THE INFLUENCE OF HEALTH BELIEFS ON ADOPTION OF PREVENTIVE HEALTH PRACTICES AMONG ADULTS IN EGOR LOCAL GOVERNMENT AREA, EDO STATE

BY

AKHALU DARLINGTON OBOH

BMS2005057

FACULTY OF NURSING SCIENCES
COLLEGE OF MEDICAL SCIENCES
UNIVERSITY OF BENIN, BENIN CITY,
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IN PARTIAL FULFILLMENT OF THE AWARD OF THE DEGREE OF BACHELOR OF NURSING SCIENCE, FACULTY OF NURSING SCIENCES, UNIVERSITY OF BENIN, BENIN CITY.

OCTOBER, 2025

DECLARATION

This is to declare that this research project titled " **THE INFLUENCE OF HEALTH BELIEFS ON ADOPTION OF PREVENTIVE HEALTH PRACTICES AMONG ADULTS IN EGOR LOCAL GOVERNMENT AREA, EDO STATE"** was carried out by **AKHALU DARLINGTON OBOH** is solely the result of my work except were acknowledged as being derived from other persons (s) or resources.

MATRICULATION NUMBER: BMS2005057

FACULTY/COLLEGE: NURSING SCIENCES/ COLLEGE OF MEDICAL SCIENCES, UNIVERSITY OF BENIN, BENIN CITY.

SIGNATURE: _____

DATE: _____

CERTIFICATION/APPROVAL

This is to certify that this research project by **AKHALU DARLINGTON OBOH** with matriculation number **BMS2005057.** Faculty of Nursing Sciences, under the supervision of **MRS. RUKAYAT LAWAL.**

Signature: _____ _____

Mrs. RUKAYAT LAWAL **DATE**

(Project Supervisor)

Signature: _____ _____

PROF. (MRS.) C.E. OMOROGBE **DATE**
Head of Department of
Medical Surgical Nursing

Signature: _____ _____

EXTERNAL EXAMINER **DATE**

DEDICATION

This work is dedicated to GOD ALMIGHTY who made this made this project work a success and for His strength to complete my academic journey.

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ABSTRACT

Preventive health practices are vital in reducing the burden of communicable and non-communicable diseases. Health beliefs significantly influence individuals' decisions to adopt these practices. In Nigeria, a gap often exists between awareness and actual adoption due to cultural, spiritual, and socioeconomic factors. This study examined the influence of health beliefs on the adoption of preventive health practices among adults in Egor Local Government Area, Edo State. A descriptive cross-sectional design was employed, and 384 adults were selected through a multistage sampling technique. Structured questionnaires were administered, with 373 valid responses obtained, yielding a 97.1% response rate. Data were analyzed using SPSS version 26.0. Descriptive and inferential statistics summarized socio-demographic characteristics, awareness, adoption levels, and health beliefs. The chi-square test examined the relationship between awareness and adoption. Findings revealed that 93% of respondents had good awareness of preventive health practices, but only 44% demonstrated high adoption, showing a knowledge-practice gap. Among those with poor awareness (7%), adoption was similarly low. The chi-square test ($\chi^2 = 6.785$, $df = 1$, $p = 0.08$) showed no significant relationship between awareness and adoption. However, 63% held favorable health beliefs, and 70% acknowledged that these beliefs influenced their practice adoption, highlighting their mediating role in translating knowledge into behavior. Despite high awareness and positive beliefs, adoption remains suboptimal due to cultural, spiritual, and socioeconomic barriers. Culturally sensitive, community-based interventions, health education, and behavior-focused nursing strategies are essential to bridge the gap. Policies should enhance accessibility and affordability of preventive services. Future research should explore qualitative and longitudinal approaches to understand barriers more deeply.

Keywords: Influence, Health beliefs, Adoption, Preventive health practices, Adults, Egor Local Government Area, Edo State.

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CHAPTER ONE

INTRODUCTION

1.1 Background to the study

The importance of preventive health practices cannot be overemphasized in any society aiming to improve health outcomes and reduce the burden of disease. Preventive health involves activities or behaviors aimed at preventing illness or detecting health conditions at an early stage (Yap et al., 2023). These practices include regular medical check-ups, immunizations, screenings, healthy eating, physical activity, and avoidance of harmful behaviors such as smoking and excessive alcohol intake (AbdulRaheem, 2023). In the Nigerian context, and particularly in Egor Local Government Area (LGA) of Edo State, the adoption of these preventive practices remains low, raising critical questions about the role of individual health beliefs in shaping health behaviors.

The Health Belief Model (HBM) offers a valuable theoretical framework for understanding why people engage or fail to engage in health-promoting behaviors. It posits that individuals' beliefs about health problems, perceived benefits of action, and barriers to action can predict health-related behaviors (Alyafei & Easton-Carr, 2024). Key constructs of the model include perceived susceptibility, perceived severity, perceived benefits, perceived barriers, cues to action, and self-efficacy (Alagili & Bamashmous, 2021). These factors interact to influence how people perceive their health risks and what motivates them to act in preventive ways.

Studies have shown that health beliefs significantly impact the adoption of preventive health practices across various populations. For example, Abraham et al. (2023) demonstrated that individuals with chronic conditions who perceived a high risk of COVID-19 complications were more likely to adopt protective measures such as wearing masks and seeking timely medical attention. Similarly, Bechard et al. (2021) found that age-related differences in

COVID-19 preventive behavior could be explained through different perceptions of susceptibility and severity, aligned with HBM constructs.

In Nigeria, research by Adesina et al. (2021) showed that despite widespread knowledge of COVID-19, many individuals in urban poor communities failed to adopt preventive practices due to perceived barriers such as economic hardship and misinformation. This aligns with earlier findings by Erubami et al. (2022), who modeled predictors of vaccine uptake among Nigerians using an extended HBM framework and highlighted the influence of media exposure, trust, and perceived benefits.

Health literacy is another critical factor that intersects with health beliefs to shape behavior. Ghorbani-Dehbalaei et al. (2021) established that higher health literacy levels among women were associated with better adoption of health-promoting behaviors. In Nigeria, Ayo (2025) found a strong relationship between adult literacy and the adoption of preventive health behaviors in rural communities. This underscores the importance of health education and communication in enhancing preventive practices.

Additionally, cultural and societal beliefs play a vital role in shaping health perceptions. Badru and Adekola (2023) noted that sociocultural beliefs significantly influenced health-seeking behaviors among older adults in Lagos, often leading to delays in adopting preventive measures. Similarly, Ukpabi (2021) reported that superstitious and cultural beliefs negatively impacted self-care practices among diabetic patients in Warri, Nigeria. These findings are relevant in understanding the unique socio-cultural dynamics of Egor LGA.

Gender, age, socioeconomic status, and access to healthcare also modulate the relationship between health beliefs and preventive practices. Akinyemi et al. (2021) reported that staff at a Nigerian university had high awareness of preventive services but varying levels of uptake depending on their socio-demographic background. Likewise, Akinniyi et al. (2025) found

that health expectations and the quality of care significantly influenced health-seeking behavior among health workers themselves.

Technological factors are increasingly becoming relevant. The rise of digital health platforms has introduced new dimensions to health behavior. Ahadzadeh et al. (2021) found that internal health locus of control positively influenced mobile health adoption, especially when mediated by acceptance of digital technology. Similarly, Liu et al. (2023) observed that trust and habitual use influenced mHealth adoption among older adults, suggesting that digital literacy could be an emerging determinant of preventive behavior.

During pandemics like COVID-19, these beliefs become even more prominent. Jadil and Ouzir (2021) conducted a multi-country study that found consistent correlations between health beliefs and the adoption of protective behaviors such as mask-wearing and social distancing. In the Nigerian context, Twum et al. (2021) used a health belief model framework to examine vaccination intentions and found that perceived benefits and susceptibility were the most influential predictors.

Egor LGA, located in Edo State, is home to a mix of urban and peri-urban communities with varied access to health services and information. Understanding the health beliefs of adults in this region is crucial for tailoring public health interventions that promote preventive health practices. Despite national efforts to encourage preventive health, there remains a significant gap in behavior adoption at the community level, which may be influenced by individual and collective beliefs (Ngyozie et al., 2024).

Moreover, the role of behavioral change communication has been emphasized in improving preventive health knowledge and practice. Akuiyibo et al. (2022) demonstrated the positive impact of targeted communication on improving hypertension and diabetes knowledge and behaviors in Imo and Kaduna states. Similarly, Omotunde et al. (n.d.) found that health

education significantly improved hypertension knowledge and preventive practices among pre-hypertensive traders in Lagos.

Given the multi-dimensional nature of health behavior, it is necessary to examine not only awareness and adoption of preventive practices but also the beliefs that drive or hinder such actions. This is particularly important in areas like Egor LGA, where diverse socio-cultural, economic, and educational factors intersect to influence health outcomes.

This study therefore aims to fill the gap in literature by exploring how health beliefs affect the adoption of preventive health practices among adults in Egor Local Government Area, Edo State. By using the Health Belief Model as a theoretical lens, this research will provide insights that can guide targeted health interventions and policy reforms aimed at promoting preventive health behavior in the region.

1.2 Statement of Problem

Globally, there has been a persistent concern over the suboptimal adoption of preventive health practices despite increased access to health information and services. Non-communicable diseases, vaccine-preventable illnesses, and poor lifestyle choices continue to place a heavy burden on healthcare systems (Wang et al., 2022). The core issue lies in the gap between awareness and actual adoption of preventive measures, often influenced by individual health beliefs (Alagili & Bamashmous, 2021). This disconnect underscores a fundamental public health dilemma: knowledge alone does not always translate into action.

The Health Belief Model (HBM) has been widely used to explain the psychological mechanisms behind health behavior adoption. Studies across various contexts such as the United States, South Korea, and the Middle East have shown that perceived susceptibility, perceived severity, perceived benefits, and self-efficacy are strong predictors of preventive health behavior (Baek et al., 2022; Bechard et al., 2021; Karl et al., 2022). In Africa, however,

the influence of sociocultural beliefs, low health literacy, and misinformation further complicate the adoption of these behaviors (Saah et al., 2021; Abraham et al., 2023). Cultural norms, fatalism, and limited access to credible health education hinder effective behavior change, making prevention efforts difficult to sustain.

In Nigeria, despite national health campaigns and awareness programs, preventive health behaviors such as cancer screening, immunization, and routine check-ups remain low, especially among adults in semi-urban communities (Akinyemi et al., 2021; Iluno et al., 2024). For instance, Gbadebo et al. (2025) observed that many Nigerians delay preventive care until symptoms become severe, often due to poor risk perception or misconceptions about disease causation. In Egor Local Government Area of Edo State, where a mix of urban and peri-urban populations exists, the extent to which adults adopt preventive health practices remains unclear, as limited data is available on what influences their health behavior choices.

Failure to adopt preventive health practices results in increased morbidity, higher healthcare costs, reduced productivity, and preventable deaths (Ndejjo et al., 2022; AbdulRaheem, 2023). At the individual level, poor preventive behavior increases vulnerability to chronic illnesses, while at the community level, it places undue pressure on an already overstretched health system. If the underlying beliefs that hinder preventive behavior are not understood and addressed, health interventions will continue to yield suboptimal results.

While numerous studies have explored preventive health behavior globally and nationally, there is a paucity of localized data focusing on the role of health beliefs in influencing these behaviors in Egor LGA. Most existing studies address awareness and access, but few examine the psychological and cultural dimensions using a theoretical framework like the Health Belief Model (Erubami et al., 2022; Ngyozie et al., 2024). This limits the design of targeted interventions suitable for the local population.

This study intends to fill this gap by assessing the influence of health beliefs on the adoption of preventive health practices among adults in Egor LGA, Edo State. Grounded in the Health Belief Model, the research will evaluate the levels of awareness, actual adoption of preventive practices, and the underlying beliefs shaping these behaviors. The findings are expected to inform the development of culturally appropriate, evidence-based strategies that promote preventive health behaviors in similar communities across Nigeria.

1.3 Objective of the study

The general Objective of the study is to assess the influence of health beliefs on the adoption of preventive health practices among adults in Egor Local Government Area, Edo State.

The specific objectives are:

1. To assess the level of awareness of preventive health practices among adults in Egor local government area, Edo state.
2. To assess the level adoption of preventive health practices among adults in Egor local government area, Edo state.
3. To identify the health beliefs of preventive health practices among adults in Egor local government area, Edo state.
4. To examine the perceived influence of health beliefs on the adoption of preventive health practices among adults in Egor local government area, Edo state.

1.4 Research Questions

1. What is the level of awareness of preventive health practices among adults in Egor local government area, Edo state?
2. What is the level adoption of preventive health practices among adults in Egor local government area, Edo state?

3. What are the health beliefs of preventive health practices among adults in Egor local government area, Edo state?
4. Wat is the perceived influence of health beliefs on the adoption of preventive health practices among adults in Egor local government area, Edo state?

1.5 Hypotheses

1. There is no significant relationship between the level of awareness of preventive health practices and the adoption of preventive health practices among adults in Egor LGA.

1.6 Significance of the Study

To the Nursing Profession

This study holds great relevance for the nursing profession, particularly in the areas of community health nursing, health promotion, and patient education. By uncovering the specific health beliefs that influence preventive health practices among adults in Egor LGA, the findings will equip nurses with evidence-based insights to design and deliver culturally appropriate health education interventions. Nurses, being frontline caregivers and educators, can use this knowledge to improve patient compliance, encourage routine health screenings, and foster trust within the communities they serve. Additionally, the study supports the shift from curative to preventive-focused care in nursing, aligning with global health goals to reduce the burden of disease through early intervention and lifestyle modification.

To Healthcare Providers

Healthcare providers, including doctors, public health officers, and policymakers, will benefit from the study by gaining a clearer understanding of the psychological and cultural factors that shape health behaviors. This will enable them to develop more targeted, belief-sensitive health promotion campaigns and services. It will also assist in resource allocation and the planning of community-based programs that address real barriers to preventive health behavior adoption. For instance, understanding that low perceived susceptibility or fear of side effects may prevent adults from participating in preventive care could inform how interventions are communicated and delivered.

To the Society

At the societal level, the study contributes to improving public health outcomes by promoting greater engagement in preventive health behaviors. By addressing the beliefs that hinder such behaviors, the research supports efforts to reduce the incidence of preventable diseases, minimize healthcare costs, and enhance the overall well-being of the population. When individuals are empowered with knowledge and guided by positive health beliefs, they are more likely to take responsibility for their health, which ultimately leads to healthier families and more productive communities. The study also adds to the body of local evidence needed for grassroots-level health planning and sustainable development in Edo State and Nigeria at large.

1.6 Scope of the Study

This study is limited to assessing the influence of health beliefs on the adoption of preventive health practices among adults aged 18 years and above residing in Egor Local Government Area, Edo State. It focuses on measuring levels of awareness, health beliefs (such as

perceived susceptibility, severity, benefits, and barriers), and the extent of adoption of preventive health behaviors. The study does not cover treatment practices or populations outside Egor LGA and is confined to adults within the community, excluding institutionalized individuals such as those in hospitals or care homes.

1.7 Operational Definition of terms

- **Health Beliefs**: In this study, health beliefs refer to individuals' perceptions about their vulnerability to diseases (perceived susceptibility), the seriousness of those diseases (perceived severity), the perceived benefits of taking preventive action, and perceived barriers to such actions. These beliefs are measured using constructs from the Health Belief Model (HBM).
- **Preventive Health Practices:** These are routine health-related actions taken by individuals to prevent illness or detect health issues early. Examples include immunizations, regular health check-ups, cancer screenings, healthy lifestyle behaviors (diet, exercise), and personal hygiene practices. Adoption of these practices will be assessed through a structured questionnaire.
- **Adoption**: Adoption refers to the extent to which adults in Egor LGA engage in or incorporate preventive health practices into their daily lives. It is measured by self-reported frequency and consistency of engaging in such behaviors.
- **Adults**: Adults, in the context of this study, refer to individuals aged 18 years and above who are permanent residents of Egor Local Government Area, Edo State.
- **Egor Local Government Area:** This refers to the geographical area in Edo State, Nigeria, where the study is conducted. It includes urban and peri-urban communities that represent a diverse adult population in terms of education, occupation, and access to healthcare.

CHAPTER TWO

LITERATURE REVIEW

This chapter focuses on the review of related literature under the following headings; conceptual review, theoretical review and empirical review. Necessary literature would be gotten from published and unpublished works, articles and journals in this study.

2.1 Conceptual Review

2.1.1 Concept of Health

Health is a multifaceted and dynamic concept that has evolved beyond the mere absence of disease or infirmity. The World Health Organization (WHO) famously defines health as "a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity" (WHO, 1948, as cited in Alagili & Bamashmous, 2021). This holistic definition emphasizes the importance of overall well-being and not just the absence of pathology, serving as a foundation for modern public health strategies.

Building on this, scholars have proposed expanded definitions of health that incorporate functional, emotional, and environmental well-being. Feinberg et al. (2022) proposed a family-centered approach to health, conceptualizing it as a dynamic process influenced by biological, social, emotional, and economic factors. Similarly, Alyafei and Easton-Carr (2024) noted that health should be seen as a multidimensional construct encompassing a person's ability to function in their societal role, adapt to challenges, and maintain resilience.

In line with contemporary perspectives, Gbadebo et al. (2025) emphasized that health perception is shaped by social norms and cultural contexts, which influence how individuals

engage in health-seeking behaviors. Thus, understanding health in broader terms is crucial for developing effective preventive health strategies, particularly in diverse populations.

Dimensions of Health

Health comprises several interrelated dimensions, with the physical, mental, and social aspects being the most recognized.

1. **Physical Health**: Physical health refers to the proper functioning of the body and its systems, enabling an individual to perform daily tasks without physical restriction or fatigue. It encompasses a wide range of factors including nutrition, physical activity, immunity, and the absence of disease. As highlighted by Agunbiade and Gilbert (2023), physical health practices such as sexual health awareness and screening are influenced by individual risk perceptions and beliefs. Preventive health actions like routine medical check-ups, vaccinations, and hygienic practices are often grounded in one's understanding and valuation of their physical well-being (Adesina et al., 2021).

2. **Mental Health**: Mental health is concerned with cognitive functioning, emotional stability, and the ability to cope with life stressors. Bechard et al. (2021) demonstrated that mental health was a key determinant of preventive behavior during the COVID-19 pandemic, with individuals' perceptions of threat and self-efficacy affecting their decision-making processes. Similarly, Rahman et al. (2025) emphasized the role of psychosocial well-being in shaping older adults' responses to public health interventions, noting that anxiety, depression, and loneliness can reduce willingness to adopt preventive health measures.

