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Health-Promoting Lifestyle in Iranian Dormitory-Resident Students

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ABSTRACT

Aims Promoting healthy lifestyles among students is crucial, as they can facilitate health education within families and communities. This study aimed to assess health-promoting lifestyles among dormitory-residing students at North Khorasan University of Medical Sciences.

Instrument & Methods This cross-sectional study was conducted in 2024 among 348 dormitory-resident students at North Khorasan University of Medical Sciences, Iran, selected via multistage sampling. Data on demographics and health-promoting behaviors were collected using a validated 49-item Persian HPLP-II questionnaire. Data were analyzed using SPSS 22, which included descriptive statistics, t-tests, and ANOVA.

Findings Of the 348 dormitory-residing students (mean age 22.42±2.32 years; 34.8% male), the mean health-promoting lifestyle score was 135.82±19.35. Females exhibited significantly higher total and subscale scores than males ($p<0.05$). Employed students scored higher in total, health responsibility, physical activity, and nutrition ($p<0.05$). Significant differences were observed based on educational level, mother's education, father's occupation, and family income ($p<0.05$), with lower scores generally associated with lower socioeconomic factors. No differences were found by marital status (except for health responsibility), semester, field of study, or mother's occupation.

Conclusion Sociodemographic factors, including gender, employment, educational level, mother's education, father's occupation, and family income play a significant role in health-promoting lifestyles.

Keywords Lifestyle; Health Promotion; Students; Education

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Introduction

Health-promoting lifestyles, which involve actions and beliefs aimed at maintaining health and preventing disease, significantly influence mortality, morbidity, and the mitigation of chronic diseases. Over the past two decades, noncommunicable diseases, such as diabetes, cancer, hypertension, and obesity, have emerged as major global threats, increasingly affecting younger populations due to poor habits, sedentary behaviors, and unhealthy diets [1, 2]. Promoting such lifestyles is essential to reduce the incidence of noncommunicable diseases and disability across all ages [3, 4]. Evidence suggests that behavior and lifestyle choices determine 60% of an individual's health status and quality of life [5]. The World Health Organization (WHO) estimates that lifestyle-related diseases account for 70-80% of deaths in developed countries and 40-50% in developing countries [6].

A health-promoting lifestyle, defined as a multidimensional pattern of actions that enhance well-being, is a crucial determinant of health status and a key strategy for preventing chronic diseases. Based on Pender's model, a health-promoting lifestyle encompasses six behaviors, namely health responsibility, physical activity, nutrition, spiritual growth, interpersonal relationships, and stress management [7, 8]. These behaviors are often established during youth, a critical period exemplified by the university years, when students make independent lifestyle choices. However, global research indicates that many students engage in risky behaviors, such as physical inactivity and poor nutrition [9, 10]. While students often exhibit strengths in self-actualization and interpersonal support, areas such as stress management, exercise, nutrition, and health responsibility require improvement, highlighting the need for targeted health interventions in this population [2, 3, 10].

University dormitory living constitutes a transitional phase that can substantially influence students' lifestyles and health-promoting behaviors due to its unique conditions [7]. International research demonstrates that individuals aged 15-24, including most university students, are more prone to high-risk behaviors such as smoking, alcohol consumption, risky sexual practices, and unhealthy eating habits [11]. Dormitory living may heighten this vulnerability, thereby endangering the health of this critical demographic and elevating disability and mortality rates. Nevertheless, many adverse health determinants in youth are modifiable if risk factors are identified and addressed early [12, 13].

Studies from various countries indicate that only a minority of students exhibit desirable health-promoting lifestyles. Similarly, research in Iran shows that university students' health-promoting behaviors are suboptimal [3, 14]. As students represent a substantial portion of the nation's youth and serve as role models due to their age and educational status, their lifestyle choices affect not only their own well-being but also the behaviors of broader populations [15]. Thus, promoting healthy lifestyles among students is crucial, as they can facilitate health education within families and communities. Accordingly, this study aimed to evaluate health-promoting lifestyles among students residing in dormitories at North Khorasan University of Medical Sciences.

Instrument and Methods

Study design and sample

This cross-sectional study was conducted in 2024 among students residing in dormitories at North Khorasan University of Medical Sciences, Iran. The population consisted of all students living in the university dormitories. Inclusion criteria included active enrollment at the university and willingness to participate. Incomplete or inaccurate questionnaires were excluded from analysis.

