ORIGINAL ARTICLE

The Influence of Health Literacy, the Health Belief Model, and Preventive Practices against Food Poisoning in the Service Area of Phanat Nikhom Hospital

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ABSTRACT

BACKGROUND: Food is a fundamental factor directly impacting human health. However, when food is contaminated with pathogens, toxins, or foreign substances, it leads to “food poisoning,” a critical public health issue worldwide. In Thailand, food poisoning can occur acutely and significantly affects the economy, healthcare resources, and the quality of life of consumers. According to the World Health Organization, the primary causes are microorganisms, microbial toxins, chemical contaminants, and natural toxins.

OBJECTIVES: The aim of this study was to investigate the demographic characteristics, Health Literacy, Health Belief Model (HBM) factors, and food poisoning Preventive Practices among residents in the service area of Phanat Nikhom Hospital. Furthermore, the influence of these variables was analyzed.

METHODS: This research is a cross-sectional analytical study. The sample consisted of 354 residents selected through convenience sampling. Data were analyzed using descriptive statistics and multiple regression analysis.

RESULTS: The majority of the participants were female, ranging from working age to early elderly, with primary to secondary education, and low income. Most were the primary food preparers in their households. Although Health Literacy was generally high, both the Health Belief Model and Preventive Practices were at a moderate level.

CONCLUSIONS: Health Literacy and Health Belief Model showed a statistically significant positive correlation with Preventive Practices ($p<0.05$). Therefore, health education programs should focus on reducing perceived severity and enhancing communication skills to effectively bridge the gap between knowledge and practice. Specifically, interventions should aim to heighten perceived susceptibility by illustrating how even ‘mild’ cases can lead to long-term health complications or economic loss for the family. By enhancing communication skills, residents can more effectively advocate for food safety standards within their households and local markets. Ultimately, focusing on reducing perceived barriers and enhancing self-efficacy will empower residents to manage household hygiene effectively.

KEYWORDS: health literacy, health belief model, primary prevention, food poisoning

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INTRODUCTION

Food plays a fundamental role in human health; however, when food is contaminated with pathogens, toxins, or foreign substances, it can cause food poisoning, which is a common acute public health problem worldwide, including in Thailand. Food poisoning occurs as a result of consuming contaminated food or beverages and commonly presents with symptoms such as nausea, vomiting, abdominal pain, and diarrhea; in severe cases, it may lead to death.

Food poisoning stemming from pathogenic microorganisms, toxins, or chemical contaminants significantly impacts both economic stability and quality of life. To combat this, the World Health Organization advocates for the "Five Keys to Safer Food," which include cleanliness, separation, thorough cooking, safe temperatures, and pure ingredients, as the primary framework for improving public health outcomes through behavioral change.[1] Therefore, increasing knowledge and promoting hygienic food consumption behaviors are essential strategies for reducing the incidence of food poisoning.

While over 90% of Thai consumers recognize that food safety is a critical issue, specifically citing concerns regarding chemicals and vendor hygiene, there is a stark disconnect between this high level of awareness and the physical reality of food contamination. Research in Bangkok examining these risks reveals that, despite public concern, approximately 80% of meat samples from both fresh markets and supermarkets tested positive for Salmonella spp.[2]

Reflecting on trends occurring since the beginning of 2023, at that time the incidence of food poisoning stood at 9.35 per 100,000 population.[3] However, the situation escalated dramatically by 2025, and data as of March 14 revealed that the morbidity rate surged to 58.28 per 100,000 population, accounting for more than 37,831 cases.[4]

This comparison highlights that the threat of food poisoning is not static but is expanding significantly. The most vulnerable group is school-aged children (5–9 years old).[5] This shift underscores an urgent need to elevate food safety standards in both educational institutions and households, particularly during the transition from winter to the summer period when pathogens proliferate with exceptional ease.

