

HEALTH PROMOTING BEHAVIORS AMONG ADOLESCENTS IN A GOVERNMENT SCHOOL OF CHITWAN, NEPAL

Dipti Koirala*, Prof. Milan Lopchan and Associate Prof. Subina Bajracharya

Chitwan Medical College, School of Nursing, Bharatpur-5, Chitwan.

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*Corresponding Author

Dipti Koirala

Chitwan Medical College,
School of Nursing, Bharatpur-
5, Chitwan.

ABSTRACT

Adolescent period is a foundation of the future life. Modifiable unhealthy behaviors during adolescence can lead to emergence of Non-communicable diseases (NCDs) in later stages of life. This study aimed to find out the health promoting behaviors among adolescents in a government school of Chitwan, Nepal. Descriptive cross-sectional study was conducted among 201 students of grade nine at a government school of Bharatpur, Chitwan. Data were collected using self-administered questionnaire (a standard tool: AHP scale) and the data were analyzed using descriptive and inferential statistics. The mean age of the respondents was 14.84 ± 0.75 and majority of the respondents were male (51.7%). The total mean score of AHP scale was 78.95 ± 12.20 , and the percent of mean score was 75.19%. The highest score was obtained in the area of life appreciation (17.47 ± 3.39), and least score in exercise (9.61 ± 3.39). Statistically significant association was found between health promoting behaviors among adolescents and sources of health information {school teachers ($p=0.008$), family members ($p=0.032$), newspapers ($p=0.003$), internet ($p=0.043$), radio ($p=0.025$) and health workers ($p=0.023$)}. Statistically significant association was found between subscales (nutrition behavior) and father's employment status ($p=0.016$), and between subscale (health responsibility) and mother's educational status ($p=0.021$). Health promoting behaviors among adolescents was found inadequate, mainly in the area of nutrition and exercise. Thus, the school management and the parents, both needs to pay more attention to the adolescents; consultation and educational services to the adolescents need to be emphasized; internet, radio and newspaper need to be utilized to enhance health promoting behaviors among adolescents.

KEYWORDS: Health promoting behaviors, Adolescents, School.

MATERIALS AND METHODS

The adolescent's population (10-19 years old) in the world is about 1.2 billion. ^[1]This is the period of physical, emotional and evolutionary changes which can affect the health behavior of one in adulthood. ^[2]In this stage, according to Walker & Townsend, people start to take responsibility of their own health and at the same time, many of them often involve themselves in unhealthy practices (inadequate intake of nutritious food, inadequate rest and inadequate exercise) and in health risk behaviors such as smoking, drug use, etc. These activities are often associated with Non-communicable diseases (NCDs), such as cardiac or respiratory diseases, cancer, complicated pregnancies or deliveries, and psychological disorders in later life. ^[3]The NCDs such as cardiovascular disease, cancer, chronic respiratory disease and diabetes are the leading cause of mortality in the world contributing to 71% of global deaths. In 2012, there were 56 million global deaths due to NCDs. ^[4]To prevent these NCDs, it is important for the adolescents to follow a health-promoting lifestyle (HPL) such as eating a low-fat diet, regular physical activities, maintaining a

healthy body weight, avoiding smoking and stress, etc. Following a healthy diet is very important to prevent chronic disease like diabetes mellitus, hypertension, cardiovascular disease and some type of cancers. ^[5]A HPL include the "physical activity", "nutrition", "health responsibility", "spiritual growth", "interpersonal relations" and "stress management which help to promote both physical and mental health. ^[6]

A Descriptive cross-sectional research design was used to find out the health promoting behaviors among adolescents. The study was conducted in a government school of Bharatpur, Chitwan i.e., Narayani Model Higher Secondary school. The study population was the adolescent group of the government school. The school and grade nine within the school were selected purposively. Five sections, out of seven sections of grade 9 were selected through cluster sampling technique and all the students within those five sections were taken as the study sample. Data collection was done on March, 2016. Data regarding socio-demographic characteristics of the adolescents were collected by using semi-structured, self-administered questionnaire, and data

regarding health promoting behaviors were collected by using AHP scale, a standard tool developed by Chen, lai, Chen, & Gaete.^[7] Two-stage-back translation of the tool was done with the help of language expert and the cronbach's alpha value calculated for the tool was 0.63 (acceptable range >0.6). Ethical clearance was obtained from Institutional Review Committee (IRC), CMC and formal written permission was taken from the selected school.

