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Health Promoting Behaviour among School Going Adolescents of Government School in Gaidakot, Nawalparasi

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ABSTRACT

Background: A health-promoting behavior is an endpoint or action-outcome directed toward attaining positive health outcomes such as optimal wellbeing, personal fulfillment, and productive living. Adolescents make up as much as a quarter of the population and the number of adolescents is expected to rise through 2050. Adolescents are vulnerable to the risk factors contributing to Noncommunicable diseases, whether from unhealthy diets, physical inactivity, exposure to tobacco smoke or the harmful use of alcohol.

Method: A cross sectional analytical study design was used among 89 adolescents of grade 9 and 10 was selected through enumerative sampling technique. Data was collected using a self–administered questionnaire from Adolescent Health Promoting – Short Form scale and entered in excel and analyzed by Statistical Package for Social Science (SPSS) version 20.0 using Descriptive statistics (Frequency, percentage, mean, standard deviation) and interferential statistics (chi-square).

Result: Findings revealed that 48.3% respondents obtained below average mean score on health promoting behaviour. The overall mean ± S.D of status of health promoting behaviour was 68.12±8.847. Among 6 subscales, life appreciation obtained the highest mean score (with standard deviation) i.e. 15.35±3.72, whereas exercise obtained least mean score (with standard deviation) i.e. 7.80±2.66 and there is statistically significant association with health promoting behaviours among adolescents and educational status of mother (p=0.033).

Conclusion: Overall health promoting behaviours among adolescents is below average so it is necessary to improve in areas like nutrition and exercise. There is significant association between parental education and health promoting behaviours of the adolescents, so parental education should be improved by school committee, should introduce educational session, awareness program, physical activity program and nutrition exhibition program regarding health promoting behaviours since early grade.

Key words: adolescents; health promoting behaviours.

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INTRODUCTION

Good health is a major resource for social, economic, and personal development and an important dimension of quality of life. Political, economic, social, cultural, environmental, behavioral, and biological factors can all favour health or be harmful to it. Health promotion action aims at making these conditions favourable through advocacy for health. Health promotion is the process of enabling people to increase control over, and to improve their health. Health is, therefore, seen as a resource for everyday life, not the objective of living. Health is a positive concept emphasizing social and personal resources, as well as physical capacities. Therefore, health promotion is not just the responsibility of the health sector but goes beyond healthy life-styles to well-being.[1]Adolescence is the phase of life between childhood and adulthood, from ages 10 to 19. It is a unique stage of human development and an important time for laying the foundations of good health.[2] A health-promoting behavior is an endpoint or action-outcome directed toward attaining positive health outcomes such as optimal wellbeing, personal fulfillment, and productive living.[3] Adolescents make up as much as a quarter of the population and the number of adolescents is expected to rise through 2050, particularly in low- and middle-income countries (LMICs). Globally, each year there are more than 1.2 million adolescent deaths.[4] Promoting healthy behavior during adolescence and taking steps to better protect young people from health risks are critical for the prevention of health problems in adulthood, and for countries' future health and ability to develop and thrive.[5] Among school-going

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adolescents in low- and middle-income countries 42 percent consume carbonated sugary soft drinks at least once a day and 46 percent eat fast food at least once a week. Those rates go up to 62 percent and 49 percent, respectively, for adolescents in high-income countries. As a result, overweight and obesity levels in adolescence are increasing worldwide. In Nepal, obesity among adolescents has increased by 29 times in the past four decades. Today, 1 in 13 adolescents of this age are obese. Adolescents in wealthy and urban families have more prevalence of obesity. [6] Three thousand adolescents die every day – 1.2 million every year – from largely preventable causes. More than two-thirds of these occurred in low- and middle-income countries in Africa and South-East Asia.[7] Studying health-promoting behavior among school-going students is crucial for several reasons. First, it helps identify the factors that influence students' health choices, enabling the development of targeted interventions. Second, understanding these behaviors during the formative years can lead to the establishment of lifelong healthy habits. Third, such research aids in assessing the effectiveness of existing health education programs and policies. Furthermore, investigating the topic can provide insights into the barriers and challenges students face in adopting healthy behaviors. Ultimately, addressing these factors can contribute to improved overall well-being, reduced risk of chronic diseases, and enhanced academic performance among students. By shedding light on the dynamics of health-promoting behavior, this research can contribute to evidence-based strategies that positively impact both individual students and the broader school community.