The sample size was calculated to be 348 participants using a standard deviation of 20 from Maheri *et al.* [16], a margin of error of 2 (10% of the standard deviation), and a 95% confidence level. Participants were selected via multistage sampling. First, the population was stratified by faculty (n=6), with proportional allocation based on the number of students per stratum. Second, simple random sampling was employed within each stratum to select participants from the dormitory resident lists.

Data collection tools

Data were collected using a two-part questionnaire. The first part assessed demographic characteristics, including age, gender, field of study, marital status, educational level, parents' education, and family income. The second part comprised the 49-item Persian-validated Health-Promoting Lifestyle Profile II (HPLP-II) questionnaire, adapted by Mohammadi Zeidi *et al.* [17] from the original 52-item version [18]. Based on Pender's health promotion model, it evaluates health-promoting behaviors. Validity and reliability assessments, including factor analysis, led to the removal of three items. In Mohammadi Zeidi *et al.*'s study, Cronbach's alpha was 0.82 overall (0.79-0.91 for subscales), with item-total correlations ranging from 0.21 to 0.72 [17].

The questionnaire assesses six domains: health responsibility, which consists of 8 items (1-8), physical activity, comprising 8 items (9-16), nutrition, including 9 items (17-25), self-actualization and spiritual growth, with 8 items (26-33), social support and interpersonal relations, containing 9 items (34-42), and stress management, featuring 7 items (43-49). Items were scored on a 4-point Likert scale (1=never to 4=always). Total scores ranged from 49 to 196 and were calculated as the mean of responses; higher scores indicated healthier lifestyles.

Procedure

Institutional approvals were obtained before data collection. Trained researchers visited the dormitories, explained the study objectives, assured data confidentiality, and obtained written informed consent. Questionnaires were self-administered. The study was approved by the Research Ethics Committee of North Khorasan University of Medical Sciences and adhered to ethical guidelines. Participation was voluntary, and data were handled anonymously.

Data analysis

Data were analyzed using SPSS 22 software. Inferential analyses, assuming normality of scores, included independent t-tests and one-way ANOVA to examine associations between health-promoting lifestyle scores and categorical parameters (dichotomous or polytomous).

Post hoc analyses were conducted following significant ANOVA results to determine specific pairwise differences between groups.

Findings

The mean age of 348 students residing in dormitories was 22.42±2.32 years (Table 1).

The mean total health-promoting lifestyle score was 135.82±19.35 (range: 57-194; Table 2).

Total health-promoting lifestyle scores and all subscale scores were significantly higher in females than in males (all $p<0.001$; Table 3).

No significant differences were observed in total health-promoting lifestyle scores or subscales between married and single students, except for health responsibility (Table 4).

Total health-promoting lifestyle scores, as well as health responsibility, physical activity, and nutrition scores, were significantly higher in employed than in unemployed students ($p<0.05$). No differences were found for spiritual growth, interpersonal relations, or stress management ($p>0.05$; Table 5).

Significant differences were observed in total health-promoting lifestyle scores and all subscales, except spiritual growth, across educational levels ($p < 0.05$). Tukey's post hoc test results, including specific intergroup comparisons, are detailed in Table 6.

No significant differences were found in health responsibility, physical activity, or stress management scores by academic semester ($p>0.05$), nor in total health-promoting lifestyle scores or health responsibility, physical activity, or nutrition subscales by field of study ($p>0.05$).

No significant differences in total health-promoting lifestyle scores or any subscales were observed by fathers' education ($p>0.05$). For mothers' education, significant differences were noted in health responsibility, nutrition, spiritual growth, and stress management subscales ($p<0.05$), but not in physical activity or interpersonal relations ($p>0.05$).

