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Knowledge and Cognitive Determinants of Health-Seeking Behaviour Among Healthcare Professionals in a Nigerian Tertiary Hospital: A Behavioural Science Perspective

The PENKUP Collaboration

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ABSTRACT

Healthcare professionals play a central role in promoting the health of communities, yet their own health-seeking practices remain poorly understood. This study examines how knowledge, cognitive beliefs, and behavioural determinants shape the health-seeking behaviour of healthcare professionals in a major Nigerian teaching hospital. Drawing on concepts from the Health Belief Model and the Andersen Behavioural Model, the study investigates how perceived susceptibility, perceived severity, perceived benefits, perceived barriers, and enabling factors interact with demographic characteristics to influence behaviour.

A descriptive cross-sectional survey was conducted among 260 healthcare workers in a tertiary hospital in Ekiti State, Nigeria. A validated, self-administered questionnaire assessed knowledge of proper health-seeking behaviour, consultation patterns, use of self-medication, and perceived predictors. Quantitative data were analysed using frequencies, chi-square tests, and binary logistic regression. Knowledge scores were summarised as percentages and classified using a 75% cut-off.

Results showed a high level of knowledge, with 81.5% demonstrating good understanding of appropriate health-seeking behaviour. However, 41.9% exhibited improper health-seeking behaviour, most commonly characterised by self-medication. Younger professionals were significantly more likely to engage in improper behaviour than their older colleagues. Male professionals also had higher odds of improper health-seeking behaviour. Longer work hours and very high workload were associated with poorer behaviour, while enrolment in health insurance reduced the

likelihood of improper practices. Despite their knowledge, many respondents relied on informal consultations, including phone calls, corridor discussions, and home visits, rather than formal clinic appointments.

The findings indicate a persistent gap between knowledge and actual health-seeking practices. Behaviour appears shaped not only by knowledge but also by workload pressures, professional identity, perceived invulnerability, and cognitive biases. Strengthening workplace policies, reducing burnout, improving confidentiality, and promoting behavioural-change communication may improve the adoption of healthier practices among healthcare workers. Addressing these issues is essential for safeguarding the health workforce and strengthening the health system.

Keywords: Health-seeking behaviour; Self-medication; Health Belief Model; Andersen Model; Healthcare workers; Behavioural science; Nigeria.

INTRODUCTION

Healthcare professionals occupy a distinctive position within health systems. They are entrusted with diagnosing illness, delivering treatment, promoting prevention, and encouraging timely use of health services. At the same time, they are widely regarded as role models for healthy behaviour. Yet a growing body of evidence reveals a persistent contradiction between professional knowledge and personal practice. Across diverse health systems, many doctors, nurses, pharmacists, and allied professionals delay seeking care, rely on self-diagnosis and self-medication, and neglect preventive health services, despite clear awareness of the associated risks (Chen et al., 2008; Agaba et al., 2011; Bansal et al., 2012; Adamu et al., 2018). This paradox of high clinical knowledge but poor personal health seeking has emerged as a significant concern in global public health.

The wellbeing of the health workforce is now recognised as a cornerstone of resilient and effective health systems. The World Health Organization has emphasised that a healthy workforce is essential for achieving universal health coverage and sustaining service delivery, particularly in low- and middle-income countries where staff shortages are most acute (WHO, 2022). When healthcare professionals neglect their own health, the consequences extend beyond individual wellbeing. Reduced productivity, increased absenteeism, burnout, and compromised quality of care can follow, alongside the erosion of public trust when professionals are unable to model the behaviours they promote to patients. Understanding why this contradiction persists therefore has implications for workforce sustainability, patient safety, and health system performance.

Health seeking behaviour is not a simple or linear outcome of knowledge. Behavioural research consistently demonstrates that human decision making is shaped by cognitive appraisals, emotional responses, beliefs, social norms, and practical constraints, rather than rational assessment alone (Glanz et al., 2015). Individuals differ in how they interpret symptoms, assess risk, and judge the costs and benefits of seeking care (Damrongplasit & Wangdi, 2017; He et al., 2024). These processes are particularly complex for healthcare professionals, whose decisions are embedded within demanding work environments and professional cultures that value resilience, endurance, and self-reliance.

Behavioural science frameworks offer important insights into these dynamics. The Health Belief Model proposes that health seeking is influenced by perceived susceptibility to illness, perceived severity, perceived benefits of action, perceived barriers, cues to action, and self-efficacy (Janz & Becker, 1984; Rosenstock et al., 1988; Champion & Skinner, 2008). These perceptions are subjective and may be shaped by professional experience. Repeated exposure to illness can foster confidence in self-management and reduce perceived vulnerability, even when objective risk is understood. Similarly, the Andersen Behavioural Model emphasises the role of predisposing factors such as beliefs and professional norms, enabling factors such as access and organisational support, and perceived need for care in shaping service utilisation (Andersen, 1995). Within healthcare settings, concerns about confidentiality, fear of stigma, and the perception that seeking help signals weakness can further inhibit formal engagement with health services (Kay et al., 2008; Adams et al., 2010).

Empirical evidence from low-, middle-, and high-income countries shows that healthcare professionals frequently normalise working through illness, postpone routine check-ups, and substitute structured clinical encounters with informal consultations among colleagues (Gonçlaves Silva et al., 2010; Dyrbye et al., 2017; West et al., 2018). Heavy workloads, staff shortages, and workplace cultures that prioritise presence over self-care reinforce these patterns. Over time, such behaviours can undermine both personal wellbeing and professional performance.

In Nigeria, these challenges are particularly pronounced. Healthcare professionals often work in resource constrained environments characterised by high patient volumes, limited infrastructure, and persistent systemic strain (Nwosu et al., 2020). Within this context, self-diagnosis, self-medication, and delayed formal consultation are commonly viewed as coping strategies rather than risky behaviours. Studies from Nigerian hospitals and tertiary health institutions consistently report widespread reliance on informal treatment pathways among healthcare workers, despite clear awareness of recommended clinical practices (Adewoye et al., 2019; Adejumo et al., 2025; Ema & Abubakar,

2025).

In a tertiary hospital in Southwest Nigeria, doctors and nurses demonstrated a high level of awareness about appropriate health-seeking behaviour, yet this knowledge did not translate into practice. Routine medical check-ups were uncommon, with only 24-28% reporting regular attendance, and self-medication remained widespread, affecting 62% of doctors and 78% of nurses (Adewoye et al., 2019). Several factors have been linked to this pattern, including younger age, limited years of professional experience, long and demanding work schedules, lack of health insurance, concerns about confidentiality, and dissatisfaction with available services, all of which contributed to the rise in self-medication (Table 1). Additional barriers such as limited time, fear of receiving an unfavourable diagnosis, and persistent worries about privacy further discourage healthcare workers from seeking formal care, deepening the gap between what they know and how they act when managing their own health (Gado and Danraka, 2025).