3. **Social Health**: Social health relates to the ability of an individual to form satisfying interpersonal relationships and fulfill roles within the family, workplace, and community. According to Badru and Adekola (2023), sociocultural beliefs and community norms significantly influence the health-seeking behavior of adults, particularly in urban and rural Nigerian settings. Social connectedness also plays a vital role in information dissemination and collective action for public health. Ezugwu et al. (2025) observed that media campaigns and peer influence were effective tools for encouraging hypertension screening among youths.

These three dimensions are interdependent and contribute collectively to an individual's overall health status. A disturbance in one dimension often affects the others, emphasizing the need for a holistic approach to health care and promotion.

Health Promotion and Its Relevance to Preventive Practices

Health promotion is a proactive process that enables individuals and communities to increase control over their health and its determinants. It focuses on empowerment, education, and creating supportive environments that facilitate healthy choices. According to AbdulRaheem (2023), integrating preventive levels in healthcare practice is essential for building resilient health systems, as it shifts the focus from curative interventions to preemptive strategies.

Health promotion is inherently linked to preventive health practices, which include immunizations, screenings, lifestyle changes, and public awareness campaigns. These measures aim to reduce the risk of disease and improve population health outcomes. As supported by Akinyemi et al. (2021), awareness and perception of preventive health services among university staff were strong predictors of service utilization, underscoring the role of health promotion in behavior change.

The Health Belief Model (HBM) serves as a foundational theory in health promotion, explaining how individual beliefs about health conditions, perceived benefits, and barriers to action influence health behaviors (Alagili & Bamashmous, 2021). The model has been extensively applied to understand compliance with preventive behaviors during the COVID-19 pandemic (Abraham et al., 2023; Erubami et al., 2022). For instance, Karimy et al. (2021) found that individuals with higher perceived severity and susceptibility were more likely to engage in hand hygiene and mask-wearing practices.

Digital health tools have also become integral to modern health promotion. Ahadzadeh et al. (2021) emphasized that mobile health (mHealth) technologies improve preventive health adoption when coupled with high health literacy and internal health locus of control. Alruwaili et al. (2023) further highlighted the role of user experience and engagement in sustaining digital health interventions aimed at promoting healthy aging.

2.1.2 Concept of Preventive Health Practices

Preventive health practices refer to actions undertaken to prevent the occurrence, progression, or complications of diseases and health conditions. These practices are grounded in the principle of proactively safeguarding health, rather than reacting after illness sets in. According to AbdulRaheem (2023), preventive health encompasses a range of strategies at individual, community, and policy levels aimed at reducing risk factors and promoting well-being. It includes medical interventions like immunizations, behavioral strategies such as dietary changes, and systemic efforts such as health education and policy advocacy.

The scope of preventive health extends beyond infectious disease control to encompass chronic diseases, mental health, environmental health, and occupational safety (Ngyozie, Eniola, & Olumide, 2024). As emphasized by Yap et al. (2023), preventive health is integral

to sustainable health systems, reducing healthcare costs, and improving quality of life by promoting long-term wellness.

Types of Preventive Health

Preventive health is categorized into three broad levels primary, secondary, and tertiary prevention each targeting different stages in the disease continuum.

1**. Primary Prevention**: Primary prevention aims to prevent the onset of disease by eliminating risk factors and enhancing resistance to illness. This includes health education, immunization, sanitation, nutrition, and lifestyle modification (Alagili & Bamashmous, 2021). Examples include vaccination against infectious diseases, promoting regular physical activity, healthy eating habits, and abstinence from tobacco or substance abuse.

In a study by Akinyemi et al. (2021), university staff who were more aware of preventive services such as routine checkups and vaccinations were significantly more likely to adopt healthy behaviors, underscoring the role of awareness in primary prevention. Similarly, Omotunde et al. (n.d.) found that health education significantly improved hypertension knowledge and preventive behavior among traders in Lagos State, Nigeria.

2. Secondary Prevention: Secondary prevention focuses on early detection and prompt intervention to halt disease progression. Screening programs for hypertension, diabetes, cancer, and other chronic diseases fall under this category. According to Iluno et al. (2024), cervical cancer screening among Nigerian women was influenced by health beliefs and perceived susceptibility, indicating the critical role of personal perception in secondary prevention uptake.

Early detection allows for timely treatment, reducing the risk of complications and improving outcomes. As highlighted by Ezugwu et al. (2025), media sensitization campaigns in Nsukka increased knowledge and screening practices among youth, demonstrating that accessible information and behavior change communication strategies can drive secondary prevention.

3. Tertiary Prevention: Tertiary prevention seeks to reduce the impact of ongoing illness or injury by managing complications and promoting rehabilitation. It includes actions to prevent recurrence, disability, or further deterioration, such as physiotherapy after a stroke, medication adherence for chronic diseases, and support groups for mental health conditions.

Gbadebo et al. (2025) found that social and cultural beliefs influence oral health-seeking behavior among Nigerians, often delaying the adoption of tertiary preventive services like dental rehabilitation. Likewise, Vincenzo et al. (2022) used the Health Belief Model to understand older adults' cues to engage in fall prevention, showing how tertiary prevention is closely linked to perception, motivation, and environmental support.

Importance of Preventive Health in Disease Control

Preventive health is a cornerstone of public health and a cost-effective strategy for managing population health. It reduces disease burden, promotes longevity, and eases pressure on healthcare systems (Ayo, 2025). For instance, during the COVID-19 pandemic, adherence to preventive behaviors such as mask-wearing, hand hygiene, and social distancing significantly curbed disease spread. Baek, Kim, and Choi (2022) demonstrated that Health Belief Model constructs like perceived severity and benefits predicted adherence to these preventive behaviors in South Korea.

Preventive measures are also crucial for controlling non-communicable diseases (NCDs), which are on the rise in low- and middle-income countries. Wang et al. (2022) stressed the

importance of health beliefs and behavior change in reducing risk factors for NCDs like diabetes and cardiovascular diseases.

In Nigeria and similar settings, preventive health practices are essential to address structural barriers, including poor access to healthcare, low health literacy, and underfunded systems. Akuiyibo et al. (2022) confirmed that behavior change communication interventions improved knowledge, attitude, and practices related to hypertension and diabetes in Imo and Kaduna States, illustrating the effectiveness of community-based prevention.

Factors Influencing Adoption of Preventive Practices

Adoption of preventive health behaviors is influenced by several interrelated factors:

1. Health Beliefs and Perceptions: According to the Health Belief Model, individual behavior is shaped by perceived susceptibility, severity, benefits, and barriers to action (Alagili & Bamashmous, 2021; Alyafei & Easton-Carr, 2024). Studies such as that by Erubami et al. (2022) showed that Nigerians' perception of the severity of COVID-19 and vaccine safety influenced their willingness to get vaccinated.

2. Health Literacy: Health literacy significantly affects individuals' ability to access, understand, and act upon health information. Eslami et al. (2023) found that higher levels of health literacy and self-efficacy were positively associated with preventive behaviors among Iranian pregnant women. Similarly, Itasanmi et al. (2023) demonstrated that improved health literacy led to better contraceptive knowledge and practices in Nigeria.

3. Socio-demographic and Cultural Factors: Education, income, gender, religion, and cultural beliefs play major roles in determining health behavior. Badru and Adekola (2023) noted that older adults in Lagos were influenced by sociocultural beliefs when deciding

whether to seek medical care. In another study, Keren et al. (2021) reported that media exposure and scientific self-efficacy were critical in shaping health behaviors across cultural groups.

4. Access to Health Services: Proximity, affordability, and quality of health services can facilitate or hinder preventive practices. Akinniyi et al. (2025) emphasized that care quality, expectations, and socio-demographic moderators influenced health-seeking behaviors among health workers. When services are not user-friendly or culturally sensitive, uptake remains low.

5. Social Support and Community Norms: Community engagement and peer influence also determine preventive behavior. Fallucca et al. (2022) highlighted that HPV vaccination acceptability was enhanced when peer groups and family supported the decision. This aligns with findings by Ndejjo et al. (2022), who reported that community-based cardiovascular interventions led to healthier lifestyles among Ugandan adults.

2.1.3 Concept of Health Beliefs

Health beliefs refer to the personal convictions or perceptions that individuals hold regarding their health, illness, and health-related behaviors. These beliefs influence how people interpret symptoms, when they seek care, whether they follow medical advice, and what preventive or therapeutic strategies they choose. The Health Belief Model (HBM), one of the most widely applied frameworks in health psychology, was developed to explain and predict health-related behaviors by focusing on individuals' attitudes and beliefs (Alagili & Bamashmous, 2021; Alyafei & Easton-Carr, 2024).

According to the HBM, an individual's decision to engage in a health behavior is determined by six constructs: perceived susceptibility (likelihood of getting a condition), perceived

severity (seriousness of the condition), perceived benefits (advantages of action), perceived barriers (obstacles to action), cues to action (triggers to act), and self-efficacy (confidence in one's ability to act) (Alyafei & Easton-Carr, 2024).

Health beliefs are formed and shaped by a combination of personal experience, cultural norms, religious teachings, social learning, education, and environmental context. They serve as cognitive filters through which individuals interpret health information and decide on appropriate courses of action (Erubami et al., 2022; Baek, Kim, & Choi, 2022).

For instance, during the COVID-19 pandemic, varying beliefs about the virus and vaccines significantly influenced adherence to prevention guidelines, with factors like perceived severity and vaccine efficacy playing critical roles (Erubami et al., 2022).

Types of Health Beliefs

Health beliefs are not uniform; they vary based on cultural background, spiritual orientation, and personal experience. These beliefs can be broadly categorized as follows:

1. Personal Health Beliefs: These refer to an individual's internalized views about health, often shaped by personal experiences, knowledge, and psychological factors. For example, someone who has experienced the benefits of regular exercise may believe strongly in its role in preventing disease. These beliefs guide everyday behaviors like diet, exercise, substance use, and adherence to medication. Karimy et al. (2021) demonstrated that individual beliefs about COVID-19 severity and vulnerability influenced Iranian citizens' compliance with health guidelines.

2. Cultural Health Beliefs: Cultural beliefs are shared understandings within a community about health, illness, causes, and appropriate treatments. In many African settings, illness

may be seen as a result of spiritual imbalance, social transgressions, or ancestral displeasure, influencing whether people seek biomedical or traditional care (Gbadebo et al., 2025). Badru and Adekola (2023) found that older adults in Lagos, Nigeria, often relied on cultural interpretations of illness, which significantly influenced their willingness to seek formal healthcare.

These beliefs often guide attitudes toward modern medicine, preventive care, and the use of alternative or traditional remedies. Failure to recognize or respect cultural health beliefs can lead to mistrust of health providers and non-adherence to treatments.

3. Spiritual and Religious Beliefs: Spiritual beliefs play a prominent role in health behavior, particularly in deeply religious societies. Some individuals may view health as a gift from God and illness as a test of faith or punishment for moral failings. In such contexts, prayers, fasting, and other religious rituals are often prioritized over medical interventions.

Erubami et al. (2022) noted that religious beliefs were among the predictors of COVID-19 vaccine uptake among Nigerian social media users, with some individuals rejecting vaccines due to faith-based interpretations. Similarly, Gbadebo et al. (2025) observed that beliefs in spiritual causes of dental problems delayed professional oral care among Nigerian adults.

These spiritual dimensions, while potentially supportive of well-being, can sometimes conflict with medical advice if individuals believe that divine intervention alone is sufficient for healing.

Role of Beliefs in Health Decision-Making and Behavior

Health beliefs significantly influence decisions across the continuum of care from prevention and early detection to treatment and rehabilitation. People use their beliefs to assess risks,

interpret symptoms, weigh treatment options, and make lifestyle choices. The Health Belief Model has been widely used to understand these processes in various populations.

Baek et al., (2022), in a study conducted in South Korea, found that higher perceived benefits and severity were positively associated with personal preventive behaviors like mask-wearing and hand hygiene during the early COVID-19 outbreak. This illustrates how health beliefs shape compliance with public health recommendations

Similarly, Fallucca et al. (2022) explored acceptability of HPV vaccination in young people and found that health beliefs, informed by perceived risk and literacy levels, predicted vaccine acceptance. This supports the role of beliefs not just in decision-making but in the formation of health intentions.

In Uganda, Ndejjo et al. (2022) revealed that community-based cardiovascular disease prevention programs were more effective when tailored to existing community beliefs and practices. This shows how health interventions are more likely to succeed when they align with or respectfully challenge prevailing beliefs.

Importantly, negative or inaccurate health beliefs can act as barriers to preventive health. For instance, when people do not believe in the benefits of immunization or perceive low risk for disease, they are less likely to vaccinate themselves or their children (Erubami et al., 2022). Likewise, beliefs that certain illnesses are not serious or are part of normal aging may delay health-seeking behavior.

Conversely, positive health beliefs, such as a strong sense of self-efficacy or belief in the value of preventive screening, often lead to proactive health behavior. Eslami et al. (2023) found that women with high health literacy and belief in their ability to prevent urinary tract infections were more likely to practice preventive behaviors.

Understanding health beliefs is, therefore, essential for designing effective health education, promoting behavioral change, and delivering culturally competent care.

2.1.4 Components of the Health Belief Model (HBM)

The Health Belief Model (HBM) is a psychological model developed in the 1950s to explain and predict health-related behaviors by focusing on individuals' perceptions and attitudes toward health (Alyafei & Easton-Carr, 2024). It is one of the most widely used theoretical frameworks in health behavior research, especially in understanding the adoption of preventive health practices. The HBM postulates that individuals are likely to engage in health-promoting behaviors if they believe they are susceptible to a condition, perceive the condition as serious, believe the benefits of taking action outweigh the barriers, and are exposed to cues that prompt action (Alagili & Bamashmous, 2021). Later revisions to the model added self-efficacy as a critical component (Alyafei & Easton-Carr, 2024).

Each of these six components plays a unique role in influencing preventive health behavior:

1. Perceived Susceptibility

Perceived susceptibility refers to an individual's belief about the likelihood of contracting a disease or health condition. This component is crucial because people are more likely to engage in preventive behaviors if they believe they are personally at risk (Baek, Kim, & Choi, 2022).

For example, during the early stages of the COVID-19 pandemic in South Korea, individuals who believed they were highly susceptible to the virus were significantly more likely to adhere to preventive practices such as mask-wearing and hand hygiene (Baek et al., 2022). Similarly, Karimy et al. (2021) found that among the Iranian population, perceived

vulnerability to COVID-19 was a strong predictor of adopting preventive measures like avoiding crowded places.

In the context of preventive health practices, adults who perceive themselves to be at risk of diseases such as malaria, hypertension, or COVID-19 may be more inclined to participate in health screenings or modify their lifestyle accordingly.

2. Perceived Severity

Perceived severity refers to the belief about the seriousness of contracting an illness or of leaving it untreated. It includes both medical consequences (e.g., death, disability, pain) and social consequences (e.g., job loss, family strain) (Alyafei & Easton-Carr, 2024).

If individuals believe a health condition has serious outcomes, they are more motivated to take preventive action. For instance, Fallucca et al. (2022) observed that adolescents who considered cervical cancer to be a severe illness were more likely to accept HPV vaccination. In the Nigerian context, Erubami et al. (2022) found that individuals who perceived COVID-19 as a severe illness were more likely to seek vaccination and adhere to government health directives.

This suggests that public health campaigns highlighting the consequences of untreated health conditions can enhance preventive behaviors.

3. Perceived Benefits

Perceived benefits refer to an individual's belief in the efficacy of the advised preventive behavior to reduce the risk or seriousness of impact (Alagili & Bamashmous, 2021). This component addresses the question: What will I gain if I take action?

For example, individuals who believe that using mosquito nets can effectively prevent malaria, or that regular exercise can reduce the risk of hypertension, are more likely to adopt such practices. Eslami et al. (2023) found that pregnant women in Iran who understood the benefits of personal hygiene and hydration were more consistent in practicing behaviors to prevent urinary tract infections.

4. Perceived Barriers

Perceived barriers refer to an individual's assessment of the obstacles or costs associated with performing a health behavior. These may include financial costs, physical inconvenience, social stigma, or fear of discovering illness (Alyafei & Easton-Carr, 2024).

Barriers often deter individuals from engaging in health-promoting behaviors even when they acknowledge their susceptibility and the seriousness of the health issue. For example, Badru and Adekola (2023) found that older adults in Lagos were discouraged from accessing formal healthcare due to cultural norms, financial constraints, and transportation difficulties.

In a similar vein, Gbadebo et al. (2025) reported that the absence of pain led many Nigerians to delay or avoid dental visits, indicating that low perceived benefit and high perceived barrier can influence health decisions.

Health interventions should, therefore, aim to minimize perceived barriers through strategies like subsidized services, mobile clinics, and culturally sensitive communication.

5. Cues to Action

Cues to action are external or internal stimuli that trigger individuals to take health-related action. These may include media campaigns, advice from others, illness in a loved one, reminder messages, or personal symptoms (Alyafei & Easton-Carr, 2024).

For example, exposure to COVID-19 news updates or seeing others fall sick served as powerful cues for many people to adopt preventive behaviors during the pandemic (Erubami et al., 2022). Likewise, community health talks and mobile health alerts have been effective in prompting people to attend health screenings or take medication.

6. Self-Efficacy

Self-efficacy refers to an individual's confidence in their ability to successfully perform a health behavior. It was added to the original HBM in the 1980s and has since become a central construct (Alagili & Bamashmous, 2021).

High self-efficacy enables people to overcome barriers and persist in health-promoting behaviors, even in challenging situations. Eslami et al. (2023) reported that women with higher self-efficacy were significantly more likely to engage in preventive practices for urinary tract infections.

Baek et al. (2022) also found that South Koreans with strong confidence in their ability to perform protective behaviors (e.g., wearing masks, sanitizing hands) were more compliant with COVID-19 recommendations.

2.1.5 Relationship Between Health Beliefs and Preventive Health Practices

Health beliefs are powerful determinants of how individuals perceive, engage with, or reject health-promoting behaviors. According to the Health Belief Model (HBM), personal beliefs about health conditions such as perceived susceptibility, severity, benefits, and barriers

directly influence the likelihood of adopting preventive health practices (Alyafei & Easton-Carr, 2024). When individuals hold accurate, positive health beliefs, they are more inclined to practice preventive behaviors; however, distorted, negative, or culturally entrenched beliefs can serve as significant barriers.

