



Effect of Perceived Self-efficacy on Health Promoting Lifestyle of Female Employees

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Abstract

The paper discusses the effect of perceived self-efficacy on health promoting lifestyle of female employees. The five dimensions of nutrition, stress management, spiritual growth, physical activity and health responsibility of Health Promoting Lifestyle Profile II have been used to measure the lifestyle. The perceived self-efficacy has been measured through four dimensions of nutrition, psychological wellbeing, exercise and responsible health behaviour of Self-Rated Abilities for Health Practices Scale. The descriptive study is based on a sample of 824 working females taken from Delhi/National Capital Region of India by using stratified sampling method. The study's constructs have been validated by confirmatory factor analysis and the relationship has been analysed through structural equation modelling. The study finds that perceived self-efficacy's effect on health promoting lifestyle of female employees is found to be positive and significant. The self-efficacy enhancing health interventions are an effective way to improve health promoting lifestyle of the people. The findings of the study indicate the key role of perceived self-efficacy in attaining healthy lifestyle.

Keywords: Healthy Promoting Lifestyle, Perceived Self-efficacy, Employee, Structural Equation Modelling

JEL Classification: I1, I10

Paper Classification: Research Paper

Introduction

The rise in the education level, growing career expectations, increased costs of living and household expenses, etc. have made the females in India to break the established traditions and norms of the society regarding their roles and status in families. Today, apart from looking after their children and performing the household chorus, they are ready to seek employment and work. The multiplicity of the tasks viz. competing demands of the family, children and job have put considerable pressure on their health. The females have been forced to sacrifice their health

to fulfil the needs of their families and jobs (Agazio et al., 2002). Despite widespread accessibility of health care services in the country, the females have to face stiff challenge in the context of the preventive actions for maintaining their health. The government contributes only 20 percent of the total health care expenses and the balance comes out of the pockets of the public, majority of whom cannot afford the high costs of health care services (Kumar, 2010). Considering the multiplicity of roles and tasks that females perform in India, their health promoting lifestyle requires more attention. The demographic variables like age, monthly income, marital status and the number of children play a prominent role in influencing the adoption of health promoting lifestyle, as living a healthy lifestyle does not depend completely on the individuals. It relies heavily on the surroundings and socioeconomic status in which we live (Denton et al., 2004; Johnson, 2005; Ochieng, 2006; Fong et al., 2007). Thus, working females face a unique challenge emanating from the hectic life and as such, it is necessary to determine the specific factors influencing their participation in health promoting lifestyle.

A large number of factors motivate an individual in the adoption of a healthy lifestyle but self-efficacy has been proved to be strong predictors of promoting healthy lifestyle (Clark, 1998; Padden et al., 2012). Self-efficacy means people's belief in their abilities to perform the desired behaviours to achieve something (Bandura, 1977, 1986 & 1997). Lifestyle has been defined as a customary daily activities performed by individuals during their life span. These activities affect the health of individuals (Darby & Crump, 1999; Delaun & Ladner, 2003). Self-efficacy and perceived health status were found significantly related to health-promoting behaviours (Sohng et al., 2002). Health behaviour refers to any kind of activity undertaken by individuals for preventing the occurrence of disease or improving the health and wellbeing (Conner & Norman, 1996). Health behaviour may be health enhancing and health compromising (Khatoon, 2012). The theory of planned behaviour (TPB) emphasizes that intention is an important determinant of health behaviour (Ajzen, 1991).

The social cognitive theory (SCT) shows the contribution of personal sense of control in improving the health behaviour (Bandura, 1997). Health belief model (HBM) postulates that the likelihood of the behaviour depends upon individuals' belief in personal threat and the effectiveness of proposed behaviour (Rosenstock et al., 1988). The protection motivation theory (PMT) highlights the role of fear appeal in influencing attitude and behaviour (Rogers, 1975). Self-efficacy is the core component of SCT, TPB, and HBM (Lefebvre, 2000). The social marketing campaigns with a focus on enhancing self-efficacy produce positive outcomes (Rimal & Creel, 2008). The smoking cessation rate increases with an increase in self-efficacy enhancement (Naeem, 2010). Pender's health promotion model (HPM) is based on Bandura's social cognitive theory (Bandura, 1986) and expectancy value theory of motivation (Fishbein & Ajzen, 1975). HPM model has three components of personal characteristics, behaviour specific knowledge (cognitive variables) and desired behaviour (outcome). The four behaviour specific variables have an equal influence on the behavioural outcomes (Pender, 1996). Health-care professionals should focus on modifiable behaviour specific variables of Pender's HPM for effective handling of diabetes self-management (Ho et al., 2010). Pender's health promotion model addresses significant aspects of health promotion behaviour (Haydari & Khorashadizadeh, 2014). Health promotion can be divided into four major components of human biology, environment, lifestyle and health institutions (Naidoo & Wills, 1991). Health promotion comprises nutrition behaviour, use of alcohol, absence of exercise or physical fitness, fruit and vegetable consumption. The present research paper analyses the effect of perceived self-efficacy of female employees on their health promoting lifestyle.