Table 1: Key cognitive and belief drivers of healthcare professionals' health-seeking behaviours

Cognitive/belief factors	Behavioural effect in healthcare professionals	Relevant Literature
"I have the knowledge to treat myself" (professional overconfidence)	↑ Self-medication, ↓ formal consultation	(Adewoye et al., 2019; Chukwu et al., 2021)
Low perceived need / optimism bias	Delay in check-ups, seeking care late	(Adewoye et al., 2019; Alhaji et al., 2025)
Fear of stigma, confidentiality concerns	Avoidance of facility use, especially for sensitive issues	(Adewoye et al., 2019; Odufuwa et al., 2022)
Past experience & knowledge of illness	Drives choice of self-care vs. professional care	(Adewoye et al., 2019; Adeke et al., 2025; Usman et al., 2020; Aham-Onyebuchi & Atulomah, 2020)

Although healthcare professionals generally possess high levels of clinical knowledge, these persistent patterns indicate that personal health decisions are shaped by low perceived vulnerability, confidence in self-management, professional identity, and the realities of demanding work environments. Importantly, much of the existing research in sub–Saharan Africa has focused on describing these behaviours rather than explaining the cognitive mechanisms that sustain them. As a result, interventions often fail to address the underlying behavioural drivers of poor health seeking practices.

This study seeks to address this gap by examining both knowledge and the cognitive determinants of health seeking behaviour among healthcare professionals working in tertiary health institutions in Nigeria. Drawing on the Health Belief Model and the Andersen Behavioural Model, the paper moves beyond description to explain why knowledgeable professionals may still neglect their own health. Through this behavioural science lens, the study identifies predictors of improper health seeking behaviour and offers insights for institutional policies and occupational health strategies that recognise healthcare professionals not only as providers of care but as individuals whose wellbeing is fundamental to the sustainability and effectiveness of the health system.

THEORETICAL FRAMEWORK

Health Belief Model

The Health Belief Model (HBM) remains one of the most widely applied psychological frameworks for explaining health-related behaviour. Developed in the 1950s to understand why individuals failed to participate in preventive health programmes, the model proposes that people are more likely to take health-related action when they believe they are susceptible to a condition, perceive the condition as serious, believe that the recommended action will be beneficial, and perceive barriers to action as minimal (Rosenstock, 1974; Rosenstock et al., 1988; Alyafei & Easton-Carr, 2024). Later refinements introduced the concepts of cues to action and self-efficacy, recognising that external triggers and confidence in one's ability to act are critical determinants of behaviour (Bandura, 1997; Champion & Skinner, 2008).

Among healthcare professionals, the application of the HBM reveals unique dynamics. Perceived susceptibility is often low because of familiarity with disease patterns and confidence in clinical knowledge. This reduced perception of risk may diminish motivation to seek timely care, even when symptoms are present (Patey, 2022; Aini, 2024). Similarly, perceived benefits of early care may be overshadowed by professional competence or confidence in self-treatment (Kazeem, Ishola & Raji, 2025). Healthcare workers may believe that their medical

expertise allows them to manage conditions independently, thereby reducing the perceived need for formal consultation. Barriers such as time constraints, fear of stigma, and concerns about confidentiality further complicate decision-making. Recent studies confirm that physicians and nurses often delay care-seeking because they underestimate personal vulnerability and overestimate their ability to self-manage illness (Kay et al., 2020; Gado & Danraka, 2025). The HBM therefore provides a useful lens for understanding the cognitive dissonance between knowledge and practice in this professional group.

Andersen Behavioural Model

The Andersen Behavioural Model offers a complementary perspective by situating health-seeking behaviour within a broader socio-structural context. Originally developed to explain access to medical care in the United States, the model identifies three categories of determinants: predisposing factors, enabling factors, and perceived need (Andersen, 1995; Alkhawaldeh, 2023). Predisposing factors include demographic characteristics such as age, sex, and profession, which shape attitudes toward health and care utilisation. Enabling factors refer to the resources and conditions that facilitate or hinder access, including income, insurance coverage, workload, and availability of services. Perceived need reflects both subjective assessments of health status and objective evaluations of illness severity.

For healthcare professionals, enabling factors are particularly salient. Long work hours, heavy workloads, and the demands of patient care often constrain the ability to engage in formal health services (Patey, 2022; Aini, 2024). Even when services are available, professionals may prioritise patient needs over their own, leading to delayed or neglected care. Studies in Nigeria and other low-resource settings highlight how systemic pressures, including inadequate staffing and limited institutional support, exacerbate these enabling constraints (Oluchi et al., 2019; Akinniyi, Kazeem & Ishola, 2025; Kazeem, Ishola & Raji, 2025). The Andersen Model thus underscores the importance of structural and organisational determinants in shaping health-seeking behaviour among healthcare workers.

Integrating the Models

Combining the HBM and the Andersen Model, this study interprets empirical findings through cognitive, behavioural, and structural lenses. The HBM explains why healthcare professionals may underestimate personal risk and rely on self-treatment, while the Andersen Model highlights how systemic pressures such as workload and access barriers reinforce these behaviours. Collectively, these models offer a fuller picture of how healthcare workers seek care, showing that their decisions arise from a blend of personal reasoning and the institutional and contextual environments in which they work. They make it possible to explore both the *structural forces* that shape behaviour and the *individual cognitive factors* that influence how health professionals respond when they need care (Figure 1).