How Beliefs Promote or Hinder Adoption of Preventive Behaviors

Health beliefs can promote preventive behaviors when individuals recognize their vulnerability to disease, acknowledge the seriousness of health threats, and trust in the effectiveness of recommended preventive actions. For example, in a study conducted in South Korea, Baek, Kim, and Choi (2022) found that individuals who believed in the efficacy of mask-wearing and social distancing were significantly more likely to adopt these COVID-19 preventive measures.

On the other hand, harmful or misinformed beliefs can hinder the uptake of preventive practices. For instance, some Nigerians have delayed seeking oral healthcare due to the belief that the absence of pain means the absence of disease, thereby hindering regular dental checkups (Gbadebo et al., 2025). Likewise, a study by Badru and Adekola (2023) revealed that cultural and religious interpretations often discourage older adults in Lagos from accessing formal healthcare, instead preferring spiritual or traditional healers.

Erubami et al. (2022) also demonstrated that vaccine hesitancy during the COVID-19 pandemic in Nigeria was largely influenced by health beliefs shaped by misinformation and mistrust, particularly from social media sources.

Real-life Examples and Illustrations

A variety of real-life examples illustrate how health beliefs directly impact preventive behaviors across different settings and health issues:

HPV Vaccination: Fallucca et al. (2022) found that adolescents who believed cervical cancer was a serious and preventable disease were more likely to accept the HPV vaccine. Conversely, those who doubted the vaccine's efficacy or feared side effects often refused vaccination.

COVID-19 Prevention: In Iran, Karimy et al. (2021) showed that perceived severity and susceptibility were major drivers of handwashing, mask use, and social distancing during the COVID-19 pandemic. Individuals with low perceived risk were significantly less compliant with public health recommendations.

Urinary Tract Infection (UTI) Prevention in Pregnant Women: Eslami et al. (2023) found that Iranian women with high self-efficacy and belief in the effectiveness of hydration and hygiene were more consistent in preventive UTI practices during pregnancy.

Oral Health Behavior: In Nigeria, oral health behaviors were negatively influenced by a belief that preventive visits to the dentist were unnecessary unless pain was experienced, thus delaying essential care (Gbadebo et al., 2025).

These examples highlight that beliefs act as both motivators and obstacles, depending on whether they align with accurate health information and awareness.

Influence of Education, Culture, Gender, and Access to Care on Health Beliefs

Health beliefs are not formed in a vacuum; they are significantly shaped by sociodemographic and structural factors such as education, culture, gender, and access to healthcare.

Education: Education enhances health literacy, which in turn fosters accurate health beliefs and promotes preventive behaviors. According to Eslami et al. (2023), pregnant women with higher levels of education were more likely to understand and believe in the efficacy of preventive measures against infections. Similarly, Alyafei and Easton-Carr (2024) assert that educated individuals are more likely to correctly interpret health information and respond positively to public health campaigns.

Culture: Culture strongly influences how health and illness are perceived. In many African settings, illnesses are sometimes seen as spiritual afflictions, which may lead individuals to seek religious or traditional interventions over medical solutions (Badru & Adekola, 2023). Cultural taboos can also hinder discussions on certain preventive measures such as family planning or cancer screening, thus affecting uptake.

Gender: Gender roles and expectations may determine health-seeking behavior and belief systems. In patriarchal societies, men may see preventive health practices as signs of weakness, while women may lack the autonomy to access care independently. For instance, societal expectations sometimes prevent women from accessing HPV vaccines or breast cancer screenings without male consent, as observed in various conservative communities (Fallucca et al., 2022).

Access to Healthcare: Even when individuals hold positive health beliefs, the absence of accessible and affordable healthcare can hinder the actual adoption of preventive behaviors. Gbadebo et al. (2025) found that even among those aware of the importance of dental visits,

many Nigerians failed to access care due to financial and systemic barriers. Similarly, Badru and Adekola (2023) noted that rural older adults in Lagos avoided healthcare facilities not only due to cultural beliefs but also due to distance and cost.

2.2 Theoretical Framework

The Health Belief Model (HBM)

The Health Belief Model (HBM) is a widely used psychological framework for understanding health behaviors, particularly those related to disease prevention and health promotion. It was originally developed in the 1950s by social psychologists Hochbaum, Rosenstock, and Kegels to explain the failure of individuals to participate in disease prevention programs such as tuberculosis screening (Alyafei & Easton-Carr, 2024). Over the decades, the HBM has evolved and been adapted to study a wide range of health behaviors, including vaccination, cancer screening, hygiene practices, and lifestyle changes.

The central tenet of the HBM is that individuals are more likely to engage in preventive health behaviors if they believe they are susceptible to a health problem, believe the health problem has serious consequences, believe that taking a specific action would reduce their susceptibility or severity, and believe the benefits of action outweigh the barriers (Karimy et al., 2021). In addition, cues to action and self-efficacy have been included as important components that influence the likelihood of action.

Components of the HBM

Perceived Susceptibility: This refers to an individual's belief about the likelihood of getting a disease or health condition. In the context of this study, if adults in Egor LGA believe they are at risk of illnesses like hypertension, malaria, or infectious diseases, they are more likely to adopt preventive measures (Eslami et al., 2023).

Perceived Severity: This is the belief about the seriousness of the consequences of the disease. If individuals believe a disease could cause severe health problems, disability, or death, their motivation to engage in preventive practices increases (Fallucca et al., 2022).

Perceived Benefits: This refers to the belief in the efficacy of the advised preventive action to reduce risk or severity. For example, belief in the effectiveness of handwashing, vaccination, or routine screening can enhance adoption of these practices (Baek, Kim, & Choi, 2022).

Perceived Barriers: These are perceived obstacles to taking action, such as cost, cultural norms, fear of side effects, or lack of time. Understanding these barriers is essential to explaining why some adults in Egor LGA may not adopt preventive practices despite being aware of their importance (Gbadebo et al., 2025).

Cues to Action: Cues to action are internal or external prompts that trigger health behavior. These could include health campaigns, advice from health workers, media reports, or symptoms (Erubami et al., 2022). In Egor LGA, cues like church health outreach programs or community health announcements can serve this purpose.

Self-Efficacy: Self-efficacy refers to an individual's confidence in their ability to take the necessary action. If adults believe they are capable of adopting preventive behaviors, such as maintaining a healthy diet or regularly attending health checks, they are more likely to follow through (Alyafei & Easton-Carr, 2024).

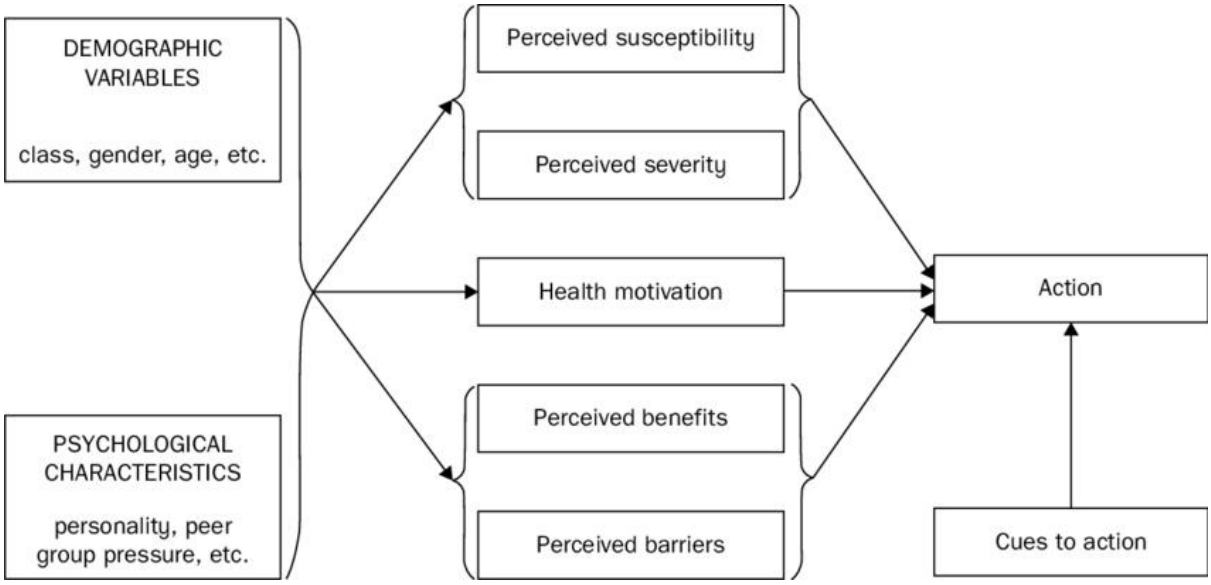

Figure 1: HEALTH BELIEF MODEL (https://www.researchgate.net/profile/Paschal-Sheeran/publication/290193215/figure/fig1/AS:614167950131227@1523440458439/The-health-belief-model_W640.jpg)

2.2.2 Application of the objective to the Study

The Health Belief Model (HBM) offers a robust theoretical lens through which to explore the relationship between individual health beliefs and the adoption of preventive health practices.

The first objective of the study seeks to assess the level of awareness of preventive health practices among adults in Egor Local Government Area. Awareness is a foundational element in the pathway to behavior change and is often influenced by individuals' perceived susceptibility and perceived severity. If adults perceive that they are at risk of developing certain diseases such as hypertension, diabetes, or infectious diseases they are more likely to seek information and become aware of available preventive measures. Additionally, if they perceive these conditions as severe or life-threatening, their awareness and concern about health maintenance tend to increase. Thus, the HBM helps explain how awareness arises not merely from information availability, but from internal beliefs about personal vulnerability and the seriousness of health threats (Karimy et al., 2021).

The second objective, which is to assess the level of adoption of preventive health practices, aligns closely with the constructs of perceived benefits, perceived barriers, and self-efficacy. The adoption of behaviors such as immunization, regular health screenings, balanced nutrition, and physical activity often depends on the extent to which individuals believe these actions will effectively prevent illness. Perceived benefits can motivate behavior, while perceived barriers such as cost, lack of access, cultural beliefs, or fear of side effects can inhibit it (Gbadebo et al., 2025). Additionally, self-efficacy, or the belief in one's capability to perform a given behavior, plays a vital role in whether people initiate and sustain health-promoting actions. In Egor LGA, factors such as education, socioeconomic status, and previous experiences with the healthcare system may shape self-efficacy and, by extension, behavior adoption.

The third objective aims to identify the health beliefs that influence preventive health practices among adults in the study area. This objective taps directly into all six constructs of the HBM. Health beliefs are multi-dimensional and are shaped by personal experiences, cultural norms, religious beliefs, and social influences. For instance, some individuals may believe that illness is a result of spiritual forces and therefore rely on traditional healing methods rather than biomedical prevention. Others may hold strong beliefs in the efficacy of modern medicine and willingly engage in routine screenings and vaccinations. By identifying these diverse beliefs whether they act as facilitators or deterrents the study can uncover underlying motivations and hesitations that affect health behavior (Erubami et al., 2022).

Finally, the fourth objective focuses on examining the perceived influence of health beliefs on the adoption of preventive health practices. This objective integrates the full structure of the HBM to analyze how individual perceptions shape health behaviors. In practice, even if awareness is high, the adoption of preventive practices may remain low if perceived barriers outweigh perceived benefits or if individuals lack confidence in their ability to take action.

Additionally, cues to action such as public health campaigns, illness experiences, or reminders from healthcare workers can trigger behavior change by prompting individuals to act on their existing beliefs (Alyafei & Easton-Carr, 2024). This component of the model highlights the dynamic nature of health behavior and emphasizes the importance of targeted interventions that address not just knowledge, but also belief systems and motivational triggers.

2.3 Empirical Review

2.3.1 The level of awareness of preventive health practices among adults

In a study carried out by Akinyemi et al. (2021) at Obafemi Awolowo University, Ile-Ife, Osun State, the perception and determinants of uptake of preventive health services (PHS) among academic and non-academic staff were examined. A cross-sectional analytical design was adopted, and 290 participants were selected using a stratified random sampling technique. Data were collected through self-administered questionnaires, and binary logistic regression was used for analysis. Findings revealed that while 96.6% had good perception and 92.4% demonstrated positive attitudes toward PHS, only 32.4% showed adequate uptake. Barriers identified included availability, affordability, and time constraints. The study concluded that although perception and attitude toward PHS were generally positive, uptake remained low due to systemic access barriers, underscoring the need for supportive institutional policies.

Similarly, Ngyozie, Eniola, and Olumide (2024) conducted a study in urban and rural areas of Nigeria to explore the impact of health awareness on the effectiveness of preventive health measures. The researchers employed a quantitative survey-based approach involving 400 respondents. Findings showed that higher awareness significantly correlated with participation in preventive practices. In particular, awareness of non-communicable diseases (NCDs) like hypertension and diabetes had a stronger influence on health behavior than awareness of infectious diseases. The study concluded that targeted health education

initiatives improve participation in preventive health measures, especially when context-sensitive and disease-specific.

In Portugal, Silva and Santos (2021) investigated the impact of health literacy on knowledge and attitudes toward COVID-19 preventive strategies among students at the University of Porto. A cross-sectional design was used with 871 participants, and health literacy was assessed via the Newest Vital Sign tool. Results indicated that 92% of respondents demonstrated adequate literacy, and 90.4% held adequate attitudes, though knowledge was not significantly correlated with literacy. The study concluded that higher health literacy predicts more favorable attitudes, suggesting that literacy-enhancing interventions could play a pivotal role in public health compliance during pandemics.

Focusing on media influence, Ezugwu et al., (2025) examined youths' attitude, knowledge, and screening practices regarding hypertension in Nsukka Urban. The study was grounded in the Health Belief Model (HBM) and used a descriptive survey design with 398 respondents aged 18–35. A multi-stage sampling technique was used, and data analysis employed descriptive statistics and t-tests. Results showed moderate knowledge levels, with media playing a statistically significant role in awareness. Attitudes were generally positive, and screening practices were above average. The authors concluded that media sensitization enhances preventive behavior, recommending increased use of digital platforms and mobile interventions.

In a Lagos-based study, Omotunde et al. explored the impact of health education on hypertension knowledge, motivation, and preventive practices among pre-hypertensive traders. The research adopted a quasi-experimental design with 140 participants, divided into control and experimental groups, selected through multistage sampling. Data were collected at baseline, immediately after intervention, and at six-week follow-up. Analysis revealed a

statistically significant improvement in knowledge and preventive practices in the experimental group. The study concluded that structured health education interventions effectively improve preventive behaviors toward hypertension management.

2.3.2 The level of adoption of preventive health practices among adults

In a study conducted by Adesina et al. (2021) in Ogun State, Nigeria, the Health Belief Model (HBM) was applied to investigate behavioral practices of the urban poor toward COVID-19. The study adopted a cross-sectional design and surveyed 405 residents, assessing HBM constructs such as perceived susceptibility, severity, benefits, and barriers using a 4-point Likert scale. Findings showed that participants aged 30–40 years felt more susceptible to COVID-19 (mean = 2.59), and perceived higher benefits of non-pharmaceutical interventions (NPIs) (mean = 2.95) than other age groups. However, unhealthy practices such as indiscriminate use of facemasks were prevalent 47.6% wore them even when alone. The study concluded that although the urban poor feel threatened by COVID-19, their adoption of preventive behaviors was hindered by financial hardship, inadequate knowledge, and limited access to healthcare, highlighting the need for targeted health communication strategies.

In a quasi-experimental study conducted in Imo and Kaduna States, Akuiyibo et al. (2022) assessed the effectiveness of behavior change communication (BCC) interventions targeting hypertension and diabetes. The 12-month intervention was implemented among adults aged 35 and above. Using baseline and endline surveys across study and control groups, the study recorded significant improvements. Awareness of hypertension rose from 94.4% to 98.9%, and blood glucose checks increased from 30.6% to 71.9% ($\chi^2 = 243.34$, $p = 0.002$). The mean knowledge score improved significantly (from 11.84 to 18.12; $p < 0.001$). Additionally, there was a notable reduction in alcohol consumption among the study group. The researchers concluded that community-based BCC interventions are effective in improving knowledge, lifestyle behaviors, and health-seeking attitudes related to non-communicable diseases.

In Cross River State, Ayo (2025) investigated the relationship between adult literacy and health-promoting behaviors in rural communities. The study employed a descriptive survey design with a sample of 400 adults from Ogoja and Obudu Local Government Areas. Results revealed that although 58% of respondents had basic literacy, only 42% practiced consistent health-promoting behaviors like routine medical checkups or proper nutrition. A significant positive correlation was found between literacy and health behavior ($r = 0.67$, $p < 0.05$). Barriers included lack of health education (75%) and inadequate access to healthcare (82%), with cultural and economic constraints also playing roles. The study concluded that literacy is a strong predictor of health behavior, advocating for integrated literacy and health education programs to improve rural health outcomes.

In Ibadan, Nigeria, Gbadebo et al. (2025) conducted a qualitative study exploring social perceptions and influencers of oral health-seeking behavior. Using a thematic approach, 25 adults attending the University College Hospital Dental Centre were purposively selected for in-depth interviews. Three themes emerged: (1) care-seeking behavior driven by pain, (2) influencers such as family and social media, and (3) the impact of delayed care on quality of life. The findings revealed that oral care was predominantly symptom-driven, with barriers including cost, fear, misinformation, and poor access. Participants expressed regret about delaying care due to the negative effects on self-esteem and well-being. The authors concluded that oral health-seeking in Nigeria is shaped by a complex interplay of cultural, psychological, and systemic factors, and called for community education, integrated services, and patient-centered care.

In South Korea, Baek, Kim, and Choi (2022) examined the determinants of adherence to COVID-19 preventive behaviors using the Health Belief Model. This cross-sectional online study included 1,207 participants aged 20–59. Using regression analysis, the stu6dy found that perceived susceptibility ($\beta = .197$, $p < .001$) and self-efficacy ($\beta = .404$, $p < .001$) were

strong predictors of adherence. Interestingly, trust in information sources also influenced behavior trust in government websites and social networks increased compliance, while trust in radio showed a negative association ($\beta = -.080$, $p = .006$). The study concluded that psychological and informational factors significantly influence preventive behavior, emphasizing the need for reliable communication and empowerment-focused public health campaigns.

