

“EFFECTIVENESS OF VIDEO-ASSISTED TEACHING ON KNOWLEDGE AND PRACTICE REGARDING LIFESTYLE DISEASE RISK BEHAVIOURS AMONG ADOLESCENTS”

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ABSTRACT

BACKGROUND: Lifestyle diseases are increasing among adolescents due to unhealthy behavior such as poor diet, lack of physical activity and other risk practices. Adolescence is a crucial period for developing lifelong habits and inadequate knowledge may increase the risk of future health problems. Educational interventions like video-assisted teaching can effectively improve awareness and promote healthy practices. Therefore, it is important to check the strength of such instruction methods in improving Learning and practice regarding lifestyle disease risk behavior.

OBJECTIVE OF THE STUDY ARE TO: To assess the pre-test knowledge and practice of risk behaviour towards life style disease among adolescents in selected collage of Belagavi.

To assess the effectiveness of video assisted teaching on knowledge and practice of risk behaviour towards life style disease.

To compare knowledge and practice of risk behaviour.

To find out the association between pretest knowledge score of risk behaviour towards life style disease with selected sociodemographic variables.

METHODOLOGY: The study adopted a pre-experimental one group pre-test and post-test design. A total of 180 adolescents from selected college of Belagavi were selected using a non-probability convenient Sampling procedure. Data were obtained using a structured socio-demographic questionnaire, knowledge questionnaire, and practice scale. After direct the pre-test, visual - approved teaching was conducted a post-test after that. Descriptive statistics (frequency and percent) and inferential statistics (Wilcoxon signed-rank test, Chi-square test) were used to evaluate the data.

RESULTS: The findings showed that most adolescents were 17 years old (66.1%), male (73.3%), and belonged to middle-income families (40.6%). In the pre-test, the majority had average knowledge (73.3%) and average practice (61.7%), with some showing poor levels. After the intervention, 100% of participants achieved good knowledge, and 83.3% demonstrated good practice, indicating significant improvement.

The statistical analysis revealed a significant development in knowledge ($Z = -11.664, p < 0.05$) and practice ($Z = -10.381, p < 0.05$) after the intervention. Among socio-demographic variables, religion showed a significant association with both knowledge and practice, while other variables did not show significant association ($p > 0.05$).

CONCLUSION: The study concluded that audio-visual teaching method was highly effective in increasing knowledge and practice regarding lifestyle disease risk behavior among adolescents. Although most socio-demographic variables were not significantly associated, religion showed a significant relationship. The findings highlight the importance of health education programs in promoting healthy lifestyles and preventing lifestyle diseases among adolescents.

KEYWORDS: Lifestyle Diseases, Adolescents, Video-Assisted Teaching, Knowledge, Practice, Health Education

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INTRODUCTION

Chronic disease is strongly influenced by lifestyle risk behavior, such as smoking, drinking alcohol, eating poorly, not exercising, getting little to no sleep, and using screens for leisure. These habits frequently start to appear in adolescence.¹

Preventive practices can help avoid oral illnesses. The preventive aspect has an educational component. A preventative program's success is largely dependent on health education. Health education has long been seen as a key instrument for raising awareness, encouraging healthy lifestyle choices, and improving quality of life.²

Non-communicable diseases such as diabetes, infectious diseases, and cardiovascular ailments are becoming more prevalent worldwide. Inadequate health information among the populace is thought to be the cause of poor health, which raises morbidity and mortality.³

Obese children and adolescents, particularly those in the higher BMI percentages, are more probable to be obese adults, according to the majority of research. Obesity can have negative health effects in early life, although the longer a person remains fat, the higher their risk of developing adult health issues. The risks of adult diabetes and heart disease in adults are roughly tripled and five times increased, respectively, by a high adolescent BMI. One of the most dangerous side effects of childhood obesity is type 2 diabetes.⁴