Demographic data indicate that the highest incidence rates occurred among young adults, specifically in the 15–24 and 25–34 age groups. Regarding occupational distribution, the majority of the patients were general employees (40.33%), followed by students (23.07%). These statistics underscore the prevalence of food poisoning in urban and industrial areas within the region, including Chonburi Province and its semi-industrialized agricultural zones. Although Thailand maintains an efficient disease surveillance system, emerging challenges have surfaced within these semi-industrialized agricultural zones, areas that represent a critical juncture of lifestyle transition, where a significant portion of the population faces 'time poverty' driven by industrial shift-work. This constraint has shifted consumption patterns toward a heavy reliance on out-of-home food sources. While previous research has primarily focused on basic knowledge surveys, there remains a critical gap in in-depth analyses of Health Literacy and the Health Belief Model (HBM) as they relate to actual Preventive Practices within this specific context.[6-7] Previous research on food poisoning in Thailand includes studies on patients in Nong Khai Province[8], Rayong Province[9-10], Bangkok[11], Uthai Thani Province[12], and Nakhon Ratchasima Province[13].

This research is a cross-sectional analytical study designed to explore the relationship between Health Literacy and the Health Belief Model in influencing food poisoning Preventive Practices among industrial workers. It specifically addresses the issue of 'time poverty,' which drives high-risk consumption habits despite existing baseline knowledge. The findings suggest a shift in traditional health education toward practical communication strategies and health promotion measures that align with the real-life constraints of the target population.

METHODS

This study is cross-sectional research aimed at investigating Health Literacy and Health Belief Model associated with food poisoning prevention practices within the service area of Phanat Nikhom Hospital. The research was conducted from October 12, 2025 to February 12, 2026 (CBO REC 2568-089).

Population and Sample Size

The population frame for this study consists of 4,648 people within the service area of Phanat Nikhom Hospital.[6] A probability sampling method was used for the sample selection, and the calculated sample size was 354 people, based on Krejcie and Morgan (1970)[14], with the margin of error (e) set at 0.05.

Research Methodology

Quantitative data were collected from October 12, 2025 to February 12, 2026 using a researcher-developed questionnaire by applying the following steps:

1. Consultation and preparation.
2. Preparation and training of the data collection assistant team.
3. Meeting with the target residents living within the service area of Phanat Nikhom Hospital.

Research Instruments and Instrument Quality

The questionnaire consists of the following sections:

Part 1: General Information of the Respondents

This section includes the gender, age, education level, monthly household income, and the person primarily responsible for meal preparation in the household.

Part 2: History and Experience Related to Food Poisoning

Part 3: Assessment of Health Literacy

This section measures levels of Health Literacy in terms of knowledge and understanding, access to health information and services, communication skills, decision-making skills, self-management skills, and media literacy. A five-point Likert scale was used, ranging from "Very High" to "High," "Moderate," "Low," and "Very Low."

Part 4: Assessment of the Health Belief Model

This section evaluates the Health Belief Model in terms of perceived susceptibility, perceived severity, perceived benefits, perceived barriers, cues to action, and self-efficacy. A five-point Likert scale was used, ranging from "Very High," to "High," "Moderate," "Low," and "Very Low."

Part 5: Assessment of Preventive Practices Against Food Poisoning

Preventive Practices were assessed using a four-point Likert scale, consisting of "Regularly," "Frequently," "Occasionally," and "Never."

Reliability Testing

The questionnaire was pilot-tested with a pre-test among 30 residents with characteristics similar to the target population living within the service area of Phanat Nikhom Hospital. Cronbach's alpha coefficients were calculated for each section, with results ranging from 0.74 to 0.95, which exceed the acceptable standard value of 0.70,[15] The Index of Item-Objective Congruence (IOC) values ranged from 0.80 to 1.00, indicating a high level of content validity.

