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| The title should be “Health awareness, lifestyle and dietary behavior of university students in the northeast part of Bangladesh” as it does not capture the full scenario of Bangladesh. This is expected that the significant proportion of students are from the same part of Bangladesh.  Authors’ response: Thank you for your suggestion. We have changed the title as you suggested.  1. Abstract: The methods section is quite long but the results section is insufficient. I would suggest to provide more data in the results section. Not only significant findings are important, non-significant findings are also important. I don’t know what does the disease "Fibromyalgia" mean and why this less known disease was included in the abstract. What was the rational of introducing this disease or is there any hypothesis that this disease could be associated with awareness for a reason.  Authors’ response: We reduced the methods section in the abstract and added more data in the result section. Please see on page 2 in the revised manuscript. In model building process, we selected a parsimonious model by selecting only the significant variables. So, we presented the interpretation of significant variables. However, in the current version of the manuscript, we have presented the results of some important variables those were not statistically significant (p>0.20) for the “Awareness Status”. Please see Table 5 for two non-significant variables; Food Preferences and Duration of Exercise. About the non-communicable disease symptoms of Fibromyalgia: While preparing the questionnaire for our study, we searched the list of non-communicable diseases. Besides heart disease and diabetes, we found the symptoms of Fibromyalgia (“Fibromyalgia syndrome affects the muscles and soft tissue. Symptoms include chronic muscle pain, fatigue, sleep problems, and painful tender points or trigger points, which can be relieved through medications, lifestyle changes and stress management”) is quite interesting. Because the experience of student life provides the evidence that the symptoms are prevalent among the students. Moreover one of the risk factors for non-communicable disease is obesity, which is closely related to the symptoms of Fibromyalgia. Students should be aware of the consequence of the obesity. But the impact of obesity on fibromyalgia has not been thoroughly explored. After our analysis, we discussed our finding related to symptoms of Fibromyalgia and concluded that it should be analyzed in future (please see the discussion of the revised manuscript: Page 10, Line: 5- 14, track changed version). References: • Gota CE, Kaouk S, Wilke WS: Fibromyalgia and obesity: the association between body mass index and disability, depression, history of abuse, medications, and comorbidities. JCR: Journal of Clinical Rheumatology 2015, 21(6):289-295.) • Timmerman, G. M., Calfa, N. A., & Stuifbergen, A. K. (2013). Correlates of Body Mass Index in Women with Fibromyalgia. Orthopaedic Nursing / National Association of Orthopaedic Nurses, 32(2), 113–119. • Wolfe, Frederick, et al. "The prevalence and characteristics of fibromyalgia in the general population." Arthritis & Rheumatology38.1 (1995): 19-28. • https://www.webmd.com/fibromyalgia/default.htm  2. Conclusion: Conclusion is very general. According to the findings, it should be stated that the health education program is specifically needed for students who feel that they are already leading a healthy lifestyle. Otherwise, the conclusion does not support the findings.  Authors’ response: We have changed the conclusion. The revised conclusion is: “To improve the health awareness status among the university students who have the misconception about healthy lifestyle and the students who used to play daily but not aware; universities should facilitate nutritional education program and health awareness plans. To develop healthy eating habit for the students who eat because of feeling happy; effective and tailored programs should be held which may include enhancing self-discipline and self-control.” (Page 12: Line 3-9, track changed version).  3. Introduction: In Bangladesh, health awareness is significantly low irrespective of students or the general population. Please see some references, Islam et al. (PLoS One. 2014: 10.1371/journal.pone.0110368; doi: 10.1371/journal.pone.0133043) which have reported a low level of awareness of diabetes and common eye disease among general population in Bangladesh.  