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A STUDY TO DETERMINE THE HEALTHY LIFESTYLE BEHAVIORS OF ACADEMIC STAFF IN TÜRKİYE

TÜRKİYE'DE AKADEMİK PERSONELİN SAĞLIKLI YAŞAM BİÇİMİ DAVRANIŞLARININ BELİRLENMESİNE YÖNELİK BİR ARAŞTIRMA

[1]Damla TUNA, *[1]Aslı KAYA

[1]Istanbul Gelişim University, Health Sciences Faculty, Department of Health Management, İstanbul, Türkiye

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***Corresponding Author:** aslkaya@gelisim.edu.tr

Abstract

The most important desire of humans is to live a long and healthy life. To achieve good health, an individual must maintain complete physical and mental well-being, including proper nutrition, regular exercise, personal care, mental health, and psychological balance. Therefore, individuals strive to live healthy and long lives. To live healthily, both physical and mental conditions must be optimized, and individuals must be aware of healthy-living practices. It is essential to understand how an individual's physical and psychological health deteriorates, how they attempt to protect their health against this decline, and how to correct harmful behaviors, change their habits, and improve their quality of life. This study examined the extent to which academicians pay attention to healthy living, the actions they take to maintain their health, and how they reflect a healthy lifestyle in their behaviors. The survey method used in this research consisted of two parts. Data were collected using a sociodemographic data form and the "Healthy Lifestyle Behaviors Scale," which includes 52 statements rated on a 4-point Likert scale. A random sample of 400 academicians working in 81 provinces in Turkey was selected for the study. The health behaviors of the academicians were measured in terms of health responsibility (HBS), physical activity (PA), nutrition (N), spiritual development (PD), interpersonal relationships (IR), and stress management (SM). The findings of this research will help determine what academic staff do and how they behave to maintain a healthy lifestyle.

Keywords: Academic staff, Behavior, Health, Healthy living awareness

Öz

İnsanlığın en önemli isteği sağlıklı ve uzun ömürlü yaşayabilmektir. Bir bireyin sağlıklı olabilmesi için beslenme, egzersiz, kişisel bakım, mental sağlığı, psikolojisi vs gibi fiziksel ve ruhsal sağlığının tam olması gerekir. Bu nedenle bireyler sağlıklı ve uzun ömürlü yaşayabilmek için arayış içerisindedir. Bu nedenle bireyin sağlıklı yaşayabilmesi için hem koşulların oluşması gerekmekte hem de birey sağlıklı yaşam bilincinde olmalıdır. Bu bakımdan bireyin fiziksel ve psikolojik olarak sağlığının bozulması ve bu bozulmaya karşı bireyin sağlığını nasıl korumaya çalıştığını bilmek ve yanlış davranışları düzeltmek ve bireyi alışkanların değişmesi bireyin yaşam kalitesini yeniden dizayn etmesi gerektiğidir. Bu çalışmada akademisyenlerin sağlıklı yaşama ne kadar özen gösterdikleri, sağlıklı yaşayabilmek için neler yapabildikleri ve sağlıklı yaşam biçimini davranışlarına nasıl yansıttıkları incelenmesi gereken bir konu incelemeye alınmıştır. Çalışmada anket yöntemi kullanılmıştır. Bu çalışma iki bölümden oluşmuştur. Araştırmanın verileri sosyodemografik veri formu ile 52 ifadeden ve 4'lü likert ölçeğinden oluşan "Sağlıklı Yaşam Biçimi Davranışları Ölçeği" ile toplanmıştır. Çalışmaya Türkiye'de 81 ilde çalışan 400 kişilik akademisyenlerden oluşan tesadüfi örneklem yöntemiyle araştırma grubu seçilmiştir. Çalışmada akademisyenlerin sağlık davranışı sağlık sorumluluğu (SS), fiziksel aktivite (FA), beslenme (B), manevi gelişim (MG), kişilerarası ilişkiler (Kİ) ve stres yönetimi (SY) olmak üzere altı boyuttu üzerinden incelenecektir. Araştırma sonucunda elde edilen bulgular akademik personelin sağlıklı yaşamak için neler yaptığını ve nasıl davrandıklarının belirlenmesinde yardımcı olacaktır.