2.3.3 The health beliefs of preventive health practices among adults

In a study conducted by Abraham et al. (2023) in Cape Coast Metropolis, Ghana, the researchers explored the influence of the COVID-19 pandemic on the health-seeking behaviors of adults living with chronic conditions through the lens of the Health Belief Model (HBM). An exploratory descriptive design was employed using semi-structured interviews among individuals with chronic diseases. Data were analyzed using both inductive and deductive thematic analysis. The study revealed that participants perceived themselves as highly susceptible to COVID-19 due to their pre-existing conditions. Major barriers to healthcare access included limited interaction with healthcare providers and fear of contracting the virus at health facilities. Media served as an effective cue to action, encouraging preventive behavior changes such as lifestyle modifications, dietary adjustments, and self-medication. Missed appointments were largely attributed to perceived susceptibility. The study concluded that the HBM was a useful framework for understanding behavior changes among this population, and recommended targeted health education to support chronic disease management during future pandemics.

Bechard et al. (2021) conducted a study in Ontario, Canada, using the Health Belief Model to explore age differences in perceptions and responses to the COVID-19 pandemic. The researchers implemented a web-based cross-sectional survey and analyzed data from 820 participants using proportional odds logistic regression and structural equation modeling.

Findings indicated that middle-aged and older adults perceived higher risks of hospitalization and mortality from COVID-19 compared to younger adults. Interestingly, adoption of preventive health behaviors such as mask-wearing and hand hygiene was consistently high across all age groups, although perceptions of efficacy differed slightly. Structural modeling showed that perceived benefits were the strongest predictor of behavior uptake, with socioeconomic status, perceived susceptibility, and severity indirectly influencing behavior through this construct. The study concluded that public health messaging should emphasize the benefits of preventive behaviors to enhance compliance across all age groups.

Ghorbani-Dehbalaei et al. (2021) conducted a descriptive study among 431 female university students at Rafsanjan University of Medical Sciences in Iran, to examine the role of health beliefs and health literacy in health-promoting behaviors based on the Health Belief Model. Participants were selected using a stratified sampling technique, and data were collected using an electronic questionnaire. Analyses were carried out using t-tests, ANOVA, Pearson correlation, and multiple linear regression. Results showed that 75.57% of participants engaged in preventive health behaviors, while the average health literacy score was 52.71 out of 100. The strongest predictors of behavior were self-efficacy ($\beta = 0.414$) and cues to action ($\beta = 0.299$). In total, health literacy and key HBM constructs accounted for 52.1% of the variance in behavior. The researchers concluded that interventions aiming to improve women's health should be theory-driven, particularly emphasizing self-efficacy.

Iluno et al. (2024) investigated cervical cancer screening adoption behaviors among female postgraduate students at the University of Ibadan, Nigeria, using a descriptive cross-sectional survey grounded in the Health Belief Model. A multi-stage sampling technique was used to recruit 372 women aged 20–52 years. Data were collected using a pretested semi-structured questionnaire and analyzed with SPSS. Only 4% of participants had undergone cervical cancer screening, although 86.3% expressed willingness to do so in the future. Most

respondents believed that cervical cancer is a serious illness and acknowledged the benefits of screening. Preferred screening providers were female doctors (73.2%), and antenatal clinics were the most preferred locations. A statistically significant relationship was found between screening behavior and sexual activity ($p = 0.0007$). The study concluded that while current utilization of screening services was low, future uptake could be improved by aligning delivery methods with women's preferences and increasing accessibility.

Kim et al., (2022) carried out a cross-sectional online survey in South Korea among 526 health college students to identify the factors affecting COVID-19 preventive behaviors. A hierarchical regression analysis was used to explore predictors. Results indicated that education on infectious diseases significantly improved preventive behavior ($\beta = 0.22$, $p < 0.001$), while stronger health beliefs about COVID-19 also positively influenced behavior ($\beta = 0.15$, $p = 0.004$). Conversely, negative lifestyle changes such as increased smoking and drinking were found to reduce compliance with preventive measures ($\beta = -0.12$, $p = 0.007$). The authors concluded that both educational exposure and health beliefs significantly affect adherence to preventive practices. The study emphasized the importance of embedding infectious disease education and behavioral reinforcement into healthcare training programs.

2.3.4 The perceived influence of health beliefs on the adoption of preventive health practices among adults

In a study carried out by Erubami et al. (2022) in Nigeria, the researchers examined the predictors of COVID-19 vaccine uptake among social media users, extending the Health Belief Model (HBM). Using a cross-sectional online survey with 436 respondents, the study employed structural equation modeling to assess the influence of social media exposure, fear, and anticipated regret on vaccine decisions. Results showed that perceived susceptibility, severity, perceived barriers, and exposure to vaccine-critical posts on social media significantly predicted vaccine uptake. Interestingly, perceived benefits and anticipated regret

for inaction did not significantly influence behavior. The study concluded that social media trends play a vital role in shaping public health decisions, and misinformation must be countered with credible, targeted information.

In a Malaysian-based study, Ahadzadeh et al. (2021) explored the relationship between internal health locus of control (HLOC) and mobile health (mHealth) adoption, applying the Unified Theory of Acceptance and Use of Technology (UTAUT) as a mediating model. The researchers conducted a cross-sectional survey with 374 adult mHealth users, selected using convenience and snowball sampling. Using partial least squares structural equation modeling, they found that HLOC had no direct effect on the intention to use mHealth, but UTAUT constructs performance expectancy, effort expectancy, and social influence fully mediated the relationship. The study concluded that behavioral intent to adopt mHealth is influenced more by perceived usefulness and social norms than personal health control beliefs, indicating a need to design user-friendly, socially endorsed digital health tools.

Alruwaili et al. (2023) conducted a systematic review to evaluate the adoption, efficacy, and user experience of digital health interventions promoting healthy aging globally. The review included 15 studies retrieved from PubMed, Embase, and the Cochrane Library, focusing on adults aged 50 years and above. Findings revealed that digital health adoption increased during COVID-19, yet barriers like technological challenges and distrust remained prominent. Interventions such as web-based programs and telerehabilitation showed promise in improving behavior and physical balance. The study concluded that while digital tools enhance access and self-care for older adults, implementation strategies must be patient-centered and ethical, especially to address disparities in digital health engagement.

In a study conducted in Ibadan, Nigeria, Akinniyi et al. (2025) investigated the interplay of health expectations, perceived care quality, and socio-demographic factors in determining

health-seeking behavior among health workers. A cross-sectional survey involving 108 health workers was conducted, and structural equation modeling was used to analyze the relationships. Results indicated that health expectations significantly predicted perceived care quality and health-seeking behavior (HSB). Additionally, age, ethnicity, and marital status moderated these relationships. The study concluded that improving care quality and recognizing socio-demographic diversity can enhance proactive health-seeking behavior within the healthcare workforce.

Badru and Adekola (2023) examined the influence of sociocultural beliefs on health-seeking behavior among older adults in both urban and rural areas in Lagos State, Nigeria. Using a descriptive qualitative approach, the study found that traditional beliefs, cultural identity, and generational shifts significantly shaped health behaviors and attitudes toward modern health systems. While older adults exhibited resilience and adaptive strategies, challenges such as colonial legacies and socio-economic transformation hindered consistent engagement with formal health services. The study concluded that context-specific strategies that honor cultural beliefs while integrating modern healthcare approaches are essential for improving health outcomes among older populations.

2.4 Summary of Literature Review

The literature review highlights the evolving understanding of health beyond the absence of disease to a state of complete physical, mental, and social well-being, as defined by the World Health Organization (WHO). This holistic view supports the need for health promotion and preventive practices, which empower individuals and communities to take proactive steps in maintaining and improving health. Health promotion plays a vital role in creating awareness, building capacity, and reducing the burden of illness through informed behavioral choices.

Preventive health practices are categorized into three levels: primary prevention (such as immunization and healthy lifestyle choices), secondary prevention (including health screenings and early detection), and tertiary prevention (such as rehabilitation and disease management). These practices are essential in controlling the spread of diseases and improving population health outcomes. However, the literature also notes that the adoption of preventive practices is influenced by a variety of factors including education, cultural beliefs, health literacy, gender, and access to healthcare services.

Health beliefs shaped by personal experiences, cultural norms, and spiritual understandings play a critical role in influencing whether individuals engage in preventive health behaviors. While some beliefs encourage individuals to seek preventive care, others may lead to fear, stigma, or reliance on non-medical practices that hinder timely action. Therefore, understanding these belief systems is vital in promoting positive health behavior and tailoring public health interventions to suit the needs and perceptions of specific populations.

To guide this understanding, the Health Belief Model (HBM) provides a theoretical framework for analyzing how individual beliefs impact preventive health actions. The model outlines six constructs: perceived susceptibility, perceived severity, perceived benefits, perceived barriers, cues to action, and self-efficacy. Each component plays a role in determining whether a person adopts preventive behaviors. The model is particularly useful for this study as it aligns with the specific objectives assessing awareness, identifying beliefs, and understanding the perceived influence of those beliefs on preventive health practices among adults in Egor Local Government Area, Edo State.

CHAPTER THREE

RESEARCH METHODOLOGY

This chapter describes the research methodology that the researcher adopted in conducting this study. The various components of research methodology were discussed under their respective headings, including research design, study setting, target population, sample and sampling technique, instruments of data collection, validity and reliability of instruments, method of data collection, method of data analysis, and ethical considerations.

3.1 Research design

The study adopts a descriptive cross-sectional survey design. The design was suitable because it allowed the researcher to assess the health beliefs and adoption of preventive health practices among adults in Egor Local Government Area at a single point in time. A cross-sectional survey enables the collection of data from a large, diverse population, making it possible to describe patterns, attitudes, and relationships between variables such as awareness, health beliefs, and preventive behaviors. Additionally, this design was cost-effective, time-efficient, and ideal for identifying associations between health beliefs and the adoption of preventive practices without manipulating any variables. Since the study aimed to observe and describe existing conditions rather than establish causality, the descriptive cross-sectional design aligned well with the objectives of the research.

3.2 Research Setting

The study was conducted in Egor Local Government Area of Edo State, located in the southern region of Nigeria. Egor LGA is one of the metropolitan local government areas that make up Benin City, the capital of Edo State. It comprises both urban and semi-urban communities with a mix of residential, commercial, and institutional establishments. The area

is known for its diverse population in terms of ethnicity, religion, occupation, and education, making it a suitable location for a study focused on health beliefs and preventive health practices. Egor LGA provided a relevant context for the study due to the availability of primary health centers, private hospitals, clinics, and various public health campaigns. These resources will ensure access to a wide range of adult respondents who may have differing levels of awareness and beliefs about preventive health. The setting allowed the researcher to gather data from individuals across various wards and communities, thereby increasing the generalizability of the study findings to similar urban and semi-urban populations in Nigeria.

3.3 Target Population

The target population for this study consisted of adult residents (18 years and above) living in Egor Local Government Area of Edo State. This included individuals from various wards, socio-economic backgrounds, educational levels, and occupations. The study focused on both male and female adults who are permanent residents and have lived in the area for at least six months, ensuring they are familiar with local health services and practices. This population was appropriate for assessing the influence of health beliefs on the adoption of preventive health practices.

3.4 Sample Size Determination

The sample size for this study was determined using Cochran's formula, which is appropriate for large populations where the exact population size is not known. This method ensures a statistically valid sample size for estimating population proportions. The formula is as follows:

$$n_0 = (Z^2 \times p \times (1 - p)) / e^2$$

Where:

n_0 = required sample size

Z = standard normal deviate at 95% confidence level = 1.96

p = estimated proportion of the population (set at 0.5 to ensure maximum variability)

e = margin of error = 0.05

Substituting into the formula:

$n_0 = (1.96^2 \times 0.5 \times (1 - 0.5)) / 0.05^2$

$n_0 = (3.8416 \times 0.25) / 0.0025$

$n_0 = 0.9604 / 0.0025 = 384.16$

Therefore, the calculated minimum sample size is approximately 384 respondents. To account for potential non-responses or incomplete questionnaires, the sample size will be rounded up. Thus, a final sample of 400 adult residents of Egor Local Government Area will be selected for this study. This sample size will ensure sufficient statistical power and enhance the generalizability of the findings.

3.5 Sampling Technique

The study employed the multistage sampling technique. This technique was suitable because it allowed for a systematic and manageable selection of participants from a large and diverse population such as that of Egor Local Government Area. In the first stage, a selection of wards within the local government area was made using simple random sampling. In the second stage, specific communities or streets within the selected wards was also randomly chosen. Finally, households within the selected areas were approached, and eligible adult

respondents (aged 18 years and above) were selected using systematic sampling. This approach ensured that the sample was well-distributed across different parts of the local government area, capturing variability in demographic, social, and health-related characteristics. Multistage sampling was also cost-effective and practical for fieldwork, especially in an area with multiple administrative divisions and a large population size.

3.6 Instrument for Data Collection

The instrument for data collection in this study was a self-structured questionnaire. This was developed based on the objectives of the study. The questionnaire was made up of four sections. The questions were carefully drafted, sequenced and constructed in a bid to get in-depth information that was useful and relevant to the study.

Section A: consist of the demographic data of the participants (Age, Marital Status, Current Educational Level, Ethnicity).

Section B: The level of awareness of preventive health practices among adults in Egor local government area, Edo state.

Section C: The level adoption of preventive health practices among adults in Egor local government area, Edo state.

Section D: The health beliefs of preventive health practices among adults in Egor local government area, Edo state.

SECTION E: The perceived influence of health beliefs on the adoption of preventive health practices among adults in Egor local government area, Edo state.

3.7 Validity of the Instrument

The instrument's validity pertained to its capability to accurately measure the intended construct or concept (Lim., 2024). Researcher assessed various validity types such as content,

construct, criterion, and face to evaluate the instrument's accuracy. For this research, face and content validity was utilized to validate the research tool. The questionnaire was validated by both the project supervisor and a field expert, and necessary adjustments were implemented by the researcher before starting the main study.

3.8 Reliability of the Instrument

The reliability of an instrument referred to its stability and consistency in delivering uniform outcomes when assessing the same criteria under identical circumstances (Izah et al., 2023). It essentially gauged how consistently the instrument produced similar results across multiple trials. A reliable instrument is one that could produce the same results if the behavior was measured again by the same scale. The Cronbach's alpha reliability technique was employed in this study. This researcher conducted a reliability testing on the instrument by distributing 40 questionnaires, which constituted 10% of the total sample size of 400, to adults in Ovia North-East Local Government Area (which are outside the sampled population). A coefficient of 0.71 was obtained and the instrument was considered reliable.

3.9 Method of Data Collection

A well-structured questionnaire was administered to the adults until the required sample size of 400 was achieved. The adults were approached at their various houses. The purpose of the study was explained to them, and the instrument for data collection were administered. Data collection was conducted by the researchers. The data collection took place during day (morning, afternoon and early evening maximum 7pm), and on-the-spot retrieval of the administered copies of the questionnaire ensured that all copies were collected on the same day. Data collection lasted for about one week.

3.10 Method of Data Analysis

The data collected was analysed using the Statistical Package for the Social Sciences (SPSS) version 26.0. Descriptive statistics such as mean, frequency, and percentages were computed to summarize the data. Hypothesis testing was conducted using the Chi-square test of association, with the level of significance set at $p < 0.05$. The results of the analyses were then presented using tables, graphs, frequencies, and percentages to provide a clear overview of the findings.

3.11 Ethical Considerations

Ethical approval was obtained from the Health Research Committee, Egor Local Government Area, Benin City. Permission was obtained from the various ward chairman before proceeding with the research. Before data collection began, participants received detailed explanations about the research's purpose, content, and implications. They were assured of confidentiality, ensuring the protection of their personal and private information. Throughout the research, ethical guidelines were strictly adhered to, including the following considerations:

Confidentiality: Respondents' information were treated confidentially, with no request for names or addresses in the questionnaire. Participants were made to understand that their responses were confidential and solely used for research purposes. No personal identifiers was used in any document or questionnaire to maintain anonymity.

Voluntary Participation: Participant were informed of their right to voluntary participation without facing penalties or bias. They could choose to withdraw or decline to provide information at any point if they feel uncomfortable or unsure.

Avoidance of Plagiarism: Proper citation of all authors used in the study was ensured, both within the content and in the reference page.

CHAPTER FOUR

RESULT AND FINDINGS

This chapter deals with the representation of data collected regarding the the influence of health beliefs on adoption of preventive health practices among adults in Egor local government area, Edo state. A total of 384 questionnaires were distributed to the adults in Egor local government area, Edo state during the period of this study. 373 were properly filled and valid for data analysis, giving a response rate of 97.1 %.

Table 4.1: Socio-demographic data of respondents

Variable	Frequency (n=373)	Percent (%)
Age		
18–25	89	23.8
26–35	72	19.3
36–45	81	21.7
46–55	66	17.7
56 and above	65	17.5
Sex		
Male	182	48.8

Female	191	51.2
Marital Status		
Single	135	36.2
Married	183	49.1
Divorced	25	6.7
Widowed	18	4.8
Separated	12	3.2
Religion		
Christianity	240	64.3
Islam	105	28.2
Traditional	18	4.8
Others (please specify)	10	2.7
Educational Level		
No formal education	34	9.1
Primary education	67	18.0
Secondary education	112	30.0
Tertiary education	123	33.0
Postgraduate	37	9.9
Occupation		

Unemployed	78	20.9
Self-employed	102	27.3
Civil servant	88	23.6
Artisan	42	11.3
Trader	50	13.4
Other (please specify)	13	3.5

Table 4.1 Cont'd

Variable	**Frequency (n=373)**	**Percent (%)**
Monthly Income (₦)		
Less than ₦20,000	81	21.7
₦20,000–₦49,999	94	25.2
₦50,000–₦99,999	97	26.0
₦100,000–₦199,999	65	17.4
₦200,000 and above	36	9.7

Table 4.1 shows the socio-demographic distribution of the 373 respondents. The age distribution indicates that the largest proportion of respondents (23.8%) were between 18–25 years, followed by 21.7% within the 36–45 age bracket. Respondents aged 26–35 accounted for 19.3%, while those aged 46–55 and 56 years and above represented 17.7% and 17.5% respectively. In terms of sex, females (51.2%) slightly outnumbered males (48.8%). With

respect to marital status, nearly half of the respondents (49.1%) were married, while 36.2% were single. Smaller proportions were divorced (6.7%), widowed (4.8%), or separated (3.2%). Religion-wise, the majority of respondents identified as Christians (64.3%), followed by Muslims (28.2%). A few practiced traditional religion (4.8%) or belonged to other faiths (2.7%). On educational attainment, the highest proportion had tertiary education (33.0%), while 30.0% had completed secondary education. Those with primary education constituted 18.0%, and 9.1% reported no formal education. A further 9.9% had postgraduate qualifications. Occupation data revealed that 27.3% of respondents were self-employed, 23.6% were civil servants, and 20.9% were unemployed. Traders made up 13.4%, artisans 11.3%, while 3.5% fell into other categories. Regarding monthly income, 26.0% of respondents earned between ₦50,000–₦99,999, while 25.2% earned between ₦20,000–₦49,999. About 21.7% reported less than ₦20,000 monthly income, 17.4% earned ₦100,000–₦199,999, and only 9.7% earned ₦200,000 and above**.**

Answering Research Questions

Research Question 1: What is the level of awareness of preventive health practices among adults in Egor local government area, Edo state?

