Knowledge, attitude, and behaviours on diet, physical activity, and tobacco use among school students: A cross-sectional study in two Indian states [version 1; peer review: 1 approved with reservations]

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Abstract
Background: Non-communicable diseases (NCDs) are escalating in India and can be attributed to behavioural risk factors such as unhealthy diet, physical inactivity and tobacco use that began in early years. Understanding adolescents' knowledge, attitudes and behaviours (KAB) related to NCD risk factors would inform the development of school-based health programmes to prevent NCDs.
Methods: Sixth-grade students (n=1026) in 20 schools (10 private, 10 public) from two Indian cities (n=667 from Pune; n=359 from Bengaluru) participated in a KAB survey in 2019. Differences in KAB by gender, school type within cities were investigated.
Results: Knowledge about the harms of tobacco use was higher than knowledge about a healthy diet and the importance of physical activity. Only a small proportion of students did not eat breakfast (8.7%) or fruits (11.3%) daily. Only 33.4% of students read nutrition labels before choosing their food. Moderate-to-vigorous physical activity of less than an hour per day was reported by 42.5% of students. Approximately one-third of students had ever tried smoking tobacco (30.1%), smokeless tobacco (30.5%), and e-cigarettes (32.4%). Differences in these behaviours by gender and school type showed that both boys, girls and students of private and public schools are
vulnerable.

**Conclusions:** The findings highlight that knowledge is low for thematic areas like diet and physical activity. Low knowledge can be attributed to unfavourable behaviours like lack of reading nutrition labels and indulgence in sedentary activities. To protect India’s young population (adolescents), there is a need to amplify health education activities and context-specific health intervention materials for them by engaging parents and communities. Thus, these programmes should be incorporated into the curriculum as part of the regular teaching, as they may induce positive changes in their knowledge and behaviours. In India, school health programmes should dedicate significant time to health promotion and NCD risk prevention.

**Keywords**
Non-communicable diseases, risk factors, school, children, lifestyle related behaviours, health promotion
Introduction
The rising epidemic of non-communicable diseases (NCDs), such as cardiovascular diseases, cancers, diabetes and chronic respiratory diseases, is recognised as a leading cause of mortality and morbidity across all age groups in India and globally.1 NCDs are responsible for more deaths in India each year than all other causes of death combined.2 In the year 2019, 9.3 million deaths in India were attributed to all cause mortality, of which 6.1 million (64.9%) were due to NCDs.3 Most NCDs are attributable to potentially modifiable behavioural risk factors, including unhealthy diets, physical inactivity, tobacco and alcohol use.4 Synergistic effects of demographic transition, globalisation, and economic growth have resulted in an environment where more children and adolescents are exposed to and/or engage in these behaviours than ever before.5 It is a well-known fact that lifestyle-related behaviours are often formed early and persist throughout life.6,7 Evidence has shown that 70% of premature deaths in adults due to NCDs are associated with risky behaviours that began in childhood.8 Primordial prevention, including community-based intervention to promote healthier lifestyles, is extremely important for national development and to achieve the Sustainable Development Goals by 2030. Investment at an early age can yield a triple dividend of benefits, i.e., improving health later during adolescence, enhancing health throughout the course of life, and eventually contributing to the health of the next generation of children.9 By 2030, India is expected to be the first country in the world to become home to more than 1.5 billion people, and its population is on target to reach 1.7 billion by 2050.10 Thus, protecting and supporting child and adolescent health in this country is paramount not only to India’s overall well-being, but also to global health and economy.

Schools have been widely recognised as an important location for promoting healthy behaviours among children and adolescents.11,12 Incorporating health-based programmes into the school curriculum can substantially influence both health promoting behaviours and educational achievements. The above outcomes can be achieved by providing children and adolescents with adequate knowledge and skills, allowing them to establish healthy attitudes and social norms through such a curriculum.13 Understanding their current knowledge, attitudes and lifestyle-related behaviours would immensely help both the health and education sectors in developing and implementing effective and efficient school-based health lifestyle programmes.

We have developed Project PaTHWay, a three-year, school-based programme (2018-2021), to promote healthier lifestyle practices among children.14,15 The overall objective of the programme is to prevent and control the risk factors of NCDs by delivering a school-based health lifestyle programmes to students from two cities in India. Specifically, the programme aims to addresses key behavioural NCD risk factors, such as unhealthy diet, physical inactivity, and tobacco use among school children. The students followed for three years in the project PaTHWay. The first year of the programme included, baseline knowledge, attitude, and behaviour (KAB) assessment and development of the health education programme based on the KAB assessment. Subsequently, school-based health lifestyle programme is being implemented for two years, followed by endline evaluation. In this paper, we present the baseline KAB of students relevant to these NCD behavioural risk factors, which have helped us develop Project PaTHWay school intervention.

Methods
Study design
A cross-sectional study was conducted during January- March 2019 in schools of Pune and Bengaluru to understand the KAB of school students related to diet, physical activity and tobacco use.

Setting
The programme is being carried out in two cities of India, namely Pune (Maharashtra) and Bengaluru (Karnataka). Pune is situated in Western India, while Bengaluru is situated in Southern India. The number of NCD related deaths in both Maharashtra (70.6%) and Karnataka (72.4%) is higher than the national average of all Indian states (64.9%), across all age groups and both sexes.16 Both Pune and Bengaluru are densely populated and highly urbanised cities. The total population of Pune is 9,429,408, of which there are 4,924,105 males and 4,505,303 females. The average literacy rate is 86.2%.17 Similarly, Bengaluru is home to 9,621,551 individuals, of which there are 5,022,661 males and 4,598,890 females, and the average literacy rate is 87.6%.18

Twenty schools (n = 10 public and n = 10 private) in Pune and Bengaluru were selected to implement Project PaTHWay. These schools were purposely selected to represent different socioeconomic strata (private schools: middle to higher socioeconomic status; public schools: lower socioeconomic status) within the two cities. The selected schools had common characteristics, such as each school having a division of the sixth grade into not more than one to two subsections, availability of playgrounds and equipment for physical activity, and provision of a school meal programme (public schools only).
Participants
Students from these 20 schools, enrolled in the sixth grade (n = 1238; Pune: n = 806; Bengaluru: n = 432) were eligible and invited to participate in the baseline KAB questionnaire administered in 2019. Total sample of 1238 students (Pune: n = 806; Bengaluru: n = 432) were included in the present study.

