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### RESEARCH ARTICLE

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## Health Promotion and Disease Prevention Practices of the Teachers: Basis for Enhanced Wellness Program

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### ABSTRACT

In the sedentary nature of an employee's most working status, this group can be at risk of developing non-communicable diseases and become susceptible to the Covid-19 pandemic. This study utilized a quantitative descriptive design for it aims to identify the practices of the respondents regarding health promotion and disease prevention that can serve as a basis for enhancement programs that may improve their health. The study's respondents were the teachers of the educational institution, where they were selected using the purposive random sampling (fish bowl method) technique. Using the weighted mean, frequency and percentage, T-test and analysis of variance (ANOVA) as statistical treatment, the study's findings revealed that the majority of the respondents do not practice disease prevention. 71.7% don't practice an annual checkup, 67.9% in blood pressure monitoring, 81.1% in weight monitoring, 96.2% in sugar level monitoring, 83% don't take maintenance drugs, and 58.5% have an average sleep of 5-7 hours. While 81.1% are taking a vitamin supplement. In health promotion, the practices that are routinely done, together with the average mean are spiritual growth (2.99), interpersonal relationships (2.80) and stress management (2.50). While nutrition management (2.45), health responsibility (2.30) and physical activity (2.10) are only practiced sometimes. The study concluded that health teaching and programs are needed to improve the practices of the teachers in educational institutions regarding health promotion and disease prevention.

**Keywords:** teachers; health promotion; disease prevention; health; practice

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### INTRODUCTION

According to the University Infirmary of the educational institution (2018) on the latest census data, from the month of January to September there are 16 health concern reported at the infirmary and the respiratory and cardiovascular problems are the most common health concern manifested by the university teachers. The overall result of health concerns from January to September in descending order were 291 in respiratory problems, 266 in cardiovascular problem, 95 in neurologic, 83 in musculoskeletal joints, 63 in abdominal, 60 in wounds/dressing, 39 in EENT (eyes, ears, nose and throat), 35 in viral infections, 32 in allergy, 19 in urinary, 17 in nutritional and hormonal/gyne, 9 in hematology, 6 in skin and hair, 6 in anxiety, and 3 in endocrinology and OB case.

Recent research has indicated that teachers have a higher prevalence in asthma compared to non-industrial occupation, teachers are most likely exposed to various home and school environmental hazards that affects indoor air quality<sup>(1)</sup>. Food and nutrition are necessary aspects, which leads to health promotion and disease prevention. An appropriate diet contributes to healthy development, healthy ageing and greater resilience against disease while

lack of essential nutrient to one's diet leads to health problems and illnesses. Exercise and physical activities are considered as a crucial ways to maintain adequate body weight and prevent the occurrence of any health problems or illnesses. As the individuals emerged into adults, they will recognized the significance of the activities that are positively correlated with physical fitness. Therefore, individual need to get engaged in exercise and physical activities in accordance to their age, body weight, and physical abilities to maintain good health and prevent the occurrence of health problems and illness <sup>(2)</sup>.

From these data, the study measured and identified the knowledge and the healthy lifestyle and practices of the teachers in the University and differentiated the data that will be gathered to the health diseases and concerns that are presented in the record of the University infirmary. Through the results that we gathered from the respondents we can use them as a basis to implement programs that can help them to be aware of the co morbidities that mostly affects their health, and which can also motivate the teachers to accomplish their health promoting practices, to engage in physical activities and proper nutrition. Health education renders significant contribution in providing information in terms of health promotion and disease prevention. There are initiation of programs by imparting information to individuals in terms of adoption of healthy behaviours which can lead them to have healthy lifestyles, and lowers the health risk thus individuals may not experience health problems and illnesses. If the measured result is ineffective, this study can be a basis in the policy that will improve the health status of the teachers in the educational institution.

## METHODS

Desig of this research was cross-sectional. The researchers used this research studies and designs to determine the self-care management of the teachers in an education institution and to know the things they needed to improve as health promotion in maintaining their healthy lifestyle<sup>(3)</sup>. The study was conducted among the permanent teachers of an educational institution. The University was located along the high way of Pan-Philippine Highway Echague, Isabela.

To achieve the objectives of the study, the researchers divided the questionnaire in four parts. Part 1 is the respondent profile and it is composed of names (optional), the age, gender, marital status, familial disease and vices that the respondent have. Part 2 is anthropometric measurements and it is composed of body weight, height and waist circumference. Part 3 is disease prevention practices and it is composed of annual checkups, hours of sleep, BP monitoring, sugar level monitoring, weight monitoring, taking drug maintenance and taking vitamin supplements. Part 4 is health promotion practices where the researchers adopted a ready-made and comprehensive set of questions to Walker, et al. entitled Health-Promoting Lifestyle Profile. The researchers used likert scale and the questions presents 4 alternatives reactions such as never to routinely to measures attitude, also measures how people feel about something and to specified their level with agreement to a statement.

### Date Gathering Procedure

The respondents were the permanent teachers of an educational institution, particularly the faculty and staff employed in the university. The educational institution had a total population of 233 permanent teaching staff. Using the Slovin's formula with a confidence level of 90% with a margin of error at 10%, the sample size computed was 53 respondents. The permanent teachers had 233 respondents. The participants were selected randomly to fulfill the so-called respondents.

