

The Health Belief Model and Self-Care Behaviors among Type 2 Diabetic Patients

Hossein Vazini¹, Majid Barati^{2*}

1- Department of Nursing, Hamadan Branch, Islamic Azad University, Hamadan, Iran.

2- Assistant Professor of Health Education and Health Promotion, Social Determinants of Health Research Center, Hamadan University of Medical Sciences, Hamadan, Iran.

***Correspondence:**

Majid Barati, Assistant Professor of Health Education and Health Promotion, Social Determinants of Health Research Center, Hamadan University of Medical Sciences, Hamadan, Iran.

Email: Barati@umsha.ac.ir

Tel: (98) 813 838 0025

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Abstract

Objective: Diabetes mellitus is a major health problem worldwide. The diabetes self-care behavior is an effective strategy to control diabetes. The study aimed to investigate the predictors of self-care behavior based on the Health Belief Model (HBM) among type 2 diabetic patients.

Materials and Methods: This cross-sectional study was carried out on 390 diabetic patients referred to Hamadan Diabetes Research Center with a simple random sampling method. The participants completed a self-administered questionnaire including demographic characteristics, self-care behaviors and HBM constructs. Data were analyzed using parametric tests in SPSS-19 software.

Results: According to the findings, the diabetic patients had a moderate level of self-care behaviors. Also results showed that, HBM explained 29.6% of the variance in frequency of self-care behaviors. Perceived self-efficacy, perceived severity, perceived barrier and perceived susceptibility were the best significant predictors ($P<0.05$).

Conclusion: The researchers suggest to promote self-care behaviors, preparing training packages tailored to the needs of diabetic patients with emphasis on increasing self-efficacy and removal barriers of normal self-care behaviors are necessary.

Keywords: Attitude, Diabetes complications, Health belief model, Self-care

Introduction

Diabetes is the most common important metabolic disease. Due to its high prevalence, diabetes is considered as a health problem worldwide (1). Diabetes type 2 constitutes about 90 to 95 percent of diabetic patients and occurs most often in older than 40 years (2). This disease imposes great direct and indirect costs to health care systems (3). Major part of these costs is related to long-term complications of the disease, such as coronary heart diseases, stroke, blindness,

lower limb amputation and kidney diseases (4). In 2010, about 285 million people worldwide were suffering from diabetes. Prevalence of diabetes will increase in future due to population growth, urbanization, the prevalence of obesity and sedentary lifestyle (1). According to studies (5,6) conducted in Iran 2% of the population are diabetics, and in people over 30 years is about 7.3 %.

Considering the multiple chronic complications of diabetes, such as visual,

renal, cardiovascular and nervous impairments, by appropriate and immediate prevention, control and treatment of this disease, numerous limitations and problems will be solved for diabetic patients (7). The diabetes care, treatment and complication costs, change of behavior and improving metabolic control is a major goal in the treatment of diabetes which is dependent on the patient's self-care behavior (8). Self-care will improve quality of life and continuous follow-up can prevent acute and chronic complications of the disease or delay its onset (9). Results of Ricci-Cabello et al (10) and Fransen et al (11) showed that lack of attention to self-care behaviors in diabetic patients is a major cause of failure of diabetes health programs. Also, several studies have shown that supporting self-care will provide beneficial outcomes such as improving health and quality of life, increasing patient satisfaction, reducing health costs, better management of symptoms and increasing life expectancy (12).

Obviously training diabetic patients is one of the fundamental principles of promoting self-care behaviors because the treatment will not be effective, unless a diabetic patient knows the nature of disease and takes positive steps to deal with it. In fact, the aim of education should be giving courage to them to personally face as much as possible with the control and treatment of diseases with the use of the mental and practical data (13). However, available evidences suggest that self-care behaviors among patients with diabetes are low which recommends failure of the health centers educational programs (14).