Instrument and measures
A self-administered, baseline questionnaire was implemented, to assess the students’ KAB related to NCD behavioural risk factors (unhealthy diet, physical inactivity, and tobacco use). The questionnaire included a section on socio-demographic profile of the student on aspects such as age, gender as well as education and occupation of their parents and other section on KAB. The diet related knowledge was measured with six questions, each related to elements of a balanced diet (e.g., How many times per week should one eat breakfast?). Knowledge about physical activity was measured with five questions (e.g., How many minutes of physical activity should people of your age have daily?); and tobacco use knowledge was assessed with 16 questions (e.g., Does using chewing tobacco cause oral cancer?).

The questionnaire also included the behaviours specific to diet (e.g., It is important for me to eat breakfast daily), physical activity (e.g., Taking part in physical activities can help me get better marks at school) and tobacco use (e.g., Using tobacco makes a person appear to be braver and more grown-up) were measured using a 5-point Likert scale - strongly agree, agree, not sure, disagree and strongly disagree. Cronbach alpha was calculated for this construct as the mean score was calculated and presented for attitude towards diet, physical activity, and tobacco use. A higher diet and physical activity score denotes a positive attitude towards a healthy diet and physical activity, indicating lower risk of indulging in risky behaviours. A higher score for tobacco indicates that the adolescents have a less favourable attitude towards tobacco use, indicating a lower risk of tobacco consumption.

Attitudes towards diet (e.g., It is important for me to eat breakfast daily), physical activity (e.g., Taking part in physical activities can help me get better marks at school) and tobacco use (e.g., Using tobacco makes a person appear to be braver and more grown-up) were measured using a 5-point Likert scale - strongly agree, agree, not sure, disagree and strongly disagree. Cronbach alpha was calculated for this construct as the mean score was calculated and presented for attitude towards diet, physical activity, and tobacco use. A higher diet and physical activity score denotes a positive attitude towards a healthy diet and physical activity, indicating lower risk of indulging in risky behaviours. A higher score for tobacco indicates that the adolescents have a less favourable attitude towards tobacco use, indicating a lower risk of tobacco consumption.

This questionnaire was developed based on the socio-ecological model and adapting measures from reliable instruments that have been validated with adolescents in India. Surveys that we referred were, Global Youth Tobacco Survey (GYTS-2010),20 Global Adult Tobacco Survey (GATS-2016-17),21 Project EAT,22 SPAN survey23 and surveys used by the author of this study in previous studies conducted in India.24–26 An English version of the questionnaire was administered in private schools, and Kannada and Marathi versions were administered in public schools in Bengaluru and Pune, respectively. The questionnaire was pre-tested to assess its validity (face and content) and reliability (internal reliability of attitude construct).

For content validity, feedback was obtained from experts (n = 5) from multi-disciplinary field. These national and international experts have more than two decades of experience in psychology, epidemiology, public health and nutrition. Based on their feedback, the sequence of the questions was modified, more relevant questions were incorporated and language edits were made to simplify the questionnaire for students for better comprehension. To assess face validity, focus group discussions were conducted with students (n = 80) of grade six from both cities. These 80 students were selected from two schools in each city (one public and one private). To assess reliability, the questionnaire was administered with another 177 students from both cities. These schools or the students who were involved in face validity and internal reliability were not part of the main study. Based on students' feedback and internal reliability findings, language of the questionnaire was simplified, repeated and offending questions were deleted, options for questions were changed and added, detailed marking instructions were added to the questionnaire. Revised questionnaire was administered by a trained research team of the project. The questionnaire was administered during school hours, using a standardised protocol. Students were given unique identification codes to ensure confidentiality. Copies of the questionnaire in all three languages (English, Marathi, and Kannada) are available in Extended data.

Ethics statement
Permissions for implementation of the study were obtained from the Maharashtra State Board of Secondary and Higher Education and Karnataka Secondary Education Examination Board. We also received permission from authorities at schools, written active informed parental consent, and student assent, indicated by a signature on the consent form. Information sheets were sent from the schools to the parents of all eligible students, wherein details of the study and questionnaire were outlined. The consent stated the permission for data collection, scientific publications, dissemination in conferences by maintaining the confidentiality of the study participants and anonymity of the collected data. Ethical
approval for this study was obtained from the Institutional Ethics Committee of both PHFI (TRC-IEC-373/18) and NIMHANS [NIMHANS/EC (BEH.SC.DIV.)].

**Statistical analysis**

Statistical analyses were performed using STATA Version.13.1 software. The descriptive data were expressed as mean with standard deviation (SD) or proportions (%). A chi-square test was performed to examine differences in the categorical variables by socio-demographic factors (gender, school type). The summary scores for all attitude scales by gender and school type within each city were compared using the t-test. All statistics were analysed through a two-sided test; p-value less than or equal to 0.05 was considered statistically significant. Participants with missing information, parent refusal, student refusal or absenteeism on the day of questionnaire administration were excluded.

**Results**

82.8% of the recruited sample participated in the baseline questionnaire (n = 1026 out of 1238). The reasons for non-participation included absenteeism (n = 112; boys: 67, girls: 45) and parent refusal (n = 100, boys: 54, girls: 46). The final sample size was 1026 (Private: 518 and Public: 508) consisting of 61.1% boys and 55.1% of the sample was from private schools. The mean age of the students recruited for the study was 12.5 ± 0.75 years. The full, de-identified dataset of student responses is available in *Underlying data*.

**Knowledge**

**Diet**

Overall, students’ knowledge about healthy dietary practices was low (Table 1). Many students (67.5%) knew that breakfast was the most important meal of the day. Only a few students (6.8%) knew they should eat at least five servings of fruits and/or vegetables a day. Knowledge about healthy dietary practices was generally highest among girls and private school students. In Pune, more girls (68%) knew breakfast was the most important meal of the day compared to boys (59.4%) (p = 0.02). Similarly, more girls (15.1%) were able to identify iron rich foods than boys (7.7%) (p = 0.03). In Bengaluru, more girls (42.2%) knew about the importance of a balanced diet than boys (22.2%) (p = 0.000). Knowledge on the importance of a balanced diet was more prevalent among private school students than public school students in both cities (p < 0.01). In Bengaluru, more private school students (49.2%) knew salty foods could lead to hypertension, compared to public school students (32.9%) (p = 0.002) (Table 1).