Theoretical Framework

Perceived Self-efficacy

Self-efficacy being one of the strongest determinants affects the chances of adopting the specific behaviour required to perform activities satisfactorily (Strecher et al., 1986; O'Leary, 1992; Holloway & Watson, 2002). Self-efficacy as a central concept in self-management refers to individual's confidence in achieving desired goals (Zotti et al., 2007). The students' academic performance is positively related with self-efficacy (Bandura, 1982; Gist & Mitchell, 1992). The population based approaches of public health campaigns help in promoting changes in the people who have a high perceived efficacy for self-management and the positive expectations from the prescribed changes improving their health (Bandura, 2004). The three dimensions of perceived self-efficacy are level, strength, and generality (Bandura, 1997). Self-efficacy beliefs may originate from personal accomplishment, vicarious experiences, verbal persuasion, and emotional arousal (Bandura, 1997). People are more likely to imitate the behaviours of people similar to them (Bandura, 1986). Verbal persuasion is an effective method to influence exercise related self-efficacy of the people (Fitzsimmons et al., 1991) and is a very commonly used method of health education. The emotional arousal explains that a person does not get confused in a threatening situation and as a result he/she is capable in overcoming the situation (Bandura et al., 1977). Emotional arousal influences the self-efficacy (Bandura & Adams, 1977).

Health Promoting Lifestyle

By adopting a healthy lifestyle, an individual tries to maintain and promote his/her health and starts taking proper diet, following exercise plan, avoiding unhealthy activities (Phipps & Sands, 2003). Health promoting lifestyle construct encompasses the self-initiated actions and perceptions which serve in maintaining and enhancing the levels of wellness, self-actualisation and fulfilment of individuals (Edelman & Mandle, 2006). There are varieties of factors that motivate a person to modify his/her lifestyle. (Hoek and Jones 2011) explained the role of individual and environment alteration in modifying specific lifestyle or behaviour. Public policy and regulations largely affect the environmental adaptation. Time constraints following the exercise programs and schedule conflicts have been identified as barriers to participation in health promotion programs by the employees of universities (Lisa et al., 2015). The age and occupation influences the stress management behaviour of female employees (Ram & Laxmi, 2015) Lifestyle modification requires behavioural changes that constitute a major part of daily habits. Social marketing applies the tools and techniques of marketing management to modify the behaviour or lifestyle (Kotler & Zaltman, 1971). Health interventions need to be directed to promote behavioural and lifestyle changes like healthy nutritional practices and active living, etc. It can help in preventing or delaying some health problems, (World Health Organisation 2009).

Perceived Self-efficacy and Health Promoting Lifestyle

Does one's perceived self-efficacy affects the adoption of health promotion activities? A person wants to jog but he/she feels shy of jogging in Public Park, and therefore lacks the ability (self-efficacy) to perform the health enhancing activity. Self-efficacy is known as a predictor of health promoting behaviour because internal motivation or confidence must be present to initiate any action (Rimal, 2000; Hong et al., 2007). A person will be less likely to perform a particular behaviour when there is less control over personal and situational factors (Pender, 1982). Self-efficacy is a vital element of health promoting lifestyle. Person's belief in his/her abilities is essential to adopt health promoting lifestyle (Bandura, 1977). Jackson et al. (2007) have found that

both health value and health self-efficacy are significant indicators of health-promoting lifestyle. Susanna et al. (2015) have observed that psychological distress and nutrition and exercise self-efficacy are significantly associated with a health-promoting lifestyle. Health promoting lifestyle has a significant positive correlation with self-efficacy and self-efficacy is a strong factor predictor of health promoting lifestyle profile of obese students (Park & Oh, 2004). Perceived self-efficacy is an important determinant of health promoting behaviours among military women with children (Agazio et al., 2002). Self-efficacy enhancing interventions were found effective in promoting health behaviour in people with critical illness (Stuifbergen & Becker, 1994; Jones et al., 2007; Hoffman Amy J., 2013). Gillis (1994) has found that the adolescent's health promoting lifestyle is strongly influenced by self-efficacy, perceived health status, ethnicity and health promoting lifestyle of parents. Based on above discussed reviews, following research hypothesis has been formulated for the present study:

