UGC MINOR RESEARCH

PROJECT

FILE NO: 23- 1793/10 (WRO),

15th Oct.2010.

A STUDY ON HEALTH RISK BEHAVIOUR AND ACADEMIC ACHIEVEMENT AMONG THE DEGREE LEVEL COLLEGE STUDENTS OF SOLAPUR UNIVERSITY, SOLAPUR.

By

KIRAN PANDURANG CHOUGULE.

DIRECTOR OF PHYSICAL EDUCATION AND SPORTS,

HIRACHAND NEMCHAND COLLEGE OF COMMERCE,

SOLAPUR.

ACKNOWLEDGEMENTS

The investigator record his sincere thanks to the management of our institution and Principal of our college, Shri S.K. Shah for his co-operation and support in the conduct of the study.

Thanks are also to the then Principals of H. N. College of Commerce, Solapur Prin. Dr. V. B. Kakade and Dr. B. N. Barkul for their motivation and support in the conduct of the study.

I extend my thanks to all colleagues and non teaching staff for their co-operation, guidance, and valuable suggestions during the accomplishment of the present study.

I am thankful to my beloved younger brother Mr . Mahesh P. Chougule and all family members for their support for believing me in completion of this project.

I am indebted to the University Grants Commission, New Delhi, for sanctioning this minor research project and providing financial assistance for the same.

I am also thankful to all the participants of the research study and providing their valuable time.

Kiran Pandurang Chougule.
Director of Physical Education and Sports,
Hirachand Nemchand College of Commerce,
Solapur.

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Project Title: A STUDY ON HEALTH RISK BEHAVIOUR AND ACADEMIC ACHIEVEMENT AMONG THE DEGREE LEVEL COLLEGE STUDENTS OF SOLAPUR UNIVERSITY, SOLAPUR

1.1 INTRODUCTION

Student's normal behaviour depends on various natural and environmental circumstances in which students grow and observes the way of there best possible conduct within their reach and interact amongst those who respond them. Defiantly parents are the first to whom students makes and develops their concerns regarding needs and wants. Here we can simply say that normal behaviour developments required normal circumstances and equal participations of parents and teachers in bringing up students for exactly normal behaviour and positive attitudes either essence of real life realities to accept and cop with them.

HOW BAD ATTITUDE COME ACROSS -

This is what we except from our student to have understood about their parents and their status of life with have and have not phenomenal approaches meanwhile we do realize that our kids are not knowledge in advance that their parents manage the life and how they grab possibilities out of just impossible . so this is the stage where most of abnormal behaviour problem occupy the situation and spoil the tender feelings of kids with negative attitudes. Actually there is nothing like bad attitudes but a repeated action that make child realize that he is being respondent on such an aggressive and loud in voice and shaky in move action , thus he adjust his frequency on to the misconducts which develop abnormal student's behaviour.

1.2 HEALTH-RISK BEHAVIOUR : Overview and Definition

Health-risk behaviors contribute to the leading causes of mortality and morbidity among children, are established during childhood, extend into adulthood, and are interrelated. Participation in these activities compromises well-being, health, and life-course development that may contribute to disparities in health care. Health-risk behavior includes: (a) activities that contribute to unintentional and intentional injuries and violence, (b) tobacco use, (c) alcohol and other drug use, (d) sexual behavior, (e) dietary practices, and (f) physical inactivity according to the Centers for Disease Control and Prevention (Grunbaum et al., 2004).

According to Grunbaum et al. (2004), activities that contribute to unintentional injuries include not wearing seat belts or helmets, riding with a driver who has been drinking alcohol, and swimming without a lifeguard. Activities that contribute to intentional injuries and violence include weapon carrying, physical fighting, feeling unsafe at school, participating in theft, and thinking about suicide. Tobacco use includes cigarette smoking and tobacco chewing. Alcohol use includes drinking beer, wine, and liquor, and drug use generally refers to accepting street drugs, smoking marijuana, and inhaling fumes of butane, glue, or gasoline to get high. Sexual behavior includes "going out" with a boyfriend or girlfriend and holding hands, putting arms around, or kissing a boyfriend or girlfriend. Eating habits refer to trying to lose weight very fast, whereas exercise refers to engaging in sports or vigorous physical activity that raises the heart rate and results in sweating for at least 20 min almost everyday. Sleep habits refer to the number of hours of sleep the child gets each weeknight.

1.3 CONDITION OF STUDENTS –

When we think of the condition of students as they enter school , we must consider students development and learning in five areas.

1] - Health and physical development.

2]- Social and emotional development.

3]- Approaches towards learning.

4]- Language development and communication.

5]- Cognition and general knowledge.

Health and physical development includes students' physical development [for example , rate of growth], health status[for example, ability to see and here], and physical abilities [for example, ability to move around the environment , assisted or unassisted]

Social and emotional development includes student's feeling about themselves and others to form relationships, interest in and skills needed to maintain positive relationship with adults and student, ability to understood the perspective and feelings of others, and skills needed to get along well in a group setting[for example, conflict resolution skills].

An approach toward learning includes curiosity, enjoyment of learning, confidence creativity, and attention to task, reflection and interests. Language development and communication includes verbal ad nonverbal skills to convey ad understand others meaning [for example , speaks clearly or uses a nonverbal system of print , understands that writing means something] these skills and competencies apply to all languages, we should expect student who do not demonstrate these skills in their primary language before they o so in English. Cognition of general knowledge includes basic knowledge bout the world [for example, knows own name known basic science concept] and others cognitive competencies like early mathematical skills [for example, knowledge of numbers, shapes ad simple patterns],and basic problem solving[for example understanding of similarities and differences].

These five areas linked together often development in one area affects development in another. Thus, no single adequately represents student's condition as they enter school. Student from various cultures and with various experiences will express their competencies differently and should be expected to show different parents of development. The same is true for student with disabilities.

We then who is listening, or who is morally responsible in our appreciated democracy to play a role of mediator to maintain growth with peace.

Present study intends to explore and explains the consciousness about health risk behaviour and academic achievement of degree level students of Solapur University, Solapur in understanding; also evolve Physical Education & Health education intervention model that can help students, teachers, and peoples organizations in general.

1.4 ORIGIN OF THE RESEARCH PROBLEM

World has experienced the extremism of many subjects and their consequences. As per the facts published in 'Daily Sakal news paper on 21st February 2010 of Solapur edition. In Maharashtra more than 50 unnatural deaths were committed daily, raising the number of 759 in only 15 days in the month of February 2010. Most of the deaths were suicides committed by the students, farmers, women.

The present study will attempt to understand the reasons of health risk behaviours of the students of Solapur University and to suggest the possible interventions in Physical education & Health Education modelling the healthy personality and good academic achievements of the students.

1.5 REVIEW OF RESEARCH :

The present study is very much relevant to the present problems and needs of the society and country. International Charter of Physical Education & Sports ,UNESCO 1978 *"Every human has fundamental right of access to physical education & sports .which are essential for the full development of his/her personality. The freedom to develop physical, intellectual and moral powers through physical education and sports must be guaranteed both within the educational system and in other aspects of social life."* UN agencies have identified sports as being integral to quality education. Mandatory physical education has been recognized in a number of countries as a universal pillar to foster education, health and personal development. A core purpose of physical education & health education is to develop human personality in its totality well planned activity programs. In some words, physical education aim at the all round development of the personality of an individual or wholesome development of human personality and it includes physical, mental, social, emotional and moral aspects to make an individual a good citizen who is able to make contribution in process of nation in one's own way. Thus, physical education means, making an

individual physically fit, mentally alert, emotionally balanced, socially well adjusted, morally true and spiritually uplifted.

As a result, the physical education & health education literature, emphasizes the necessity of physical education & health education intervention models for healthy practices in school and colleges and a good pattern of academic achievement.

Sophie Titus "Sports and Human well Being" (University News Vol.No.05 Feb 2010)

Human personality is a very complex topic to understand. Personality development is the development of the organized pattern of behaviours and attitudes that makes a person distinctive. Personality development occurs by the ongoing interaction of temperament, character, and environment. Human-wellness is all –inclusive umbrella covering a variety of health –related factors. A wellness lifestyle requires the implementation of positive programmes to change behaviour and thereby improve health and quality of life.

Hilmer, (1998) "Better use of free time"

Increased individual and community participation, ethical and democratic practices and racial tolerance; better family interactions and peer influence; behavioural standards and goals that contribute to positive social relations and motivation to succeed.

Treblay, Inman, wilms,1998; CFLRI,1993; James,1995 "Sports is an effective behaviour change methodology (CARICOM,2002)

Individuals who are regularly active demonstrate improved academic performance and are more likely to stay in return to school. India is the second most populous country in the world with total population of over 1081 million. Adolescents (10-19 years) form a large section of population- about 22.5 percent.that is about 225 million. They are living in diverse circumstances and have diverse health needs. The total population of young people (10-24 years) is approximately 331 million comprising nearly 30 percent of the total population of India (Census,2001).They are a positive force for a Nation and are responsible for its future productivity provided they develop in a healthy manner. In India, where huge number of population is below poverty line and significant number of population are in world's richest people so

their is economic inequality, students from high class have different health risk behaviour and from the lower class have different psychological problems which also effects their academic achievement in the colleges and universities.

1.6 INTERNATIONAL STATUS

The national youth risk behaviour Survey (YRBS) has shown the following results and findings on What is the relationship between health-risk behaviors and academic achievement? Data presented below, from the 2003 National Youth Risk Behavior Survey (YRBS), show a negative association between health-risk behaviors and academic achievement among high school students after controlling for sex, race/ethnicity, and grade level. This means that students with higher grades are less likely to engage in health-risk behaviors than their classmates with lower grades, and students who do not engage in health-risk behaviors receive higher grades than their classmates who do engage in health-risk behaviors. These associations do not prove causation. Further research is needed to determine whether low grades lead to health-risk behaviors, health-risk behaviors lead to low grades, or some other factors lead to both of these problems. Students with higher grades are significantly less likely to have engaged in behaviors such as:

Carried a weapon? (For example, a gun, knife, or club on at least 1 day during the 30 days before the survey). Current cigarette use? (Smoked cigarettes on at least 1 day during the 30 days before the survey). Current alcohol use? (Had at least one drink of alcohol on at least 1 day during the 30 days before the survey). Ever had sexual intercourse?. Did not eat for 24 or more hours to lose weight or to keep from gaining weight? (During the 30 days before the survey). Watched television 3 or more hours per day ?(On an average school day).

Figure 1. Percentage of U.S. high school students who carried a weapon, currently smoked cigarettes, currently drank alcohol, ever had sexual intercourse, did not eat for 24 or more hours to lose weight or keep from gaining weight, and watched television 3 or more hours per day, by types of grades earned (mostly A’s, B’s, C’s, or D/F’s) — National YRBS, 2003.

1.7 NATIONAL STATUS

Very few intellectuals have got interest in Health risk behaviour and academic achievements of the students, very few efforts are made to understand the reasons behind the health risk behaviour and competitions for academic achievement.

The profession of Physical Education & Health Education is guided by the responsibility to challenge social injustice and advocate on behalf of clients and the profession. Profession should provide opportunities for individual, organizational, community, and political change to improve the well-being of all people. Therefore, the structure and activities of national and voluntary organizations are important in promoting social change and providing opportunities for the same.

1.8 SIGNIFICANCE OF THE STUDY

The present study would like to go with the assumption based the initial meetings, focus group discussions with academicians, students and general public that people have no or very little knowledge about healthy practice which determine many aspects of individual life. The study itself is innovative and has root in local context. The present study intends to describe the health risk behaviour and academic achievement among the students which may come up with practical educational intervention model that can be implemented to form fair, transparent education system.

• Its potential contribution to knowledge in the field of Physical Education & Health Education or national importance

The present study attempts to contribute in knowledge and national importance in following ways;

- This study will be coming up with such a huge data on Academic achievement and health risk behaviour which can be used for further analysis by govt., NGOs, Universities.
- Educational streams like Physical education& Health Education, psychology and social work will have very pragmatic field work practicum that will emphasize on health risk behaviour and may involve research for contemporary challenges of good academic achievements.
- The study may emerge with the Physical education & Health education intervention model that will describe and explain educational needs, measurement of educational.

- This study may facilitate the new education pattern especially in less developed regions of nation.
- Physical Education & Health Education may open new avenues for Physical& Health Educators to engage in developmental tasks.

1.9 OBJECTIVES

Following objectives have been formulated for the study.

1. To explore and explain the relationship between health risk behaviour and academic achievement.
2. To highlight the reasons and consequences of health risk behaviour.
3. To study the affinity and assumed reasons for the Academic achievement.
4. To evolve the Physical Education & Health Education intervention model for academic achievement and healthy behaviour.