Anahtar Kelimeler: Akademik personel, Davranış, Sağlık, Sağlıklı yaşam farkındalığı

1. Introduction

The World Health Organization (1947) defines health as a phenomenon that covers physical, mental, and social areas as well as illness and disability, in the process extending from birth to death of an individual. An increase in an individual's quality of life depends on the creation of healthy lifestyle processes specific to him/her. A healthy lifestyle is the sum of an individual's attitudes and behaviors towards it.

According to Walker, Sechrist, and Pender (1987), a healthy lifestyle behavior includes taking responsibility for protecting and improving one's health, adequate and balanced nutrition, coping with stress, regular exercise, spiritual development, and interpersonal relationships. A healthy lifestyle is an inevitable fact that healthy lifestyle behaviors, such as sleep, nutrition, exercise, hygiene, stress, spirituality, and interpersonal relationships, have effects on the health of individuals. Therefore, every individual has the right to live a healthy life, as well as being aware of healthy living and having knowledge about healthy life and quality of life in order to maintain a healthy life. Individuals should acquire healthy lifestyle behaviors to prevent lifestyle-related diseases and deaths due to these diseases. The acquisition of these behaviors is of great importance in preventing chronic diseases, increasing the quality of life in chronic diseases and healthy ageing, as well as having more knowledge about oneself and the disease (Savucu, 2020;35). Each society's healthy living behaviors and attitudes vary from culture to culture and are shaped within the framework of the geography in which they live.

The following six topics were considered appropriate for this study to determine the health behaviors of academic staff: The responsibility for health is the individual's active sense of responsibility for his/her own well-being. Individuals should take care of their own health, be informed about health, and be able to apply for professional help when necessary. Physical activity includes performing light, moderate, and heavy exercises regularly. It is conducted in a planned manner as part of daily life. Nutrition assessment determines an individual's value in choosing and organizing meals and food. Spiritual development focuses on the development of inner resources. Development can be realized through relationship building and transcendence. Transcending provides inner peace and creates the possibility of providing opportunities for new experiences beyond who we are and what we do in our work. Relationalisation is being in a relationship with the universe and feeling in harmony with it. Progress is working towards goals in life and maximizing an individual's power towards well-being. Interpersonal relationships are relationships with others that require communication to establish a meaningful relationship outside of causal necessities. Communication involves sharing thoughts and feelings through verbal and nonverbal messages. The management of stress is an individual's ability to identify and mobilize physiological and psychological resources to reduce or effectively control tension (Walker et al., 1996; Bahar et al., 2008). In addition, the individual can adopt healthy lifestyle.

2. Materials and Methods

Data were collected using the "Healthy Lifestyle Behaviors Scale-II" questionnaire, developed by Walker et al. in 1996 and adapted into Turkish by Bahar et al. in 2008. A total of 400 academicians from 81 provinces in Turkey participated in this study. The questionnaire was administered online using Google Forms. The research group was selected using random sampling. The study employed a sociodemographic data form consisting of six dimensions: health responsibility (HR), physical activity (PA), nutrition (N), spiritual development (SD), interpersonal relationships (IR), and stress management (SM). The questionnaire included 52 statements rated on a 4-point Likert scale (1 = never, 2 = sometimes, 3 = frequently, 4 = regularly) to measure the health behaviors of academicians. Data will be collected between June 1, 2024, and September 30, 2024. At the meeting of Istanbul Gelisim University held on April 19, 2024 (decision number 2024-05), reports from the academic staff assigned to evaluate the study, in accordance with Article 12(1) of the IGU Ethics Committee Directive, were reviewed. It was unanimously decided that scientific research complied with the ethical standards. Statistical analyses were conducted using SPSS version 26. Frequency analysis, validity and reliability analysis, scale statistics, and various tests were applied to examine the research variables concerning demographic variables.

3. Results and Discussion

3.1. Frequency tables

According to the findings, 54.8% of the participants worked at state universities, while 45.3% worked at foundation universities. Among the participants, 31.3% were employed in FE/ISBF, 15.5% in Vocational Schools, 14.8% in the Faculty of Health Sciences, 8.3% in the Faculties of Engineering, Natural Sciences, Architecture, and Agriculture, 5.3% in the Faculty of Arts and Sciences, and 18.0% in other faculties. Regarding academic titles, 9.3% of the participants were professors, 16.3% were

Associate Professors, 37.0% were Assistant Professors, 16.8% were lecturers, and 20.8% were Research Assistants. The gender distribution shows that 52.3% of the participants were female and 47.8% were male. In terms of age, 25.3% were 33 years old or younger, 28.5% were between 34 and 40 years old, 22.5% were between 41 and 46 years old, and 23.8% were 47 years old or older. Regarding marital status, 63.3% of the participants were married, while 36.8% were single. Finally, 72.3% of the participants engaged in sports activities, whereas 27.8% did not.

