HEALTH BELIEF MODEL

History and Orientation

The Health Belief Model (HBM) is a psychological model that attempts to explain and predict health behaviors. This is done by focusing on the attitudes and beliefs of individuals. The HBM was first developed in the 1950s by social psychologists Hochbaum, Rosenstock and Kegels working in the U.S. Public Health Services. The model was developed in response to the failure of a free tuberculosis (TB) health screening program. Since then, the HBM has been adapted to explore a variety of long- and short-term health behaviors, including sexual risk behaviors and the transmission of HIV/AIDS.

Core Assumptions and Statements

The HBM is based on the understanding that a person will take a health-related action (i.e., use condoms) if that person:

1. feels that a negative health condition (i.e., HIV) can be avoided,
2. has a positive expectation that by taking a recommended action, he/she will avoid a negative health condition (i.e., using condoms will be effective at preventing HIV), and
3. believes that he/she can successfully take a recommended health action (i.e., he/she can use condoms comfortably and with confidence).

The HBM was spelled out in terms of four constructs representing the perceived threat and net benefits: perceived *susceptibility*, perceived *severity*, perceived *benefits*, and perceived *barriers.* These concepts were proposed as accounting for people's "readiness to act." An added concept, *cues to action*, would activate that readiness and stimulate overt behavior. A recent addition to the HBM is the concept of *self-efficacy*, or one's confidence in the ability to successfully perform an action. This concept was added by Rosenstock and others in 1988 to help the HBM better fit the challenges of changing habitual unhealthy behaviors, such as being sedentary, smoking, or overeating.

Table from “Theory at a Glance: A Guide for Health Promotion Practice" (1997)

Concept	Definition	Application
Perceived Susceptibility	One's opinion of chances of getting a condition	Define population(s) at risk, risk levels; personalize risk based on a person's features or behavior; heighten perceived susceptibility if too low.
Perceived Severity	One's opinion of how serious a condition and its consequences are	Specify consequences of the risk and the condition
Perceived Benefits	One's belief in the efficacy of the advised action to reduce risk or seriousness of impact	Define action to take; how, where, when; clarify the positive effects to be expected.
Perceived Barriers	One's opinion of the tangible and psychological costs of the advised action	Identify and reduce barriers through reassurance, incentives, assistance.
Cues to Action	Strategies to activate "readiness"	Provide how-to information, promote awareness, reminders.
Self-Efficacy	Confidence in one's ability to take action	Provide training, guidance in performing action.

