
Introduction

Adolescence is a complex stage of development spanning gap between childhood and adulthood. It starts with the biological changes of puberty and ends with full maturity but its timing, length and experience is highly culture dependent. Adolescence has become a stage spanning several years leading to independence from the family of origin and is characterized by physical growth, sexual, cognitive and social development, (*Gowers, 2005*).

According to (*WHO, 2000*), adolescents make up one fifth of the worlds population, and 86% live in developing countries of which 16% live in Africa. In Egypt, adolescents constitute nearly one quarter of the population there are 3.37 million adolescents enrolled in preparatory schools nationwide and 2.52 millions students in general and technical secondary schools, (*Galal et al., 2001*).

As reported by *Karium (2002)*, there are 14 million adolescent in Egypt. 47% of them are anemic, two thirds had parasitic disease, 18% of males and 14% of females had delayed sexual maturity due to anemia and low family income. And according to the last population census, (*Egypt, 2006*). Egypt has 7766386 persons aged 10-15 years, they represent 10.74% of all Egyptian population and the Kalyobia governorate has 425.322 persons which represent 10.04% of all population aged between 10 to 15 years.

Lifestyle is denoted "the way people live" reflecting a whole range of social values, attitudes, and activities. A healthy lifestyle is easier to

maintain when healthful pattern of behavior are learned early in life, (*Bakr et al., 2002*).

Lifestyle diseases are responsible for 58.4% of morbidity and 68.4% of mortality globally. Many of these – smoking, risky sexual behavior, alcohol and drug dependency – have their roots in adolescence. Preventing risky behavior and promoting healthy choice among adolescence can yield positive health outcomes, not just during adolescence but also during adulthood, (*WHO, 1999*).

The World Health Organization (WHO) has defined the term “health-related quality of life” as the individuals’ perceptions of their positions of life in the context of the culture and value systems in which they live and in relation to their goals, expectations, and concerns, (*Mohangoo, et al., 2007*).

Quality of life (QOL) is generally considered to be a multifactorial construct that focuses on individuals’ subjective evaluation of their physical health, mental health, and social functioning. It may be linked with the World Health Organization (WHO) definition of health as ‘a state of complete physical, mental, and social well-being and not merely the absence of disease and infirmity, (*Chen, et al., 2004*).

Quality of life has three domains: Being, Belonging, Becoming. Being reflects three subdomains: physical, psychological, and spiritual being. Physical being encompasses physical health, personal hygiene nutrition, exercise, clothing and general physical appearance. Psychological being includes person's psychological health and adjustment, cognition, feeling and self concept. Spiritual being refers to personal values and spiritual

beliefs. Belonging concerns the person fit with his environment which includes his connection with the physical environment, his relationships with other and access to community resources as adequate income, health and social services .Becoming refers purposeful activities carried out top achieve personal goals, hopes, aspiration, stress reduction, and the maintenance of knowledge and skills and adaptation to change, (*Abd El Gawad ,2000*).

According to World Health Organization's (WHO) goal of health for all is encompasses a range of component activities contributing to health, such as building healthy public policy, creating supportive environments, strengthening community action, developing personal skills, and reorienting health services. Health promotion was generally accepted as beginning with people who were basically healthy and seeking to enhance their lifestyles and achieve well-being, (*Chen, et al., 2007*).

Health education is any combination of planned learning experiences based on sound theories that provide individuals, groups, and communities the opportunity to acquire the information and the skills needed to make quality health decision, this process involves several key component s .First, health education involves the use of learning teaching strategies .Second, learner maintain voluntary control over the decision to make changes in their actions. Third, health education focuses on behavior changes that have been found to improve health status, (*Edelman & Mandle, 2006*).

Adolescents' health is the responsibility of the society ,parents and adolescents themselves, many health problems commonly occurring in adolescence can be prevented, thus improved quality of life and equally importantly, future savings in person and state health expenditures. A basic

tent of effective health provision for both sexes is the need to identify conflict between health promotion and culture values, (*Galal, et al., 2001*).

Failure to address the adolescents needs today can cause problems tomorrow if they are not adequately prepared to be physically able to undertake their productive and reproductive responsibilities as adult, the consequences will be costly for the country. Thus, United Nation International Conference on Population and Development (ICPD), held in Cairo 1994, emphasized on the importance of promoting actively the health, well being and potentials of all adolescents and to meet their special needs, (*Abou El Yazed, 2006*).

School nurse is seen as a resource to be involved in planning and delivery of Personal, Social and Health Education (PSHE) within schools. The nurse may contribute to curriculum development and support teaching staff in delivering health education to groups within the classroom or elsewhere. Events such as health fairs or parent meetings also provide a form in which advice can be imparted health-related behaviors, (*Fitton & Ellimans, 2001*).