The researchers allotted so much time, effort and collaboration to gather a survey questionnaire that will be fitted in our study. Questionnaires were the main instrument in gathering the data needed in our study. The questionnaire is an adopted survey and mainly focuses on the health promotion and disease prevention of the respondents. The researchers adopted questionnaire in previous study to be used as a primary draft of the instrument to be determined in collaboration with the research professor or adviser who identified and validated its reliability. However, the survey is composed of four different parts which are the respondents profile, anthropometric measurements, health promotion practices and disease prevention practices. The researchers created the other parts alongside with the health promotion and disease prevention practices to fulfill needed data in our study that cannot be seen in the adopted questionnaire. After the research coordinator, executive officer and all the deans of each department approved the questionnaire by giving consent letter, the researchers distributed the survey questionnaires to the 53 respondents of certain educational institution through online via Google form. The respondents were given time to respond and the researchers collected the data afterwards.

### Statistical Treatment of Data

The researchers analyzed the data collected thought; Frequency and percentage, to determine the profile of the respondents, anthropometric measurement and their disease prevention; Weighted Mean was utilized to determine the level of practices used by the permanent teachers in terms of health promotion; T-test was used to determine the differentiation of the respondents health promoting lifestyle based on gender and civil status; and Analysis of Variance (ANOVA) was used to exploit the differentiation of the respondents health promoting lifestyle based on their age.

## RESULTS

### Profile of the Respondents

As presented in the Table 1, the data imply that most of our respondents' age group was within 21-35 because they have access to cell phones or gadgets since we gathered the data online. In addition, ages 21-35 were the ideal age for a person to work. Group ages 36-50 is the second highest while 51-65 are the lowest because at this age optional and mandatory retirement happens.

In terms of gender may imply that most of the teachers in the University are female rather than male. With regards to the respondent's civil status, the findings suggests that most of our respondents' are married because they are already at the right age to marry and they are employed.

For the familial disease regarding diabetes, it is evident that majority of the respondents have no familial disease of diabetes. This data implies that the location of the study has a lower prevalence of familial disease of diabetes. As for hypertension, it is evident that majority of the respondents have a familial disease of hypertension. This data implies that the study's location has a higher prevalence of familial disease of hypertension. The population in the location As for cancer, it is evident that majority of the respondents have no familial disease of cancer. This data implies that the study's location, which is a rural place, has a lower rate of incidence of familial disease of cancer. As for the heart disease, it is evident that majority of the respondents have no familial disease of heart disease. This data implies that the study's location, a rural place, has a low incidence risk of familial disease of heart disease. As for stroke, it is evident that majority of the respondents have no familial disease of stroke. This data implies that the study's location, which is a rural place, has a lower rate of incidence of familial disease of stroke. As for allergies, it is evident that majority of the respondents have no familial disease of allergies. This data implies that the study's location has a lower risk of developing allergies. In terms of the vices of the respondents, most of the respondents' has no vices because majority of our respondents are female with no vices. Alcohol drinkers mostly are male including the smokers.

Table 1. Frequency and percentage of respondent's profile

Profile of the respondents	Frequency	Percentage
<b>Age</b>		
21-35	30	56.6
36-50	16	30.2
51-65	7	13.2
<b>Gender</b>		
Male	24	45.3
Female	29	54.7
<b>Civil status</b>		
Single	20	37.7
Married	33	62.3
<b>Diabetes</b>		
No	33	62.3
Yes	20	37.7
<b>Hypertension</b>		
No	16	30.2
Yes	37	69.8
<b>Cancer</b>		
No	38	71.7
Yes	15	28.3
<b>Heart disease</b>		
No	37	69.8
Yes	16	30.2
<b>Stroke</b>		
No	41	77.4
Yes	12	22.6
<b>Allergies</b>		
No	27	50.9
Yes	26	49.1
<b>Vices</b>		
None	30	56.6
Smoking	7	13.2
Alcohol drinking	16	30.2

### Body Mass Index (BMI)

Table 2. Frequency and percentage of the Body Mass Index of the respondents

Body Mass Index (BMI)	Frequency	Percentage
Underweight	1	1.9
Normal	34	64.2
Overweight	18	34

As presented in Table 2, the body mass index of the respondents, it implies that most of the respondents' has no vices because majority of our respondents are female with no vices. Alcohol drinkers mostly are male including the smokers.

### Disease Prevention

As presented in Table 3, for the disease prevention activities of the respondent, the respondents think that they are already healthy and they don't see the importance of annual check-up.

In terms of the average hours of sleep of the respondents, it presents that 1-3 hours of sleeping with a frequency of 1 or 1.9 percent being the lowest average sleep of the respondents; followed by 7-9 hours; then 3-5 hours; and lastly 5-7 hours, which holds the largest frequency percentage of 58.5. The data above may imply that respondents have a limited time of sleep because they are aware that they have to wake up early to make food for their families and so they can be able to enter their workplace on time.

As for the Blood Pressure Monitoring, it implies that the respondents doesn't see the importance of checking once-self blood pressure and thus, should know the importance of BP monitoring in their health. As for the sugar level monitoring, it implies that the respondents doesn't see the importance of checking once-self blood pressure and thus, should know the importance of BP monitoring in their health. As for the taking of maintenance drugs, it implies that majority of the respondents should know the importance of taking maintenance drug and it's for lifetime. As for the taking of vitamin supplements, it implies that the respondents are aware that taking vitamins is essential these days and they know that it can strengthen their immunity especially they are working.

