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Article

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Original Article

Assessment of Healthy Living Awareness and Knowledge Among Health Sciences Students: A Descriptive Study in Turkey

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Abstract

Background

Healthy lifestyle behaviors during university life are critical to long-term health outcomes. However, there is typically a discrepancy between knowledge and practice among health sciences students.

Purpose

The study aimed to assess the level of healthy living awareness and knowledge of health sciences students in Turkey. Furthermore, the study highlighted the crucial lifestyle areas such as diet, physical activity, and self-monitoring, and explored how educational exposure and demographic factors impact this awareness.

Methods

A descriptive cross-sectional study was carried out among 493 students who studied nursing, midwifery, and nutrition/dietetics programs from January 2023 to March 2023. An online questionnaire was used to gather data, which included the Healthy Living Awareness Scale (HLAS). SPSS was used to conduct statistical analysis with a significance level of $p<0.05$. The study was guided by the Strengthening the Reporting of Observational Studies in Epidemiology (STROBE) guidelines to guarantee transparent, thorough, and consistent demonstration of the observational methods and results.

Results

The average HLAS score (56.43+10.84) was above moderate and revealed awareness. The "change" subscale showed the highest mean (20.06±4.23), while "nutrition" was lowest (9.96±3.10). Significant differences in awareness were observed according to age ($p=0.003$),

academic year (p=0.001) and department (p=0.014), with nutrition students scoring highest. The subscale of nutrition also differed significantly among departments (p=0.001). There was a positive but weak correlation between age and total HLAS score (r=0.141, p=0.002). Gender variations showed no significant differences, except in nutrition (p=0.023). Inter-rater reliability was good (Cronbach 0.904).

Conclusion

Despite the satisfactory level of awareness, the domain-specific gaps, especially in nutrition, remain strong. Targeted educational interventions are needed to bridge the knowledge–practice gap.

Keywords

Health Knowledge, Attitudes, Practice; Health Behavior; Life Style; Students, Health Occupations

Introduction

Healthy living is a multidimensional phenomenon that includes optimum nutrition, frequent exercise, sufficient sleep and psychological health. It also involves non-exposure to high-risk behavioural patterns, thereby promoting non-communicable disease prevention and preservation of functional health conditions [1]. According to preventive medicine, these elements regulate metabolic homeostasis, cardiovascular performance, and immune competence [2]. One of the most critical developmental stages is the university transition, whereby individuals are exposed to autonomous patterns of life that in most cases carry on into adulthood [3]. Significant behavioural changes during this stage, including consumption of energy-dense foods, lack of exercise, disrupted sleep cycles and high levels of psychological stress, result in early onset of obesity, insulin resistance, and other cardiometabolic risk factors [4].

Students of health sciences make up an independent subgroup of the university population since they are formally exposed to biomedical and public health training [5]. Their training in academics gives them background information about disease etiology, risk factor modification, and health promotion. They are supposed to act as role models to patients and the wider society in terms of adhering to evidence-based healthy behaviors as future healthcare professionals. The degree to which students apply their knowledge has not only an implication on their own health, but also on their professional credibility in providing preventive health interventions [6].

Risk factors in the lifestyle determinants of disease among university students are multifactorial and depend on the behavioral, environmental, and psychosocial determinants [7]. Eating habits tend to be more favorable towards the consumption of processed foods, saturated fats, and refined sugars, which is mostly due to time, cost, and availability [8]. At the same time, physical activity is likely to decrease as a result of school-related factors and lack of physical activity, which leads to decreased energy use. Sleep disorders, such as the lack of adequate duration and quality of sleep, have been common and associated with impaired cognitive functioning and metabolic deregulation [9]. Moreover, high levels of stress related to academic requirements can result in some maladaptive coping strategies like smoking, too much caffeine intake, and poor eating habits. All of these factors, which are interrelated, make a person more vulnerable to physical and mental health disorders [10].

Theoretical models, including the Health Belief Model and Social Cognitive Theory, have made health awareness and knowledge one of the most important determinants of behavior since

they focus on the importance of cognitive processes in making health-related decisions [11]. Proper knowledge will help them to be aware of the risk factors, assess the impact of unhealthy behaviors, and implement preventive measures. Health literacy levels would be anticipated to be higher among health sciences students in translating theoretical knowledge into practical lifestyle changes [12].

Nonetheless, there is an increasing body of literature that shows that there is a persistent gap between the knowledge and real health practices among health sciences students. Several studies have proven that despite enough awareness, students have about the important principles of a healthy lifestyle, they do not follow the behaviors optimally [13, 14]. This knowledge practice gap may be attributed to competing academic priorities, time limitations, environmental constraints, and psychosocial factors such as motivation and perceived behavioral control. The fact that unhealthy behaviors persist in a population that has received formal health education highlights the complexity of behavior change. It indicates that knowledge is not enough to assure adherence to healthy living behaviors[15].

The Turkish setting has experienced a high rate of urbanization, globalization of food habits, and changes in the sociocultural environment that have played a major role in the change in lifestyle behavior among young adults in the country [16]. University settings can also contribute to these developments by encouraging sedentary lifestyles and easy access to energy-rich and nutrient-dense food. Although previous studies have explored specific aspects of student health, such as dietary intake or physical activity levels, comprehensive assessments of healthy living awareness and knowledge among health sciences students in Turkey remain limited [17]. Further, there is a tendency in the available literature to not integrate across various domains of lifestyle and inadequately consider the cognitive aspects underlying health behaviors[18].