1.10 METHODOLOGY

Following methodology has been adopted for the study.

Hypothesis

Considering the objectives of the study following hypothesis have formed;

1. Personal and professional background of the students has no association with the consciousness about health risk behaviour.
2. Formal education has nothing to do with the healthy physic and good academic achievement.
3. Students have no or little knowledge about healthy living.
4. Students don't have interest on academic system and healthy health practices.

Research design

Present study adopts exploratory research design to explore and explain the interdependence among various factors, which influence health risk behaviour and Academic Achievement. Dependent–independent variable design, associational and co-relational design will be adopted to fulfil the nature of the study.

Universe and Sampling

Solapur district of Maharashtra state is formed the geographical area of study. Where, convenient sampling method will be adopted to draw the sample. Total sample size will be 500 (500 students of university departments and colleges) from Solapur University.

Scope of research

Present study will be conducted in Solapur University, Solapur, state Maharashtra. The nature of study is quantitative where in qualitative methodology will also be adopted to support the study.

Sources of data

Since the study is exploratory in nature, data will be collected from primary sources i.e. directly from respondents. Secondary data will be emerging from the previous research studies on the relevant topic.

Methods of data collection

Following methods will be adopted to fulfil the objectives of the study.

Interview method

Observation method

Focus group discussion method

Statistical design

To fulfil the objectives; the data will be analyzed by using Statistical Package for Social Sciences (SPSS) to draw: Descriptive and cross tables

Associational and co-relational analysis

Multi-variate analysis

Tools of data collection

Following tools will be used to collect the data for the present study.

Interview schedule

Focus group discussion checklist

Observation checklist

CHAPTER-2

REVIEW OF LITERATURE

Review of the literature offers close look in to research work to researcher. Reviews suggested a method and a technique of dealing with a problematic situation, which may also suggest avenues of approach to the situation of similar difficulties, scholars facing similar situation can provide the investigator new idea and approaches it also assist the researcher in evaluating own research efforts by comparing them with related efforts done by other. Before completing a plan for a research undertaking the researcher has made every effort literature related to the problem in the field of Health Education, Physical Education, Sports & Sports Sciences. Therefore the researcher has gone through the reviews of articles, books and similar research to understand the study more. A brief review of the studies relevant to the problem has been presented in this chapter. The literature pertaining to it has been abstracted in this chapter to provide the back ground material so as to evaluate the study well as to interpret its findings.

A review of literature related to the present study was collected from the Walchand College of Arts & Science Solapur, Kasturabai College of Education Solapur. College of Education, Barshi, Hirachand Nemchand College of Commerce Solapur, University of Solapur, and few other sources.

Abdurrahman Aktop (2010), in paper, "Socioeconomic Status, Physical Fitness, Self-Concept, Attitude toward Physical Education, and Academic Achievement of Children " analyzed the physical fitness, self-concept, attitudes toward physical education, and academic achievement of Turkish elementary school children by socioeconomic status. 198 (101 boys, 97 girls) students from Grades 7 and 8 completed the Children's Attitude Inventory towards Physical Education, the Piers Harris Children's Self-concept Scale, and Euro fit Physical Fitness Test Battery. In his study Significant differences were found between the groups of Low and High socioeconomic status (SES) in terms of physical fitness and academic achievement. While the Low SES group had higher mean scores on physical fitness, mean academic achievements of the High SES group were higher. Mean differences in height, self-concept, and children's attitudes toward physical education by socioeconomic status

were not statistically significant. Particular attention should be paid to physical fitness in children of high socioeconomic status and the academic achievement of children with low socioeconomic status.

Adler, Nancy E.; Boyce, Thomas; Chesney, Margaret A.; Cohen, Sheldon; Folkman, Susan; Kahn, Robert L.; Syme, S. Leonard, (1994) said that SES is consistently associated with health outcomes, yet little is known about the psychosocial and behavioral mechanisms that might explain this association. Researchers usually control for SES rather than examine it. When it is studied, only effects of lower, poverty-level SES are generally examined. However, there is evidence of a graded association with health at all levels of SES, an observation that requires new thought about domains through which SES may exert its health effects. Variables are highlighted that show a graded relationship with both SES and health to provide examples of possible pathways between SES and health end points. Examples are also given of new analytic approaches that can better illuminate the complexities of the SES-health gradient.

Ayal Kimhi, (2003) shows the dependence of health and physical fitness on the socio-economic factors of rural families in southern Ethiopia is investigated, with particular emphasis on the role of inequality. This paper contributes to our knowledge of the effect of inequality on health in several ways: it compares the results of objective and subjective health measures, it distinguishes between wealth inequality and nutrition inequality, and it evaluates the impact of nutrition inequality both at the village level and at the household level. Height has a positive and significant effect on health and fitness and the same is true for per-capita wealth measured at the village level. Availability of satisfactory health facilities has a negative effect on morbidity. Per-capita wealth inequality is positively associated with morbidity and with a low BMI. Within-household nutrition inequality has a complex effect on health and physical fitness: the effect is negative, but only for household members whose nutritional status is above the household mean. They indicated a clear positive effect of economic well-being on health and physical fitness. The role of inequality is less clear, and certainly deserves further analyses at both the theoretical and empirical levels.

Chen, Edith; Matthews, Karen A.; Boyce, W. Thomas shows the socioeconomic differences in children's health, (2002) According to them the effects of socioeconomic status (SES) on health are well documented in adulthood, but far less is known about its effects in childhood. The authors reviewed the literature and found support for a childhood SES effect, whereby each decrease in SES was associated with an increased health risk. The authors explored how this relationship changed as children underwent normal developmental changes and proposed 3 models to describe the temporal patterns. The authors found that a model's capacity to explain SES-health relationships varied across health outcomes. Childhood injury showed stronger relationships with SES at younger ages, whereas smoking showed stronger relationships with SES in adolescence. Finally, the authors proposed a developmental approach to exploring mechanisms that link SES and child health.

Dawn K. Wilson, Karen A. Kirtland, Barbara E. Ainsworth, M.P.H., Cheryl L. Addy, (2004) said that environmental factors may play an important role on influencing physical activity (PA) behaviors **methodology of their study** Residents of a U.S. southeastern county (N = 1,194, 18–96 years of age) were contacted using a random-digit-dial method and asked about neighborhood and community environmental supports for PA. A Geographic Information System (GIS) was used to identify trails, sidewalks, public recreation facilities, and violent crime incidents. **Their finding are;** A cluster analysis identified 10 census tracts as low SES and 11 census tracts as high SES (median household income, owner-occupied houses). More African Americans (66.5%) than Whites (33.5%) were classified as living in low-SES areas. Respondents from low-SES areas also reported engaging in less PA based on Centers for Disease Control and Prevention and American College of Sports Medicine recommendations than respondents from high-SES areas ($p < .05$). Respondents from low-SES (vs. high-SES) areas reported higher perceptions of neighborhood crime, unattended dogs, unpleasantness of neighborhoods, untrustworthy neighbors, and less access to public recreation facilities ($ps < .05$). GIS data for presence of sidewalks, recreation facilities, and crime did not support these differences in perceptions; however, respondents from low-SES (vs. high-SES) areas had substantially fewer trails. Having and using trails in one's community predicted sufficient PA and walking for 150 min/week for low-SES respondents but not for high SES respondents ($ps = .05$, adjusted for covariates).They concluded that having access to trails is an

important environmental feature among low-SES communities and should be the focus of future community-based PA inter

James B Grissom (2005) in his paper, "Physical Fitness and Academic Achievement" evaluated the relationship between physical fitness and academic achievement. A physical fitness test, were compared to reading and mathematics scores on the Stanford Achievement Test 9^{th} edition, a standardized norm-referenced achievement test. Subjects were all 5^{th}, 7^{th}, and 9^{th} grade California school children enrolled in public school in 2002 for whom there was complete data on both the physical fitness and academic achievement tests. The Grissom was Selected the sample of 884,715 students. Results indicate a consistent positive relationship between overall fitness and academic achievement. This relationship between fitness and achievement appeared to be stronger for females than males and stronger for higher socio-economic status (SES) than lower SES students. It is more likely that physical and mental processes influence each other in ways that are still being understood.

Marco Bonhauser, Gonzalo Fernandez, Klaus Puschel, Fernando (2005) concluded that regular physical activity is associated with a reduced risk of all-cause mortality, and mortality due to cardiovascular disease and cancer. Among adolescents, physical activity is associated with benefits in the prevention and control of emotional distress, and improvement of self-esteem. Countries in transitional epidemiological scenarios, such as Chile, need to develop effective strategies to improve physical activity as a way to face the epidemic of chronic diseases. The objective of this study was to evaluate the effects of a school-based physical activity program on physical fitness and mental health status of adolescents living in a low socioeconomic status area in Santiago, Chile. A quasi-experimental design was used to evaluate the effects of the program over one academic year. The study included 198 students aged 15 years old. Two ninth grade classes were randomly selected as the intervention group, with two classes of the same grade as controls. A social planning approach was used to develop the intervention. The program was designed and implemented based on student preferences, teachers' expertise and local resources. Changes in physiological and mental health status were assessed. After the intervention, maximum oxygen capacity achieved a significant increase of 8.5% in the

intervention versus 1.8% in the control group ($p < 0.0001$). Speed and jump performance scores improved significantly more in the intervention versus the control group ($p > 0.01$). Anxiety score decreased 13.7% in the intervention group versus 2.8% in the control group ($p < 0.01$), and self-esteem score increased 2.3% in the intervention group and decreased 0.1% in the control group after the end of the program ($p < 0.0001$). No significant change was observed in the depressive score. Student participation and compliance with the program was >80%. To conclude, a school-based program to improve physical activity in adolescents of low socioeconomic status, obtained a high level of participation and achieved significant benefits in terms of physical fitness and mental health status.

Margaret D. Hanson, (2007)determined the direction of associations between SES and health behaviors during the period of adolescence. They found that associations between SES and health behaviors conformed to two patterns. First, low SES was associated with poorer diets, less physical activity, and greater cigarette smoking. Second, there was no clear pattern of associations between SES and alcohol consumption or marijuana use. Finally they conclude that, although some associations between SES and health behaviors exist during adolescence, the associations are not as robust as those in adulthood. Efforts to curb poor diet, inactivity, and smoking behaviors should target low SES adolescents, whereas efforts to curb teen drinking and marijuana use may be useful across the SES spectrum.

Mustafa Dosemeci, Richard B. Hayes, Renate Vetter, Robert N. Hoover,Margaret Tucker, Kayihan Engin, Mustafa Unsal, Aaron Blair, (1993) conducted A multiple-site case-control study of 15 cancers (stomach; colon; rectum; larynx; lung; melanoma; skin; female breast; male breast; cervix; ovary; uterus; prostate; testis; and bladder) to evaluate their association with occupational physical activity and socioeconomic status (SES). A hospital-based study population (3,486 male cases and 379 female cases, and 2,127 male and 244 female controls) was established in an on ecological treatment center in Istanbul, Turkey, from 1979–84. Assessment of physical activity and SES was based on job titles held by the study subjects. Two measures of physical activity were developed based on energy expenditure and 'sitting time' during working hours. Observed risks were adjusted for age, smoking, and SES. Elevated risks were observed among workers who held sedentary jobs for cancers of the colon (odds ratio [OR=1.6), rectum (OR=1.3),

melanoma (OR=1.9), male breast (OR=1.4), prostate (OR=5.0), and ovary (OR=2.0). Cancers of the cervix and uterus showed significantly decreasing risks with decreased activity. Risks of cancers of the colon, rectum, larynx, ovary, and melanoma were enhanced after risks for physical activity indices were adjusted for SES, while the associations between physical activity and cancers of the prostate, cervix, and uterus were weakened after SES adjustment. Risks of melanoma rose significantly with both activity indices after SES adjustment. The results of this study support previously reported associations between physical activity and cancers of the colon and rectum observed in developed countries, and provide additional evidence for cancers of the larynx, prostate, cervix, uterus, and melanoma, and point out the importance of SES in evaluation of physical activity and cancers of the colon, rectum, larynx, prostate, breast, cervix, and melanoma in developing countries.

Paul T. Williams, (2001) compared the dose-response relationships between cardiovascular disease endpoints with leisure-time physical activity and fitness from published studies. Relative risks were plotted as a function of the cumulative percentages of the samples when ranked from least fit or active, to most fit or active. To combine study results, a weighted average of the relative risks over the 16 physical activity or seven fitness cohorts was computed at every 5th percentile between the 5% and 100%. he analyzed that the risks of coronary heart disease or cardiovascular disease decrease linearly in association with increasing percentiles of physical activity. In contrast, there is a precipitous drop in risk occurring before the 25th percentile of the fitness distribution. As a consequence of this drop, there is a significant difference in the risk reduction associated with being more physically active or physically fit ($P \leq 0.04$).Finally he conclude that unfit warrants consideration as a risk factor, distinctly from inactivity, and worthy of screening and intervention. Formulating physical activity recommendations on the basis of fitness studies may inappropriately demote the status of physical fitness as a risk factor while exaggerating the public health benefits of moderate amounts of physical activity.