Table 3. Frequency and percentage of the disease prevention of the respondents

Disease prevention		Frequency	Percentage
Annual check-up	No	38	71.7
	Yes	15	28.3
Average hour of sleep	1-3 hours	1	1.9
	3-5 hours	11	20.8
	5-7 hours	31	58.5
	7-9 hours	10	18.9
BP monitoring	No	36	67.9
	Yes	17	32.1
Weight monitoring	No	43	81.1
	Yes	10	18.9
Sugar level monitoring	No	51	96.2
	Yes	2	3.8
Taking maintenance drugs	No	44	83
	Yes	9	17
Taking vitamin supplements	No	10	18.9
	Yes	43	81.1

**Health Promoting Lifestyle**

Table 4. Health promoting lifestyle

	Average	Remarks
Health Responsibilities	2.30	Sometimes
Physical Activity	2.10	Sometimes
Nutrition	2.45	Sometimes
Spiritual Growth	2.99	Often
Interpersonal Relationship	2.80	Often
Stress Management	2.50	Often
Over-all Average Mean	2.52	Often

Table 4 shows the overall health promoting lifestyle of the respondents. This implies that the respondents are more knowledgeable in health promoting lifestyle when in terms of spiritual growth, interpersonal relationship, and stress management than nutrition, health responsibilities and physical activity therefore the overall average showed that almost all of the respondents have past knowledge about health promoting lifestyle but do not practice routinely.

**Differentiation of Health Promoting Lifestyle Based on Age**

Health responsibility

Table 5. Analysis of health responsibility according to age

	Sum of squares	Df	Mean square	F	Sig.
Between groups	1.636	2	0.818	2.454	0.096
Within groups	16.666	50	0.333		
Total	18.302	52			

Table 5 showed that there is no significant difference between the health responsibilities of the respondents when grouped into their age. F ratio = 2.454 with p-value of 0.096 which is >0.05 level of significance, hence the difference is not significant. This implies that there is no difference in the practices of health responsibilities among the respondents when the respondents are group into their age.

Physical activity

Table 6. Analysis of physical activity according to age

	Sum of squares	Df	Mean square	F	Sig.
Between groups	2.367	2	1.184	1.505	0.232
Within Groups	39.331	50	0.787		
Total	41.698	52			

Table 6 showed that there is no significant difference between the physical activities of the respondents when grouped into their age. F ratio = 1.505 with p-value of 0.232 which is >0.05 level of significance, hence the difference is not significant. This implies that there is no difference in the practice of physical activity among the respondents when groups into their age.

Nutrition

Table 7. Analysis of nutrition lifestyle according to age

	Sum of squares	Df	Mean Square	F	Sig.
Between groups	0.558	2	0.279	1.003	0.374
Within groups	13.895	50	0.278		
Total	14.453	52			

Table 7 showed that there is no significant difference between the nutrition of the respondents when grouped into their age. F ratio = 1.003 with p-value of 0.374 which is >0.05 level of significance, hence the difference is not significant. This implies that there is no difference in the practice of nutrition among the respondents when groups into their age.

Spiritual growth

Table 8. Analysis of spiritual growth lifestyle according to age

	Sum of squares	Df	Mean square	F	Sig.
Between groups	0.147	2	0.074	0.149	0.862
Within groups	24.645	50	0.493		
Total	24.792	52			

Table 8 showed that there is no significant difference between the spiritual growth of the respondents when grouped into their age. F ratio = 0.149 with p-value of 0.862 which is >0.05 level of significance, hence the difference is not significant. This implies that there is no difference in the practice of spiritual growth among the respondents when groups into their age.

Interpersonal relationship

Table 9. Analysis of interpersonal relationship lifestyle according to age

	Sum of squares	Df	Mean square	F	Sig.
Between groups	0.224	2	0.112	0.213	0.809
Within groups	26.304	50	0.526		
Total	26.528	52			

Table 9 showed that there is no significant difference between the interpersonal relationships of the respondents when grouped into their age. F ratio = 0.213 with p-value of 0.809 which is >0.05 level of significance, hence the difference is not significant. This implies that there is no difference in the practice of interpersonal relationship among the respondents when groups into their age.

Stress management

Table 10. Analysis of stress management lifestyle according to age

	Sum of squares	df	Mean square	F	Sig.
Between Groups	0.502	2	0.251	0.616	0.544
Within Groups	20.366	50	0.407		
Total	20.868	52			

Table 10 showed that there is no significant difference between the stress management relationships of the respondents when grouped into their age. F ratio = 0.616 with p-value of 0.544 which is >0.05 level of significance, hence the difference is not significant. This implies that there is no difference in the practice of stress management among the respondents when groups into their age.

Overall health promoting lifestyle

Table 11. Health promoting lifestyle according to age group

	21-35			36-50			51-65		
	Mean	SD	Remarks	Mean	SD	Remarks	Mean	SD	Remarks
Health responsibility	2.20	0.551	Sometimes	2.19	0.544	Sometimes	2.71	0.756	Often
Physical activity	2.07	0.944	Sometimes	1.88	0.719	Sometimes	2.57	0.976	Often
Nutrition	2.47	0.507	Sometimes	2.25	0.577	Sometimes	2.29	0.488	Sometimes
Spiritual growth	3.13	0.730	Often	3.13	0.719	Often	3.29	0.488	Routinely
Interpersonal relationship	2.93	0.740	Often	2.81	0.655	Often	3.00	0.816	Often
Stress management	2.50	0.630	Often	2.69	0.602	Often	2.71	0.756	Often
Average mean	2.50	0.630	Often	2.50	0.632	Often	2.71	0.756	Often

Table 11 showed that the average mean of ages 51-65 years old is 2.71 and indicated that they are often practicing a health promotion lifestyle, and ages 21-35 and 36-50 years old resulted in the same score with an average mean of 2.50 and indicated that these groups are also often practicing a health promotion lifestyle.

