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ABSTRACT

Background: Obesity is a rapidly growing health risk all over the world. Even in mild degrees, it has serious adverse effects and is associated with diminished life span. The study was aimed at determining the most suitable obesity index derived from height and weight in a young adult Nigerian population.

Methods: A cross-sectional study of students of University of Nigeria Enugu Campus was done. Heights and weights of 402 males and 268 females aged between 20 and 28 were measured. Weight-height ratio (WHR), body mass index (BMI), Rohrer’s index (WHR$^2$) and ponderal index (BMI$^3$) were calculated.

Results: Zero-order correlation coefficients of these indices with height and weight showed that body mass index was the only index not significantly correlated with height in both sexes. Weight-height ratio and Rohrer’s index underestimated the degree of obesity in short subjects and overestimated it in tall subjects. The reverse was the case for ponderal index.

Conclusions: Body mass index (WHR) is the most suitable index derived from height and weight for the assessment of obesity in our study population. We recommend its use in busy clinical practice and epidemiological studies.

KEYWORDS: Height, Weight, Obesity indices.

Paper accepted for publication 30th May 2005.

INTRODUCTION

Obesity is widely recognized as a rapidly growing health risk all over the world. Reminable increases in obesity have occurred in both higher and lower income countries, particularly during the 1990s. Overweight and obesity, defined as a BMI >25 and 30 kg/m$^2$ respectively, now often affect an alarming 50-65% of a nation’s population, not only in the USA, Europe, and Australia, but also in countries as varied as Mexico, Egypt, and the black population of South Africa. The highest concentration of obesity is now found in some of the Pacific Islands, and in parts of the Middle East. Even in mild degrees, obesity has serious adverse effects on health and is associated with diminished life span. It is a risk factor for a number of diseases including diabetes mellitus, heart disease, high blood cholesterol, high blood pressure, and stroke as well as for certain malignancies. Obese women are more than non-obese women to die from cancer of the gallbladder, breast, uterus, cervix, and ovaries.

Recent epidemiological and nutritional studies directed attention towards the relative merits of various obesity indices for the assessment of obesity in different population groups. Zinyowera and McMillan found that in population differences in the suitability of different obesity indices and emphasized the need for appropriate indices of obesity to be derived for each population. Deurenberg-Yap et al. advocated that the WHO cut-off values for the various indices of obesity should be revised in respect of different populations. Usually, obesity should be assessed by direct measurement of the degree of fatness by techniques such as air displacement plethysmography, skin-fold thickness measurements and somatotyping. However, if direct measurements are too laborious and consuming to be useful in usually busy clinical practice or in epidemiological studies. Consequently, in such situations, indirect estimates obtained from weight-height formulae are routinely used for assessing some obesity. Indirect measurements are not only as obtainable; they have been shown to be reason- accuracy.

Commonly used weight and height obesity indices include weight-height ratio (WHR), body mass index (BMI), Rohrer’s index (WHR$^2$) and ponderal index (BMI$^3$). Data on the suitability of these indices Caucasian populations abound in the literature. However, the same cannot be said for all populations. The paucity of such data for Nigerians necessitated the present study.

SUBJECTS AND METHODS

A total of 402 males and 269 females, 20-28 year-old students of the University of Nigeria, Enugu Campus participated in the study which was conducted in 1997. Most of the subjects were Igbos but small numbers of other Southern ethnic groups were included in the study sample. The selection was simple random sampling. Their heights and weights were obtained by the same investigator for consistency using a fixed wall ruler with a spirit level as bar for
height, and a beam balance for the weight. Heights were recorded to the nearest 0.1 cm and weights to the nearest 0.1 kg. Heights were measured to 0.1 cm. Weights were measured to 0.1 kg. All measurements were taken according to previously described standard procedures. Weight-height ratio ( WHR), body mass index (BMI), Rohrer's index (WHR) and ponderal index (PI) were calculated for males and females.