According to the findings, 6.0% of the participants reported not having a hobby, while 94.0% indicated that they did. Table 1 presents the frequency distribution of respondents based on regular annual health checkups. The data showed that 40.5% of the participants underwent regular annual health check-ups, whereas 59.5% did not. Additionally, 17.8% of the participants received dietitian support, compared to 82.3% who did not. Table 1 also displays the frequency distribution of participants according to their receipt of psychological support; 15.5% reported receiving support from a psychologist, whereas 84.5% did not. Regarding health status, 63.3% of the participants reported having no disease, whereas 36.8% reported various illnesses. Table 1 further details the frequency distribution of respondents according to disease type. The most common condition was diabetes, affecting 7.8% of the participants, followed by hypertension (7.0 %) and heart disease (3.3 %).

Table 1. Frequency table

University of Study	**Number**	**Percent**
State	219	54.8
Foundation	181	45.3
Faculty of Study	**Number**	**Percent**
FEAS/ISBF	125	31.3
Vocational School/School	62	15.5
Faculty of Health Sciences	59	14.8
Engineering, Natural Sciences, Architecture, Agriculture	33	8.3
Faculty of Applied Sciences	28	7.0
Faculty of Arts and Sciences	21	5.3
Other	72	18.0
Title	**Number**	**Percent**
Prof.	37	9.3
Assoc. Prof.	65	16.3
Assist. Prof.	148	37.0
Leco.	67	16.8
Res.Assist.	83	20.8
Gender	**Number**	**Percent**
Woman	209	52.3
Man	191	47.8
Age Group	**Number**	**Percent**
33 years and below	101	25.3
34-40 years	114	28.5
41-46 years	90	22.5
47 years and above	95	23.8
Marital Status	**Number**	**Percent**
Married	253	63.3
Single	147	36.8
Sports Status	**Number**	**Percent**

No	111	27.8
Yes	289	72.3
Hobby Status	**Number**	**Percent**
No	24	6.0
Yes	376	94.0
Status of having regular annual health check-ups	**Number**	**Percent**
Yes	162	40.5
No	238	59.5
Status of dietitian support	**Number**	**Percent**
Yes	71	17.8
No	329	82.3
Status of receiving psychologist support	**Number**	**Percent**
Yes	62	15.5
No	338	84.5
Disease status	**Number**	**Percent**
None	253	63.3
Have	147	36.8
Types of disease	**Number**	**Percent**
None	253	63.3
Thyroid/hypothyroidism	11	2.8
Blood Pressure	28	7.0
Diabetes	31	7.8
Orthopedic conditions	6	1.5
Obesity	12	3.0
Heart Disease	13	3.3
Asthma	4	1.0
Other	42	10.5
Total	**400**	**100.0**

The frequency distributions of the individuals participating in the survey according to the type of sport are presented in Table 2. According to the findings, the highest accumulation was in walking (38.5 %), followed by Pilates (12.8 %) and fitness (7.5 %).

Table 2. Frequency distribution of the individuals participating in the survey according to the types of sports they do

Types of Sports	**Number**	**Percent**
Walking	154	38.5
Pilates	51	12.8
Fitness	30	7.5
Yoga	14	3.5
Swimming	14	3.5
Football	11	2.8
Running	11	2.8
Tennis	7	1.8
Cycling	5	1.3
Volleyball	5	1.3
Exercise	5	1.3
Other	40	10.0

Table 3 presents the frequency distributions of respondents according to their types of hobbies. According to the findings obtained, the largest cluster is in the hobby of "Reading books/magazines/articles/news" with 30.8%, followed by "Sports (table tennis, swimming, rowing, skiing, fitness, sailing, archery, canoeing, brush craft)" with 19.8%, and scuba diving. with a

rate of 17.0%, followed by" Watching television, watching football, TV series, movies, cinema, TV series, documentaries"with a rate of 17.0% and" Music (guitar, ney, baglama, choir, piano)" with a rate of 16.0%.

