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EVALUATION OF HEALTHY LIVING STYLE BEHAVIOURS OF HIGH SCHOOL STUDENTS (ADIYAMAN CITY EXAMPLE)

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ABSTRACT

The study was done to obtain if healthy living style behaviours of high school students that are educating in Adıyaman city centre show difference according to gender, class and school type variables. The students educating in high schools belonging to provincial directorate of education of Adıyaman city in 2015-2016 academic year formed the population of research. The participant students were chosen by using random sampling method. In order to obtain research datas, personal information form consisting demographic datas and the variability and reliability study of scale that was developed by Walker et. al (1987) as 48 items and then became 52 items by being added 4 more items, was done by Akça (1998). The scale is consisted of six sub dimensions as health responsibility, physical activity, nutrition, spiritual development, interpersonal relations and stress management. Research findings show that healthy living style behaviours of students are at "sometimes" level. Healthy living style behaviours of high school students were found to have difference between levels of scale according to school type, gender, class variables.

Key words: High school students, Adolescence period, Healthy Living Style

1. INTRODUCTION

Health is one of the concepts that is put on emphasis most since the beginning of humanity (Phalank, 1991). Healthy living style is defined as controlling of all behaviours that can affect the health of individual as well as regulating of daily activities by choosing suitable behaviours for his health status (Ocakçı, 2009). Getting the health better in other words developing health aims to improve general health and status more apart from preventing any disease or disorder (Ünalın, Şenol, Öztürk, Erkorkmaz, 2007). Healthy living style behaviours involve sufficient and balanced nutrition, stress management, doing regular exercise, spiritual development, interpersonal relations and individual's taking responsibility regarding protection and development of his health (Pender, Walker, Sechrist, 1987).

Today supporting positive health behaviours and adopting healthy life style play a key role in developing health and preventing diseases. This understanding bases on individual's gaining behaviours to keep, continue and improve his well-being and taking right decisions about his own health (Semerci, 2007). Many diseases base on childhood and adolescence period however this relation between common diseases and

childhood and adolescence period mostly escape the attention (Vicente-Rodriguez, Libersa, Mesana, Béghin, Iliescu, Aznar, 2007).

The changes that come out during adolescence and youth in fact show parallelism with the changes of health behaviours. Especially bad nutrition of adolescences that are under the risk in terms of smoking, alcohol and other negative behaviours, brings similar anxiety along⁷.(Aslan and Yeşildal, 2003).

Efforts of improving health becomes more of an issue for individuals taking their health behaviours to the ultimate level⁸.(Komduur, Korthals, Molder, 2009). Studies show that there is a relation between living style and health status as well as using of health service and health service systems⁹.(Fleming and Marshall, 2008). Healthy living style can take health status to a better level since it can control behaviours that can affect the health of an individual as he is organizing his daily activities¹⁰.(Zaybak and Fadiloğlu, 2004). Nutrition, stress management, exercise, sexuality, interpersonal relations and health responsibility are considered as behaviours of healthy living style¹¹.(Esin, 1997).

Most part of the lives of adolescents passes at school. Schools are important education institutions where adolescents are in groups. World Health Organization stated that schools are effective for an individual and his parents in gaining of positive health behaviour and they are also suitable places to develop and apply health improving programmes¹².(WHO, 2009). As Health Behaviour is considered as a behaviour to protect healthy life of an individual, it is seen as an important condition for high school students to form a healthy life conscious, gain healthy living style behaviours and apply these gaining to life. This study was aimed to evaluate healthy living style behaviors of high school students.

2. MATERIAL AND METHOD

In the study scanning modal was used to evaluate healthy living style behaviours of high school students. Scanning modals are research approaches that aim to define a past or a present situation as it is. The main thing in this approach is to observe present situation without changing it¹³.(Karasar, 2003). Since this research is a descriptive research that aimed to obtain healthy living style behaviour levels of high school students, similar way was followed.

2.1. Population and Sample

The students educating in high schools of Adıyaman City Provincial Directorate for National Education during 2015-2016 academic year formed the population of research. The participant students were identified by random sampling method without considering their genders and high school types. 445 students which 44.6% of them from Anatolian high school, 17.1% of them from vocational school of health and 34.7% of them from religious vocational high school, formed the sampling of research. The high school students that are consisted of 228 female and 217 male were applied personal information form and healthy living style behaviour scale questionnaire. As a result of evaluation the ones who are not suitable to reliability tolerance of scales, unvolunteer or made answering mistakes, were left out of assessment. At the end of evaluations totally 411 high school students consisting of 218 female and 193 male were participated to the study. The datas were analysed with 411 questionnaires and scale questions that were filled completely by students.