RESULTS
As shown in Table I, mean heights were 174.9 cm for males and 165.0 cm for females. The corresponding weights were 65.9 kg and 58.3 kg, respectively. As expected, males were significantly taller and heavier than females (p<0.001). Males had significantly higher weight-height ratio (WHR) and ponderal index (PI) compared to females (p<0.001). There was no significant sex difference for body mass index (BMI). Table II shows that weight-height ratio and ponderal index increased with weight in both sexes. The converse was the case for Rohrer's index. Body mass index showed a strong positive correlation with weight and was the only index not significantly correlated with height (Table III) in both sexes. Although weight-height ratio had the strongest correlation with weight, it was also significantly correlated with height. Ponderal index was negatively correlated with weight (p<0.001). Comparative data on the relative merits of all the obesity indices studied are shown in Tables IV and V.

Table I: Heights, Weights and Height/Weight Indices of Males and Females

<table>
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<tr>
<th>Group</th>
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<th>SD BMI</th>
<th>Mean WHR</th>
<th>SD WHR</th>
<th>Mean PI</th>
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<tr>
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<td>25.2</td>
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<td>24.0</td>
<td>3.0</td>
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Table II: Height/Weight Indices of Males and Females by Weight Groups

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<tr>
<th>Group</th>
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<th>SD BMI</th>
<th>Mean WHR</th>
<th>SD WHR</th>
<th>Mean PI</th>
<th>SD PI</th>
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<tr>
<td>Group</td>
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<td>Mean BMI</td>
<td>SD BMI</td>
<td>Males</td>
<td>Females</td>
<td>Males</td>
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<td>Males</td>
<td>25.0</td>
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Table III: Zero-order Correlation Coefficients of Obesity Indices of Males and Females by Weight and Height

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<td>PI</td>
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Table IV: Correlation Data on Zero-order Correlation Coefficients of Obesity Indices of Males by Weight and Height

<table>
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<th>Females</th>
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<tr>
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<tr>
<td>PI</td>
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Discussion
A most appropriate obesity index derived from weight and height is one that is most strongly, positively correlated with weight and minimally correlated with height. We are forced to be independent of height. Our data show that Rohrer's index (WHR) and ponderal index (PI) are not suitable obesity indices because they were significantly correlated with height and only poorly correlated with weight.
moderately correlated with weight. Ponderal index had the additional disadvantage of being negatively correlated with weight. Referrer’s index underestimated the degree of obesity in short subjects and overestimated it in tall subjects. The converse was the case for ponderal index. Although weight-height ratio (WHR) had the strongest positive correlation with weight, it is not a suitable obesity index because it was also significantly correlated with height and it underestimated the degree of obesity in short- and overestimated it in tall subjects.

Body mass index (BMI) was the only index not significantly correlated with weight in both sexes while being strongly positively correlated with weight. Thus, it is the most suitable index of obesity for our study population. Our findings are in keeping with those of Evans and Price and Bjelica. These authors found body mass index to be the least height biased obesity index in both sexes. Watson et al. reported that although weight-height ratio and body mass index were almost equally comparable for the prediction of body fat, body mass index was slightly better for men while weight-height ratio was preferable for women. Fiorey (Britons) and Lee et al. (Gaucanians Americans) found body mass index to be the least height biased index in males, and weight-height ratio the least height biased in females. In studies done on British (Khosla and Lowe) and Israeli subjects (Gbolou and Mirafzil), body mass index was found least correlated with height in males. These authors did not study females.

The present study has shown body mass index (BMI) to be the most suitable index derived from weight and height for the assessment of obesity in our Nigerian population. Sania et al. studied the sensitivity and specificity of body mass index as a predictor of percentage total body fat (TBF %) obtained from underwater weighing and found that it predicted TBF % quite well. We propose the use of body mass index for the assessment of obesity in our Nigerian population both in clinical practice and in epidemiological screening.

ACKNOWLEDGEMENT

We wish to express our gratitude to Mr. U. Atiweke and Dr. (Mos) T. B. Ekane of the University of Cebu for their assistance. Prof. P. O. Okwolo of the University of Nigeria, Enugu Campus provides us with some materials for our study.

REFERENCES
REF: WAIM/ASSESSEIS/VOL.2

1st December, 2005

Dear Dr. [Name],

GALLEY PROOF FOR PREVIEW:

Please find enclosed the galleym Proof of your paper titled

[Title of Paper]

To expedite the printing of your paper, please return for publication not later than three days from the date on this letter.

