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Confidence of Application Health Beliefs Models with Addiction

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Abstract:

Background: Confidence refers to one's beliefs of they can to perform something (perceived capacity) and adaptive for lifestyles. The aim of the study to assess of Confidence of Application Health Beliefs Models with Addiction.

Material and Method: The current study intends to ascertain how well a health beliefs model-based intervention can alter the attitudes of university students in Mosul City toward drug abuse between January 15, 2024, and February 28, 2024. It does this by using a randomized controlled trial methodology and a true experimental design.

Results: The study's conclusions show that there were statistically significant variations in students' self-efficacy of health belief models toward addiction..

Conclusions: The findings of this study indicated that students' knowledge and smoking-related behaviors may be influenced by the design of an HBM-based study. Considering the positive correlation between the construct of Confidence in health belief models.

Keywords: Self- efficacy , Health Beliefs Models , addiction , students.

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Introduction

The HBM was developed by Rosenstock in 1966 in the middle of the last century and has become one of the most generally known conceptual models of health behavior change and health enhancement. Becker's research (1974) on health beliefs was published. This paper explained how the health belief model relates specifically to a person's cognitive factors that predispose him to pursue or change a health behavior, along with a belief in his or her self-efficacy to engage in the activity. Who indicated that health habits, including health promotion (e.g. use of contraception, diet, exercise) and disease or risk prevention (e.g. smoking, childhood vaccination) are described as preventive health behaviors; compliance with prescribed medical regimes; and use of clinical and medical services (1). The reason why HBM has made such an important contribution to the health sector is that it has been built to help recognize faulty values and to identify individual barriers to adequate participation in programs to prevent and diagnose diseases. Health educators will be better prepared to develop interventions that resolve mistaken values and maladaptive behaviors by identifying and recognizing these obstacles (2).The HBM claims that he or she must feel personally exposed to the disease for which he or she is expected to take action in order to take a prescribed measure to improve his or her health (3).Self-efficacy refers to the amount of trust a person has in his or her ability to perform a behavior successfully. Most recently, this structure was applied to the platform in mid-1980. Like several behavioral theory, self-efficacy is a phenomenon as it relates directly to how a human performs the desired actions. The idea of self-efficacy is the most important aspect of the Health Belief Model. It is an item not introduced to the platform until 1988. Self-efficacy explores the confidence a person has in his / her ability to make a change related to health. It may seem trivial, but faith in your ability to do something has a huge impact on your ability to actually do it (4). Indeed, in recent years, one of the most significant factors in an individual's ability to change behavior has been self-efficacy. Perceived motives are both assumptions about behavioral outcomes and the acceptance of a particular behavior by significant others will encourage a person to perform certain behaviors (5).Intentions are characterized as the amount of people intending to conduct action in the future, and intentions are considered the most direct and proximate predictor of action participation (6).The rest of this chapter tries to demonstrate evidence about how health belief model constructs applied to substance use disorders, and it involves an overview of substance use (Smoking, Hookah, Alcohol, Drug abuse) as well as the previous studies related to this dissertation problem statement.The HBM has expanded over time reach to six constructs that predict the readiness of an individual to change: "perceived susceptibility, perceived severity, perceived benefits, perceived barriers, indications of action, and self-efficacy". Firstly, a person must assume that the health issue or the associated negative result is at risk (perceived susceptibility). Secondly, the degree of perceived severity must be high for a person to seek care or take the recommended action. Tandem, the levels of susceptibility and severity perceived by the individual are conceived as the perceived overall threat (7). At this point a patient is likely to be provided with various preventive or intervention options or recommendations. To adhere to the recommendations a person must believe it would be advantageous to do so. In a cost-benefit study, he or she always considers potential obstacles, weighing up the pros and cons. Another important element within the HBM is the "readiness to alter" (cues to action) of a person. Despite everything, the patient decides whether to participate in behavior, such as associating with treatment or adhering to it. A person also makes an evaluation of how capable he/she of implementing recommendations despite the obstacles is of "self-efficacy.The aim of the study to assess Confidence of Application Health Beliefs Models with Addiction.

Methods and Materials:

The current study intends to ascertain the efficacy of a health beliefs model-based intervention in altering the attitudes of university students in Mosul City toward substance use between January 15, 2024, and February 28, 2024. It does this by using a true experimental design and a randomized controlled trial methodology. Eighty students who took part in a behavior modification training program made up the study sample. Four colleges at the University of Mosul will be included in the study sample: engineering, science, medicine, and education. Random assignments were made to place participants in either the experimental or control groups for each behavior. As an intervention, a health education lecture regarding substance use was given to the experimental group. Using SPSS, Version 23, I performed chi-square,

t-test, and descriptive and inferential statistics (Means, SD, Number, and Percent) on the data. In addition to a Pearson's correlation coefficient used to ascertain the relationship between Health Belief Model concepts, behavioral motivation, behavioral control, and intentions to changing beliefs related to substance use, a mixed design analysis of variance (ANOVA) is utilized to measure changes among participant beliefs, motivation, control, and intentions over three times (pre-test, post-test1, and post-test2). (8-94).

Results:

Table 1: Repeated Measures ANOVA Tests the health beliefs model in changing the belief related to addiction among university students (Confidence).