Table 4.2: The level of awareness of preventive health practices among adults in Egor local government area**,** Edo state.

Variables	Frequency	Correct	Wrong	Mean	Remark
Which of the following is a preventive health practice?		351 (94.1)	22 (5.9)	1.9	Good
Regular exercise	351 (94.1)				
Self-medication	15 (4.0)				
Smoking	7 (1.9)				
Which vaccine is commonly given to prevent tuberculosis?		272 (72.9)	101 (27.1)	1.7	Good
BCG vaccine	272 (72.9)				
Yellow fever vaccine	67 (18.0)				
Tetanus vaccine	34 (9.1)				
What is the purpose of handwashing with soap and water?		361 (96.8)	12 (3.2)	2.0	Good
To prevent the spread of infections	361 (96.8)				
To change body temperature	5 (1.3)				

To clean wounds only	7 (1.9)				
Which of the following can help in early detection of diseases?		362 (97.1)	11 (2.9)	2.0	Good
Health screening	362 (97.1)				
Prayer alone	6 (1.6)				
Ignoring symptoms	5 (1.3)				
Which lifestyle choice is a form of primary prevention?		360 (96.5)	13 (3.5)	2.0	Good
Eating a balanced diet	360 (96.5)				
Drinking alcohol regularly	8 (2.1)				
Avoiding fruits and vegetables	5 (1.3)				
What is the goal of preventive health practices?		352 (94.4)	21 (5.6)	1.9	Good
To avoid illness before it occurs	352 (94.4)				
To delay treatment	5 (1.3)				
To treat advanced diseases only	16 (4.3)				

Table 4.2 Cont'd

Variables	Frequency	Correct	Wrong	Mean	Remark
Which of these is a recognized form of preventive health service?		337 (90.3)	36 (9.7)	1.9	Good
Immunization	337 (90.3)				
Spiritual cleansing	11 (2.9)				
Herbal mixtures from unverified sources	25 (6.7)				
Which activity is considered a preventive measure for malaria?		359 (96.2)	14 (3.8)	2.0	Good
Sleeping under insecticide-treated nets	359 (96.2)				
Drinking cold water	5 (1.3)				
Eating spicy food	9 (2.4)				
Which of the following helps prevent the spread of sexually transmitted infections (STIs)?		363 (97.3)	10 (2.7)	2.0	Good
Condom use	363 (97.3)				
Sharing sharp objects	6 (1.6)				
Ignoring symptoms	4 (1.1)				
Which health practice helps to prevent dental problems?		365 (97.9)	8 (2.1)	2.0	Good

Brushing teeth twice daily	365 (97.9)			
Eating only sugary foods	5 (1.3)			
Avoiding dental checkups	3 (0.8)			
		Grand Mean	**1.9**	**Good**

Mean Cut-off = 1.5

Table 4.2 shows the level of awareness of preventive health practices among adults in Egor local government area, Edo state. The highest mean score of 2.0 was recorded in several items including knowledge of the purpose of handwashing with soap and water (96.8%), early detection of diseases through health screening (97.1%), lifestyle choice as a form of primary prevention (96.5%), preventive measure for malaria (96.2%), prevention of sexually transmitted infections through condom use (97.3%), and dental health practices such as brushing teeth twice daily (97.9%). This was followed by items with a mean score of 1.9, which include awareness of preventive health practices (94.1%), the goal of preventive health practices (94.4%), and recognition of immunization as a preventive health service (90.3%). The lowest mean score of 1.7 was observed in knowledge of the vaccine commonly given to prevent tuberculosis, where 72.9% correctly identified the BCG vaccine. The overall grand mean of 1.9 indicates a good level of awareness of preventive health practices among adults in Egor local government area.

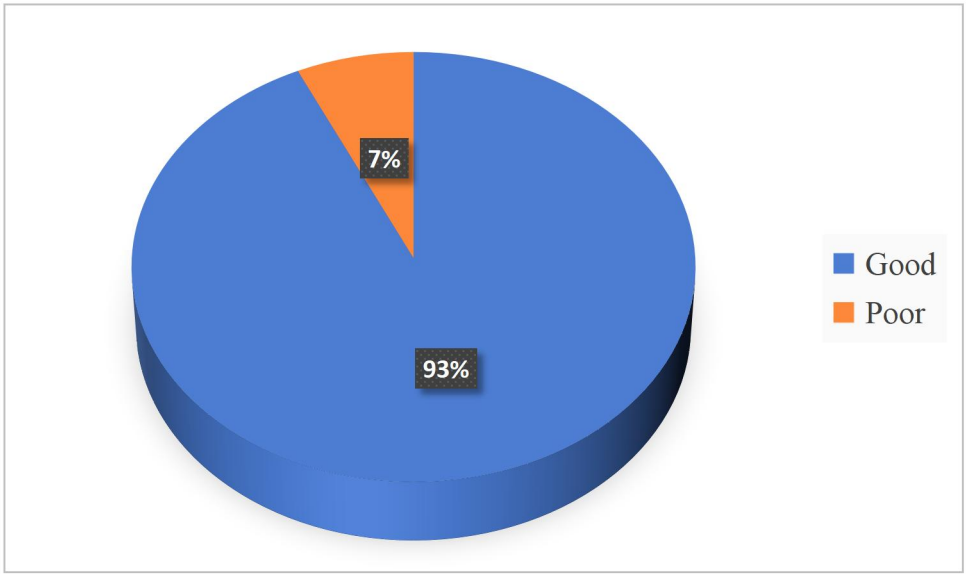

Fig 4.1: Pie-chart showing the level of awareness of preventive health practices among adults in Egor local government area, Edo state.

Figure 4.1 shows that the majority of respondents 348 (93%) demonstrated good awareness of preventive health practices, while only 25(7%) exhibited poor awareness.

Research Question 2: What is the level adoption of preventive health practices among adults in Egor local government area**,** Edo state?

Table 4.3: The level of adoption of preventive health practices among adults in Egor local government area**,** Edo state**.**

Items	Always	Sometimes	Rarely	Never	Mean	Remark
I go for regular medical check-ups even when I am not sick.	58 (15.5)	121 (32.4)	109 (29.2)	85 (22.8)	2.4	Low
I ensure I and my family receive recommended immunizations.	49 (13.1)	141 (37.8)	94 (25.2)	89 (23.9)	2.4	Low
I sleep under an insecticide-treated mosquito net.	53 (14.2)	128 (34.3)	99 (26.5)	93 (24.9)	2.4	Low
I brush my teeth at least twice daily to prevent dental diseases.	53 (14.2)	122 (32.7)	95 (25.5)	103 (27.6)	2.3	Low
I eat a balanced diet as part of maintaining my health.	43 (11.5)	105 (28.2)	131 (35.1)	94 (25.2)	2.3	Low
I avoid self-medication and consult health professionals when sick.	41 (11.0)	95 (25.5)	140 (37.5)	97 (26.0)	2.2	Low
I use condoms or other protective methods during sexual intercourse.	53 (14.2)	111 (29.8)	124 (33.2)	85 (22.8)	2.4	Low
I wash my hands with soap and water regularly.	42 (11.3)	95 (25.5)	136 (36.5)	100 (26.8)	2.2	Low

I exercise to stay fit and prevent lifestyle diseases.	51 (13.7)	102 (27.3)	141 (37.8)	79 (21.2)	2.3	Low
I attend health education programs when available in my community.	58 (15.5)	110 (29.5)	130 (34.9)	75 (20.1)	2.4	Low
				Grand Mean	**2.3**	**Low**

Mean Cut-off= 2.5

Table 4.3 shows the level of adoption of preventive health practices among adults in Egor local government area. The mean scores ranged from 2.2 to 2.4, all falling below the cut-off point of 2.5, indicating a generally low level of adoption. The lowest mean score of 2.2 was observed in avoiding self-medication and consulting health professionals (11.0% always) and regular handwashing with soap and water (11.3% always). Mean scores of 2.3 were recorded in practices such as eating a balanced diet (11.5% always) and exercising to stay fit (13.7% always). The highest mean score of 2.4 was reported in going for regular medical check-ups (15.5% always), receiving recommended immunizations (13.1% always), sleeping under insecticide-treated nets (14.2% always), condom use during sexual intercourse (14.2% always), and attending health education programs (15.5% always). Overall, the grand mean of 2.3 reflects a low level of adoption of preventive health practices among the respondents.

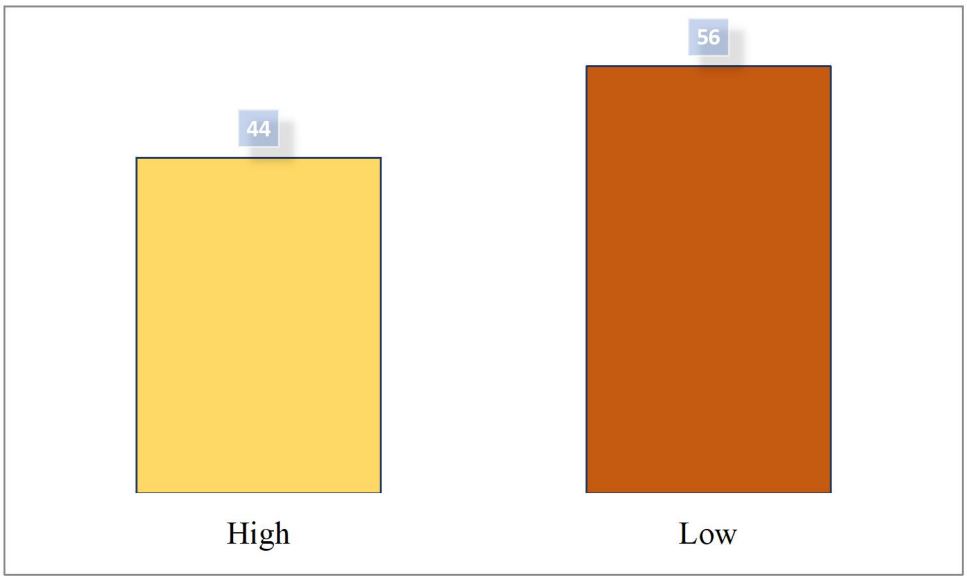

Figure 4.2: Bar chart showing the level adoption of preventive health practices among adults in Egor local government area**,** Edo state**.**

Figure 4.2 shows that 163(44%) of respondents demonstrated a high level of adoption of preventive health practices, while a larger proportion, 210(56%), recorded a low level of adoption.

Research question 3: What are the health beliefs of preventive health practices among adults in Egor local government area, Edo state?

Table 4.4: The health beliefs of preventive health practices among adults in Egor local government area, Edo state.

Items	Strongly Agree	Agree	Disagree	Strongly Disagree	Mean	Remark
I believe I can prevent many diseases by practicing good hygiene.	141 (37.8)	159 (42.6)	51 (13.7)	22 (5.9)	3.1	Positive
I believe that my faith or religious practice alone can protect me from illnesses.	82 (22.0)	149 (39.9)	81 (21.7)	61 (16.4)	2.3	Negative
I believe that traditional medicine is more effective than modern preventive health services.	91 (24.4)	169 (45.3)	56 (15.0)	57 (15.3)	2.2	Negative
I believe that health problems only occur when one has sinned or offended the gods.	61 (16.4)	181 (48.5)	84 (22.5)	47 (12.6)	2.3	Negative
I believe that going for regular checkups is only necessary when one is sick.	41 (11.0)	76 (20.4)	171 (45.8)	85 (22.8)	2.8	Positive

I believe that immunizations are important in preventing serious diseases.	149 (39.9)	161 (43.2)	41 (11.0)	22 (5.9)	3.2	Positive
I believe that preventive practices are only for the wealthy or educated.	75 (20.1)	141 (37.8)	81 (21.7)	76 (20.4)	2.4	Negative
I believe that my lifestyle choices directly affect my health.	131 (35.1)	161 (43.2)	55 (14.7)	26 (7.0)	3.1	Positive
I believe that seeking medical help early can prevent complications from diseases.	139 (37.2)	156 (41.8)	51 (13.7)	27 (7.2)	3.1	Positive
I believe that using insecticide-treated nets is a waste of time.	33 (8.8)	56 (15.0)	179 (48.0)	105 (28.2)	2.0	Negative
				Grand Mean	**2.7**	**Positive**

Mean Cut-off = 2.5

Table 4.4 shows the health beliefs of respondents regarding preventive health practices in Egor local government area. The mean scores ranged from 2.0 to 3.2, with a grand mean of 2.7, indicating an overall positive belief. The highest mean score of 3.2 was recorded for the belief that immunizations are important in preventing serious diseases (39.9% strongly agree, 43.2% agree). This was closely followed by a mean of 3.1 for the belief that good hygiene prevents many diseases (37.8% strongly agree, 42.6% agree), lifestyle choices directly affect health (35.1% strongly agree, 43.2% agree), and seeking medical help early prevents

complications (37.2% strongly agree, 41.8% agree). A mean of 2.8 was observed for the belief that regular checkups are only necessary when sick. On the negative side, the lowest mean score of 2.0 was recorded for the belief that using insecticide-treated nets is a waste of time (48.0% disagree, 28.2% strongly disagree). Other negative beliefs included reliance on faith or religion alone for protection (mean = 2.3), attributing health problems to sin or offending the gods (mean = 2.3), and preference for traditional medicine over modern preventive services (mean = 2.2). The belief that preventive practices are only for the wealthy or educated also scored low (mean = 2.4). Overall, while misconceptions still exist, respondents generally hold positive health beliefs toward preventive practices.

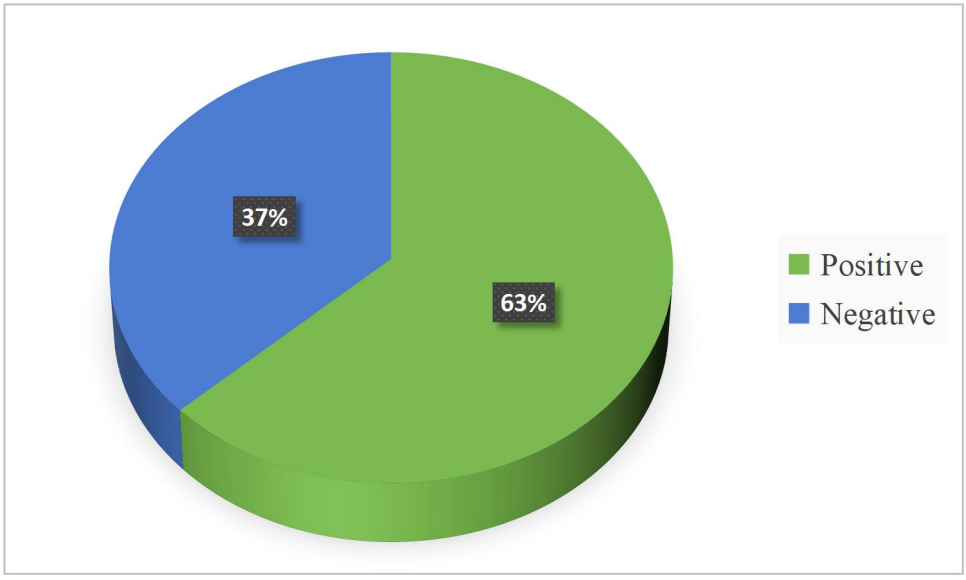

Fig 4.3: Pie chart showing the health beliefs of preventive health practices among adults in Egor local government area, Edo state.

Figure 4.3 shows that 235(63%) of respondents held positive health beliefs about preventive health practices, while 138(37%) exhibited negative beliefs.

Research Question 4: What is the perceived influence of health beliefs on the adoption of preventive health practices among adults in Egor local government area, Edo state?

Table 4.5: The perceived influence of health beliefs on the adoption of preventive health practices among adults in Egor local government area, Edo state.

Items	Strongly Agree	Agree	Disagree	Strongly Disagree	Mean	Remark
My belief in traditional medicine affects my willingness to receive vaccinations.	109 (29.2)	156 (41.8)	67 (18.0)	41 (11.0)	2.9	Influential
I am more likely to adopt preventive health practices if I believe I am at risk of illness.	141 (37.8)	159 (42.6)	49 (13.1)	24 (6.4)	3.1	Influential
I often avoid preventive health practices because I believe illness is a spiritual issue.	57 (15.3)	74 (19.8)	159 (42.6)	83 (22.3)	2.7	Influential
My religious beliefs influence my decision to attend medical check-ups.	136 (36.5)	144 (38.6)	54 (14.5)	39 (10.5)	3.0	Influential
I adopt preventive health measures only when I believe the disease is severe.	111 (29.8)	119 (31.9)	81 (21.7)	62 (16.6)	2.7	Influential

I avoid certain preventive practices due to cultural beliefs.	90 (24.1)	161 (43.2)	71 (19.0)	51 (13.7)	2.8	Influential
I practice good hygiene because I believe it will keep me safe from illness.	144 (38.6)	156 (41.8)	49 (13.1)	24 (6.4)	3.1	Influential
I do not participate in health screenings because I believe they are unnecessary.	109 (29.2)	164 (44.0)	59 (15.8)	41 (11.0)	2.9	Influential
I am more likely to take preventive action if I believe it will benefit me in the long term.	136 (36.5)	159 (42.6)	55 (14.7)	23 (6.2)	3.1	Influential
My health beliefs strongly influence how often I engage in preventive health practices.	131 (35.1)	154 (41.3)	61 (16.4)	27 (7.2)	3.0	Influential
			Grand Mean		**2.9**	**Influential**

Mean Cut-off = 2.5

Table 4.5 shows the perceived influence of health beliefs on the adoption of preventive health practices among adults in Egor local government area. The mean scores ranged from 2.7 to 3.1, all above the cut-off point of 2.5, with a grand mean of 2.9, indicating that health beliefs were generally influential. The highest mean score of 3.1 was observed in items such as the likelihood of adopting preventive practices when believing to be at risk of illness

(37.8% strongly agree, 42.6% agree), practicing good hygiene for protection against illness (38.6% strongly agree, 41.8% agree), and taking preventive action when believed to be beneficial in the long term (36.5% strongly agree, 42.6% agree). Mean scores of 3.0 were recorded for the influence of religious beliefs on attending medical check-ups and the extent to which health beliefs determine frequency of preventive practice. Items with mean scores of 2.9 included the influence of belief in traditional medicine on vaccination decisions and non-participation in health screenings due to beliefs of unnecessary testing. The lowest mean scores of 2.7 were found in avoiding preventive practices due to spiritual beliefs and adopting them only when diseases are perceived as severe. Overall, the findings suggest that health beliefs significantly shape the extent to which adults engage in preventive health practices in the study area.