Considering the above factors, a scientific assessment of the awareness and knowledge of healthy living among students of health sciences is justified. Knowing how well the students understand and internalize major health concepts is important in determining discrepancies between theoretical understanding and actual practice [19]. Thus, the current study evaluated the extent of awareness and knowledge about healthy living among health sciences students in Turkey, typically focusing on the key lifestyle determinants and their applicability to the future practices of health promotion.

Methodology

Study Design

A descriptive cross-sectional study was conducted, including 493 active enrolled students in health sciences departments aged >18 years in other parts of Turkey. There was no specific sampling technique used. The departments include midwifery, nursing, and nutrition/dietetics. The duration of the study was January to March 2023.

Eligibility Criteria

The study involved the following inclusion and exclusion criteria;

Inclusion Criteria

i. Participants enrolled in health sciences programs
ii. Participants aged 18 years or above
iii. Participants who voluntarily agreed to participate during the data collection period
iv. Students with access to a smartphone and the ability to complete an online questionnaire

Exclusion Criteria

i. Participants enrolled in non-health sciences disciplines
ii. Participants younger than 18 years of age
iii. Participants who did not provide consent or declined to participate
iv. Incomplete or improperly filled questionnaire responses result in unusable data

Ethical Considerations

Mardin Artuklu University Committee on Scientific Research and Publication Ethics committee of the institution approved the study. Written informed consent was obtained from all the participants. The study was guided by the Strengthening the Reporting of Observational Studies in Epidemiology (STROBE) guidelines to guarantee transparent, thorough, and consistent demonstration of the observational methods and results.

Data Collection Procedure

A survey questionnaire consisting the four-question (age, gender, department and academic year) Introductory Information Form prepared for this study and a 15-question questionnaire including Healthy Living Awareness Scale (HLAS) was prepared.

Expert opinions were sought regarding the content and face validity of the scale used as a data collection tool, whilst exploratory factor analysis (EFA) and first- and second-order confirmatory factor analysis (CFA) were conducted to assess its construct validity. The EFA yielded a structure comprising 15 items and four factors, explaining 55.50% of the total variance. The results of the DFA indicated that the four-factor structure comprising 15 items yielded good fit indices and was validated as a model. Reliability was assessed using Cronbach's alpha and the test-retest method. The Cronbach's alpha value for the entire scale was found to be 0.813 and the test-retest reliability coefficient 0.849, demonstrating that the scale is highly reliable [25].

HLAS is a 5-point Likert scale with 15 items and 4 sub-dimensions: change (1-5), socialization (6-9), responsibility (10-12), and nutrition (13-15). The minimum score that can be attained in the scale is 15, and the maximum score is 75. A large score on the scale signifies that there is a high awareness of healthy life [25]. The students studying in other provinces in universities were accessed using the snowball technique. The questionnaires were sent out in the period between January and March 2023.

Figure 1 shows the systematic study design that was used in this study. The stepwise procedure shows the meticulousness of the selection of participants, data gathering via online mediums and thorough statistical examination. The reliability and validity of the results on healthy living awareness among health sciences students are provided by the use of validated tools (HLAS), corroborated by relevant statistical tests.

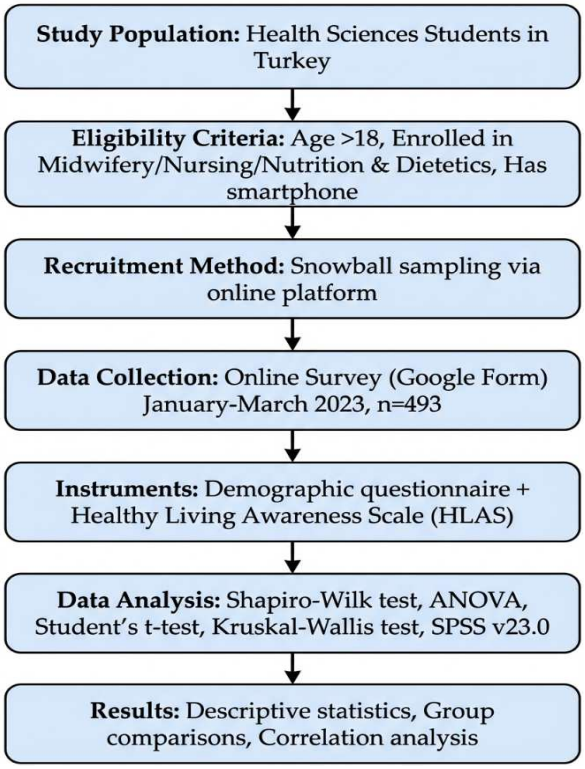


Figure 1: Study Methodology Flowchart

Statistical Analysis

Statistical analysis was performed using IBM SPSS Statistics version 23.0. The normal distribution of the numerical data was used to check the distribution through the Shapiro-Wilk test. Student t-test or one-way analysis of variance (ANOVA) was used when comparing normally distributed numerical factors between groups. Non-normally distributed variables were tested using the nonparametric Mann-Whitney U test or Kruskal-Wallis ANOVA. The coefficients of alpha of Cronbach were calculated in order to determine the reliability of the scale. The statistically significant p-value was considered to be 0.05.