The World Health Organization defines teenage years as the period between the ages of 10 and 19. It is a crucial time for growth and development. Adolescents make up a significant section of the population worldwide, and in India, they make up around one-fifth of the population as a whole. Despite being regarded to be a generally healthy age group, avoidable factors, especially those pertaining to diet and lifestyle, account for a sizable portion of adolescent mortality and morbidity. Adolescent nutritional status has a significant impact on both current and future health. Frequent junk food consumption and inadequate nutritional intake are examples of poor dietary habits that might hinder long-term health, cognitive function, and physical growth. Adolescent girls who are overweight or obese are particularly at risk for diabetes, high blood pressure, and intergenerational overweight in the future. Adolescence, on the other hand, provides a great chance for catch-up growth, addressing past nutritional inadequacies, and forming lifetime healthy eating habits. In light of this, agencies like UNICEF back policies and initiatives in India that enhance adolescent nutrition, encourage wholesome food choices, promote physical activity, and fend off diseases like anemia. Therefore, addressing nutrition for adolescents is crucial to creating a healthy population today and averting health issues in the future.⁵

n between the ages of 10 and 19, adolescence is a

time of rapid mental, substantial, and social growth that marks the transition from childhood to adulthood. With around one-fifth of India's population being adolescents, they make up a sizable section of the population and are an essential human source for the country's future. Developing a healthy society requires ensuring their entire growth. Risk factors linked to lifestyle choices, such as poor eating habits, sedentary lifestyles, alcohol and tobacco use, obesity, and high blood pressure, have been more prevalent among youth in recent years. These habits, which are frequently picked up throughout adolescence, are closely linked to the early development of non-communicable diseases including diabetes and hypertension. Even though most people are aware of the negative effects of alcohol and tobacco, many teenagers start using these substances because of peer pressure and false beliefs about acceptance. The past few years there has been an increase in the frequency of risk factors associated with lifestyle choices among young

A huge worldwide medical, cultural, and economic crisis, the COVID-19 epidemic has drastically altered daily life. Lockdowns, physical separation, and quarantine are examples of measures that have upset regular routines, resulting in harmful lifestyle choices like less exercise, poor eating habits, more screen time, sleep problems, and elevated anxiety, depression, and stress levels. A greater exposure to risk variables related to non-communicable illnesses (NCDs), which are strongly associated with higher rates of morbidity and mortality, has resulted from these developments. Children and teenagers are more susceptible to the immediate and long-term consequences of these changes in lifestyle. The necessity for preventative measures in younger ages is highlighted by the fact that early exposure to hazardous behavior might raise the likelihood of obesity, metabolic illnesses, and mental health issues. In addition to lowering the risk of NCDs, encouraging healthy habits during and after the global epidemic is crucial for boosting immunity and lessening the seriousness of infectious disorders like COVID-19. In addition to outlining important issues and potential prevention strategies, this review concentrates on the most recent data on how pandemic-related lifestyle modifications—such as poor eating habits, sedentary behaviour, excessive screen time, sleep deprivation, and mental health issues—affect children's and adolescents' risk of developing noncommunicable diseases.⁸

THE OBJECTIVES OF THE STUDY ARE:

To assess the pre-test knowledge and practice of risk behaviour towards life style disease among adolescents in selected collage of Belagavi.

To assess the effectiveness of video assisted teaching on knowledge and practice of risk behaviour towards life style disease.

To compare knowledge and practice of risk

behaviour

To find out the associate between pretest knowledge score of risk behaviour towards life style disease with selected sociodemographic variables

MATERIALS AND METHODS

This study utilizes a quantitative research approach with a one-group pre-test and post-test pre-experimental research design to evaluate the effectiveness of video-assisted teaching on knowledge and practice regarding risk behaviour towards lifestyle diseases among adolescents studying in selected colleges of Belagavi, Karnataka. A total of 180 adolescents aged 16–18 years who meet the inclusion criteria are recruited through a non-probability convenience sampling technique. Data are collected using a structured socio-demographic questionnaire, a structured knowledge questionnaire on risk behaviour towards lifestyle diseases, and a practice assessment scale. The study methodology begins with a baseline assessment through a pre-test to evaluate the existing knowledge and practice of adolescents regarding risk behaviours associated with lifestyle diseases. This is followed by the administration of video-assisted teaching as an educational intervention. Subsequently, a post-test is conducted using the same instruments to assess the effectiveness of the intervention. The independent variable is video-assisted teaching on risk behaviour towards lifestyle diseases, while the dependent

Table 1 Distribution of adolescents in selected collage of Belagavi by socio demographic variable

		n	%
Age	16	27	15.0
	17	119	66.1
	18	34	18.9
Gender	Male	132	73.3

	Female	48	26.7
Religion	Hindu	113	62.8
	Muslim	67	37.2

variables are knowledge and practice regarding risk behaviour towards lifestyle diseases among adolescents. Data are analysed

using descriptive statistics such as frequency, percentage, mean, and standard deviation, and inferential statistics including paired t-test to determine the effectiveness of the intervention and chi-square test to identify the association between selected socio-demographic variables and levels of knowledge and practice regarding risk behaviour towards lifestyle diseases.