All the collected data were reviewed and checked and entered in EPI 3.1. Then, the entered data were exported into Statistical package for social science (version 20.0). The data were analyzed by using descriptive statistics (frequency, percentage, mean, and standard deviation), and inferential statistics (Chi-square test, Fisher's exact test, and Karl Pearson's coefficient of correlation).

RESULTS

Table 1: Mean Scores of Total Adolescents Health Promoting Scale and Its Subscales n=201.

Subscales of Health Promoting Behavior	Mean Score \pm SD	Percent of Mean Score	Range	Maximum Possible Score
Nutrition	10.00 \pm 2.39	66.69	11	15
Social support	16.77 \pm 3.05	83.85	16	20
Health responsibility	13.51 \pm 3.39	67.58	16	20
Life appreciation	17.47 \pm 3.39	87.38	16	20
Exercise	9.61 \pm 3.39	64.07	12	15
Stress management	11.56 \pm 2.90	77.11	12	15
Total AHP scale	78.95 \pm 12.20	75.19	79	105

Table 1 shows that the mean score and standard deviation of total AHP scale was 78.95 \pm 12.20 and the percent of mean score was 75.19%. Regarding the subscales of the AHP scale, respondents have obtained

higher percent of mean score than the total AHP scale mean score in the area of life appreciation (87.38%), social support (83.85%), and stress management (77.11%).

Table 2: Score Status of Health Promoting Behaviors of the Respondents n=201.

Health promoting Behaviors	High Score n (%)	Low Score n (%)
Nutrition	90(44.8)	111(55.2)
Social-support	128(63.7)	73(36.3)
Health responsibility	103(51.2)	98(48.8)
Life appreciation	123(61.2)	78(38.8)
Exercise	98(48.8)	103(51.2)
Stress management	124(61.7)	77(38.3)
Total AHP scale	111(55.2)	90(44.8)

Table 2 shows that out of 201 respondents, 55.2% of the respondents had obtained high score and 44.8% of the respondents had obtained low score in total AHP scale. Regarding the subscales of the health promoting

behaviors, high scores were obtained in the area of social support (63.7%), and least score in the area of nutrition (44.8%).

Table 3: Association of Status of Health Promoting Behaviors among Adolescents with their Socio-demographic Characteristics n=201.

Variables	Status of Health Promoting Behaviors		χ^2	p-value
	High Score N (%)	Low Score N (%)		
Age				
≤ 15	91 (54.8)	75 (45.2)	0.063	0.802
> 15 years	20 (57.1)	15(42.9)		
Sex				
Male	64(61.5)	40(38.5)	3.475	0.062
Female	47(48.5)	50(43.4)		
BMI				
Underweight	10(37.0)	17(63.0)	4.785	0.091
Normal weight	94(57.3)	70(42.7)		
Overweight*	7(70.0)	3(30.0)		

Ethnicity				
Dalit	6(50.0)	6(50)	0.141	0.707
Upper caste groups	105(55.6)	84(44.4)		
Type of family				
Nuclear family	98(56.0)	77(44.0)	0.330	0.566
Joint family	13(50.0)	13(50.0)		
No. of family members				
≤5	88(54.7)	73(45.3)	0.105	0.746
>5	23(57.5)	17(42.5)		
Living arrangement				
Own home	77(54.2)	65(45.8)	0.195	0.659
Rented home	34(57.6)	25(42.4)		
Presence of chronic disease among family members				
Yes	27(57.4)	20(42.6)	0.123	0.726
No	84(54.5)	70(45.5)		

Significance level at 0.05, *Overweight-includes both overweight and obesity,

Table 3 shows that there is no statistically significant association between health promoting behaviors among respondents and age, sex, BMI, ethnicity, type of family,

no. of family members, living arrangement and presence of chronic diseases in family members of the respondents.

Table 4: Association of Status of Health Promoting Behaviors among Adolescents with Parents' Educational and Occupational Characteristics.