In the gathered data, it is evident that the highest scored group regarding health promotion lifestyle is the age group of 51-65 years old. This data implies that this age group tends to give more importance and time to their health because this group tends to have more health problems and the occurrence of diseases.

Analysis of variance according to age group

Table 12 showed that there is no significant difference between the health promoting lifestyle of a single or married person. F ratio = 0.333 with p-value of 0.718 which is >0.05 level of significance, hence the difference is not significant. This implies that there is no difference in the practice of health promoting lifestyle among the respondents when groups into their age.

Table 12. Analysis of health promoting lifestyle according to age

	Sum of squares	Df	Mean square	F	Sig.
Between groups	0.279	2	0.139	0.333	0.718
Within groups	20.929	50	0.419		
Total	21.208	52			

**Differentiation of Health Promoting Lifestyle Based on Sex**

Health responsibility

Table 13. Analysis of respondent’s health responsibility by sex

	Levene’s test for equality of variances				t-test for equality of means				
	F	Sig.	t	df	Sig. (2-tailed)	Mean difference	Std. error difference	95% Confidence interval of the difference	
								Lower	Upper
Equal variances assumed	0.731	0.397	-0.619	51	0.538	-0.102	0.165	-0.433	0.229
Equal variances not assumed			-0.608	44.514	0.546	-0.102	0.168	-0.440	0.236

Table 13 showed that there is no significant difference between the health responsibility of a male and female respondents. T-test = -0.608 with p-value of 0.546, hence the difference is not significant. This implies that there is no difference in the practice of health responsibility among the respondents when group by sex.

Physical activity

Table 14. Analysis of respondent’s physical activity by sex

	Levene’s test for equality of variances				T-test for equality of means				
	F	Sig.	t	Df	Sig. (2-tailed)	Mean difference	Std. Error difference	95% confidence interval of the difference	
								Lower	Upper
Equal variances assumed	0.048	0.827	0.058	51	0.954	0.014	0.250	-0.487	0.515
Equal variances not assumed			0.057	48.168	0.955	0.014	0.251	-0.490	0.518

Table 14 showed that there is no significant difference between the physical activities of male and female respondents. T-test = 0.057 with p-value of 0.955, hence the difference is not significant. This implies that there is no difference in the practice of physical activity among the respondents when group by sex.

Nutrition

Table 15. Analysis of respondent’s nutrition by sex

	Levene’s test for equality of variances				T-test for equality of means				
	F	Sig.	t	Df	Sig. (2-tailed)	Mean difference	Std. Error difference	95% confidence interval of the difference	
								Lower	Upper
Equal variances assumed	0.885	0.351	-0.029	51	0.977	-0.004	0.147	-0.299	0.291
Equal variances not assumed			-0.030	50.779	0.976	-0.004	0.145	-0.296	0.287

Table 15 showed that there is no significant difference between the nutrition of a male and female respondents. T-test = -0.030 with p-value of 0.976 which is >0.05 level of significance, hence the difference is not significant. This implies that there is no difference in the practice of nutrition among the respondents when group by sex.

Spiritual growth

Table 16. Analysis of respondent’s spiritual growth by sex

	Levene’s test for equality of variances				T-test for equality of means				
	F	Sig.	t	Df	Sig. (2-tailed)	Mean difference	Std. Error difference	95% confidence interval of the difference	
								Lower	Upper
Equal variances assumed	0.679	0.414	-1.049	51	0.299	-0.200	0.190	-0.582	0.182
Equal variances not assumed			-1.049	49.142	0.299	-0.200	0.190	-0.582	0.183

Table 16 showed that there is no significant difference between the spiritual growth of a male and female respondents. T-test = -1.049 with p-value of 0.299, hence the difference is not significant. This implies that there is no difference in the practice of spiritual growth among the respondents when group by sex.

Interpersonal relationship

Table 17. Analysis of respondent’s interpersonal relations by sex

	Levene’s test for equality of variances				T-test for equality of means				
	F	Sig.	t	Df	Sig. (2-tailed)	Mean difference	Std. Error difference	95% confidence interval of the difference	
								Lower	Upper
Equal variances assumed	0.840	0.364	-0.667	51	0.508	-0.132	0.198	-0.530	0.266
Equal variances not assumed			-0.680	50.997	0.500	-0.132	0.194	-0.523	0.258

Table 17 showed that there is no significant difference between the health interpersonal relations of male and female respondents. T-test = -0.680 with p-value of 0.500, hence the difference is not significant. This implies that there is no difference in the practice of interpersonal relations among the respondents when group by sex.

Stress management

Table 18. Analysis of respondent’s stress management by sex

	Levene's test for equality of variances				T-test for equality of means				
	F	Sig.	t	Df	Sig. (2-tailed)	Mean difference	Std. Error difference	95% confidence interval of the difference	
								Lower	Upper
Equal variances assumed	0.001	0.976	0.416	51	0.679	0.073	0.176	-0.280	0.427
Equal variances not assumed			0.415	48.707	0.680	0.073	0.177	-0.282	0.428

Table 18 above showed that there is no significant difference between the stress management of a male and female respondents. T-test = 0.415 with p-value of 0.680, hence the difference is not significant. This implies that there is no difference in the practice of stress management among the respondents when group by sex.