Ha: Perceived self-efficacy significantly positively influences health promoting lifestyle (HPL) of female employees.

Method

Procedure and Participants

The primary data has been collected with the help of the structured questionnaires. A sample of 824 female employees in the age of 20 years and above, engaged in teaching, health, corporate and bank/insurance profession was taken from Delhi/National Capital Region of India by stratified sampling method. The respondents were surveyed regarding demographic profile, perceived self-efficacy and health promoting lifestyle. The consent for conducting the survey was obtained from branch heads of the organizations. On the basis of age, the sample respondents were categorised into 03 groups. The number (per cent) of the participants in the age groups of 20-30, 30-40 and above 40 years were 475 (57.6 per cent), 177 (21.5 per cent) and 172 (20.9 per cent) respectively. The participants engaged in school teaching, college teaching, health professionals, banking/insurance and corporate sector were 128 (15.5 per cent), 132 (16.0 per cent), 229 (27.8 per cent), 226 (27.4 per cent) and 109 (13.2 per cent) respectively. Health status of 20 (2.4 per cent), 156 (18.9 per cent), 422 (51.2) and 226 (27.4 per cent) participants were found poor, average, good and very good respectively. In the sample of 824; the number of married, unmarried, divorced and widow female employees were 446 (54.1 per cent), 353 (42.8 per cent), 13 (1.6 per cent) and 12 (1.5 per cent) respectively. Perceived self-efficacy and health promoting lifestyle (HPLP II) have been taken as exogenous and endogenous variables of the study and validated by first order confirmatory factor analysis and their relationship has been analysed by structural equation modelling (SEM).

Instruments

The health related self-efficacy was measured by Self-Rated Abilities for Health Practices Scale (SRAHP), which is a twenty eight items scale with the four dimensions of nutrition, psychological wellbeing, exercise and responsible health practices. The scale items have been rated on a 5-point Likert scale varying from zero (not at all) to four (completely). Health Promoting Lifestyle Profile II (HPLP II) designed and revised by Walker et al. (1987) and SRAHP by Becker et al. (1993) have been adopted in the study for measuring health promoting lifestyle and self-efficacy of female employees. HPLP II has 52 items Walker et al., (1987) containing the six sub-scales. In the study, the modified 42 items instrument has been used with five sub-scales i.e. Health Responsibility (9 items), Physical Activity (8 items), Nutrition (8 items), Spiritual Growth (9

items) and Stress Management (8 items). Every sub-scale has been measured independently. The responses have been evaluated on a four point Likert scale ranging from 1 (never), 2 (sometimes), 3 (often) to 4 (routinely). One item (item number 38) has been excluded from the final analysis because of cultural adaptability of the item. Both the scales were validated by applying first order confirmatory factor analysis on the collected data.

Validation of Self-rated Abilities for Health Practices Scale (SRAHP)