Pinar Salih, Kucuk Yetgin Meral, Kaya Fatih, Ozdol Yeliz and Biçer Bilal (2011), stated that, Inactive life style sustained together with bad eating habits brings many healthy problems such as obesity and cardiovascular disease Approach: Technological development brings with it improving life style causing sedentary life for the public in developed and also developing Country. Physical activity can be

viewed as a form of healthy life because it predicts functioning and adaptation and offers capabilities that enable people to live healthy. In this purposed three different socio-economic levels of six schools were determined accordance with declaration of National Education Department in Beykoz province. They observed that the effects of Socio Economic Status, gender and Body Mass Index on Physical Activity Level were not statistically significant. On the other hand, there were a significant interaction between Physical Activity Level and Socio Economic Status, Socio Economic Status and Body Mass Index.

Robert G. McMurray, Joanne S. Harrell, Shibing Deng, Chyrise B. Bradley, Lori M. Cox, Shrikant I. Bangdiwala, (2000) examined the effects of physical activity, television viewing, video game play, socioeconomic status (SES), and ethnicity on body mass index (BMI). According to them watching television on non-school days was related to being overweight ($p < 0.005$). However, when BMI analyses were adjusted for ethnicity and SES, there were no significant effects of television viewing on BMI ($p > 0.061$). Increased hours of video game play enhanced the risk of being overweight for both genders when analyses were adjusted for ethnicity and SES ($p < 0.019$). In males, participation in as little as one high-intensity physical activity 3 to 5 days a week decreased the ethnic- and SES-adjusted relative risk of being overweight (RR = 0.646; CI: 0.427 to 0.977). For females, the ethnic- and SES-adjusted relative risk for being overweight was not significantly altered by physical activity. The logistic analyses further indicated the influence of low SES and African American ethnicity overshadowed any direct effect of television or videos. They conclude that weight status of male adolescents appears to be more related to exercise habits than to television or video game habits; increased participation in high-intensity exercise appears to be important. For females, neither videos nor exercise habits appear to be related to risk of being overweight. However, ethnicity and SES may be important factors that can influence body weight status, while television viewing may be of some importance. Thus, programs to reduce obesity in female adolescent should focus their efforts in lower SES communities.

Sobal, Jeffery; Stunkard, Albert J. , (1989) studies the review of 144 published studies of the relationship between socioeconomic status (SES) and obesity reveals a strong inverse relationship among women in developed societies. The relationship is inconsistent for men and children in developed societies. In developing societies,

however, a strong direct relationship exists between SES and obesity among men, women, and children. A review of social attitudes toward obesity and thinness reveals values congruent with the distribution of obesity by SES in different societies. According to researcher several variables may mediate the influence of attitudes toward obesity and thinness among women in developed societies that result in the inverse relationship between SES and obesity. They include dietary restraint, physical activity, social mobility, and inheritance.

Sven Schneider, Holger Schmitt, Silke Zoller, Marcus Schiltenwolf, (2005) investigated the prevalence of back pain in the German working population and the relationship between back pain and workplace stresses, lifestyle and social factors. The first National Health Survey of the Federal Republic of Germany was carried out by them between October 1997 and March 1999. It comprised a representative epidemiological cross-sectional study of the working population, with a total sample of 3,488 persons between the ages of 18 and 69 years. The participants took part in a medical examination and answered a self-rating questionnaire. The relationship between subjective back pain and workplace stresses and social and lifestyle factors was investigated with bivariate tests and multiple logistical regression analyses. The 7-day prevalence for back pain in the German working population was found to be 34%, and the 1-year prevalence was 60%. The odds ratios were significantly higher in women, persons of lower socioeconomic status, married and depressed persons and non-athletes. Carrying heavy loads or maintaining a single working posture were the most significant work-related correlates of back pain, for members of both the female and male working population, while environmental stress and psychological stress correlated significantly with back pain in men only. The study concludes that the first representative epidemiological prevalence data for back pain, and its correlates and potential risk factors, for the German working population. To reduce the negative impact of back pain the most promising behavioural and conditional prevention measures in the workplace would be to reduce carrying stress and to vary working posture. In addition, a more active, athletic lifestyle, plus the avoidance of being overweight, should provide an additional protective or preventive effect.

Brad Robert Davidson was assessed the current practices of school health education faculty members at institutes of higher education that have school health teacher preparation programs. Specifically, this study determined the amount of time and the content taught related to the following school health education materials tools: Youth Risk Behavior Surveillance (YRBSS); School Health Profiles Survey (Profiles); School Health Policies and Programs Study (SHPPS); Characteristics of Effective Health Education Curriculum; National Health Education Standards (NHES); Health and Academics; School Health Index (SHI); Health Education Curriculum Analysis Tool (HECAT); and the CDC's School Health Education Resources (SHER). A valid and reliable survey with 87 items was mailed to a national sample of 225 lead school health education faculty members at institutes of higher education (IHE). The response rate was iv 59.55% (134/225). The respondents were predominately female (67.9%), with a Ph.D. or equivalent (76.9%), worked as a tenured faculty member (56.0%), was an associate professor (29.9%), had a state license/certification to teach health education (62.7%), and most (83.6%) belonged to a health education professional organization.

A majority of IHEs taught about the results and trends as well as general information about the YRBSS (79.9% and 80.6%). However, the results and trends of both the Profiles and SHPPS were not taught at IHEs (61.2% and 48.5% respectively).

Interestingly, a majority of IHEs taught about the purpose of the SHI (59.0%) but did not teach about how to conduct a needs assessment using the SHI (51.5%), nor did IHEs teach about how to use the results to create healthy changes in schools (52.2%). A majority of IHEs described both the Characteristics of Effective Health Education Curricula (88.1%) and the NHES (89.6%) to their students. Moreover, the relationship between health and academic achievement was taught at most IHEs (61.9%). Finally, 51.5% of IHEs do not teach about using the CDC's School Health Education Resources (SHER) web tool. A primary responsibility of IHEs is to provide the tools necessary to pre-service teachers to utilize the tools and products described in this study. This study found that many IHEs do not train their pre-service school health education majors to use these tools and products. It is imperative that IHE school health teacher preparation faculty be trained on how to use these tools and products.

CDC developed the Youth Risk Behavior Surveillance System (YRBSS) to monitor six categories of priority health-risk behaviors among youth — behaviors that

contribute to unintentional injuries and violence; tobacco use; alcohol and other drug use; sexual behaviors that contribute to unintended pregnancy and sexually transmitted diseases, including human immunodeficiency virus (HIV) infection; unhealthy dietary behaviors; and physical inactivity — plus overweight. These risk behaviors contribute markedly to the leading causes of death, disability, and social problems among youth and adults in the United States. YRBSS includes a national school-based survey conducted by CDC as well as state, territorial, and local school-based surveys conducted by education and health agencies. In these surveys, conducted biennially since 1991, representative samples of students in grades 9–12 are drawn. In 2003, a total of 15,214 students completed the national survey, and 32 states and 20 school districts also obtained data representative of their jurisdiction. Although multiple publications have described certain methodologic features of YRBSS, no report has included a comprehensive description of the system and its methodology.

This report describes the background and rationale for YRBSS and includes a detailed description of the methodologic features of the system, including its questionnaire; operational procedures; sampling, weighting, and response rates; data-collection protocols; data-processing

procedures; reports and publications; and data quality. YRBSS is evolving to meet the needs of CDC and other users of the data.

Curt E. I. Hagquist stated that traditionally, the socio-economic position of adolescents has been measured using information about parents' occupation, parents' level of education, or household income. Since the adolescence is a developmental stage characterised by a search for and a move into individual life tracks a shift of focus from socio-economic position of origin to socio-economic position of destination is justified. Academic orientation may be used as a rough indicator of future social position. The purpose of the study was to elucidate the link between academic orientation and parents' education on the one hand and subjective health and health-related behaviour among adolescents on the other. Methods: The study was based on cross-sectional questionnaire data collected in 1999 and 2003 among 1828 18-year-old students in year 2 of upper secondary school in a Swedish city. The data were analysed using contingency tables and logistic regression. Results: Subjective health and health-related behaviour was strongly linked to academic orientation but

not directly to parents' education. The pattern is unambiguous, poor health and health-damaging behaviour being significantly higher among students in non theoretical programmes than among students in theoretical programmes. Conclusion: Academic orientation is a useful concept in order to detect health inequalities and a powerful way of identifying adolescents at higher risk. The unequal distribution of health and health-damaging behaviour according to academic orientation among adolescents turns out to be an important challenge for public health work.

Inga Do´ra Sigfu´sdo´ ttir, A´ lfgeir Logi Kristja´nsson1 and John P. Allegrante were stated in their study Health behaviour and academic achievement in Icelandic school children that Interest in the relationship between health behaviours and academic achievement has recently intensified in the face of an epidemic of childhood and adolescent obesity and converging school reforms in the United States and other nations with advanced economies. Epidemiologic research has demonstrated that poor diet and lack of adequate physical activity place children at risk for being overweight and obese and thus influence future health status. Additional research has also shown that children and adolescents whose diets are nutritious and whose participation in physical activity is high tend to perform better on various measures of cognitive performance and academic achievement. They analysed cross-sectional survey data from 5810 Icelandic school children to explore the relationship between selected health behaviours and academic achievement. Body mass index, diet and physical activity explained up to 24% ($P < 0.01$) of the variance in academic achievement when controlling for gender, parental education, family structure and absenteeism. Variance explained increases to 27% when depressed mood ($P < 0.05$) and self esteem ($P < 0.01$) are added to the model, but confounds the role of physical activity. Although not robust, these findings are consistent with previous work and affirm the complexity of the relationship of health to academic achievement.

Norman Anderssen stated in the study that from a public health perspective, physical activity in children and adolescents is seen as important for disease prevention and health promotion. Physical activity patterns are learned through socialization processes where one of the influential sources is the school through physical education classes. The purpose of the present study was (1) to examine young adolescents' general perception of physical education classes, and (2) to

explore the relationship between these perceptions and students' social resources, gender and level of leisure time physical activity and self-evaluated competence hi physical education. A total of 895 seventh graders (13 year olds) were surveyed in Norway concerning their perception of physical education classes. Indicators of social resources were chosen from the arenas of family, friends
and school. The main finding was that a majority of students liked physical education classes. Physical education classes seemed, however, not to offer the less socially resourceful minority the same opportunities for positive experience with physical activity as the resourceful majority. Boys' general perception of physical education classes seemed to be more positive than girls' and
physically active students perceived physical education classes more favorably than less physically active students.

M. T. Kantomaa1, T. H. Tammelin, P. Demakakos, H. E. Ebeling and A. M. Taanila1,

In this study they were examined whether physical activity, mental health and socio-economic position were associated with the overall academic performance and future educational plans of adolescents aged 15–16 years. We used a sample of 7002 boys and girls from the Northern Finland Birth Cohort 1986. Data were collected by a postal enquiry in 2001–02. Multivariable logistic regression models were estimated and adjusted for family structure and all variables in the models. In the fully adjusted models, higher levels of physical activity and high parental socio-economic position were associated with higher overall academic performance and future plans for higher education. High scoring on behavioural problems was related to lower overall academic performance and poorer future academic plans. In summary, a higher level of physical activity, fewer behavioural problems and higher socio-economic position were independently associated with high selfperceived overall academic performance and plans for higher education among adolescents. The interrelations of these factors and the positive relationship between physical activity, mental health and school outcomes provide a context of critical importance for future research, intervention programming and policy directed at improving the educational attainment of adolescents.

Sabine Drieskens, Herman Van Oyen, Stefaan Demarest, Johan Van der Heyden, Lydia Gisle, Jean Tafforeau Unhealthy behaviours often occur in combination. In this study they stated that relationship between education and lifestyle, defined as a cluster of risk behaviours, has been analysed with the purpose to assess socio-economic changes in multiple risk behaviour over time. Methods: Cross-sectional data from the Belgian Health Interview Surveys 1997, 2001 and 2004 were analysed. This study is restricted to persons aged _15 years with information on those health behaviours and education (n = 7431, n = 8142 and n = 7459, respectively). A lifestyle index was created based on the sum of the four unhealthy behaviours: smokers vs. non-smokers, risky versus non-risky alcohol use, sedentaryness vs. physically active and poor vs. healthy diet. The lifestyle index was dichotomized as low (0–2) vs. high (3–4). For the assessment of socio-economic inequalities in multiple risk behaviour, summary measures as Odds Ratio (OR) and Relative Index of Inequality (RII) were calculated using logistic regression, stratified by sex. Results: Of the adult population, 7.5% combined three to four unhealthy behaviours. Lower educated men are the most at risk. Besides, the OR among men significantly increased from 1.6 in 2001 to 3.4 in 2004 (P = 0.029). The increase of the OR among women was less pronounced. The RII, on the other hand, did not show any gradient, neither for men nor for women.