**Physical activity**

Compared to knowledge about healthy dietary practices, students’ understanding of the benefits of physical activity was higher (Table 1). Around 66%-69% of students were aware of the positive impact physical activity can have on reducing the risk of NCDs such as diabetes, heart disease, and obesity. Difference in the knowledge level of boys and girls was seen in both Pune and Bengaluru but a significant difference was seen only in Bengaluru for variables linking physical activity with low risk of diabetes (boys: 84.8% vs girls: 73.9%, p = 0.01) and obesity (boys: 79.3% vs girls: 86.9%, p = 0.05). However, less than one-fifth of the students (18.9%, overall) knew that the level of recommended daily physical activity is 60 minutes or more. More students (59.2%, overall) knew screen time should be limited to two hours or less per day.

**Tobacco use**

Few differences in tobacco use knowledge by gender were seen in Pune and Bengaluru. Where present, there was higher comprehension among boys in Pune for items like tobacco use is harmful to health (boys: 83.2% vs girls: 76%, p = 0.025) and the legal age for buying or selling tobacco (boys: 61% vs girls: 52.1%, p = 0.025). In Bengaluru, girls had higher knowledge for smoking and its association with heart attack (boys: 84.3% vs girls: 95%, p = 0.001) and cancer (boys: 88.8%, girls: 95%, p = 0.03). In Bengaluru, significantly more public school students were knowledgeable about tobacco use related harms and policies in India than private school students (p < 0.01) (Table 2).

**Attitudes**

**Diet**

The maximum score a participant could achieve for attitude towards diet was 40. The mean score of students was 28.4 ± 6.5, which is 70% of the maximum score. Within the two cities, students’ attitude about healthy dietary practices was similar for boys and girls (p > 0.05) and was similar in both school types (p > 0.05) (Table 3).
<table>
<thead>
<tr>
<th>Variable</th>
<th>Overall (N = 1026)</th>
<th>Pune (N = 667)</th>
<th>Bengaluru (N = 359)</th>
<th>Pune (N = 667)</th>
<th>Bengaluru (N = 359)</th>
<th>p-value</th>
<th>p-value</th>
<th>p-value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Diet</td>
<td></td>
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<tr>
<td>Knowledge about balanced diet</td>
<td>262 (25.5)</td>
<td>93 (21.6)</td>
<td>57 (23.9)</td>
<td>0.5</td>
<td>44 (22.2)</td>
<td>0.000**</td>
<td>33 (11.9)</td>
<td>117 (30)</td>
</tr>
<tr>
<td>Should have five servings of fruits and vegetables daily</td>
<td>70 (6.8)</td>
<td>27 (6.3)</td>
<td>12 (5)</td>
<td>0.5</td>
<td>17 (8.6)</td>
<td>0.97</td>
<td>11 (4)</td>
<td>28 (7.1)</td>
</tr>
<tr>
<td>Eating breakfast daily is important</td>
<td>693 (67.5)</td>
<td>255 (59.4)</td>
<td>162 (68.0)</td>
<td>0.02*</td>
<td>143 (72.2)</td>
<td>0.02*</td>
<td>178 (64.3)</td>
<td>239 (61.3)</td>
</tr>
<tr>
<td>Fat is a calorie dense nutrient</td>
<td>186 (18.1)</td>
<td>81 (18.8)</td>
<td>45 (18.9)</td>
<td>0.99</td>
<td>33 (16.6)</td>
<td>0.979</td>
<td>20 (7.2)</td>
<td>106 (27.1)</td>
</tr>
<tr>
<td>Excessive intake of salty foods can lead to hypertension</td>
<td>335 (32.6)</td>
<td>123 (28.7)</td>
<td>73 (30.7)</td>
<td>0.58</td>
<td>78 (39.4)</td>
<td>0.771</td>
<td>77 (27.8)</td>
<td>119 (30.5)</td>
</tr>
<tr>
<td>Sources of iron rich food</td>
<td>101 (9.8)</td>
<td>33 (7.7)</td>
<td>36 (15.1)</td>
<td>0.003*</td>
<td>21 (10.6)</td>
<td>0.212</td>
<td>17 (6.1)</td>
<td>52 (13.3)</td>
</tr>
<tr>
<td>Physical activity</td>
<td></td>
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</tr>
<tr>
<td>Physical activity decreases the risk of diabetes</td>
<td>681 (66.3)</td>
<td>255 (59.4)</td>
<td>139 (58.4)</td>
<td>0.794</td>
<td>168 (84.8)</td>
<td>0.01*</td>
<td>151 (54.5)</td>
<td>243 (62.3)</td>
</tr>
<tr>
<td>Physical activity decreases the risk of heart diseases</td>
<td>680 (66.2)</td>
<td>264 (61.5)</td>
<td>158 (66.4)</td>
<td>0.213</td>
<td>138 (69.7)</td>
<td>0.311</td>
<td>170 (61.3)</td>
<td>252 (64.6)</td>
</tr>
<tr>
<td>Physical activity decreases the risk of obesity</td>
<td>714 (69.5)</td>
<td>257 (55.9)</td>
<td>160 (67.2)</td>
<td>0.06</td>
<td>157 (79.3)</td>
<td>0.05*</td>
<td>167 (60.3)</td>
<td>250 (64.1)</td>
</tr>
<tr>
<td>60 minutes of physical activity is recommended</td>
<td>194 (18.9)</td>
<td>70 (16.3)</td>
<td>43 (18.0)</td>
<td>0.564</td>
<td>46 (23.2)</td>
<td>0.73</td>
<td>47 (16.9)</td>
<td>66 (16.9)</td>
</tr>
<tr>
<td>Screen time should be less than 2 hours a day</td>
<td>608 (59.2)</td>
<td>250 (58.2)</td>
<td>154 (64.7)</td>
<td>0.104</td>
<td>102 (51.5)</td>
<td>0.02*</td>
<td>158 (57.0)</td>
<td>246 (63.0)</td>
</tr>
</tbody>
</table>

*P < 0.05, **p < 0.01.
Table 2. Tobacco related knowledge by gender and school type.

