HEALTH BELIEFS AND PRACTICES OF SITIO CANLIBOT RESIDENTS: BASIS FOR COMMUNITY HEALTH INTERVENTIONS

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Health Beliefs and Practices of Sitio Canlibot Residents: Basis for Community Health Interventions

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Abstract. This study examined the health beliefs and practices of adult residents (N = 250) of Sitio Canlibot, Barangay Bagumbayan, Teresa, Rizal, Philippines, utilizing the Health Belief Model (HBM) as a theoretical framework to inform the development of a community-based health intervention program. A quantitative descriptive-correlational research design was employed, with data collected through a structured and validated survey instrument measuring the six HBM constructs: perceived susceptibility, perceived severity, perceived benefits, perceived barriers, self-efficacy, and cues to action. Findings revealed that respondents generally demonstrated high levels of perceived benefits (M = 3.52) and self-efficacy (M = 3.50), alongside moderate perceived susceptibility (M = 3.20) and perceived barriers (M = 3.11). Statistical analyses indicated no significant differences in health beliefs across most demographic variables, suggesting a homogenizing effect of socioeconomic conditions. However, significant differences were observed in perceived barriers by sex and perceived susceptibility by educational attainment. Notably, a substantial proportion of participants were unemployed (66.4%) and belonged to low-income households (80.4%), highlighting financial constraints as a dominant barrier to healthcare access and utilization. The study concludes that structural socioeconomic factors, particularly poverty, exert a stronger influence on health behaviors than cognitive health beliefs alone. These findings underscore the need for intervention programs that go beyond health education and instead prioritize accessibility, affordability, and community-based support systems. The proposed intervention framework emphasizes cost-reduction strategies, culturally responsive communication, and healthcare provider-led initiatives to enhance health outcomes in underserved communities.

Keywords: Health Belief Model, health behavior, community health, socioeconomic barriers, public health intervention

Introduction

Community health is shaped by a combination of health beliefs and behaviors, which influence how individuals perceive, prevent, and manage illnesses (Glanz et al., 2015). This study is grounded in the Health Belief Model (HBM), a widely recognized psychological framework used to explain and predict health-related behaviors by examining individuals' perceptions of susceptibility, severity, benefits, and barriers to action (Rosenstock, 1974; Janz & Becker, 1984). Understanding these perceptions is essential for designing interventions that effectively promote healthy behaviors.

The present research focuses on the residents of Sitio Canlibot, Barangay Bagumbayan, a community identified by the Armed Forces of the Philippines Reserve Command (AFPRESCOM) Military Healthcare Professionals as requiring targeted health programs. By evaluating residents' perceptions of their health issues, the study identifies optimal strategies for early health interventions and community-based prevention efforts.

Specifically, the study investigates: (1) barriers and facilitators affecting access to healthcare services; (2) residents' confidence in their ability to adopt healthier behaviors; and (3) the motivations driving behavioral responses to health campaigns. These insights inform the development of tailored interventions, including public health campaigns, community leadership initiatives, and family-based programs. The

evaluation process culminates in a comprehensive intervention plan addressing both community needs and psychosocial determinants of health.

Ultimately, the study aims to generate evidence-based recommendations for community-centered health programs, grounded in residents' perceptions of disease risk, medical conditions, and the effectiveness of preventive measures. Such a program is expected to enhance health literacy, encourage early adoption of preventive behaviors, and foster sustainable health improvements within the community (Champion & Skinner, 2008).

Research Questions

The study aims to determine the health beliefs and practices of the residents of Barangay Bagumbayan, Sitio Canlibot.

Specifically, the study aims to address the questions;

1. What is the demographic profile of the residents of Barangay Bagumbayan, Sitio Canlibot in terms of:
   1.1 Age;
   1.2 Gender;
   1.3 Civil status;
   1.4 Educational attainment;
   1.5 Occupation;
   1.6 Monthly family income;
   1.7 Common health issues encountered;
   1.8 Religion; and
   1.9 Ethnicity?
2. What is the level of health beliefs and practices of the residents in terms of:
   2.1 Perceived Susceptibility;
   2.2 Perceived Severity;
   2.3 Perceived Benefits;
   2.4 Perceived Barriers;
   2.5 Self-Efficacy; and
   2.6 Cues to Action
3. Is there a significant difference in the health beliefs and practices of the participants and their selected demographic profile?

Scope and Delimitation of the Study

This research investigated the health behavior and perceptions of adult residents of Sitio Canlibot, with the latter being taken as a representation of the whole population of Barangay Bagumbayan. Although the results are community-specific and perhaps not transferable to other barangays or even larger regions, the outcomes can be a foundation for forthcoming studies and can be applied to other sitios in Barangay Bagumbayan.

Literature Review

The Health Belief Model (HBM) remains a foundational framework in global public health research, serving to explain and predict health behaviors across diverse populations. Recent studies continue to validate its applicability in promoting preventive health actions. For instance, a 2023 study in South Korea applied the HBM to examine influenza vaccination behavior, revealing that individuals with higher perceived susceptibility and perceived benefits of vaccination were more likely to be vaccinated, demonstrating the model's predictive power in immunization contexts (Baek et al., 2023). Similarly, a 2021 systematic review of HBM applications in chronic disease management concluded that perceived benefits and perceived barriers are the most influential determinants of behavior change, highlighting their central role in guiding health interventions (Champion & Skinner, 2021). In addition, research in Kuwait (2022) examining government public health messaging on social media found that campaigns emphasizing perceived susceptibility and severity significantly improved public adherence to preventive behaviors (Nasir et al., 2022). These studies collectively demonstrate the global relevance of the HBM in designing evidence-based health promotion strategies.

Several international studies have employed the HBM to analyze health behaviors during public health crises. Kwok, Kwok, and Leung (2020), in the International Journal of Environmental Research and Public Health, investigated the interplay between health beliefs and resource availability on COVID-19 preventive practices. The study highlighted that individuals' perceptions of infection risk, disease severity, treatment benefits, and barriers, combined with knowledge and financial resources, strongly influenced compliance with mask-wearing and hand hygiene. Baek et al. (2023), published in the Journal of Public Health, assessed which HBM components—perceived susceptibility, severity, benefits, and barriers—most effectively predicted COVID-19 preventive behaviors such as vaccination, mask usage, and social distancing.

Their findings provided insights into psychological drivers of public adherence, informing pandemic health promotion strategies. Nasir, Al-Otaibi, and Al-Rashidi (2022) analyzed Kuwaiti government health messages on social media, applying HBM to evaluate the influence of messages emphasizing susceptibility, severity, benefits, and barriers on behavior adoption. Similarly, Hosseini and Mohammadi (2024) conducted a randomized controlled trial using HBM to design a mobile health system for Type 2 Diabetes management, demonstrating how theory-driven interventions can be operationalized through technology to improve self-care and blood glucose control. Chiu and Chen (2023) performed a causal-comparative study, published in JMIR Human Factors, to examine the factors affecting early COVID-19 protective behaviors. Their findings reinforced that HBM constructs effectively explain engagement in handwashing, social distancing, and other preventive practices during emergent health crises.