Best regards,

Yours sincerely,

M.I. Agboola (Mgr.)
Business Manager (WAIM)
Transverse thoracic diameter in frontal chest radiographs of an adult Nigerian population

*E. N. Olibizi and J. I. Olaye
Department of Radiology Medicine
University of Nigeria Teaching Hospital, Enugu, Nigeria

Email: obibizien@yahoo.com

Summary

Background: Normal standards for thoracic diameters that are available to us in our environment are often based on studies conducted on Caucasians. Application of such published data to a Nigerian population may lead to erroneous conclusions in terms of clinical implication.

Objective: Our study aimed to establish age and sex specific transverse thoracic diameter (TDD) for our environment.

Patients and Methods: The TDD of 303 males and females aged between 20 and 93 were obtained in a cross sectional study at a tertiary hospital.

Results: The mean values for the 20-29, 30-49 and the 60 year-old males were 20.6, 29.0, 27.8 cm respectively. The corresponding values for females were 26.3, 27.1 and 25.1 cm. Males had significantly larger thoracic diameter than females. The largest mean TDD females and males were in the 20-39 and 40-59 age groups respectively. The TDD had a significant positive correlation with weight, height, body mass index and body surface area. The best correlation were with body surface area and weight.

Conclusions: Nigerians have a smaller TDD than Caucasians. Scanty TDD in Nigerians is likely to be responsible for their larger cardiovascular ratio in comparison with Caucasians or Asians.

Keywords: Transverse thoracic diameter, frontal chest roentgenography, adult Nigerians.

Introduction

The transverse thoracic diameter (TDD) is not only invaluable in the calculation of cardiothoracic and aortic diameter ratios but also in the comparison of the physiques of different racial groups. It also serves imaging modalities like computed tomography and magnetic resonance imaging provide accurate and absolute of TDD, what is affordable and available in most centers, especially in developing countries, is conventional radiography. Chest radiography therefore remains an important radiological investigative tool for the detection of cardiomegaly and the evaluation of cardiothoracic ratios. There is paucity of studies on chest diameters in Africans. Normal standards for thoracic diameters that are available to us in our environment are often based on studies conducted on Caucasians. The possibility of racial differences does exist. The present study was aimed at establishing age and sex specific transverse thoracic diameter for our environment.

Materials and methods

The subjects studied were individuals referred to the Department of Radiology and Medicine, University of Nigeria Teaching Hospital, Enugu, for pre-emergency chest radiographs or for routine medical examinations.
The period of study was from 1997 to 1999. The subjects were asked their ages and their heights and weights were recorded using a fixed wall scale with a spring level in bare
for the height, and a beam balance for the weight.
Posteroanterior chest radiographs were obtained in full
exposition with the subjects standing erect.

The focus film distance was constant at 2 metres.
At this distance projection distortion is minimal and
magnification is about 5%. Only good quality standard
posteroanterior chest radiographs were studied. The
radiographs that did not meet the criteria proposed by
Kabali and Wilder3 and Brooks et al and Bolte4 were
excluded from the study.

Measurements
The transverse thoracic diameter (TD) was measured
from the internal surfaces of the ribs above the costal
attachments of the diaphragm at the point where the chest
skeleton was greatest (see figure 1). Body mass index (BMI) was calculated from the formula
BMI = W/H² (W is the weight in kilograms while H is
the height in metres) and body surface area (BSA) was
also calculated from the formula BSA = W⁰⁴⁷ x H²⁰⁴⁷ x
0.007184 (Weight is in kilograms while height is in
centimetres. BSA is in square metres). The TD obtained
from this study were compared with those reported by
other authors 5-7.