Results

Table 1 shows the demographic characteristics of participants.

Table 1: Demographic Characteristics of Participants

Characteristic	**Category**	**N**	**%**
Age	≤19	109	22.1
	20-21	195	39.6

	≥22	189	38.3
Gender	Male	107	21.7
	Female	386	78.3
Department	Nutrition/Dietetics	56	11.4
	Midwifery	166	33.7
	Nursing	271	55.0
Academic Year	1	167	33.9
	2	89	18.1
	3	103	20.9
	4	134	27.2

Table 2 suggests the average HLAS score (56.43 ± 10.84; range 16-75) is above moderately healthy living awareness, and the range of scores among students is significant. Change subscale achieved the highest mean (20.06 ± 4.23), followed by Socialization, Responsibility, and Nutrition, indicating that self-monitoring skills were better compared to awareness in nutrition. The data were analyzed in terms of reliability, which indicated excellent internal consistency of the total scale (Cronbach's alpha = 0.904) and good reliability of the subscales (0.793-0.875). The relatively low reliability of nutrition could reflect the variation in the perception of the diet. The scale, in general, exhibits good psychometric characteristics and is effective in measuring multidimensional awareness in health sciences students.

Table 2: Descriptive Statistics and Reliability Analysis of HLAS Scores

Scale/Subscale	**Mean ± SD**	**Min-Max**	**Cronbach's Alpha**
HLAS Total	56.43 ± 10.84	16-75	0.904
Change	20.06 ± 4.23	5-25	0.875
Socialization	14.61 ± 3.81	4-20	0.832
Responsibility	11.82 ± 2.60	3-15	0.809
Nutrition	9.96 ± 3.10	3-15	0.793

Figure 2 shows that the average total HLAS score was 56.43+10.84, which depicts the above-moderate standard of healthy living awareness among health sciences students. The Change subscale had the maximum mean score (20.06±4.23), and the next subscale scores are socialization (14.61±3.81), responsibility (11.82±2.60), and nutrition (9.96±3.10), which proves that the students master the recognition of changes in their bodies (change). These results indicate that health education is also good at building the self-monitoring skills of students that are vital in health promotion behaviors.

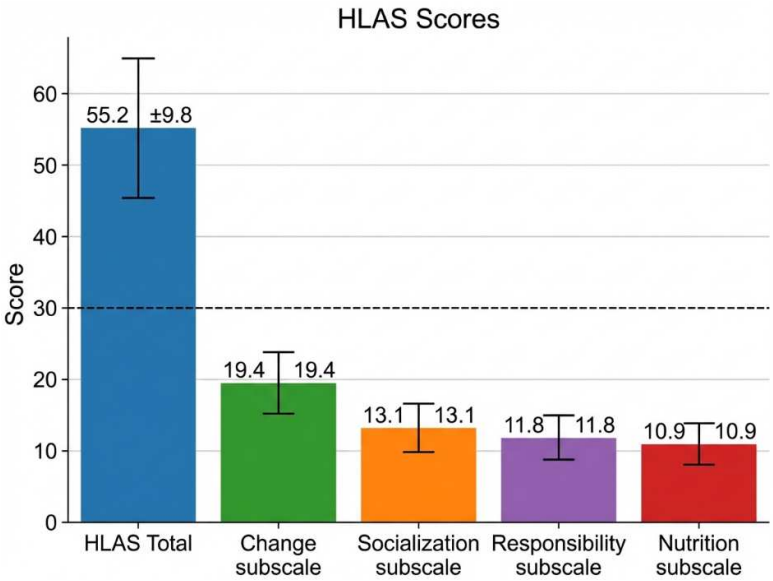


Figure 2: HLAS Total and Subscale Scores

Table 3 suggests that HLAS items generally showed a high level of agreement, which implies high self-awareness among students in terms of physical, emotional, and stress-related changes in health. The majority of answers are grouped on the basis of agree and strongly agree, especially in the identification of the impact of stress and physical changes. Nonetheless, a significant share of indifferent answers indicates that the awareness does not necessarily have a consistent internalization. A low level of disagreement on the items demonstrates that the overall perceptions were rather positive. Yet, the variability suggests that a certain group of students might not be sure about their ability to detect and interpret health-related cues consistently.

Table 3: Distribution of Responses to HLAS Items (Selected Items)

No	Statements	Strongly Disagree n(%)	Disagree n(%)	Neutral n(%)	Agree n(%)	Strongly Agree n(%)
1	I notice physical changes in my body.	18 (3.7)	33 (6.7)	77 (15.7)	151 (30.8)	211 (43.1)
2	When I experience a change in my health, I can describe it.	12 (2.4)	29 (5.9)	114 (23.2)	153 (31.1)	184 (37.4)
3	When I have thoughts/feelings that cause distress, I recognize them.	8 (1.6)	24 (4.9)	112 (22.8)	156 (31.7)	192 (39.0)
4	I recognize the effect of stress on my body.	18 (3.7)	20 (4.1)	78 (15.8)	139 (28.2)	238 (48.3)
5	I recognize the signs of illness that appear in my body.	9 (1.8)	40 (8.1)	120 (24.3)	153 (31.0)	171 (34.7)

Figure 3 shows that there was the greatest amount of agreement in the character of statement- I notice physical changes in my body, with the highest percentage of 43.1 completely agreeing and 30.8 agreeing. This reflects a high level of self-knowledge when it comes to physical modifications, and this is central to staying healthy and early detection of diseases in future health practitioners. This result contributes to the idea that health consciousness is a vital element of health promotion behaviors, as promoted in health promotion models.