Conclusion: Multiple risk behaviour is more common among lower educated people. An increasing polarization in socio-economic inequalities is assessed from 2001 to 2004 among men. Therefore, health promotion programmes should focus on the lower socio-economic classes and target risk behaviours simultaneously.

Jo Anne Grunbaum, Laura Kann, Steven A. Kinchen, Barbara Williams, James G. Ross, Richard Lowry and Lloyd Kolbe Youth Risk Behavior Surveillance — United States, 2001

Priority health-risk behaviors, which contribute to the leading causes of mortality and morbidity among youth and adults, often are established during youth, extend into adulthood, are interrelated, and are preventable. This report covers data during February-December 2001. The Youth Risk Behavior Surveillance System (YRBSS) monitors six categories of priority healthrisk behaviors among youth and young adults; these behaviors contribute to unintentional injuries and violence; tobacco use;

alcohol and other drug use; sexual behaviors that contribute to unintended pregnancy and sexually transmitted diseases (STDs), including human immunodeficiency virus (HIV) infection; unhealthy dietary behaviors; and physical inactivity. The YRBSS includes a national school-based survey conducted by CDC as well as state, territorial, and local school-based surveys conducted by education and health agencies. This report summarizes results from the national survey, 34 state surveys, and 18 local surveys conducted among students in grades 9–12 during February-December 2001.

In the United States, approximately three-fourths of all deaths among persons aged 10–24 years result from only four causes: motor-vehicle crashes, other unintentional injuries, homicide, and suicide. Results from the 2001 national Youth Risk Behavior Survey demonstrated that numerous high school students engage in behaviors that increase their likelihood of death from these four causes: 14.1% had rarely or never worn a seat belt during the 30 days preceding the survey; 30.7% had ridden with a driver who had been drinking alcohol; 17.4% had carried a weapon during the 30 days preceding the survey; 47.1% had drunk alcohol during the 30 days preceding the survey; 23.9% had used marijuana during the 30 days preceding the survey; and 8.8% had attempted suicide during the 12 months preceding the survey. Substantial morbidity and social problems among young persons also result from unintended pregnancies and STDs, including HIV infection. In 2001, 45.6% of high school students had ever had sexual intercourse; 42.1% of sexually active students had not used a condom at last sexual intercourse; and 23% had ever injected an illegal drug. Two-thirds of all deaths among persons aged ≥25 years result from only two causes: cardiovascular disease and cancer. The majority of risk behaviors associated with these two causes of death are initiated during adolescence. In 2001, 28.5% of high school students had smoked cigarettes during the 30 days preceding the survey; 78.6% had not eaten ≥5 servings per day of fruits and vegetables during the 7 days preceding the survey; 105% were overweight; and 67.8% did not attend physical education class daily.

Health and education officials at national, state, and local levels are using these YRBSS data to analyze and improve policies and programs to reduce priority health-risk behaviors among youth. The YRBSS data also are being used to measure

progress toward achieving 16 national health objectives for 2010 and 3 of the 10 leading health indicators.

Rahul Sharma, Vijay L. Grover, and Sanjay Chaturvedi The present study covered six categories of the important health risk behaviors among adolescents. These included tobacco use, alcohol and other drug use, sexual risk behaviors, unhealthy dietary behaviors, inadequate physical activity, and behaviors that may result in injuries and violence. In this paper, the findings related to suicidal behavior among the adolescent students are presented.

Suicidal behavior amongst adolescent students is a matter of great concern due to the tragic loss of prime years of life it entails. It is vital to study both the prevalence and the correlates of such behaviors.

The study was a cross-sectional analysis of the subject population. The units of the study were 14- to 19-year-old adolescents studying in various schools and colleges in south Delhi. The study being a doctoral thesis was reviewed and approved by the institutional ethics committee. For the purpose of the present study, two districts of Delhi, south and southwest districts, were together considered as south Delhi region. All the schools and colleges in south Delhi region were included in the sampling frame. A two-stage cluster sampling design was used to draw a representative sample of students in classes 9 to 12 in schools and the first two years of graduation in colleges. These classes were chosen as they correspond to the desired age group of 14 to 19 years. Details of the methodology have been published earlier.

All students from the selected classes present on the day of the survey were eligible to participate, allowing for anonymous and voluntary participation. At the time of data analysis, the forms of respondents who had stated their age to be either less than 14 years or more than 19 years were excluded from the analysis. A pre-tested, semi-open-ended and self-administered questionnaire was used in the study. Statistical analysis of the data was done on the SPSS software, using cross-tabulation with the chi-square test. Binary logistic regression was applied to analyze the relationship between suicidal risk behavior and various independent variables under study.

S. Fairclough and G. Stratton they stated that **t**he purpose of study was to assess physical activity levels during high school physical education lessons. The data were considered in relation to recommended levels of physical activity to ascertain whether or not physical education can be effective in helping young people meet health-related goals. Sixty-two boys and 60 girls (aged 11–14 years) wore heart rate telemeters during physical education lessons. Percentages of lesson time spent in moderate-and-vigorous (MVPA) and vigorous intensity physical activity (VPA) were recorded for each student. Students engaged in MVPA and VPA for 34.3 6 21.8 and 8.3 6 11.1% of lesson time, respectively. This equated to 17.5 6 12.9 (MVPA) and 3.9 6 5.3 (VPA) min. Boys participated in MVPA for 39.4 6 19.1% of lesson time compared to the girls (29.1 6 23.4%; $P < 0.01$). High-ability students were more active than the average- and low-ability students. Students participated in most MVPA during team games (43.2 6 19.5%; $P < 0.01$), while the least MVPA was observed during movement activities (22.2 6 20.0%). Physical education may make a more significant contribution to young people's regular physical activity participation if lessons are planned and delivered with MVPA goals in mind.

Riesch, Susan K; Anderson, Lori S; Krueger, Heather stated that the purpose of this study was review individual, family, and environmental factors that predict health-risk behavior among children and to propose parentchild communication processes as a mechanism to mediate them.

Improving parent-child communication processes may: reduce individual risk factors, such as poor academic achievement or self-esteem; modify parenting practices such as providing regulation and structure and acting as models of health behavior; and facilitate discussion about factors that lead to involvement in healthrisk behaviors. . Assessment strategies to identify youth at risk for health-risk behavior are recommended and community-based strategies to improve communication among parents and children need development.

The purpose of this paper is to provide an overview of individual, family, and environmental factors that increase the probability of health-risk behavior among children and to propose parent-child communication processes as a mechanism to mediate those factors. This is a theoretical paper to stimulate thinking among

clinicians by proposing a model of health-risk behavior prevention. Figure 1 depicts our conceptual model for reducing health-risk behaviors in middle childhood.

Health disparities are inequalities or inequities as a result of environment, access, quality, and utilization of health care, health status, or particular health outcomes (Carter-Pokas & Baquet, 2002).

This paper is pertinent to the issue of health disparities because the factors that predict health-risk behavior among children and adolescents-individual, family, and community factors-overlap with those that characterize populations who do not typically benefit from ongoing preventive health care. Furthermore, the health-risk behaviors themselves may affect health status and outcomes that contribute to health disparities. Pediatric nurses and other healthcare providers can reduce health disparities by taking steps to (a) prevent children from engaging in health-risk behaviors and (b) promote positive eating, exercise, and sleep behaviors.

Pediatric nurses and other healthcare providers have a number of strategies available to prevent or modify health-risk behavior. Examples include a number of nationally tested programs such as the Community Tool Kit for early sexual activity prevention (Sexuality Information and Education Council of the United States [SIECUS], 2005), Teens Against Tobacco Use for tobacco use prevention (American Lung Association, 2005), and Heart Power! for overweight prevention (American Heart Association, 2005).

Another promising strategy that may appeal to pediatric nurses is aimed at the family level of intervention. Because family and communication processes are modifiable and may mediate the effects of risk factors, identifying risk factors and promoting communication processes may reduce the need for health care associated with health-risk behaviors such as treatment of diseases (i.e., injuries, cancers, sexually transmitted infections, obesity).

CHAPTER-3

DATA ANALYSIS AND INTERPRETATION

Table no. 1

Age of the respondent

Sr.No	Age	Frequency	Percent
1	17 years	6	1.2
3	18 years	29	5.8
4	19 years	109	21.8
5	20 years	198	39.6
6	21 years	97	19.4
7	22 years	33	6.6
8	23 years	28	5.6
	Total	500	100.0

Table no .1 is classified into four columns and nine rows such that column denotes the age, frequency and percentage of the respondents where as rows denotes the numbers of respondents falls in each age groups.

From the above table it can be seen that majority of the respondents near about fourty percent of the respondents were from age group of 20 years old, very less that is merely one percentage of the respondents were from age group of seventeen years of age.

Thus majority of the respondents near about fourty percentage were from the age group of twenty years and very less of the respondents nearly one percent were from age group of seventeen years.

Table no. 2

Religion of the respondent

Sr.No	Religion	Frequency	Percent
1	Hindu	442	88.4
2	Muslim	20	4.0
3	Cristian	10	2.0
4	Buddhist	5	1.0
5	Jain	7	1.4
6	Others	16	3.2
	Total	500	100.0

Table no. 2 is classified into four columns and seven rows such that column denotes the Religion, frequency and percentage of the respondents where as rows denotes the numbers of respondents falls in each Religion groups.

From the above table it can be seen that majority of the respondents more than Eighty eight percent of the respondents were Hindus and only one percentage of the respondents are Buddhist.

Thus majority of the respondents more than Eighty eight percentage were Hindus and very less of the respondents only one percentage were Buddhist.

Table no. 3

Sex of the respondent

Sr. No	Sex	Frequency	Percent
1	Female	273	54.6
2	Male	227	45.4
	Total	500	100.0

Table no. 3 is classified into four columns and three rows such that column denotes the Sex, frequency and percentage of the respondents where as rows denotes the numbers of respondents falls in each sex groups.

From the above table it can be seen that majority of the respondents more than fifty four percent of the respondents were female and more than fourty five percentage of the respondents are male.

Thus majority of the respondents more than Fifty four percentage were female and more than fourty five percent respondents were male.

Table no. 4

Cast of the respondent

Sr.No	Cast	Frequency	Percent
1	SC	39	7.8
2	ST	12	2.4
3	OBC	123	24.6
4	NT	36	7.2
5	SBC	165	33.0
6	NTDNT	8	1.6
7	Open	117	23.4
	Total	500	100.0

Table no. 4 is classified into four columns and three rows such that column denotes the Cast, frequency and percentage of the respondents where as rows denotes the numbers of respondents falls in each cast groups.

From the above table it can be seen that majority of the respondents more than Twenty four percent of the respondents were OBC and less than two percentage of the respondents are NTDNT.

Thus majority of the respondents more than Twenty four percentage were OBC and less than two percent respondents were NTDNT.

Table no. 5

Stream of the respondent

Sr.No	Stream	Frequency	Percent
1	B.A	57	11.4
2	B.Sc	23	4.6
3	B.Com	334	66.8
4	B.B.A	71	14.2
5	B.C.A	1	.2
6	Other	14	2.8
	Total	500	100.0

Table no. 5 is classified into four columns and seven rows such that column denotes the Stream, frequency and percentage of the respondents where as rows denotes the numbers of respondents falls in each Stream groups.

From the above table it can be seen that majority of the respondents more than Sixty six percent of the respondents from B Com and only point two percentage of the respondents from BCA.

Thus majority of the respondents more than Sixty six percentage from B Com and only point two percent respondents from BCA.

Table no. 6

Father's Education of the respondent

Sr.No	Education	Frequency	Percent
1	Primary	161	32.2
2	Secondary	136	27.2
3	Graduate	142	28.4
4	Post-Graduate	41	8.2
5	Illiterate	20	4.0
	Total	500	100.0

Table no. 6 is classified into four columns and six rows such that column denotes the Father's Education , frequency and percentage of the respondents where as rows denotes the numbers of respondents falls in each Education groups.

From the above table it can be seen that majority of the respondents more than Thirty two percent of the respondents were primary stage education holders and only four percentage of the respondents are illiterate.

Thus majority of the respondents more than Thirty two percentage were primary stage education holders and only four percent respondents were Illiterate.