The original confirmatory model of SRAHP has a poor fit of indices (CMIN=2055.2; DF=344; CMIN/DF=5.97; GFI=0.83; CFI=0.74; AGFI=0.80; TLI=0.71; RMSEA=0.07). The modification indices were used to improve the original model. The items i.e. SE3 (Figure out how much I should weigh to be healthy), SE5 (Tell which foods are high in fibre content), SE9 (Keep myself from feeling lonely), SE11 (Avoid being bored) and SE23 (watch for negative changes in my body's condition) of SRAHP have cross loadings on other dimensions. These items were removed and the modified model was re-estimated. The modified model-1 has a better fit (CMIN=1163.1; DF=203; CMIN/DF=5.73; GFI=0.87; CFI=0.80; AGFI=0.85; TLI=0.78; RMSEA=0.07) in comparison to the original model but still not good. In model-1, items SE12 (Talk to friends and family about the things that are bothering me), SE15 (Do exercises that are good for me), SE16 (Fit exercise into my regular routine), SE17 (Find ways to exercise that I enjoy) and SE22 (Figure out where to get information on how to take care of my health) were removed on the basis of covariance between error terms of two different dimensions, lower factor loadings and cross loadings on other items. The items with correlated error terms have been removed in the modified model-2 because the content of the items were different. The correlated errors undoubtedly show the dramatic improvement in overall model with unwanted co-variation but at the cost of meaning and conclusion drawn from the model (Gerbing & Anderson, 1984). The modified model-2 satisfies the condition of zero cross loading and goodness of fit (CMIN=517.5; DF=129; CMIN/DF=4.01; GFI=0.93; CFI=0.89; AGFI=0.91; TLI=0.87; RMSEA=0.06). First order confirmatory validation of SRAHP has shown good fitness indices (Ram & Laxmi, 2016). The acceptable range of incremental indices is 0 to 1 (Malhotra & Dash, 2010); (Stevens, 2009); (Ho, 2006). The factor loadings of the items of SRAHP were found ranging from 0.40 to 0.81. The overall reliability (Cronbach alpha) of SRAHP scale is 0.80. The eighteen observed variables of the study confirmed into four dimensions of health related self-efficacy (Table 1).

Table 1: Results of first order confirmatory factor analysis of SRAHP

Sub-scales (Cronbach's alpha)		Items	Factor Loading
Nutrition (0.71)	SE 1.	Find healthy foods that are within my budget.	.79
	SE 2.	Eat a balanced diet.	.66
	SE 4.	Brush my teeth regularly.	.40
	SE 6.	Figure out from labels what foods are good for me.	.42
	SE 7.	Drink as much water as I need to drink every day.	.68
Psychological Well Being (0.62)	SE 8	Figure out things I can do to help me relax.	.66
	SE 10	Do things that make me feel good about myself.	.42
	SE 13	Figure out how I respond to stress.	.55
	SE 14	Change things in my life to reduce my stress.	.54

Exercise (0.78)	SE 18	Find accessible places for me to exercise in the community.	.63
	SE 19	Know when to quit exercising.	.70
	SE 20	Do stretching exercises.	.81
	SE 21	Keep from getting hurt when I exercise.	.64
Responsible Health Behavior (0.73)	SE 24	Recognize what symptoms should be reported to a doctor or nurse.	.61
	SE 25	Use medication correctly.	.60
	SE 26	Find a doctor or nurse who gives me good advice about how to stay healthy.	.67
	SE 27	Know my rights and stand up for myself effectively.	.64
	SE 28	Get help from others when I need it.	.48

Significant covariance ($CR > 1.96$; $p < 0.001$) has been found among all the dimension of SRAHP except in nutrition and exercise related self-efficacy. The standardized correlation coefficients of self-efficacy (nutrition, psychological wellbeing, exercise and responsible health practices) are positive. The correlation coefficient of all these factors ranged from 0.01 to 0.70. The values show that eighteen observed variables of the study significantly represent the four latent dimensions of self-efficacy construct.

Validation of Health Promoting Lifestyle (HPLP II)

The fit indices ($CMIN=3975.8$; $DF=809$; $CMIN/DF=4.91$; $GFI=0.79$; $CFI=0.61$; $AGFI=0.76$; $TLI=0.58$; $RMSEA=0.06$) of the original confirmatory model of HPLP II are having very poor fit. The study has used items parcel method (Russell et al., 1998) for improving the original model, instead of the modification indices requiring theoretical justification while correlating the error terms of individual items (Gerbing & Anderson, 1984; Hair et al., 1998; Ho, 2006). The reason behind using item parcels is to confirm the assumptions of multivariate normality and to limit the requirement of large sample size. The five dimensions of HPLP II have been assessed separately. The factor items have been ranked according to their factor loadings. The individual items have been assigned to different parcels in a manner so that each parcel of concerned factor has almost equal average loading. The modified model of HPLP II has a better fit indices ($CMIN=167$; $DF=44$; $CMIN/DF=3.79$; $GFI=0.96$; $CFI=0.95$; $AGFI=0.94$; $TLI=0.93$; $RMSEA=0.05$). The overall reliability (Cronbach alpha) of HPLP II scale is 0.86. The items assigned to each parcel as well as their loadings have been illustrated in Table 2.