<table>
<thead>
<tr>
<th>Tobacco</th>
<th>Overall (N = 1026)</th>
<th>Pune (N = 667)</th>
<th>Bengaluru (N = 359)</th>
<th>Pune (N = 667)</th>
<th>Bengaluru (N = 359)</th>
<th>p-value</th>
<th>p-value</th>
<th>p-value</th>
<th>p-value</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>N (%)</td>
<td>Boys N (%)</td>
<td>Girls N (%)</td>
<td>p-value</td>
<td>Boys N (%)</td>
<td>Girls N (%)</td>
<td>p-value</td>
<td>p-value</td>
<td>p-value</td>
</tr>
<tr>
<td>All kinds of tobacco use are harmful to health</td>
<td>871 (84.9)</td>
<td>357 (83.2)</td>
<td>181 (76.0)</td>
<td>0.025*</td>
<td>186 (93.9)</td>
<td>147 (91.3)</td>
<td>0.338</td>
<td>0.268</td>
<td>0.01*</td>
</tr>
<tr>
<td>Tobacco use by a young person harms his/her health immediately</td>
<td>679 (66.2)</td>
<td>254 (59.2)</td>
<td>133 (55.8)</td>
<td>0.405</td>
<td>155 (78.3)</td>
<td>137 (85.1)</td>
<td>0.100</td>
<td>0.062</td>
<td>0.000**</td>
</tr>
<tr>
<td>Safe to use tobacco products for one or two years</td>
<td>724 (70.5)</td>
<td>272 (63.4)</td>
<td>145 (60.9)</td>
<td>0.526</td>
<td>164 (82.8)</td>
<td>143 (88.8)</td>
<td>0.109</td>
<td>0.977</td>
<td>0.000**</td>
</tr>
<tr>
<td>Smoking tobacco (e.g., cigarettes, bidis) causes heart attack</td>
<td>811 (79.0)</td>
<td>321 (74.8)</td>
<td>170 (71.4)</td>
<td>0.340</td>
<td>167 (84.3)</td>
<td>153 (95.0)</td>
<td>0.001**</td>
<td>0.582</td>
<td>0.07</td>
</tr>
<tr>
<td>Chewing tobacco (guthka, khaini etc.) causes heart attack</td>
<td>790 (77)</td>
<td>301 (70.1)</td>
<td>181 (76.0)</td>
<td>0.104</td>
<td>170 (85.8)</td>
<td>138 (85.7)</td>
<td>0.969</td>
<td>0.231</td>
<td>0.000**</td>
</tr>
<tr>
<td>Safe to use tobacco products for one or two years</td>
<td>776 (75.6)</td>
<td>308 (71.7)</td>
<td>160 (67.2)</td>
<td>0.217</td>
<td>169 (85.3)</td>
<td>139 (86.3)</td>
<td>0.791</td>
<td>0.912</td>
<td>0.000**</td>
</tr>
<tr>
<td>Smoking tobacco (e.g., cigarettes, bidis) causes stroke</td>
<td>765 (74.5)</td>
<td>305 (71.1)</td>
<td>163 (68.4)</td>
<td>0.481</td>
<td>164 (82.8)</td>
<td>133 (82.6)</td>
<td>0.956</td>
<td>0.358</td>
<td>0.01*</td>
</tr>
<tr>
<td>Chewing tobacco (guthka, khaini etc.) causes stroke</td>
<td>820 (79.9)</td>
<td>314 (73.1)</td>
<td>177 (74.3)</td>
<td>0.741</td>
<td>176 (88.8)</td>
<td>153 (95.0)</td>
<td>0.036*</td>
<td>0.871</td>
<td>0.087</td>
</tr>
<tr>
<td>Smoking tobacco (e.g., cigarettes, bidis) causes lung cancer</td>
<td>792 (77.1)</td>
<td>302 (70.4)</td>
<td>163 (68.4)</td>
<td>0.607</td>
<td>176 (88.8)</td>
<td>151 (93.7)</td>
<td>0.105</td>
<td>0.718</td>
<td>0.003**</td>
</tr>
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<td>Chewing tobacco (guthka, khaini etc.) causes oral cancer</td>
<td>788 (76.8)</td>
<td>291 (67.8)</td>
<td>165 (69.3)</td>
<td>0.691</td>
<td>181 (91.4)</td>
<td>151 (93.7)</td>
<td>0.396</td>
<td>0.950</td>
<td>0.000**</td>
</tr>
<tr>
<td>It’s harmful to your health if you are near a person who is smoking</td>
<td>707 (68.9)</td>
<td>254 (59.2)</td>
<td>137 (87.5)</td>
<td>0.680</td>
<td>177 (89.3)</td>
<td>139 (86.3)</td>
<td>0.375</td>
<td>0.216</td>
<td>0.000**</td>
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<tr>
<td>Quitting tobacco improves a person’s health</td>
<td>680 (66.2)</td>
<td>262 (61.0)</td>
<td>124 (52.1)</td>
<td>0.025*</td>
<td>159 (80.3)</td>
<td>125 (83.8)</td>
<td>0.385</td>
<td>0.787</td>
<td>0.000**</td>
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* indicates significance at the 0.05 level; ** indicates significance at the 0.01 level.
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<tr>
<td></td>
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<td>Boys N (%)</td>
<td>Girls N (%)</td>
<td>p-value</td>
<td>Boys N (%)</td>
<td>Girls N (%)</td>
<td>p-value</td>
<td>Public School N (%)</td>
<td>Private School N (%)</td>
<td>Public School N (%)</td>
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<td>Public School N (%)</td>
<td>Private School N (%)</td>
<td>Public School N (%)</td>
<td>Private School N (%)</td>
<td>Public School N (%)</td>
<td>Private School N (%)</td>
</tr>
<tr>
<td>Is there a law which mandates display of a “Tobacco Free School” or “Tobacco Free Institution” sign at a prominent place on the boundary wall outside the main entrance of your school</td>
<td>594 (57.9)</td>
<td>207 (48.2)</td>
<td>117 (49.1)</td>
<td>0.822</td>
<td>140 (70.7)</td>
<td>130 (80.7)</td>
<td>0.028*</td>
<td>135 (48.7)</td>
<td>189 (48.4)</td>
<td>0.944</td>
<td>209 (90.4)</td>
<td>61 (47.6)</td>
<td>0.000**</td>
<td></td>
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<tr>
<td>Is there a law which mandates display of a “No smoking area - smoking here is an offence” sign inside your school?</td>
<td>654 (63.7)</td>
<td>248 (57.8)</td>
<td>128 (53.7)</td>
<td>0.315</td>
<td>160 (80.8)</td>
<td>118 (73.3)</td>
<td>0.090</td>
<td>158 (57.0)</td>
<td>218 (55.9)</td>
<td>0.769</td>
<td>195 (84.4)</td>
<td>83 (64.8)</td>
<td>0.000**</td>
<td></td>
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<tr>
<td>Is there a law which bans tobacco advertising on television channels and print media?</td>
<td>674 (65.6)</td>
<td>237 (55.2)</td>
<td>120 (50.4)</td>
<td>0.231</td>
<td>176 (88.9)</td>
<td>141 (87.5)</td>
<td>0.701</td>
<td>128 (46.2)</td>
<td>229 (58.7)</td>
<td>0.001**</td>
<td>216 (93.5)</td>
<td>101 (78.9)</td>
<td>0.000**</td>
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<tr>
<td>Is there a law which stops people from smoking in public places (like within the premises of your school)?</td>
<td>726 (70.7)</td>
<td>260 (60.6)</td>
<td>150 (63.0)</td>
<td>0.539</td>
<td>172 (86.8)</td>
<td>144 (89.4)</td>
<td>0.455</td>
<td>158 (57.0)</td>
<td>252 (64.6)</td>
<td>0.048*</td>
<td>216 (93.5)</td>
<td>100 (78.1)</td>
<td>0.000**</td>
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</tbody>
</table>

*P < 0.05. **p < 0.01.
Table 3. Attitude related to diet, physical activity and tobacco by gender and school type.