Statistical Data Analysis

Data obtained from 354 completed questionnaires were analyzed using a statistical software package. The following statistical methods were applied:

Descriptive Statistics: frequency, percentage, mean, and standard deviation were used to describe the general information, Health Literacy, Health Belief Model factors, and Preventive Practices.

Inferential Statistics: multiple regression analysis with coefficients at a 95% confidence level was used to determine the influence of Health Literacy, Health Belief Model, and Preventive Practices regarding food poisoning prevention.

RESULTS

The majority of the respondents were female, accounting for 53.4%, followed by males at 46.6%. Most participants were aged 41–50 years (20.6%), followed by those aged 51–60 years (20.3%) and 31–40 years (19.8%).

Regarding educational attainment, 33.3% had completed primary education, followed by 29.4% with secondary education and 27.4% with a bachelor's degree.

In terms of monthly household income, 27.4% reported earning less than 10,000 baht or between 10,000–19,999 baht, followed by 26.3% earning 20,000–39,999 baht and 11.3% earning 40,000–59,999 baht.

The majority of the respondents reported that they themselves were primarily responsible for food preparation in the household (54.5%), followed by their spouse (20.1%) or parents (16.7%), respectively.

Most respondents had previously experienced food poisoning, accounting for 58.5%, while 41.5% reported having no prior experience. Among those who had experienced food poisoning, 61.2% reported no severe symptoms, followed by 18.1% who experienced mild symptoms that resolved on their own, and 15.3% who required medical attention at a hospital or clinic. Additionally, 64.4% stated that no family members or close contacts had experienced food poisoning within the past 12 months, whereas 35.6% reported that family members or close contacts had experienced food poisoning during the same period.

Descriptive Analysis of Health Literacy, Health Belief Model, and Food Poisoning Preventive Practices

Table 1 Mean and Standard Deviation of Health Literacy, Health Belief Model, and Preventive Practices against Food Poisoning. n=354

Variable	$\bar{x}$	SD	Level of Opinion
Health Literacy	3.47	0.38	High
Knowledge and Understanding		0.60	High
Access to Health Information and Services	3.45	0.61	High
Communication Skills	3.43	0.60	High
Decision-Making Skills	3.42	0.63	High
Self-Management Skills	3.50	0.64	High
Media Literacy	3.54	0.58	High
Health Belief Model	3.22	0.23	Moderate
Perceived Susceptibility to Food Poisoning	3.23	0.53	Moderate
Perceived Severity	3.20	0.51	Moderate

Table 1 Mean and Standard Deviation of Health Literacy, Health Belief Model, and Preventive Practices against Food Poisoning. n=354 (continue)

Variable	$\bar{x}$	SD	Level of Opinion
Perceived Benefits of Prevention	3.27	0.51	Moderate
Perceived Barriers to Action	3.18	0.50	Moderate
Cues to Action	3.21	0.53	Moderate
Self-Efficacy	3.25	0.55	Moderate
Preventive Practices against Food Poisoning	3.10	0.17	Moderate

The analysis reveals that Health Literacy, including health communication skills as well as the Health Belief Model (perceived severity, perceived benefits, perceived barriers, cues to action, and self-efficacy) are statistically significantly correlated with food poisoning prevention practices at the 0.05 level.

Table 2 Multiple Regression Analysis Coefficients of Health Literacy, the Health Belief Model and Practices for Prevention