Table 2: Results of first order confirmatory factor analysis of HPLP II

Sub-scales (Cronbach's alpha)	Parcels	Items	Factor Loading
Nutrition (0.59)	N1	Item 8	0.67
		Item 14	
		Item 26	
		Item 44	
	N2	Item 2	0.63
		Item 20	
		Item 32	
		Item 50	

Stress Management (0.57)	SM1	Item 5	0.58
		Item 11	
		Item 17	
		Item 29	
	SM2	Item 23	0.70
		Item 35	
		Item 41	
		Item 47	
Spiritual Growth (0.70)	SG1	Item 12	0.62
		Item 18	
		Item 48	
	SG2	Item 6	0.68
		Item 30	
		Item 36	
	SG3	Item 24	0.72
		Item 42	
		Item 52	
Physical Activity (0.73)	PA1	Item 16	0.73
		Item 22	
		Item 28	
		Item 34	
	PA2	Item 4	0.80
		Item 10	
		Item 40	
		Item 46	
Health Responsibility (0.73)	HR1	Item 9	0.66
		Item 27	
		Item 33	
	HR2	Item 15	0.71
		Item 45	
		Item 51	
	HR3	Item 3	0.72
		Item 21	
		Item 39	

The covariances among five predictor variables were found significant by the Critical Ratio (CR>1.96; p<0.001). The correlation coefficients of nutrition, stress management (SM), spiritual growth (SG), physical activity (PA) and health responsibility (HR) are positive. Correlation coefficient of all the factors ranged from 0.28 to 0.85. This indicates that the 42 items contained in 12 parcels were significantly represented by respective latent constructs.

Effect of Self-efficacy on Health Promoting Lifestyle

Structural equation modeling (SEM) has analyzed the effect of self-efficacy on health promoting lifestyle. SEM has used the second order confirmatory factor models of the two constructs. This is an over identified model because the parameters to be estimated are less than the data points ($p(p+1)/2$) in the model (p is the number of observed variables). The model has estimated 70 parameters and 465 sample movements. Therefore, the structural model with 395 (465-70) degree of freedom (df) yields a significant chi-square value of 1765.9 ($p < 0.05$). Usually, chi-square value has a very high probability to be significant. However with reference to SEM, it is expected to be insignificant (Ho, 2006). The fitness indices of the model (CMIN=1765.9; DF=395; CMIN/DF=4.47; GFI=0.865; CFI=0.821; IFI=0.822; TLI=0.803; RMSEA=0.065), which are not excellent but show a good fit considering the complexity of the model. The acceptable range of incremental indices is 0 to 1 (Malhotra and Dash, 2010; Stevens, 2009; Ho, 2006), where 0 indicates that a fit not better than baseline model and close to 0.9 for better fit. The GFI for the model is 0.86, which is in the acceptable range for goodness of fit. CFI (0.82), IFI (0.82) and TLI (0.80) are incremental fit indices which compare proposed model to the baseline model or independent model. Although Marsh et al. (2004) warned about using the indices as a thumb rule, especially where the cut off values of more than 0.900 may not work equally well with different sample sizes and fitness indices. While deciding the fit of model, adequacy and interpretability of parameters to be estimated, complexity of the model and theoretical aspects must be taken into consideration (Hu & Bentler, 1998; Marsh et al., 2004). RMSEA calculated for error of approximation in population is 0.065. The values ranging from 0.050 to 0.080 are acceptable (Browne & Cudeck, 1993; MacCallum et al., 1996).