Variables	Status of Health Promoting Behaviors		χ^2	p-value
	High Score n(%)	Low Score n(%)		
Fathers' educational status(n=201) ^ε				
Literate	106(54.9)	87(45.1)	-	0.733
Illiterate	5(62.5)	3(37.5)		
Fathers' educational level (n=193)				
Secondary level and below	45(54.9)	37(45.1)	0.000	0.992
Higher secondary level and above	61(55)	50(45)		
Fathers' employment status (n=201)				
Employed	101(55.2)	82(44.8)	0.001	0.976
Unemployed	10(55.6)	8(44.4)		
Fathers' occupation (n=183)				
Service	59(51.8)	55(48.2)	1.444	0.229
Others	42(60.9)	27(39.1)		
Mothers' educational status (n=201)				
Literate	101(54.3)	85(45.7)	0.858	0.354
Illiterate	10(66.7)	5(33.3)		
Mothers' educational level (n= 186)				
Secondary level and below	94(55.6)	75(44.4)	1.299	0.254
Higher secondary level and above	7(41.2)	10(7.8)		
Mothers' employment status (n=201)				
Employed	44(53.0)	39(47.0)	0.280	0.597
Unemployed	67(56.8)	51(43.2)		
Mothers' occupation (n=83)				
Service	17(47.2)	19(52.8)	0.856	0.355
Others	27(57.4)	20(42.6)		

Significance level at 0.05, ^εFisher's exact test

Table 4 shows that there is no statistically significant association between health promoting behavior among respondents and parents' educational status, educational level, employment status and occupation.

Table 5: Association of the Status of Health Promoting Behaviors among Adolescents with Sources of Health Information n=196.

Sources of health information**	Health Promoting Behaviors		χ^2	p-value
	High Scores n(%)	Low Scores n(%)		
TV	78(56.1)	61(43.9)	0.145	0.704
School teachers	77(62.6)	46(37.4)	6.977	0.008
Family members	71(61.7)	44(38.3)	4.614	0.032
Course Books	67(61.5)	42(38.5)	3.755	0.053
Internet	64(62.1)	39(37.9)	4.082	0.043
Newspapers	65(65.7)	34(34.3)	8.587	0.003
Radio	62(63.3)	36(36.7)	5.001	0.025
Health workers	61(63.5)	35(36.5)	5.142	0.023

Significance level at 0.05, ** Multiple answers

Table 5 shows that there is statistically significant association between health promoting behaviors among respondents and school teachers (p=0.008), family

members (p=0.032), internet (p=0.043), newspaper (p=0.003), radio (p=0.025), and health worker (p=0.023).

Table 6: Association of Subscales of Adolescents Health Promoting Scale with Socio-demographic Characteristics n=201.

Socio-demographic Characteristics	Nutrition			Social Support			Health Responsibility			Life Appreciation			Exercise			Stress Management		
	H (%)	L (%)	P	H (%)	L (%)	P	H (%)	L (%)	P	H (%)	L (%)	P	H (%)	L (%)	P	H (%)	L (%)	P
Age																		
≤15	56.0	44.0	0.421	63.3	36.7	0.783	49.4	50.6	0.254	63.9	36.1	0.92	50.0	50.0	0.442	62.0	38.0	0.821
> 15 years	48.6	51.4		65.7	34.3		60.0	40.0		48.6	51.4		42.9	57.1		60.0	40.0	
Sex																		
Male	59.6	40.4	0.149	66.3	33.7	0.416	54.8	45.2	0.295	63.5	36.5	0.495	54.8	45.2	0.076	60.6	39.4	0.736
Female	49.5	50.5		60.8	39.2		47.4	52.6		58.8	41.2		42.3	57.7		62.9	37.1	
Ethnicity																		
Dalit	58.3	41.7	0.796	75.0	25.0	0.400	41.7	58.3	0.494	66.7	33.3	0.688	33.3	66.7	0.270	83.3	16.7	0.112
Upper caste groups	54.5	45.5		63.0	37.0		51.9	48.1		60.8	39.2		49.7	50.3		60.3	39.7	
Type of family																		
Nuclear family	56.0	44.0	0.347	64.0	36.0	0.808	52.6	47.4	0.329	62.3	37.7	0.410	50.3	49.7	0.260	60.6	39.4	0.397
Joint family	46.2	53.8		61.5	38.5		42.3	57.7		53.8	46.2		38.5	61.5		69.2	30.8	
No. of family members																		
≤ 5	55.3	44.7	0.752	62.7	37.3	0.575	54.0	46.0	0.112	61.5	38.5	0.863	49.1	50.9	0.859	58.4	41.6	0.053
>5	52.5	47.5		67.5	32.5		40.0	60.0		60.0	40.0		47.5	52.5		75.0	25.0	
Living arrangement																		
Own home	54.9	45.1	0.928	62.7	37.3	0.646	52.1	47.9	0.702	57.0	43.0	0.061	47.2	52.8	0.489	62.0	38.0	0.899
Rented home	54.2	45.8		66.1	33.9		49.2	50.8		71.2	28.8		52.5	47.5		61.0	39.0	
Chronic disease in family members																		
Yes	46.8	53.2	0.213	63.8	36.2	0.981	53.2	46.8	0.760	68.1	31.9	0.268	51.1	48.9	0.718	68.1	31.9	0.303
No	57.1	42.9		63.6	36.4		50.6	49.4		59.1	40.9		48.1	51.9		59.7	40.3	