The training program failure reason is ignoring analytical studies and establishing them regardless of psychosocial models as a specified theoretical framework, in the training program (15). Therefore, HBM was used as a behavioral-analytical model to predict the proper health behaviors related to diabetes. The basis HBM is people's motivation to actions, and emphasizes on how the individual perception leads to motivation and motion, and

causes some behaviors. This model shows the relationship between health beliefs and behaviors. HBM assumes proper health behavior is formed based on personal beliefs (16). HBM specifically suggests that people show good reactivity toward health when they feel they are in risk (Perceived Susceptibility), the risk is very serious (Perceived Severity) and change of behavior is beneficial for them (Perceived Benefits) and they can eliminate the barriers to health behavior (Perceived Barriers). On the other hand, self-efficacy refers to the belief in the ability to perform an action, and improve a person's health behaviors, and withdraw behaviors detrimental to health (16). Since, knowing the patient's attitudes and beliefs about diabetes and its consequences is effective in solving the problem, therefore, this study aimed to analyze the beliefs associated with self-care behaviors in diabetic patients of Hamadan using the HBM.

Materials and Methods

This analytical cross-sectional study in 2012 was conducted on 390 patients with type 2 diabetes attending the Diabetes Research Center of Hamadan (DRCH). Participants were selected by simple random sampling. The self-administered questionnaires were offered to them. For this purpose, the list of patients' health records was obtained from DRCH. Then, participants were randomly selected from health records using random numbers table. The Inclusion criteria were: Having health records in DRCH, at least one year of diabetes duration, the absence of associated diseases and complications of diabetes. Data collection methods were based on anonymous questionnaires that were completed by 2 trained interviewers. This study was conducted with approval from Islamic Azad University' institutional review board and ethical committee. Informed assent and consent were obtained from participants.

The self-administered questionnaire included closed questions and required approximately 20 min to complete. The questionnaire

included three sections: 1- demographic variables: including age, gender, education, marital status and family history; 2- Self-care behaviors: this section was measured based on a standard questionnaire (8) and evaluated the patients' self-care behaviors in the past week in the form of 8 questions. This questionnaire included Options, "No", "Yes, sometimes," and "Yes, always". Score of 2 was always given to Option Yes. Score of 1 was sometimes given to Option "Yes, always". And score of zero was given to Option No; 3- HBM Theoretical constructs: HBM scales were measured in relation to diabetes beliefs that were modified from scales of Morowatisharifabad (9,17-18) and 43 items were composed under six major constructs: (a) perceived susceptibility; (b) perceived severity; (c) perceived benefit; (d) perceived barriers; (e) perceived self-efficacy and (f) cause to action. Moreover, the perceived susceptibility with 4 questions, perceived severity with 10 questions, perceived benefits with 6 questions, perceived barriers with 10 questions, perceived self-efficacy with 6 questions with 5-choice scale of 1 (Completely Disagree) to 5 (Completely Agree) and cause to action with 7 questions with 3-likert scale (Yes, No, Partially) were measured.

Content validity of questionnaire was confirmed by 10 health education and promotion experts through calculating the content validity index (CVI) and content validity ratio (CVR). Furthermore, due to the use of interview technique, equivalent validity was assessed using two interviewers on 10 subjects, that showed acceptable reliability ($r=0.82$). To assess the internal consistency reliability of the questionnaire, a pilot study was conducted on 30 diabetic patients' who

were similar to the target population. Based on the results of this pilot study, the internal consistency coefficient of questions (Cronbach's alpha) was 0.73 for perceived susceptibility, 0.71 for perceived severity, 0.79 for perceived benefits, 0.81 for perceived barriers, 0.88 for perceived self-efficacy and 0.72 for cause to action was obtained respectively.

All statistical analyses were performed using version 19.0 of the statistical software package SPSS (SPSS Inc., Chicago, IL, USA) and an alpha level of .05 for all statistical tests. A series of independent T-tests, one-way ANOVA, linear regression and bivariate correlations and descriptive analysis were computed to determine self-care behaviors and predictive factors.