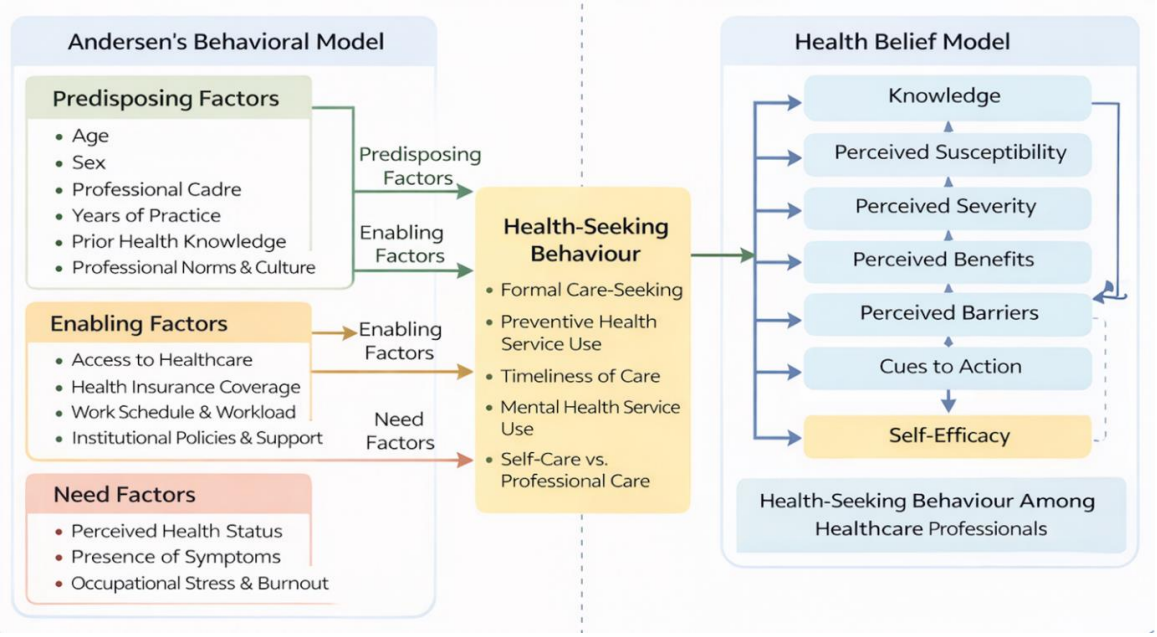

Figure 1: Knowledge and cognitive determinants of health-seeking behavior among health professionals

This integrated framework makes it possible to look more closely at the puzzling reality that even well-informed health professionals sometimes engage in health-seeking practices that fall short of what they know to be best. It helps to unpack why individuals who understand illness, risk and treatment pathways may still delay care, rely on informal networks or minimise their own needs. The framework brings together insights about personal beliefs, workplace pressures and wider organisational conditions, offering a clearer view of how these

behaviours take shape in everyday professional life. It also creates a foundation for developing interventions that respond not only to the psychological factors that influence decision making but also to the structural constraints that shape what options are realistically available. In doing so, it supports a more grounded and compassionate approach to improving the wellbeing of healthcare workers.

METHODS

Study Design

This study adopted a descriptive cross-sectional design to investigate the patterns and predictors of health-seeking behaviour among healthcare professionals. A cross-sectional approach was considered appropriate because it provides a snapshot of prevailing behaviours and attitudes within a defined population at a single point in time. Such designs are widely used in behavioural and occupational health research to identify associations between demographic characteristics and health-related practices without requiring long-term follow-up (Setia, 2016).

Study Setting

The research was conducted at the Federal Teaching Hospital, Ido-Ekiti, a tertiary health facility in Ekiti State, Nigeria. The hospital serves as a referral centre for the state and neighbouring regions, offering a wide range of clinical and diagnostic services. As a teaching hospital, it employs a diverse cadre of healthcare professionals, including doctors, nurses, pharmacists, physiotherapists, dietitians, and medical laboratory scientists. This diversity made the institution an ideal setting for examining health-seeking behaviour across multiple professional groups.

Study Population and Sample Size

The study population comprised healthcare professionals working in the hospital. A total of 270 questionnaires were distributed, of which 260 were completed and returned, yielding a response rate of 96.3%. This high response rate enhanced the reliability of the findings and reduced the risk of non-response bias. The sample included representatives from all major professional categories, ensuring that the results reflected the breadth of experiences within the healthcare workforce.

Data Collection Instrument

Data were collected using a validated self-administered questionnaire. The instrument was structured into four sections:

1. Socio-demographic characteristics (age, sex, marital status, profession, years of practice).
2. Medical history (previous illnesses, chronic conditions, frequency of checkups).
3. Knowledge of proper health-seeking behaviour, assessed through a series of items measuring awareness of recommended practices.
4. Patterns and predictors of behaviour, including self-medication, informal consultations, and use of preventive services.

Knowledge scores were calculated as percenage values. Respondents scoring 75% or higher were classified as having good knowledge, while those scoring below 75% were classified as having poor knowledge. The questionnaire was pre-tested among a small group of healthcare workers in another facility to ensure clarity, reliability, and validity.

Data Collection Procedure

Questionnaires were distributed during departmental meetings and work breaks to minimise disruption to clinical duties. Participation was voluntary, and informed consent was obtained from all respondents. Completed questionnaires were retrieved immediately to reduce non-response and ensure confidentiality.

Data Analysis

Data were entered and analysed using IBM SPSS version 26. Descriptive statistics, including frequencies and percentages, were used to summarise socio-demographic characteristics and behavioural patterns. Chi-square tests were employed to assess associations between demographic variables and health-seeking behaviour. Binary logistic regression was conducted to identify predictors of improper health-seeking behaviour, with independent variables including age, sex, profession, years of practice, and knowledge scores. Statistical significance was set at $p < 0.05$.

Ethical Considerations

Ethical approval was obtained from the Department of Community Medicine, Afe Babalola University, Ido-Ekiti. Permission to conduct the study was also granted by the management of the Federal Teaching Hospital, Ido-Ekiti. Participation was voluntary, and informed consent was secured from all respondents. Confidentiality was maintained throughout the study, and data were used solely for research purposes.

RESULTS

Descriptive Characteristics of the Respondents

A total of 260 healthcare professionals participated in the study, representing a 96.3% response rate. The sample included doctors, nurses, pharmacists, physiotherapists, dietitians, medical laboratory scientists, and other allied health workers, reflecting the diversity of staff in the tertiary hospital.

The demographic profile of respondents highlights a predominantly young, female workforce, with a substantial proportion working long hours and lacking health insurance (Table 2). These characteristics provide

important context for interpreting subsequent findings on knowledge, patterns, and predictors of health-seeking behaviour.

Table 2: Socio-demographic characteristics of respondents

Variable	Frequency N = 260	Percentage (%)
Age (in years)		
20 – 29	56	21.5
30 – 39	108	41.5
40 – 49	60	23.2
50 – 59	36	13.8
Mean ± SD	*38.1 ± 6.7*	
Sex		
Male	99	38.1
Female	161	61.9
Marital		
Single	53	20.4
Married	179	68.8
Separated/Divorced	24	9.2
Widowed	4	1.5
Religion		
Christian	211	81.2
Muslim	43	16.5
Others	6	2.3
Healthcare cadre		
Doctor	76	29.2
Nurse	110	42.3
Medical Lab Scientist	21	8.1
Pharmacist	20	7.7
Dietician	9	3.5
Physiotherapist	12	4.6
Others	12	4.6
Years of experience		
≤10 years	48	18.5
11 – 20 years	164	63.1
> 20 years	48	18.5
Number of work hours per week		

<40 hours	70	26.9
40 – 60 hours	136	52.3
>60 hours	54	20.8
Rate the level of your current workload		
Low	24	9.2
Moderate	84	32.3
High	124	47.7
Very high	28	10.8
Have health insurance		
Yes	228	87.7
No	32	12.3

A. Age and Sex Distribution

Respondents ranged in age from 20 to 59 years, with the majority clustered in the younger age groups. Professionals aged 20–29 years accounted for 38.5% of the sample, while those aged 30–39 years represented 34.2%. Smaller proportions were observed among those aged 40–49 years (18.1%) and 50 years and above (9.2%). Females constituted 56.9% of the respondents, while males accounted for 43.1%.

