,154,695 (74.16%), Hindus are 689,073 (23.72%), Sikhs are 25828 (0.89%), and Buddhists are 35047 (1.21%) (equivalent to 935 (0.032%)).

Hindus are mainly distributed in Jammu, accounting for less than 60% of the population. In the Kashmir Valley, the Hindu representative “has 524 out of every 10,000 people (ie 5.24%), while in the border area of Ladakh and Gilgit there are only 94 out of every 10,000 people (0.94%).” The total population of the Kashmir Valley in the 1901 census was 1,157,394, of which the Muslim population was 1,083,766, or 93.6%, and the Indian population

was 60,641. Among the Hindus in Jammu province, there are 626,177 people (accounting for 90.87% of the Hindu population in Prince State), and the most important castes recorded in the census are “Brahman (186,000), Rajput (167,000),Catharis (48,000) "and Thakkars (93,000). "

In the 1911 British Indian Census, the total population of Kashmir and Jammu increased to 3,158,126. Among them, there are 2,398,320 (75.94%) Muslims, 696,830 (22.06%) Hindus, 31,658 (1%) Sikhs, and 36,512 (1.16%) Buddhists. In the last census of British India in 1941, the total population of Kashmir and Jammu (due to World War II, estimated according to the 1931 census) was 3,945,000. Among them, the total Muslim population is 2,997,000 (75.97%), Hindus are 808,000 (20.48%), and Sikhs are 55,000 (1.39%).

Kashmiri Pandits were the only Hindus in the Kashmir Valley, and during the Dogra reign (1846-1947) steadily constituted about 4% to 5% of the population of the valley, of which 20% were by 1950. More people left the Kashmir Valley in the 1990s. According to some authors, about 100,000 of Kashmir Pandit's total population of 140,000 left the valley during that decade. Other authors have proposed a higher number of exodus, ranging from 150 to 190,000 (1.5 to 190,000) of the total population of the Pan-German population of 200,000 (200,000) to a high population of 300,000 (300,000).

People in the Jammu region speak Hindi, Punjabi, and Dogari, Kashmir Valley speaks Kashmiri, and the sparsely populated Ladakh region speaks Tibetan and Balti.

The total population of the Jammu and Kashmir branch in India is 12,541,302, the total population of the Kashmir branch in Pakistan is 2.58 million, and the total population of Gilgit-Balstan is 870,347.

Sample
300 samples were selected for the present study. Among them 150 sample were randomly selected in the age group 15-39 years and 150 samples were randomly selected in the age group 40 years and above.

Sampling Techniques
Random and Incidental sampling was used for collection of samples for the present study.

Tools

1. Attitude scale towards impact of nutrition and physical activities on health; related to obesity (ATT-Scale) -The attitude scale was prepared and standardised by the researcher using Cronbach alpha reliability websitehttps://www.wessa.net/rwasp_cronbach.wasp.15 samples were selected for the pilot study. For each sample, scoring was done separately for positive items and negative items. The positive items were correlated with each other separately for nutritionstatement, physical health statement and obesity statement. The reliability was found to be 0.8, 0.9 and 0.7. Similarly, the negative items were correlated with each other separately for nutrition statements, physical activity statement and obesity statement. The reliability was found to be 0.8, 0.9 and 0.8. The Attitude Scale was considered to be reliable for the present study.
2. Awareness scale towards impact of nutrition and physical activities on health; related to obesity (AW-Scale) - The awareness scale was prepared and standardised by the researcher. The test was first administered to a group of 15 samples for pilot study. The test was again (re-test) administered to the same group after a period of 15 days to test the reliability of the tool. The responses collected through the test-retest of the scale were then compared. The responses collected from the test, re-test; ranged in between 0.7-0.8 that means acceptable reliability and so the tool was considered to be reliable for the present study.

Procedure Of Collection Of Data
Survey was conducted using the tools which was in the form of questionnaire. The researcher first randomly selected the houses of the societies in Kashmir. After selection of the houses the researcher than distributed the Questionnaires to whoever is present in the houses in the age group 15-39 years, and 40 years and above. After 3 hours the questionnaires were collected back. The raw scores collected was then inserted in the excel sheets which were later used to calculate the percentage, mean, t-value and r-ratio.