<table>
<thead>
<tr>
<th>Variable</th>
<th>Overall (N = 1026)</th>
<th>Pune (N = 667)</th>
<th>Bengaluru (N = 359)</th>
<th>Pune (N = 667)</th>
<th>Bengaluru (N = 359)</th>
<th>p-value</th>
<th>Pune (N = 667)</th>
<th>Bengaluru (N = 359)</th>
<th>p-value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cronbach Alpha</td>
<td>0.68</td>
<td>28.4 ± 6.5</td>
<td>27.0 ± 7.3</td>
<td>27.8 ± 7.3</td>
<td>27.8 ± 7.3</td>
<td>0.153</td>
<td>30.2 ± 3.8</td>
<td>27.7 ± 7.5</td>
<td>0.256</td>
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<tr>
<td>Diet</td>
<td>0.71</td>
<td>29.5 ± 7.5</td>
<td>27.4 ± 8.5</td>
<td>28.3 ± 7.5</td>
<td>28.3 ± 7.5</td>
<td>0.152</td>
<td>32.6 ± 4.5</td>
<td>28.5 ± 7.9</td>
<td>0.005*</td>
</tr>
<tr>
<td></td>
<td>(29.1-30.0)</td>
<td>(26.6-28.2)</td>
<td>(27.4-29.3)</td>
<td>(31.9-33.2)</td>
<td>(27.7-29.3)</td>
<td></td>
<td>(31.9-33.2)</td>
<td>(27.7-29.3)</td>
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<tr>
<td>Tobacco</td>
<td>0.89</td>
<td>31.3 ± 12.7</td>
<td>26.8 ± 14.1</td>
<td>29.7 ± 13.3</td>
<td>29.7 ± 13.3</td>
<td>0.011*</td>
<td>37.5 ± 6.5</td>
<td>27.6 ± 14.8</td>
<td>0.043</td>
</tr>
<tr>
<td>use</td>
<td>(30.6-32.1)</td>
<td>(25.5-28.2)</td>
<td>(28.0-31.4)</td>
<td>(36.6-38.4)</td>
<td>(26.8-29.8)</td>
<td></td>
<td>(37.2-39.0)</td>
<td>(26.1-29.0)</td>
<td></td>
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</tbody>
</table>
* p < 0.05.
** p < 0.01.*SD: Standard deviation, Higher the score better is the attitude towards diet and physical activity and less favourable to tobacco use.

F1000Research 2021, 10:544 Last updated: 17 AUG 2021
Physical activity

The highest score a student could achieve for attitude towards physical activity was 45. The students’ mean score was 29.5 ± 7.5, which is 65% of the maximum score. No significant differences were observed between boys and girls in both cities, highlighting that both have a positive attitude towards physical activity (p > 0.05). In Bengaluru, public school students had a more positive attitude towards physical activity in comparison to private school students (p = 0.001), whereas the opposite was observed in Pune (Table 3).

Tobacco use

The maximum score a student could achieve in this construct was 45. The students’ mean score was 31.3 ± 12.7, which is 68% of the maximum score. In Pune, mean scores were significantly higher among girls than boys (29.7 ± 13.3 in girls vs 26.8 ± 14.1 in boys; p = 0.01) and among public school (28.3 ± 12.5) students than private schools’ students (27.6 ± 4.8) (p = 0.01), suggesting girls and public school students had less favourable attitudes towards initiating a tobacco habit. In Bengaluru, no significant differences between gender were observed but a significant difference in scores by school type was observed (public school: 38.5 ± 5.8 vs private school: 36.4 ± 6.6, p = 0.002) (Table 3).

Behaviours

Diet

Overall, the vast majority of students (94.7%) were eating “outside food” (i.e. takeaway/ street food) daily. Few students (8.7%) skipped breakfast daily. In Pune, fewer girls (8.8%) than boys (18.9%) reported that they had never eaten fruits (p = 0.001) or pulses (p = 0.004). In Bengaluru, fewer girls than boys reported that they had never eaten pulses (4.3% girls and 14.1% boys; p = 0.002) or salads (1.2% girls and 11.1% boys; p = 0.000) and more boys (51.8%) than girls (39.4%) reported that they had never read nutrition labels (p = 0.020). In Bengaluru, more girls (46.3%) than boys (35.2%) reported watching television while eating meals (p < 0.01), while the reverse was observed in Pune (boys: 20.2% vs girls 17.2%) (p < 0.01).

With respect to school type, in Pune skipping breakfast and never reading nutrition labels were more common among students in public schools (15.2%) compared to private school (9.7%) (p < 0.05). Nearly one-third of public school students (30%) and 22.7% of private school students never read a food label before buying food items (p < 0.005). Never reading nutrition labels was also very common among public school students in Bengaluru (64.8%) (Table 4).

Physical activity

Overall, very few students (3.3%) watched screens (television, computer, video games etc.) for more than two hours a day. No significant differences were seen between girls and boys for screen time either in Pune or Bengaluru (p > 0.05). However, significantly more public-school students compared to private school students reported at least two hours of screen time a day in both Pune (4.3% in public school and 1.0% in private schools; p = 0.006) and Bengaluru (6.9% in public schools and 1.6% in private schools; p = 0.026).

No significant differences in moderate-to-vigorous physical activity were seen by gender or school type in both cities (p > 0.05). However, fewer students in Bengaluru (21.9%–29.9%) reported that they had less than adequate moderate-to-vigorous physical activity per day compared to students in Pune (50.3%–52.1%) (Table 4).