Table 3. Frequency distribution of the respondents according to the types of hobbies they have

Hobbies	Number	Percent
Reading books/magazines/articles/news	123	30.8
Sports (table tennis, swimming, rowing, skiing, fitness, sailing, archery, canoeing, brushcraft, scuba diving)	79	19.8
Watching TV, watching football, TV series, movies, Cinema, TV series, documentaries	68	17.0
Music (guitar, ney, baglama, choir, piano.)	64	16.0
Trekking, hiking, camping	62	15.5
Traveling, sightseeing	46	11.5
Crafts and visual arts (ceramics, wood carving, painting, oil painting, calligraphy, sculpture, charcoal, painting, marbling	37	9.3
Gardening (flowers, fruit growing, beekeeping.)	17	4.3
Project work, scientific studies, reading philosophy, sociology, anthropology, research	16	4.0
Games (puzzles, sudoku, puzzles, chess, playing computer games, video games,	15	3.8
Cooking, tasting different flavors	14	3.5
Handicrafts, knitting, knitting, amigurimi, sewing, jewelry dress design,	13	3.3
Other	87	21.8

The minimum, maximum, and average daily sleep durations of the individuals who participated in the survey are presented in Table 4. According to the findings, the participants had a minimum daily sleep time of 4 hours, a maximum daily sleep time of 10 hours, and an average daily sleep time of 6.97 hours.

Table 4. Minimum, maximum, and average daily sleep duration of the individuals surveyed

	Minimum	Maximum	Mean	Std. Deviation
Sleep Duration	4.00	10.00	6.97	1.095

3.2. Validity and reliability analysis findings

The Cronbach's alpha coefficients for the Healthy Lifestyle Behaviors Scale and its sub-dimensions are presented in Table 5. According to the results, the Nutrition and Interpersonal Relations sub-dimensions of the Healthy Lifestyle Behaviors Scale demonstrated high reliability, as did the overall scale and its other dimensions.

Table 5. Cronbach's Alpha coefficient findings for the Healthy Lifestyle Behaviors scale and its sub-dimensions used in the study

	Item Number	Cronbach's Alpha
Measurement of Healthy Lifestyle Behaviors	51	0.941
Health responsibility	9	0.830
Physical activity	7	0.867
Nutrition	8	0.691
Spiritual development	9	0.811
Interpersonal relationships	9	0.783
Stress management	8	0.804

The Level 1 and Level 2 fit statistic values for the validity of the Healthy Lifestyle Behaviors Scale CFA model are presented in Table 6. The findings indicate that the fit index values for structural validity at both levels were within the acceptable range.

Table 6. Fit statistic values for the validity of the Healthy Lifestyle Behaviors Scale CFA model

	CMIN/DF	GFI	CFI	RMSEA
Level 1	2.366	0.949	0.941	0.059
Level 2	2.585	0.941	0.93	0.063
Acceptable Compliance	≤3	≥0.90	≥0.90	≤0.080

When examining the effect coefficients of the sub-dimensions of the Healthy Lifestyle Behaviors Scale, it is evident that the effects of all dimensions were statistically significant. According to the standardized estimation values, the highest effect was observed in the 'Stress Management' dimension, while the lowest effect was found in the 'Physical Activity' dimension.

Table 7. Healthy Lifestyle Behaviors Scale, effect coefficients of sub-dimensions on the scale

Healthy Lifestyle Behaviors Scale	Estimate	Std. Estimate	S.E.	C.R.	P
Physical Activity	1	0.755			
Stress Management	0.621	0.933	0.078	7.949	***
Spiritual Development	0.632	0.794	0.067	9.394	***
Interpersonal Relationships	0.439	0.819	0.064	6.832	***
Nutrition	0.643	0.893	0.08	8.000	***
Health Responsibility	0.592	0.764	0.066	8.923	***

(***: p<0.001)

Descriptive statistics, including skewness and kurtosis values for the Healthy Lifestyle Behaviors scale and its dimensions, are presented in Table 8. Analysis of the means reveals that the highest average score is in the 'Spiritual Development' sub-dimension (3.06), while the lowest average score is in the 'Health Responsibility' sub-dimension (2.15). The findings indicate that the skewness and kurtosis values for the Healthy Lifestyle Behaviors scale and its sub-dimensions fall within the acceptable range for a normal distribution (Hair et al., 2022).