2.3. Data Collection Tools

The datas were obtained by socio-demographic questionnaire that describes student and parents of student and “Healthy Living Style Behaviours Scale” (HLSBS). The scale was developed by Walker, Sechrist and Pender (1987) and in 1996 it was revised again by Walker, Hill- Polerecky and named as Healthy Living Style Behaviours Scale II¹⁴.(Walker, Sechrist, Pender, 1987). The validity and reliability of scale in Turkey was done by Esin (1997) and Akça (1998). The alpha value was found as 0.91 in the study of Esin whereas it was found as 0.90 in the study of Akça. The alpha value of sub factors was found as 0,55- 0,84 in the study of Esin whereas it was found as 0,52-0,81 in the study of Akça. In the research the scale that was adopted to Turkish by Akça (1998), was used. The general point of scale gives the point of healthy living style behaviours. The scale is consisted of 52 items and 6 sub groups¹⁵.(Bahar, Beşer, Gördes, Ersin, Kıssal, 2008).

2.3. Evaluation of Datas

The statistical analysis of datas obtained from research was done by SPSS package programme. For categorical variables descriptive statisticals were presented in frequency and percentage type whereas for continuous variables they were presented in average \pm standard deviation type. After obtaining normal

distribution of datas, the points obtained from scale were compared by t test for independent two groups and for more than two groups it was done by One-way ANOVA test. In obtaining of differences in points found as a result of variance analysis LSD post hoc test was used. In statistical analyses if $p < 0.05$ the results were accepted as significant.

3. FINDINGS

Socio-demographic properties of students and parents were given in Table 1.

Table 1. Demographic Properties of High School Students (n=411)

Properties	Number (n)	Percent(%)	Properties Gender	Number (n)	Percent
School type					
Anatolian H.S	190	46.1			
Health V.H.S	73	17.5	Female	218	52
Religious V.H.S	148	36.4	Male	193	48
Class					
9th grade	147	35.8	11th grade	86	20.9
10th grade	79	19.2	12th grade	99	24.1

As 44.6% of participant students were from Anatolian High school, 17.1% of them from Health Vocational High school, 34.7% of them from Religious Vocational High school, approximately half of them 48% were male whereas 52% of them were female students. 35.6% of students were educating in 9th Grade.

Table 2. Distribution of HLSBS points and Sub group points of High school students according to Gender variable and t Test Validity Coefficients regarding Sub dimensions

Dimensions	Groups	N	\bar{X}	ss	t	Sd	P
Health responsibility	Female	218	2,04	,52121	-2,230	409	,026
	Male	193	2,16	,55807			
Physical activity	Female	218	1,89	,59512	-7,227	409	,000
	Male	193	2,31	,58450			
Nutrition	Female	218	2,11	,39919	-3,156	409	,002
	Male	193	2,25	,47915			
Spiritual development	Female	218	2,85	,52535	-1,229	409	,220
	Male	193	2,91	,53765			
Interpersonal relations	Female	218	2,69	,53971	,301	409	,763
	Male	193	2,67	,47396			
Stress Management	Female	218	2,38	,50352	-2,752	409	,006
	Male	193	2,52	,50941			

The comparison of HLSBS points and sub group point averages of high school students according to gender were given in Table 2. Except health responsibility it was seen that the points of male students in all sub points are higher than the points of female students. According to gender variable as a result of paired group t test the difference between arithmetical averages was not found statistically significant ($p > .05$) in terms of Health responsibility ($t = 2.20$; $p < .05$), physical activity ($t = -7.227$; $p > .05$), Nutrition ($t = -3.156$; $p > .05$), Spiritual development ($t = -1.229$; $p > .05$), Stress management ($t = -2.752$; $p > .05$), they were found significant in terms of Interpersonal relations ($t = 301$; $p < .05$).

Table 3. Distribution of HLSBS and sub group points of high school students according to School Type variable

Dimensio ns	School type	N	\bar{X}	ANOVA						
				Variance source	Total of squares	sd	Average of squares	F	p	LSD
Health responsibility	Anatolian H.S	190	2,0637	Intergroups Within group Total	4,557	2	2,278	8,039	,000	1-2 2-3
	Health V.H.S	73	2,3212		115,634	408	,283			
	Religious V.H.S	148	2,0293		120,190	410				
	Total	411	2,0971							
Physical activity	Anatolian H.S	190	2,1178	Intergroups Within group Total	,508	2	,254	,648	,524	
	Health V.H.S	73	2,1216		160,134	408	,392			
	Religious V.H.S	148	2,0456		160,643	410				
	Total	411	2,0925							