Overall health promoting lifestyle

Table 19. Health promoting lifestyle according to gender

	Male			Female		
	Mean	Std. deviation	Remarks	Mean	Std. deviation	Remarks
Health responsibility	2.21	0.658	Sometimes	2.31	0.541	Sometimes
Physical activity	2.08	0.929	Sometimes	2.07	0.884	Sometimes
Nutrition	2.38	0.495	Sometimes	2.38	0.561	Sometimes
Spiritual growth	3.04	0.690	Often	3.24	0.689	Often
Interpersonal relationship	2.83	0.637	Often	2.97	0.778	Often
Stress management	2.63	0.647	Often	2.55	0.632	Often
Average mean	2.54	0.721	Often	2.52	0.574	Often

Table 19 showed that the average mean of male is 2.54 and indicated in remarks as “Often” and in female with an average mean of 2.52 which remarks are also indicated as “Often”. It is showed in the table that they almost have the same score but still Male has the highest average mean, but is not enough to have a significant difference in the practice of health promoting life style when respondents are group by sex.

T-test according to gender

Table 20. Analysis of respondent’s health promoting lifestyle by sex

	Levene's test for equality of variances				T-test for equality of means				
	F	Sig.	t	Df	Sig. (2-tailed)	Mean difference	Std. Error difference	95% confidence interval of the difference	
								Lower	Upper
Equal variances assumed	1.897	0.174	0.137	51	0.891	0.02443	0.17792	-0.33275	0.38161
Equal variances not assumed			0.134	43.624	0.894	0.02443	0.18178	-0.34202	0.39087

Table 20 showed that there is no significant difference between the health promoting lifestyle of a male and female respondents. T-test = 0.134 with p-value of 0.894, hence the difference is not significant. This implies that there is no difference in the practice of health promoting lifestyle among the respondents when group by sex.

**Differentiation of Health Promoting Lifestyle Based on Marital Status**

Health responsibility

Table 21. Analysis of respondent’s health responsibility according to marital status

	Levene's test for equality of variances				T-test for equality of means				
	F	Sig.	t	Df	Sig. (2-tailed)	Mean difference	Std. Error difference	95% confidence interval of the difference	
								Lower	Upper
Equal variances assumed	9.745	0.003	-1.591	51	0.118	-0.264	0.166	-0.596	0.069
Equal variances not assumed			-1.742	50.125	0.088	-0.264	0.151	-0.568	0.040

Table 21 showed that there is no significant difference between the health responsibilities of a single or married person. T-test = -1.742 with p-value of 0.088, hence the difference is not significant. This implies that there is no difference in the practice of health responsibility among the respondents when group by their marital status.

Physical activity

Table 22. Analysis of respondent’s physical activity according to marital status

	Levene's test for equality of variances				T-test for equality of means				
	F	Sig.	t	Df	Sig. (2-tailed)	Mean difference	Std. Error difference	95% confidence interval of the difference	
								Lower	Upper
Equal variances assumed	4.829	0.033	1.107	51	0.273	0.280	0.253	-0.228	0.789
Equal variances not assumed			1.022	30.986	0.315	0.280	0.274	-0.279	0.840

Table 22 showed that there is no significant difference between the physical activities of a single or married person. T-test = -1.022 with p-value of 0.315, hence the difference is not significant. This implies that there is no difference in the practice of physical activity among the respondents when group by their marital status.

Nutrition

Table 23. Analysis of respondent’s nutrition according to marital status

	Levene's test for equality of variances				T-test for equality of means				
	F	Sig.	t	Df	Sig. (2-tailed)	Mean difference	Std. Error difference	95% confidence interval of the difference	
								Lower	Upper
Equal variances assumed	0.189	0.665	0.241	51	0.810	0.036	0.151	-0.266	0.339
Equal variances not assumed			0.247	43.033	0.806	0.036	0.148	-0.261	0.334

Table 23 showed that there is no significant difference between the nutrition of a single or married person. T-test = -0.247 with p-value of 0.806, hence the difference is not significant. This implies that there is no difference in the practice of nutrition among the respondents when group by their marital status.

Spiritual growth

Table 24. Analysis of respondent’s spiritual growth according to marital status

	Levene's test for equality of variances				T-test for equality of means				
	F	Sig.	t	Df	Sig. (2-tailed)	Mean difference	Std. Error difference	95% confidence interval of the difference	
								Lower	Upper
Equal variances assumed	0.002	0.964	-0.415	51	0.680	-0.082	0.197	-0.478	0.314
Equal variances not assumed			-0.410	38.624	0.684	-0.082	0.200	-0.486	0.322

Table 24 showed that there is no significant difference between the spiritual growths of a single or married person. T-test = -0.410 with p-value of 0.684, hence the difference is not significant. This implies that there is no difference in the practice of spiritual growth among the respondents when group by their marital status.

Interpersonal relationship

Table 25. Analysis of respondent’s interpersonal relationship according to marital status

	Levene's test for equality of variances				T-test for equality of means				
	F	Sig.	t	Df	Sig. (2-tailed)	Mean difference	Std. Error difference	95% confidence interval of the difference	
								Lower	Upper
Equal variances assumed	0.057	0.811	-0.836	51	0.407	-0.170	0.203	-0.577	0.238
Equal variances not assumed			-0.846	41.688	0.403	-0.170	0.201	-0.575	0.235

Table 25 showed that there is no significant difference between the interpersonal relations of a single or married person. T-test = -0.846 with p-value of 0.403, hence the difference is not significant. This implies that there is no difference in the practice of interpersonal relationship among the respondents when group by their marital status.