Table 1. Demographic characteristics of dormitory-resident students at North Khorasan University of Medical Sciences (n=348)

Parameter	Frequency (%)
Field of study	
Operating room technology	15 (4.3)
Occupational health	17 (4.9)
Public health	30 (8.6)
Environmental health	26 (7.5)
Nursing	35 (10.1)
Medicine	79 (22.7)
Dentistry	28 (8)
Radiology	16 (4.6)
Anesthesiology	17 (4.9)
Laboratory sciences	22 (6.3)
Nutrition sciences	16 (4.6)
Emergency medical services	28 (8)
Midwifery	15 (4.3)
Nanotechnology	4 (1.1)
Level of education	
Bachelor's degree	319 (91.7)
Doctor of medicine	26 (7.5)
Master's degree	3 (9)
Father's occupation	
Unemployed	2 (0.6)
Self-employed	143 (41.1)
Livestock farmer	4 (1.1)
Farmer	52 (14.9)
Laborer	28 (8)
Employee	119 (34.2)
Employment status	
Unemployed	288 (82.8)
Employed	60 (17.2)
Gender	
Male	121 (34.8)
Female	227 (65.2)
Father's education	
Illiterate	2 (0.6)
Primary school	23 (6.6)
Lower secondary school	51 (14.7)
High school diploma	105 (30.2)
Associate degree	48 (13.8)
Bachelor's degree	89 (25.6)
Master's degree	24 (6.9)
PhD	6 (1.7)
Mother's education	
Illiterate	1 (0.3)
Primary school	27 (7.8)
Lower secondary school	52 (14.9)
High school diploma	143 (41.1)
Associate degree	43 (12.4)
Bachelor's degree	69 (20.9)
Master's degree	9 (2.6)
PhD	4 (1.1)
Mother's occupation	
Self-employed	8 (2.3)
Livestock farmer	1 (0.3)
Farmer	1 (0.3)
Homemaker	274 (78.7)
Employee	64 (18.4)
Marital status	
Married	59 (16.9)
Single	289 (83.1)
Place of residence	
Rural	85 (24.4)
Urban	263 (75.6)

Students with mothers who had primary education had lower physical activity scores than all groups except those with mothers holding master's degrees or higher ($p<0.05$).

Table 2. Mean scores of health-promoting lifestyle subscales among dormitory-resident students

Subscale	Mean	Minimum	Maximum
Health responsibility	21.99±4.26	8	32
Physical activity	20.11±4.89	8	32
Nutrition	24.22±4.40	10	35
Spiritual growth	23.33±4.39	8	32
Interpersonal relations	26.40±3.91	9	36
Stress management	19.77±3.46	7	28
Health-promoting lifestyle	21.99±4.26	8	32

They also had lower interpersonal relations scores than those with mothers who held bachelor's degrees or higher ($p<0.05$), and lower total health-promoting lifestyle scores than those with mothers who held master's degrees ($p<0.05$).

Table 3. Health-promoting lifestyle scores by gender among dormitory-resident students

Parameter	Gender	Mean	df	t
Health responsibility	Male	19.87±4.69	193.97	-6.69
	Female	23.12±3.53		
Physical activity	Male	16.13±4.66	193.69	-12.52
	Female	22.22±3.50		
Nutrition	Male	21.40±4.93	175.93	-8.71
	Female	25.72±3.22		
Spiritual growth	Male	21.93±5.89	155.71	-3.74
	Female	24.08±3.08		
Interpersonal relations	Male	25.79±5.48	151.51	-1.78
	Female	26.73±2.69		
Stress management	Male	18.04±4.20	168.32	-6.34
	Female	20.69±2.55		
Health-promoting lifestyle (total score)	Male	123.16±21.07	181.26	-9.07
	Female	142.56±14.40		

Significant differences were observed in total health-promoting lifestyle scores and all subscales based on fathers' occupation ($p<0.05$). Students with laborer fathers had lower health responsibility scores compared to those with self-employed, farmer, or livestock breeder fathers. They also had lower physical activity scores than those with fathers who were self-employed, farmers, or livestock breeders. Additionally, their nutrition scores were lower than those of students with fathers who were self-employed or farmers/livestock breeders. Furthermore, they had lower spiritual growth scores than those with self-employed fathers, as well as lower interpersonal relations and stress management scores than all other groups. Students with employee fathers had lower health responsibility and physical activity scores than those with farmer or livestock breeder fathers, lower nutrition scores than those with self-employed or farmer/livestock breeder fathers, and lower total scores than those with self-employed, farmer, or livestock breeder fathers. No differences were found based on mothers' occupation ($p>0.05$).

Significant differences were observed in total health-promoting lifestyle scores and all subscales by family income ($p<0.05$). Students from low-income families had lower health responsibility scores than all other groups; lower physical activity scores than those from good- or excellent-income families; and lower nutrition, spiritual growth, interpersonal relations, stress management, and total scores than all other groups.