Nutrition	Anatolian H.S	190	2,1637	Intergroups Within group Total	,074	2	,037					
	Health V.H.S	73	2,1842		80,500	408	,197				,189	,828
	Religious	148	2,1929		80,575	410						
	V.H.S Total	411	2,1779									
Spiritual Develop ment	Anatolian H.S	190	2,9146	Gruplar arası Grup içi Toplam	495	2	,247					
	Health V.H.S	73	2,8965		115,323	408	,283				,875	,418
	Religious	148	2,8386		115,817	410						
	V.H.S Total	411	2,8840									
Interperso nal relations	Anatolian H.S	190	2,7135	Gruplar arası Grup içi Toplam	1,049	2	,525					
	Health V.H.S	73	2,7428		105,314	408	,258				2,033	,132
	Religious	148	2,6186		106,363	410						
	V.H.S Total	411	2,6845									
Stress Managem ent	Anatolian H.S	190	2,4829	Gruplar arası Grup içi Toplam	1,277	2	,638					
	Health V.H.S	73	2,5051		105,505	408	,259				2,469	,086
	Religious	148	2,3742		106,782	410						
	V.H.S Total	411	2,4477									

As it can be seen in Table 3, as a result of (ANOVA) analysis done to obtain if arithmetical averages show a significant difference in all dimensions of HLSBS according to school type, there obtained a significant difference in “Health responsibility” sub dimensions ($p<.05$), there was not obtained a significant difference in other sub dimensions of scale ($p>0,05$).

Table 4. Distribution of HLSBS and sub group points of high school students according to Class variable

Dimensio ns	Class	N	\bar{X}	ANOVA							
				Variance Source	Total of squares	Sd	Average of squares	F	p	LSD	
Health responsibi lity	9th class	146	2,1781	Intergroups Within group Total	2,698	3	,899	3,116	,026	1-3 1-4	
	10th class	82	2,1518		117,492	407	,289				
	11th class	86	1,9922		120,190	410					
	12th class	97	2,0218								
	Total	411	2,0971								
Physical activity	9th class	146	2,1396	Intergroups Within group Total	4,985	3	1,662	4,345	,005	1-3 2-3 2-4	
	10th class	82	2,2454		155,658	407	,382				
	11th class	86	1,9215		160,643	410					
	12th class	97	2,0438								
	Total	411	2,0925								
Nutrition	9th class	146	2,2336	Intergroups Within group Total	1,819	3	,606	3,133	,026	1-3 2-3	
	10th class	82	2,2398		78,756	407	,194				
	11th class	86	2,0814		80,575	410					
	12th class	97	2,1271								
	Total	411	2,1779								
Spiritual developm ent	9th class	146	2,9665	Intergroups Within group Total	1,641	3	,547	1,949	,121		
	10th class	82	2,8333		114,177	407	,281				
	11th class	86	2,8165		115,817	410					
	12th class	97	2,8625								
	Total	411	2,8840								
Interperso nal relations	9th class	146	2,7108	Intergroups Within group Total	,551	3	,184	,706	,549		
	10th class	82	2,6165		105,812	407	,260				
	11th class	86	2,6757		106,363	410					
	12th class	97	2,7102								
	Toplam	411	2,6845								
Stress Managem ent	9th class	146	2,5325	Intergroups Within group Total	1,751	3	,584	2,262	,081		
	10th class	82	2,4101		105,030	407	,258				
	11th class	86	2,3706		106,782	410					
	12th class	97	2,4201								
	Total	411	2,4477								

As it can be seen in Table 4, as a result of (ANOVA) analysis done to obtain if arithmetical averages show a significant difference in all dimensions of HLSBS according to class, there obtained a significant difference in “Health responsibility”, “Physical activity” and “Nutrition” sub dimensions ($p<.05$), there was not obtained a significant difference in other sub dimensions of scale ($p>0,05$).