Significance level at 0.05, H-High score, L-Low Score, p p-value,

Table 6 shows that there is no statistically significant association between the subscales of health promoting behaviors (social-support, health responsibility, life appreciation, nutrition, exercise and stress management)

and the socio-demographic characteristics of the Respondents (age, sex, ethnicity, type of family, number of family members, living arrangement and presence of chronic disease in family members).

Table 7: Association of Subscales of Adolescents Health Promoting Scale with Parents' Educational and Occupational Characteristics.

Variables	Nutrition Behaviors			Social Support			Health Responsibility			Life Appreciation			Exercise			Stress Management		
	H (%)	L (%)	P	H (%)	L (%)	P	H (%)	L (%)	P	H (%)	L (%)	P	H (%)	L (%)	P	H (%)	L (%)	P
Father's educational status (n=201)																		
Literate	55.4	44.6	0.472 ^e	63.2	36.8	0.497	51.3	48.7	1.000 ^e	60.1	39.9	0.154 ^e	49.7	50.3	0.280 ^e	62.2	37.8	0.485 ^e
Illiterate	37.5	63.5		75.0	25.0		50.0	50.0		87.5	12.5		25.0	75.0		50.0	50.0	
Father's educational level (n=193)																		
Secondary level and below	56.1	43.9	0.875	63.4	36.6	0.960	50.0	50.0	0.757	65.9	34.1	0.161	48.8	51.2	0.819	65.9	34.1	0.365
Higher secondary level and above	55.0	45.0		63.1	36.9		52.3	47.7		55.9	44.1		50.5	49.5		59.5	40.5	
Fathers' employment status (n=201)																		
Employed	57.4	42.6	0.016	61.7	38.3	0.069	51.9	48.1	0.545	61.2	38.8	0.994	48.1	51.9	0.545	63.4	36.6	0.115
Unemployed	27.8	72.2		83.3	16.7		44.4	55.6		61.1	38.9		55.6	44.4		44.4	55.6	

Father's occupation																		
Service	53.7	46.3	0.162	58.7	41.3	0.232	50.4	49.6	0.571	62.0	38.0	0.762	43.8	56.2	0.105	62.0	38.0	0.582
Others	64.5	35.5		67.7	32.3		54.8	45.2		59.7	40.3		56.5	43.5		66.1	33.9	
Mother's educational status (n=201)																		
Literate	53.2	46.8	0.132	64.0	36.0	0.758	48.9	51.1	0.021	61.3	38.7	0.921	50.5	49.5	0.075	61.8	38.2	0.889
Illiterate	73.3	26.7		60.0	40.0		80.0	20.0		60.0	40.0		26.7	73.3		60.0	40.0	
Mother's educational level (n= 186)																		
Secondary level and below	56.0	44.0	0.323	62.9	37.1	0.702	46.6	53.4	0.405	63.8	36.2	0.367	54.3	45.7	0.185	63.8	36.2	0.478
Higher secondary and above	48.6	51.4		65.7	34.3		52.9	47.1		57.1	42.9		44.3	55.7		58.6	41.4	
Mothers employment status (n=201)																		
Employed	57.8	42.2	0.458	69.9	30.1	0.125	53.0	47.0	0.674	62.7	37.3	0.722	47.0	53.0	0.674	56.6	43.4	0.215
Unemployed	52.5	47.5		59.3	40.7		50.0	50.0		60.2	39.8		50.0	50.0		65.3	34.7	
Mother's Occupation (n=83)																		
Service	57.9	42.1	0.991	73.7	26.3	0.488	50.0	50.0	0.613	65.8	34.2	0.587	44.7	55.3	0.706	60.5	39.5	0.510
Others	57.8	42.2		66.7	33.3		55.6	44.4		60.0	40.0		48.9	51.1		53.3	46.7	

Significance level at 0.05, H-High score, L-Low Score, p p-value, ^c Fisher's exact test

Table 7 shows that there statistically significant association between nutrition behaviors of the respondents and father's employment status (p=0.016); between health responsibility behavior of the respondents and mother's educational status (p=0.021).