METHODS

A cross sectional analytical study design was used to assess the health promoting behaviour among school going adolescents of government school in Gaindakot, Nawalparasi. The study was conducted in Shree Nepal Rastrya Samsher Aadarsh Madhyamik Vidhyalayey, Gaindakot-1. Shree Nepal Rastrya Samsher Aadarsh Madhyamik Vidhyalayey was established in 2023 B.S. The researcher selected government school for this study purpose, whether adolescent population of government school were aware about health promoting behavior or not. The population includes adolescents of Shree Nepal Rastrya Samsher Aadarsh Madhyamik Vidhyalayey, Gaindakot-1. Both male and female students were included. Researcher purposively select Gaindakot-1 as the study site. There are 2 Government Schools in Gaindakot-1 i.e Shree Nepal Rastrya Samsher Aadarsh Madhyamik Vidhyalayey, other one is Nabadurga Aadharbhut Bidhyalayey. Using simple random sampling method in which lottery method was used. One school was selected among 2, the selected school was Shree Nepal Rastrya Samsher Aadarsh Madhyamik Vidhyalayey where classes 9 and 10 were running. Non-probability consecutive / total enumeration method was used to collect the data to find out status of health promoting behavior among school going adolescents. The total number of students who are currently studying in grade 9 and 10 are 91 and two of them didn't give parental consent (A student who doesn't give consent to participate in the study and those who doesn't get parental consent), so obtained sample was 89. A semi-structured, self-administered questionnaire was developed by the researcher herself by reviewing literature and consulting with subject experts. Instruments was divided into following two parts. Part I: Questions related to socio- demographic information. Part II: Questions related to health promoting behavior assessed by Adolescent Health Promotion Short Form (AHP-SF) scale.[8] The content validity of the instrument was maintained by seeking consultation with the subject experts, research advisor, research teachers and by reviewing related literature. The instrument was translated into Nepali language and retranslated back into English language by seeking the help of research advisor and Nepali and English subject expert. The total Cronbach's alpha coefficient of the scale was 0.85, the Cronbach's alpha coefficient of the scale sub-scales were as follows: for the first sub-scale, 0.712; for the second sub-scale, 0.697; for the third sub-scale, 0.700; for the fourth sub-scale, 0.730; for the fifth sub-scale, 0.701; and for the sixth sub-scale, 0.702. Administrative approval was obtained from

Shree Medical and Technical College (SMTC) and ethical approval was obtained from Shree Medical and Technical College-Institutional Review Committee (SMTC-IRC-20240210-10), Bharatpur-12, Chitwan. Formal administrative permission for data collection was taken from Government School of Gaindakot-1. Written informed consent was obtained from each respondent's parents by clarifying the purpose of the study prior to data collection and then only written informed consent obtained from the respondents. Confidentiality of the information was maintained by not disclosing the information and using the information only for research purpose. Anonymity was maintained by coding the research questions instead of using their name. Each participant was allowed to have a voluntary choice for participation. Data was collected during the break time of students. After obtaining written informed consent form respondents, self-administered questions were given to fill the answer to each respondent. Each respondent was allowed 15 to 20 min to complete the questions. The questionnaire was collected immediately after completion by the researcher. The obtained data was checked, reviewed and organized for its accuracy, completeness and consistency. All the data was coded and entered into Excel, and analyzed by Statistical Package for Social Science (SPSS IBM version 20). The collected data was analyzed and interpreted by using descriptive statistics in terms of frequency, percentage, mean, median, standard deviation and for interferential statistics by using Chi-square, P-value (<0.05) which was considered statistically significant. The findings were presented in different tables.

RESULTS

Analysis and interpretation of data concerning status of Health Promoting Behaviour among school going adolescents of government school of Gaindakot, Nawalparasi. All the data was analyzed and interpreted in SPSS version 20.

Table 1 shows that ,61.8% respondents were in the age group 10-15 and the female respondents 56.2% were more compared to the male 43.8%. Almost all the respondents 83.1% were Hindu religion and

Table 1. Sociodemographic information of adolescents (age, gender, religion, ethnicity, type of family, number of members in family). (n=89)

Sociodemographic variables	Frequency(%)
Age (year)	
10-15	55(61.8)
15-20	34(38.2)
Mean ± SD, Minimum (Maximum) = 15.43±0.964, 13(18)	
Gender	
Male	39(43.8)
Female	50(56.2)
Religion	
Hindu	74(83.1)
Buddhist	10(11.2)
christianity	5(5.6)
Ethnicity	
Dalit	10(11.2)
Janajati	38(42.7)
Madhesi	1(1.1)
Brahmin/Chhetri	40(44.9)
Types of family	
Nuclear	50(56.2)
Joint	39(43.8)
Number of members in family	
<5	55(61.8)
>5	34(38.2)
Educational status of father	
Illiterate	14(15.7)
General literate	16(18)
Basic education	20(22.5)
Secondary level	39(43.8)
Educational status of mother	
Illiterate	17(19.1)
General literate	29(32.6)
Basic education	20(22.5)
Secondary level	23(25.8)
Occupation of father	
Farmer	19(21.4)
Involvement in public sector	20(22.5)
Involvement in private sector	12(13.5)
Foreign employment	31(34.8)
Business	6(6.7)
Daily wages	1(1.1)
Occupation of mother	
Homemaker	62(69.7)
Farmer	7(7.9)
Involvement in public sector	3(3.4)
Involvement in private sector	7(7.9)
Foreign employment	4(4.5)
Business	6(6.6)
Family history of chronic illness	
Yes	20(22.5)
No	69(77.5)