Table no.7

Father's Occupation of the respondent

Sr.No	Occupation	Frequency	Percent
1	Govt. Servant	92	18.4
2	Business	138	27.6
3	Private Employee	42	8.4
4	Labour	144	28.8
5	Skilled-labour	20	4.0
6	Unemployed	3	.6
7	Others	61	12.2
	Total	500	100.0

Table no. 7 is classified into four columns and Eight rows such that column denotes the Father's Occupation , frequency and percentage of the respondents where as rows denotes the numbers of respondents falls in each Occupation groups.

From the above table it can be seen that majority of the respondents more than Twenty Eight percent of the respondents were Labour and only point six percentage of the respondents are unemployed.

Thus majority of the respondents more than Twenty Eight percentage were labour and only point six percent respondents were unemployed.

Table no.8

Mather's Education of the respondent

Sr.No	Education	Frequency	Percent
1	Primary	250	50.0
2	Secondary	117	23.4
3	Graduate	70	14.0
4	Post-Graduate	9	1.8
5	Illiterate	54	10.8
	Total	500	100.0

Table no. 8 is classified into four columns and six rows such that column denotes the Mather's Education , frequency and percentage of the respondents where as rows denotes the numbers of respondents falls in each Education groups.

From the above table it can be seen that majority of the respondents exact fifty percent of the respondents were primary stage education holders and less than two percentage of the respondents are Post graduates.

Thus majority of the respondents more than Thirty two percentage were primary stage education holders and only four percent respondents were Illiterate.

Table no. 9

Mather's Occupation of the respondent

Sr.No	Occupation	Frequency	Percent
1	Govt. Servant	21	4.2
2	Business	15	3.0
3	Private Employee	25	5.0
4	Labour	98	19.6
5	Skilled-Labour	20	4.0
6	Housewife	271	54.2
7	Unemployed	6	1.2
8	Others	44	8.8
	Total	500	100.0

Table no. 9 is classified into four columns and Nine rows such that column denotes the Mather's Occupation, frequency and percentage of the respondents where as rows denotes the numbers of respondents falls in each Occupation groups.

From the above table it can be seen that majority of the respondents more than Fifty four percent of the respondents were house wife and less than two percentage of the respondents are unemployed.

Thus majority of the respondents more than Fifty four percentage were house wife and less than two percent respondents were unemployed.

Table no.10

No of Family members of the respondent

Sr.No	No of Family members	Frequency	Percent
1	2-4	233	46.6
2	5-7	215	43.0
3	8 and above	52	10.4
	Total	500	100.0

Table no. 10 is classified into four columns and four rows such that column denotes the No of Family members, frequency and percentage of the respondents where as rows denotes the numbers of respondents falls in each No of Family members groups.

From the above table it can be seen that majority of the respondents more than Fourty six percent of the respondents were two to four family members and less than eleven percentage of the respondents were eight and above family members.

Thus majority of the respondents more than Fourty six percentage were two to four family members and less than eleven percentage of the respondents were eight and above family members.

Table no.11

Annual Family Income of the respondent

Sr.No	Annual Family Income	Frequency	Percent
1	below25k	199	39.8
2	25-50 k	103	20.6
3	50-75 k	23	4.6
4	75-1 lakh	64	12.8
5	1 lakh and above	111	22.2
	Total	500	100.0

Table no. 11 is classified into four columns and six rows such that column denotes the Annual Family Income, frequency and percentage of the respondents where as rows denotes the numbers of respondents falls in each Annual Family Income groups.

From the above table it can be seen that majority of the respondents more than thirty nine percent of the respondents were below 25 k and less than five percentage of the respondents were 50 to 75 k.

Thus majority of the respondents more than thirty nine percentage were below 25 k and less than five percentage of the respondents were 50 to 75 k.

Table no.12

Type of Family of the respondent

Sr.No	Type of Family	Frequency	Percent
1	Nuclear	288	57.6
2	Joint	183	36.6
3	Expanded	29	5.8
	Total	500	100.0

Table no. 12 is classified into four columns and four rows such that column denotes the Type of Family, frequency and percentage of the respondents where as rows denotes the numbers of respondents falls in each Type of Family groups.

From the above table it can be seen that majority of the respondents more than fifty seven percent of the respondents were Nuclear family and less than six percentage of the respondents were expanded family.

Thus majority of the respondents more than fifty seven percentage were Nuclear family and less than six percentage of the respondents were expanded family.

Table no.13

Marital Status of the respondent

Sr.No	Type of Family	Frequency	Percent
1	Single	446	89.2
2	Married	47	9.4
3	Deserted	2	.4
4	Widow	5	1.0
	Total	500	100.0

Table no. 13 is classified into four columns and five rows such that column denotes the Marrital Status, frequency and percentage of the respondents where as rows denotes the numbers of respondents falls in each Marrital Status groups.

From the above table it can be seen that majority of the respondents more than eighty nine percent of the respondents were single and only point four percentage of the respondents were Deserted.

Thus majority of the respondents more than eighty nine percentage were single and only point four percentage of the respondents were Deserted.

Table no. 14 : Correlations

		Driving Without License	How many Days U not Go To College Because Felt Unsafe	U Ever Seriously Consider attempting Suicide	Do U Study Daily	Do U attain The College Periods Regularly	How may Hours Do U Spend In Reading Room
Driving Without License	Pearson Correlation	1	.141**	-.149**	.020	-.054	.045
	Sig. (2-tailed)		**.009**	**.006**	.718	.317	.406
	N	500	500	500	500	500	500
How many Days U not Go To College Because Felt Unsafe	Pearson Correlation	.141**	1	-.173**	-.001	-.027	-.010
	Sig. (2-tailed)	**.009**		**.001**	.979	.622	.857
	N	500	500	500	500	500	500
U Ever Seriously Consider attempting Suicide	Pearson Correlation	.149**	.173**	1	-.131*	-.165**	-.198**
	Sig. (2-tailed)	**.006**	**.001**		**.015**	**.002**	**.000**
	N	500	500	500	500	500	500

Do U Study Daily	Pearson Correlation	.020	-.001	-.131*	1	-.003	.078
	Sig. (2-tailed)	.718	.979	**.015**		.954	.150
	N	500	500	500	500	500	500
Do U attain The College Periods Regularly	Pearson Correlation	-.054	-.027	.165**	-.003	1	-.034
	Sig. (2-tailed)	.317	.622	**.002**	.954		.536
	N	500	500	500	500	500	500
How may Hours Do U Spend In Reading Room	Pearson Correlation	.045	-.010	-.198**	.078	-.034	1
	Sig. (2-tailed)	.406	.857	**.000**	.150	.536	
	N	500	500	500	500	500	500

**. Correlation is significant at the 0.01 level (2-tailed).

*. Correlation is significant at the 0.05 level (2-tailed).

From the above table of correlation six variables were intersected to each other to find the correlations between the variables. The variables tested for the correlation are students driving the motor cycle without having license, how many days student did not go to college because feeling of unsafe, ever student considered attempting suicide, do study daily, do students attain college daily and how many hours students spending time in reading rooms.

After analyzing the correlation between the variable it has been found that, the health risk behavior of the students like driving without license show positive correlation with not going to college because feeling unsafe in college with P value of 0.009 which is less than 0.05 i.e 0.009 <0.05 thus the two variable are correlated positively. Similarly driving without license show correlation to seriously attempting suicide in students with p value of 0.006 which is also less than significant value 0.05 i.e. 0.006< 0.05. Further the behavior of not going college because of unsafe feeling and seriously consideration of attempting suicide is also seen to be positively correlated with the p value of 0.001 which is less than the significant value 0.005 i.e. 0.001 <0.005, thus it can be said that the students who feels unsafe at college going can seriously consider for attempting suicide. It has seen that the feeling of seriously consideration of attempting suicide is negatively correlated to the daily study with p value of 0.015 which is also lee than the significant value 0.05 i.e. 0.015<0.05 thus both variables shows negative correlation. Similarly, feeling of seriously consideration of attempting suicide is negatively correlated to going to college regularly with P value of 0.002 which is less than the value 0.005. i.e 0.002<0.05 thus it shows negative correlation. Also feeling of seriously consideration of attempting suicide is negatively correlated to spending time in reading room with P value of 0.00 which is less then significant value 0.05, i.e. 0.00<0.05 thus shows negative correlation.

Table no. 15: Correlations

		Concentrate In Studies	What Mostly Interrupt In Studies	Ever Compare Academic Achievements With your Friends	Preparing For Next Examination	Think Getting Less Percentage Is Stigma In Society
Concentrate In your Studies	Pearson Correlation	1	-.109*	.016	-.167**	-.003
	Sig. (2-tailed)		**.015**	.720	**.000**	.950
	N	500	500	500	500	500
What Mostly Interrupt In your Studies	Pearson Correlation	-.109*	1	.020	.127**	-.081
	Sig. (2-tailed)	**.015**		.651	**.004**	.071
	N	500	500	500	500	500
Ever Compare Academic Achievements With Friends	Pearson Correlation	.016	.020	1	.081	.103*
	Sig. (2-tailed)	.720	.651		.070	**.021**
	N	500	500	500	500	500

Preparing For Next Examination	Pearson Correlation	-.167**	.127**	.081	1	-.072
	Sig. (2-tailed)	**.000**	**.004**	.070		.107
	N	500	500	500	500	500
Think Getting Less Percentage Is Stigma In Society	Pearson Correlation	-.003	-.081	.103*	-.072	1
	Sig. (2-tailed)	.950	.071	**.021**	.107	
	N	500	500	500	500	500

*. Correlation is significant at the 0.05 level (2-tailed). **. Correlation is significant at the 0.01 level (2-tailed).

Table no.15 is five variables intersected table showing the correlation among each other. The five variable are intersected to find out the nature of correlation between them. The variables tested are student's concentration in studies, factors interrupting in the studies, comparison of academic achievement with friends, exam preparation and student think less percentage in examination is a stigma.

Table no. 16

The affinity and assumed reasons for the Academic achievement

		Who Pressurizes the respondents the Most				
		Family members	Friends	Girlfriend/boyfriend	Teachers	Total
What are The Reasons you Miss The Periods	Not interested in subject	134	76	5	3	218
	Do not understand the teaching	56	25	4	0	85
	Friends force to bang the class	31	8	0	0	39
	Due to sickness	22	4	0	1	27
	Due to work at house	26	4	1	0	31
	Work at some place	12	5	0	0	17
	I dont miss the periods	55	25	3	0	83
		336	147	13	4	500

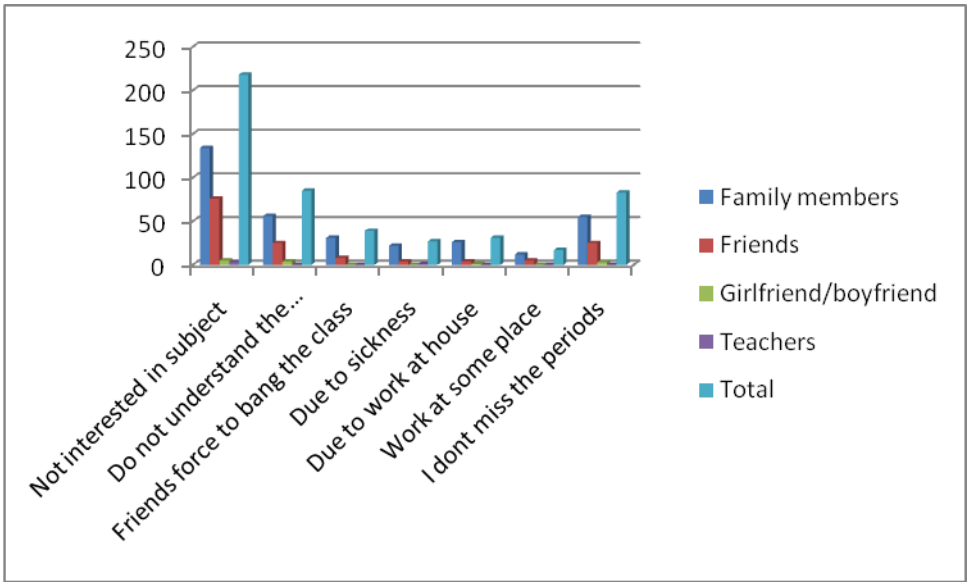

Table no 16 reveals relationship between seven variables denoting the reason of absentee in the college and not attending the college for longer period of time viz, not interested in the subject so not attending the colleges. Not understanding what is been taught, friends forced to bang the class, due to sickness did not attended the class, due to house work students did not attended the class and the students do not frequently miss the class. The seven variables is crossed with frequencies of the variable who pressurize the respondents for academic achievement those were family members, friends, girl friend or boyfriend and teachers.