B. Marital Status and Years of Experience

Most respondents were married (62.7%), with single professionals comprising 34.6% and a small proportion widowed or divorced (2.7%). Years of professional experience varied: 41.5% had fewer than five years of practice, 33.8% had between five and ten years, and 24.7% had more than ten years of experience.

C. Professional Categories

Doctors made up 29.6% of the sample, nurses 37.3%, pharmacists 8.5%, medical laboratory scientists 7.7%, physiotherapists 6.2%, dietitians 3.1%, and other allied professionals 7.6%. This distribution reflects the staffing composition of the hospital and ensured representation across major cadres.

D. Workload and Health Insurance Coverage

Workload indicators revealed that 58.1% of respondents reported working more than 40 hours per week, with many citing irregular shifts and extended duty hours. Health insurance coverage was reported by 61.2% of respondents, while 38.8% lacked coverage. Those without insurance were more likely to report financial barriers to accessing care.

E. Medical History of Respondents

Around one-third (33.5%) of the respondents reported being ill at least once in the past year, and a smaller group (4.2%) experienced illness on three or more occasions (Table 3). Every respondent said they had checked their blood pressure for hypertension at some point, while 92.7% had tested their blood sugar levels and 26.2% had been screened for asthma, among other conditions. In terms of ongoing health management, 22.3% reported taking routine medication, 29.2% attended clinics regularly, and 15.0% had previously been admitted to hospital. Strikingly, a large majority (81.2%) believed that healthcare professionals working in hospitals are themselves vulnerable to hospital-acquired infections.

Table 3: Medical history of respondents

Variable	Frequency N = 260	Percentage (%)
Ever been ill in the last one year		
Yes	87	33.5
No	173	66.5
How many times		
None	173	66.5
1	34	13.1
2	42	16.2
≥3	11	4.2
Ever been screened for the following		
Diabetes Mellitus	241	92.7
Hypertension	260	100.0
Asthma	68	26.2
Sickle cell disease	26	10.0
Others	260	100.0
On routine medication		
Yes	58	22.3
No	202	77.7
Frequent on your clinic visits		
Yes	76	29.2
No	184	70.8
Had any previous hospital admission		
Yes	39	15.0
No	221	85.0
Think healthcare professionals working in hospital are prone to hospital acquired infections		
Yes	211	81.2
No	49	18.8

F. Knowledge of Proper Health-Seeking Behaviour

Overall knowledge of appropriate health-seeking behaviour among respondents was high (Table 4). Of the 260 healthcare professionals surveyed, 81.5% were classified as having good knowledge, with a mean score of 75.8 ± 9.2%. Most respondents (81.2%) correctly identified that periodic medical check-ups should occur at least once per year, and all agreed that routine check-ups are important for maintaining health and preventing disease progression. Awareness of the risks associated with delayed care was also widespread, with the majority recognising that postponing medical consultation could lead to adverse outcomes. These findings suggest that healthcare professionals

in the study setting possess a strong theoretical understanding of recommended practices, consistent with evidence from similar studies in Nigeria and internationally (Kay et al., 2020; Gado & Danraka, 2025).

Table 4: Knowledge of proper health-seeking behaviours among healthcare workers

Variable	Frequency N = 260	Percentage (%)
Routine medical check-ups are not important		
Yes	0	0.0
No	260	100.0
How often should periodic medical check-ups be performed ideally		
At least once in a year	211	81.2
Others	49	18.8
Periodic medical check-ups should be made compulsory for all health workers		
Yes	193	74.2
No	67	25.8
Advice given by doctors during medical check-up/consultation is important		
Yes	254	97.7
No	6	2.3
It is okay for a health worker to diagnose himself/herself for a perceived illness		
Yes	43	16.5
No	217	83.5
It is okay for a health worker to treat himself/herself for a perceived illness		
Yes	61	23.5
No	199	76.5

Figure 2 illustrates the main reasons respondents gave for attending routine medical check-ups. Over half (53%) said their primary motivation was simply to understand the state of their health. Nearly one-third (32%) emphasised the importance of early disease detection, while a smaller group (15%) viewed check-ups as a way to prevent illness altogether.