44.9% of them were Brahmin/Chhetri in ethnicity, 56.2% of the respondents belongs to nuclear type of family. Almost 61.8% of respondents have less than 5 members in their family. Over 43.8% of respondents' father had completed secondary level education and very few were illiterate (15.7%) and about 34.8% were involved in foreign employment. Likewise, 32.6% of respondents' mothers are general literate and very few (19.1%) were illiterate and 69.7% were involved in homemaker. Among 22.5% adolescents had history of chronic illness.

Table 2. Health promoting behavior short form: subscale mean score of respondents. (n=89)

HPLSF subscale	No of items	Mean±S.D
Nutrition	3	10.37±2.45
Social support	4	12.73±3.47
Health responsibility	4	12.46±3.21
Life appreciation	4	15.35±3.72
Exercise	3	7.80±2.66
Stress management	3	9.39±2.68

Table 2 shows that among 6 subscales of Health promoting behaviour, life appreciation obtained the highest mean score (with standard deviation) i.e. 15.35±3.72, whereas subscale exercise obtained least mean score (with standard deviation) i.e. 7.80±2.66.

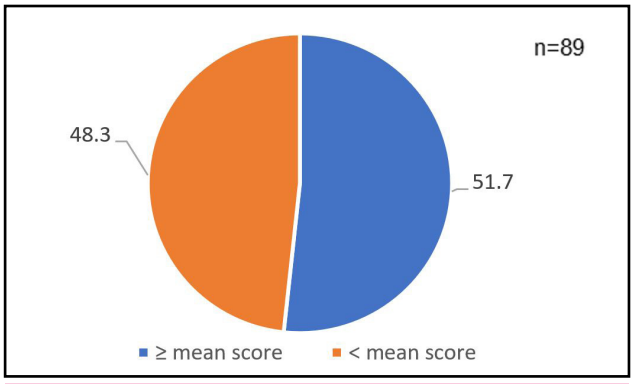

Figure 1. Health promoting behaviour status.

Figure 1 shows that most of the respondents, i.e. 51.7% respondents had obtained above average mean score on health promoting behaviour and nearly 48.3% respondents obtained below average mean score on health promoting behaviour. The overall mean±S.D of status of health promoting behaviour was 68.12±8.847. The minimum score was 46 while maximum score was 89.

Table 3. Respondents' association between status of health promoting behavior and sociodemographic variables (age, gender, religion, ethnicity, type and number of family member). (n=89)

Sociodemographic variable	Health promoting behaviors		Chi square	p-value
	High	Low		
Age (years)				
10-15	27(49%)	28(50.9%)	0.035	0.852*
15-20	16(47%)	18(52.9%)		
Gender				
Male	23(59.0%)	16(41.0%)	3.159	0.076*
Female	20(40.0%)	30(60.0%)		
Religion				
Hindusim	37(50.0%)	37(50.0%)	0.503	0.778**
Buddhism	4(40.0%)	6(60.0%)		
christianity	2(40.0%)	3(60.0%)		
Ethnicity				
Dalit	5(50.0%)	5(50.0%)	2.337	0.506**
Janajati	16(42.1%)	22(57.9%)		
Madhesi	1(100.0%)	0(0.0%)		
Brahmin/Chhetri	21(52.2%)	19(47.5%)		
Type of family				
Nuclear	25(50.0%)	25(50.0%)	0.13	0.719*
Joint	18(46.2%)	21(53.8%)		
Number of members in family				
< 5	25(45.5%)	30(54.5%)	0.472	0.492*
> 5	18(52.9%)	16(47.1%)		

*Pearson *, Likelihood ***

Above table 3 shows that there is no statistically significant association between status of health promoting behaviors and sociodemographic variables (age, gender, religion, ethnicity, type of family,number of members in family). Table 4 shows that there is a statistically significant association between health promoting behaviour and educational status of the mother (p=0.002).

DISCUSSION

This study was carried out to identify the status of health promoting behavior among adolescents on 89 students studying in grade 9 and 10 of Government school of Gaindakot. The major finding of this study is discussed with comparison of relevant studies and documented literature.