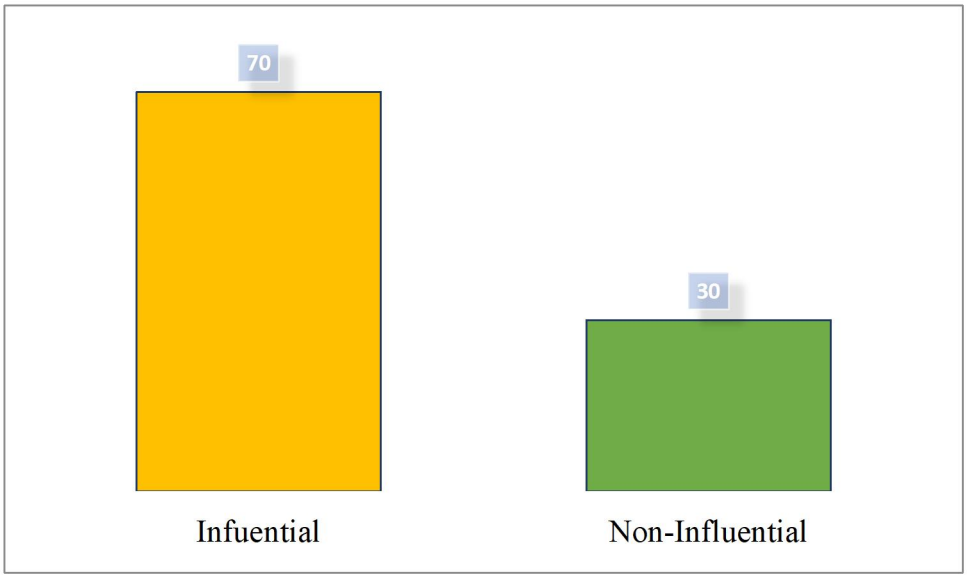

Fig 4.4: Bar chart showing the perceived influence of health beliefs on the adoption of preventive health practices among adults in Egor local government area, Edo state.

Figure 4.4 shows that 261(70%) of respondents reported that health beliefs were influential in their adoption of preventive health practices, while 112(30%) indicated that health beliefs were non-influential.

Hypothesis Testing.

2. There is no significant relationship between the level of awareness of preventive health practices and the adoption of preventive health practices among adults in Egor LGA.

Table 4.6: Relationship between the level of awareness of preventive health practices and the adoption of preventive health practices among adults in Egor LGA.

Awareness		**Adoption**		**Test Statistics (χ^2)**	**df**	**P value**	**Decision**
Good	348(93%)	**High**	**Low**				
Poor	25(7%)	163(44%)	210(56%)	6.785	1	0.08	Accepted

Table 4.6 shows the relationship between the level of awareness of preventive health practices and the adoption of such practices among adults in Egor local government area. Among respondents with good awareness (93%, n=348), 44% recorded high adoption while 56% had low adoption. Those with poor awareness (7%, n=25) showed similar trends. The chi-square test yielded $\chi^2 = 6.785$, df = 1, and p = 0.08, indicating no statistically significant relationship between awareness and adoption. Therefore, the null hypothesis that there is no significant relationship between awareness and adoption is accepted.

CHAPTER FIVE

DISCUSSION AND FINDINGS

This chapter discusses the major findings of the research compared with the literature reviewed, the implication for nursing, summary, conclusion, Recommendations and Suggestions for further Studies.

5.1. Discussion of major Findings

The study assessed the influence of health beliefs on adoption of preventive health practices among adults in Egor local government area, Edo state. The socio-demographic profile of the 373 respondents in this study reveals important characteristics that both align with and diverge from patterns observed in previous research on preventive health practices. The age distribution shows a relatively balanced representation across different life stages, with young adults (18-25 years) comprising 23.8% of the sample, while middle-aged groups (26-45 years) collectively represent 41% of participants. This demographic spread contrasts with studies like Ezugwu et al. (2025), which focused specifically on youth aged 18-35, and provides a broader perspective on health beliefs across the adult lifespan. The gender composition, with females slightly outnumbering males (51.2% versus 48.8%), mirrors the participant demographics in several previous studies, including the work by Ghorbani-Dehbalaei et al. (2021) and Iluno et al. (2024), both of which examined health behaviors among women. This near-equal gender distribution enhances the generalizability of findings compared to studies with more pronounced gender imbalances. Marital status patterns reveal that married individuals constitute the largest group (49.1%), followed by single persons (36.2%). This distribution is particularly relevant when considered alongside findings from Akinniyi et al. (2025), which identified marital status as a moderating factor in health-seeking behavior. The presence of divorced, widowed, and separated individuals, though smaller in number,

provides representation of various life circumstances that may influence health beliefs and practices. The religious composition, predominantly Christian (64.3%) with a significant Muslim population (28.2%), reflects the broader religious landscape of Edo State and aligns with the cultural context examined in Badru and Adekola's (2023) study on sociocultural beliefs and health-seeking behavior. The inclusion of traditional religious practitioners (4.8%) adds valuable cultural diversity to the sample, potentially offering insights into how indigenous belief systems influence preventive health practices. Educational attainment shows encouraging levels of formal education, with 42.9% having tertiary or postgraduate qualifications and only 9.1% lacking formal education. This educational profile suggests higher health literacy potential compared to rural populations studied by Ayo (2025), where basic literacy was observed in only 58% of respondents. The educational distribution in this study more closely resembles urban-based research like Silva and Santos (2021), where university students demonstrated high health literacy levels. Occupational diversity is evident, with self-employed individuals forming the largest group (27.3%), followed by civil servants (23.6%). The unemployment rate of 20.9% reflects economic challenges that may influence health-seeking behavior, similar to barriers identified in Adesina et al.'s (2021) study of urban poor populations. The substantial representation of traders (13.4%) connects to Omotunde et al.'s research on preventive practices among trading populations. Income distribution reveals economic stratification within the sample, with over half (52.9%) earning below ₦50,000 monthly, while only 9.7% earn ₦200,000 and above. This income pattern is consistent with findings from multiple studies that identified affordability as a significant barrier to preventive health service uptake, including Akinyemi et al. (2021) and Adesina et al. (2021). The predominance of lower-income respondents provides valuable insight into how economic constraints might influence health beliefs and preventive practice adoption. The socio-demographic characteristics of this Egor Local Government Area sample suggest a diverse

population that experiences varying degrees of economic, educational, and social advantages. Unlike studies conducted in university settings or among healthcare workers, this community-based sample captures the realities of ordinary adults navigating preventive health decisions within their socio-economic constraints, potentially offering more generalizable insights into the relationship between health beliefs and preventive practice adoption in similar Nigerian communities.

The level of awareness of preventive health practices among adults in Egor local government area, Edo state.

The findings reveal exceptionally high levels of awareness of preventive health practices among adults in Egor Local Government Area, with 93% of respondents demonstrating good awareness and a grand mean score of 1.9. This impressive level of awareness significantly surpasses findings from several comparable studies and suggests a well-informed population regarding fundamental preventive health concepts. The awareness levels observed in this study notably exceed those reported by Ezugwu et al. (2025) in Nsukka Urban, where participants demonstrated only moderate knowledge levels about hypertension prevention. Similarly, the current findings contrast with Ayo's (2025) study in Cross River State rural communities, where despite 58% having basic literacy, only 42% practiced consistent health-promoting behaviors, suggesting a potential knowledge-practice gap that may be less pronounced in the Egor population. Particularly striking is the near-universal recognition of basic preventive concepts. For instance, 97.9% of respondents correctly identified tooth brushing as essential for preventing dental problems, 97.3% understood condom use for STI prevention, and 96.8% recognized handwashing's role in infection prevention. These awareness levels are remarkably higher than those found in studies like Gbadebo et al. (2025), where oral health-seeking behavior in Ibadan was predominantly symptom-driven, suggesting

limited preventive awareness among participants. The high awareness of malaria prevention through insecticide-treated nets (96.2%) and immunization as a preventive service (90.3%) demonstrates strong knowledge of region-specific health challenges. This contrasts with the moderate awareness levels reported in various Nigerian studies, including Ngyozie, Eniola, and Olumide's (2024) findings where higher awareness correlated with participation in preventive practices, but baseline awareness levels were not as universally high as observed in Egor. The exceptional performance on vaccination knowledge, with 72.9% correctly identifying BCG as the tuberculosis vaccine, surpasses expectations given that vaccine hesitancy and misinformation have been documented challenges in Nigerian populations. This finding aligns more closely with Silva and Santos' (2021) study among Portuguese university students, where 92% demonstrated adequate health literacy, though the current study's community-based sample achieving similar levels is particularly noteworthy. The comprehensive understanding of primary prevention concepts, with 96.5% recognizing balanced diet as preventive and 94.4% understanding the goal of preventive practices, indicates that health education initiatives may have been particularly effective in this region. This level of conceptual clarity exceeds findings from Akinyemi et al. (2021) at Obafemi Awolowo University, where despite 96.6% having good perception of preventive health services, the study population was academically inclined, making the community-based achievement in Egor even more impressive. Interestingly, the uniformly high performance across diverse preventive health domains suggests that awareness is not limited to specific conditions but represents comprehensive health literacy. This broad-based knowledge contrasts with Ngyozie et al.'s (2024) finding that awareness of non-communicable diseases had stronger influence on behavior than infectious disease awareness, implying that the Egor population may have more balanced preventive health knowledge. The minimal wrong responses across all questions, with error rates ranging from 2.1% to 27.1%, indicate that

misinformation and misconceptions are relatively limited in this population. This stands in stark contrast to challenges identified in studies like Erubami et al. (2022), where social media misinformation significantly influenced health decisions, and Gbadebo et al. (2025), where misinformation was identified as a barrier to oral health-seeking behavior. However, while these awareness levels are encouraging, they must be interpreted within the context of previous research demonstrating that knowledge does not automatically translate to practice. Akinyemi et al.'s (2021) study showed that despite positive perceptions and attitudes, only 32.4% demonstrated adequate uptake of preventive services due to systemic barriers. Similarly, Adesina et al. (2021) found that although urban poor populations felt threatened by COVID-19, their adoption of preventive behaviors was hindered by financial constraints and limited healthcare access. The high awareness levels in Egor Local Government Area may reflect successful health education campaigns, improved media influence as suggested by Ezugwu et al. (2025), or the educational profile of the population, with 42.9% having tertiary education. This educational advantage may contribute to the superior awareness levels compared to studies in more rural or economically disadvantaged settings, positioning the Egor population favorably for translating knowledge into preventive health practices.

The level adoption of preventive health practices among adults in Egor local government area, **Edo state.**

The findings reveal a concerning paradox between awareness and practice among adults in Egor Local Government Area, where despite 93% demonstrating good awareness of preventive health practices, only 44% showed high levels of adoption, with the majority (56%) recording low adoption levels. The grand mean of 2.3 indicates overall low adoption, creating a significant knowledge-practice gap that mirrors patterns observed in several previous studies. This disparity between knowledge and practice aligns closely with

Akinyemi et al.'s (2021) findings at Obafemi Awolowo University, where 96.6% had good perception and 92.4% demonstrated positive attitudes toward preventive health services, yet only 32.4% showed adequate uptake. The consistency of this pattern across different Nigerian populations suggests systemic barriers that transcend individual awareness levels, pointing to structural challenges in healthcare access and utilization. The low adoption rates across all preventive practices in Egor contrast sharply with some international studies but align with patterns in similar Nigerian contexts. For instance, while Silva and Santos (2021) found that 92% of Portuguese university students demonstrated adequate health literacy with correspondingly positive attitudes, the current study reveals that high awareness in Nigerian settings does not automatically translate to behavioral change. This suggests that contextual factors play a crucial role in bridging the knowledge-practice gap. Regular medical check-ups showed particularly low adoption, with only 15.5% of respondents consistently attending check-ups when not sick, while 52% rarely or never engaged in this practice. This finding resonates with Ayo's (2025) study in Cross River State, where only 42% practiced consistent health-promoting behaviors like routine medical checkups despite basic literacy levels. The pattern suggests that preventive healthcare seeking remains challenging across different Nigerian communities, possibly due to healthcare system limitations and cultural orientation toward symptom-driven care as identified by Gbadebo et al. (2025). Immunization practices show similarly concerning patterns, with only 13.1% ensuring consistent vaccination for themselves and their families, while nearly half (49.1%) rarely or never prioritize immunizations. This contrasts with the high awareness of vaccination benefits observed in the awareness assessment, highlighting the complexity of translating knowledge into sustained health behaviors. These findings align with challenges identified in vaccine uptake studies like Erubami et al. (2022), where perceived barriers significantly influenced vaccination decisions despite awareness of benefits. Personal hygiene practices, including

handwashing and dental care, showed mixed results. While 96.8% of respondents correctly identified handwashing's importance in the awareness assessment, only 11.3% consistently practiced regular handwashing, with 63.3% rarely or never maintaining this basic preventive behavior. Similarly, despite 97.9% recognizing tooth brushing importance, only 14.2% consistently brushed teeth twice daily. This pattern echoes findings from Gbadebo et al. (2025), where oral health-seeking behavior was predominantly symptom-driven rather than preventive. The low adoption of protective sexual practices is particularly concerning, with only 14.2% consistently using protection during sexual intercourse, despite 97.3% understanding its importance for STI prevention. This finding highlights the complex interplay between knowledge, personal agency, and behavioral implementation in intimate relationships, suggesting that awareness alone is insufficient for behavior change in sensitive health domains. Lifestyle modification practices showed universally low adoption rates. Exercise for fitness showed only 13.7% consistent engagement, while balanced diet maintenance was practiced consistently by only 11.5% of respondents. These findings contrast with successful behavior change interventions reported by Akuiyibo et al. (2022) in Imo and Kaduna States, where community-based interventions significantly improved lifestyle behaviors. The difference suggests that targeted, sustained interventions may be necessary to bridge the knowledge-practice gap. The pattern of low adoption despite high awareness reflects broader challenges identified in Nigerian health behavior research. Adesina et al.'s (2021) study among urban poor populations found that although participants felt threatened by COVID-19, their adoption of preventive behaviors was hindered by financial hardship, inadequate knowledge translation, and limited healthcare access. The current findings suggest similar barriers may be operating in Egor, where economic constraints (with 52.9% earning below ₦50,000 monthly) likely limit access to preventive services. Interestingly, the adoption patterns in Egor differ from some international contexts

where behavior change interventions have shown greater success. Baek, Kim, and Choi's (2022) study in South Korea found that perceived susceptibility and self-efficacy were strong predictors of adherence to COVID-19 preventive behaviors, suggesting that psychological factors may play different roles across cultural contexts. The low participation in community health education programs (only 15.5% consistently attending) may partially explain the knowledge-practice gap. While Ezugwu et al. (2025) found that media played a significant role in awareness, the current findings suggest that passive information acquisition may be insufficient for behavior change, requiring more intensive, community-based interventions as successfully demonstrated by Omotunde et al. in Lagos. The overall pattern of low adoption despite high awareness in Egor Local Government Area reflects a critical challenge in preventive health promotion, where systemic barriers including affordability, accessibility, and cultural factors override individual knowledge and intentions. This finding underscores the need for comprehensive interventions that address both individual and structural determinants of health behavior, moving beyond awareness creation to include policy changes, healthcare system strengthening, and community-based support systems.

The health beliefs of preventive health practices among adults in Egor local government area, Edo state.