Self-efficacy	"Repeated Measures ANOVA Tests"			
	F	P	(η2)	O.P.
Main time effect	17. 404	0.000	0.331	1.000
Between groups effect	7.006	0.010	0.082	0.744
Groups Interaction overtime	9.703	0.000	0.201	0.979

η2: Partial Eta Squared (size effect). O.P. Observed Power.

The findings of Table 1 show that the important interaction indicates that the Health Beliefs Models between the research participants (research and control) shift over time and change in different ways, i.e., the lines of the two groups are not parallel in the figure (6). Thus, the effect size (Table 1) reveals that the time is accountable for about 33% of variance from changed Beliefs (Confidence).

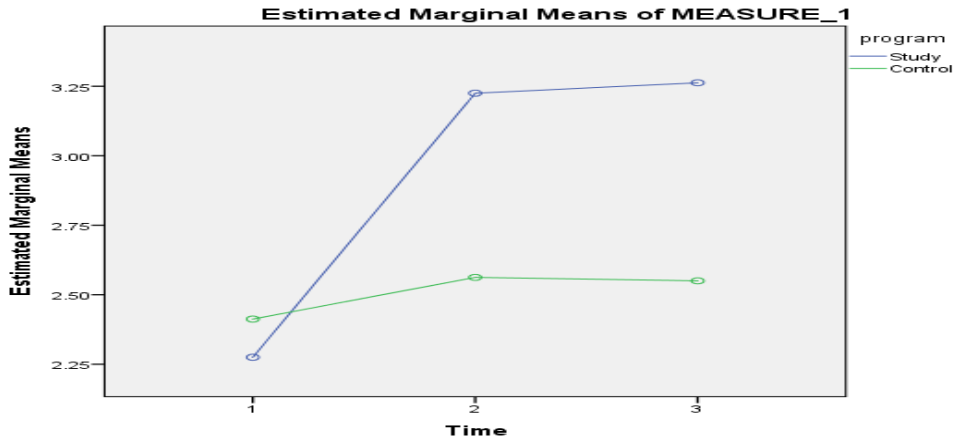

Figure 1: Changing in beliefs related to addiction among university students (Confidence) for the study and control groups throughout the three times.

Table 2: Post-hoc Test Using Bonferroni Corrections Procedure for Changing in the Students' Beliefs about Health beliefs Model (Confidence) among Study and Control Group over Times

HBM	Groups	Post hoc Using Bonferroni		
		(pretest) vs (post 1)	(pretest) vs (post 2)	(Post1) vs (post 2)
Self-Efficacy	Exp	**0.000**	**0.000**	**1.000**
	Con	**0.776**	**0.808**	**1.000**

The table 2 shows that the score of Health Beliefs Model (Self-Efficacy) among study group participants differed significantly from pre-test to posttes-1(sig=0.000) and from pre-test to posttest-2 (sig=0.000). There are no statistically

significant variations in the information score from posttest-1 to post-test-2.Table 2reveals that there is no statistically meaningful change in student views over time when it comes to the control group.

Discussion:

Table (1) demonstrated that the study and control groups were changing over time but in different levels of their Beliefs regarding self-efficacy. There was a dramatic increase in beliefs levels for study group participants at posttest-1 and then the participants showed a slight increase at posttest-2. This was a good indicator that students were acquired an adequate knowledge and retained their information which they learned over the period of the educational program. This result was surely due to that students have benefited from the information that was learned from the program. During the application of Self-efficacy and through the educational program, the effect of the interference became clear on the individual by gaining full confidence and then changing the behavior. This study recorded that after the course, the mean perceived self-efficacy score in changing the belief related to drug use among university students increased significantly in the experimental study group compared with the control group (Table:1).These findings consistent with (95), who found the repeated measures ANOVA is a significant differences in the study group in Health Belief Model constructs and also self-efficacy toward substance abuse ($P < 0.001$). Relative to the control group participants, the results identified that there was a very little increase in Beliefs levels for control group participants at posttest-1 and then a very slight increase at posttest-2. This result was surely because the students of control group had not participated in the educational program (Table 1; Figure 1).These findings consistent with (96-98), which demonstrates the positive effects of educational intervention on student self-efficiency based on the Health Belief Model. Table(2), indicated that the Bonferroni corrections test revealed that the score of the changed Beliefs in especially self-efficacy differed significantly among study group participants over times .Specifically, the transitions from (pre-test) to (post-test 1) and from (pre-test) to (post-test 2) indicated that there was a significant improvement in the study group participants' Beliefs about the concepts of health belief model (Self-efficacy) ($p < 0.000$). The transitions period from (post-test1) to (post-test 2) revealed that there was a continuous stable enhancement upon students' beliefs after three months (Table 2).These findings supported by (90-92)who found were significant inter- and intra-group differences, as well as the group-time interaction in self-efficacy ($P < 0.001$).Concerning the control group, the post-hoc procedures signaled the fluctuation of the knowledge's mean score over times. However, no exact improvement or stable continuous significant changes in the score of beliefs were observed (Table 2).

Conclusion:

The study's findings indicated that students' knowledge and drug-related behaviors may be influenced by the design of an HBM-based study. Considering the positive correlation between the concept of Confidence

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