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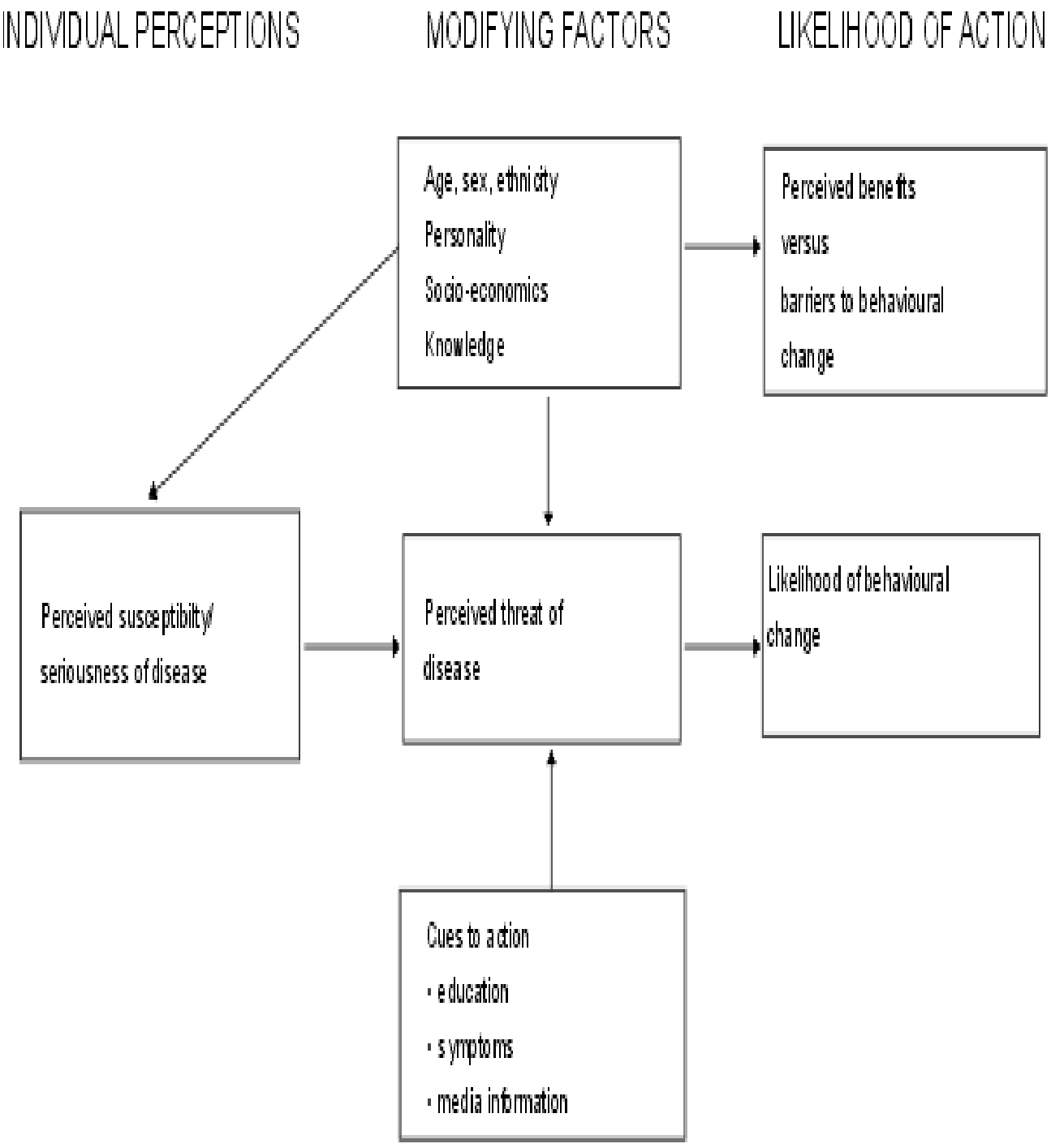
Conceptual Model



Source: Glanz et al, 2002, p. 52

Scope and Application

The Health Belief Model has been applied to a broad range of health behaviors and subject populations. Three broad areas can be identified (Conner & Norman, 1996): 1) Preventive health behaviors, which include health-promoting (e.g. diet, exercise) and health-risk (e.g. smoking) behaviors as well as vaccination and contraceptive practices. 2) Sick role behaviors, which refer to compliance with recommended medical regimens, usually following professional diagnosis of illness. 3) Clinic use, which includes physician visits for a variety of reasons.

Example

This is an example from two sexual health actions. (http://www.etr.org/recapp/theories/hbm/Resources.htm)

Concept	Condom Use Education Example	STI Screening or HIV Testing
1. Perceived Susceptibility	Youth believe they can get STIs or HIV or create a pregnancy.	Youth believe they may have been exposed to STIs or HIV.
2. Perceived Severity	Youth believe that the consequences of getting STIs or HIV or creating a pregnancy are significant enough to try to avoid.	Youth believe the consequences of having STIs or HIV without knowledge or treatment is significant enough to try to avoid.
3. Perceived Benefits	Youth believe that the recommended action of using condoms would protect them from getting STIs or HIV or creating a pregnancy.	Youth believe that the recommended action of getting tested for STIs and HIV would benefit them — possibly by allowing them to get early treatment or preventing them from infecting others.
4. Perceived Barriers	Youth identify their personal barriers to using condoms (i.e., condoms limit the feeling or they are too embarrassed to talk to their partner about it) and explore ways to eliminate or reduce these barriers (i.e., teach them to put lubricant inside the condom to increase sensation for the male and have them practice condom communication skills to decrease their embarrassment level).	Youth identify their personal barriers to getting tested (i.e., getting to the clinic or being seen at the clinic by someone they know) and explore ways to eliminate or reduce these barriers (i.e., brainstorm transportation and disguise options).
5. Cues to Action	Youth receive reminder cues for action in the form of incentives (such as pencils with the printed message "no glove, no love") or reminder messages (such as messages in the school newsletter).	Youth receive reminder cues for action in the form of incentives (such as a key chain that says, "Got sex? Get tested!") or reminder messages (such as posters that say, "25% of sexually active teens contract an STI. Are you one of them? Find out now").
6. Self-Efficacy	Youth confident in using a condom correctly in all circumstances.	Youth receive guidance (such as information on where to get tested) or training (such as practice in making an appointment).