Stress management

Table 26. Analysis of respondent’s stress management according to marital status

	Levene's test for equality of variances				T-test for equality of means				
	F	Sig.	t	Df	Sig. (2-tailed)	Mean difference	Std. Error difference	95% confidence interval of the difference	
								Lower	Upper
Equal variances assumed	0.600	0.442	-0.756	51	0.453	-0.136	0.180	-0.498	0.226
Equal variances not assumed			-0.732	36.147	0.469	-0.136	0.186	-0.514	0.241

Table 26 showed that there is no significant difference between the stress management of a single or married person T-test = -0.732 with p-value of 0.469, hence the difference is not significant. This implies that there is no difference in the practice of stress management among the respondents when group by their marital status.

Overall health promoting lifestyle

Table 27. Health promoting lifestyle according to marital status

	Single			Married		
	Mean	Std. Deviation	Remarks	Mean	Std. Deviation	Remarks
Health Responsibility	2.10	0.447	Sometimes	2.36	0.653	Sometimes
Physical Activity	2.25	1.070	Sometimes	1.97	0.770	Sometimes
Nutrition	2.40	0.503	Sometimes	2.36	0.549	Sometimes
Spiritual Growth	3.10	0.718	Often	3.18	0.683	Often
Interpersonal Relations	2.80	0.696	Often	2.97	0.728	Often
Stress Management	2.50	0.688	Often	2.64	0.603	Often
Average Mean	2.45	0.686	Sometimes	2.58	0.614	Often

Table 27 indicates that overall, the health promoting lifestyle of married got an average mean of 2.58 having a remark as “often” while the single got an overall average mean of 2.45 having a remark as “sometimes”. In the data gathered, it is evident that the married respondents got the highest scored mean regarding health promotion lifestyle but not too far with the mean score of single respondents. This data implies that married individual were more likely to practice health promoting lifestyle but individually, both of them practices often in spiritual growth, interpersonal relations, and stress management.

T-test according to marital status

Table 28. Analysis of respondent’s health promoting lifestyle according to marital status

	Levene's test for equality of variances		T-test for equality of means						
	F	Sig.	t	Df	Sig. (2-tailed)	Mean difference	Std. Error difference	95% confidence interval of the difference	
								Lower	Upper
Equal variances assumed	0.117	0.734	-0.691	51	0.492	-0.12576	0.18189	-0.49091	0.23939
Equal variances not assumed			-0.672	36.762	0.505	-0.12576	0.18701	-0.50476	0.25325

Table 28 showed that there is no significant difference between the health promoting lifestyle of a single or married person. T-test = -0.672 with p-value of 0.505, hence the difference is not significant. This implies that there is no difference in the practice of health promoting lifestyle among the respondents when group by their marital status.

**Differentiation of Health Promoting Lifestyle Based on Body Mass Index**

Health responsibility

Table 29. Analysis of health responsibility according to body mass index

		Sum of squares	df	Mean square	F	Sig.
Ave_Rem	Between groups	0.073	2	0.037	0.1	0.905
	Within groups	18.229	50	0.365		
	Total	18.302	52			

Table 29 showed that there is no significant difference in health responsibilities when grouped according to BMI of the respondents. F ratio = 0.100 with p-value of 0.905, hence the difference is not significant. This implies that there is no difference in the practice of health responsibility among the respondents when based in their body mass index.

Physical activity

Table 30. Analysis of physical activity according to body mass index

		Sum of squares	df	Mean square	F	Sig.
Ave_Rem	Between groups	1.812	2	0.906	1.136	0.329
	Within groups	39.886	50	0.798		
	Total	41.698	52			

Table 30 showed that there is no significant difference in physical activity when grouped according to BMI of the respondents. F ratio = 1.136 with p-value of 0.329, hence the difference is not significant. This implies that there is no difference in the practice of physical activity among the respondents when based in their body mass index.

Nutrition

Table 31. Analysis of nutrition according to body mass index

		Sum of squares	df	Mean square	F	Sig.
Ave_Rem	Between groups	0.41	2	0.205	0.731	0.487
	Within groups	14.042	50	0.281		
	Total	14.453	52			

Table 31 showed that there is no significant difference in nutrition when grouped according to BMI of the respondents. F ratio = 0.731 with p-value of 0.487, hence the difference is not significant. This implies that there is no difference in the practice of nutrition among the respondents when based in their body mass index.

Spiritual growth

Table 32. Analysis of spiritual growth according to body mass index

		Sum of squares	df	Mean square	F	Sig.
Ave_Rem	Between groups	0.75	2	0.375	0.78	0.464
	Within groups	24.042	50	0.481		
	Total	24.792	52			

Table 32 showed that there is no significant difference in spiritual growth when grouped according to BMI of the respondents. F ratio = 0.780 with p-value of 0.464, hence the difference is not significant. This implies that there is no difference in the practice of spiritual growth among the respondents when based in their body mass index.

Interpersonal relationship

Table 33. Analysis of interpersonal relationship according to body mass index

		Sum of squares	df	Mean square	F	Sig.
Ave_Rem	Between groups	0.643	2	0.321	0.621	0.542
	Within groups	25.886	50	0.518		
	Total	26.528	52			

Table 33 showed that there is no significant difference in interpersonal relationship when grouped according to BMI of the respondents. F ratio = 0.621 with p-value of 0.542, hence the difference is not significant. This implies that there is no difference in the practice of interpersonal relationship among the respondents when based in their body mass index.