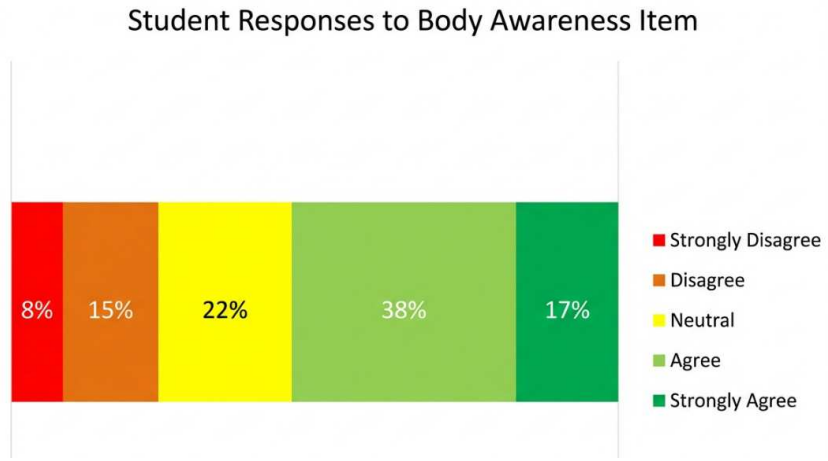


Figure 3: Student Responses to Body Awareness Item

Figure 4 shows that the scores of HLAS differed significantly (p=0.003) between age categories. The young students at age 22 years and above showed a high level of awareness (58.48), which was significantly higher than the young students of 19 years and below (54.3) and even more so for the students of 20-21 years (55.64). That maturity and higher education levels lead to an increase in health consciousness. This is a gradual increase in age, which is in agreement with developmental theories and exposure to health concepts in education.

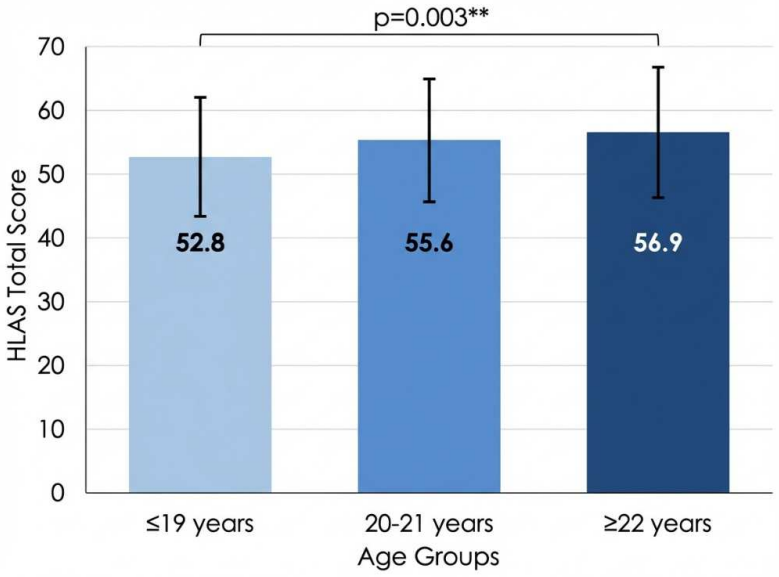


Figure 4: HLAS Total Scores by Age Group

Figure 5 shows the change subscale; there was progressive age improvement (p=0.002); the scores of both the older students (≥22 years) and the youngest one (19.22±4.35) were

20.9±3.85. This trend indicates greater capability of identifying and articulating the changes in health as students proceed in their studies and become clinically exposed. Self-care and professional competence in healthcare facilities depend on the development of this awareness.

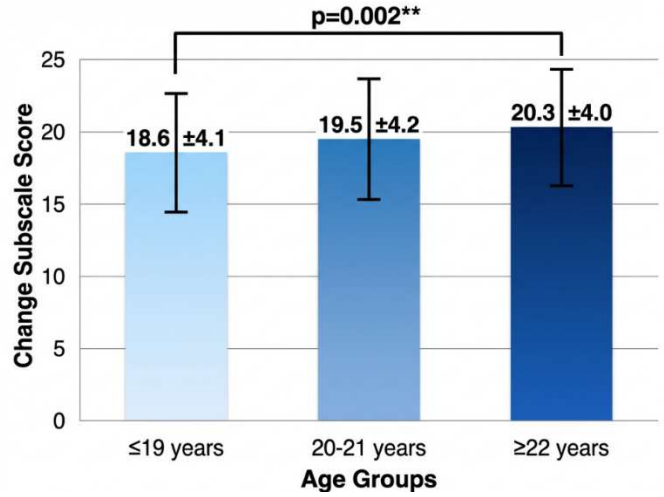


Figure 5: Change Subscale Scores by Age Group

Table 4 indicates that the score of HLAS rises with age and academic year, with a progressive increase in them, which points to the cumulative impact of maturity and education on health awareness. Students aged ≥22 years and those in senior years achieved higher scores across all subscales. Differences based on departments were also present, with students of nutrition scoring the highest, especially within the Nutrition domain, which is curriculum-specific. Conversely, the lower scores of first-year students imply limited exposure in the early stages, which explains the need to incorporate the concepts of health promotion during the initial stages of academic training.