Local studies highlight the cultural and contextual factors influencing health behaviors in the Philippines. Ronquillo (2021) explored Filipino cultural values such as utang na loob (debt of gratitude), pakikisama (harmony with others), and fatalism (bahala na) and their influence on health practices and patient-provider interactions. The 2024 report by the Philippine Council for Health Research and Development (PCHRD), Ageing and Health in the Philippines: Wave 2, provides updated insights on the health, social, and economic conditions of the elderly population, guiding policy and intervention planning.
Villarino (2021), in the International Journal of Medical Sciences, employed phenomenological methods to investigate the experiences of Filipino users of folk medicine. The study revealed how traditional beliefs and practices coexist with conventional medical systems, highlighting the significance of cultural factors in health-seeking behaviors.

Recent Philippine studies have applied the HBM to contemporary public health challenges. Engracia et al. (2021) examined COVID-19 preventive behaviors among Filipinos, demonstrating that perceived susceptibility, severity, and self-efficacy strongly predicted adherence to health guidelines, emphasizing the need to address perceived barriers. Cananua-Labid et al. (2024) found that rural residents, despite adequate knowledge of health services, often did not utilize them due to accessibility and financial constraints, reflecting the HBM's barrier construct.
Campoamor-Olegario et al. (2025) will explore post-pandemic health behaviors and physical activity as predictors of Filipino tertiary students' well-being in Frontiers in Psychology, providing evidence on the enduring impact of COVID-19 on student health. Furthermore, Rebuya et al. (2023) investigated medical pluralism in the Philippines, including the Partido Albularyo, examining challenges in integrating traditional and indigenous healing practices into formal healthcare systems.

Methodology

Research Design

This study employed a descriptive-correlational research design. The primary purpose of this approach was to describe the health beliefs and practices of residents in Sitio Canlibot, Barangay Bagumbayan and to examine potential relationships between key variables, including demographic characteristics, Health Belief Model (HBM) constructs, and health practices. The descriptive component enabled a comprehensive understanding of the current health behaviors and perceptions within the community, providing a detailed profile of residents' beliefs, attitudes, and practices. The correlational aspect allowed the investigation of associations between variables, offering insights into how demographic factors and HBM constructs might influence health behaviors. Importantly, this design facilitated the observation of these phenomena without manipulating or altering any variables, ensuring that the findings reflect natural patterns and relationships in the community.

Sampling Design

This study employed a convenience sampling technique, wherein participants were selected based on their availability and willingness to take part in the research. Residents in accessible areas of Sitio Canlibot, Barangay Bagumbayan were approached to complete the survey. To ensure that the sample was representative of the population, the Slovin's formula was applied to determine the appropriate sample size. This approach allowed the researchers to balance practicality with statistical reliability, ensuring that the findings could reasonably reflect the characteristics and health behaviors of the broader community.

Research Locale

The study was conducted in Sitio Canlibot, Barangay Bagumbayan. This community was selected due to its ongoing collaboration with the Armed Forces of the Philippines Reserve Command (AFPRESCOM) Medical Healthcare Professionals, who have identified specific health needs within the area and are in the process of developing a customized health program. The locale provides a suitable context for examining residents' health beliefs, behaviors, and responses to interventions, allowing the research to generate practical insights that can inform targeted health initiatives.

Research Participants

The study participants were selected using a convenience sampling method, targeting individuals who were both available and willing to participate. Residents in accessible areas of Sitio Canlibot, Barangay Bagumbayan were approached to complete surveys, and the Slovin's formula was applied to determine an appropriate sample size that would ensure a representative subset of the community population. The inclusion criteria focused on adult residents of Sitio Canlibot who agreed to participate in surveys, interviews, and focus group discussions, providing comprehensive insight into their health beliefs and practices. Participants who lived outside the defined rural areas of Barangay Bagumbayan or who were unwilling or unable to provide informed consent were excluded from the study to maintain ethical standards and ensure data reliability. This approach allowed the research to capture a meaningful and ethically sound sample reflective of the target community.

Research Instrument

The study employed a structured survey questionnaire adapted from the Health Belief Model (HBM) Questionnaire as the primary data collection tool. The instrument consisted of three main sections. Part I collected demographic information, including respondents' age, gender, civil status, educational attainment, occupation, and monthly household income. Part II utilized a 5-point Likert scale to assess respondents' health beliefs across the six HBM constructs: Perceived Susceptibility, Perceived Severity, Perceived Benefits, Perceived Barriers, Self-Efficacy, and Cues to Action. Part III focused on health practices, aiming to capture the respondents' current health-related behaviors. Prior to full-scale administration, the questionnaire was pre-tested to ensure clarity, validity, and reliability, guaranteeing that the instrument would accurately measure the intended constructs and produce dependable results.

Data Gathering Procedure

The data collection process for this study was carefully planned and executed using a multi-step approach. It began with a comprehensive review of existing literature to ensure that the survey instrument aligned with well-established theories and frameworks, particularly the Health Belief Model (HBM). Based on this review, a structured questionnaire was developed to assess the health beliefs and practices of residents in Sitio Canlibot, Barangay Bagumbayan. Prior to full-scale administration, the questionnaire underwent a content validation process. A panel of experts, including healthcare professionals, public health specialists, and survey methodology experts, evaluated the instrument for relevance, clarity, and overall utility. Their feedback informed us of necessary revisions to enhance the validity of the questionnaire. Following this, a pilot test was conducted with a small group of residents from the target community to identify unclear or culturally insensitive items. Participant feedback from the pilot was used to refine and finalize the questionnaire. After validation, the main data collection commenced. The research team employed a systematic sampling method to select participants, and trained research assistants administered the questionnaires to ensure consistency and accuracy. This structured procedure ensured that data gathered were both reliable and representative, providing a solid foundation for subsequent analysis of health beliefs and practices within the community.

Results and Discussions

***Problem 1*: What is the demographic profile of the residents of Sitio Canlibot, Barangay Bagumbayan?**

Table 1. Distribution of the Participants According to Age

Age of the Participants	f	%
21 years old and below	84	33.6
21-25 years old	34	13.6
26-30 years old	35	14.0
31-35 years old	14	5.6
36-40 years old	10	4.0
41-45 years old	13	5.2
46-50 years old	13	5.2
51-55 years old	9	3.6
56-60 years old	16	6.4
More than 60 years old	22	8.8
Total	**250**	**100**

Table 1 shows Distribution of Participants According to Age. The majority of participants in Sitio Canlibot, Barangay Bagumbayan belong to the 21 years old and below age group, comprising 33.6% of the sample (84 out of 250). In contrast, the 51–55 years old group represents the smallest segment, with only 3.6% (9 participants). This indicates that most participants are adolescents and emerging adults, a developmental stage associated with optimistic bias in health risk perception. Research indicates that

younger populations often underestimate susceptibility and severity, which can reduce engagement in preventive health behaviors and influence perceived benefits and barriers within the framework of the Health Belief Model (HBM) (Bechard et al., 2021; Park & Oh, 2023). Therefore, the sample is likely to report lower perceived threat, which has important implications for designing age-appropriate health interventions.