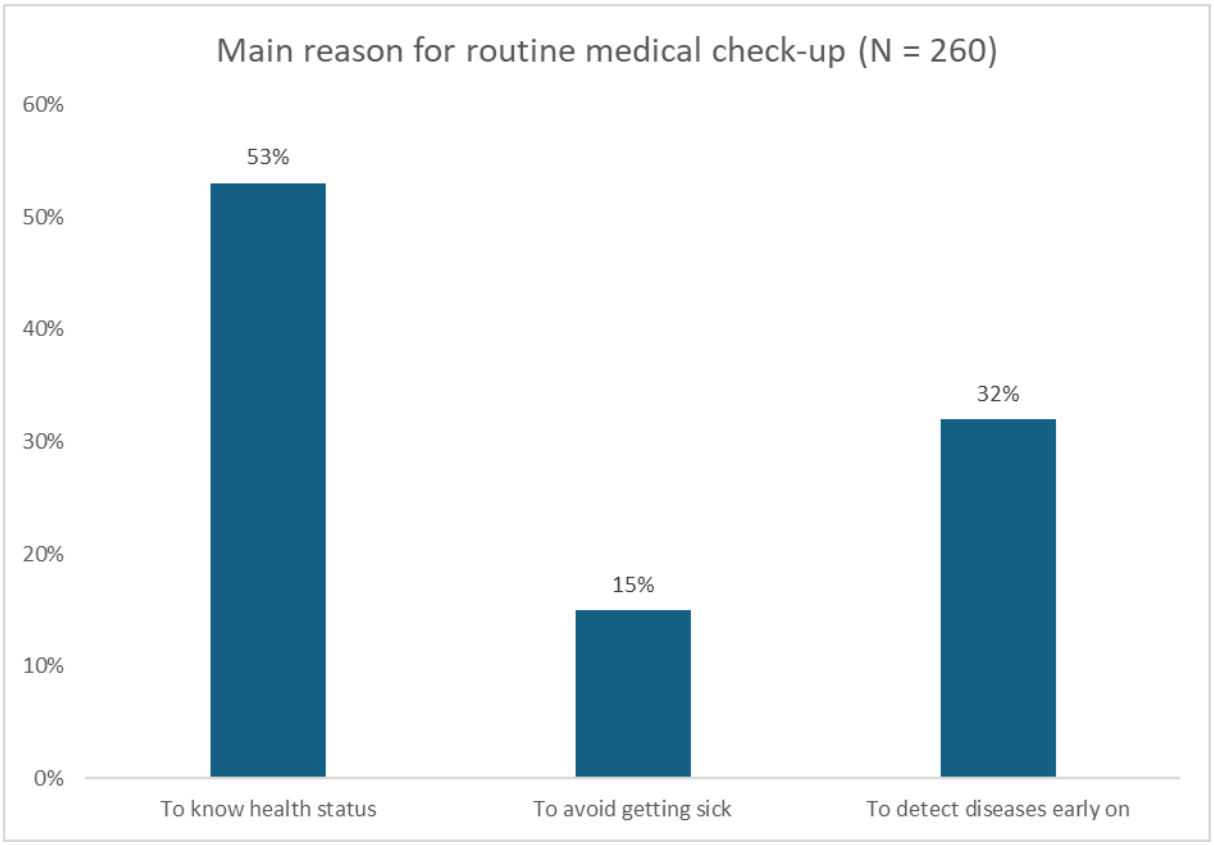

Figure 2: Main reason for routine medical check-up (N = 260)

Table 5 presents the assessed knowledge levels of respondents regarding proper health-seeking behaviour. A large majority, around 81.5%, were found in this study to possess good knowledge in this area.

Table 5: Assessed knowledge of proper health-seeking behaviour

Variable	Frequency N = 260	Percentage (%)
Knowledge of proper health –seeking behaviour		
Good (≥75%)	212	81.5
Poor (<75%)	48	18.5
Mean score ± SD (%)	*75.8 ± 9.2*	

Patterns of Health-Seeking Behaviour

Despite high knowledge levels, behavioural practices revealed notable gaps. A total of 41.9% of respondents (Table 6) exhibited improper health-seeking behaviour, most commonly characterised by self-medication. Informal consultations were also prevalent, with 28.5% reporting reliance on phone calls to colleagues, 1.9% engaging in corridor consultations, and 13.8% using home visits as substitutes for formal medical care. Only 55.8% of respondents reported using formal clinic appointments when ill. Preventive practices such as routine medical check-ups were irregular, with many respondents indicating that they sought care only when symptoms became severe. These findings highlight a persistent knowledge–practice gap, where awareness of appropriate behaviour does not consistently translate into action. Similar patterns have been documented in other Nigerian studies, where healthcare workers often rely on self-treatment and informal consultations due to time constraints, workload pressures, and cultural norms (Adewoye et al., 2019).

Table 6: Patterns of health seeking behaviour among healthcare professionals

Variable	Frequency N = 260	Percentage (%)
Have you ever gone for voluntary medical check-up?		
Yes	260	100.0
No	0	0.0
If yes, when was the last time.		
Within the past 1 month	26	10.0
Within the past 6 months	142	54.6
Within the past 1 year	39	15.0
More than a year ago	32	12.3
How do you consult a doctor when ill		
Over the phone	74	28.5
On the corridor	5	1.9
Home visit	36	13.8
Clinic appointment	145	55.8
Do you comply with your treatment prescription from the doctor?		
Yes	243	93.5
No	17	6.5
Do you feel health care work experience is enough reason to self-medicate?		0.0
Yes	26	10.0
No	234	90.0
Ever self-medicated in the past 1 year		
Yes	109	41.9
No	251	96.5
If you self-medicate, how long do you keep on self-medicating before seeing a doctor.	**n = 109**	
1-2 weeks	64	24.6
3-4 weeks	29	11.2
More than 4 weeks	10	3.8
Till the symptoms get severe enough	6	2.3
Do you delay in seeking proper healthcare?		
Yes	142	54.6
No	118	45.4

Ever experienced any negative interactions with health care professionals that affected you seeking professional health care.		
Yes	150	57.7
No	110	42.3

Table 7 highlights the consultation patterns of respondents when ill. A small proportion (8.8%) reported never consulting a doctor, while a much larger share (60.4%) said they had never visited a pharmacy shop. Similarly, 40.0% had never sought care from a patent medicine vendor. Traditional and spiritual healers were rarely consulted, with 90.8% and 73.8% respectively indicating they had never used these options. In terms of self-care, 58.1% stated they had never self-medicated, and 42.3% reported never turning to friends or colleagues for advice when unwell.

Table 7: Who Do Healthcare Professionals Consult When Ill?

Type of Healthcare Service	Every time n (%)	Very often n (%)	Often n (%)	Rarely n (%)	Never n (%)
Doctor's clinic	125 (48.1)	41 (15.8)	49 (18.8)	22 (8.5)	23 (8.8)
Pharmacy shop	34 (13.1)	18 (6.9)	7 (2.7)	44 (16.9)	157 (60.4)
Patent medicine vendor	11 (4.2)	52 (20.0)	32 (12.3)	61 (23.5)	104 (40.0)
Traditional healer	0 (0.0)	4 (1.5)	3 (1.2)	17 (6.5)	236 (90.8)
Spiritual healer (religious)	0 (0.0)	3 (1.2)	18 (6.9)	47 (18.1)	192 (73.8)
Self-medication	36 (13.8)	24 (9.2)	13 (5.0)	36 (13.8)	151 (58.1)
Friends/colleagues	16 (6.2)	33 (12.7)	17 (6.5)	84 (32.3)	110 (42.3)

Predictors of Health-Seeking Behaviour

Table 8 highlights the challenges respondents reported facing whenever they sought healthcare. A small proportion (5.8%) said they always worried about the cost of care, while 8.8% were consistently concerned about long waiting times. Very few (0.4%) felt they lacked sufficient information, and 4.6% cited accessibility issues. Attitudes of healthcare workers were a recurring concern for 7.3% of respondents, and 1.5% noted that medicines were frequently out of stock. Notably, 10.4% admitted that they had always contemplated self-medication when ill.