Tobacco

Overall more students in Pune (50.7%) than Bengaluru (2.8%) reported having ever used tobacco. In both cities, no significant differences by gender were observed. However, the prevalence of ever smoking (65.4% vs. 33.0%, p = 0.001), ever use of smokeless tobacco (64.8% vs. 33.5%, p = 0.000), and ever e-cigarette use (69.2% vs. 36.7%, p = 0.001) was significantly higher among public school students in Pune than private school students (Table 4).

The boys from the participating schools of Pune were found to be more susceptible to tobacco use (23.3% smoking and 25.9% smokeless tobacco) in comparison to the girls (15.5% both smoking and smokeless tobacco use) (p < 0.05) (Table 5).
<table>
<thead>
<tr>
<th>Behaviour</th>
<th>Overall (N = 1026)</th>
<th>Pune (N = 667)</th>
<th>Bengaluru (N = 359)</th>
<th>Pune (N = 667)</th>
<th>Bengaluru (N = 359)</th>
<th>p-value</th>
<th>Boys (Public School)</th>
<th>Girls (Public School)</th>
<th>Boys (Private School)</th>
<th>Girls (Private School)</th>
<th>p-value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Skipping breakfast (daily)</td>
<td>90 (8.7)</td>
<td>56 (10.1)</td>
<td>34 (15.2)</td>
<td>24 (3.9)</td>
<td>38 (8.7)</td>
<td>0.023</td>
<td>5</td>
<td>42 (6.3)</td>
<td>38 (8.7)</td>
<td>24 (7.5)</td>
<td>0.089</td>
</tr>
<tr>
<td>Eat whole fruits in a week (never)</td>
<td>116 (11.3)</td>
<td>81 (17.9)</td>
<td>35 (16.2)</td>
<td>81 (12.1)</td>
<td>35 (16.2)</td>
<td>0.001</td>
<td>10</td>
<td>10 (15.2)</td>
<td>4 (6.3)</td>
<td>4 (2.4)</td>
<td>0.013</td>
</tr>
<tr>
<td>Eat pulses and lentils in a week (never)</td>
<td>167 (16.2)</td>
<td>114 (26.6)</td>
<td>53 (23.1)</td>
<td>114 (17.1)</td>
<td>53 (23.1)</td>
<td>0.004</td>
<td>28</td>
<td>28 (16.1)</td>
<td>28 (16.1)</td>
<td>28 (16.1)</td>
<td>0.000</td>
</tr>
<tr>
<td>Eat salads in a week (never)</td>
<td>187 (18.2)</td>
<td>114 (26.6)</td>
<td>73 (32.4)</td>
<td>114 (26.6)</td>
<td>73 (32.4)</td>
<td>0.001</td>
<td>22</td>
<td>22 (12.1)</td>
<td>22 (12.1)</td>
<td>22 (12.1)</td>
<td>0.000</td>
</tr>
<tr>
<td>Eat food/snack while watching TV (always)</td>
<td>261 (25.7)</td>
<td>179 (40.2)</td>
<td>82 (36.3)</td>
<td>179 (36.3)</td>
<td>82 (36.3)</td>
<td>0.002</td>
<td>39</td>
<td>39 (21.2)</td>
<td>39 (21.2)</td>
<td>39 (21.2)</td>
<td>0.000</td>
</tr>
<tr>
<td>Read the food labels to choose if the food is healthy or not (never)</td>
<td>311 (30.4)</td>
<td>227 (50.3)</td>
<td>84 (37.8)</td>
<td>227 (50.3)</td>
<td>84 (37.8)</td>
<td>0.01</td>
<td>10</td>
<td>10 (14.1)</td>
<td>10 (14.1)</td>
<td>10 (14.1)</td>
<td>0.002</td>
</tr>
<tr>
<td>Ever tried smoked tobacco (cigarette/beedi/hookah, etc.)</td>
<td>289 (28.3)</td>
<td>174 (39.3)</td>
<td>115 (52.1)</td>
<td>174 (39.3)</td>
<td>115 (52.1)</td>
<td>0.000</td>
<td>121</td>
<td>121 (44.5)</td>
<td>121 (44.5)</td>
<td>121 (44.5)</td>
<td>0.000</td>
</tr>
<tr>
<td>Ever tried smokeless tobacco (gutkha, khan, etc.)</td>
<td>203 (20.2)</td>
<td>129 (29.0)</td>
<td>74 (32.4)</td>
<td>129 (29.0)</td>
<td>74 (32.4)</td>
<td>0.001</td>
<td>78</td>
<td>78 (35.6)</td>
<td>78 (35.6)</td>
<td>78 (35.6)</td>
<td>0.000</td>
</tr>
<tr>
<td>Ever tried electronic vapor product</td>
<td>310 (30.2)</td>
<td>187 (42.1)</td>
<td>123 (52.1)</td>
<td>187 (42.1)</td>
<td>123 (52.1)</td>
<td>0.000</td>
<td>147</td>
<td>147 (41.7)</td>
<td>147 (41.7)</td>
<td>147 (41.7)</td>
<td>0.000</td>
</tr>
</tbody>
</table>

*P < 0.05.  **p < 0.01.
Table 5. Tobacco use susceptibility of students by gender and school type.

<table>
<thead>
<tr>
<th>Tobacco</th>
<th>Overall (N = 1026)</th>
<th>Pune (N = 667)</th>
<th>Bengaluru (N = 359)</th>
<th>Pune (N = 667)</th>
<th>Bengaluru (N = 359)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>N (%)</td>
<td>Boys N (%)</td>
<td>Girls N (%)</td>
<td>p-value</td>
<td>Public School N (%)</td>
</tr>
<tr>
<td>Susceptibility to smokeless tobacco</td>
<td>168 (16.4)</td>
<td>111 (25.9)</td>
<td>37 (15.5)</td>
<td>0.002**</td>
<td>58 (20.9)</td>
</tr>
<tr>
<td>Susceptibility to smoke tobacco</td>
<td>157 (15.3)</td>
<td>100 (23.3)</td>
<td>37 (15.5)</td>
<td>0.017**</td>
<td>58 (20.9)</td>
</tr>
</tbody>
</table>

*P < 0.05.  
**p < 0.01.
Discussion

This is one of the few studies on NCD risk factors that has comprehensively assessed KAB of school going children from two major metropolitan areas of India and the KAB findings helped to develop the school-based health lifestyle programme. During recruitment, it was ensured that the schools included in the study had similar characteristics, as differences in school characteristics might have influenced the results. Given the wide geographic variability in NCDs in this country, it is important to assess students’ KAB in a myriad of contexts.