- Prior permission will be obtained from the college authority.

- Consent will be taken from individual participants.

Eligibility criteria

INCLUSION CRITERIA:

- Adolescents studying in selected colleges of Belagavi.
- Adolescents aged between 16–18 years
- Adolescents who are open to taking part in the research.
- Adolescents who are present during the time of data collection.

EXCLUSION CRITERIA:

teenagers who refuse to take part in the research.

teenagers who were not there when the data was being collected.

RESULTS

	Christian	0	0.0
	Other	0	0.0
Monthly income	<10000	67	37.2

family of	10000-20000	73	40.6
	>25000	40	22.2
Area of residence	Rural	82	45.6
	Urban	98	54.4
Educational status of person	No formal education	0	0.0
	Primary	0	0.0
	High school	0	0.0
	PUC	180	100.0
TYPE OF FAMILY	Joint family	93	51.7
	Nuclear family	87	48.3
Diatry pattern	Mixed diet	121	67.2
	Vegetarian	59	32.8

fewer being 18 (18.9%) and 16 (15.0%). There was a gender imbalance as the majority of participants (73.3%) were men.

Regarding religion, the majority were Hindus (62.8%) and Muslims (37.2%). In terms of financial standing, the majority (40.6%) fell into the ₹10,000–20,000 income range, indicating a middle-class upbringing. The proportion of participants from urban areas slightly

higher than that from rural areas (54.4%). 100% of the teenagers were enrolled in PUC, guaranteeing consistency in their educational standing. The distribution of family types was nearly equal, with joint families slightly predominating (51.7%). Fathers were primarily employed in the private sector (38.9%), followed by other occupations and government jobs, and the majority had a mixed diet (67.2%).

Table 1 The results show a mid-adolescent preponderance, with the majority of teenagers being 17 years old (66.1%) and Table 2 Assessment of the knowledge of risk disease

occupation of the father	Government	50	27.8
	Private	70	38.9
	Other	60	33.3

pre-test & posttest behaviour towards life style

Knowledge		n	%
Pre test	Poor	28	15.6

Post test	Average	132	73.3
	Good	20	11.1
	Poor	0	0.0
	Average	0	0.0
	Good	180	100.0
	Poor	0	0.0

Table 2 Prior to the intervention, 73.3% of teenagers had average knowledge, 15.6% had bad knowledge, and just 11.1% had good knowledge, suggesting a widespread lack of sufficient understanding on lifestyle behaviors that increase the risk of disease. There was a total change following the video-assisted instruction, with all participants achieving good knowledge and none staying in the poor or mediocre categories. This indicates that the intervention was quite successful in raising knowledge levels.

Table 3 Assessment of the pre-test & post test practice of risk behavior towards life style disease

Practice		n	%
Pre test	Poor	49	27.2
	Average	111	61.7
	Good	20	11.1
Post test	Poor	0	0.0
	Average	30	16.7
	Good	150	83.3
	Poor	0	0.0

Table 3 In the pre-test, the majority of teenagers exhibited average practice (61.7%), a sizable percentage had poor practice (27.2%), and just 11.1% showed good practice, indicating less-than-ideal health behavior. Following the intervention, there was a notable improvement, with 83.3% of individuals showing good practice and the

remaining 16.7% showing average practice; none of the participants fell into the poor category. This suggests that the intervention had a good impact on behavioural practices in addition to increasing knowledge.

Table 4 Assess the effectiveness of video assisted teaching on knowledge of risk behaviour towards life style disease.

	Median	IQR	Z	Sig.
Pre test	15.00	2.00	-11.664	<0.05*
Post test	23.00	3.00		

*<0.05 significance is obtained by Wilcoxon sign rank test

Table 4 In the pre-test, the median knowledge score was 15.00 (IQR = 2.00); in the post-test, it was 23.00 (IQR = 3.00). A statistically significant difference was revealed by the Wilcoxon signed-rank test ($Z = -11.664$, $p < 0.05$). This demonstrates that the video-assisted instruction was quite successful in raising awareness of lifestyle disease risk behavior.

Table 5 Assess the effectiveness of video assisted teaching practice of risk behaviour towards life style disease

	Median	IQR	Z	Sig.
Pre test	10.50	4.00	-10.381	<0.05*
Post test	15.00	1.00		

*<0.05 significance is obtained by Wilcoxon sign rank test

Table 5 Between the pre-test and the post-test, the median practice score increased from 10.50 (IQR = 4.00) to 15.00 (IQR = 1.00). The intervention was successful in improving healthy behavior among teenagers, as seen by the statistically significant difference ($Z = -10.381$, $p < 0.05$).