ANALYSIS AND INTERPRETATION

Statistical analysis was done for analysis and interpretation of data using mean, t-test and r-ratio

Analysis of hypothesis 1. There is no significant difference in the attitude towards impact of nutrition and physical activities on health related to obesity in the age group 15-39 years and 40 years and above
Tool used: (ATT-Scale)

Table 1: Showing significant difference in the attitude towards impact of nutrition and physical activities on health related to obesity in the age group 15-39 years and 40 years and above

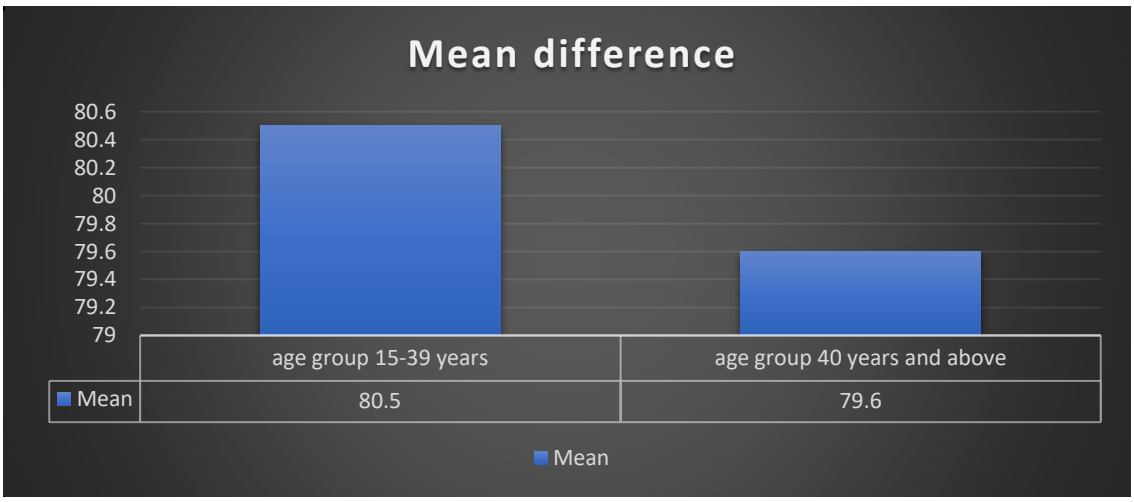
Groups (VARIABLES)	Sample	Mean	t-value
age group 15-39 years	150	80.5	0.5
age group 40 years and above	150	79.6	

**Not significant .05level*(*Ref.* https://www.socscistatistics.com/tests/studentttest)

Findings of*Hypothesis* 1. There is no significant difference in the attitude towards impact of nutrition and physical activities on health related to obesity in the age group 15-39 years and 40 years and abovestand **rejected** at .05 level of significance. It can be stated that a significant difference does exist in the attitudetowards impact of nutrition and physical activities on health related to obesity in the age group 15-39 years and 40 years and above.

Conclusion of *Hypothesis* 1. It can be concluded that the age group 15-39 years has higher or positive attitude towards impact of nutrition and physical activities on health related to obesity than 40 years and above age group.

FIG.1. BAR diagram Showing mean difference in the attitude towards impact of nutrition and physical activities on health related to obesity in the age group 15-39 years and 40 years and above



Analysis of hypothesis 2. There is no significant difference in the awareness towards impact of nutrition and physical activities on health related to obesity in the age group 15-39 years and 40 years and above
Tool used: (AW-Scale)
Table 2: Showing significant difference in the awareness towards impact of nutrition and physical activities on health related to obesity in the age group 15-39 years and 40 years and above

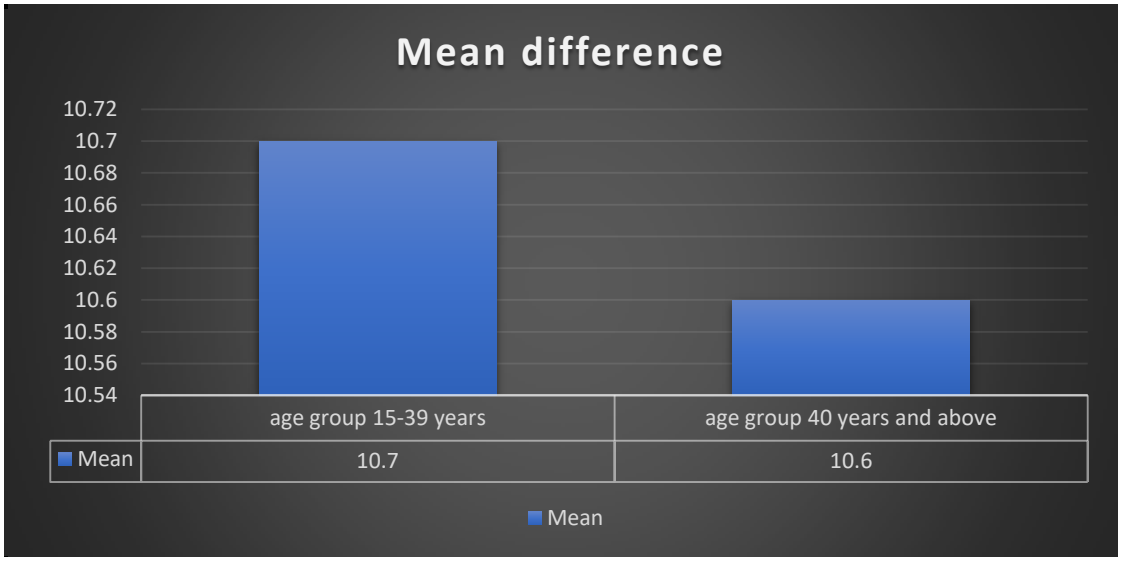
Groups (VARIABLES)	Sample	Mean	t-value
age group 15-39 years	150	10.7	0.1
age group 40 years and above	150	**10.6**	