Table 4. Health-promoting lifestyle scores by marital status among dormitory-resident students

Parameter	Gender	Mean	df	t	p-value
Health responsibility	Married	23.31±3.96	346	2.51	0.013
	Single	21.75±4.27			
Physical activity	Married	20.61±4.60	346	0.83	0.41
	Single	20.01±4.94			
Nutrition	Married	24.52±3.82	346	0.55	0.58
	Single	24.16±4.50			
Spiritual growth	Married	23.46±3.47	346	0.24	0.81
	Single	23.31±4.54			
Interpersonal relations	Married	26.19±3.14	346	-0.44	0.66
	Single	26.44±4.04			
Stress management	Married	20.09±2.84	346	0.75	0.45
	Single	19.71±3.56			
Health-promoting lifestyle (total score)	Married	138.19±16.89	346	0.99	0.32
	Single	135.38±19.76			

Table 5. Health-promoting lifestyle scores by employment status among dormitory-resident students

Parameter	Employment status	Mean	t	df	p-value
Health responsibility	Unemployed	21.67±4.32	-3.52	97.96	0.001
	Employed	23.53±3.60			
Physical activity	Unemployed	19.60±4.99	-5.42	116.1	<0.001
	Employed	22.52±3.48			
Nutrition	Unemployed	23.91±4.61	-3.85	133.33	<0.001
	Employed	25.67±2.84			
Spiritual growth	Unemployed	23.34±4.58	0.080	112.23	0.937
	Employed	23.30±3.30			
Interpersonal relations	Unemployed	26.38±4.15	-0.35	133.25	0.730
	Employed	26.52±2.55			
Stress management	Unemployed	19.64±3.57	-1.79	104.72	0.076
	Employed	20.38±2.76			
Health-promoting lifestyle	Unemployed	134.55±19.83	-3.17	103.27	0.002
	Employed	141.92±15.56			

Table 6. Health-promoting lifestyle scores by educational level among dormitory-resident students

Parameter	Educational Level	Mean	df	F	p-value
Health responsibility	Bachelor	22.50±3.89	2.345	32.038	<0.001
	Medical Doctor	16.46±4.33			
	Master	16.00±2.65			
Physical activity	Bachelor	21.99±4.26	2.345	16.547	<0.001
	Medical Doctor	20.54±4.62			
	Master	15.15±5.60			
Nutrition	Bachelor	17.00±2.00	2.345	33.038	<0.001
	Medical Doctor	20.11±4.89			
	Master	24.75±4.06			
Spiritual growth	Bachelor	18.27±3.95	2.345	1.575	0.208
	Medical Doctor	19.33±2.31			
	Master	24.22±4.40			
Interpersonal relations	Bachelor	23.44±4.17	2.345	9.911	<0.001
	Medical Doctor	21.92±6.19			
	Master	24.67±7.57			
Stress management	Bachelor	23.33±4.39	2.345	11.237	<0.001
	Medical Doctor	26.57±3.75			
	Master	23.65±4.66			
health-promoting lifestyle	Bachelor	31.67±3.06	2.345	24.056	<0.001
	Medical Doctor	26.40±3.91			
	Master	20.02±3.29			

Discussion

This study aimed to evaluate health-promoting lifestyles among students residing in dormitories at North Khorasan University of Medical Sciences. Investigating health-promoting lifestyles among

college students is essential, as this demographic undergoes a critical transition during which established habits influence long-term health. Studies indicate that students frequently face stress, suboptimal dietary habits, and insufficient physical activity, heightening the risks for adverse outcomes, such as anxiety, depression, and obesity. Identifying these risk factors enables targeted interventions to enhance nutrition, exercise, and mental well-being, thereby boosting academic performance and social engagement. Ultimately, such efforts support public health objectives by fostering healthier generations, reducing healthcare expenditures, and elevating quality of life [19, 20].

We assessed health-promoting lifestyles among dormitory-residing students at North Khorasan University of Medical Sciences using the health-promoting lifestyle profile II questionnaire (possible score range: 52-208). The mean total score was 135.82±19.35, with the highest subscale scores in interpersonal relations and nutrition, and the lowest in stress management and physical activity. Significant differences in total scores were observed by gender (higher in females), employment status (higher in employed), educational level, mother's education, father's occupation, and family income. No significant differences emerged by marital status (except for health responsibility), academic semester, field of study, father's education, or mother's occupation.