Results
There were 303 subjects in the study group: 157

| Table 1 Thoracic diameter (cm) of males and females by age |
|---|---|---|---|
| Age (yr) | No. | Mean | SD |
| <20 | 108 | 26.5 | 1.9 | 25.4 ± 0.000 |
| 20-39 | 108 | 27.0 | 1.7 | 28.7 ± 0.000 |
| 40-60 | 13 | 35.8 | 1.3 | 34.5 ± 0.014 |

| Table 2 Correlation of thoracic diameter with weight, height, body mass index and body surface area in males and females |
|---|---|---|---|
| | Height | Weight | BMI |
| Male | 0.577* | 0.725* | 0.5216* |
| Female | 0.421* | 0.6753* | 0.5154* |

Statistically significant at p < 0.01

males and 146 females. Their ages ranged from 20 to 93
in males and 20 to 89 in females. The mean TD of the 20-
24, 25-39 and the ≥ 60 year-old males were 26.9, 26.0,
27.0 cm respectively. The corresponding values for
females were 26.3, 27.1 and 25.4 cm. The range was 23.3cm
to 35cm in males and 21.7 to 20.8cm in females. As shown
in table 1, the TD decreased with age in male; while in
females it initially increased with age and later decreased
with it. At all age groups, males had significantly larger
TD than females. There was a significant negative
correlation of TD with age in males but not in females (r =
-0,1 and 0.014 in males and females). However between
the 40-59 and ≥ 60 age groups, there was a significant
decrease in females r 0.01, but not in males, as shown in
table 2, the TD had a significant positive correlation
with weight, height, body mass index and body surface
area in both sexes.

Table 3 and figure 2 show comparative data on the
TD of males and females as reported by various authors.
The mean TD in males and females in the present study
were smaller than the values reported for the Americans
and the British. The differences were statistically
significant except for the British females. Overall, the
mean TD in the present study was similar to the values
reported for Jamaicans.

Fig. 1 Transverse thoracic diameter (TD) was taken from
the internal surfaces of the ribs above the costal attachments of
the diaphragm at the point where the chest diameter was
greatest.

Fig. 2 Thoracic diameter of whole males and females in the
older age group as reported by various authors.
## Table 3. Comparative data on thoracic diameter (cm) of males and females as reported by various authors

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### Discussion

The TD correlated better with body surface area and weight than with body mass index and height. The TD decreased with advancing age in males. This is in keeping with the findings of Porter et al. who showed that the TD in males, tended to decrease with advancing age. In our study, the negative correlation of TD with age was significant in males but not in females but between the 49-59 and the 60+ year-old age groups there was a significant decrease in weight in females but not in males. This observation indicates that the decrease of TD with advancing age was gradual in males. The decrease started later in females but was more marked.

The steep decrease of TD with age in females corroborates the findings of Edge et al., Cowan and Milne and Landau. Edge et al. noted a more striking reduction in TD with increasing age in women than in men. Cowan, in a study of older people, found a significant negative correlation of TD with age in females but not in males. He indicated that this could be because women are subject to greater degrees of kyphosis than men, with a corresponding decrease in the transverse diameter. This greater degree of kyphosis in older females may be due to menopausal osteoporosis. Although secular growth trend in height was reported in Nigeria by Obik吉利 and Singh, it appears unlikely that the decrease in TD with advancing age in our study could be accounted for by secular growth trend alone. Similar and postmenopausal osteoporotic changes are contributory factors. Milne and Landau postulated that the age differences in TD were unlikely to be the result of secular trend towards larger chest diameters. For them, it seemed more likely, particularly in older women, that the development of kyphosis increased the intercostal chest diameter with a resultant change in the thoracic shape and reduction in the transverse diameter.

The mean values of TD of males and females in the present study were smaller than those reported for Caucasians. This finding corroborates the report of Nickel and Wade and Mauro-Figue et al. They showed that Africans have narrower chests at all ages than Caucasians or Asians. The smaller TD in Nigerians is likely to be responsible for their larger cardiothoracic ratio in comparison with Caucasians or Asians.

### References


VS. Mousa-Ghosh AD, Bhattia JI, Balaji CT, Cedes BC.