Stress management

Table 34. Analysis of stress management according to body mass index

		Sum of squares	df	Mean square	F	Sig.
Ave_Rem	Between groups	0.603	2	0.302	0.744	0.48
	Within groups	20.265	50	0.405		
	Total	20.868	52			

Table 34 showed that there is no significant difference in stress management when grouped according to BMI of the respondents. F ratio = 0.744 with p-value of 0.48, hence the difference is not significant. This implies that there is no difference in the practice of stress management among the respondents when based in their body mass index.

Overall health promotion lifestyle

Table 35. Health promotion lifestyle according to body mass index

	Underweight			Normal			Overweight		
	Mean	Sd	Remarks	Mean	Sd	Remarks	Mean	Sd	Remarks
Health responsibilities	2	-	Sometimes	2.26	0.666	Sometimes	2.28	0.461	Sometimes
Physical activity	1	-	Never	2.18	0.999	Sometimes	1.94	0.639	Sometimes
Nutrition	3	-	Often	2.35	0.544	Sometimes	2.39	0.502	Sometimes
Spiritual growth	4	-	Routinely	3.15	0.744	Often	3.11	0.583	Often
Interpersonal relationship	3	-	Often	2.82	0.758	Often	3.06	0.639	Often
Stress management	2	-	Sometimes	2.53	0.706	Often	2.56	0.511	Often
Average mean	2.5	-	Often	2.55	0.736	Often	2.56	0.556	Often

Table 35 showed that there is no significant difference in health promoting lifestyle of respondents base on their body mass index. In the gathered data, is it exhibited in the table that all of the respondents no matter the status of their body mass index has no significant differences in regards with their health promoting lifestyle. This indicated that the practice of health promoting life style of the respondents has no difference with each other.

Analysis of variance according to body mass index

Table 36. Analysis Health promoting life style according to body mass index

		Sum of squares	df	Mean square	F	Sig.
Ave_Rem	Between groups	0.293	2	0.146	0.35	0.707
	Within groups	20.915	50	0.418		
	Total	21.208	52			

Table 36 showed that there is no significant difference in stress management when grouped according to BMI of the respondents. F ratio = 0.35 with p-value of 0.707, hence the difference is not significant. This implies that there is no difference in the practice of health promoting lifestyle among the respondents when based in their body mass index.

**DISCUSSION**

In the respondents’ profile, majority of our respondents are aged group 21-35 since we gathered the data online. In the generation of millennial, age group 18-34 owns a cellphone making it by far the most popular devices among adults (4). In terms of gender, female respondents are dominant than male which indicates that permanent teachers in the University are most likely female. While in the civil status, most of the respondents are married and others are single. This finding suggests that most of our respondents are married because they are already at the right age to marry and they are employed. According to Executive Order No. 209 article 5, any male and female age eighteen (18) years or above may contract marriage. In relation to employment, full time employment is related with the desire of one person to marry which has a high percentage of almost 70% (5).

As to familial disease of the respondents, majority of the respondents have a familial disease of hypertension wherein they are at high risk of developing this disease. This may be due to the population in the location of the study which may have a poor lifestyle, specially in the diet as Filipinos eat salty and fatty foods. It is seen that hypertension is higher among the rural population in the Philippines. Their research observed that population has a dietary salt intake which can cause hypertension (6). In terms of diabetes, cancer, heart disease, stroke, and allergies majority of the respondents have no familial disease recorded. Whereas this may imply that geographical location has relation in terms of the prevalence of the disease and urban areas have a higher risk of developing non-communicable diseases than rural areas. This data is due to the urban population’s lifestyle habits, which have become more westernized with unhealthy diets and insufficient physical activity that may trigger or develop non-communicable disease like cancer (7).

Since female are dominant among the respondents, it reflects that majority of the respondents have no vices. Alcohol drinkers mostly are male including the smokers. The Global Status report on alcohol and health indicated 6.6 liters per year of alcohol consumption in the Philippines. Men are estimated to consume 11.3 as much alcohol as women which were 1.9 (8). Meanwhile, the results of Global Adult tobacco Survey indicate that ages 15 years and older, 40% of Filipino men are currently cigarette smokers (Epidemiology of Bureau and Department of Health 2015, as cited in (8))

In the anthropometric measurement of the respondents specifically Body Mass Index (BMI), majority of the respondents are in normal range. This data may indicate that most of the respondents are aware and concerned about their health. The changes in the working condition of many professional categories, particularly teachers, have contributed to the development of lifestyle related diseases, including overweight or obesity (9).

When it comes to disease prevention practices, respondents think that they are already healthy enough that is why they don’t see the importance of annual check-ups. This data is justified to healthy people often don’t need annual checkups because they think annual checkups usually don’t make them healthier (ABIM F. 2014). In contrast, the importance of medical check-up is the periodic medical evaluation of apparently healthy individuals with the view to detect abnormalities (10). In terms of average hour of sleep, respondents have limited time of sleep because they need to wake up early in the morning to make food for their families also to prepare themselves and

able to enter their workplace on time. Occupational task interferes mainly with sleep duration specially in the nature of working condition <sup>(11)</sup>. In the practices of blood pressure monitoring, weight monitoring, drug maintenance, and sugar level monitoring, majority of the respondents answered “no” meaning they don’t find time and know the importance of these practices. The importance of accurate blood pressure monitoring and measurement is vital in the prevention and treatment of blood-pressure-related diseases <sup>(12)</sup>. In terms of blood glucose monitoring, it is important for it would help to identify a patient’s compliance with blood glucose monitoring and the factors that affect it <sup>(13)</sup>. In the drug maintenance, taking maintenance medications regimen is the one that prevents common problem, maintain healthy lifestyle and decrease in the health care costs <sup>(14)</sup>. Lastly, for the taking of vitamins supplements respondents are aware that it is essential these days and it can strengthen their immunity especially they are working. People take these supplements to make sure they get enough essential nutrients that help maintain and improve their immunity and health while they are working or not <sup>(15)</sup>.