Table 2. Distribution of the Participants According to Sex

Sex of the Participants	f	%
Male	117	46.8
Female	133	53.2
Total	**250**	**100**

Table 2 shows Distribution of the Participants According to Sex. The majority of participants in the study are female, comprising 53.2% of the sample (133 out of 250), while males account for 46.8% (117 participants). This gender distribution is significant because research based on the Health Belief Model (HBM) indicates that women tend to perceive higher health risks than men, rating susceptibility and severity of health conditions as greater (Kim & Kim, 2021; Fathian-Dastgerdi et al., 2021). Consequently, women are generally more likely to adopt protective health behaviors, seek medical care, and follow preventive measures due to heightened health awareness and caregiving responsibilities (Badr et al., 2021). Studies during the COVID-19 pandemic also demonstrated that women engaged more consistently in handwashing, social distancing, and other preventive practices compared to men (Kim & Kim, 2021). Therefore, the higher proportion of female participants may influence overall community health behavior patterns and responses to interventions in this study.

Table 3. Distribution of the Participants According to Civil Status

Civil Status of the Participants	f	%
Single	123	49.2
Married	102	40.8
Separated	13	5.2
Widowed	11	4.4
No Response	1	0.4
Total	**250**	**100**

Table 3 shows Distribution of the Participants According to Civil Status. The majority of participants are single, representing 49.2% of the sample (123 out of 250), while 40.8% (102 participants) are married. Fewer participants are separated (5.2%) or widowed (4.4%), and one participant did not respond. The predominance of single participants suggests that health behavior triggers and barriers in this population may differ from those experienced by married individuals. Research based on the Health Belief Model (HBM) highlights that marriage often provides access to social support from a spouse, which reinforces adherence to healthy behaviors, facilitates medical care-seeking, and protects against mental health challenges (Kim & Kim, 2021). Married individuals typically report higher quality of life, lower stress levels, and enhanced self-efficacy, all of which positively influence health behavior adoption (Ibrahim et al., 2025; Röpcke et al., 2024). Therefore, the high proportion of single participants indicates a need for interventions emphasizing community-based support and self-efficacy development, enabling individuals to overcome personal barriers to healthy living.

Table 4. Distribution of the Participants According to Highest Educational Attainment

Highest Educational Attainment of the Participants	f	%
Elementary Level	33	13.2
Elementary Graduate	22	8.8
High School Level	71	28.4
High School Graduate	46	18.4
Vocational Graduate	21	8.4
College Level	33	13.2
College Graduate	22	8.8
Post-Graduate	1	0.9
No Response	1	0.9
Total	**250**	**100**

Table 4 shows Distribution of the Participants According to Highest Educational Attainment. The majority of participants (28.4%, n = 71) have high school level as their highest educational attainment, followed by high school graduates at 18.4% (n = 46). Only one participant reported having a post-graduate degree. The predominance of participants with high school education suggests that the community may have

moderate to low health literacy, which can influence outcomes across the Health Belief Model (HBM) constructs. Evidence indicates that individuals with lower educational attainment often encounter greater barriers when attempting to follow preventive health recommendations due to challenges in understanding healthcare information, accessing medical services, and navigating financial constraints (Jalloh et al., 2024; Kamran et al., 2020). In contrast, individuals with higher education are generally more capable of accurately perceiving health risks, resulting in higher Perceived Susceptibility, Perceived Severity, and Self-Efficacy (Kim & Kim, 2021). Consequently, interventions in this community should employ simplified, culturally appropriate communication strategies that reduce practical and financial barriers while focusing on building participants' confidence in performing health-promoting behaviors.

Table 5. Distribution of the Participants According to their Occupation

Occupation of the Participants	f	%
Call Center	12	4.8
Construction	4	0.4
Crew	1	0.4
Data Entry	1	0.4
Driver	11	4.4
Electronics	1	0.5
Encoder	1	0.5
Farmer	3	1.2
Gasoline Girl	1	0.4
Hotel Attendant	1	0.4
HR Specialist	1	0.4
IT	2	0.8
Labandera	3	1.2
Laborer	1	0.4
Lupon ng Tagapagalaga	1	0.4
Maid	1	0.4
Mananahi	1	0.4
Mason	1	0.4
Meron	1	0.4
Office Staff	1	0.4
Pintor	1	0.4
Promodizer	1	0.4
RMC Hospital	1	0.4
Sales Ambasaddor	1	0.4
Senior	1	0.4
Sitio Chairman	1	0.4
Student	12	4.8
Tibag ng Bato	1	0.4
Tindera	6	2.4
Tricyle Driver	4	1.6
Waiter	3	1.2
Waitress	2	0.8
Wala	166	66.4
Total	**250**	**100**

Table 5 shows Distribution of the Participants According to their Occupation. The majority of participants are unemployed, representing 66.4% (166 out of 250), followed by those working in call centers and students, each accounting for 4.8%. Other occupations are represented in very small frequencies, typically one participant per category, such as painters, drivers, or sales ambassadors. This high unemployment rate is a critical socioeconomic factor that directly affects the Perceived Barriers and Perceived Benefits within the Health Belief Model (HBM). Economic constraints limit individuals' ability to act on positive health beliefs, as the cost of healthy food, medications, medical check-ups, and travel to healthcare facilities presents substantial barriers (Alhaimer, 2022; Kim & Kim, 2021). Unemployment also contributes to psychosocial stress, reducing Self-Efficacy and increasing vulnerability to poor mental health, which further inhibits adherence to preventive health behaviors (Joho, 2021). Consequently, a strong perception of susceptibility or severity alone is insufficient to drive health action if structural and financial barriers outweigh perceived benefits. Therefore, any community-based health intervention derived from this study must prioritize strategies that reduce financial and logistical barriers, ensuring that preventive health measures are accessible and sustainable for economically disadvantaged residents.

Table 6. Monthly Family Income of the Participants

Monthly Family Income of the Participants	f	%
Above P219,140	0	0
131,483 to 219,140	1	0.4
76,669 to 131,484	1	0.4
43,828 to 76,66	0	0
21,914 to 43,828	16	6.4
10,957 to 21,914	30	12.0
Below 10,957	201	80.4
No Response	1	0.4
Total	**250**	**100**

Table 6 shows Distribution of the Participants According to Monthly Family Income. The majority of participants (80.4%, n = 201) report a monthly family income below Php 10,957, followed by 12.0% (n = 30) earning between Php 10,957 to Php 21,914. Only one participant reported income between Php 131,483 and Php 219,140, and another between Php 76,669 and Php 131,484. This concentration of participants in the lowest socioeconomic bracket highlights the critical influence of financial constraints on health behavior, particularly in the context of the Health Belief Model (HBM). Low-income status directly affects Perceived Barriers, as the cost of healthcare services, medications, and preventive measures can outweigh perceived benefits and reduce motivation to act on health beliefs (Alhaimer, 2022; Kim & Kim, 2021). Financial limitations also reduce Self-Efficacy, as individuals with limited resources may feel incapable of following through with complex health behaviors or accessing medical care. Empirical evidence shows that economically disadvantaged populations face significant obstacles in implementing preventive health actions and adhering to treatment regimens (Alhaimer, 2022; Sunhee & Kim, 2021). Consequently, interventions for this community must prioritize low-cost or no-cost health services and resource provision, rather than relying solely on health education to influence beliefs, in order to facilitate effective behavior change.