Table 4: Distribution of HLAS and Subscale Scores by Socio-demographic Characteristics

Variable	Category	HLAS Total	Change	Socialization	Responsibility	Nutrition
Age	≤19	54.3 ± 11.04	19.22 ± 4.35	13.78 ± 4.14	11.43 ± 2.6	9.87 ± 3.37
	20-21	55.64 ± 11.28	19.77 ± 4.27	14.47 ± 3.85	11.77 ± 2.7	9.64 ± 3.2
	≥22	58.48 ± 9.99	20.9 ± 3.85	15.2 ± 3.47	12.14 ± 2.42	10.34 ± 2.81

Department	Nutrition	60.35 ± 10.06	21.02 ± 3.8	15.26 ± 3.71	12.33 ± 2.59	11.65 ± 2.67
	Midwifery	56.34 ± 10.44	20.17 ± 4.1	15.13 ± 3.65	11.9 ± 2.65	9.23 ± 3.01
	Nursing	55.69 ± 11.11	19.85 ± 4.29	14.15 ± 3.88	11.67 ± 2.56	10.07 ± 3.09
Year	1	53.67 ± 12.16	18.92 ± 4.78	13.88 ± 4.27	11.25 ± 2.95	9.68 ± 3.35
	2	55.12 ± 10.87	19.68 ± 4.12	14.24 ± 3.78	11.6 ± 2.53	9.66 ± 3.27
	3	58.24 ± 9.37	20.72 ± 3.62	15.26 ± 3.43	12.32 ± 2.35	9.94 ± 2.8
	4	59.34 ± 9.13	21.33 ± 3.34	15.25 ± 3.31	12.29 ± 2.18	10.53 ± 2.82

Figure 6 indicates significant differences existed between departments (p=0.014) with nutrition/dietetics students having the highest mean score (60.35±10.06), midwifery (56.34±10.44) and nursing (55.69±11.11). The findings indicate that the content of the curriculum and professional orientation are some of the factors that affect the aspect of healthy living awareness among students. Probably, because of the specialized interest in nutrition and wellness of dietetics programs, the overall knowledge of health is higher.

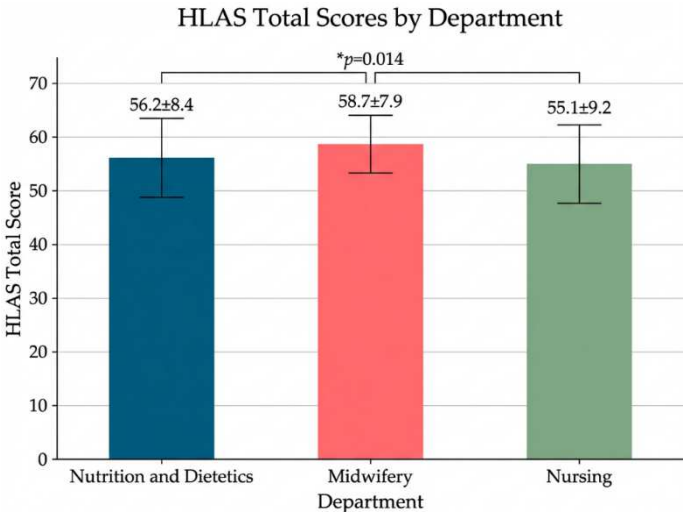


Figure 6: HLAS Total Scores by Department

Figure 7 shows that the Nutrition subscale recorded the biggest differences in the departments (p=0.001). The highest score was observed among the nutrition/dietetics students (11.65±2.67), then the nursing (10.07±3.09) and midwifery (9.23±3.01), showing expected knowledge translation into the curriculum and demonstrating curriculum specificity. This result highlights the role of discipline-specific education in the development of specific features of health awareness.

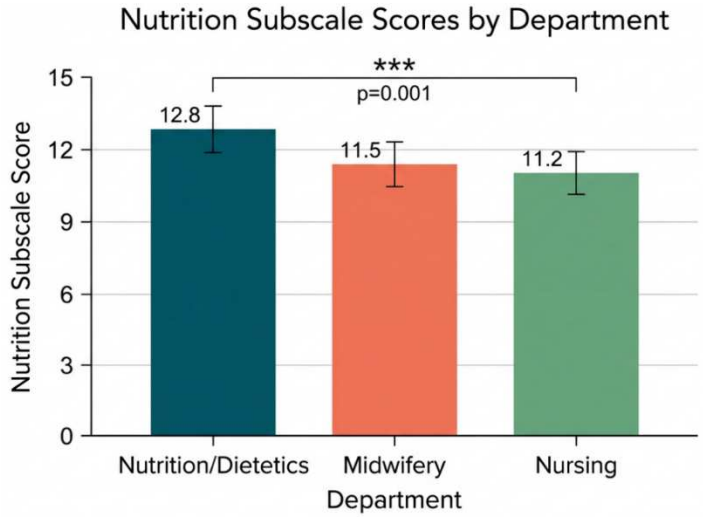


Figure 7: Nutrition Subscale Scores by Department

Figure 8 indicates that A significant upwards trend was evident in HLAS scores as students advanced in academic years (p=0.001), it rose by 53.67 12.16 in Year 1 to 59.34 9.13 in Year 4. This gradual betterment shows the framing effect of health education and professional

socialization in the process of developing awareness among the students on healthy living practices. These findings affirm the usefulness of health sciences programs in the enhancement of health consciousness in the long term.