Results

From 390 participants, 64.6% were female, and 79% were married. Age of respondents ranged from 30 to 85 years, with a mean age of 57.1 years old ($SD=9.6$). About 40% of participants between 61-70 years old. Regarding the educational status, 47.9% of respondents were illiterate, and 17.7% were primary. Also, 31.5% of participants reported that had history of diabetes in first-degree family members.

Table 1 shows bivariate associations between the HBM variables. According to the results, severity, self-efficacy and cause to action with perceived susceptibility were positively correlated and with perceived barriers were negatively correlated ($P<0.01$). Additionally, perceived severity was positively correlated with perceived benefit and self-efficacy and is negatively correlated with perceived barriers ($P<0.01$). Perceived benefits is positively

Table 1. Descriptive statistics and inter correlations between the HBM variables (n=390)

| Variables | 1 | 2 | 3 | 4 | 5 | 6 | Mean (\pm SD) |
|-----------------------------|---|--------|---------|----------|---------|----------|------------------|
| 1. Perceived susceptibility | 1 | 0.298* | 0.072 | -0.141** | 0.341** | 0.167** | 10.4(\pm 2.8) |
| 2. Perceived severity | | 1 | 0.262** | -0.501** | 0.496** | 0.079 | 31.1(\pm 6.1) |
| 3. Perceived benefit | | | 1 | -0.474** | 0.305** | 0.105* | 25.1(\pm 6.4) |
| 4. Perceived barrier | | | | 1 | -0.120* | -0.234** | 30.8(\pm 7.3) |
| 5. Perceived self-efficacy | | | | | 1 | -0.182** | 20.1(\pm 4.7) |
| 6. Cause to action | | | | | | 1 | 11.1(\pm 2.8) |

Note. ** $P<0.001$, * $P<0.05$

correlated with cause to action ($P<0.05$). Self-efficacy showed a negative correlation with perceived barriers ($P<0.01$). Perceived barriers was negatively correlated with self-efficacy ($P<0.05$) and cause to action. In addition cause to action & self-efficacy were negatively correlated ($P<0.01$). Also in this study, the mean self-care behaviors were 10.5 ± 2.4 from acquired range of zero to 16 which was intermediate level.

Linear regression to predict the probability of doing on not-doing self-care behaviors (Table 2), self-efficacy, perceived severity, perceived barriers and perceived susceptibility were considered as factors related to self-care behavior. In total, 29.6% of the variance of behavior was predicted by these factors ($P<0.05$).

Table 3 presents association between demographic variables and HBM constructs, using independent t-tests and ANOVA. Test results showed that demographic variables were significantly related to HBM constructs ($P<0.01$).

Discussion

This study aimed to analyze the beliefs related to self-care behaviors in Type 2 diabetic Patients according with HBM. Results of present study confirmed the findings of previous studies which reported that self-care behaviors had a moderate level among diabetic patients. Our study participants obtained 65% of the maximum achievable score of self-care behaviors suggesting appropriate behavior among diabetic patients. This finding is consistent with results of Morowati Sharifabad et al (18) that reported the rate of self-care behaviors in diabetic patients as 62%. Additionally, in studies of Khosravi et al (19), Newell et al (20) and Barati et al (21)

conducted about diabetic patients' lifestyle and hypertensive patients, similar results were reported.

The results showed that, HBM constructs could explain 29.6% of the variance in self-care behaviors in type 2 diabetic patients. This finding is consistent with the results of Skinner et al (22) and Galilean et al (23) about the application of the HBM in prediction of self-care behaviors of non-communicable diseases (<30 %). Through the HBM constructs, perceived self-efficacy, susceptibility, severity and barriers were the best factors for predicting self-care behavior. Other studies also confirm the impact of self-efficacy in increasing self-care including Didarlu et al (6) that reported self-efficacy as a predictive factor of self-care behavior in diabetic patients. Also in a study by Henrietta (24) & Wen et al (25) similar results with the findings of the present study were reported. The self-efficacy is extremely important factor of behavior that is required to solve the problem in difficult conditions (26). Self-care behaviors require awareness, skill and different sources. Despite the present limitations, the patients should know when and how to do self-care behaviors, and be able to do self-care behaviors. Because providing all these requirements is somewhat difficult (18), so it's very necessary to improve patient's self-efficacy.