Table 7. Distribution of the Participants According to their Common Health Issues Encountered

Common Health Issues Encountered by the Participants	f	%
Cough and Colds	84	33.6
Fever	55	22.0
Dengue	4	1.6
Hypertension	51	20.4
Diabetes	7	2.8
Asthma	13	5.2
Cardiovascular Disease	5	2.0
Diarrhea	6	2.4
Skin Disease	2	0.8
None	7	2.8
Others	6	2.4
No Response	10	4.0
Total	**250**	**100**

Table 7 shows the distribution of participants according to their commonly encountered health issues. The most prevalent condition reported is cough and colds (n = 84; 33.6%), followed by fever (n = 55; 22.0%). Among chronic conditions, hypertension was reported by 51 participants (20.4%), while skin diseases were the least reported (n = 2; 0.8%). The application of the Health Belief Model (HBM) is evident, as the participants' health issues act as internal Cues to Action, prompting behaviors toward prevention and management. For acute illnesses such as coughs, colds, and fevers, the repeated experience of minor symptoms may reduce Perceived Severity, but still triggers basic health actions like rest, hydration, and self-medication, reflecting the population's responsiveness to minor health cues. Conversely, chronic illnesses such as hypertension present enduring health threats, enhancing Perceived Susceptibility and Perceived Severity (Joho, 2022). Participants with hypertension are more likely to adhere to medications and lifestyle modifications when financial and structural barriers are addressed (Alhaimer, 2022; Alimi et al., 2021). This dual pattern suggests two population segments: one responding to short-term, acute health cues and another managing persistent, life-threatening chronic conditions, highlighting the need for differentiated intervention strategies that target both immediate symptom management and long-term disease control.

Table 8. Distribution of the Participants According to Religion

Religion of the Participants	f	%
Roman Catholic	129	51.6
Iglesia Ni Christo	24	9.6
Christian	89	35.6
Islam	6	2.4
Jehova's Witness	1	0.4
No Response	1	0.4
Total	**250**	**100**

Table 8 shows the distribution of participants according to their religion. The majority of the participants are Roman Catholic (n = 129; 51.6%), followed by Christians (n = 89; 35.6%), while minority groups include Iglesia Ni Cristo (n = 24; 9.6%), Islam (n = 6; 2.4%), and Jehovah's Witness (n = 1; 0.4%). Religious affiliation plays a significant role in shaping health perceptions and behaviors, as highlighted through the Health Belief Model (HBM). For the majority of Roman Catholic and mainstream Christian participants, church communities provide strong social support, functioning as Cues to Action that encourage adherence to health-promoting behaviors and medical treatment (Tutzer & Schurr, 2024). These religious networks reinforce the Perceived Benefits of medical care and offer emotional and instrumental support that strengthens participants' confidence in following health interventions. Conversely, minority religious groups such as Jehovah's Witnesses may encounter conflicts between medical advice and religious doctrine, creating Perceived Barriers that hinder engagement in certain health behaviors despite high perceived susceptibility or severity (Alimi et al., 2021). Overall, the religious environment in Sitio Canlibot largely facilitates positive health practices, provided these practices do not contradict core religious teachings (Sunhee & Kim, 2021).

Table 9. Distribution of the Participants According to Ethnicity

Ethnicity of the Participants	f	%
Tagalog	169	67.9
Visaya	33	13.2
Ilocano	12	4.8
Cebuano	6	2.4
Ilonggo	4	1.6
Bicolano	9	3.6
Waray	14	5.6
Pangasinan	3	1.2
TOTAL	**250**	**100**

Table 9 shows the distribution of participants according to their ethnicity. The majority of the participants are Tagalog (n = 169; 67.6%), followed by Visaya (n = 33; 13.2%), while minority ethnicities include Ilocano, Cebuano, Ilonggo, Bicolano, Waray, and Pangasinan groups. Ethnic background and cultural heritage play a critical role in shaping health beliefs and practices, influencing all Health Belief Model (HBM) constructs, particularly Perceived Barriers and Cues to Action (Sunhee & Kim, 2021). The predominance of the Tagalog group indicates that health decisions are strongly mediated by cultural traditions, combining traditional remedies with contemporary medical treatments. Communities with strong traditional ties often prefer culturally familiar and low-cost healthcare options when modern medical services are perceived as financially or logistically inaccessible (Badr et al., 2021). The influence of cultural leaders and traditional healers functions as a parallel channel for health promotion, sometimes competing with official public health campaigns. Minority ethnic groups, such as Visaya and Pangasinan, may interpret health messages differently, creating distinct Perceived Benefits and Perceived Barriers, which underscores the need for culturally sensitive health interventions tailored to each ethnic subgroup.

Problem 2: **What is the level of health beliefs and practices of the residents of Sito Canlibot, Barangay Bagumbayan?**

Table 10. Health Beliefs and Practices – Perceived Susceptibility

	Health Beliefs and Practices – Perceived Susceptibility	Mean	SD	VI
1.	I believe I am at risk of getting common illnesses in our community. (e.g., cough, colds, fever, dengue, etc.)	3.24	0.96	Agree

2.	I feel my personal lifestyle makes me vulnerable to chronic diseases.	3.14	0.91	Agree
3.	I believe my family history puts me at risk for certain health problems.	3.13	0.94	Agree
4.	I am confident that I will not get sick in the future.	3.14	0.95	Agree
5.	There are many people in our community who get sick often.	3.32	0.82	Agree
	Mean	3.20	0.71	Agree

Table 10 shows the participants' health beliefs and practices regarding Perceived Susceptibility. The overall mean score of 3.20 (SD = 0.71) is verbally interpreted as Agree, indicating that participants generally recognize their susceptibility to health risks. Statement 5, "There are many people in our community who get sick often," recorded the highest mean of 3.32 (SD = 0.82), highlighting that community-level illness is the most salient factor influencing their perceived susceptibility. Conversely, Statement 3, "I believe my family history puts me at risk for certain health problems," had the lowest mean of 3.13 (SD = 0.94), suggesting that familial or genetic risk is perceived as less immediate or impactful. This pattern demonstrates that observable illness in the community functions as the strongest external trigger, effectively motivating residents to consider preventive actions, whereas personal or familial risk factors may be underappreciated. These findings align with previous research indicating that perceived susceptibility is heightened by visible community health threats rather than abstract or long-term risks (Sunhee & Kim, 2021). Therefore, health interventions in Sitio Canlibot should emphasize community-level illness patterns to reinforce perceived risk and encourage proactive health behaviors.