Authors’ response: Thank you for sharing an article by Islam et al (Islam, F. M. A., Chakrabarti, R., Islam, S. Z., Finger, R. P., & Critchley, C. (2015). Factors Associated with Awareness, Attitudes and Practices Regarding Common Eye Diseases in the General Population in a Rural District in Bangladesh: The Bangladesh Population-based Diabetes and Eye Study (BPDES). PLoS ONE, 10(7).). In this suggested article, the participants were aged between 30 and 89 years with a mean (SD) age of 51 (12) years. We agree with the reviewer that the health awareness is significantly low irrespective of students or the general population. Moreover, our study revealed the low health awareness status with respect to the university students only. We have added a sentence related to the article in the introduction. (please see page 3, line: 22-23, track changed version)  Materials and Methods: 4. From the study area and sampling technique, it seems [34] and [35], [36] are three references but the maximum number of reference is 31. What do these numbers mean after the reference number 18? Suggest a through check up and do the corrections.  Authors’ response: We checked the reference throughout the Manuscript. We deleted the wrong placement of [34], [35] and [36]. After reference [18], the [19] is used to refer the questionnaire. After [19], the rest of the references were used to compare and contrast the finding of our study with those.  5. There are 216 classes in total and 30 classes were selected using a stratified sampling but would be informative, how many total students are there in the source population. This is not clear and further information is needed, the authors selected 30 classes but how did they reach to the number of students needed, what was the effect size to estimate the sample size, what was the margin of error as there are some previous data. Please see any of the referenced article to see how the sample size calculations can be reported.  Author’s Response: We have re-explained the method of selecting the sample size by the paragraphs titled “study area and sampling techniques” and “sample size” (Page 4, track changed version). In the paragraph with the title “sample size”; we mentioned the “Supplement I” to elaborate the equations and process of reaching to the final sample size. We used the theory for calculating the sample size from Chapter 4: Stratified Sampling from “Islam, M. N. (2005). An Introduction to Sampling Methods. Book World, Dhaka, Bangladesh.”. From this book, we used the section 4.6: Estimating Sample Size. Considering time and cost we choose bound on the error of estimation as e=7. We followed the method of Neyman Allocation from section 4.8: Disproportionate Stratified Sampling from the same book. After the data collection, we found the margin of error (critical value\*SE) as 7.58 for 95% confidence interval. We found that the absolute effect size for the total students is 85%. (See Page 28, Supplement I: Section c)  6. Is it all students from the selected classes? In the results section, it is mentioned that out of 1143 students, 296 from first year and the response rate was 59.44%, indicating 498 students were in first year. If this is the calculation or what so ever, I would suggest to present this study participants section under methods and remove from results. Preferred to present with a tabular format, number of students in the source population by different years, how many were selected for sampling and how many responded.  Author’s response: To clearly present the number of students in the source population and number of students in the sample strata and the number of students after collection of data “Table 1” is now included to the end of the paragraph titled “Sample Size”. (Page 5, Line: 22-24).  7. Write down for the first time, mean ±SD age of 21.32±1.75 years. Mean age is not equal to “21.32±1.75” but it is mean and SD.  Author’s Response: Thank you for pointing this mistake. Now we have changed as mean (SD). For example, “Among 1,143 students the mean (standard deviation (SD)) age of 21.32 (1.75) years with the highest value of 28 years and the lowest value of 17 years. The mean (SD) of the calculated body mass index (BMI) was 21.15 (3.41)”. (Page 7, Line: 12-14[¬)  8. Insufficient results are presented in the Abstract but too much results are presented in the results section. I would suggest to significantly reduce the results section by referring them in the tables. It seems every single points are written in the results section. Suggest presenting the main results and then refer the Table number for the rest (A manuscript is attached to follow how to present the results and the Tables, concisely).  Author’s Response: We have reduced the unnecessary text in the result section. (Page 7-9)  9. Results section: The significance level <0.0001 is not standard, <0.001 is standard. What is AIC? Needs to spell out for the first time.  