Variable	Practices for Prevention					Collinearity	
	B	Beta (β) Coefficient	Standard Error	t	*p*	Tolerance	VIF
Health Literacy	2.680		0.083	32.245*	0.00		
Knowledge and Understanding	0.019	0.067	0.017	1.170	0.24	0.825	1.211
Access to Health Information and Services	0.010	0.036	0.017	0.628	0.53	0.804	1.244
Communication Skills	0.034	0.118	0.017	2.015*	0.04	0.785	1.274
Decision-Making Skills	0.011	0.041	0.016	0.719	0.47	0.806	1.241
Self-Management Skills	0.016	0.058	0.015	1.022	0.30	0.821	1.219
Media Literacy	0.031	0.105	0.017	1.865	0.06	0.850	1.177
Health Belief Model	2.223		0.118	18.808	0.00		
Perceived Susceptibility	0.024	0.074	0.017	1.467	0.14	0.961	1.041
Perceived Severity	0.065	0.190	0.017	3.773*	0.00	0.963	1.038
Perceived Benefits	0.047	0.140	0.017	2.771*	0.00	0.966	1.036
Perceived Barriers	0.059	-0.172	0.017	3.445*	0.00	0.982	1.018
Cues to Action	0.036	0.111	0.016	2.214*	0.02	0.977	1.024
2.6 Self-Efficacy	0.042	0.132	0.016	2.648*	0.00	0.980	1.020

*$p<0.05$

DISCUSSION

General Characteristics of the Sample Group: The majority of respondents were female (53.4%). Most were aged between 41 and 50 years (20.6%) and had completed primary education (33.3%). Regarding economic status, most household incomes were below 20,000 baht per month. Notably, more than half of the respondents (54.5%) were responsible for preparing their own meals. This demographic structure reflects a sample group consisting of the working-age population and early elderly who play a primary role in the household, particularly with regard to food preparation. The fact that most of the participants had primary or secondary education suggests that access to health information depends heavily on the communication format.

History of Food Poisoning Experiences: The study found that 58.5% of the sample group had previously experienced food poisoning; however, most of these cases were mild to moderate in severity. In the past 12 months, 64.4% of households reported no members with food poisoning symptoms. These results suggest that while many respondents have previously experienced food poisoning, the lack of severe symptoms may cause Preventive Practices to be overlooked, as the perceived severity is not adequately high. This aligns with the subsequent Health Belief Model assessment, which remained at a moderate level, suggesting that non-severe experiences are insufficient to drive consistent preventive actions.

Health Literacy, Health Belief Model, and Food Poisoning Prevention Practices: Although overall Health Literacy was at a high level, the Health Belief Model and Preventive Practices were found to be at moderate levels. This indicates that solely having knowledge does not automatically translate into appropriate behavior. This is consistent with the Health Belief Model (HBM), which asserts that health behavior depends on multiple components, including perceived risk, perceived benefits, perceived barriers, and cues to action. Consequently, in order to achieve tangible results, the providing of knowledge must be coupled with the creation of motivation for modifying behavior. These findings are in line with those of Nutbeam (2000)[16], which indicate that Health Literacy must encompass the understanding, appraisal, and application of information, rather than being limited to mere content knowledge.

The present study demonstrates that Health Literacy is significantly and positively associated with Preventive Practices, with all its subcomponents showing statistically significant effects (p<0.05). These results highlight that Health Literacy should be conceptualized as a multidimensional and holistic construct rather than being limited to the possession of health-related knowledge alone. Among the Health Literacy components, communication skills emerged as the strongest predictor of Preventive Practices, suggesting consistency with Nutbeam (2000)[16], which emphasizes that communication and social interaction skills are essential for transforming health knowledge into actual practice and that the capability to engage in dialogue, ask questions, and understand guidance from healthcare providers plays a critical role in fostering effective health behaviors, beyond the mere possession of knowledge. Furthermore, the findings suggest that, regardless of an individual's level of health knowledge, insufficient communication skills or limited ability to express personal health needs may result in improper or inconsistent Preventive Practices, reinforcing the need for health promotion strategies that prioritize interactive and participatory skill development over one-way information delivery.

In addition, knowledge and understanding,

communication skills, and media literacy exhibited comparable levels of influence on Preventive Practices. This indicates that the ability to comprehend health information, communicate effectively with health professionals, and critically evaluate health-related messages from various media sources collectively facilitates appropriate Preventive Practices. Access to health information and health services were also shown to significantly contribute to Preventive Practices, emphasizing that the availability of reliable information and accessible services provides an enabling factor that reduces the structural barriers to health-promoting behaviors.