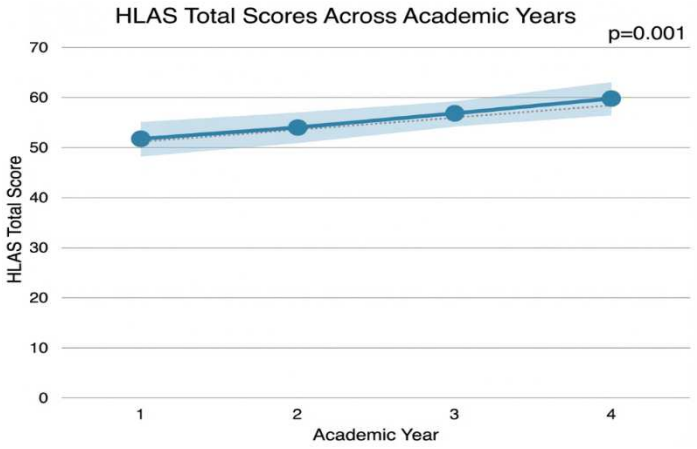


Figure 8: HLAS Total Scores Across Academic Years

Figure 9 indicates that all subscales, with the exception of nutrition, recorded a significant increment in academic years. The Subscales Change, Socialization, and Responsibility have shown the same improvement ($p<0.05$), indicating the holistic approach in teaching health sciences in developing a multi-faceted awareness. The comparatively reliable Nutrition scores indicate the possibility of a baseline nutritional knowledge at an early age of educational attainment or the necessity of certain nutrition knowledge reinforcement during the education process.

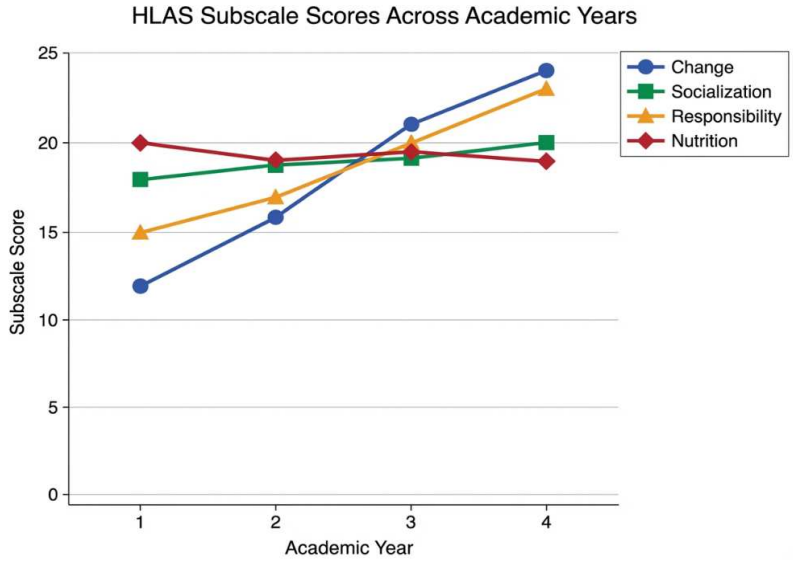


Figure 9: HLAS Subscale Scores Across Academic Years

Table 5 shows weakly significant positive relationships between age and HLAS scores. The total score ($r = 0.141$, $p = 0.002$) indicates that awareness increases slightly with age. These patterns were also noted among subscales, where change ($r = 0.131$) and nutrition ($r = 0.102$) had the highest and lowest correlation, respectively. Although important, small effect sizes indicate that age is not a significant predictor of awareness. Other variables like education, exposure to the curriculum, and individual motivation probably have a greater effect. The results confirm a multifactorial theory, in which age has a minor but significant impact on the formation of healthy living awareness.

Table 5: Correlation Analysis of Scale Scores with Age Variable

Variable	**Age (r)**	**Age (p)**	**Age (n)**
HLAS Total	0.141	0.002	481
Change	0.131	0.004	483
Socializing	0.126	0.005	487
Responsibility	0.111	0.014	486
Nutrition	0.102	0.024	486

Figure 10 revealed positive correlations between age and HLAS Total scores ($r=0.141$, $p=0.002$), which confirms the observation that with the increase in age, the level of health awareness also increases. The relationship highlights the collectivity of biological maturation, life experiences, and educational progression in health consciousness development. The positive, low but significant correlation indicates that age may be one of the many factors that lead to health awareness.