4. DISCUSSION AND RESULT

The comparison of HLSBS points and sub group point averages of high school students according to gender were given in Table 2. Except health responsibility it was seen that the points of male students in all sub points are higher than the points of female students. According to gender variable as a result of paired group t test the difference between arithmetical averages was not found statistically significant ($p>.05$) in terms of Health responsibility ($t=2.20$; $p<.05$), physical activity ($t=-7,227$; $p>.05$), Nutrition ($t=-3,156$; $p>.05$), Spiritual development ($t=-1,229$; $p>.05$), Stress management ($t=-2,7521$; $p>.05$), they were found significant in terms of Interpersonal relations ($t=301$; $p<.05$). Similar result to the findings of this research Bozhüyük (2010) in his study done with health science students, he did not find HLSBS points of students statistically significant according to gender ($p>0,05$)¹⁶.(Bozhüyük, 2010). Ünalın, Öztıp, Elmalı, Öztürk, Konak,Pırlak et. al., (2009) in their studies that they did with male and female students in Health Occupation High school, found that there is a significant difference between HLSBS point averages in terms of gender ($p>0,05$)¹⁷.(Ünalın, Öztıp, Elmalı, Öztürk, Konak, Pırlak, 2009). In the study it was seen that only Physical activity sub point average of scale is higher in male students. Zaybak, Fadıllođlu, (2004) in the study they did with university students they obtained that there is not a significant difference between HLSBS point averages of male and female students¹⁸.(Zaybak and Fadıllođlu, 2004) Karadeniz, Uçum, Dedeli, Karaađaç (2008) in their study about healthy living style behaviours of university students, did not find HLSBS point averages statistically significant in terms of gender ($p>0,05$)¹⁹.(Karadeniz, Uçum, Dedeli, Karaađaç, 2008). Karadamar, Yiđit, Sungur, (2014) in their study done to evaluate healthy living styles of adolescents, as they found a significant difference between HLSBS and sub groups points of female and male adolescents ($p=0.043$) they did not find a significant difference between the point averages of developing oneself ($p=0.104$), health responsibility ($p=0.268$), interpersonal support ($p=0.136$) and coping with stress ($p=0.485$) and gender ($p>0.05$)²⁰.(Karadamar, Yiđit, Sungur, 2014). Yıldırım, (2005) in his study regarding healthy living style behaviours of students, did not find HLSBS point averages statistically significant according to gender ($p>0.05$)²¹.(Yıldırım, 2005). Koçođlu ve Akın, (2010) in their study regarding the effect of sociometric inequalities on healthy living style behavior, they did not find HLSBS point averages statistically significant according to gender²².(Koçođlu and Akın, 2009).

Kaya, Ünüvar, Bıçak, Yorgancı, Çınar, Öz, Kankaya, (2008) in their study regarding Health care, they got similar results²³.(Kaya, Ünüvar, Bıçak, Yorgancı, Çınar, Öz, Kankaya, 2008). Sanchez, Norman, Sallis, Calfas, Cella, (2007) in their study obtained that male students show more doing exercise behaviour than female students²⁴.(Sanchez, Norman,Sallis,Calfas,Cella, 2007). According to the studies show difference with the findings obtained from this research; Fırınacı, (2010) in his study done with adolescents he compared HLSBS points of male and female students and observed that female students got higher points than male students from “Interpersonal relations” and “Spiritual development” sub dimensions²⁵.(Fırınacı, 2010). Özbaşaran, Çetinkaya ve Güngör, (2004) also got similar results²⁶.(Özbaşaran, Çetinkaya, Güngör, 2004). Karadeniz, Yanık, Kerem, Uçum, Dedeli and Karaađaç, (2008) in their study with university students found that “Nutrition” points of female students is higher than male students and stated the difference between groups is statistically significant¹⁸.(Zaybak and Fadıllođlu, 2004). Yalçınkaya, Özer and Karamanođlu (2007) in their study done with health staff they observed women get higher points than men from health responsibility and nutrition sub groups²⁷.(Yalçınkaya, Özer, Karamanođlu, 2007). The environment that the individual is in, effects gaining of health development behaviour. Also motivation or personal characteristics of an individual affect health development behaviour in positive or negative way²⁸.(Tanrıverdi, Bedir, Sevig, 2007). This difference that came out in our study, can be generated from increasing importance of relations of students with their peers or having a tendency of acting independently from parents. When in it is thought from another angle, girls got higher points than boys in terms of interpersonal support sub dimension in this study. This high points can be generated from the importance that girls give to appearance, self care, protecting health status and being conscious and sensitive in friendship relations. Also although this result is not rather high compared to other research results, it makes people think that students are in better relation with their environment.

As it can be seen in Table 3, as a result of (ANOVA) analysis done to obtain if arithmetical averages show a significant difference in all dimensions of HLSBS according to school type, there obtained a significant difference in “Health responsibility” sub dimensions ($p<.05$), there was not obtained a significant difference in other sub dimensions of scale ($p>0,05$). It was observed that within groups Health V.H.S has the highest point in “Health responsibility” subdimension 2,3212, Anatolian H.S has 2,0637, Religious V.H.S has 2,293, in “Physical activity” subdimension Health V.H.S has 2,1216, Anatolian H.S has 2,1178, Religious V.H.S has 2,0456, in “Nutrition” subdimension Health V.H.S has 2,1842, Anatolian