Table 8: Respondents' perceived factors affecting health seeking behaviour

Factor	Every time n (%)	Very often n (%)	Often n (%)	Rarely n (%)	Never n (%)
Cost of care	15 (5.8)	8 (3.1)	10 (3.8)	31 (11.9)	196 (75.4)
Waiting time	23 (8.8)	19 (7.3)	21 (8.1)	48 (18.5)	149 (57.3)
Lack of sufficient information	1 (0.4)	6 (2.3)	5 (1.9)	36 (13.8)	212 (81.5)
Accessibility (distance)	12 (4.6)	26 (10.0)	14 (5.4)	42 (16.2)	166 (63.8)
Attitude of workers	19 (7.3)	22 (8.5)	14 (5.4)	29 (11.2)	176 (67.7)
Medicine out of stock	4 (1.5)	25 (9.6)	48 (18.5)	34 (13.1)	111 (42.7)
Self-	27 (10.4)	49 (18.8)	10 (3.8)	23 (8.8)	151 (58.1)

medication

Figure 3 shows the health-seeking behaviour of respondents who reported that they do not self-medicate. Among this group, 41.9% were judged to have improper health-seeking behaviour, while 58.1% demonstrated proper practices.

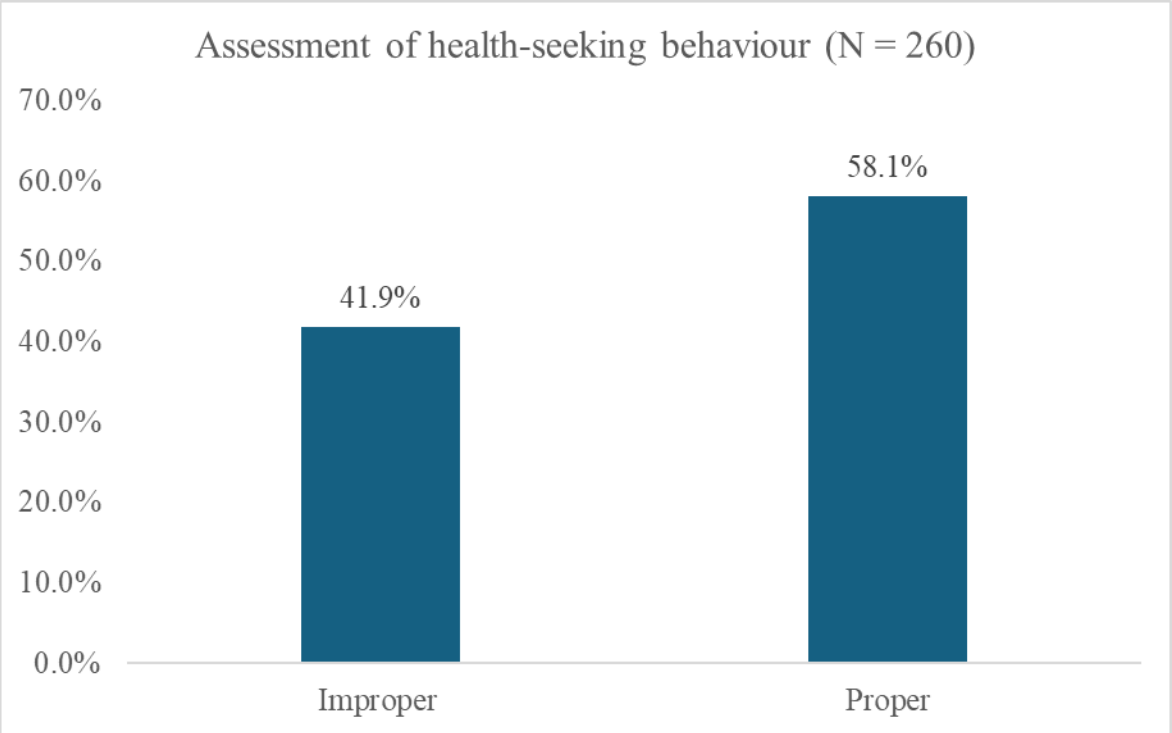

Figure 3: Assessment of health-seeking behaviour among respondents (N = 260)

Table 9 demonstrates that statistically significant relationships were identified at the 0.05 level between respondents' health-seeking behaviour and several key factors. Age ($p = 0.001$) and sex ($p < 0.001$) both showed strong associations, while years of experience ($p = 0.015$) and weekly work hours ($p = 0.003$) also influenced patterns of health-seeking. In addition, having health insurance ($p = 0.049$) was significantly linked to respondents' behaviour.

Table 9: Socio-demographic characteristics of respondents and their health-seeking behaviour

Variable	Health Seeking Behaviour			
	Improper n (%)	Proper n (%)	Chi square	p-value
Age (in years)				
20 – 29	32 (57.1)	24 (42.9)	15.815	**0.001**
30 – 39	51 47.2)	57 (41.5)		
40 – 49	18 (30.0)	42 (70.0)		
50 – 59	8 (22.2)	28 (77.8)		
Sex				
Male	62 (62.6)	37 (37.4)	28.150	**<0.001**
Female	47 (29.2)	114 (70.8)		
Marital				
Single	33 (62.3)	20 (37.7)	2.132	0.344
Married	64 (35.8)	115 (64.2)		
Separated/Divorced	11 (45.8)	13 (54.2)		

Widowed	1 (25.0)	3 (75.0)		
Religion				
Christian	93 (44.1)	118 (55.9)	2.132	0.344
Muslim	14 (32.6)	29 (67.4)		
Others	2 (33.3)	4 (66.7)		
Healthcare cadre				
Doctor	40 (52.6)	36 (47.4)	5.515	0.480
Nurse	42 (38.2)	68 (61.8)		
Medical Lab Scientist	7 (33.3)	14 (66.7)		
Pharmacist	8 (40.0)	12 (60.0)		
Dietician	2 (22.2)	7 (77.8)		
Physiotherapist	4 (33.3)	8 (66.7)		
Others	6 (50.0)	6 (50.0)		
Years of experience				
≤10 years	27 (56.3)	21 (43.7)	8.390	**0.015**
11 – 20 years	69 (42.1)	95 (57.1)		
> 20 years	13 (27.1)	35 (72.9)		
Number of work hours per week				
<40 hours	20 (28.6)	50 (71.4)	11.791	**0.003**
40 – 60 hours	57 (41.9)	79 (58.1)		
>60 hours	32 (59.3)	22 (40.7)		
Rate the level of your current workload.				
Low	8 (33.3)	16 (66.7)	6.846	0.077
Moderate	34 (40.5)	50 (59.5)		
High	49 (39.5)	75 (60.5)		
Very high	18 (64.3)	10 (35.7)		
Have health insurance				
Yes	90 (39.5)	138 (60.5)	3.880	**0.049**
No	19 (59.4)	13 (40.6)		

Analysis of predictors revealed significant associations between health-seeking behaviour and several demographic and occupational variables. Age was strongly associated with behaviour ($p = 0.001$), with younger professionals (20–29 years and 30–39 years) more likely to exhibit improper practices compared to older colleagues. Sex was also significant ($p < 0.001$), with male professionals demonstrating higher odds of self-medication and informal consultations. Years of experience influenced behaviour ($p = 0.015$), with less experienced staff more likely to adopt improper practices. Work hours were another important predictor ($p = 0.003$), as long shifts and heavy workloads reduced the likelihood of formal care-seeking. Health insurance coverage was also significant ($p = 0.049$), with uninsured professionals more likely to delay or avoid formal consultation.