Table 6 Association between level of knowledge of of risk behaviour towards life style disease and socio demographic characteristics

		Poor		Average		Good		Chi-square (sig.)
		n	%	n	%	n	%	
Age	16	6	22.2	19	70.4	2	7.4	4.450 (0.339)
	17	18	15.1	90	75.6	11	9.2	
	18	4	11.8	23	67.6	7	20.6	
Gender	Male	23	17.4	93	70.5	16	12.1	1.892 (0.371)
	Female	5	10.4	39	81.3	4	8.3	

Religion	Hindu	20	17.7	86	76.1	7	6.2	7.430 (0.025)*
	Muslim	8	11.9	46	68.7	13	19.4	
	Christian	0	0.0	0	0.0	0	0.0	
	Other	0	0.0	0	0.0	0	0.0	
Monthly income of family	<10000	10	14.9	51	76.1	6	9.0	1.552 (0.824)
	10000-20000	10	13.7	54	74.0	9	12.3	
	>25000	8	20.0	27	67.5	5	12.5	
Area of residence	Rural	13	15.9	62	75.6	7	8.5	1.000 (0.629)
	Urban	15	15.3	70	71.4	13	13.3	

Educational status of person	No formal education	0	0.0	0	0.0	0	0.0	-
	Primary	0	0.0	0	0.0	0	0.0	
	High school	0	0.0	0	0.0	0	0.0	
	PUC	28	15.6	132	73.3	20	11.1	
Type of family	Joint family	18	19.4	65	69.9	10	10.8	2.112 (0.359)
	Nuclear family	10	11.5	67	77.0	10	11.5	
Dietary pattern	Mixed diet	16	13.2	93	76.9	12	9.9	2.513 (0.299)
	Vegetarian	12	20.3	39	66.1	8	13.6	
occupation of the father	Government	10	20.0	35	70.0	5	10.0	2.378 (0.681)
	Private	10	14.3	54	77.1	6	8.6	
	Other	8	13.3	43	71.7	9	15.0	

*<0.05 significance is obtained by fisher exact test

Table 6: There is a statistically significant correlation ($\chi^2 = 7.430$, $p = 0.025$) between knowledge of lifestyle disease risk behavior and certain sociodemographic characteristics. While a comparatively higher percentage of Muslims had good knowledge (19.4%), the majority of Hindus had average knowledge (76.1%), with fewer having good knowledge (6.2%). This suggests that religious groups' levels of understanding varied considerably.

On the other hand, teenagers who were 18 years old showed a relatively greater percentage of good knowledge (20.6%) than those who were 16 and 17 years old, but age did not exhibit a significant correlation ($p = 0.339$). Similarly, whereas females had slightly greater average knowledge (81.3%) than males (70.5%), gender was not significantly linked ($p = 0.371$).

Furthermore, despite slight differences in the

Table 7 Association between level of practice of risk behaviour towards life style disease and socio demographic characteristics

		Poor		Average		Good		Chi-square (sig.)
		n	%	n	%	n	%	
Age	16	6	22.2	19	70.4	2	7.4	2.915 (0.574)
	17	18	15.1	90	75.6	11	9.2	
	18	4	11.8	23	67.6	7	20.6	
Gender	Male	23	17.4	93	70.5	16	12.1	2.740 (0.259)
	Female	5	10.4	39	81.3	4	8.3	
Religion	Hindu	20	17.7	86	76.1	7	6.2	8.658 (0.013) *
	Muslim	8	11.9	46	68.7	13	19.4	
	Christian	0	0.0	0	0.0	0	0.0	
	Other	0	0.0	0	0.0	0	0.0	

distribution of knowledge among income groups, monthly family income ($p = 0.824$) did not exhibit any significant connection. Knowledge was similarly unaffected by home area ($p = 0.629$), with identical trends observed in both rural and urban teenagers.

Adolescents from nuclear families showed somewhat greater average knowledge (77.0%) than those from joint households (69.9%) when it came to family type ($p = 0.359$), but the difference was not statistically significant. Additionally, there was no significant correlation between knowledge levels and father's occupation ($p = 0.681$) or dietary pattern ($p = 0.299$).

Overall, none of the sociodemographic factors—aside from religion—had a statistically significant impact on knowledge, suggesting that the baseline knowledge levels were largely unaffected by these variables.