H.S has 2,1637, Religious V.H.S has 2,1929, in “Spiritual development” subdimension Helath V.H.S has 2,8965, Anatolian H.S has 2,9146, Religious V.H.S has 2,8840 , in “Interpersonal relations” subdimension Helath V.H.S has 2,7428, Anatolian H.S has 2,7135, Religious V.H.S has 2,6186, in “Stress management” subdimension Helath V.H.S has 2,5051, Anatolian H.S has 2,4829, Religious V.H.S has 2,3742. In terms of school type the reason of this difference that came out in Helath V.H.S in “Helath responsibility” subdimension can be generated from the students are more sensitive and conscious about health in the first years of school. The reason of the difference in Religious V.H.S can be the effort of school management and teachers in gaining of the concept “Helping others” to students more. Approximately in all dimensions of HLSBS the reson of Helath V.H.S had got the highest point can be the programme of school is mostly consisted of lessons regarding health, students are mostly in vocational training applications and both school management and students are more conscious and sensitive about health than other school types.

As it can be seen in Table 4, as a result of (ANOVA) analysis done to obtain if arithmetical averages show a significant difference in all dimensions of HLSBS according to class, there obtained a significant difference in “Health responsibility”, “Physical activity” and “Nutrition” subdimensions ($p < 0,05$), there was not obtained a significant difference in other subdimensions of scale ($p > 0,05$). In our research it was seen that in “Health responsibility” subdimension the points of 9th and 11th grade students are more significant than the points of 10th and 12th grade students. In order to improve health sensitivity to health should be increased, positive health behaviours should be gained and continued. During education period the students are expected to develop healthy living style behaviours in positive way emotionally. The reason of difference that came out in 9th and 11th grade can be students are more sensitive and conscious about health in the first years of school, the gainings given in health lesson that is obligatory in 9th grade and again students are informed about health subjects at specific periods by attendant health teams in scope of community health care and protective health service. In this research the reason of obtaining a statistical significant difference can be physical education is one hour in some schools and again 12th grade students do not have spare time for physical activity because of university exam. In the research the significance in nutrition subdimension can be generated from students can reach natural nutrients easily since the region they live in leaning against agriculture and stockbreeding, they give more importance to their nutrition or the place they live in affects their nutrition habits in a positive way. The reason of absence of difference in other subdimensions of scale can be explained as the mood of students during adolescence, their attitudes and expectations about future, not be thinking clearly and changing their mind often, do not show enough effort to put what they have learned about health during education period into practice. yaşadıkları yerin beslenme alışkanlıklarını olumlu yönde etkilemesine bağlanabilir. Choi Hui,(2002) in his study on developing healthy living style of nurse students, stated that first grade students get the highest point from HLSBS, this point decreases as the grade increases and the difference between is important²⁹.(Hui, 2002). Callaghan, 1995; Marais et. al.(1990) in their study on developing healthy living style of nurse students found that as grade of nurse students increases their behaviours towards health increases in parallel to this³⁰.(Callaghan, 2005). Berçin, (2010) in his study about healthy living style of high school students found that there is a statistical significant relation between exercise and nutrition subdimension point averages as their point averages from HLSBS scale and subdimensions ($p < 0,05$)³¹.(Berçin, 2010). Özyazıcıoğlu, Kılınc, Erdem, Yavuz and Afacan(2011) in their study done to obtain healthy living style behaviours of nurse students, obtained that there is no significant difference between scale points of first and fourth grade students³².(Özyazıcıoğlu, Kılınc, Erdem, Yavuz, Afacan, (2011).

5. RESULT

It was found out that the participants students depend on preferences of their parents in terms of taking their own health responsibilities since they are in a period between childhood and adolescence, have economical dependencies although they develop more positive behaviour in interpersonal relations in terms of HLSBS gender. In the research there obtained a significant difference in “Health responsibility”, “Physical activity” and “Nutrition” subgroups of HLSBS in terms of school type.

6. SUGGESTIONS

Providing students to from be healthy generations it will be beneficial to teach students HLSB in their adolescence period and give suitable health training at schools for application, both parents and school staff should be participated to this training, take continuous support from specialists about healthy living, in the scope of school health services development and growth of students should regularly be followed and both awareness and consciousness should be formed via health, students should be given consultancy, personal characteristics of each student should be obtained via school counsellors and forming necessary

environment for social activities in order to develop health consciousness development. In future studies it will be beneficial to consider the results of this research and the results of similar research. In the research chosen school type, the city that the school in affect the healthy living style behaviours of students. That is why for future studies it will be beneficial to choose different school types and the schools in different places to obtain how healthy living style behaviours of students are affected.

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