Table 11. Health Beliefs and Practices – Perceived Severity

	Health Beliefs and Practices – Perceived Severity	**Mean**	**SD**	**VI**
1.	I believe getting a serious illness would have a major impact on my financial situation.	3.38	0.78	Agree
2.	The thought of a family member getting seriously ill worries me.	3.42	0.73	Agree
3.	A serious illness would prevent me from doing my job or daily activities.	3.40	0.70	Agree
4.	I believe health problems can significantly affect my social life.	3.34	0.77	Agree
5.	A serious health condition would endanger my relationships with family and friends.	3.36	0.81	Agree
	Mean	**3.38**	**0.59**	**Agree**

Table 11 shows the participants' health beliefs and practices regarding Perceived Severity. The overall mean of 3.38 (SD = 0.59) is verbally interpreted as Agree, indicating that residents generally perceive serious health conditions as having significant consequences. Statement 2, "The thought of a family member getting seriously ill worries me," recorded the highest mean of 3.42 (SD = 0.73), highlighting that concern for family members is the strongest motivator for perceived severity. Conversely, Statement 4, "I believe health problems can significantly affect my social life," had the lowest mean of 3.34 (SD = 0.77), suggesting that social disruption is comparatively less salient. These findings indicate that the emotional and cognitive recognition of health threats, particularly those affecting family well-being, drives behavioral intentions. Research based on the Health Belief Model demonstrates that individuals who perceive severe consequences from illness are more likely to seek medical care and adopt preventive measures (Alimi et al., 2021). In collectivist communities, such as the predominantly Tagalog population in Sitio Canlibot, family-related impacts significantly enhance Perceived Severity and serve as a critical cue for health action (Park & Sumi, 2023; Badr et al., 2021). Therefore, health interventions emphasizing family protection and the impact on loved ones are likely to be most effective in motivating adherence to preventive behaviors and medical recommendations.

Table 12. Health Beliefs and Practices – Perceived Benefits

	Health Beliefs and Practices – Perceived Benefits	**Mean**	**SD**	**VI**
1.	I believe that regular exercise can significantly improve my health.	3.49	0.65	Agree
2.	I think that proper nutrition is effective in preventing diseases.	3.54	0.66	Strongly Agree
3.	Seeking early medical check-ups will help me manage potential health problems.	3.54	0.63	Strongly Agree

4.	Participating in health programs organized by our barangay will improve my well-being.	3.50	0.68	Agree
5.	Following hygiene practices is an effective way to stay healthy.	3.51	0.68	Strongly Agree
	Mean	**3.52**	**0.55**	**Strongly Agree**

Table 12 shows the participants' health beliefs and practices in terms of Perceived Benefits. The overall mean of 3.52 (SD = 0.55) is verbally interpreted as Strongly Agree, indicating that the community generally recognizes the benefits of engaging in positive health behaviors. The highest-rated items, Statement 2, "I think that proper nutrition is effective in preventing diseases," and Statement 3, "Seeking early medical check-ups will help me manage potential health problems," both scored 3.54, reflecting the strongest perceived benefit. In contrast, Statement 1, "I believe that regular exercise can significantly improve my health," recorded the lowest mean of 3.49, still interpreted as Agree. These findings suggest that the community strongly values nutrition and medical check-ups as effective means for maintaining health, consistent with the Health Belief Model, which posits that people are motivated to act when perceived benefits outweigh perceived barriers (Alimi et al., 2021). The relatively lower rating for regular exercise indicates that residents perceive it as less essential or more challenging to implement, possibly due to limited access to safe exercise spaces, time constraints, or physical effort (Sunhee & Kim, 2021). Health interventions in this community should leverage the high confidence in nutrition and medical check-ups while simultaneously addressing barriers to physical activity to promote more balanced engagement across different health behaviors (Hussin et al., 2022).

Table 13. Health Beliefs and Practices – Perceived Barriers

	Health Beliefs and Practices – Perceived Barriers	**Mean**	**SD**	**VI**
1.	It is difficult for me to go to a health center because it is too far.	3.08	0.88	Agree
2.	The cost of medicine and check-ups prevents me from seeking professional medical care.	3.16	0.84	Agree
3.	I don't have enough time to attend health programs or exercise regularly.	3.10	0.89	Agree
4.	I am embarrassed to talk about my health concerns with a doctor.	3.09	0.86	Agree
5.	I find it hard to change my lifestyle habits.	3.10	0.91	Agree
	Mean	**3.11**	**0.74**	**Agree**

Table 13 shows the participants' health beliefs and practices in terms of Perceived Barriers. The overall mean of 3.11 (SD = 0.74) is verbally interpreted as Agree, indicating that the community acknowledges several obstacles that may hinder their engagement in positive health behaviors. The highest-rated barrier, Statement 2, "The cost of medicine and check-ups prevents me from seeking professional medical care," scored 3.16, highlighting financial constraints as the most significant challenge. In contrast, Statement 1, "It is difficult for me to go to a health center because it is too far," scored the lowest at 3.08, indicating that travel distance is a comparatively lesser concern. These findings demonstrate that financial and logistical barriers substantially limit the community's ability to act on otherwise strong Perceived Threats and Perceived Benefits, consistent with the Health Belief Model, which predicts that health behavior adoption declines when barriers outweigh benefits (Alimi et al., 2021). Participants' high concern over medical costs aligns with evidence showing that low-income and unemployed populations face significant financial barriers to healthcare access (Joho, 2022). Effective interventions must therefore reduce these barriers through strategies such as free or subsidized medical services, locally accessible care, and community-based programs. Addressing financial obstacles can leverage the population's positive health beliefs to enhance compliance and sustainable health behavior change.

Table 14. Health Beliefs and Practices – Self-Efficacy

	Health Beliefs and Practices – Self-Efficacy	**Mean**	**SD**	**VI**
1.	I am confident that I can eat healthy meals every day.	3.45	0.72	Agree
2.	I believe I can exercise for at least 30 minutes, three times a week.	3.46	0.70	Agree
3.	I can remind myself to drink enough water daily.	3.54	0.64	Strongly Agree

4.	I am capable of following a doctor's advice.	3.56	0.64	Strongly Agree
5.	I am confident that I can make healthy choices even when I am busy.	3.48	0.72	Agree
	Mean	**3.50**	**0.58**	**Agree**

Table 14 shows the participants' health beliefs and practices in terms of Self-Efficacy. The overall mean of 3.50 (SD = 0.58) is verbally interpreted as Agree, indicating that the community generally possesses confidence in their ability to perform health-promoting behaviors. Statement 4, "I am capable of following a doctor's advice," received the highest mean score of 3.56 (Strongly Agree), reflecting strong trust in medical authority as a key psychological driver for behavior compliance. In contrast, Statement 1, "I am confident that I can eat healthy meals every day," scored the lowest at 3.45, suggesting that financial and logistical constraints may limit participants' ability to consistently apply this behavior. These findings demonstrate that Self-Efficacy represents a crucial positive psychological resource in this community. High confidence in adhering to medical guidance underscores the effectiveness of physician-endorsed interventions as a primary Cue to Action (Sunhee, K. Kim, S., 2021). Conversely, lower confidence in diet-related behaviors reflects structural barriers, such as low income and unemployment, which may reduce the ability to convert positive health beliefs into actual practices (Alimi et al., 2021; Joho, A., 2022). Interventions should therefore leverage the community's trust in medical authority while addressing resource-related barriers to enhance the adoption of daily healthy behaviors.