Monthly income of family	<10000	10	14.9	51	76.1	6	9.0	8.427 (0.074)
	10000 - 20000	10	13.7	54	74.0	9	12.3	
	>25000	8	20.0	27	67.5	5	12.5	
Area of residence	Rural	13	15.9	62	75.6	7	8.5	2.011 (0.396)
	Urban	15	15.3	70	71.4	13	13.3	
Educational status of person	No formal education	0	0.0	0	0.0	0	0.0	-
	Primary	0	0.0	0	0.0	0	0.0	
	High school	0	0.0	0	0.0	0	0.0	
	PUC	28	15.6	132	73.3	20	11.1	
Type of family	Joint family	18	19.4	65	69.9	10	10.8	0.649 (0.737)
	Nuclear family	10	11.5	67	77.0	10	11.5	
Dietary pattern	Mixed diet	16	13.2	93	76.9	12	9.9	1.119 (0.5)

	Vegetarian	12	20	39	66	8	13	92)
			.3		.1		.6	
occupation of the father	Government	10	20	35	70	5	10	2.48
	Private	10	14	54	77	6	8.6	9
	Other	8	13	43	71	9	15	(0.655)
			.3		.7		.0	

<0.05 significance is obtained by fisher exact test
 Table 7 Religion and practice levels are substantially correlated, according to the association analysis ($\chi^2 = 8.658$, $p = 0.013$). The percentage of Muslims who exhibited good practice was higher (19.4%) than that of Hindus (6.2%), suggesting that religious groups differ significantly in their behavioral habits. Although teenagers aged

18 years had comparatively greater practice (20.6% good practice) compared to lower age groups, age was not statistically linked ($p = 0.574$). Although females had a slightly greater percentage of average practice (81.3%) than males (70.5%), gender also did not demonstrate any significant association ($p = 0.259$). Similarly, although it was close to significance, monthly family income ($p = 0.074$) did not exhibit a statistically significant link, indicating a potential trend where income might affect practice. There was no discernible difference between teenagers living in rural and urban areas ($p = 0.396$). Furthermore, despite minor differences in percentages, father's occupation ($p = 0.655$), food pattern ($p = 0.592$), and family type ($p = 0.737$) were not significantly correlated with practice levels.

Overall, religion was the only factor that was strongly correlated with practice, much like knowledge; all other sociodemographic factors did not have a statistically significant relationship.

		n	%
Age	16	27	15.0
	17	119	66.1
	18	34	18.9
Gender	Male	132	73.3
	Female	48	26.7
Religion	Hindu	113	62.8
	Muslim	67	37.2
	Christian	0	0.0

	Other	0	0.0
Monthly income of family	<10000	67	37.2
	10000-20000	73	40.6
	>25000	40	22.2
Area of residence	Rural	82	45.6
	Urban	98	54.4
Educational status of person	No formal education	0	0.0
	Primary	0	0.0
	High school	0	0.0
	PUC	180	100.0
TYPE OF FAMILY	Joint family	93	51.7
	Nuclear family	87	48.3
Diatry pattern	Mixed diet	121	67.2
	Vegetarian	59	32.8
occupation of the father	Government	50	27.8
	Private	70	38.9
	Other	60	33.3

DISCUSSION

This study demonstrated that video-assisted teaching was highly effective in improving knowledge and practice regarding risk behaviour towards

lifestyle diseases among adolescents studying in selected colleges of Belagavi. Prior to the intervention, the majority of adolescents had average knowledge and practice levels, indicating inadequate awareness and adoption of healthy lifestyle behaviours. Following the video-assisted teaching programme, all participants achieved good knowledge levels, and a substantial improvement was observed in practice scores, confirming the effectiveness of the educational intervention.

The median knowledge score increased significantly

from 15.00 (IQR = 2.00) in the pre-test to 23.00 (IQR = 3.00) in the post-test ($Z = -11.664$, $p < 0.05$). Similarly, the median practice score improved significantly from 10.50 (IQR = 4.00) to 15.00 (IQR = 1.00) ($Z = -10.381$, $p < 0.05$). These findings indicate that video-assisted teaching is an effective strategy for enhancing adolescents' understanding and adoption of behaviours that prevent lifestyle diseases.

Most socio-demographic variables, including age, gender, monthly family income, area of residence, family type, dietary pattern, and father's occupation, were not significantly associated with knowledge

and practice levels. However, religion showed a statistically significant association with both knowledge ($\chi^2 = 7.430$, $p = 0.025$) and practice ($\chi^2 = 8.658$, $p = 0.013$), suggesting that cultural and social factors may influence adolescents' health-related awareness and behaviours.