This research was done among 89 respondents. In the age group, the majority 55(61.8%) were in the age group (10-15) years with mean ±S. D of 15.43±0.964. While study conducted in Nepal, in age, majority (50.7%) were in the age group (≥15) years with mean±S. D of 15.15±0.3508.[9] In this study majority

Table 4. Respondents' Association of Status of Health Promoting Behaviors and Sociodemographic Variables (Educational and Occupational Status of Parents, Family history of Chronic Illness). (n=89)

Sociodemographic variable	Health promoting behaviors		Chi square	p-value
	High	Low		
Educational status of father				
Illiterate	4(28.6%)	10(71.4%)	5.783	0.123*
General literate	9(56.3%)	7(43.8%)		
Basic education	7(35.0%)	13(65.0%)		
Secondary level	23(59.0%)	16(41.0%)		
Educational status of mother				
Illiterate	6(35.3%)	11(64.7%)	8.751	0.033*
General literate	13(44.8%)	16(55.2%)		
Basic education	7(35.0%)	13(65.0%)		
Secondary level	17(73.9%)	6(26.1%)		
Occupation of father				
Farmer	11(57.9%)	8(42.1%)	7.891	0.162**
Involvement in public sector	7(35.0%)	13(65.0%)		
Involvement in private sector	8(66.7%)	4(33.3%)		
Foreign employment	16(51.6%)	15(48.4%)		
Business	1(16.7%)	5(83.3%)		
Daily wages	0(0.0%)	1(100.0%)		
Occupation of mother				
Homemaker	31(50.0%)	31(50.0%)	3.436	0.633**
Farmer	4(57.1%)	3(42.9%)		
Involvement in public sector	1(33.3%)	2(66.6%)		
Involvement in private sector	2(28.6%)	5(71.4%)		
Foreign employment	3(75.0%)	1(25.0%)		
Business	2(33.3%)	4(66.7%)		
Family history of chronic illness				
Yes	7(35.0%)	13(65.0%)	1.831	0.176*
No	36(52.2%)	33(47.8%)		

of respondents are Female 56.2%. Similarly, majority respondents are female i.e. 52.4%. [9] In this study, almost all the respondents 83.1% were Hindu religion and 44.9% of them were Brahmin/Chhetri ethnicity. About 56.2% of the respondents had a nuclear type of family. While in another study, in religion majority were Hindu 99.1%, in ethnicity majority were brahmin 30.3%, in type of family majority were nuclear 59.5%.[9] In this study, most of the students 61.8% had family members less than 5, and this finding is similar in the another study showed that majority of respondents 57.5% had family members more than 5.[10] In this study, over 43.8% of respondents' father had completed secondary level education and very few were illiterate (15.7%). About 34.8% were involved in foreign employment. Likewise, 32.6% of respondents' mothers are general literate and very few (19.1%) were illiterate and 69.7% were involved in homemaker. While in the study conducted in Nepal, majority ,47.9% of respondents father had completed secondary level education and least 1.2% were university level. Similarly, about 43.3% were involved in foreign employment. Likewise, 43.4% of respondent's mothers are secondary level and very few 0.9% were university level. Whereas 48.8% were involved in homemaker.[9] In this study, most of the adolescents 77.5% didn't have history of chronic illness. while in the study conducted in Nepal, 54.4% didn't have history of chronic illness.[10] In this study, majority of respondents received information through social media 95.5% and least received from radio (23.6%).

Health promoting behaviour of adolescents in government school of Gaindakot, shows that the total mean score obtained by the respondents in total modified AHPSF scale was 68.12±8.84, which is above the average level. Regarding the subscales, respondents has obtained highest score in the area of life appreciation (with standard deviation) i.e. 15.35±3.72, followed by social support i.e. (12.73±3.47), health responsibility (12.46±3.21), nutrition (10.37±2.45), stress management (9.33±2.68), exercise (7.80±2.66). In this study, there is statistically significant association between health promoting behaviour and educational status of mother (p=0.033) similar findings conducted in Nepal, showed that there is there is statistically significant association between health promoting behaviour and educational status of the mother (p=0.002).[9]

CONCLUSIONS

Overall health promoting behaviours among adolescents is below average so it is necessary to improve in areas like nutrition and exercise. There is significant association between parental education and health promoting behaviours of the adolescents, so parental education should be improved by school committee, should introduce educational session, awareness program, physical activity program and nutrition exhibition program regarding health promoting behaviours since early grade.

Limitations

The study was conducted in a government school

of Gaindakot, Nawalparasi. The study was cross sectional so the result may change over time.

RECOMMENDATION

Further research can be done in a large area so that findings can be generalized using more sample size.

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Conflict of Interest: None

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