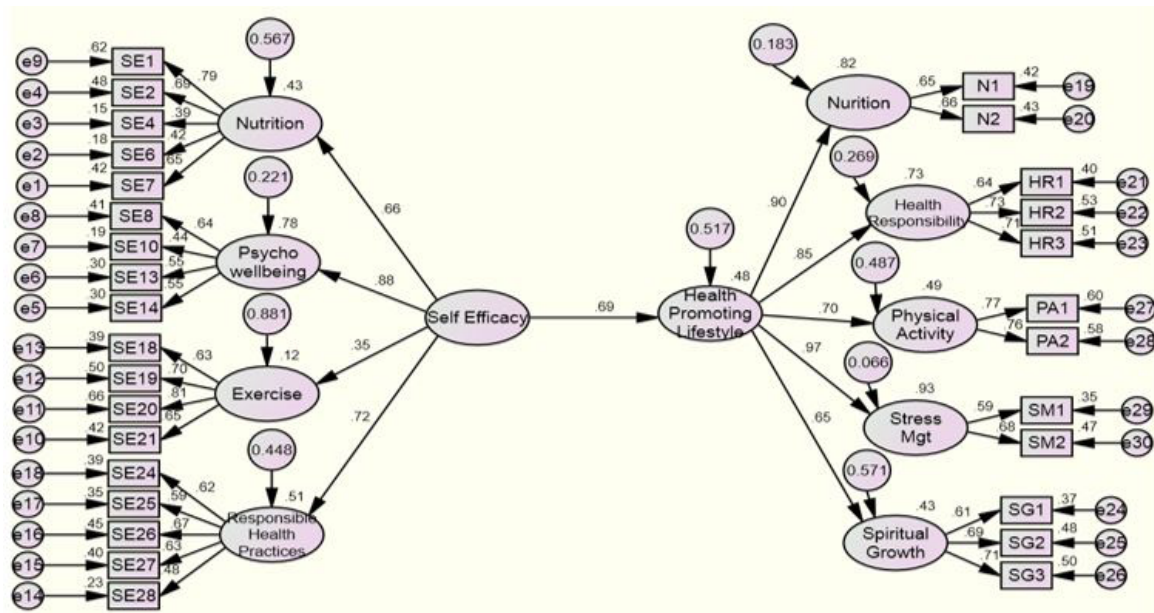
The unstandardized regression weights were found significant ($CR > 1.96$, $p < 0.05$). The standardized weights (Figure 1) of nutrition related self-efficacy, psychological wellbeing, exercise and responsible health practices range from 0.345 to 0.883. It has been found that the exercise has minimum contribution while the psychological wellbeing has maximum contribution in self-efficacy of female employees. The positive and significant standardized regression weights demonstrated that these four factors are represented by the main factor i.e. self-efficacy. It has been observed that the standardized regression weights (Figure 1) of all the dimensions of health promoting lifestyle range from 0.655 to 0.966. These four factors are significant and positively represented by the main factor i.e. health promoting lifestyle. It is also found that perceived self-efficacy is significantly ($CR > 1.96$, $p < 0.05$) related with health promoting lifestyle with regression weight of 0.695 (Figure 1). It has also been revealed that all the sub-dimensions are significantly representing or explaining their respective construct. It is reflected in Figure I that the squared multiple correlations (SMC) of the components of self-efficacy ranges from 0.119 (exercise) to 0.779 (psychological wellbeing). The squared multiple correlations (Figure 1) of health promoting lifestyle dimensions range from 0.429 (spiritual growth) to 0.934 (stress management).

Ha: Perceived self-efficacy significantly positively influences health promoting lifestyle (HPL) of female employees.

The self-efficacy's effect on health promoting lifestyle (HPL) of female employees is demonstrated in Figure 1. The unidirectional arrows pointed to the latent factors are residuals which accounted for unexplained variance in the model. It is found that the squared multiple correlation of health promoting lifestyle is positive. It is observed that 51.7 percent variance in HPL is unexplained which was not predicted by self-efficacy while it predicts 48.3 percent variance in HPL. The self-efficacy explained 48.3 percent variance in health promoting lifestyle of female employees. The self-efficacy has a positive and significant influence ($CR > 1.96$, $p < 0.05$) on

healthy lifestyle of female employees (Figure 1). It is inferred that perceived self-efficacy and HPL move in the same direction. The internal motivation should be present in individuals for initiating any action for changing/modifying the behaviour. The increase in health related self-efficacy has a significant positive effect on health promoting lifestyle activities as it creates more possibilities for adopting or maintaining healthy lifestyle. The results of the study reflect the strongest role of perceived self-efficacy in attainment of healthy lifestyle.