Author’s response: We have corrected this p-value and abbreviated the AIC in the sixth para of the Result section. (Page 9: Line: 5-7, track changed version).  10. Table 1: Assuming the diseases are self-reported and therefore, a Signiant proportion is undiagnosed. This is very unlikely that only 0.35% had diabetes and 2.45% have hypertension. Please see these articles [Prediabetes diabetes, their risk factors in rural Bangladesh\_Journal of Diabetes\_Islam et al; Undiagnosed hypertension……by Islam et al. Journal of Human Hypertension (2015), 1–8].  Author’s Response: Thank you for sharing the article (Islam et al. 2016)). This suggested article used 3104 adults aged ≥30 years. We agree with the reviewer that the result has some limitations as it was self-reported. However, We would like to mention here that our study participants were in the age between 17 and 28. In this age limit the prevalence of the diabetes in general population is very low (Haque et al. 2016; Abu-Zaiton & Al-fawwaz, 2013). References: • Islam, F. M. A., Chakrabarti, R., Islam, M. T., Wahab, M., Lamoureux, E., Finger, R. P., & Shaw, J. E. (2016). Prediabetes, diagnosed and undiagnosed diabetes, their risk factors and association with knowledge of diabetes in rural Bangladesh: The Bangladesh Population-based Diabetes and Eye Study. Journal of Diabetes, 8(2), 260–268.  • Haque, M. U., Ahmmed, S. B., Akanda, M. K. M., Hasan, M. T., Mou, S. A., Sajon, S. R., & Islam, M. A. U. (2016). Prevalence and Risk Factors of Obesity and Hypertension Among University Students in Rajshahi City, Bangladesh. Bangladesh Pharmaceutical Journal, 19(2), 179–184.  • Abu-Zaiton, A., & Al-fawwaz, A. (2013). Prevalence of diabetes, obesity, hypertension and associated factors among students of Al-albayt University, Jordan. World Journal of Medical Sciences, 9, 49–54.).  11. Alcohol consumption is 49% . Is it a true story? I am not sure whether Profs. Rahmat Ali or Ahmed Kabir are also aware of this. A 30 year’s of trend for alcohol consumption is needed to study. Smoking is 11.90% compared to 50% in the general population which is true from the previous study. However, are students moving from smoking to alcohol?  Author’s Response: This finding came from the food choice list. (See Supplement V: Questionnaire). The term was alcoholic drink not purely alcohol. Here are the actual frequencies N (%) we found: Daily: 24 (2.10) Three or more times/ Week: 29 (2.54) Once or twice/ Week: 44 (3.85) Rarely: 463 (40.51) Never: 583 (51.01) Then we re-coded like Alcoholic drink: Yes= From “Daily” to “Rarely” = 49% and No = Never= 51%. And now we are adding the result in the form we found after data collection. Find this now in “Supplement III”.  12. Table 3: Please use an “asterisk, \*” sign to show if the prevalence is significantly different or not between healthy and not healthy perception. The Tables are poorly formatted. Please do the correction throughout the Tables and the text. For example, 79.35%(77.06-81.74) compared to 48.73(45.80-51.59); 35.26(31.0-39.5) compared to 20.12%(16.53-23.67), make space between the bracket and the numbers, please look only these few numbers. Some are with one and some are with two decimal places. Every single matters are counted.  Author’s Response: Thank you for pointing these errors. We have now corrected these. Also put “\*\*” to indicating significant differences. (See Table 4)  13. Tables 4 & 5: Major changes are needed. Remove the Estimate and SE columns as these are used to compute the odds ratio, which itself is self explanatory. Instead, please give the number at risk with the events and %. Please follow the table below. †Gender 3104 Male 1072 251 23.4 1.0 Female 2032 651 32.2 1.35 (1.19, 1.52)  Author’s Response: Thank you for your instruction. We have changed the table. (See Table 5 and Table 6)  14. Merging Tables 4 and 5 together will allow to present data from the stratified analysis which is suggested below. Suggested Further analysis. I suggest to do a stratification analysis to show if the associations are different for different years of enrolment. Is there any significant increasing or decreasing trend that will allow to conduct appropriate intervention? Do they change their diet and life style as they grow older. What about alcohol consumption and smoking habit, perception etc. for different years? Getting worse or better? This can be an interesting finding.  Author’s response: We conducted the logistic regression analysis by different years and now we have added the result with the frequencies of the variables for different academic years in the last para of the “Result Section” (See Page 9, Line: 9- 23, track changed version) and also a table as “Supplement IV”. |