Mr. A: My friend got married at the age of 44.
Mr. I: These days, men marry late. The mean age at which men marry has gone up by about a decade when compared with the mean age before the Nigerian civil war.
Mr. A: Why is it so? Does the civil war have anything to do with it?
Mr. I: I think it has. There was lot of hardship during the civil war. There was breakdown of law and order. Schools were taken over after the civil war by the federal government and the moral trainers were asked to step aside.
Mr. A: In the '70s and early '80s, most men did not get married late.
Mr. I: Those that got married in the '70s and early '80s still had the benefit of good moral training when they were in primary and secondary schools.
Mr. A: Are you trying to say that moral decay is responsible for men getting married late?
Mr. I: Although there may be other factors such as economic, I think that moral decay is an important factor.
Mr. A: I think that economic hardship is the main factor.
Mr. I: Before the civil war, even poor men got married early enough because they accepted themselves the way they were. They were not envious of the rich. They were happy. Women were simple and sincere and did not demand heaven and earth from men. Men did not want to have a house or car or enough money for a glamorous wedding before getting married.
Mr. A: I think that you are right.
Mr. I: There are many men who are economically poor but who have married late because they have spent years looking for a good wife.
Mr. A: Why is it that a number of men and women are not as simple and sincere these days as in the past?
Mr. I: I think that although there are many reasons for that, lack of moral formation is the main reason. Unfortunately, some men and women who have passed through the four walls of tertiary institutions are not as pristime as those that did not have the benefit of higher education.
Mr. I: Why are women more demanding on men these days than in the past?
Mr. A: There are many reasons for that. In the past, men were more educated than women but these days, it is the opposite especially in some parts of Anambra state where boys prefer trading to schooling.
Mr. I: Many of my relations who did not have the benefit of tertiary education married women with tertiary education.
Mr. A: It happens quite often but it is not the ideal thing. A woman with a tertiary education who marries a man without one, should get the extra mile in being a good wife otherwise the husband may have a complex.
Mr. A: What advice do you have for young men and women who are planning to get married?
Mr. I: Be simple, sincere and realistic. Accept yourself as you are. Cut your cloth according to your cloth and do not be anxious of others. Be a happy person even if you are poor or wretched. Open your eyes and ears when looking for a spouse and lift up your hearts to God. Do not quit that love is blind because if you do, marriage will be the eye opener.

Mr. A: What qualities should a man look for in a woman that is going to be his wife?

Mr. I: Some men, even those that have no qualities, expect their future wives to have all the good qualities in the world. They want them to be spotless. It will take them decades to find such a woman if they are lucky.

Mr. A: You have not answered my question.

Mr. I: A man should look for four qualities in a woman that is going to be his wife because the word WIFE has four letters.

Mr. A: What are these four qualities?

Mr. I:
- She should be Womanly (and Warm-Hearted)
- She should be Industrious (and Innovative)
- She should be Fine
- She should be Efficient.

Mr. A: What qualities does a woman expect a HUSBAND to have?

Mr. I:
- He should be Humble (and Humane)
- He should be Understanding
- He should be Supportive (and Sagacious)
- He should be a Breadwinner
- He should be Available (and Appreciative)
- He should be Noble
- He should be Dependable

Mr. I: A wife that is warm-hearted and efficient in home-making and cooking is a delight to the husband.

Mr. A: A husband that realizes that men and women are wired differently, will be very understanding and appreciative with the wife and will use his veto power sparingly and sagaciously.

Mr. I: What should men and women do in order to have qualities that you enumerated?

Mr. A: They should empty themselves and lift up their hearts and minds.

Mr. I: What does the scripture say about wives?

Mr. A: There are 381 citations on wives in the scripture. I will cite only three of them:

1. **SIRACH 26:1**
   - Happy the husband of a really good wife, the number of his days will be doubled.

2. **PROV 12:4**
   - A good wife, her husband’s crown, a shameless wife, a cancer in his bones

3. **PROV 19:14**
   - From father come inheritance of house and wealth, from Yahweh, a wife who is discreet.

Mr. I: Are there no scriptural citations on husbands?

Mr. A: There are 157 but I will cite only three:

1. **SIRACH 25:1**
   - There are three things my soul delights in, and which are delightful to God and to men: concord between brothers, friendship between neighbours, and a wife and husband who live happily together.

2. **LK 16:18**
   - Everyone who divorces his wife and marries another is guilty of adultery, and the man who marries a woman divorced by her husband commits adultery.

3. **EPH 5:28**
   - In the same way, husbands must love their wives as they love their own bodies; for a man to love his wife as for him to love himself.