Table 10 reveals a statistically significant relationship between respondents' knowledge and their health-seeking behaviour ($p < 0.001$). Interestingly, 36.8% of those with good knowledge of health-seeking practices were still found to exhibit improper behaviour. In contrast, a much larger proportion (64.6%) of respondents with poor knowledge demonstrated improper health-seeking behaviour.

Table 10: Relationship between knowledge and health-seeking behaviour of respondents

Variable	Health Seeking Behaviour			
	Improper n (%)	Proper n (%)	Chi square	p-value
Knowledge of proper health–seeking behaviour				
Good (≥75%)	78 (36.8)	134 (63.2)	12.415	**<0.001**
Poor (<75%)	31 (64.6)	17 (35.4)		

Binary logistic regression confirmed these associations. Younger professionals and male respondents had significantly higher odds of engaging in improper health-seeking behaviour. Lack of health insurance, heavy workload, and extended work hours further increased the likelihood of poor practices. These findings align with behavioural theory, particularly the Andersen Model, which emphasises enabling factors such as access and resources, and the Health Belief Model, which highlights perceived susceptibility and barriers. The results suggest that both cognitive and structural determinants shape health-seeking behaviour among healthcare professionals.

Table 11 presents the results of the binary logistic regression analysis examining predictors of improper health-seeking behaviour among respondents. Healthcare professionals in their 20s and 30s were significantly more likely to report improper practices compared to colleagues in their 50s, with adjusted odds ratios (AOR) of 2.571 ($p = 0.002$) and 2.125 ($p = 0.014$), respectively. Male health workers were also at greater risk, being twice as likely to exhibit improper health-seeking behaviour compared to females (AOR = 2.145, $p < 0.001$). Years of professional experience emerged as another predictor: respondents with 10 years or less of practice were twice as likely to demonstrate improper behaviour compared to those with more than 20 years of experience (AOR = 2.077, $p = 0.007$).

Table 11: Binary logistic regression for the predictors of good HSB

Variable	AOR	95% CI for AOR		p-value
		Lower	Upper	
Age (in years)				
20 – 29	2.571	1.340	4.935	**0.002**
30 – 39	2.125	1.117	4.042	**0.014**
40 – 49	1.350	0.655	2.782	0.553
50 – 59 (ref)	1.000			
Sex				
Male	2.145	1.614	2.852	**<0.001**
Female (ref)	1.000			
Years of experience				
≤10 years	2.077	1.226	3.512	**0.007**
11 – 20 years	1.554	0.944	2.555	0.061
> 20 years (ref)	1.000			

Number of work hours per week				
<40 hours	0.482	0.313	0.742	**0.001**
40 – 60 hours	0.707	0.526	0.952	**0.031**
>60 hours (ref)	1.000			
Rate the level of your current workload				
Low	0.519	0.276	0.973	**0.049**
Moderate	0.630	0.431	0.920	**0.029**
High	0.615	0.433	1.122	0.069
Very high	1.000			
Have health insurance				
Yes	0.665	0.479	0.923	**0.033**
No	1.000			

B – Regression Coefficient AOR – Adjusted Odd Ratio 95% CI – 95% Confidence Interval ref – reference category

Workload patterns further influenced behaviour. Respondents working fewer than 40 hours per week were less likely to report improper practices, with an AOR of 0.482 (p = 0.001), compared to those working more than 60 hours weekly. This finding suggests that lower workloads reduce the likelihood of unhealthy practices, whereas very high workloads increase vulnerability. Finally, health insurance coverage was protective. Professionals registered with the National Health Insurance Authority (NHIA) were less likely to display improper health-seeking behaviour than those without coverage (AOR = 0.665, p = 0.033).

DISCUSSION

This study demonstrates a striking mismatch between knowledge and practice among healthcare professionals. Although the majority of respondents demonstrated good knowledge of appropriate health-seeking behaviours, many continued to self-medicate or rely on informal consultations. This paradox reflects a broader behavioural challenge that has been documented in multiple contexts: individuals often fail to act in accordance with what they know. In the case of healthcare professionals, this mismatch is amplified by occupational identity, professional confidence, and systemic pressures. Behavioural science literature has long described cognitive patterns such as optimism bias, professional overconfidence, and perceived invulnerability, all of which may contribute to the tendency of healthcare workers to underestimate personal risk and delay formal care (Kay et al., 2020).

The finding that younger professionals were more likely to exhibit improper health-seeking behaviour is consistent with previous studies in Nigeria and elsewhere. Younger staff may have limited clinical experience, higher self-efficacy in self-diagnosis, or reluctance to appear vulnerable in front of colleagues. These factors can reinforce a culture of self-treatment and avoidance of formal consultation. Similar observations have been made in Brazil and the United Kingdom, where younger doctors and nurses reported higher reliance on informal consultations and lower uptake of preventive services (Turner et al., 2021; Oliveira et al., 2022). This suggests that professional socialisation and early career pressures may shape health-seeking behaviour in ways that persist over time.

Workload and work hours also emerged as significant predictors of behaviour. Professionals working more than 60 hours per week were less likely to seek formal care, instead opting for quick informal solutions. This finding aligns with international evidence that long working hours and high occupational stress reduce the likelihood of preventive care and increase reliance on self-medication (Frone, 2016; West et al., 2018; Nguyen et al., 2023). In Nigeria, where staffing shortages and resource constraints are common, extended duty hours are often unavoidable. These structural pressures highlight the importance of organisational interventions, such as workload redistribution and protected time for staff health, to enable healthier practices.

Health insurance coverage was another important enabling factor. Respondents without insurance were significantly more likely to self-medicate, underscoring the role of financial protection in promoting appropriate care-seeking behaviour. This finding resonates with the Andersen Behavioural Model, which emphasises enabling resources such as income and insurance as key determinants of service utilisation (Andersen, 1995). In contexts where healthcare costs are high relative to

income, lack of insurance can act as a powerful barrier, even for professionals who understand the importance of formal care. Expanding coverage through schemes such as the National Health Insurance Authority (NHIA) could therefore play a critical role in improving health-seeking behaviour among healthcare workers.