Table 8: Association of Subscales of Adolescents Health Promoting Scale with Sources of Health Information n= 196.

Variables**	Nutrition Behaviors			Social Support			Health Responsibility			Life Appreciation			Exercise			Stress Management		
	H (%)	L (%)	P	H (%)	L (%)	P	H (%)	L (%)	P	H (%)	L (%)	P	H (%)	L (%)	P	H (%)	L (%)	P
TV	54.0	46.0	0.743	61.9	38.1	0.424	51.8	48.2	0.814	62.6	37.4	0.543	49.6	50.4	0.707	61.9	38.1	0.938
School teachers	56.9	43.1	0.435	66.7	33.3	0.269	57.7	42.3	0.021	65.0	35.0	0.160	51.2	48.8	0.380	66.7	33.3	0.068
Family members	57.4	42.6	0.380	67.0	33.0	0.264	53.9	46.1	0.381	65.2	34.8	0.176	54.8	45.2	0.048	67.0	33.0	0.076
Course Books	58.7	41.3	0.216	67.0	33.0	0.291	51.4	48.6	0.967	63.3	36.7	0.504	49.5	50.5	0.808	66.1	33.9	0.166
Internet	63.1	36.9	0.014	64.1	35.9	0.905	52.4	47.6	0.731	62.1	37.9	0.779	50.5	49.5	0.615	65.0	35.0	0.316
Newspaper	57.6	42.4	0.424	63.6	36.4	0.990	51.5	48.5	0.940	65.7	34.3	0.201	55.6	44.4	0.057	67.7	32.3	0.085
Radio	59.2	40.8	0.216	62.2	37.8	0.680	56.1	43.9	0.177	67.3	32.7	0.081	54.1	45.9	0.141	69.4	30.6	0.029
Health workers	57.3	42.7	0.485	65.6	34.4	0.584	56.3	43.8	0.175	59.4	40.6	0.613	52.1	47.9	0.367	68.8	31.3	0.049

Significance level at 0.05, ** Multiple answers, H-High score, L-Low Score, p p-value

Table 8 shows that there is statistically significant association between nutrition behavior of the respondents and internet (p=0.014); health responsibility behaviors of the respondents and school teachers (p=0.021); exercise behaviors of the respondents and family members (p=0.048); and between stress

management behavior of the respondents and radio (p=0.029), and health workers (p=0.049). The association between other subscales of health promoting behaviors and other sources of health information was found statistically insignificant.

Table 9: Relationship between the Subscales of Adolescents Health Promoting Scale.

Subscales of AHP Scale	NU	SP	HR	LA	EX	SM
Nutrition	1					
Social support	0.082	1				
Health responsibility	0.233**	0.153*	1			
Life appreciation	0.137	0.290**	0.204**	1		
Exercise	0.187**	0.116	0.294**	0.246**	1	
Stress management	0.188**	0.150*	0.276**	0.318**	0.195**	1
AHP scale	0.307**	0.423**	0.443**	0.474**	0.518**	0.484**

** Correlation is significant at 0.01 level, * Correlation is significant at 0.05 level, NU- nutrition, SP-Social support, HR-Health responsibility, LA-life appreciation, EX-Exercise, SM-Stress management

Table 9 shows that there is statistically significant positive correlation between total AHP scale and all subscales of AHP scale {nutrition (r= 0.307), social support (r= 0.423), health responsibility (r= 0.443), life appreciation (r=0.474), exercise (r= 0.518) and stress management (r= 0.484)}, at 0.01 level of significance. Regarding correlation between subscales, there is statistically significant positive correlation of subscale

nutrition with subscales health responsibility (r=0.233), exercise (r=0.187), and stress management (r= 0.188) at 0.01 level of significance. Likewise, there is statistically significant positive correlation of subscale social support with subscale life appreciation (r=0.290) at 0.01 level of significance and with subscales health responsibility (r=0.153) and stress management (r=0.188) at 0.05 level of significance. Similarly, there is statistically significant

positive correlation of subscale health responsibility with subscales life appreciation ($r=0.204$), exercise ($r=0.294$), and stress management ($r=0.276$) at 0.01 level of significance. There is also statistically significant positive correlation between subscale exercise and subscale stress management ($r= 0.195$) at 0.01 level of significance.