The findings of our study revealed low dietary knowledge among students irrespective of gender and school type. Knowledge was better among girls and private school students. Similar differences were reported in school going students of Haryana (North India). The students’ knowledge of physical activity was better than their knowledge of diet and 66%-69% of students were aware of association between NCDs and physical inactivity. In contrast to our study findings, a better knowledge about physical activity (88%) was reported in students of Gujarat, and Delhi-India. Similarly, adolescents from the eighth and ninth grade in other low-and-middle-income countries (LMICs) such as Nepal, knew that physical activity is imperative for disease prevention and for staying healthy.

In our study, students’ knowledge about the harms of tobacco use was much higher in comparison to their knowledge about diet and physical activity. This increase in knowledge could be attributed to the Government of India’s efforts to combat rising burden of tobacco use and its associate health impact, including comprehensive national tobacco control law i.e., COTPA-2003, National Tobacco Control Programme as well as tobacco-free educational institutional guidelines. Evidence from other LMICs, including Bangladesh, also reported high awareness of the harms of tobacco use among rural adolescents (13-18 years).

With regard to behaviours, only 8.7% of students were missing their breakfast daily. This is similar to the findings of a study conducted among school students of Gujarat, India. Findings from a study conducted in Kenya also showed similar results, wherein 92.1% of the children and adolescents (8-11 years) consumed breakfast daily. In our study, more students from public schools reported missing their daily breakfast than students in private schools. This could be attributed to a low level of knowledge and the presence of students from lower middle-income families in these schools. Students from lower income families are more likely to experience scarcity of good quality food, meaning they may lack a wholesome breakfast as well as other meals of the day. An additional factor could be the availability of a mid-day meal scheme (i.e., school meal) in public schools, which may preclude the importance of their first meal at home (i.e., breakfast).

Other protective dietary factors include fruit consumption, and only 11.3% of students did not eat fruits daily. The Comprehensive National Nutrition Survey (2019) showed that among adolescents (10-14 years), 59% in Maharashtra and 74% in Karnataka ate whole fruits only once a week. Though fruits are “price elastic” (a term that describes the connection between income and the demand of a product), no difference in consumption was seen by school type. Results from other LMICs were poorer, with only 9% of adolescents (8-11 years) consuming fruits four to seven times a week. On other hand, in a cross-country comparison among 49 LMICs, India had highest percentage (29.5%) of adolescents (13-17 years old) who met WHO’s recommendation for fruit and vegetable consumption. All of the included 49 countries were selected due to the availability of the Global School Based Student Health Survey (GSHS) data from 2004-2013 for this ecological study and provided a data on a total of 164,771 adolescents.

Another worrisome behaviour observed among students was the habit of eating “outside food” (i.e., takeout) every day (95%). Contributing factors to its popularity could be ease of access, taste, parent’s occupation, and fast-food companies marketing strategies. Fast food consumption data from 153,496 young adolescents (12-15 years) from 54 LMICs showed that 55.2% (51.3–59.1%) of the adolescents consumed fast food at least once per week, and 10.3% (8.3–12.4%) consumed fast food between four to seven days per week. The prevalence of fast-food consumption for four to seven days per week was lowest in the Americas (8.3%; 95% CI: 6.7–9.9) and highest in Southeast Asia (17.7%; 95% CI: 2.3–33.2%). Our study found that students are not reading nutritional labels while making food choices, as only 33% of students read labels. Students in public schools were practicing this behaviour more often than students in private schools. In contrast to this trend, 88% of students in Kolkata reported reading nutritional labels, and this was most common among girls.

Lack of physical activity among adolescents is a major NCD risk factor. More than half of the students (57.5%) in this study reported engaging in moderate-to-vigorous physical activity for at least 60 minutes, daily, with no significant differences by gender or school type. One recent publication showed that 73.9% of adolescents in India are insufficiently physically active. However, a global study of 49 LMICs with 164,771 adolescents found that India had the highest percentage (29.5%) of adolescents who met WHO’s recommendations for physical activity. On an encouraging note, in
the same study, few adolescents (3%) reported screen time of more than two hours a day. This is in contrast to 52.5% of school going adolescents in Tamil Nadu (Southmost part of India) who had an average daily screen time of more than two hours a day.49

One third of adolescents had ever tried tobacco (smoke, smokeless and e-cigarette). Evidence from 68 LMICs showed that mean prevalence of tobacco use among adolescents (12-15 years) was 13.6%, ranging from 2.8% in Tajikistan to 44.7% in Samoa and in most countries prevalence among boys was higher compared to girls.50 However, no difference among boys and girls was observed in this study, indicating a narrowing of gender gap for tobacco use which is much wider among adults in India.51 In Pune, public school students used more tobacco (all forms) in comparison to private schools. Whereas in Bengaluru, smokeless tobacco was more commonly used among public school students in comparison to smoke forms. Tobacco use (all forms) was found to be more prevalent in public school boys (13.4%) in comparison to private school boys (11.7%).52 This could be due to the students’ lack of compliance with provisions of Indian tobacco control law as well as the availability and ease of access to tobacco products outside of their schools.53 Surprisingly, 32.4% of the students also reported that they have tried e-cigarettes in the past. To the best of our knowledge, no other study in India has yet reported the prevalence of e-cigarette use among school going children. The prevalence found in our study was much higher than that found in a study from Mexico.54

Results suggest that tobacco use prevention will be especially important for schools in Pune, while promoting physical activity may be a key strategy to pursue in Bengaluru. Students in both cities would benefit from additional school-based intervention to support healthy dietary practices, including eating pulses and vegetables frequently; eating healthier, eating home-cooked meals; and reading nutrition labels.

As the 2030 deadline for Sustainable Development Goals are only a decade away, the low levels of knowledge, particularly about unhealthy diet and physical inactivity, are a matter of concern.55 Aiming to reduce the NCD burden, the budding role of education in primary prevention was emphasised at the 2011 United Nations’ Meeting on the Prevention and Control of NCDs.56 Lack of healthy behaviours among adolescents has been linked with lack of sufficient knowledge, and research has also indicated a positive relationship between information level and overt behaviour.57 Sufficiently designed health promotion programmes58 may provide the much needed knowledge that will help to reduce risk behaviours such as unhealthy diet, physical inactivity, and tobacco use, hence providing a pathway for behaviour change. Health promotion strategies in schools provide an avenue to reach school children at a time coinciding with their cognitive development. Such an approach can impart information effectively, especially with respect to lifestyle choices.59 Studies have shown that if implemented efficiently, health promoting schools can enhance decision-making skills among students, too.60

In India, various education programmes have been designed for school going adolescents but there are only few comprehensive education programs addressing diet, physical activity and tobacco.61 In 2018, the Government of India launched the National School Health Programme under Ayushman Bharat or Healthy India. The programme comprehensively addresses the above risk factors, and is delivered by health ambassadors (two teachers per school) only in government and government aided schools across country.62

The results of the present study are being used to inform the development of a two-year intervention programme in these cities which will target students in the sixth to eighth grades, their parents, and community members. This intervention programme is being implemented from 2019-2021 by trained teachers and is facilitated by trained peer leaders in both public and private schools. This model of delivery has proven successful in India and elsewhere globally for tobacco63 and nutrition12 education.