The findings reveal a predominantly positive health belief system among adults in Egor Local Government Area, with 63% holding positive beliefs and a grand mean of 2.7. However, this positive orientation exists alongside concerning traditional and spiritual beliefs that may impede preventive health practice adoption, creating a complex belief landscape that both supports and undermines evidence-based health behaviors. The strong positive beliefs regarding hygiene and disease prevention (mean = 3.1) align closely with findings from Ghorbani-Dehbalaei et al. (2021) among Iranian university students, where health beliefs

significantly predicted health-promoting behaviors. The recognition that lifestyle choices directly affect health (mean = 3.1) and that early medical intervention prevents complications (mean = 3.1) demonstrates sophisticated understanding of health causation that exceeds patterns observed in some previous studies. Particularly encouraging is the strong belief in immunization importance (mean = 3.2), with 83.1% agreeing or strongly agreeing that immunizations prevent serious diseases. This positive orientation contrasts sharply with vaccine hesitancy challenges documented by Erubami et al. (2022), where perceived barriers and social media misinformation significantly influenced vaccine uptake decisions. The favorable immunization beliefs in Egor suggest a foundation for successful vaccination programs, though the earlier adoption findings indicate that beliefs may not translate directly to behavior. However, the coexistence of positive scientific beliefs with traditional and spiritual health beliefs presents a complex picture. The finding that 61.9% believe faith or religious practice alone can protect from illness (mean = 2.3) reflects the dual health belief systems identified in Badru and Adekola's (2023) study among older adults in Lagos State, where traditional beliefs significantly shaped health behaviors alongside modern healthcare approaches. This religious orientation to health protection may explain some of the knowledge-practice gaps observed in the adoption findings. The persistence of traditional medicine preferences is evident, with 69.7% believing traditional medicine is more effective than modern preventive services (mean = 2.2). This finding aligns with patterns observed in Abraham et al.'s (2023) study in Ghana, where participants engaged in self-medication and lifestyle modifications based on traditional health beliefs during COVID-19. The preference for traditional approaches may partially explain the low adoption rates of formal preventive services observed earlier, despite high awareness levels. Particularly concerning is the spiritual attribution of illness, with 64.9% believing health problems result from sin or offending gods (mean = 2.3). This belief system contrasts with the biomedical understanding

demonstrated in awareness assessments and may create cognitive dissonance that influences health-seeking behavior. Such spiritual health attributions were also noted in Abraham et al.'s (2023) work, where participants' health behaviors were significantly influenced by perceived susceptibility within their cultural belief framework. The socioeconomic dimension of health beliefs reveals mixed perspectives, with 57.9% believing preventive practices are only for the wealthy or educated (mean = 2.4). This perception may reflect the economic realities of the population, where 52.9% earn below ₦50,000 monthly, and aligns with barriers identified by Adesina et al. (2021) among urban poor populations. Such beliefs may create psychological barriers to accessing preventive services even when available, contributing to the low adoption rates despite positive health awareness. Encouragingly, most respondents reject the notion that checkups are only necessary when sick, with 68.6% disagreeing with this statement (mean = 2.8). This positive belief about preventive care contradicts the symptom-driven healthcare seeking patterns identified by Gbadebo et al. (2025) in oral health behavior and suggests that beliefs may be more progressive than actual practices. The disconnect between believing in preventive care importance and actual utilization patterns highlights the complexity of behavior change beyond belief modification. The strong rejection of beliefs that insecticide-treated nets are wasteful (mean = 2.0) demonstrates positive attitudes toward specific preventive interventions relevant to the Nigerian context. This finding contrasts with traditional medicine preferences, suggesting that beliefs about specific interventions may be more malleable than broader healthcare system preferences. The health belief patterns in Egor Local Government Area differ from some international contexts but show similarities to other Nigerian studies. Unlike Bechard et al.'s (2021) Canadian study, where perceived benefits were the strongest predictors of behavior across age groups with less traditional belief interference, the Egor population navigates competing belief systems that may create internal conflicts about health decision-making. The predominance of positive beliefs despite

low adoption rates suggests that the Health Belief Model constructs of perceived susceptibility, severity, and benefits may be present but are mediated by barriers that extend beyond individual beliefs. This pattern aligns with Kim et al.'s (2022) findings in South Korea, where health beliefs positively influenced COVID-19 preventive behaviors, but the effect was moderated by other factors including education and lifestyle changes. The coexistence of positive scientific health beliefs with traditional spiritual beliefs reflects the cultural complexity identified in multiple Nigerian studies. Like participants in Abraham et al.'s (2023) Ghana study, Egor residents appear to maintain dual belief systems that can both support and undermine evidence-based health practices. This suggests that effective health promotion interventions must acknowledge and work within existing belief frameworks rather than attempting to replace traditional beliefs entirely. The health beliefs profile in Egor Local Government Area reveals a population with strong foundational understanding of health causation and prevention benefits, but whose beliefs are embedded within broader cultural and spiritual frameworks that may influence the translation of positive beliefs into consistent health behaviors. This complex belief landscape provides both opportunities and challenges for preventive health promotion initiatives.

The perceived influence of health beliefs on the adoption of preventive health practices among adults in Egor local government area, Edo state.

The findings reveal a strong perceived influence of health beliefs on preventive health practice adoption among adults in Egor Local Government Area, with 70% of respondents acknowledging this influence and a grand mean of 2.9. This high level of perceived influence provides crucial insight into the mechanisms underlying the knowledge-practice gap observed in earlier findings and aligns with theoretical frameworks employed in previous health behavior research. The strong acknowledgment that personal health beliefs influence

preventive practice engagement (mean = 3.0) supports the relevance of the Health Belief Model in understanding health behaviors within this population. This finding aligns closely with Ghorbani-Dehbalaei et al.'s (2021) study among Iranian students, where Health Belief Model constructs accounted for 52.1% of variance in health-promoting behaviors, with self-efficacy and cues to action being strongest predictors. The recognition of belief influence in Egor suggests that interventions targeting belief modification may be particularly effective in this context. Risk perception emerges as a powerful motivator, with 80.4% agreeing that they are more likely to adopt preventive practices when believing themselves at risk of illness (mean = 3.1). This finding resonates strongly with Baek, Kim, and Choi's (2022) South Korean study, where perceived susceptibility was a strong predictor of adherence to COVID-19 preventive behaviors ($\beta = .197$, $p < .001$). The high acknowledgment of risk-based motivation in Egor suggests that effective health promotion should emphasize personal vulnerability to encourage behavior change. Long-term benefit perception shows equally strong influence, with 79.1% acknowledging greater likelihood of preventive action when believing in long-term benefits (mean = 3.1). This mirrors findings from Bechard et al.'s (2021) Canadian study, where perceived benefits were the strongest predictor of behavior uptake across all age groups. The recognition of benefit-driven decision-making in Egor indicates that health education emphasizing tangible, long-term advantages of preventive practices may be particularly effective. The positive influence of hygiene beliefs on practice (mean = 3.1) demonstrates direct translation of scientific health beliefs into behavioral intention. With 80.4% acknowledging that they practice good hygiene because they believe it prevents illness, this finding explains the relatively better performance in basic hygiene awareness observed earlier and aligns with the high hygiene-related awareness levels documented in objective one. However, the data also reveals concerning influences of traditional and spiritual beliefs on health behavior. The acknowledgment that traditional

medicine beliefs affect vaccination willingness (mean = 2.9) among 71% of respondents helps explain the low immunization adoption rates despite high awareness of vaccine benefits. This pattern echoes challenges identified by Erubami et al. (2022), where social media exposure to vaccine-critical information significantly predicted vaccine hesitancy, though in Egor the influence appears to stem from traditional rather than digital sources. Religious influence on medical check-up decisions shows substantial impact, with 75.1% acknowledging this influence (mean = 3.0). This finding aligns with patterns observed in Abraham et al.'s (2023) Ghanaian study, where participants' health-seeking behaviors during COVID-19 were significantly shaped by spiritual beliefs and perceived susceptibility within their cultural framework. The strong religious influence in Egor may partially explain the low rates of regular medical check-ups despite positive beliefs about preventive care importance. Cultural belief barriers show significant influence, with 67.3% acknowledging that cultural beliefs cause them to avoid certain preventive practices (mean = 2.8). This finding resonates with Badru and Adekola's (2023) research in Lagos State, where traditional beliefs, cultural identity, and generational dynamics significantly shaped health behaviors among older adults. The acknowledged cultural barriers in Egor suggest that health promotion interventions must be culturally sensitive and work within existing belief systems rather than challenging them directly. The influence of spiritual attribution of illness shows mixed patterns, with 35.1% agreeing that they avoid preventive practices because they view illness as spiritual, while 64.9% disagree (mean = 2.7). This division suggests heterogeneity in spiritual health beliefs within the population, which may create opportunities for targeted interventions among those with more biomedical orientations while requiring different approaches for those with stronger spiritual attributions. Disease severity perception shows substantial influence on preventive behavior, with 61.7% acknowledging they adopt preventive measures only when believing diseases are severe (mean = 2.7). This finding aligns with the Health Belief Model's

perceived severity construct and mirrors patterns in Kim et al.'s (2022) Korean study, where stronger health beliefs about COVID-19 positively influenced preventive behavior. However, this severity-dependent motivation may explain inconsistent engagement in routine preventive practices for conditions perceived as less threatening. The high influence of beliefs on health screening participation, with 73.2% acknowledging they avoid screenings because they believe them unnecessary (mean = 2.9), provides insight into the low medical check-up rates observed earlier. This belief-behavior connection contrasts with findings from Iluno et al.'s (2024) study among University of Ibadan postgraduate students, where despite low cervical cancer screening uptake (4%), 86.3% expressed willingness for future screening, suggesting different belief-behavior relationships across populations. The perceived influence patterns in Egor Local Government Area demonstrate remarkable consistency with Health Belief Model predictions across diverse cultural contexts. Unlike some studies where external factors like access and affordability dominate behavior determination, the Egor population shows strong acknowledgment of belief-mediated decision-making, similar to patterns observed in Akinniyi et al.'s (2025) study among health workers in Ibadan, where health expectations significantly predicted health-seeking behavior. The strong perceived influence of health beliefs (70% acknowledgment) provides both explanation for the knowledge-practice gaps observed earlier and direction for intervention strategies. Unlike populations where structural barriers predominate, the Egor community appears to have belief systems that are amenable to modification through targeted, culturally appropriate interventions that acknowledge traditional beliefs while promoting evidence-based preventive practices. The findings suggest that health beliefs operate as powerful mediating factors between knowledge and practice in Egor Local Government Area, creating opportunities for theory-based interventions that address both scientific understanding and cultural belief systems to improve preventive health practice adoption.

5.2 Implications to Nursing Practice

The findings of this study have significant implications for nursing practice, particularly in the areas of preventive health and community engagement. Despite the high level of awareness of preventive health practices among adults in Egor Local Government Area, the adoption of these practices remains low. This highlights a critical knowledge-practice gap that nurses must address through interventions that go beyond education. Nursing strategies should focus on behavioral reinforcement, motivation, and practical guidance to help individuals translate knowledge into consistent health-promoting actions. Regular follow-ups, counseling, and reminders can be integrated into nursing care to encourage adherence to preventive measures such as immunizations, hand hygiene, and routine medical check-ups.

Cultural and spiritual beliefs emerged as significant factors influencing health behaviors, with many residents holding traditional or religious views alongside positive scientific beliefs. This underscores the importance of culturally sensitive nursing interventions. Nurses should deliver health education that respects local beliefs while promoting evidence-based practices, integrating community and religious leaders where appropriate to foster trust and improve engagement. By acknowledging and working within existing belief systems, nurses can enhance the effectiveness of health promotion programs and reduce resistance to preventive interventions.

Socioeconomic factors also play a critical role in the adoption of preventive health practices, as over half of the respondents earn below the national minimum monthly income. Nurses must consider these economic constraints when designing interventions, ensuring that preventive services are accessible and affordable. Community-based initiatives such as free or low-cost screenings, mobile clinics, and subsidized immunizations can help overcome

financial barriers. Additionally, nurses can advocate for policy changes and collaborate with local authorities to improve healthcare access, addressing systemic challenges that impede the consistent practice of preventive health behaviors.

Finally, the study highlights the need for nursing education and practice to integrate behavioral theories and health belief models into preventive care strategies. Recognizing the strong influence of perceived susceptibility, severity, and benefits on health behavior, nurses can tailor interventions to emphasize personal risk and the long-term advantages of preventive actions. By combining health education, culturally sensitive counseling, behavioral interventions, and community engagement, nurses are well-positioned to bridge the gap between awareness and action, ultimately improving preventive health outcomes in communities such as Egor Local Government Area.

5.3 Summary

This study examined the influence of health beliefs on the adoption of preventive health practices among adults in Egor Local Government Area, Edo State. A total of 373 adults participated, representing diverse socio-demographic characteristics in terms of age, gender, marital status, religion, education, occupation, and income. The findings revealed exceptionally high awareness of preventive health practices, with 93% of respondents demonstrating good knowledge across areas such as hygiene, vaccination, malaria prevention, and lifestyle modifications. However, despite this awareness, only 44% of respondents consistently adopted preventive health behaviors, highlighting a significant knowledge-practice gap.

The study also explored the health beliefs of participants, revealing a predominantly positive orientation toward scientific preventive measures. Most respondents recognized the

importance of hygiene, early medical intervention, and immunization. At the same time, traditional and spiritual beliefs were prevalent, with many participants believing in faith, traditional medicine, or spiritual causes of illness. These dual belief systems were found to influence the adoption of preventive practices, contributing to the observed gap between awareness and actual behavior.

Further, the perceived influence of health beliefs on preventive practice adoption was substantial, with 70% of participants acknowledging that their beliefs affected their health decisions. Beliefs about personal risk, disease severity, and long-term benefits positively motivated engagement in preventive practices. Conversely, traditional, spiritual, and cultural beliefs sometimes acted as barriers, particularly in areas such as vaccination, regular medical check-ups, and lifestyle modifications. Socioeconomic constraints, including low income and limited access to health services, were also identified as significant factors limiting adoption.

Overall, the study underscores the complexity of preventive health behavior in Egor LGA, showing that high awareness and positive health beliefs alone are insufficient to ensure practice. The findings highlight the need for culturally sensitive, community-based interventions that address both belief systems and structural barriers. These results provide valuable insights for public health strategies, emphasizing the role of health education, behavior-focused nursing interventions, and policy measures in improving preventive health practice adoption in similar Nigerian communities.

5.4 Conclusion

The study concludes that while adults in Egor Local Government Area exhibit exceptionally high awareness of preventive health practices and generally hold positive health beliefs, the actual adoption of these practices remains low. This disparity highlights a significant knowledge-practice gap, influenced not only by individual awareness and beliefs but also by

traditional, spiritual, cultural, and socioeconomic factors. Health beliefs were found to strongly affect preventive behavior, serving both as motivators and barriers depending on their alignment with scientific understanding. The coexistence of positive scientific beliefs with traditional and spiritual perspectives underscores the complexity of health behavior in the community.

Overall, the findings indicate that awareness alone is insufficient to drive preventive health behavior; effective interventions must address behavioral, cultural, and structural determinants. Culturally sensitive health education, community engagement, and accessible, affordable preventive services are essential to bridge the gap between knowledge and practice. The study emphasizes the critical role of nursing and public health initiatives in designing targeted strategies that consider both scientific and traditional belief systems to enhance the adoption of preventive health practices.

5.5 Limitations of the Study

The study has several limitations that should be considered when interpreting the findings. First, the research was conducted in a single local government area—Egor in Edo State—which may limit the generalizability of the results to other regions with different socio-cultural, economic, or healthcare contexts. Second, data collection relied on self-reported measures of awareness, beliefs, and preventive health practices, which are subject to social desirability and recall biases, potentially overestimating awareness and underestimating or misrepresenting actual behavior.

5.6 Recommendations

1. Health education programs should go beyond raising awareness to include practical demonstrations, behavior reinforcement, and follow-up support. Nurses and public health workers should provide targeted education that emphasizes the importance of routine preventive practices, such as medical check-ups, vaccination, hygiene, and lifestyle modifications, and tailor messages to different age groups and educational levels.

2. Interventions should be culturally sensitive and respectful of local traditions and spiritual beliefs. Collaborating with community and religious leaders can help bridge the gap between traditional beliefs and evidence-based preventive practices. Health promotion strategies should aim to align modern health recommendations with culturally accepted practices to increase acceptance and adherence.

3. Economic constraints were identified as barriers to adoption. Policymakers and healthcare providers should implement strategies such as subsidized preventive services, mobile health clinics, and community vaccination drives to make preventive care more accessible, particularly for low-income populations. Nurses can play a key role in facilitating and promoting these services.

4. Programs should address the gap between awareness and practice through behavior-focused strategies. Techniques such as motivational interviewing, reminder systems, and community support groups can encourage consistent adoption of preventive practices. Emphasizing personal risk, disease severity, and long-term benefits may enhance motivation and action.

5. Nursing curricula and continuing education programs should incorporate behavioral change theories, the Health Belief Model, and cultural competence training. This will equip

nurses with the skills to design and implement effective preventive health interventions that consider both scientific knowledge and local belief systems.

6. Future studies should explore the impact of structural, social, and environmental factors on preventive health practice adoption, possibly using longitudinal or mixed-methods approaches. Qualitative research could provide deeper insights into how traditional, spiritual, and cultural beliefs shape health behaviors, informing more effective intervention design.

5.7 Suggestions for Further Study

Based on the findings and limitations of this study, the following suggestions for further research are proposed:

1. **Longitudinal Studies:** Future research could employ longitudinal designs to track changes in awareness, health beliefs, and preventive practice adoption over time. This would help establish causal relationships and examine how interventions impact behavior sustainably.
2. **Qualitative Exploration of Beliefs:** In-depth qualitative studies, such as interviews or focus group discussions, could provide richer insights into how traditional, spiritual, and cultural beliefs influence preventive health practices. Understanding the nuances of these beliefs could guide culturally sensitive interventions.
3. **Intervention-Based Research:** Experimental studies testing specific behavior-change interventions—such as community-based health education, mobile health services, or culturally tailored counseling—could identify effective strategies for bridging the knowledge-practice gap.
4. **Comparative Studies Across Regions:** Conducting similar research in different Nigerian communities or in rural versus urban settings could reveal regional

variations in health beliefs and preventive practice adoption, enhancing generalizability and informing location-specific interventions.

5. **Impact of Socioeconomic and Structural Factors:** Further studies could investigate how healthcare access, affordability, family support, and social networks influence preventive health behaviors, providing a more comprehensive understanding of barriers beyond individual knowledge and beliefs.
6. **Focus on Specific Preventive Practices:** Future research could examine particular preventive measures, such as vaccination, lifestyle modification, or sexual health practices, to identify targeted strategies for improving adoption rates in specific health domains.

REFERENCE

AbdulRaheem, Y. (2023). Unveiling the significance and challenges of integrating prevention levels in healthcare practice. *Journal of primary care & community health*, *14*, 21501319231186500.

Abraham, S. A., Agyare, D. F., Yeboa, N. K., Owusu-Sarpong, A. A., Banulanzeki, E. S., Doku, D. T., & Obiri-Yeboah, D. (2023). The influence of COVID-19 pandemic on the health seeking behaviors of adults living with chronic conditions: a view through the health belief model. *Journal of Primary Care & Community Health*, *14*, 21501319231159459.

Adesina, E., Oyero, O., Amodu, L., Amoo, E., Oyesomi, K., Adeyeye, B., & Yartey, D. (2021). Health belief model and behavioural practice of urban poor towards COVID-19 in Nigeria. *Heliyon*, *7*(9).

Agunbiade, O. M., & Gilbert, L. (2023). Risky sexual practices and approaches to preventing sexually transmitted infections among urban dwelling older Yoruba men in Southwest Nigeria. *SSM-Qualitative Research in Health*, *3*, 100252.

Ahadzadeh, A. S., Wu, S. L., Ong, F. S., & Deng, R. (2021). The mediating influence of the unified theory of acceptance and use of technology on the relationship between internal health locus of control and mobile health adoption: cross-sectional study. *Journal of medical Internet research*, *23*(12), e28086.

Akinniyi, R. J., Kazeem, K. L., & Ishola, A. A. (2025). From Expectation to Action: The Interplay of Health Expectations, Care Quality, and Socio-demographic Moderators in

Health-Seeking Behaviour of Health workers. *Journal of Management and Social Sciences*, *14*(1).