**Not significant .05level*(*Ref.* https://www.socscistatistics.com/tests/studentttest)

Findings of *Hypothesis* 2. There is no significant difference in the awareness towards impact of nutrition and physical activities on health related to obesity in the age group 15-39 years and 40 years and abovestands **rejected** at .05 level of significance. It can be stated that a significant difference does exist in the awareness towards impact of nutrition and physical activities on health related to obesity in the age group 15-39 years and 40 years and above.

***Conclusions of Hypothesis* 2.** It can be concluded thatthe age group 15-39 years has higher awareness than the age group40 years and above.

FIG.2. BAR diagram significant difference in the awareness towards impact of nutrition and physical activities on health related to obesity in the age group 15-39 years and 40 years and above.



Analysis of hypothesis 3. There is a significant relationship between attitude and awareness towards impact of nutrition and physical activities on health related to obesity
Tool used: (ATT-Scale) and (AW-scale)

Table 3: Showing significant relationship between attitude and awareness towards impact of nutrition and physical activities on health related to obesity

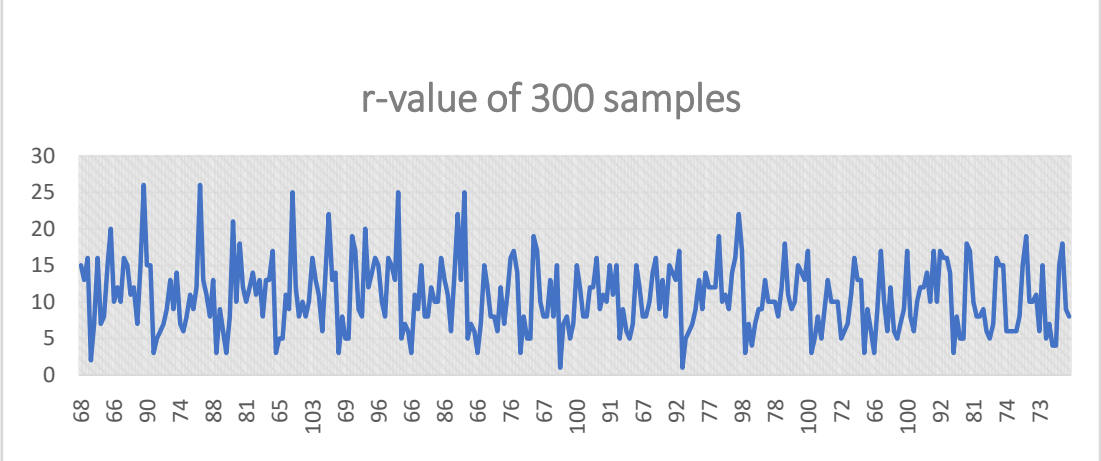
VARIABLES	Sample	Mean	r-value
attitude	300	80.2	0.85
Awareness	300	10.7	

**significant at .05(ref.* https://www.socscistatistics.com/tests/pearson)

Findings of *Hypothesis*3. There is a significant relationship between attitude and awareness towards impact of nutrition and physical activities on health related to obesity stands **accepted** at .05 level of significance.

Conclusion of Hypothesis3. It can be concluded that the higher the attitude the higher will be the awareness. In the present study the attitude towards impact of nutrition and physical activities on health related to obesity are high among common men in Kashmir so their awareness is also considered to be high.

FIG.3.SCATTER DIAGRAM showing significant relationship between attitude and awareness towards impact of nutrition and physical activities on health related to obesity



CONCLUSION

To reach to a conclusion of hypothesis-1; comparison was done between the two variables age group 15-39 years (independent variable) and 40 years and above (independent variable) on attitude towards impact of nutrition and physical activities on health related to obesity.The hypothesis was rejected and conclusion is made that the age

group 15-39 years has higher or positive attitude towards impact of nutrition and physical activities on health related to obesity than 40 years and above.

To reach to a conclusion of hypothesis-2; comparison was done between the two variables age group 15-39 years (independent variable) and 40 years and above (independent variable) on awareness towards impact of nutrition and physical activities on health related to obesity. The hypothesis was rejected and conclusion is made that the age group 15-39 years has higher awareness towards impact of nutrition and physical activities on health related to obesity than 40 years and above.

To reach to a conclusion of hypothesis-3; comparison was done between the two variables attitude (independent variable) and awareness (dependent variable) towards impact of nutrition and physical activities on health related to obesity. The hypothesis was accepted.

It has been assumed that since the attitude towards impact of nutrition and physical activities on health related to obesity are high the awareness is also high among men of Kashmir.

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