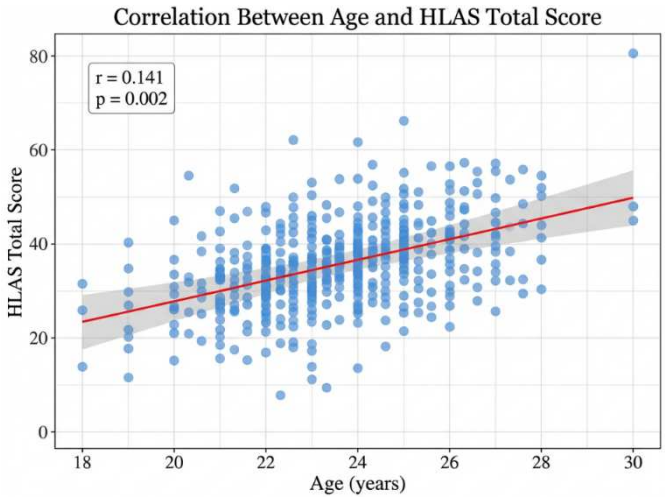


Figure 10: Correlation Between Age and HLAS Total Score

In Figure 11, the correlation analysis showed weak yet statistically significant positive relations between age and all of the scale components ($p<0.05$). Change subscale had the highest correlation ($r=0.131$, $p=0.004$) and nutrition was the least correlated ($r=0.102$, $p=0.024$), which demonstrated that development of awareness was more diverse among various dimensions of a healthy lifestyle. The pattern of differentiation development indicates that some of the dimensions of health awareness are age and experience-responsive, compared to others.

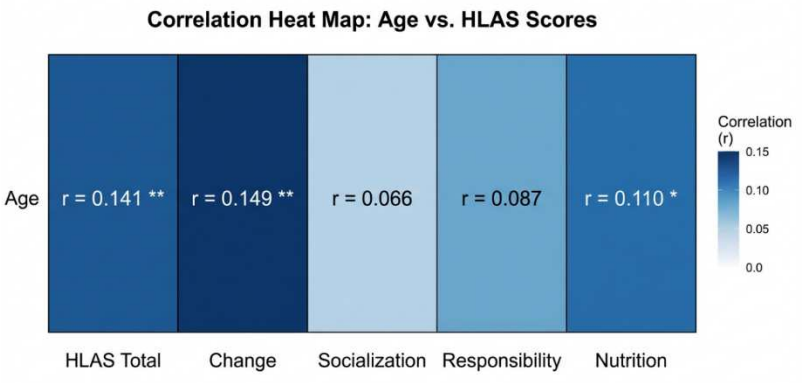


Figure 11: Correlation Heat Map - Age vs. HLAS Scores

The samples in the study, as shown in Figure 12, indicate that the study population was mainly composed of female students (78.3, n=386) as opposed to male students (21.7, n=107), which resembles the normal gender distribution in health sciences programs, especially in the nursing and midwifery field. The only statistic that showed a significant difference between males and females was the Nutrition subscale ($p=0.023$), where male students had a higher score (10.52 ± 3.20) than the female students (9.81 ± 3.06). This observation is different from certain

literature, indicating that females express an increased level of health awareness, hence context-specific differences in health behaviors.

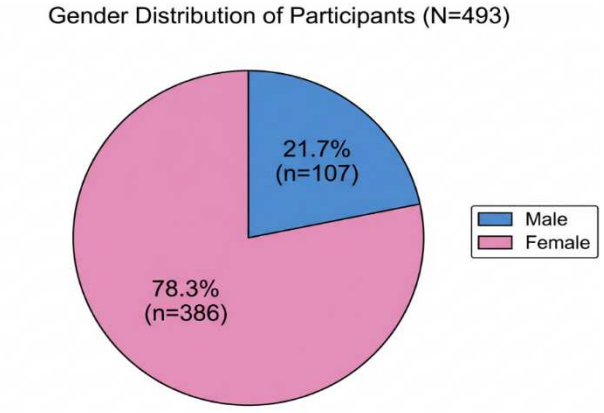


Figure 12: Gender Distribution of Participants (N=493)

Figure 13 demonstrates the imbalanced profile of the healthy living awareness, with Change and Socialization dimensions constituting the strongest ones, and at the same time, a more significant dimension of responsibility and the most significant improvement opportunity belonging to nutrition. This trend indicates that students are successful at identifying the change in their health and interacting with health information at the social level, but to convert such awareness into nutritional behavior, further stress in education is necessary. These findings can be applied to the curriculum development in health sciences programs.

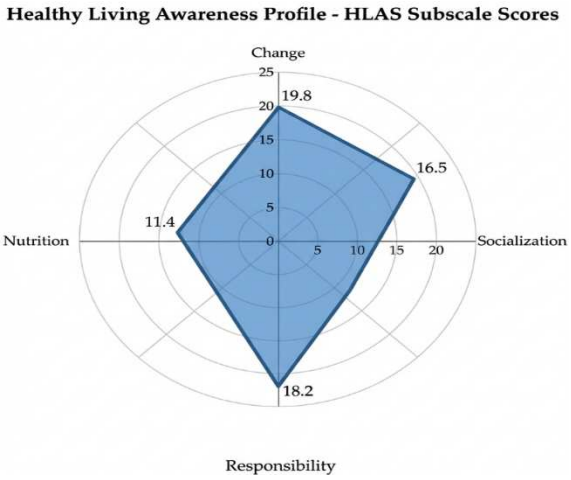


Figure 13: Healthy Living Awareness Profile - HLAS Subscale Scores

Discussion

Healthy living encompasses good nutrition, exercise, sleep, and the mind. Students in universities and in health sciences tend to acquire lifelong habits at this stage. Still, there is usually a disparity between what they know about their health and what they actually do. The present study indicated a moderate to high level of knowledge of healthy living awareness that can be compared with the randomized controlled study by N. Alotaibi et al. (2021). The study showed that the level of knowledge about the strategies of a healthy lifestyle was significantly improved ($p<0.001$) in 155 participants, particularly in intervention groups. Interestingly, the workshop group had the greatest effect size (1.54), followed by Instagram (0.99) and brochure (0.91), which supports the findings of the current study that awareness levels can be increased through organized educational exposure [20].