From the table it can be seen that the majority of the reason of academic affinity is related to many

Table no.17

The respondents Ride Motorcycle Wearing or without wearing Helmet

Sr.No	Ride Motorcycle Wearing or without wearing Helmet	Frequency	Percent
1	I did not ride a motorcycle during the past 12 months	218	43.6
2	Never wore a helmet	148	29.6
3	Rarely wore a helmet	28	5.6
4	Sometime wore a helmet	50	10.0
5	Most of the time wore a helmet	6	1.2
6	Always wore a helmet	50	10.0
	Total	500	100.0

Table no.17 is classified into four columns and six rows such that column denotes the Ride Motorcycle Wearing or without wearing Helmet, frequency and percentage of the respondents where as rows denotes the numbers of respondents falls in each categories.

From the above table it can be seen that majority of the respondents near about Thirty percent of the respondents were never wore a helmet while riding a motorcycle and very less that is merely one percentage of the respondents were Most of the time wore a helmet.

Thus majority of the respondents near about Thirty percent of the respondents were never wore a helmet while riding e motorcycle and very less that is merely one percentage of the respondents were Most of the time wore a helmet.

Table no.18

How many times were you in a physical fight

Sr.No	How many times were you in a physical fight	Frequency	Percent
1	0 Times	362	72.4
2	1 Times	85	17.0
3	2 or 3 Times	22	4.4
4	4 or 5 Times	12	2.4
5	6 or 7 Times	7	1.4
6	8 or 9 Times	3	.6
7	12 or more Times	9	1.8
	Total	500	100.0

Table no18. is classified into four columns and seven rows such that column denotes the How many times were you in a physical fight, frequency and percentage of the respondents where as rows denotes the numbers of
respondents falls in each categories.

From the above table it can be seen that majority of the respondents near about Seventeen percent of the respondents were at list one time involved in physical fight and near about two percentage of the respondents were involved in physical fight more than 12 times in last 30 days.

Thus majority of the respondents near about seventy two percent of the respondents were never involved in physical fight in last thirty days & seventeen percent of respondent were involved in physical fight at list one time in last thirty days and near about two percentage of the respondents were involved in physical fight more than 12 times in last 30 days.

Table no.19

How many Cigarette Did you Smoke Per Day

Sr.No	How many Cigarette Did you Smoke Per Day	Frequency	Percent
1	I did not smoke cigarettes during the past 30 days	452	90.4
2	Less than 1 Cigarette per day	31	6.2
3	1 cigarette per day	6	1.2
4	2 to 5 cigarette per day	6	1.2
5	6 to 10 cigarettes per day	2	.4
6	11 to 20 cigarettes per day	2	.4
7	More than 20 cigarettes per day	1	.2
	Total	500	100.0

Table no19 is classified into four columns and seven rows such that column denotes the How many Cigarette Did you Smoke Per Day, frequency and percentage of the respondents where as rows denotes the numbers of respondents falls in each categories.

From the above table it can be seen that the six percent of the respondents were smokes Less than 1 Cigarette per day and very less that is merely point two percentage of the respondents were More than 20 cigarettes per day

Thus the six percent of the respondents were smokes Less than one Cigarette per day and very less that is merely point two percentage of the respondents were smoking More than 20 cigarettes per day

Table no.20

How many Days Did you Use Chewing Tobacco Snuff

Sr. No	How many Days Did you Use Chewing Tobacco Snuff	Frequency	Percent
1	0 days	455	91.0
2	1 or 2 days	20	4.0
3	3 to 5 days	17	3.4
4	6 to 9 days	3	.6
5	10 to 19 days	2	.4
6	20 to 29 days	1	.2
7	all 30 days	2	.4
	Total	500	100.0

Table no20 is classified into four columns and seven rows such that column denotes the How many Days Did you Use Chewing Tobacco Snuff, frequency and percentage of the respondents where as rows denotes the numbers of respondents falls in each categories.

From the above table it can be seen that the four percent of the respondents were Chewing Tobacco Snuff One or two days in a last thirty days and very less that is merely point four percentage of the respondents were Chewing Tobacco Snuff every day

Thus the four percent of the respondents were Chewing Tobacco Snuff One or two days in a last thirty days and very less that is merely point four percentage of the respondents were Chewing Tobacco Snuff every day

Table no.21

How many Days Have you Had At Least 1 Drink Of Alcohol

Sr.No	How many Days Have you Had At Least 1 Drink Of Alcohol	Frequency	Percent
1	0 days	479	95.8
2	1 or 2 days	12	2.4
3	3 to 9 days	1	.2
4	10 to 19 days	4	.8
5	20 to 39 days	2	.4
6	40 to 99 days	1	.2
7	100 or more days	1	.2
	Total	500	100.0

Table no21 is classified into four columns and seven rows such that column denotes the How many Days Have you Had At Least 1 Drink Of Alcohol , frequency and percentage of the respondents where as rows denotes the numbers of respondents falls in each categories.

From the above table it can be seen that the two percent of the respondents were drinking alcohol at list one time in One or two days and very less that is merely point two percentage of the respondents were drinking alcohol at list one time from last hundred days

Thus the two percent of the respondents were drinking alcohol at list one time in One or two days and very less that is merely point two percentage of the respondents were drinking alcohol at list one time every day from last hundred days

Table no.22

How many Times Have you Used any Form Of Cocaine

Sr.No	How many Times Have you Used any Form Of Cocain	Frequency	Percent
1	0 Times	460	92.0
2	1 or 2 Times	30	6.0
3	3 to 9 Times	5	1.0
4	10 to 19 Times	1	.2
5	20 to 39 Times	1	.2
6	40 or more Times	3	.6
	Total	500	100.0

Table no 22 is classified into four columns and six rows such that column denotes the How many Times Have you Used any Form Of Cocaine, frequency and percentage of the respondents where as rows denotes the numbers of respondents falls in each categories.

From the above table it can be seen that the six percent of the respondents were Used any Form Of Cocaine at list one or two time and very less that is merely point six percentage of the respondents were Used any Form Of Cocaine more than forty times

Thus the six percent of the respondents were Used any Form Of Cocaine at list one or two time and very less that is merely point six percentage of the respondents were Used any Form Of Cocaine more than forty times

Table no.23

How many Times you Drink hundred percent Fruit Juices

Sr.No	How many Times you Drink 100 percent Fruit Juices	Frequency	Percent
1	I did not drink 100% fruit juice during past 7 days	318	63.6
2	1 to 3 Times during the past 7 days	106	21.2
3	4 to 6 times during the past 7 days	23	4.6
4	1 times per day	34	6.8
5	2 times per day	6	1.2
6	3 times per day	5	1.0
	4 or more times per day	8	1.6
	Total	500	100.0

Table no 23 is classified into four columns and seven rows such that column denotes the How many Times you Drink hundred percent Fruit Juices, frequency and percentage of the respondents where as rows denotes the numbers of respondents falls in each categories.

From the above table it can be seen that the sixty three percent of the respondents were did not drink 100% fruit juice during past seven days and very less that is nearly seven six percent of the respondents were drink hundred percent fruit juice one time per day

Thus the sixty three percent of the respondents were did not drink hundred percent fruit juice during past seven days and very less that is nearly seven percent of the respondents were drink hundred percent fruit juice one time per day

Table no.24

How Old Were you When you Had Sexual Intercourse For The First Time

Sr.No	How Old Were you When you Had Sexual Intercourse For The First Time	Frequency	Percent
1	I have never had sexual intercourse	380	76.0
2	11 years old or younger	54	10.8
3	12 years old	31	6.2
4	13 years old	7	1.4
5	14 years old	5	1.0
6	15 years old	8	1.6
7	16 years old	5	1.0
8	17 years old or older	10	2.0
	Total	500	100.0

Table no 24 is classified into four columns and eight rows such that column denotes the How Old Were you When you Had Sexual Intercourse For The First Time, frequency and percentage of the respondents where as rows denotes the numbers of respondents falls in each categories.

From the above table it can be seen that the seventy six percent of the respondents were have never had sexual intercourse and thirteen percent of the respondents were had sexual intercourse in their teen age (while 11 and above year)

Thus the seventy six percent of the respondents were have never had sexual intercourse and thirteen percent of the respondents were had sexual intercourse in their teen age (while 11 and above year)

Table no.25

How many Times you eat Fruit Do Not Count Juice

Sr.No	How many Times you eat Fruit Do Not Count Juice	Frequency	Percent
1	I did not eat fruit during the past 7 days	174	34.8
2	1 to 3 times during the past 7 days	216	43.2
3	4 to 6 times during the past 7 days	35	7.0
4	1 times per day	54	10.8
5	2 times per day	7	1.4
6	3 times per day	9	1.8
7	4 times per day	5	1.0
	Total	500	100.0

Table no 25 is classified into four columns and seven rows such that column denotes the How many Times you eat Fruit Do Not Count Juice, frequency and percentage of the respondents where as rows denotes the numbers of respondents falls in each categories.

From the above table it can be seen that the forty three percent of the respondents were eating fruits one or three times during the past seven days and near about thirty five percent of the respondents were did not eat fruit during the past seven days.

Thus the forty three percent of the respondents were eating fruits one or three times during the past seven days and near about thirty five percent of the respondents were did not eat fruits during the past seven days.

Table no.26

How many Times you Eat Green Salad

Sr.No	How many Times you Eat Green Salad	Frequency	Percent
1	I did not eat green salad during the past 7 days	210	42.0
2	1 to 3 times during past 7 days	110	22.0
3	4 to 6 times during the past 7 days	81	16.2
4	1 times per day	50	10.0
5	2 times per day	33	6.6
6	3 times per day	7	1.4
7	4 or more times per day	9	1.8
	Total	500	100.0

Table no 26 is classified into four columns and seven rows such that column denotes the How many Times you Eat Green Salad, frequency and percentage of the respondents where as rows denotes the numbers of respondents falls in each categories.

From the above table it can be seen that the twenty two percent of the respondents were eating green salad one or three times during the past seven days and forty two percent of the respondents were did not eat green salad during the past seven days.

Thus the twenty two percent of the respondents were eating green salad one or three times during the past seven days and forty two percent of the respondents were did not eat green salad during the past seven days.

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Table no.27

How many Days Did you Participate In Physical Activity 20 min

Sr.No	How many Days Did you Participate In Physical Activity 20 min	Frequency	Percent
1	0 days	207	41.4
2	1 day	85	17.0
3	2 days	35	7.0
4	3 days	31	6.2
5	4 days	13	2.6
6	5 days	15	3.0
7	6 days	21	4.2
8	7 days	93	18.6
	Total	500	100.0

Table no 27 is classified into four columns and eight rows such that column denotes the How many Days Did you Participate In Physical Activity 20 min, frequency and percentage of the respondents where as rows denotes the numbers of respondents falls in each categories.

From the above table it can be seen that the forty one percent of the respondents were not Participating In any Physical Activity for at list20 min from last seven days and near about three percent of the respondents were Participating In Physical Activity only four days at list20 min from last seven days

Thus the forty one percent of the respondents were not Participating In any Physical Activity for at list20 min from last seven days but near about twenty three percent of respondents were Participating one two six days In any Physical Activity for at list20 min and nineteen percent of the respondents were Participating In Physical Activity seven days at list20 min from last seven days.

Table no.28

On Average College Day How many Hrs Do you Watch TV

Sr.No	On Average College Day How many Hrs Do you Watch TV	Frequency	Percent
1	I do not watch TV on average college day	138	27.6
2	Less than 1 hrs per day	75	15.0
3	1 hours per day	109	21.8
4	2 hours per day	72	14.4
5	3 hours per day	40	8.0
6	4 hours per day	32	6.4
7	5 hours per day	34	6.8
	Total	500	100.0

Table no 28 is classified into four columns and seven rows such that column denotes the On Average College Day How many Hrs Do you Watch TV, frequency and percentage of the respondents where as rows denotes the numbers of respondents falls in each categories.

From the above table it can be seen that the near about twenty eight percent of the respondents were do not watch TV on average college day and near about seven percent of the respondents were watch TV on average five hours per day on college day

Thus near about twenty eight percent of the respondents were do not watch TV on average college day and near about seven percent of the respondents were watch TV on average five hours per day on college day and remaining fifty percent of the respondents were watch TV on average one to four hours per day on college day and fifteen percent respondents less than one hour per day.

Table no.29

On An Average In Night How many hours Of Sleep Do you Get

Sr.No	On An Average In Night How many hours Of Sleep Do you Get	Frequency	Percent
1	4 or less hours	95	19.0
2	5 hours	62	12.4
3	6 hours	131	26.2
4	7 hours	114	22.8
5	8 hours	69	13.8
6	9 hours	17	3.4
7	10 or more hours	12	2.4
	Total	500	100.0

Table no 29 is classified into four columns and seven rows such that column denotes the On An Average In Night How many hours Of Sleep Do you Get, frequency and percentage of the respondents where as rows denotes the numbers of respondents falls in each categories.