One of the limitations of this study was that the sample of schools was not randomly selected from the population but was representative of the mix of types of schools in these two cities. This limits generalisability of the findings. The self-reported method utilised (i.e., survey) also may have led to skewed estimates of dietary intake, physical activity and tobacco use patterns among the students due to the fact that adolescents would have wanted to report positive health behaviours (social desirability - reporting bias). Behaviour for every type of tobacco use was evaluated without further investigating the number of times the tobacco was used by the students. Given budgetary constraints, no anthropometric or biochemical (e.g., salivary cotinine) measurements were completed, which may be a drawback of this study.

**Conclusion**

There is a need to amplify health education activities in schools in India, and school health interventions need to be adequately designed to ensure that they do not further widen existing socio-economic inequalities. This study highlights the need to augment school health programmes in India with a differential approach based on the issues which are specific
to each school type (public and private) and city (Pune and Bengaluru). School health programmes should be structured with a dedicated focus on health promotion and NCD prevention. Developed intervention materials should be incorporated in the curriculum to become part of the regular teaching.

### Data availability

#### Underlying data

Figsare: Knowledge, Attitude and Behaviours (KAB) on diet, physical activity, and tobacco use among school students: Survey Dataset. [https://doi.org/10.6084/m9.figshare.14760147.v4](https://doi.org/10.6084/m9.figshare.14760147.v4)

This project contains the following underlying data:

- KAB Survey Dataset.xlsx (student knowledge, attitude and behaviour responses regarding their diet, physical activity and tobacco consumption).

#### Extended data

Figsare: Knowledge, Attitude and Behaviours (KAB) on diet, physical activity, and tobacco use among school students: Survey Tool. [https://doi.org/10.6084/m9.figshare.14760480.v2](https://doi.org/10.6084/m9.figshare.14760480.v2)

This project contains the following extended data:

- KAB Questionnaire_English.pdf
- KAB Questionnaire_Marathi.pdf
- KAB Questionnaire_Kannada.pdf

Data are available under the terms of the [Creative Commons Attribution 4.0 International license](https://creativecommons.org/licenses/by/4.0/).

### Acknowledgements

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### References


3. Institute for Health Metrics and Evaluation: Global Health Data. [GBD Results Tool](https://ghdx.healthdata.org/gbd-results-tool) [GHDx].


13. Langford R, Bonell CP, Jones HE, et al.: The WHO Health Promoting School framework for improving the health and well-being of...


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This is a well-written paper that provides data on the knowledge, attitude and behaviours of school students in two Indian states. Such data will provide a baseline against which the impact of any behaviour change intervention can be measured in the future. As such, this is a timely and valuable paper.

A few areas where the authors may want to improve on:

Abstract
1. Conclusions: The last few sentences are policy speculations, not study conclusions, so they may be better placed in the Discussion section instead (of course with some backup references there).

Methods
1. Setting: Purposive sampling technique - explain a bit further to explain how exactly the 20 schools were selected. What was the sampling frame (total number of schools) and how exactly did you balance various characteristics mentioned here.

2. Participants: The number given for the final sample size (n=1238) does not match the number given in the Results section. Need to rephrase this sentence.

3. Statistical analysis: A commentary needs to be added in the limitation section later saying that statistical tests are indicative only, as the sampling design was purposive (not random). Also, need justification for a t-test in the light of Likert-scale data.

Results
1. The presentation looks fine as this is largely descriptive data. However, I wonder whether additional analysis examining if the reported KAB differed by parental education and occupation may provide more helpful insights. In other words, would observed gender differences in KAB disappear (or the other way around) once you have controlled for parental education and/or parental occupation? Note that in the Discussion section (p.13,
You hypothesise the habit of eating outside food may have been influenced by parental occupation, among other things. Why not test these when you have collected your own data?

**Discussion**

1. Most space in the Discussion section has been devoted to compare and contrast study findings with wider literature, which is important but doing so has limited the ability for the study to provide valuable insights for policymakers in relation to answering “what next”. So, you may choose to summarise the comparison of your findings with the study results in addition to providing a succinct discussion as to how Indian (and wider South Asian) policymakers can go from here. For example, for the sake of the argument, if we followed COM-B model of behaviour change to design and implement interventions for this age group, how can the study results help us identify where capabilities, opportunities and motivations lie and how can adolescents be supported in their lacking space to change their behaviour. I think the rich discussion in this area makes this paper more useful.

2. A confusion/error, p.13, para 5: Seems to be a confusion between “price elasticity” and “income elasticity”. Please revise the sentence.

3. Limitations: Acknowledge that statistical tests are indicative only as the whole sample was purposive.

**Conclusion**

1. Strongly recommend revising the conclusion section. The sentences here must be backed up by the study findings and leave any speculative policies to the Discussion section above. An example conclusion may be: “In the two states of India, a higher proportion of school students know the harm of tobacco use than the benefits of a healthy diet and physical activity. Both gender of the student and which type of the school that the student went to influenced specific KABs but both the magnitude and direction of such influence were variable. The data suggests that there is an urgent need for designing and implementing interventions that can improve school students’ capability and motivation as well as create opportunities to change their unhealthy behaviours.

**Is the work clearly and accurately presented and does it cite the current literature?**

Yes

**Is the study design appropriate and is the work technically sound?**

Yes

**Are sufficient details of methods and analysis provided to allow replication by others?**

Yes

**If applicable, is the statistical analysis and its interpretation appropriate?**

Partly

**Are all the source data underlying the results available to ensure full reproducibility?**

Yes

**Are the conclusions drawn adequately supported by the results?**
Partly

**Competing Interests:** No competing interests were disclosed.

**Reviewer Expertise:** Public health, behaviour change, health economics

I confirm that I have read this submission and believe that I have an appropriate level of expertise to confirm that it is of an acceptable scientific standard, however I have significant reservations, as outlined above.

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