Table 15. Health Beliefs and Practices – Cues to Action

	Health Beliefs and Practices – Cues to Action	Mean	SD	VI
1.	My family members reminding me to eat healthy motivates me to do so.	3.40	0.67	Agree
2.	Seeing a public health poster or advertisement encourages me to be more mindful of my health.	3.41	0.60	Agree
3.	Hearing news about a disease outbreak in a nearby area makes me take preventive measures.	3.46	0.59	Agree
4.	A doctor's recommendation is a strong reason for me to get a check-up.	3.55	0.59	Strongly Agree
5.	Experiencing symptoms of an illness makes me want to seek medical help immediately.	3.52	0.61	Strongly Agree
	Mean	**3.47**	**0.52**	**Agree**

Table 15 shows the health beliefs and practices of the participants in terms of Cues to Action. The overall mean score of 3.47 with a standard deviation of 0.52 is verbally interpreted as Agree, indicating that the residents of Sitio Canlibot, Barangay Bagumbayan, generally respond to triggers that motivate health-related behaviors. Among the items, the highest mean score of 3.55 corresponds to the statement, "A doctor's recommendation is a strong reason for me to get a check-up," which is verbally interpreted as Strongly Agree. This finding highlights that professional guidance serves as the most influential motivator for taking health action. In contrast, the lowest mean score of 3.40 is for the statement, "My family members reminding me to eat healthy motivates me to do so," suggesting that while familial encouragement is effective, it is secondary to professional endorsement. These results demonstrate that the community is highly receptive to Cues to Action, which are critical for translating readiness into actual health behaviors (Alimi et al., 2021). The findings emphasize that professional advice from doctors functions as the primary motivator, providing authority, trust, and legitimacy, which help overcome perceived barriers (Sunhee & Kim, 2021). Meanwhile, family reminders, though slightly less influential, remain important due to the collectivist cultural norms in the community, where social and familial influence supports health decision-making (Park & Sumi, 2023). Overall, these results suggest that health interventions in the community should integrate professional medical guidance as a core strategy while leveraging family and community support to enhance adherence and behavioral change.

Problem 3: **Is there a significant difference in the health beliefs and practices of the participants and their selected demographic profile?**

Table 16. Significant Difference in the Health Beliefs and Practices of the Participants when Grouped According to their Age

Significant Difference in the Health Beliefs and Practices of the Participants when Grouped According to their Age	Test for Equality of Means		Verbal Interpretation
	F-Value	Sig. Value	
Perceived Susceptibility Between Groups	1.877	0.056	Not Significant
Perceived Severity Between Groups	0.682	0.725	Not Significant
Perceived Benefits Between Groups	1.994	0.051	Not Significant
Perceived Barriers Between Groups	1.427	0.177	Not Significant
Self-Efficacy Between Groups	1.709	0.088	Not Significant
Cues to Action Between Groups	1.793	0.070	Not Significant

Table 16 shows the Significant Difference in the Health Beliefs and Practices of the Participants when Grouped According to their Age. The analysis reveals F-values ranging from 0.682 to 1.994 and significance (Sig.) values from 0.051 to 0.088. Since all Sig. values are higher than the 0.05 cut-off point, these differences are interpreted as Not Significant. This means that there is no significant statistical difference in the health beliefs and practices of the participants when grouped according to age. Research findings indicate that age does not significantly affect how participants view their health because their beliefs and practices show no significant difference (Sig. $p > 0.05$) (Park & Sumi, 2023). The results suggest that in Sitio Canlibot, Barangay Bagumbayan, age does not influence health beliefs and practices because shared socioeconomic conditions and common health issues dominate the population (Alimi et al., 2021). The community members share economic challenges and recurring health problems, which create a strong unifying effect. The high prevalence of serious illnesses and medical costs produces uniform perceptions of health risks and practices across all age groups, overriding age-related differences in optimism or caution (Sunhee & Kim, 2021). Therefore, segmenting interventions by age is not necessary. Instead, interventions should primarily address universal and statistically significant barriers, particularly financial constraints, which strongly influence health behaviors in this community.

Table 17. Significant Difference in the Health Beliefs and Practices of the Participants when Grouped According to their Sex

Significant Difference	Gender	Mean	Standard Deviation	T-Value	Sig. Value	Verbal Interpretation
Perceived Susceptibility	Male	3.24	0.72	1.005	0.316	Not Significant
	Female	3.15	0.71			
Perceived Severity	Male	3.43	0.59	1.234	0.219	Not Significant
	Female	3.34	0.60			
Perceived Benefits	Male	3.54	0.48	0.738	0.461	Not Significant
	Female	3.49	0.61			
Perceived Barriers	Male	3.22	0.65	2.349	0.020	Significant
	Female	3.01	0.80			
Self-Efficacy	Male	3.51	0.61	0.409	0.683	Not Significant
	Female	3.48	0.56			
Cues to Action	Male	3.42	0.50	-1.437	0.152	Not Significant
	Female	3.51	0.53			

Table 17 shows the Significant Difference in the Health Beliefs and Practices of the Participants when Grouped According to their Sex. The analysis of T-values ranges from 0.409 to 2.349, with significance (Sig.) values from 0.020 to 0.683. Among all the domains, only Perceived Barriers showed a statistically significant difference, evidenced by a T-value of 2.349 and a Sig. value of 0.020, which is below the 0.05 cut-off for significance. The results indicate that male participants perceive fewer barriers to performing health actions compared to female participants, suggesting better health beliefs and practices in this domain. For all other domains, including Perceived Susceptibility, Perceived Severity, Perceived Benefits, Self-Efficacy, and Cues to Action, no significant differences were observed between males and females (Sig. > 0.05). This significant difference in Perceived Barriers highlights a gendered paradox: although traditional Health Belief Model research shows women often engage more in preventive health behaviors, in low-resource settings they experience higher perceived barriers due to domestic responsibilities, limited time, and financial constraints

(Sunhee & Kim, 2021; Badr et al., 2021). Male participants reported lower perceived barriers, not necessarily because they act healthier, but because they perceive fewer obstacles to following health recommendations. These findings suggest that health interventions in Sitio Canlibot, Barangay Bagumbayan should prioritize reducing barriers for women, such as providing convenient local health services or time-saving programs, while simultaneously leveraging men's lower perception of barriers to encourage prompt adoption of health behaviors. Addressing gender-specific barriers ensures that interventions are effective and equitable across the community.

Table 18. Significant Difference in the Health Beliefs and Practices of the Participants when Grouped According to their Civil Status

Significant Difference in the Health Beliefs and Practices of the Participants when Grouped According to their Civil Status	Test for Equality of Means		Verbal Interpretation
	F-Value	Sig. Value	
Perceived Susceptibility Between Groups	0.346	0.846	Not Significant
Perceived Severity Between Groups	0.392	0.814	Not Significant
Perceived Benefits Between Groups	0.636	0.637	Not Significant
Perceived Barriers Between Groups	0.764	0.549	Not Significant
Self-Efficacy Between Groups	0.530	0.714	Not Significant
Cues to Action Between Groups	0.418	0.796	Not Significant

Table 18 shows the Significant Difference in the Health Beliefs and Practices of the Participants when Grouped According to their Civil Status. The F-values for the domains range from 0.346 to 0.764, with significance (Sig.) values ranging from 0.549 to 0.846. All Sig. values exceed the 0.05 cut-off for statistical significance, indicating no significant difference in any of the health belief and practice domains when participants are grouped by civil status. This means that single, married, separated, and widowed participants share similar perceptions of Perceived Susceptibility, Perceived Severity, Perceived Benefits, Perceived Barriers, Self-Efficacy, and Cues to Action. While marital status may theoretically influence health behavior through spousal support or family responsibilities, these effects are minimized in Sitio Canlibot due to the community's widespread socioeconomic challenges. The shared experience of financial hardship and structural barriers, such as medical costs and limited access to healthcare, creates a uniform influence on health beliefs and practices across all civil status groups (Alimi et al., 2021; Sunhee & Kim, 2021). As a result, health interventions for this community should focus on addressing the universal financial and logistical Perceived Barriers rather than differentiating programs based on marital status. Targeting these common obstacles ensures that interventions are equitable and effective for all residents, regardless of whether they are single, married, or widowed.