Similarly, another cross-sectional study by M. Gülşen et al. (2025) showed that health literacy scores (32.32±9.68) were positively associated with healthy lifestyle awareness scores (57.81±12.08), with 89% of students demonstrating adequate or excellent health literacy ($p<0.001$). This is similar to the findings of the present study, wherein more advanced students, in terms of academic years, had a high awareness level, which shows the cumulative influence of education. Moreover, the positive relationship between age and awareness in the present study ($r=0.141$, $p=0.002$) can be compared to a study by M. Gülşen et al. that also highlighted cognitive and behavioral maturation as a contributing factor [21].

The present study also determined that the nutrition/dietetics students scored highest in awareness (60.35, 10.06), midwifery (56.34, 10.44) and nursing (55.69, 11.11) ($p=0.014$). This is consistent with the scoping review by N. Khiri and K. Howells (2024), which noted that differences in curriculum exposure have a significant impact on nutritional knowledge. The review cited an inadequate curriculum time and the absence of standardized nutrition education as areas of knowledge gaps, which supported the finding of the current study that discipline-specific education increases awareness, especially in the subscale of nutrition (11.65±2.67, $p=0.001$) [22].

Although the awareness scores were relatively high, the nutrition subscale had the lowest mean (9.96±3.10), and there was a discrepancy between the general awareness and the specific behavioral domains. This finding is also consistent with the scoping review that highlighted the longstanding knowledge gaps on nutrition even after medical education. Likewise, a systematic review and meta-analysis by A. Shafiee et al. (2024) found a worrying worldwide prevalence of

overweight (18% 95% CI: 1720%) and obesity (9% 95% CI: 711%) in medical students and a combined rate of 24% (95% CI: 2227%). These results indicate that awareness might not always lead to healthy behaviors, which goes in line with the implication of the current study of a knowledge-practice gap [22, 23].

On the contrary, the systematic review by Shafiee et al. (2024) suggested that growing trends of obesity among medical students ($p<0.05$) reflected the deteriorating health behavior patterns over time. Although the current study shows that the better the age and education (age 22+ years: 58.48+9.99), Shafiee et al. in their study reported that the better the knowledge, the better the health outcomes may be, which is why behavior change is such a complicated issue [23].

In addition, the present study found high self-monitoring capacity, as there was strong agreement in self-awareness items, including perceiving physical changes, 43.1% strongly agree, 30.8% agree. This result is consistent with M. Gülşen et al. (2025), who highlighted the importance of cognitive processes and self-efficacy to health behavior models. Nonetheless, another study reported that this relationship was also moderated by behavioral variables (snack frequency) 0.086, $p=0.048$), which means that lifestyle habits may undermine the effect of health literacy, which was not directly investigated in the present study [21].

Gender difference in the present study indicated that males scored higher on nutrition (10.52 ± 3.20 vs 9.81 ± 3.06, $p=0.023$) as opposed to published literature, which typically indicated that females tend to have a greater health awareness. This deviation shows the presence of contextual or cultural effects, which were also indirectly supported by N. Khiri and K. Howells (2024) study, as it discussed sociocultural and perception-based barriers [24].

Strengths, Limitations and Recommendations

The strengths of the current study are a large sample size, the use of a valid and reliable scale (Cronbach's alpha=0.904), and a thorough analysis of various demographic variables. It also offers subscale-level information. Nevertheless, snowball sampling can have an impact on generalizability. Also, there was no measurement of behavioral outcome, which limited the measurement of the knowledge-practice gap regardless of the observed levels of awareness. It is suggested to reinforce the early curriculum integration of health promotion concepts, introduce practical lifestyle training, and address nutrition gaps through specific interventions. Universities

also need to create a favourable environment and educational campaigns to close the knowledge-health behaviour adoption gap.

Conclusion

The awareness of healthy living in health sciences students is a pillar to successful future healthcare practice, but awareness without significant behavior change is ineffective. Knowledge-practice gaps continue to exist, and more practice-based educational methods are needed. It is necessary to reinforce experiential learning, reinforce competencies in domains, and instill health-promoting environments in the academic setting. This gap will not only help students improve their own personal health but will also increase their ability to become effective promoters of preventive health.

Abbreviations

Healthy Living Awareness Scale (HLAS)

Strengthening the Reporting of Observational Studies in Epidemiology (STROBE)

Ethics approval and consent to participate

The ethical standards of the study were established in the Research Ethics Committee of the Mardin Artuklu University Committee on Research and Publication Ethics (Ethics code: 10/06/2023 and 2023/1-6). The research was conducted in accordance with the Helsinki Declaration. All the participants in the study were informed about their consent.

Consent for publication

Conflict of Interest: The authors declare that they have no conflict of interest. I have no conflicts of interest to disclose.

Availability of data and materials

Data or materials may be shared by the researcher upon request by the editorial board.

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Authors' contributions

Conceptualization: G.Ç.Y; Methodology: G.Ç.Y; Formal analysis and investigation: G.Ç.Y; Writing - original draft preparation: G.Ç.Y.; Writing - review and editing: G.Ç.Y.; Funding acquisition: G.Ç.Y.; Resources: G.ÇY.

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