Table 8. Descriptive statistics and skewness and kurtosis values for the Healthy Lifestyle Behaviors Scale and its sub-dimensions

Scale/Size	Minimum	Maximum	Mean	Std. Deviation	Skewness	Kurtosis
Health responsibility	1.00	3.89	2.35	0.544	0.313	-0.063
Physical activity	1.00	4.00	2.38	0.712	-0.004	-0.649
Nutrition	1.25	3.88	2.61	0.492	0.197	-0.177
Spiritual development	1.22	4.00	3.06	0.501	-0.304	-0.091
Interpersonal relationships	1.22	4.00	2.86	0.479	0.100	-0.312
Stress management	1.00	4.00	2.59	0.554	0.212	-0.002
Healthy Lifestyle Behaviors	**1.40**	**3.80**	**2.65**	**0.430**	**0.229**	**-0.055**

The Pearson correlation coefficients for the Healthy Lifestyle Behaviors scale and its dimensions are presented in Table 9. The results indicate that all the correlation coefficients are positive and statistically significant. Accordingly, a positive change in any healthy lifestyle dimension is expected to correspond with positive changes in other dimensions. Analysis of the relationships between dimensions revealed that the highest correlation coefficient existed between the interpersonal relations and spiritual development dimensions. This finding is significant because it highlights the

strength of communication and social ties among academics.

Table 9. Pearson correlation coefficient findings for the Healthy Lifestyle Behaviors scale and its dimensions

Scale/Dimensions	X1	X2	X3	X4	X5	X6	X7
Healthy Lifestyle Behaviors (X1)	1						
Health Responsibility (X2)	.786**	1					
Physical Activity (X3)	.774**	.560**	1				
Nutrition (X4)	.789**	.571**	.590**	1			
Spiritual Development (X5)	.774**	.421**	.433**	.513**	1		
Interpersonal Relationships (X6)	.798**	.569**	.410**	.525**	.744**	1	
Stress management (X7)	.851**	.595**	.652**	.617**	.610**	.590**	1

(**: p<0.01)

3.3. Analyzing the research variables in terms of demographic variables

The Healthy Lifestyle Behaviors Scale and its sub-dimensions, used in the questionnaire, were analyzed using a t-test to determine whether differences existed based on the University of Study variable. The results revealed a statistically significant difference in the overall Healthy Lifestyle Behaviors Scale, as well as in the Physical Activity and Stress Management subdimensions, according to the University of Study. Specifically, participants affiliated with the Foundation University reported higher perceptions of physical activity and stress management than those affiliated with the State University.

The Healthy Lifestyle Behaviors Scale and its sub-dimensions, used in the questionnaire, were analyzed using a t-test to determine if there were differences based on gender. The results revealed a statistically significant difference in the overall Healthy Lifestyle Behaviors Scale and in the sub-dimensions of Health Responsibility, Nutrition, and Interpersonal Relationships with respect to gender. Specifically, female participants scored higher than male participants on the Healthy Lifestyle Behaviors Scale and the sub-dimensions of Health Responsibility, Nutrition, and Interpersonal Relationships.

The t-test was used to examine whether there were differences in the Healthy Lifestyle Behaviors Scale and its sub-dimensions based on the Marital Status variable. According to the findings, no statistically significant differences were found in the Healthy Lifestyle Behaviors Scale or its sub-dimensions with respect to Marital Status.

The t-test was used to examine whether there were differences in the Healthy Lifestyle Behaviors Scale and its sub-dimensions used in the survey in terms of the variable of receiving dietitian support. According to the findings, a statistically significant difference was found in the health responsibility, Physical activity and Nutrition sub-dimensions of the Healthy Lifestyle Behaviors Scale used in the survey in terms of the variable of receiving dietitian support. The source of the difference is that the perceptions of Health responsibility, Physical activity and Nutrition were higher in participants who received dietitian support than in participants who did not receive dietitian support.

The t-test was used to examine whether there were differences in terms of the variable of receiving psychological support i. According to the findings in the Healthy Lifestyle Behaviors Scale and its sub-dimensions used in the survey, a statistically significant difference was found in terms of the variable of receiving psychological support in the Healthy Lifestyle Behaviors Scale and the Health responsibility, Physical activity and Stress management sub-dimensions used in the survey. The source of the difference is that the perceptions of Healthy Lifestyle Behaviors, Health responsibility, Physical activity and Stress management were higher in the participants who received psychological support than in the participants who did not receive psychological support.

The t-test was used to examine whether the Healthy Lifestyle Behaviors Scale and its sub-dimensions used in the survey differed in terms of the Disease status variable. According to the findings, a statistically significant difference was found in the Physical Activity and Interpersonal Relations sub-dimensions of the Healthy Lifestyle Behaviors Scale used in the survey in terms of the Disease status variable. The source of the difference is that the perceptions of Physical Activity and Interpersonal Relations were higher in participants without the disease than in participants with the disease.