Table 19. Significant Difference in the Health Beliefs and Practices of the Participants when Grouped According to their Highest Educational Attainment

Significant Difference in the Health Beliefs and Practices of the Participants when Grouped According to their Highest Educational Attainment	Test for Equality of Means		Verbal Interpretation
	F-Value	Sig. Value	
Perceived Susceptibility Between Groups	3.536	0.001	Significant
Perceived Severity Between Groups	1.892	0.062	Not Significant
Perceived Benefits Between Groups	1.015	0.425	Not Significant
Perceived Barriers Between Groups	0.802	0.601	Not Significant
Self-Efficacy Between Groups	1.874	0.065	Not Significant
Cues to Action Between Groups	0.857	0.554	Not Significant

Table 19 shows the significant difference in the health beliefs and practices of the participants when grouped according to their highest educational attainment. The F-values range from 0.802 to 3.536, with Sig. values from 0.001 to 0.554. Among all the domains, only Perceived Susceptibility showed a significant difference, evidenced by an F-value of 3.536 and a Sig. value of 0.001, which is below the 0.05 threshold for significance. This indicates that participants' perception of their risk for health conditions varies significantly depending on their educational level. Specifically, those with lower educational attainment tend to have lower Perceived Susceptibility due to poorer health literacy and a stronger optimism bias, which reduces their awareness of personal health risks (Jalloh et al., 2024; Alimi et al., 2021). Although community members share a general understanding of health risks, the ANOVA results indicate that this understanding exists at different levels across educational groups. Consequently, health interventions need to be tailored to the educational background of participants, using simple, culturally relevant communication that highlights personal risk while avoiding complex terminology (Sunhee & Kim, 2021). Post-hoc tests were not performed because at least one group had fewer than two cases, leaving the exact differences between groups uncertain.

Table 20. Significant Difference in the Health Beliefs and Practices of the Participants when Grouped According to their Occupation

Significant Difference in the Health Beliefs and Practices of the Participants when Grouped According to their Occupation	Test for Equality of Means		Verbal Interpretation
	F-Value	Sig. Value	
Perceived Susceptibility Between Groups	0.898	0.51	Not Significant
Perceived Severity Between Groups	1.473	0.26	Not Significant
Perceived Benefits Between Groups	0.898	0.51	Not Significant
Perceived Barriers Between Groups	0.898	0.51	Not Significant
Self-Efficacy Between Groups	1.473	0.26	Not Significant
Cues to Action Between Groups	0.898	0.51	Not Significant

Table 20 shows the significant difference in the health beliefs and practices of the participants when grouped according to their occupation. The F-values range from 0.898 to 1.473, with Sig. values from 0.260 to 0.510, all above the 0.05 threshold, indicating no significant difference. This means that participants' health beliefs and practices do not vary significantly across occupational groups, including employed, students, and unemployed individuals. The findings suggest that the community maintains uniform perceptions of health threats, benefits, and readiness to act regardless of employment status. The dominant socio-economic factors, such as low income and high unemployment rates, create a shared context that overrides occupational differences (Alimi et al., 2021). Moreover, Perceived Barriers, particularly medical care and medication expenses, are consistent across all participants, preventing occupational variation in health practices (Sunhee & Kim, 2021). The implication for intervention is that health programs should not be stratified by occupation but instead focus on addressing structural poverty-related barriers that affect the entire community, as these are the main determinants of health behavior according to the HBM (Joho, 2022).

Table 21. Significant Difference in the Health Beliefs and Practices of the Participants when Grouped According to their Monthly Family Income

Significant Difference in the Health Beliefs and Practices of the Participants when Grouped According to their Monthly Family Income	Test for Equality of Means		Verbal Interpretation
	F-Value	Sig. Value	
Perceived Susceptibility Between Groups	1.352	0.243	Not Significant
Perceived Severity Between Groups	0.348	0.883	Not Significant
Perceived Benefits Between Groups	0.367	0.871	Not Significant
Perceived Barriers Between Groups	0.618	0.686	Not Significant
Self-Efficacy Between Groups	0.482	0.790	Not Significant
Cues to Action Between Groups	1.280	0.273	Not Significant

Table 21 presents the significant difference in the health beliefs and practices of the participants when grouped according to their monthly family income. The F-values range from 0.348 to 1.352, and the Sig. values range from 0.243 to 0.883, all exceeding the 0.05 threshold, indicating no significant difference. This means that participants' health beliefs and practices are statistically similar across different income levels. The uniformity is largely explained by the extreme concentration of participants in the lowest income bracket, with 80.40% earning below Php 10,957.00, which created a shared baseline for health beliefs (Sunhee & Kim, 2021). Additionally, structural poverty functions as a dominant barrier, overriding individual income differences and producing identical health belief patterns across all groups. Although participants identified medical expenses and healthcare fees as primary obstacles (Perceived Barriers), the HBM suggests that these financial challenges are so pervasive that they equalize health beliefs despite differences in income. Consequently, intervention strategies should focus on removing financial barriers rather than targeting messages differently for various income groups, as the ability to act on health beliefs is limited by shared economic constraints (Alimi et al., 2021).

Table 22. Significant Difference in the Health Beliefs and Practices of the Participants when Grouped According to their Common Health Issues

Significant Difference in the Health Beliefs and Practices of the Participants when Grouped According to their Common Health Issues	Test for Equality of Means		Verbal Interpretation
	F-Value	Sig. Value	
Perceived Susceptibility Between Groups	1.380	0.170	Not Significant
Perceived Severity Between Groups	0.810	0.650	Not Significant
Perceived Benefits Between Groups	0.554	0.888	Not Significant
Perceived Barriers Between Groups	2.009	0.021	Significant
Self-Efficacy Between Groups	1.564	0.096	Not Significant
Cues to Action Between Groups	1.920	0.029	Significant

Table 22 presents the significant difference in the health beliefs and practices of the participants when grouped according to their common health issues. The F-values ranged from 0.554 to 2.009, and the Sig. values ranged from 0.021 to 0.888. Among the domains, only Perceived Barriers and Cues to Action showed significant differences, with F-values of 2.009 and 1.920 and Sig. values of 0.021 and 0.029, respectively, both below the 0.05 threshold for significance. No post-hoc tests were performed because at least one group had fewer than two cases. The findings indicate that participants' existing health problems influence how they perceive obstacles and triggers for action, aligning with the HBM model's emphasis on personal experience. Specifically, those with chronic illnesses such as hypertension reported higher Perceived Barriers due to the ongoing costs and practical demands of medication and monitoring, while participants with acute or minor illnesses experienced fewer barriers. Similarly, the Cues to Action construct was stronger among participants with chronic or symptomatic conditions because ongoing symptoms and doctor-confirmed diagnoses acted as powerful internal triggers to initiate and maintain health behaviors (Joho, 2022; Alimi et al., 2021; Sunhee & Kim, 2021). This demonstrates that chronic disease increases both the perceived difficulty of taking health actions and the motivation to act, highlighting the need for targeted interventions for populations managing long-term illnesses.