The findings also align with the Health Belief Model, which predicts that behaviour reflects perceived threat, perceived benefit, perceived barriers, and self-efficacy (Rosenstock et al., 1988; Anuar et al., 2020; Yu et al., 2020). Many professionals perceived themselves as less vulnerable to illness, saw self-treatment as efficient, and considered formal consultation an inconvenience. These perceptions illustrate how cognitive appraisals interact with structural barriers to shape behaviour. For example, high self-efficacy in self-diagnosis may reduce perceived susceptibility, while workload pressures increase perceived barriers. Together, these factors explain why knowledge alone is insufficient to drive appropriate behaviour.

Overall, the study underscores the need for organisational and behavioural interventions rather than knowledge-based solutions alone. Educational campaigns may raise awareness, but they are unlikely to change behaviour unless structural and cultural barriers are addressed. Hospitals should consider implementing confidential staff clinics, flexible scheduling, and mandatory periodic health assessments to reduce reliance on self-treatment. Professional associations could also play a role in challenging norms that discourage care-seeking and in promoting a culture of wellbeing. At the policy level, expanding health insurance coverage and strengthening occupational health programmes would provide enabling resources that support healthier practices.

Situating the findings within behavioural theory, this study contributes to a deeper understanding of why healthcare professionals, despite their knowledge, continue to adopt suboptimal health-seeking behaviours. It highlights the interplay between cognitive biases, professional identity, and systemic constraints, and calls for interventions that address these multiple dimensions. Future research should explore longitudinal patterns of behaviour, examine the role of organisational culture, and assess the effectiveness of targeted interventions in improving health-seeking among healthcare professionals.

Strengths and Limitations

This study is strong because it is clearly based on behavioural science. It uses the Health Belief Model and the Andersen Behavioural Model to understand health-seeking behaviour among healthcare professionals. Using these frameworks lets the analysis go beyond just description and look at the mental and structural factors that drive behaviour. Methodologically, the study has a high response rate, uses a validated questionnaire, and applies suitable statistical analyses, including multivariable logistic regression. These aspects improve the credibility of the findings. The focus on healthcare professionals, who are often overlooked but critical, adds importance for policy and workforce discussions, especially in low- and middle-income health systems.

However, several limitations should be noted. The cross-sectional design limits causal conclusions since the associations can't be considered over time. The data were self-reported, which raises the chance of recall or social bias, especially concerning self-medication practices. Additionally, the study took place in a single tertiary hospital, which may restrict how widely the results can be applied to other institutions or regions. Lastly, improper health-seeking behaviour was mainly defined through self-medication, which might not fully capture the complexity of care-seeking practices.

Implications for Research and Practice

The findings of this study have significant implications for both research and practice. From a research standpoint, the ongoing gap between knowledge and behavior among healthcare professionals shows the need for more detailed investigations into the cognitive and structural factors affecting health-seeking behavior. Future studies should go beyond simple descriptions and look at long-term trends, analyzing how behaviors change throughout different stages of professional careers. This research could also explore how organizational culture, peer influence, and professional identity shape attitudes towards personal health. Comparative studies across countries and health systems could enhance our understanding by pinpointing specific drivers and common behavioral patterns.

Incorporating behavioral theories such as the Health Belief Model and the Andersen Behavioral Model into research provides a useful framework for understanding these dynamics. Researchers should continue to use and refine these models, testing their predictive power in professional groups and adapting them to fit the unique challenges of healthcare settings. Specifically, the relationship between perceived susceptibility, workload, and available resources deserves deeper examination, as these factors consistently showed up as key predictors of behavior in this study.

For practice, the results emphasize the need for organizational and policy changes that extend beyond just knowledge-based strategies. Hospitals and health institutions should focus on reducing workload pressures by redistributing tasks, implementing flexible schedules, and ensuring adequate staffing. Confidential staff clinics and mandatory health assessments could offer easy and stigma-free access to care. Professional associations and regulatory bodies should also challenge cultural norms that prevent care-seeking and promote a culture of wellbeing within the profession.

At the policy level, expanding health insurance coverage through initiatives like the National Health Insurance Authority (NHIA) is essential. Financial protection

lowers barriers to formal care and encourages healthier practices among professionals. Occupational health programs should be strengthened to include proactive monitoring, counseling, and support services tailored to the needs of healthcare workers.

In the end, improving the health-seeking behavior of healthcare professionals matters not only for individual wellbeing but also for the overall strength of the health system. A workforce that demonstrates good health-seeking behavior is better equipped to provide high-quality care, maintain productivity, and build public trust in health systems.

CONCLUSION

This study highlights a continuous contradiction in how healthcare professionals seek help. Even with a solid understanding of proper practices, many respondents still engage in unhealthy behaviors like self-medication and informal consultations. The findings show that behavior is not based on knowledge alone; it is influenced by a mix of cognitive, psychological, and structural factors. Younger age, being male, heavy workloads, long hours, and lacking health insurance were all significant predictors of poor behavior, pointing to the complex nature of the issue.

The results connect with behavioral theories such as the Health Belief Model and the Andersen Behavioral Model. These theories emphasize the roles of perceived risk, perceived obstacles, available resources, and structural factors in shaping health-related choices. In this context, healthcare professionals often view themselves as less vulnerable to illness. They rely on their confidence to self-diagnose and deal with systemic challenges like tight schedules and insufficient support from their organizations. These factors explain why knowledge alone does not lead to healthier habits.

Improving health-seeking behavior among healthcare professionals will require efforts that extend beyond education. Strategies to lower workload pressures, offer confidential and easy-to-access staff clinics, and create workplace cultures that encourage seeking care are crucial. Policy measures like expanding health insurance and enhancing occupational health programs can further lessen financial and structural challenges. Behavioral-change strategies based on well-established theories should be included in organizational policies to tackle cognitive biases and support healthier decision-making.

Making sure healthcare workers have timely access to care is not just about individual well-being; it is also essential for the overall strength of the health system. A workforce that demonstrates healthy seeking behavior is better equipped to provide quality care, maintain productivity, and bolster public confidence in health systems.

AUTHOR CONTRIBUTION

All authors contributed meaningfully to the development of this study and the preparation of the manuscript. The study was conceptualised and designed through joint discussions among the research team. Data collection, cleaning, management and analysis were carried out collaboratively, with each author reviewing analytical decisions to ensure accuracy and consistency. O.I.T, O.O.D. and K.O.O. led the drafting of the manuscript, including the introduction, methods, results and discussion. Co-authors contributed to the interpretation of findings, provided critical revisions and strengthened the clarity and coherence of the final text. All authors reviewed the full manuscript, approved the final version and agreed to be accountable for the integrity of the work.

CONFLICT OF INTEREST

The authors declare no conflict of interest.

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