Akinyemi, P. A., Afolabi, O. T., Adeomi, A. A., & Olugbade, O. T. (2021). Perception and Determinants of Uptake of Preventive Health Services among the Staff of Obafemi Awolowo University, Ile-Ife, Osun State. *Journal of Community Medicine and Primary Health Care*, *33*(2), 68-82.

Akuiyibo, S., Anyanti, J., Amoo, B., Aizobu, D., & Idogho, O. (2022). Effects of behaviour change communication on hypertension and diabetes related knowledge, attitude and practices in Imo and Kaduna States: a quasi-experimental study. *BMC Public Health*, *22*(1), 715.

Alagili, D. E., & Bamashmous, M. (2021). The Health Belief Model as an explanatory framework for COVID-19 prevention practices. *Journal of infection and public health*, *14*(10), 1398-1403.

Alruwaili, M. M., Shaban, M., & Elsayed Ramadan, O. M. (2023). Digital health interventions for promoting healthy aging: a systematic review of adoption patterns, efficacy, and user experience. *Sustainability*, *15*(23), 16503.

Alyafei, A., & Easton-Carr, R. (2024). The health belief model of behavior change. *StatPearls*.

Ayo, P. M. (2025). ADULT LITERACY AND HEALTH-PROMOTING BEHAVIORS IN RURAL COMMUNITIES IN CROSS RIVER STATE, NIGERIA. *International Journal of Functional Research in Arts and Humanities (IJFRAH)*, *4*(2), 95-102.

Badru, F. A., & Adekola, O. T. (2023). Sociocultural Beliefs and Health-Seeking Behavior Among Older Adults in Selected Rural and Urban Areas in Lagos State, Nigeria. *Social Aspects of Aging in Indigenous Communities*, *105*.

Baek, J., Kim, K. H., & Choi, J. W. (2022). Determinants of adherence to personal preventive behaviours based on the health belief model: a cross-sectional study in South Korea during the initial stage of the COVID-19 pandemic. *BMC Public Health*, *22*(1), 944.

Bechard, L. E., Bergelt, M., Neudorf, B., DeSouza, T. C., & Middleton, L. E. (2021). Using the health belief model to understand age differences in perceptions and responses to the COVID-19 pandemic. *Frontiers in psychology*, *12*, 609893.

Erubami, J. A., Okpeki, P. I., Ohaja, E. U., Anorue, U. C., & Ezugwu, M. N. (2022). Beyond health belief: Modeling the predictors of COVID-19 vaccine uptake among social media users in Nigeria. *Studies in Media and Communication*, *10*(2), 39-42.

Eslami, V., Sany, S. B. T., Tehrani, H., Ghavami, V., & Peyman, N. (2023). Examining health literacy and self-efficacy levels and their association with preventive behaviors of urinary tract infection in Iranian pregnant women: across sectional study. *BMC Women's Health*, *23*(1), 258.

Ezugwu, C. M., Okoro, M. N., & Chinweobo-Onuoha-Blessing, B. N. (2025). ATTITUDE, KNOWLEDGE AND PRACTICES TOWARDS MEDIA SENSITIZATION MESSAGES ON HYPERTENSION SCREENING AMONG YOUTHS IN NSUKKA URBAN. *African Journal of Educational Management, Teaching and Entrepreneurship Studies*, *14*(2).

Fallucca, A., Immordino, P., Riggio, L., Casuccio, A., Vitale, F., & Restivo, V. (2022). Acceptability of HPV vaccination in young students by exploring health belief model and health literacy. *Vaccines*, *10*(7), 998.

Feinberg, M., Hotez, E., Roy, K., Ledford, C. J., Lewin, A. B., Perez-Brena, N., ... & Berge, J. M. (2022). Family health development: a theoretical framework. *Pediatrics*, *149*(Supplement 5), e2021053509I.

Gbadebo, S. O., Okereke, P. U., Oke, G. A., & Dosumu, O. O. (2025). “Since I never felt pain, it didn’t occur to me to visit a dental clinic”: a qualitative exploration of social perceptions and influencers of oral care-seeking behaviour among adult Nigerians. *BMC Oral Health*, *25*(1), 1196.

Ghorbani-Dehbalaei, M., Loripoor, M., & Nasirzadeh, M. (2021). The role of health beliefs and health literacy in women's health promoting behaviours based on the health belief model: a descriptive study. *BMC women's health*, *21*(1), 421.

Iluno, A. C., Oshiname, F. O., Adekunle, A. O., & Dansou, J. (2024). Cervical cancer screening adoption behaviours among Nigerian women in academics: using a health belief model. *BMC Women's Health*, *24*(1), 534.

Itasanmi, S. A., Andong, H. A., & Adelore, O. O. (2023). Impact of health literacy on contraceptive knowledge, attitude and use among the Nigerian adult population. *Journal of Health Literacy*, *8*(2), 25-40.

Izah, S. C., Sylva, L., & Hait, M. (2023). Cronbach's alpha: A cornerstone in ensuring reliability and validity in environmental health assessment. *ES Energy & Environment*, *23*, 1057.

Jadil, Y., & Ouzir, M. (2021). Exploring the predictors of health-protective behavior during the COVID-19 pandemic: A multi-country comparison. *Environmental research*, *199*, 111376.

Karimy, M., Bastami, F., Sharifat, R., Heydarabadi, A. B., Hatamzadeh, N., Pakpour, A. H., ... & Araban, M. (2021). Factors related to preventive COVID-19 behaviors using health belief model among general population: a cross-sectional study in Iran. *BMC public health*, *21*(1), 1934.

Karl, J. A., Fischer, R., Druică, E., Musso, F., & Stan, A. (2022). Testing the effectiveness of the health belief model in predicting preventive behavior during the COVID-19 pandemic: The case of Romania and Italy. *Frontiers in psychology*, *12*, 627575.

Keren, F., Siddiquei, A. N., Anwar, M. A., Asmi, F., & Ye, Q. (2021). What explains natives and sojourners preventive health behavior in a pandemic: role of media and scientific self-efficacy. *Frontiers in psychology*, *12*, 664399.

Kim, H. Y., Shin, S. H., & Lee, E. H. (2022). Effects of health belief, knowledge, and attitude toward COVID-19 on prevention behavior in health college students. *International Journal of Environmental Research and Public Health*, *19*(3), 1898.

Lim, W. M. (2024). A typology of validity: content, face, convergent, discriminant, nomological and predictive validity. *Journal of Trade Science*, *12*(3), 155-179.

Liu, J. Y. W., Sorwar, G., Rahman, M. S., & Hoque, M. R. (2023). The role of trust and habit in the adoption of mHealth by older adults in Hong Kong: a healthcare technology service acceptance (HTSA) model. *BMC geriatrics*, *23*(1), 73.

Ndejjo, R., Musinguzi, G., Nuwaha, F., Bastiaens, H., & Wanyenze, R. K. (2022). Understanding factors influencing uptake of healthy lifestyle practices among adults following a community cardiovascular disease prevention programme in Mukono and Buikwe districts in Uganda: A qualitative study. *Plos one*, *17*(2), e0263867.

Ngyozie, C., Eniola, N., & Olumide, D. (2024). Investigating the Impact of Health Awareness on the Effectiveness of Preventive Health Measures. *Journal of Asian-african Focus in Health*, *2*(2), 43-51.

Omotunde, O. I., Oyerinde, O. O. P., Olaoye, T. P., Okesiji, W. K. M., & Nwankwo, N. V. Impact of Health Education on Hypertension Knowledge, Motivation and Preventive Practices towards Hypertension Control among Pre-Hypertensive Traders in Lagos State, Nigeria. *Pharmacology*, *8*(2), 1-12.

Rahman, F. N., Iwuagwu, A. O., Ngwu, C. N., Kalu, M. E., Kasherwa, A., Tasnim, A., ... & Kader, M. (2025). Psychosocial wellbeing and risk perception of older adults during COVID-19 pandemic in Nigeria: perspectives on the role of social workers. *Frontiers in Psychiatry*, *15*, 1505279.

Saah, F. I., Amu, H., Seidu, A. A., & Bain, L. E. (2021). Health knowledge and care seeking behaviour in resource-limited settings amidst the COVID-19 pandemic: A qualitative study in Ghana. *Plos one*, *16*(5), e0250940.

Silva, M. J., & Santos, P. (2021). The impact of health literacy on knowledge and attitudes towards preventive strategies against COVID-19: a cross-sectional study. *International journal of environmental research and public health*, *18*(10), 5421.

Twum, K. K., Ofori, D., Agyapong, G. K. Q., & Yalley, A. A. (2021). Intention to vaccinate against COVID-19: a social marketing perspective using the theory of planned behaviour and health belief model. *Journal of Social Marketing*, *11*(4), 549-574.

Ukpabi, N. (2021). *Relationship among Health Literacy, Superstitious/Cultural Beliefs, and Self-Care Among Diabetic Patients in Warri, Nigeria* (Doctoral dissertation, Walden University).

Vincenzo, J. L., Patton, S. K., Lefler, L. L., McElfish, P. A., Wei, J., & Curran, G. M. (2022). A qualitative study of older adults' facilitators, barriers, and cues to action to engage in falls prevention using health belief model constructs. *Archives of gerontology and geriatrics*, *99*, 104610.

Wang, T., Wang, H., Zeng, Y., Cai, X., & Xie, L. (2022). Health beliefs associated with preventive behaviors against noncommunicable diseases. *Patient education and counseling*, *105*(1), 173-181.

Yap, S. F., Lim, W. M., Gaur, S. S., & Lim, P. Y. (2023). A framework for preventive health marketing. *Journal of Strategic Marketing*, *31*(4), 894-917.

FACULTY OF NURSING SCIENCES

COLLEGE OF MEDICAL SCIENCES

UNIVERSITY OF BENIN, BENIN CITY, EDO STATE

Dear Respondent,

I am a 500 level student of the department of nursing in the above-named institution. I am carrying out a research study on the topic; **"The influence of health beliefs on adoption of preventive health practices among adults in Egor local government area, Edo state".**

Please kindly assist me by indicating your opinion where necessary

Yours faithfully,

Instruction: please do not write your name, provide and tick the appropriate answer.

Section A: Socio-Demographic Information

1. **Age:** ( ) 18–25 ( ) 26–35 ( ) 36–45 ( ) 46–55 ( ) 56 and above
2. **Sex:** ( ) Male ( ) Female
3. **Marital Status:** ( ) Single ( ) Married ( ) Divorced ( ) Widowed ( ) Separated
4. **Religion:** ( ) Christianity ( ) Islam ( ) Traditional ( ) Others (please specify): _____
5. **Educational Level:** ( ) No formal education ( ) Primary education ( ) Secondary education ( ) Tertiary education ( ) Postgraduate
6. **Occupation:** ( ) Unemployed ( ) Self-employed ( ) Civil servant ( ) Artisan ( ) Trader ( ) Other (please specify): _____

7. **Monthly Income (₦):** ( ) Less than ₦20,000 ( ) ₦20,000–₦49,999 ( ) ₦50,000–₦99,999 ( ) ₦100,000–₦199,999 ( ) ₦200,000 and above

Section B: The level of awareness of preventive health practices among adults in Egor local government area, Edo state.

1. **Which of the following is a preventive health practice?** ( ) Regular exercise ( ) Self-medication ( ) Smoking
2. **Which vaccine is commonly given to prevent tuberculosis?** ( ) BCG vaccine ( ) Yellow fever vaccine ( ) Tetanus vaccine
3. **What is the purpose of handwashing with soap and water?** ( ) To prevent the spread of infections ( ) To change body temperature ( ) To clean wounds only
4. **Which of the following can help in early detection of diseases?** ( ) Health screening ( ) Prayer alone ( ) Ignoring symptoms
5. **Which lifestyle choice is a form of primary prevention?** ( ) Eating a balanced diet ( ) Drinking alcohol regularly ( ) Avoiding fruits and vegetables
6. **What is the goal of preventive health practices?** ( ) To avoid illness before it occurs ( ) To delay treatment ( ) To treat advanced diseases only
7. **Which of these is a recognized form of preventive health service?** ( ) Immunization ( ) Spiritual cleansing ( ) Herbal mixtures from unverified sources
8. **Which activity is considered a preventive measure for malaria?** ( ) Sleeping under insecticide-treated nets ( ) Drinking cold water ( ) Eating spicy food
9. **Which of the following helps prevent the spread of sexually transmitted infections (STIs)?** ( ) Condom use ( ) Sharing sharp objects ( ) Ignoring symptoms

10. **Which health practice helps to prevent dental problems?** ( ) Brushing teeth twice daily ( ) Eating only sugary foods ( ) Avoiding dental checkups

Section C: The level adoption of preventive health practices among adults in Egor local government area, Edo state.

S/N	Statement	Always	Sometimes	Rarely	Never
1	I go for regular medical check-ups even when I am not sick.				
2	I ensure I and my family receive recommended immunizations.				
3	I sleep under an insecticide-treated mosquito net.				
4	I brush my teeth at least twice daily to prevent dental diseases.				
5	I eat a balanced diet as part of maintaining my health.				
6	I avoid self-medication and consult health professionals when sick.				
7	I use condoms or other protective methods during sexual intercourse.				
8	I wash my hands with soap and water regularly.				
9	I exercise to stay fit and prevent lifestyle diseases.				
10	I attend health education programs when available in my community.				

Section D: The health beliefs of preventive health practices among adults in Egor local government area, Edo state.

S/N	Statement	Strongly Agree	Agree	Disagree	Strongly Disagree
1	I believe I can prevent many diseases by practicing good hygiene.				
2	I believe that my faith or religious practice alone can protect me from illnesses.				
3	I believe that traditional medicine is more effective than modern preventive health services.				
4	I believe that health problems only occur when one has sinned or offended the gods.				

5	I believe that going for regular checkups is only necessary when one is sick.				
6	I believe that immunizations are important in preventing serious diseases.				
7	I believe that preventive practices are only for the wealthy or educated.				
8	I believe that my lifestyle choices directly affect my health.				
9	I believe that seeking medical help early can prevent complications from diseases.				
10	I believe that using insecticide-treated nets is a waste of time.				

SECTION E: The perceived influence of health beliefs on the adoption of preventive health practices among adults in Egor local government area, Edo state.

S/N	Statement	Strongly Agree	Agree	Disagree	Strongly Disagree
1	My belief in traditional medicine affects my willingness to receive vaccinations.				
2	I am more likely to adopt preventive health practices if I believe I am at risk of illness.				
3	I often avoid preventive health practices because I believe illness is a spiritual issue.				
4	My religious beliefs influence my decision to attend medical check-ups.				
5	I adopt preventive health measures only when I believe the disease is severe.				
6	I avoid certain preventive practices due to cultural beliefs.				
7	I practice good hygiene because I believe it will keep me safe from illness.				
8	I do not participate in health screenings because I believe they are unnecessary.				
9	I am more likely to take preventive action if I believe it will benefit me in the long term.				
10	My health beliefs strongly influence how often I engage in preventive				

	health practices.				

3.8 Reliability of the Instrument

The reliability of an instrument referred to its stability and consistency in delivering uniform outcomes when assessing the same criteria under identical circumstances (Izah et al., 2023). It essentially gauged how consistently the instrument produced similar results across multiple trials. A reliable instrument is one that could produce the same results if the behavior was measured again by the same scale. The reliability of the research instrument was established through a pilot study, in which 40 questionnaires was administered to respondents who are not part of the study but share similar characteristics with the studied population (adults in Ovia North-East Local Government Area). Data on level of awareness of preventive health practices, which is structured using multiple choice questions was analyzed using the Kuder-Richardson-20 (KR-20) reliability statistics. On the other hand, data on level of adoption of preventive health practices, health beliefs on preventive health practices and perceived influence of health beliefs were analyzed using the Cronbach alpha reliability technique. Reliability coefficients of 0.82, 0.77, 0.83 and 0.74 were obtained for awareness, adoption, health beliefs and influence of health beliefs on adoption of adoption of preventive health practices respectively, indicating good internal consistency.

Reliability

Level of Awareness of Preventive Health Practices

Scale: ALL VARIABLES

Case Processing Summary

		N	%
Cases	Valid	40	100.0
	Excluded[a]	0	.0
	Total	40	100.0

a. Listwise deletion based on all variables in the procedure.

Reliability Statistics

Cronbach's Alpha	N of Items
0.822	10

Reliability

Scale: ALL VARIABLES

Level of Adoption of Preventive Health Practices

Case Processing Summary

		N	%
Cases	Valid	40	100.0
	Excluded[a]	0	.0
	Total	40	100.0

a. Listwise deletion based on all variables in the procedure.

Reliability Statistics

Cronbach's Alpha	N of Items
0.772	10

Reliability

Health Beliefs of Preventive Health Practices

Scale: ALL VARIABLES

Case Processing Summary

		N	%
Cases	Valid	40	100.0
	Excluded[a]	0	.0
	Total	40	100.0

a. Listwise deletion based on all variables in the procedure.

Reliability Statistics

Cronbach's Alpha	N of Items
0.832	10

Reliability

Scale: ALL VARIABLES

Case Processing Summary

		N	%
Cases	Valid	40	100.0
	Excluded[a]	0	.0
	Total	40	100.0

a. Listwise deletion based on all variables in the procedure.

Reliability Statistics

Cronbach's Alpha	N of Items
0.742	10

EGOR LOCAL GOVERNMENT

OFFICE:
Egor Local Government Secretariat,
Mela Motel Road, Uselu, Edo State.

P.M.B 001, Ugbowo
E-mail: egorlocalgovernment@gmail.com

12 August,2025

Our Ref: _____ Date: _____

The Head of Department,
Medical Surgical Nursing,
Faculty of Nursing Sciences,
School of Basic Medical Science,
University of Benin, Benin City.

LETTER OF ETHICAL APPROVAL

I am directed to inform you that the management has approved the research project ***"The Influence of Health Beliefs on Adoption of Preventive Health Practices Among Adults in Egor Local Government Area, Edo State"***, for Akhalu Darlington Oboh, a student of your department.

It is the belief of the Local Government that this study can be used to enhance the knowledge and awareness on how health beliefs affect the adoption of preventive health practices among adults in Egor Local Government Area, Benin City, and Nigeria in general.

The Local Government will appreciate if the result of this study is shared amongst the relevant stakeholders at the end of this exercise.

DR. IRAOYAH G.E
Medical Officer of Health,
For: The Chairman,
Egor Local Government.