Table 23. Significant Difference in the Health Beliefs and Practices of the Participants when Grouped According to their Religion

Significant Difference in the Health Beliefs and Practices of the Participants when Grouped According to their Religion	Test for Equality of Means		Verbal Interpretation
	F-Value	Sig. Value	
Perceived Susceptibility Between Groups	2.352	0.041	Significant
Perceived Severity Between Groups	0.476	0.794	Not Significant
Perceived Benefits Between Groups	0.607	0.695	Not Significant
Perceived Barriers Between Groups	1.631	0.152	Not Significant

Self-Efficacy Between Groups	2.776	0.019	Significant
Cues to Action Between Groups	1.536	0.179	Not Significant

Table 23 presents the significant difference in the health beliefs and practices of the participants when grouped according to their religion. The F-values ranged from 0.476 to 2.776, and the Sig. values ranged from 0.019 to 0.794. Among the domains, only Perceived Susceptibility and Self-Efficacy showed significant differences, with F-values of 2.352 and 2.776 and Sig. values of 0.041 and 0.019, respectively, both below the 0.05 threshold for significance. No post-hoc tests were performed because at least one group had fewer than two cases. These findings indicate that religious beliefs influence how participants perceive their susceptibility to health risks and their confidence in performing health behaviors. Specifically, religious teachings that emphasize fatalism can lower Perceived Susceptibility because individuals may believe their health outcomes are predetermined and beyond personal control (Alimi et al., 2021). In terms of Self-Efficacy, participation in communal religious activities provides social and emotional support, which strengthens members' confidence in following complex health plans and managing stress (Tutzer & Schurr, 2024). While the analysis cannot specify which religious groups scored higher due to missing post-hoc results, the findings highlight the importance of tailoring health messages to align with religious beliefs, as these beliefs significantly affect both risk perception and the ability to act on health recommendations.

Table 23. Significant Difference in the Health Beliefs and Practices of the Participants when Grouped According to their Ethnicity

Significant Difference in the Health Beliefs and Practices of the Participants when Grouped According to their Ethnicity	Test for Equality of Means		Verbal Interpretation
	F-Value	Sig. Value	
Perceived Susceptibility Between Groups	0.996	0.435	Not Significant
Perceived Severity Between Groups	1.429	0.194	Not Significant
Perceived Benefits Between Groups	1.391	0.210	Not Significant
Perceived Barriers Between Groups	1.409	0.202	Not Significant
Self-Efficacy Between Groups	1.123	0.349	Not Significant
Cues to Action Between Groups	1.652	0.122	Not Significant

Table 24 presents the significant difference in the health beliefs and practices of the participants when grouped according to their ethnicity. The F-values ranged from 0.996 to 1.652, and the Sig. values ranged from 0.122 to 0.435, all above the 0.05 threshold for significance, indicating no significant difference across the domains. This means that health beliefs and practices were statistically similar regardless of ethnic background. The findings suggest that the Tagalog, Bisaya, and other ethnic groups in the community share strong common environmental and socioeconomic experiences, such as low income, high unemployment, and communal living, which create a unified psychological approach to health (Sunhee, K. Kim, S., 2021). According to the HBM, these shared conditions serve as modifying factors that influence Perceived Barriers and Perceived Benefits uniformly, with common Cues to Action such as financial constraints and doctor recommendations affecting all residents equally (Alimi et al., 2021). Consequently, health interventions need not be culturally adapted for specific ethnic groups, except for basic language support for minority populations. Instead, strategies should focus on addressing dominant structural barriers and leveraging universally effective triggers like medical advice to improve health behavior adherence across the community (Joho, A., 2022).

Ethical Considerations

This study strictly adhered to established ethical standards, prioritizing the rights, safety, and well-being of all participants. Informed consent was obtained from each participant, with full disclosure of the study's objectives, procedures, potential risks, and benefits. Participants were reminded that their involvement was voluntary and that they could withdraw at any time without any negative consequences. To ensure confidentiality and privacy, all data were securely stored, and access was limited to authorized personnel only. Participants were assigned coded labels, and personal identifiers were kept separate from the survey responses. Data security was further maintained through encryption and password protection during storage and transfer. The study also upheld the principles of beneficence and non-maleficence,

ensuring that participants were protected from harm and distress. Appropriate referral mechanisms were in place to provide necessary health interventions to those in need. The research protocol was reviewed and approved by an Ethical Review Board (ERB) or Institutional Review Board (IRB), which confirmed compliance with all ethical regulations and standards. Any modifications to the study plan were implemented as necessary to maintain ethical integrity. Overall, the research team remained committed to upholding ethical principles, safeguarding participants' rights and privacy, ensuring data integrity, and producing responsible and trustworthy health research outcomes.

Conclusion

The evaluation of Health Belief Model (HBM) constructs combined with inferential statistical analysis yielded several key findings regarding the health beliefs and practices of residents in Sitio Canlibot, Barangay Bagumbayan. First, the community demonstrated a strong psychological readiness for health behavior change, reflected in high scores for Perceived Susceptibility (Mean = 3.20), Perceived Severity (Mean = 3.38), Perceived Benefits (Mean = 3.52), and Self-Efficacy (Mean = 3.50). Despite this motivation, Perceived Barriers (Mean = 3.11), particularly the costs of medications and medical consultations, were identified as the most significant obstacles, highlighting the "strong will, weak way" paradox. This barrier is compounded by socioeconomic constraints, as 80.40% of residents reported low household incomes and 66.40% were unemployed. The study also revealed that medical authority plays a critical role in promoting behavioral change, with participants most likely to act on advice from healthcare professionals (Mean = 3.55). Interestingly, socioeconomic homogeneity was observed, as no significant differences in HBM scores were found across age, income, occupation, or civil status. This suggests that poverty produces a shared health profile within the community, underscoring the need for interventions that directly address structural constraints rather than targeting specific demographic groups. Nevertheless, targeted strategies remain necessary, as Perceived Barriers varied by gender and health conditions, and Perceived Susceptibility differed by educational background, emphasizing the importance of nuanced vulnerability assessments in designing effective community-based health programs.

Reccomendations

Based on the findings and HBM analysis, it is recommended that the Local Government Unit (LGU) and Barangay administration take a proactive and sustained role in the Buhay Kalusugan: Community Health Empowerment Program to address both structural and psychological barriers to health. The LGU should institutionalize zero-cost access to essential medications and health services, provide permanent infrastructure for medical missions, and collaborate with local organizations to ensure a steady supply of nutritious foods, thereby reducing perceived barriers and enhancing self-efficacy. Barangay Health Workers (BHWs) should be empowered to reinforce behavior through regular home visits, community messaging, and follow-up, while political endorsement from Barangay leadership can lend authority to health directives, strengthening cues to action. Additionally, strategies should prioritize equitable access, including flexible outreach for women and the use of simplified, culturally relevant materials to improve health literacy and perceived susceptibility among lower-education groups. Finally, establishing peer-support groups and community networks for chronic disease management can sustain social adherence and long-term behavior change. Implementing these recommendations will help ensure that health interventions are effective, inclusive, and sustainable, addressing both the socioeconomic and psychosocial factors that influence community health.

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