The findings indicate a statistically significant difference in the Healthy Lifestyle Behaviors Scale and its sub-dimensions across different faculties (Faculty of Applied Sciences and Vocational School/College, Faculty of Economics and Administrative Sciences). The specific groups responsible for these differences were identified using the Tukey test.

The ANOVA test was conducted to determine whether there were differences in the Healthy Lifestyle Behaviors Scale and its sub-dimensions, as measured in the survey, based on the Title variable. The results indicated no statistically significant differences in the Healthy Lifestyle Behaviors Scale or its sub-dimensions with respect to the Title variable.

The ANOVA test was used to examine whether there were differences in the Healthy Lifestyle Behaviors Scale and its sub-dimensions, as measured in the survey, based on the Age Group variable. According to the findings, a statistically significant difference was found in the Healthy Lifestyle Behaviors Scale and its sub-dimensions with respect to the Age Group variable. The groups responsible for these differences were identified using the Tukey test.

4. Conclusion

Concepts such as living a balanced life, living naturally, maintaining good health, staying fit, staying in shape, living well, improving quality of life, maintaining physical and mental balance, adopting a peaceful and healthy lifestyle, and overall quality of life all convey the same meaning as the term in recent years, digitalization has made it easier to access a wealth of information about healthy living. Individuals can readily obtain a variety of health-related data, from learning about treatment options for their conditions to selecting doctors and hospitals to treat them.

The results of the research indicate that when a positive development occurs in any dimension of a healthy lifestyle, positive changes are also expected to be observed in the other dimensions. Examining the relationships between these dimensions revealed that the highest correlation coefficient existed between interpersonal relations and spiritual development. This finding is significant as it highlights the strength of communication and social ties among academics. Female participants scored higher than male participants in Health Responsibility, Nutrition, and Interpersonal Relations on the Healthy Lifestyle Behaviors Scale. Additionally, participants who engaged in sports scored higher in Healthy Lifestyle Behaviors and its sub-dimensions—Health Responsibility, Physical Activity, Nutrition, Spiritual Development, Interpersonal Relations, and Stress Management—compared to those who did not participate in sports. Similarly, participants who underwent regular annual health checkups scored higher in these areas than those who did not. A statistically significant difference was also found in the Healthy Lifestyle Behaviors Scale regarding the variable of receiving dietitian support, specifically in the sub-dimensions of Health Responsibility, Physical Activity, and Nutrition.

The differences observed stem from higher perceptions of health responsibility, physical activity, and nutrition among participants who received dietitian support compared to those who did not. Similarly, participants who received psychological support reported higher perceptions of healthy lifestyle behaviors, health responsibility, physical activity, and stress management than those who did not receive such support. A statistically significant difference was identified in the disease status variable concerning the physical activity and interpersonal relations sub-dimensions of the Healthy Lifestyle Behaviors Scale. Specifically, participants without the disease exhibited higher perceptions of physical activity and interpersonal relations than those with the disease. Regarding the age group variable within the Healthy Lifestyle Behaviors Scale and its sub-dimensions, individuals aged 33 and below and those aged 47 and above place greater importance on their health within the context of a healthy lifestyle.

Over the years, various factors such as the environment in which a person lives, economic conditions, educational status, and age-related health problems can create stress and cause individuals to worry about their health. Consequently, the anxiety experienced due to these factors may increase, negatively affecting healthy lifestyle behaviors.

Health protection methods provided by healthcare services, disease treatment processes, and post-illness rehabilitation primarily depend on the individual's awareness of the importance of their own health, as well as the behaviors and attitudes they adopt to maintain a healthy lifestyle. Before experiencing health deterioration, individuals must be conscious of their health and take responsibility for it. They should achieve a level of digital health literacy that enables them to manage their health effectively and continuously strive to develop healthy lifestyle habits.

Ethics Committee Approval

At the meeting of Istanbul Gelisim University dated 19.04.2024 and numbered 2024-05 for the study, the reports of the academic staff assigned to make an evaluation according to Article 12 (1) of the IGU Ethics Committee Directive have been examined and it has been unanimously decided that the

scientific research in the relevant study complies with the ethical rules.

Author Contributions

This article has two authors, and the contribution rate of the author is 50%.

Conflicts of interest

The authors declare no conflict of interest.

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