The respondents often practice their health promoting lifestyle and knowledgeable in terms of health responsibilities, physical activity, nutrition, spiritual growth, interpersonal relationship, and stress management. According to the overall health promoting lifestyle of the respondents in terms of their age, ages 51-65 tends to give more importance and time to their health because this group tends to have more health problems and at risk in the occurrence of diseases. With older people, more of them often report bad health and longstanding health problems than younger people <sup>(16)</sup>. There are also people with a chronic disease value and pay more attention to their health condition rather than those who don’t have any disease <sup>(17)</sup>. In accordance to gender, male happens to be more aware and shows importance on their health. The relationship between gender and health is complex, with mortality differences favoring women and many disparities in much morbidity in men. Sometimes aligned with biological sex but transcending it, gender is “an institutionalized system of social practices for constituting people as two significantly different categories, and in organizing social relations of inequality on the basis of that difference.”<sup>(18)</sup>. According to marital status, married individual is more likely to practice health promoting lifestyle. It is believed that marital status greatly affects one’s health, married individual is likely to show better health outcomes than individual who are not married. For the body mass index (BMI), it was shown that no matter what the status of their body mass index, there is no significant differences in regards with their health promoting lifestyle.

In the analysis of variance according to their age there is no significant difference when it comes to their overall health promoting lifestyle. Health promoting lifestyle and perceived social support measure of nursing students in a college of nursing, with the students at the age group of less than 8 years old, 19-21 years old, and 22 years old, there were no significant relation to the health promoting lifestyle of each of the group <sup>(19)</sup>. There is also no significant difference when it comes to the health promoting lifestyle of respondents according to their gender. Health-promoting lifestyle profile (HPLP) was used to measure health-promoting behaviors. Independent t-test analysis revealed no statistically significant gender differences for total HPLP. When controlling for spiritual understanding, marital status, activities, income, education, and nutrition there is no significant interactions were seen with gender on HPLP. For the marital status, there are no significant differences in the health promoting lifestyle among the respondents. In one of the studies we find out, single and couples were compared on the frequency of trend in healthy lifestyle factors which include eating fruits and vegetables, physical activity, BMI, having sedentary lifestyle, and smoking. Their study concluded that there was no significant difference between single and couple with their healthy lifestyle behavior <sup>(20)</sup>. Overall, there is no significant difference in the health promoting lifestyle of the respondents regardless of their age, gender, and marital status.

### CONCLUSION

From the light of the aforementioned findings, the following conclusions were drawn: in terms of profile variables that age, sex and marital status have shown no significant difference regarding the health promoting lifestyle practices of the respondents. While, when the respondents were grouped according to their body mass index (from underweight, normal, overweight, obese), it brought also no significant difference with their health promoting lifestyle practices.

The study showed that the respondents do not practice disease prevention such as taking annual checkups, blood pressure, weight, sugar levels and taking drug maintenance. This concludes that the teachers in the educational institution do not have adequate knowledge and also, due to their workload demand, they don’t find time regarding their health as the data showed that they are not routinely seeking guidance from health professionals. So, it is a great add to the educational institution to have their teachers have an annual assessment to their university infirmary on order to monitor their health and to avoid diseases.

Overall, permanent teachers of educational institutions often practice health promotion. Wherein, the study showed that the respondent’s practices that are done routinely in order are within spiritual growth, interpersonal relationships and stress management. These are due to the respondents’ awareness and beliefs that their life has a purpose and they always look forward to their future in order to grow spiritually. Followed practice in the interpersonal relationship, where the respondents praise other people easily for their individual achievements in order to build a healthy relationship with each other. And lastly, stress management where the respondents can manage to accept those things which they cannot change, get enough sleep and take some time for relaxation each day after long working hours.

On the other hand, the practices that are done sometimes are within nutrition, health responsibility and physical activity. These are due to the respondents’ practices of not often but sometimes eating servings of fruit each day and they don’t routinely limit the use of sugars and eat food containing sugar (sweets). Followed practice in the health responsibility, where the respondents did not routinely practice the following; inspect their body at least monthly for physical changes or danger signs due to deficit knowledge, seek guidance or counseling when necessary, get a second opinion when they have questions about their health care provider's advice, read or watch TV programs about improving health, report any unusual signs or symptoms to a physician or other health professional, ask for information from health professionals about how to take good care of their health, and attend

to educational programs on personal health care. And lastly, the respondents don't engage routinely in physical activities that include exercise, stretching, leisure activities and planned exercise programs. Since, it is mentioned that the respondents don't always attend educational programs about personal health care, instilling programs such as health education and seminars, can motivate the teachers to engage in physical activity, health responsibility and proper nutrition are of great significance in improving the health promoting lifestyle of the teachers in the educational institution.

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