From the above table it can be seen that the nineteen percent of the respondents were get An Average of four or less than four hours sleep In the Night and near about fourteen percent of the respondents were get eight hours sleep in the night

Thus the nineteen percent of the respondents were get An Average of four or less than four hours sleep In the Night and more than seventy five percent of the respondents were get five to eight hours sleep in the night and near about six percent of the respondents were get nine to Ten hours sleep in the night

CHAPTER-4

MAJOR FINDINGS

1 Majority of the respondents near about forty percentage were from the age group of twenty years and very less of the respondents nearly one percent were from age group of seventeen years.

2 Majority of the respondents more than Eighty eight percentage were Hindus and very less of the respondent's only one percentage were Buddhist.

3 Majority of the respondents more than Fifty four percentage were female and more than fourty five percent respondents were male.

4 Majority of the respondents more than Twenty four percentage were OBC and less than two percent respondents were NTDNT.

5 Majority of the respondents more than Sixty six percentage from B Com and only point two percent respondents from BCA.

6 Majority of the respondents more than Thirty two percentage were primary stage education holders and only four percent respondents were Illiterate.

7 Majority of the respondents more than Twenty Eight percentage were labour and only point six percent respondents were unemployed.

8 Majority of the respondents more than Thirty two percentage were primary stage education holders and only four percent respondents were Illiterate.

9 Majority of the respondents more than Fifty four percentage were house wife and less than two percent respondents were unemployed.

10 Majority of the respondents more than Fourty six percentage were two to four family members and less than eleven percentage of the respondents were eight and above family members.

11 Majority of the respondents more than thirty nine percentage were below 25 k and less than five percentage of the respondents were 50 to 75 k.

12 Majority of the respondents more than fifty seven percentage were Nuclear family and less than six percentage of the respondents were expanded family.

13 Majority of the respondents more than eighty nine percentage were single and only point four percentage of the respondents were Deserted.

14 The behavour of the students driving the motor cycle without having license and not attending college is correlated.

15 Feeling unsafe in the college and seriously consideration to attempt the suicide also shows positive correlation.

16 Students studying daily and seriously consideration to attempt the suicide shows negative correlation.

17 Students spending time in reading room shows negative correlation with students seriously consideration to attempt the suicide.

18 Students attending college regularly shows negative correlation with students seriously consideration to attempt the suicide.

19 Majority of the respondents near about Thirty percent of the respondents were never wore a helmet while riding e motorcycle and very less that is merely one percentage of the respondents were Most of the time wore a helmet.

20 Majority of the respondents near about seventy two percent of the respondents were never involved in physical fight in last thirty days & seventeen percent of respondent were involved in physical fight at list one time in last thirty days and near about two percentage of the respondents were involved in physical fight more than 12 times in last 30 days.

21 It is seen that the six percent of the respondents were smokes Less than one Cigarette per day and very less that is merely point two percentage of the respondents were smoking More than 20 cigarettes per day.

22 The four percent of the respondents were Chewing Tobacco Snuff One or two days in a last thirty days and very less that is merely point four percentage of the respondents were Chewing Tobacco Snuff every day.

23 The two percent of the respondents were drinking alcohol at list one time in One or two days and very less that is merely point two percentage of the respondents were drinking alcohol at list one time every day from last hundred days.

24 The six percent of the respondents were Used any Form Of Cocaine at list one or two time and very less that is merely point six percentage of the respondents were Used any Form Of Cocaine more than forty times.

25 The sixty three percent of the respondents were did not drink hundred percent fruit juice during past seven days and very less that is nearly seven percent of the respondents were drink hundred percent fruit juice one time per day.

26 The seventy six percent of the respondents were have never had sexual intercourse and thirteen percent of the respondents were had sexual intercourse in their teen age (while 11 and above year).

27 The forty three percent of the respondents were eating fruits one or three times during the past seven days and near about thirty five percent of the respondents were did not eat fruits during the past seven days.

28 The twenty two percent of the respondents were eating green salad one or three times during the past seven days and forty two percent of the respondents were did not eat green salad during the past seven days.

29 The forty one percent of the respondents were not Participating In any Physical Activity for at list20 min from last seven days but near about twenty three percent of respondents were Participating one two six days In any Physical Activity for at list20 min and nineteen percent of the respondents were Participating In Physical Activity seven days at list20 min from last seven days.

30 Near about twenty eight percent of the respondents were do not watch TV on average college day and near about seven percent of the respondents were watch TV on average five hours per day on college day and remaining fifty percent of the respondents were watch TV on average one to four hours per day on college day and fifteen percent respondents less than one hour per day.

31 The nineteen percent of the respondents were get An Average of four or less than four hours sleep In the Night and more than seventy five percent of the respondents were get five to eight hours sleep in the night and near about six percent of the respondents were get nine to Ten hours sleep in the night

CHAPTER-5

CONCLUSIONS & SUGGESTIONS

Herewith we come to know there are many reasons through which students cultivate unnecessary habits and health risk behavior. Results indicate that epidemic of risk behavior varies in subjects according to factors. Sometime age group is the reason and sometime something else. But it is worth noting that the key behavioral factors are widespread. My findings are evidences to make out where the needed steps should be under taken to bring awareness of health and physical education among the students.

The increasing pressure in the system of education and at the same time the taste of life among teenagers occur sudden .The parental relation with the student .A teacher can bring betterment in understanding good and bad for a student. Teachers play vital role in student's life. Teachers should feel the pressure of studies on student and must guide to release it. Students should be encouraged to play on ground. Sports and games helps in emotional, social, physical growth of a student.

Bad habits, addictions can be corrected. Eradication of such things is foremost important. Both parents and teachers equal participation helps in bringing up student. Etiquettes, good habits, good manners, literacy, culture based knowledge etc. should be taught to the students. Youngsters should be paid special attention. Normally circumstances with enriched culture lead to positive attitude. The realities of the life should be accepted and remedies should be thoughtful. One must learn this in life. Sportiveness will certainly act in improving the damages of life. Physical education teaches all these.

Talking about college activities we notice that student attempts suicide at this age group. Why a student does at this colorful age thinks of suicide? Is it a pressure, lack of positive thinking stress or lack of communication? Can we find any reason here? We can see that atmosphere at college and at home directly affects psychology of students minds A student is (due to untamed personality) unable to judge himself as an individual with circumstances that he faces around. Pressure leads to stress which do not find way to move out of students mind. Finally he /she feel very weaker and think of ending life. Physical education will definitely help such minds .Sports focus on new approaches towards life, playing games in open ground teaches defending as well as accepting defeats. Positive attitude is built unknowingly and negative correlation with suicide is grown up.

There is a close relation between health risk behavior and academic achievement. A student should be taken on ground and physical education and sports should be provided to every student so as to bring development in health, physical development and positive attitude.

Life is precious but the reasons that we have noticed among degree level students causing health risk behaviour can be removed by physical education and sports. It is

our duty to highlight the reasons and bring positiveness to eradicate risks in behavior and improve healthy behavior of a student. Academic achievements should involve theories and practical of physical education through which the study on affinity and assumed reasons for health risk behavior in student as a fundamental development of personality can be built properly or strongly. Health Education develops level of confidence among students and A sound mind in a sound body. Achievements on grounds with team or as an athlete builds a strong chain in minds which leads to success in further stages of life .Healthy behavior automatically rises in a students. It is must to evolve the physical education and Health Education intervention model for academic achievement and healthy behavior.

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APPENDIX NO 1

A STUDY ON HEALTH RISK BEHAVIOUR AND ACADEMIC ACHIEVEMENT AMONG THE DEGREE LEVEL COLLEGE STUDENTS OF SOLAPUR UNIVERSITY, SOLAPUR

This survey is about health behavior and Academic Achievement Among The Degree Level College Student Of Solapur University, Solapur. It has been developed so you can tell us what you do that may affect your health and Academic achievements. The information you give will be used to develop better health and education for young people like yourself.

The answers you give will be kept private. No one will know what you write. Answer the questions based on what you really do. Completing the survey is voluntary. If you are not comfortable answering a question, just leave it blank.

The questions that ask about your background will be used only to describe the types of students completing this survey. The information will not be used to find out your name. No names will ever be reported.

Make sure to read every question. Fill in the ovals completely. When you are finished, follow the instructions of the person giving you the survey.

Thank you very much for your help.

Following objectives have been formulated for the study.

1. **To explore and explain the relationship between health risk behaviour and academic achievement.**
2. **To highlight the reasons and consequences of health risk behaviour.**
3. **To study the affinity and assumed reasons for the Academic achievement.**
4. **To evolve the Physical education & Health Education intervention model for academic achievement and healthy behaviour.**

Interview Schedule

I. Personal Background:

1. Age: How old are you?

1. 17 years old or younger ☐
2. 18 years old ☐
3. 19 years old ☐
4. 20 years old ☐
5. 21years old ☐
6. 22 years old ☐
7. 23 years old or older ☐

2. Sex: What is your sex?

1. Female ☐
2. Male ☐

3. Height in cm: ☐☐☐☐

4. Weight in kg: ☐☐☐☐

5. Religion: What is your religion?

1.Hindu ☐
2.Muslim ☐
3.Cristian ☐
4.Buddhist. ☐
5.Jain. ☐
6.Others ☐

6. Caste: What is your caste?

1.SC ☐
2.ST ☐
3.OBC ☐
4.NT ☐
5.SBC ☐
6.NTDNT ☐
7.Open ☐

7. In what stream are you?

1. BA ☐
2. B.Sc ☐
3. B.Com ☐
4. BBA ☐
5. BCA ☐
6. BE ☐
7. Others ☐

8. Father's educational qualification:

1. Primary ☐
2. Secondary ☐
3. Graduate ☐
4. Post-Graduate. ☐
5. Illiterate. ☐

9. Father's occupation:

1. Govt Servant. ☐
2. Business ☐
3. Private employee. ☐
4. Labour ☐
5. Skilled labour. ☐
6. Unemployed ☐
7. Others ☐

10. Mother's educational qualification:

1. Primary ☐
2. Secondary ☐
3. Graduate ☐
4. Post-Graduate. ☐
5. Illiterate. ☐

11**. Mother's Occupation:**

1. Govt Servant. ☐
2. Business ☐
3. Private employee. ☐
4. Labour ☐
5. Skilled labour. ☐
6. Housewife ☐
7. Unemployed ☐
8. Others ☐

12. No.of family members:

1. 2-4 ☐
2. 5-7 ☐
3. 8 and above ☐

13. Annual Family Income:

1. below 25k ☐
2. 25-50k ☐
3. 50-75k ☐
4. 75-1 lakh ☐
5. 1 lakh and above ☐

14. Per-capita income:.....

15. Type of family:

1. Nuclear ☐
2. Joint. ☐
3. Extended. ☐

15. Marital Status:

1. Single ☐
2. Married ☐
3. Deserted ☐
4. Widow ☐

II. <u>To explores and explain the relationship between health risk behaviour and academic achievement.</u>

1. Do you have a driving license?

1. Yes ☐
2. No ☐

2. From how many years you are driving Motorcycle/car without license?

1.1year ☐
2.more than 1year. ☐

3. Do you ride a motorcycle wearing a helmet during the past 12 months?

5. I did not ride a motorcycle during the past 12 months. ☐
6. Never wore a helmet ☐
7. Rarely wore a helmet ☐
8. Sometimes wore a helmet ☐
9. Most of the time wore a helmet ☐
10. Always wore a helmet ☐

4. When you rode a bicycle during the past 12 months, how often did you wear a helmet?

1. I did not ride a bicycle during the past 12 months ☐
2. Never wore a helmet ☐
3. Rarely wore a helmet ☐
4. Sometimes wore a helmet ☐
5. Most of the time wore a helmet ☐
6. Always ☐

5. How often do you wear a seat belt when riding in a car driven by someone else?

1. Never ☐
2. Rarely ☐
3. Sometimes ☐
4. Most of the time ☐
5. Always ☐

6. During the past 30 days, how many times did you ride in a car or other vehicle driven by someone who had been drinking alcohol?

1. 0 times ☐
2. 1 time ☐
3. 2 or 3 times ☐
4. 4 or 5 times ☐
5. 6 or more times ☐

7. During the past 30 days, how many times did you drive a car or other vehicle when you had been drinking alcohol?

1. 0 times ☐
2. 1 time ☐
3. 2 or 3 times ☐
4. 4 or 5 times ☐
5. 6 or more times ☐

8. During the past 30 days, on how many days did you carry a weapon such as a gun, knife, or club on college property?

1. 0 days ☐
2. 1 day ☐
3. 2 or 3 days ☐
4. 4 or 5 days ☐
5. 6 or more days ☐

9.During the past 30 days, on how many days did you not go to college because you felt you would be unsafe at college or on your way to or from school?