The findings are consistent with previous studies that reported significant improvements in knowledge and practice following video-assisted teaching programmes among adolescents. Similar studies have demonstrated that audiovisual educational interventions enhance understanding, retention of information, and positive behavioural changes related to healthy lifestyle practices and prevention of non-communicable diseases.

In conclusion, video-assisted teaching is an effective educational method for improving knowledge and practice regarding risk behaviour towards lifestyle diseases among adolescents. The findings highlight the importance of incorporating structured health education programmes in colleges to promote healthy lifestyles and reduce future risk of lifestyle-related diseases. Further studies with larger samples and longer follow-up periods are recommended to assess the long-term sustainability of these behavioural change

CONCLUSION

The present study concluded that video-assisted teaching was highly effective in improving knowledge and practice regarding risk behaviour towards lifestyle diseases among adolescents

studying in selected colleges of Belagavi. Significant improvements were observed in both knowledge and practice scores following the educational intervention. Religion was the only socio-demographic variable found to have a significant association with knowledge and practice levels, while age, gender, income, residence, family type, dietary pattern, and father's occupation showed no significant association. These findings suggest that video-assisted teaching is an effective educational strategy for promoting awareness and healthy behavioural practices among adolescents. Therefore, incorporating structured video-based health education programmes in colleges may help reduce risk behaviours and contribute to the prevention of lifestyle-related diseases among adolescents.

LIMITATIONS AND FUTURE RECOMMENDATIONS

The study was conducted among adolescents from selected colleges of Belagavi, which may limit the generalizability of the findings to adolescents in other settings. The one-group pre-test and post-test design did not include a control group, limiting the ability to establish causal relationships. The study assessed knowledge and practice immediately after the intervention, and long-term retention of knowledge and behavioural changes were not evaluated. Future research should involve larger samples, include control groups, and conduct follow-up assessments to determine the sustained effectiveness of video-assisted teaching. Comparative studies evaluating different educational interventions and multicentre studies involving adolescents from diverse backgrounds are also recommended to further strengthen the evidence regarding lifestyle disease prevention among adolescents.

REFERENCES

1. Teesson M, Champion KE, Newton NC, Kay-Lambkin F, Chapman C, Thornton L, Slade T, Sunderland M, Mills K, Gardner LA, Parmenter B. Study protocol of the Health4Life initiative: a cluster randomized controlled trial of an eHealth school-based program targeting multiple lifestyle risk behavior among young Australians. *BMJ open*. 2020 Jul 1;10(7):e0356
2. Shah N, Mathur VP, Kathuria V, Gupta T. Effectiveness of an educational video in improving oral health knowledge in a hospital setting. *Indian Journal of Dentistry*. 2016 Apr;7(2):70.
3. Jawed S, Tariq S, Jamil Z, Ali R, Rehman R. Life style practices and health risk behavior of medical students: across sectional study. *Journal of Bahria University Medical and Dental College*. 2018;8(4):231-5
4. Golden NH, Schneider M, Wood C, Daniels S, Abrams S, Corkins M, De Ferranti S, Magge SN, Schwarzenberg S, Braverman PK, Adelman W. Preventing obesity and eating disorders in adolescents. *Paediatrics*. 2016 Sep 1;138(3).
5. Fera M, Laxmanbhai M. Issue 2 www.jetir.org (ISSN-2349-5162).
6. JETIR2502056 *Journal of Emerging Technologies and Innovative Research* [Internet]. 2025 [cited 2026 Feb 9];12. Available from: <https://www.jetir.org/papers/JETIR2502056.pdf>
7. Morgado M, Botelho J, Machado V, Mendes JJ, Olusola Adesope, Luís Proença. Full title: Video-based approaches in health education: a systematic review and meta-analysis. *Scientific Reports*. 2024 Oct 10;14(1)
8. Mahmood SE, Bilal Khan KM, Agrawal AK. Study of lifestyle disease risk factors among school going adolescents of urban Bareilly, Uttar Pradesh, India. *International Journal of Community Medicine and Public Health*. 2017 Jan 25;4(2):516.
9. Moran J, Sandercock G, Shaw BS, Freeman P, Kerr C, Shaw I. The relationship between modifiable lifestyle behavior and self-reported health in children and adolescents in the United Kingdom. Ajidahun A, editor. *PLOS ONE*. 2024 May 16;19(5): e0303575.