According to findings of this study, perceived threat (Perceived susceptibility & severity) predicts self-care behaviors. This means that by increasing the perceived threat, self-care is also increasing. These findings are consistent with results of other studies (9,27-28). In this study, the perceived threat of side effects such as impaired social relationships, dependency and blindness was at the lowest level. Also,

Table 2. Predicting self-care behaviors with HBM variable

| Variables | B | S.E | 95% CI | | P.value |
|--------------------------|-------|-------|--------|-------|---------|
| | | | Lower | Upper | |
| Perceived self-efficacy | 0.137 | 0.026 | 0.086 | 0.188 | 0.001 |
| Perceived severity | 0.146 | 0.023 | 0.101 | 0.190 | 0.001 |
| Perceived barrier | 0.049 | 0.017 | 0.016 | 0.081 | 0.003 |
| Perceived susceptibility | 0.083 | 0.040 | 0.004 | 0.162 | 0.040 |
| Constant | 0.887 | 1.006 | -1.090 | 2.865 | 0.378 |

Note. N =390. B = unstandardized regression coefficient, SE= standard Error, CI = Confidence Interval.

perceived barriers were predicting self-care behaviors namely with the reduction of perceived barriers, level of self-care behaviors increases. Mohebbi et al (29), Nagelkerk et al (30) and Krichbaum et al (31) are consistent with our findings.

In this study, younger patients were reported more perceived threats and benefits, less perceived barriers, and higher self-efficacy. It seems that younger patients with higher education's, due to greater awareness of diabetes complications, perceived severity of the problem, the higher ability and better attitudes do more self-care. By increasing the educational levels of subjects, assigning more important roles and responsibilities by them in the community, their efficacy belief will increase naturally. These findings are consistent with results of other studies

(18,21,32,33). Results of other studies suggest that patients with higher levels of education, judgment and decision making have better self-care behaviors (34). Family history of diabetes was associated with increased levels of self-efficacy and cause to action in our study. Family history of diabetes, patient involvement with this disease and observing the complications of diabetes in family members will lead to cause of action, as the internal cause. Also by copying from the other family members and enjoying their therapy experiences as one of the sources of self-efficacy enhances this ability of patients.

One of the study limitations was data collection method. This method is not always a reliable for assessing self-care, since the interviewer was not the treatment group member in this study, the patients answered

Table 3. Association between demographic variables and HBM constructs

| Variables | | Perceived susceptibility | | Perceived severity | | Perceived benefit | |
|----------------|-------------|--------------------------|---------|--------------------|---------|-------------------|---------|
| | | Mean(\pm SD) | P-value | Mean(\pm SD) | P-value | Mean(\pm SD) | P-value |
| Age (years) | 30-40 | 11.83(\pm 2.6) | 0.001 | 33.73(\pm 3.9) | 0.002 | 28.22(\pm 1.9) | 0.001 |
| | 41-50 | 11.05(\pm 2.5) | | 31.58(\pm 6.3) | | 23.91(\pm 7.4) | |
| | 51-60 | 10.37(\pm 3.1) | | 29.88(\pm 6.6) | | 23.45(\pm 7.7) | |
| | 61< | 11.26(\pm 2.6) | | 30.73(\pm 5.9) | | 25.81(\pm 5.5) | |
| Gender | Female | 10.54(\pm 2.6) | 0.085 | 31.05(\pm 6.1) | 0.966 | 24.94(\pm 6.9) | 0.423 |
| | Male | 10.89(\pm 3.1) | | 31.08(\pm 6.1) | | 25.49(\pm 5.5) | |
| | Illiterate | 9.81(\pm 2.2) | | 30.85(\pm 5.5) | | 25.67(\pm 5.7) | |
| Education | Primary | 9.69(\pm 2.5) | 0.001 | 29.92(\pm 6.9) | 0.107 | 21.92(\pm 7.6) | 0.001 |
| | Secondary | 11.58(\pm 3.5) | | 31.50(\pm 5.5) | | 25.08(\pm 7.7) | |
| | High school | 11.62(\pm 3.1) | | 32.34(\pm 6.9) | | 26.86(\pm 4.7) | |
| Marital status | Married | 10.55(\pm 2.9) | 0.135 | 31.06(\pm 6.1) | 0.786 | 24.89(\pm 6.7) | 0.371 |
| | Single | 10.01(\pm 2.1) | | 31.57(\pm 7.1) | | 26.18(\pm 5.3) | |
| | Separated | 9.75(\pm 2.1) | | 30.63(\pm 5.6) | | 25.88(\pm 5.2) | |
| Family history | Yes | 10.22(\pm 2.9) | 0.058 | 31.41(\pm 5.9) | 0.103 | 24.97(\pm 6.9) | 0.468 |
| | No | 10.80(\pm 2.5) | | 30.32(\pm 6.4) | | 25.48(\pm 5.4) | |