Figure 1: Structural model of effect of self-efficacy on health promoting lifestyle



CMIN/DF = 4.47; GFI = 0.86; CFI = 0.82; TLI = 0.80; IFI = 0.82; RMSEA = 0.06

Discussion

The study finds that the self-efficacy significantly affects health promoting lifestyle of female employees. Overall there is a positive significant effect of self-efficacy on health promoting lifestyle of female employees. Health promoting lifestyle is significance explained by self-efficacy related to health behaviour, perceived action barrier and perceived action benefits (Shu-Fen & Chiu-Chu, 2010). Self-efficacy has a positive significance on physical activity and nutritional protective behaviour (Von et al., 2004). Stuijbergen and Becker (1994) have suggested that the effectiveness of health promotion behavioural interventions in the persons with some sorts of disabilities can be enhanced by addressing the perceived abilities which encourage health promoting behaviour. Wu and Pender (2002) have confirmed that the perceived self-efficacy is one of the significant factors determining individuals’ chances of following physical activities. The specially designed interventions for the deaf adults were found to improve self-efficacy of health behaviour (Jones et al., 2007). Self-efficacy enhancing interventions have been found beneficial in optimizing patient outcomes (Hoffman, 2013). The study signifies that health promoting lifestyle can be improved by increasing health related self-efficacy.

The psychological wellbeing explained the maximum variance in self-efficacy of female employees. The psychological wellbeing includes beliefs in abilities to figure out things that can

help in relaxation, doing things that make feel good about life, deciding how to respond to stress and bringing a change in life to reduce stress. These beliefs are related with mental wellbeing of females. The positive psychological interventions significantly enhance wellbeing and decrease discouraging symptom (Sin & Lyubomirsky, 2009). The passive relaxation is an effective technique for enhancing psychological well-being and modulating immune activity among elderly people (Ferrer et al., 2014).

The exercise related self-efficacy is found to explain the minimum variance in self-efficacy. The exercise related self-efficacy incorporates beliefs about the abilities to find an accessible space to exercise in the community, know when to stop exercising, do stretching exercises and keep from getting hurt while exercising. Exercise related self-efficacy can be enhanced by making gym/exercise facilities accessible to employees, creating awareness on related aspects of exercising. Health professionals should provide the detailed information on the effect of physical activity/exercise on health while imparting health education to Japanese female employees for strengthening self-efficacy (Nishida et al., 2003). The health promotion interventions at work place improve self-efficacy and health behaviours (Schopp et al., 2015). Perceived self-efficacy has a significant influence on intentions to exercise and maintaining it for a long duration (Dzewaltowski et al., 1990; McAuley, 1992, 1993). There is a positive relationship between self-efficacy, and initiating and maintaining the exercise in heart failure (Rajati et al., 2014). Self-efficacy interventions increase cardiac rehabilitation patient's efficacy for the regular physical activities (Everett et al., 2009).

The self-efficacy has a positive significant influence on responsible health practices (RHPs). RHPs include belief in abilities to know which types of the symptoms require reporting to a medical expert; taking medicines correctly, finding a medical consultant who offers advice and information on how to stay healthy, know the rights and getting help from others when needed. The responsible health practices are concerned with the consciousness of routine health problems. The self-medication and avoiding visiting the doctor in case of routine illness are common practices which negatively affect the self-efficacy. Health education and the regulation of pharmacy stores may help in controlling the self-medication practices (Selvarajet al., 2014) which in turn can help in enhancing the self-efficacy.

The nutrition related self-efficacy is related with beliefs in abilities to improve nutritional habits. It includes belief in the abilities to finding healthy foods within the budget, eating a balanced diet regularly, brushing teeth regularly, understanding the food labels for choosing foods items which are good to consume and drinking as much water as needed every day. The nutritional information and product labels are an effective way to increase nutritional self-efficacy. A small change in the nutritional intakes may generate large public health benefits (Zarkin et al., 1993). The workplace dietary interventions are very effective in encouraging the consumptions of fruits and vegetables among the employees (Lisa et al., 2010). The discussion supports that self-efficacy can be enhanced through well-designed health interventions which in turn lead to improved health promoting lifestyle of people.

Conclusion and Implications

It is revealed that self-efficacy's influence on health promoting lifestyle of female employees is found to be positive and significant. With the increase in self-efficacy, Health Promoting Lifestyle of the females will also increase. The results of the study reflect the critical role that self-efficacy plays in attaining healthy lifestyle. The self-efficacy can be increased through health education and behavioral interventions. The evidences support that specially designed health interventions are

successful in enhancing the self-efficacy of patients with critical illness. It implies that properly designed health education and intervention strategies have greater chances of increasing the self-efficacy of persons with normal health, thereby improving the health promoting lifestyle. Despite the partial adoption of HPLP II in the study, the results have a high relevance for promoting health lifestyle of employees through the self-efficacy.

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