Moreover, all constructs of the Health Belief Model were found to be significantly associated with Preventive Practices (p<0.01), albeit with varying magnitudes of effect. Perceived barriers emerged as the most influential factor, indicating that the reduction of practical, psychological, or contextual obstacles is crucial for enhancing Preventive Practices. This finding aligns with behavioral theory, which posits that even individuals with adequate knowledge and motivation may fail to act when the perceived barriers outweigh the perceived benefits.

Perceived severity and perceived barriers were also strong predictors, suggesting that awareness of the serious consequences of illness, together with a clear understanding of the advantages of preventive actions, serves as a powerful motivational mechanism for behavior change. Self-efficacy further played a substantial role, reinforcing the notion that individuals are more likely to engage in Preventive Practices when they believe in their own ability to successfully perform such behaviors. Although cues to action and perceived susceptibility demonstrated comparatively smaller effects, their significant associations highlight the importance of external prompts and personal risk awareness in initiating actionable change.

The study identified a knowledge-action gap, in which high Health Literacy did not lead to equally strong food poisoning Preventive Practices. This may be explained by the Health Belief Model (HBM), particularly with regard to low perceived severity, as many participants had previously experienced only mild symptoms, which led to a low level of perceived risk. Consequently, their motivation to follow Preventive Practices was limited. Moreover, perceived barriers such as time constraints, financial limitations, and lifestyle demands appeared to outweigh the perceived benefits, further reducing adherence to consistent Preventive Practices.

Overall, Preventive Practices were shaped by the combined influence of Health Literacy and Health Belief Model, indicating that knowledge alone is insufficient to drive behavioral change. These findings support existing theoretical frameworks and empirical evidence, aligned with prior studies that identify Health Literacy as a critical determinant of disease prevention while emphasizing the mediating role of belief, intentions, and self-efficacy in translating knowledge into action, in accordance with Kickbusch et al. (2013)[17] and Nutbeam (2000)[16], who state that Health Literacy is a key driver of disease Preventive Practices. Also, Ajzen (1991)[18] and Fishbein and Ajzen (1975)[19] explained that belief and intentions serve as critical mediators influencing individual actions, which supports the correlational analysis results.

These findings are also consistent with the Thai social context, where people have higher levels of health knowledge, yet a gap between knowledge and practice still persists. Consequently, this reflects that knowledge alone is insufficient to change deeply rooted dietary behaviors and cultural eating habits.

CONFLICTS OF INTEREST: None

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ORIGINAL ARTICLE

ความรอบรู้ทางด้านสุขภาพ ความเชื่อทางด้านสุขภาพ ที่มีความสัมพันธ์กับการปฏิบัติเกี่ยวกับการป้องกันอาหารเป็นพิษ ในเขตพื้นที่รับผิดชอบโรงพยาบาลพนัสนิคม

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บทคัดย่อ

ที่มาของปัญหา: อาหารเป็นปัจจัยพื้นฐานที่ส่งผลกระทบโดยตรงต่อสุขภาพของมนุษย์ อย่างไรก็ตาม เมื่ออาหารปนเปื้อนด้วยเชื้อโรค สารพิษ หรือสารแปลกปลอม จะนำไปสู่ "อาหารเป็นพิษ" ซึ่งเป็นปัญหาสุขภาพที่สำคัญทั่วโลก ในประเทศไทย อาหารเป็นพิษเกิดขึ้นอย่างรุนแรงและส่งผลกระทบอย่างสูงต่อเศรษฐกิจ ทรัพยากรด้านการดูแลสุขภาพ และคุณภาพชีวิตของผู้บริโภค ตามข้อมูลขององค์การอนามัยโลก สาเหตุหลักคือจุลินทรีย์ สารพิษจากจุลินทรีย์ สารเคมีปนเปื้อน และสารพิษจากธรรมชาติ