Table 3. Association between demographic variables and HBM constructs (continued table 3)

| Variables | | Perceived barrier | | Self-efficacy | | Cause to action | |
|----------------|-------------|-------------------|---------|-------------------|---------|-------------------|---------|
| | | Mean(\pm SD) | P-value | Mean(\pm SD) | P-value | Mean(\pm SD) | P-value |
| Age (years) | 30-40 | 27.84(\pm 9.3) | 0.001 | 22.90(\pm 3.3) | 0.001 | 16.30(\pm 5.4) | 0.477 |
| | 41-50 | 31.31(\pm 7.8) | | 21.56(\pm 4.6) | | 16.20(\pm 5.1) | |
| | 51-60 | 33.13(\pm 6.3) | | 18.39(\pm 4.4) | | 16.04(\pm 4.5) | |
| | 61< | 29.98(\pm 6.5) | | 19.78(\pm 4.9) | | 16.69(\pm 5.2) | |
| Gender | Female | 31.21(\pm 7.1) | 0.137 | 19.87(\pm 4.8) | 0.104 | 16.60(\pm 4.9) | 0.526 |
| | Male | 30.05(\pm 7.7) | | 20.69(\pm 4.5) | | 16.25(\pm 5.3) | |
| | Illiterate | 29.43(\pm 6.6) | | 18.67(\pm 4.2) | | 14.26(\pm 5.1) | |
| Education | Primary | 33.34(\pm 6.4) | 0.001 | 20.95(\pm 5.2) | 0.001 | 14.80(\pm 3.6) | 0.001 |
| | Secondary | 30.93(\pm 8.6) | | 21.54(\pm 4.1) | | 17.92(\pm 4.4) | |
| | High school | 31.81(\pm 7.9) | | 22.08(\pm 5.1) | | 17.79(\pm 5.7) | |
| Marital status | Married | 31.44(\pm 7.3) | 0.001 | 20.57(\pm 4.9) | 0.005 | 17.94(\pm 5.1) | 0.145 |
| | Single | 26.84(\pm 7.9) | | 18.78(\pm 3.5) | | 18.37(\pm 4.6) | |
| | Separated | 29.77(\pm 5.7) | | 18.51(\pm 3.4) | | 18.59(\pm 3.5) | |
| Family history | Yes | 31.44(\pm 7.6) | 0.099 | 20.61(\pm 4.6) | 0.006 | 17.35(\pm 5.2) | 0.021 |
| | No | 30.41(\pm 6.5) | | 19.19(\pm 5.1) | | 16.07(\pm 4.5) | |

the questions honestly. So, the information were reliable.

Conclusion

According to the results, HBM constructs explains 29.6% of the variance of self-care behaviors in Type 2 diabetic Patients. Also, perceived self-efficacy, susceptibility, severity and barriers were considered as the best factors for predicting self-care behaviors. Therefore paying attention to these constructs

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can be used as strategies for promoting self-care behaviors of patients.

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