1. 0 days ☐
2. 1 day ☐
3. 2 or 3 days ☐
4. 4 or 5 days ☐
5. 6 or more days ☐

10. During the past 12 months, how many times has someone threatened or injured you with a weapon such as a gun, knife, or club on college property?

1.0 times ☐
2. 1 time ☐
3. 2 or 3 times ☐
4. 4 or 5 times ☐
5. 6 or 7 times ☐
6. 8 or 9 times ☐
7. 10 or 11 times ☐
8. 12or more times ☐

11. During the past 12 months, how many times were you in a physical fight?

1. 0 times ☐
2. 1 time ☐
3. 2 or 3 times ☐
4. 4 or 5 times ☐
5. 6 or 7 times ☐
6. 8 or 9 times ☐
7. 10 or 11 times ☐
8. 12 or more times ☐

12. During the past 12 months, did your boyfriend or girlfriend ever hit, slap, or physically hurt you on purpose?

1. Yes ☐
2. No ☐

13. Have you ever been physically forced to have sexual intercourse when youdid not want to?

1. Yes ☐
2. No ☐
3.

<u>The next few questions ask about bullying. Bullying is when1 or more students tease, threaten, spread rumors about, hit, shove, or hurt another student over and over again. It is not bullying when 2 students of about the same strength or power argue or fight or tease each other in a friendly way.</u>

14. During the past 12 months, have you ever been bullied in college Premises?

1. Yes ☐
2. No ☐

15. During the past 12 months, did you ever feel so sad or hopeless almost every day for two weeks or more in a row that you stopped doing some usual activities?

1. Yes ☐
2. No ☐

16. During the past 12 months, did you ever seriously consider attempting suicide?

1. Yes ☐
2. No ☐

17. Have you ever tried cigarette smoking, even one or two puffs?

1. Yes ☐
2. No ☐

18. How old were you when you smoked a whole cigarette for the first time?

1. I have never smoked a whole cigarette ☐
2. 8 years old or younger ☐
3. 9 or 10 years old ☐
4. 11 or 12 years old ☐
5. 13 or 14 years old ☐
6. 15 or 16 years old ☐
7. 17 years old or older ☐

19. During the past 30 days, on the days you smoked, how many cigarettes did you smoke per day?

1. I did not smoke cigarettes during the past 30 days ☐
2. Less than 1 cigarette per day ☐
3. 1 cigarette per day ☐
4. 2 to 5 cigarettes per day ☐
5. 6 to 10 cigarettes per day ☐
6. 11 to 20 cigarettes per day ☐
7. More than 20 cigarettes per day ☐

20. During the past 30 days, on how many days did you smoke cigarettes on school property?

1. 0 days ☐
2. 1 or 2 days ☐
3. 3 to 5 days ☐
4. 6 to 9 days ☐
5. 10 to 19 days ☐
6. 20 to 29 days ☐
7. All 30 days ☐

21. Have you ever smoked cigarettes daily, that is, at least one cigarette every day for 30 days?

1. Yes ☐
2. No ☐

22. During the past 12 months, did you ever try to quit smoking cigarettes?

1. I did not smoke during the past 12 months ☐
2. Yes ☐
3. No ☐

23. During the past 30 days, on how many days did you use chewing tobacco, snuff, or dip, such as Redman, Levi Garrett, Beechnut, Skoal, Skoal Bandits, or Copenhagen?

1. 0 days ☐
2. 1 or 2 days ☐
3. 3 to 5 days ☐
4. 6 to 9 days ☐
5. 10 to 19 days ☐
6. 20 to 29 days ☐
7. All 30 days ☐

24. During the past 30 days, on how many days did you use chewing tobacco, snuff, or dip on school property

1. 0 days ☐
2. 1 or 2 days ☐
3. 3 to 5 days ☐
4. 6 to 9 days ☐
5. 10 to 19 days ☐
6. 20 to 29 days ☐
7. All 30 days ☐

25. During your life, on how many days have you had at least one drink of alcohol?

1. 0 days ☐
2. 1 or 2 days ☐
3. 3 to 9 days ☐
4. 10 to 19 days ☐
5. 20 to 39 days ☐
6. 40 to 99 days ☐
7. 100 or more days ☐

26. How old were you when you had your first drink of alcohol other than a few sips?

1. I have never had a drink of alcohol other than a few sips ☐
2. 8 years old or younger ☐
3. 9 or 10 years old ☐
4. 11 or 12 years old ☐

27. During 30 days on how many days did you have at least one drink of alcohol?

1. 0 days ☐
2. 1 or 2 days ☐
3. 3 to 5 days ☐
4. 6 to 9 days ☐
5. 10 to 19 days ☐
6. 20 to 29 days ☐
7. All 30 days ☐

28. During your life, how many times have you used any form of cocaine, including powder, crack, or freebase?

1. 0 times ☐
2. 1 or 2 times ☐
3. 3 to 9 times ☐
4. 10 to 19 times ☐
5. 20 to 39 times ☐
6. 40 or more times ☐

29. During your life, how many times have you used a needle to inject any illegal drug into your body?

1. 0 times ☐
2. 1 time ☐
3. 2 or more times ☐

30. During the past 12 months, has anyone offered, sold, or given you an illegal drug on school property?

1. Yes ☐
2. No ☐

31. Have you ever had sexual intercourse?

1. Yes ☐
2. No ☐

32. How old were you when you had sexual intercourse for the first time?

1. I have never had sexual intercourse ☐
2. 11 years old or younger ☐
3. 12 years old ☐
4. 13 years old ☐
5. 14 years old ☐
6. 15 years old ☐
7. 16 years old ☐
8. 17 years old or older ☐

33. Did you drink alcohol or use drugs before you had sexual intercourse the last time?

1. I have never had sexual intercourse ☐
2. Yes ☐
3. No ☐

34. During the past 7 days, how many times did you drink 100% fruit juices such as orange juice, apple juice, or grape juice? (Do not count punch, Kool-Aid, sports drinks, or other fruit-flavored drinks

1. I did not drink 100% fruit juice during the past 7 days ☐
2. 1 to 3 times during the past 7 days ☐
3. 4 to 6 times during the past 7 days ☐
4. 1 time per day ☐
5. 2 times per day ☐
6. 3 times per day ☐
7. 4 or more times per day ☐

35. During the past 7 days, how many times did you eat fruit? (Do not count fruit juice.)

1. I did not eat fruit during the past 7 days ☐
2. 1 to 3 times during the past 7 days ☐
3. 4 to 6 times during the past 7 days ☐
4. 1 time per day ☐
5. 2 times per day ☐
6. 3 times per day ☐
7. 4 or more times per day ☐

36. During the past 7 days, how many times did you eat green salad?

1. I did not eat green salad during the past 7 days ☐
2. 1 to 3 times during the past 7 days ☐
3. 4 to 6 times during the past 7 days ☐
4. 1 time per day ☐
5. 2 times per day ☐
6. 3 times per day ☐
7. 4 or more times per day ☐

37. On how many of the past 7 days did you exercise or participate in physical activity for at least 20 minutes that made you sweat and breathe hard, such as basketball, soccer, running, swimming laps, fast bicycling, fast dancing, or similar aerobic activities?

1. 0 days ☐
2. 1 day ☐
3. 2 days ☐
4. 3 days ☐
5. 4 days ☐
6. 5 days ☐
7. 6 days ☐
8. 7 days ☐

38. On how many of the past 7 days did you participate in physical activity for at least 30 minutes that did not make you sweat or breathe hard, such as fast walking, slow bicycling, skating, pushing a lawn mower, or mopping floors?

1. 0 days ☐
2. 1 day ☐
3. 2 days ☐
4. 3 days ☐
5. 4 days ☐
6. 5 days ☐
7. 6 days ☐
8. 7 days ☐

39. On an average school day, how many hours do you watch TV?

1 I do not watch TV on an average College day ☐
2. Less than 1 hour per day ☐
3. 1 hour per day ☐
4. 2 hours per day ☐
5. 3 hours per day ☐
6. 4 hours per day ☐
7. 5 or more hours per day ☐

40. On an average college day, how many hours do you play video or computer games or use a computer for something that is not school work?

1.I do not play video or computer games or use a computer for something that is not College work ☐

2. Less than 1 hour per day ☐

3. 1 hour per day ☐

4. 2 hours per day ☐

5. 3 hours per day ☐

6. 4 hours per day ☐

7. 5 or more hours per day ☐

41. On an average in night, how many hours of sleep do you get?

1. 4 or less hours ☐
2. 5 hours ☐
3. 6 hours ☐
4. 7 hours ☐
5. 8 hours ☐
6. 9 hours ☐
7. 10 or more hours ☐

III. Academic Achievements:

42. During the past 12 months, how would you describe your grades in college?

1 Mostly A's ☐
2. Mostly B's ☐
3. Mostly C's ☐
4. Mostly D's ☐
5. Mostly F's ☐
6. None of these grades ☐
7. Not sure ☐

43. Academic track record:

1.Percentage in 10th STD:……
2.Percentage in 12th STD:……
3. Last year percentage:…….
4. Last semester percentage:……
5. Diffrence in percentage (last year – present year):……

44. Have you received any academic awards?

1. Yes ☐
2. No ☐

45. Do you study daily?

1. Yes ☐
2. No ☐

45. How many hours do you study daily?

1. Daily 1to 2 hour ☐
2.3 to4 hours ☐
3.5 to 6 hours. ☐
4. More than 6 hours ☐

46. Do you attain the college periods regularly?

1. Yes ☐
2. No ☐

47. What are the reasons you miss the periods?

1. Not interested in subject. ☐
2. Do not understand the teaching. ☐
3. Friends force to bang the class. ☐
4. Due to sickness. ☐
5. Due to work at house. ☐
6. Work at some place. ☐
7. I don't miss the period. ☐

48. Do you spend any time in library?

1. Yes. ☐
2. No. ☐

49. How many hours due you spend in reading room?

1.1 to 2 hours. ☐
2. 3 to 4 hours. ☐
3. More than 4 hour.

50. Give your marks of last three examinations.

1.
2.
3.

51. What is your way of preparing for examination?

.....
.....
.....
.....
.....

52.which subject you like the most ?

…….....

53. Why you like the subject most ?

.....
.....
.....

54.which subject hate most?

.....
.....
.....

55.why you hate the subject?

.....
.....
.....

56. Can you concentrate in your studies ?

1. yes ☐
2 . No ☐

57. If no give reason?

.....
.....
.....
.....

58. When is best time you feel to study?

1.
2.
3.
4.
5.

59. What mostly interrupt in you studies?

1. Family members. ☐
2. Friends ☐
3. Girlfriend/boy friend ☐
4. Fear about examination. ☐
5. Illness. ☐
6. Teachers. ☐
7. If any other please specify ☐

:.....
.....
.....

60. What motivates more for your studies?

1. Family members. ☐
2. Friends ☐
3. Girlfriend/boy friend ☐
4. Fear about examination. ☐
5. Illness. ☐
6. Teachers ☐
7. if any other please specify ☐

:.....
.....
.....

61. What is your motive to achieve high percentage in examination?

.....
.....
.....

62. Do you think that higher percentage of marks is most needed?

1. Yes ☐
2. No. ☐

63. Do you have pressure on you to achieve more percentage in examination?

1. Yes ☐
2. No. ☐

64. If yes who pressurise you the most?

1. Family members. ☐
2. Friends ☐
3. Girlfriend/boy friend ☐
4. Teachers ☐
5. If any other please specify ☐

:.....
.....
.....

65. Do you think getting less percentage is stigma in society?

1. Yes ☐
2. No. ☐

66. Do you think that can sports/health fitness and study examination go hand in hand?

1. Yes ☐
2. No. ☐

67. If yes how?

.....
.....
.....
.....

68. If No, why?

,.....
.....
.....
.....

69. When is your next examination?

.....
.....

70. How are you preparing for your next examination?

1. Studying daily. ☐
2. Searching for notes. ☐
3. Discussing the topics with teachers. ☐
4. Concentrating in class room teaching. ☐
5. Not yet thought of examination. ☐

71. What are your future carriers aims?

.....
.....
.....
.....

72. How much percentage will be required you think to achieve this aim?

1. 50 to 60 ☐
2. 60 to 70 ☐
3. 70 to 80 ☐
4. 80 and above ☐
5. Less than 50. ☐

73. Do you ever compare your academic achievements with your friends?

1. Yes ☐
2. No ☐

74. Do your parents compare your academic achievements with your friends?

1. Yes ☐
2. No ☐