วัตถุประสงค์: การศึกษาครั้งนี้มีวัตถุประสงค์เพื่อศึกษาลักษณะทางประชากรศาสตร์ ความรอบรู้ด้านสุขภาพ ปัจจัยตามแบบแผนความเชื่อด้านสุขภาพ และพฤติกรรมการป้องกันโรคอาหารเป็นพิษของประชาชนในเขตรับผิดชอบของโรงพยาบาลพนัสนิคม รวมถึงวิเคราะห์อิทธิพลระหว่างตัวแปร

วิธีการศึกษา: กลุ่มตัวอย่างประกอบด้วยประชาชนจำนวน 354 ราย คัดเลือกโดยวิธีการสุ่มแบบสะดวก ข้อมูลได้รับการวิเคราะห์โดยใช้สถิติเชิงพรรณนาและการวิเคราะห์ถดถอยพหุคูณ

ผลการศึกษา: ผู้เข้าร่วมการศึกษาส่วนใหญ่เป็นเพศหญิง อยู่ในช่วงวัยทำงานถึงวัยผู้สูงอายุตอนต้น มีระดับการศึกษาตั้งแต่ประถมศึกษาถึงมัธยมศึกษา และมีรายได้อยู่ในระดับต่ำ โดยส่วนใหญ่เป็นผู้ประกอบอาหารหลักภายในครัวเรือน แม้ว่าความรอบรู้ด้านสุขภาพโดยรวมจะอยู่ในระดับสูง แต่ความเชื่อด้านสุขภาพและพฤติกรรมการป้องกันโรคอาหารเป็นพิษกลับอยู่ในระดับ Moderate ความไม่สอดคล้องดังกล่าวอาจอธิบายได้จากประสบการณ์เดิมที่เคยมีอาการเพียงเล็กน้อยจากโรคอาหารเป็นพิษ จึงทำให้รับรู้ความเสี่ยงอยู่ในระดับต่ำ

สรุป: ความรู้ด้านสุขภาพและความเชื่อด้านสุขภาพแสดงให้เห็นถึงอิทธิพลเชิงบวกที่มีนัยสำคัญทางสถิติต่อพฤติกรรมการป้องกัน ดังนั้น โปรแกรมการให้ความรู้ด้านสุขภาพควรเน้นการลดความรุนแรงที่รับรู้ได้และการเสริมสร้างทักษะการสื่อสารเพื่อเชื่อมช่องว่างระหว่างความรู้และการปฏิบัติอย่างมีประสิทธิภาพ โดยเฉพาะอย่างยิ่ง การแทรกแซงควรมีเป้าหมายเพื่อเพิ่มการรับรู้ถึงความเสี่ยงโดยการแสดงให้เห็นว่าแม้แต่กรณี "เล็กน้อย" ก็อาจนำไปสู่ภาวะแทรกซ้อนทางสุขภาพในระยะยาวหรือความสูญเสียทางเศรษฐกิจสำหรับครอบครัวได้ การเสริมสร้างทักษะการสื่อสารจะช่วยให้ผู้อยู่อาศัยสามารถสนับสนุนมาตรฐานความปลอดภัยด้านอาหารภายในครัวเรือนและตลาดท้องถิ่นได้ดียิ่งขึ้น สุดท้ายแล้ว ควรเน้นการลดอุปสรรคที่รับรู้ได้และการเสริมสร้างความสามารถในการจัดการตนเองเพื่อเสริมศักยภาพให้ผู้อยู่อาศัยสามารถจัดการสุขอนามัยในครัวเรือนได้อย่างมีประสิทธิภาพ

คำสำคัญ: ความรอบรู้ด้านสุขภาพ, แบบแผนความเชื่อด้านสุขภาพ, การป้องกันระดับปฐมภูมิ, โรคอาหารเป็นพิษ