DISCUSSION

This study showed that the total mean score obtained by the respondents in total AHP scale was 78.95 ± 12.20 , and the percent of mean score is 75.19%, which is above the average level. Regarding the subscales, respondents have obtained highest score in the area of life appreciation, followed by social support, stress management, health responsibility and nutrition, and lowest in exercise. This result is quite similar to the results identified by Ortabag,^[8] which revealed that respondents had obtained highest scores in the area of life appreciation subscale followed by social support, stress management, health responsibility, nutrition and exercise.

The study showed no statistically significant association between health promoting behaviors and socio-demographic characteristics of the respondents such as, size of the family ($p=0.746$), living arrangement ($p=0.659$) and family income ($p=0.265$). These findings were supported by the previous study by Musavian,^[5] which revealed that health promoting behaviors did not significantly associate with family size ($p=0.055$), house type ($p=0.055$) and family monthly income ($p=0.140$).

This study revealed that there is significant association between health promoting behaviors among respondents and sources of health information such as radio ($p=0.025$), internet ($p=0.043$), newspaper ($p=0.003$), health workers ($p=0.023$), family members ($p=0.032$) and school teachers ($p=0.008$). In contrast, the study by Musavian^[5] showed no significant association between health promoting behaviors and sources of health information ($p=0.359$).

The current study showed no statistically significant association between health promoting behaviors among adolescents and parent's educational status. In contrast, Musavian.^[5] reported that the mean health promotion score was significantly associated with their fathers' and mothers' educational status ($p=0.045$ and $p=0.021$, respectively). The respondents whose parents had university education had obtained higher mean health promotion score than other students. However, the current study showed statistically significant association between the subscale (health responsibility) and the educational status of the mother. Regarding this, the respondents who had illiterate mothers had obtained high scores than the respondents who had literate mothers ($p=0.021$). In contrast, study by Ortabag.^[8] reported that, the respondents whose mothers had an elementary education level or higher, obtained high scores in health

responsibility subscales of AHP scale than the respondents whose mother has less than an elementary education level ($p=<0.05$). The mothers who are illiterate in Nepal are mostly unemployed and housewife. Thus, they may have enough time to care their children and to teach their children about health related matters. So this can be the reason that the respondents in this study with illiterate mothers had obtained high score in health responsibility than the respondents who had literate mothers.

The current study showed no statistically significant association between health promoting behaviors among respondents and parents' employment status. This finding is not supported by the study conducted in Iran by Musavian^[5] which revealed that, adolescent's health promoting behavior scale score was significantly associated with the mothers' job ($p=0.008$). However, the current study showed significant association between subscale (nutrition) and fathers' employment status ($p=0.016$). The scores of health promoting behaviors of the respondents whose fathers were employed, was significantly higher than the respondents whose fathers were unemployed in subscale nutrition. In contrast, the results of the previous study by Musavian^[5] revealed that health promoting behaviors among adolescents was significantly associated with mothers' employment status ($p=0.008$).

Correlation analysis between AHP scale and subscales of AHP scale showed that, there is statistically significant positive correlation between total AHP scale and all the subscales of AHP scale. The study showed a moderate positive correlation between total AHP scale and subscales. Similarly, it revealed that there is a significant positive correlation between subscales with each other, except nutrition with social support and life appreciation, and social support with exercise. There is a weak positive correlation between the subscales.

CONCLUSION

Based on these findings it is concluded that the health promoting behaviors is high among respondents who has received health information through school teachers, family members, internet, newspapers, radio and health workers have high score. However, the health promoting behaviors among adolescents is poor, mainly in the area of health responsibility, nutrition and exercise behavior. Thus, both the school management and the parents need to pay more attention to the health related behavior of the adolescent in-order to prevent acute illness and chronic illness in the future. The sources like internet, radio, and newspaper can be used to disseminate health information regarding health promoting behaviors, and to create awareness regarding prevention of NCDs and other illness. This will help to improve the health status of the public, ultimately improving the socio-economic conditions of the family and the nation.

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