Comparisons with studies from other Iranian universities reveal consistent patterns and variations in health-promoting lifestyles among medical sciences students. Our mean HPLP-II score is comparable to that reported by Pouresmaeil *et al.* [21] at Qazvin University and higher than those found by Maheri *et al.* [16] in Tehran, Moghaddam *et al.* [22] in Zanjan, Azami Gilan *et al.* [23] in Kermanshah, Karimian *et al.* [24] in Shiraz (moderate levels, with most subscales above midpoint except exercise), and Rahbar & Yosefi Roshan [15] in Ramsar. This suggests moderate overall scores with regional or methodological variability.

Consistent with our findings, interpersonal relations or spiritual growth emerges as the highest-scoring subscales (e.g., in Azami Gilan *et al.* [23], Karimian *et al.* [24], and Pouresmaeil *et al.* [21]), whereas physical activity ranks lowest across all cited studies, indicating a national challenge for dormitory-residing students. Stress management was also low in our study, aligning with moderate scores in Maheri *et al.* [16] and Moghaddam *et al.* [22].

Demographic parallels include higher scores among females in our study and in Azami Gilan *et al.*' research [23], although this trend was absent in studies by Maheri *et al.* [16] and Karimian *et al.* [24]. Moghaddam *et al.* [22] and Rahbar & Yosefi Roshan [15] specifically linked gender to physical activity. Employment and family income positively influenced scores in our cohort, as well as in studies by Maheri *et al.* [16] and Azami Gilan *et al.* [23]. Marital status had minimal effects (except for health responsibility), in contrast to broader associations reported by Maheri *et al.* [16] and Azami Gilan *et al.* [23]. Differences in educational level echoed Karimian *et al.*'s [24] findings linking educational level to field of study and age. Parental factors (mother's education, father's occupation) were unique to our study and merit further investigation. These patterns highlight the necessity for targeted interventions in physical activity and stress management across Iranian universities, customized to socioeconomic and gender factors.

Comparisons with international studies show consistencies and variations in health-promoting lifestyles among university students. Our mean total HPLP-II score aligns with findings from Gore *et al.* [25] in India and Musić *et al.* [26] in Croatia, but exceeds those reported by Alzahrani *et al.* [27] in Saudi Arabia and Qiu *et al.* [28] in China. Chao [2] in Taiwan reports higher per-item averages, possibly due to scale differences or contextual factors.

Consistent with our results, these studies identify interpersonal relations and nutrition as strong subscales, while physical activity and stress management are weak, reflecting common challenges among students. Gender differences align with higher female scores in our study and in the research by Gore *et al.* [25], but differ from the study by Musić *et al.* [26], reporting lower female scores in spiritual growth and stress management, and Alzahrani *et al.* [27], finding higher male scores in physical activity. Socioeconomic influences, such as income and parental occupation, parallel those in studies by Alzahrani *et al.* [27] and Gore *et al.* [25]. At the same time, our findings on employment and education align with Chao's [2] emphasis on physical activity. These variations highlight cultural effects and support tailored interventions to enhance physical activity and stress management worldwide.

This cross-sectional study cannot establish causality between sociodemographic factors and health-promoting lifestyles. Self-reported data collected via the adapted 49-item Persian HPLP-II may introduce social desirability, recall, and misclassification biases, potentially inflating scores, as evidenced in student health surveys. The sample, limited to dormitory-residing students at one Iranian university, restricts generalizability. Voluntary participation and the exclusion of incomplete questionnaires risk non-response and selection biases, while the normality assumptions for parametric tests may not fully hold.

This study underscores the importance of targeted interventions to enhance health-promoting lifestyles among dormitory-residing students at North Khorasan University of Medical Sciences. Although students exhibited strong performance in the interpersonal relations and nutrition subscales, notable deficiencies were evident in stress management and physical activity. Significant

variations by gender, employment status, educational level, mother's education, father's occupation, and family income highlight the influence of sociodemographic factors. To address these issues, we recommend implementing structured wellness programs, including stress reduction workshops, group physical activities, and peer mentoring initiatives. Educational sessions on time management and self-care, tailored to diverse student profiles, could further promote engagement. A holistic health promotion strategy may thereby improve overall student well-being.

Conclusion

Sociodemographic factors, including gender, employment, educational level, mother's education, father's occupation, and family income play a significant role in health-promoting lifestyles.

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