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Occupational stress and health help-seeking behaviour among primary healthcare workers: The predictive roles of perceived barriers and enabling factors

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Abstract

Objective: To examine the associations of perceived occupational stress, perceived barriers, and enabling factors with help-seeking behaviour among primary healthcare workers in Ogun Central Senatorial District, Nigeria.

Methods: This descriptive cross-sectional study included 322 primary healthcare workers selected using multistage sampling. We collected data using a structured questionnaire with eight perceived-stress items, six help-seeking items, eight perceived-barrier items, and seven enabling-factor items. Composite scores were calculated by summing item responses. Descriptive statistics, Pearson correlations, and multiple linear regression were reported, with statistical significance set at $p < 0.05$. The regression specification and estimates require confirmation against the original statistical output.

Results: The reported mean scores were 20.52 ± 3.62 for perceived stress, 12.23 ± 2.45 for help-seeking behaviour, 21.23 ± 3.74 for perceived barriers, and 19.28 ± 3.85 for enabling factors. Help-seeking behaviour was positively correlated with perceived stress ($r = 0.292$) and enabling factors ($r = 0.540$), and negatively correlated with perceived barriers ($r = -0.405$); the manuscript reports $p < 0.001$ for these associations. The reported regression model had $R^2 = 0.535$ and $F = 121.861$ ($p < 0.001$). These regression estimates are reproduced as reported and have not been independently verified because the original output and dataset were unavailable.

Conclusion: Institutional and psychosocial factors strongly shape help-seeking behaviour among healthcare workers.

Keywords: Occupational stress, help-seeking behaviour, primary healthcare workers, perceived barriers, enabling factors.

Plain English Summary

This study examined work-related stress and help-seeking among primary healthcare workers in Ogun Central, Nigeria. In the questionnaire, respondents were asked how often they sought support from doctors, mental health specialists, counsellors, family, friends or colleagues, and religious leaders. The reported results suggest that respondents more often reported informal sources than formal mental health professionals. Respondents also reported concerns about confidentiality, time, and handling stress alone. The study suggests that confidential services and supportive workplace policies may be important, but the cross-sectional design cannot establish cause and effect.

Introduction

Healthcare workers serve as the fundamental pillar of global health systems, playing an indispensable role in the realization of universal health coverage and the enhancement of population health outcomes. Across the globe,

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medical professionals navigate increasingly arduous work environments defined by excessive workloads, critical shortages in staffing, extended working hours, profound emotional demands, and severe resource constraints. These pervasive conditions expose healthcare personnel to significant occupational stress, elevating stress-related mental health challenges to the status of a pressing public health concern (1). Consequently, occupational stress among healthcare workers has garnered escalating scholarly scrutiny due to its detrimental impact on psychological well-being, job satisfaction, professional productivity, the quality of care delivered, and the retention of the workforce (2, 3).

The burden of this occupational stress is disproportionately heavy in low- and middle-income nations, where health systems frequently struggle under the weight of acute workforce deficits and infrastructural inadequacies. Within the African region, persistent gaps in human resources for health, insufficient financial allocation, and surging healthcare demands have exacerbated workplace pressures for medical professionals (4, 5). These workers routinely confront emotionally taxing scenarios, ranging from the management of critically ill patients and responses to disease outbreaks to the navigation of complex organisational hurdles. As a result, heightened levels of burnout, anxiety, depression, and psychological distress have been documented among healthcare professionals across diverse clinical settings (6, 7).

In Nigeria specifically, occupational stress has crystallised as a major issue, fueled by intensifying workforce shortages, inadequate compensation, substandard working conditions, and the escalating trend of health workforce migration. Empirical evidence indicates that Nigerian healthcare professionals endure substantial work-related stress stemming from overwhelming workloads, insufficient staffing levels, limited resources, and administrative pressures (8, 9). Research has demonstrated that burnout and psychological distress are widespread among Nigerian healthcare workers, correlating strongly with diminished productivity, compromised patient care quality, increased absenteeism, and a heightened propensity to emigrate (10, 11, 12, 13).

This precarious situation has been further compounded by the continuous migration of healthcare professionals from Nigeria to higher-income nations. Multiple studies have recorded the growing exodus of Nigerian doctors and nurses, a movement driven significantly by poor working conditions, burnout, and occupational dissatisfaction (14, 15, 16, 17). The resulting depletion of the workforce imposes additional burdens on the remaining staff, thereby perpetuating a vicious cycle of stress and psychological strain (11, 12). Moreover, evidence suggests that poor workplace well-being among healthcare professionals adversely affects the quality of healthcare delivery and patient outcomes (18).

Despite the high prevalence of occupational stress and mental health challenges within this demographic, a significant proportion of affected individuals refrain from seeking professional psychological support. Help-seeking behaviour encompasses the actions individuals undertake to secure assistance from formal or informal sources when grappling with psychological, emotional, or health-related difficulties. Timely support is crucial for preventing the escalation of mental health issues and fostering overall well-being. However, research consistently reveals that healthcare workers frequently delay or avoid seeking help, even when experiencing profound levels of stress and psychological distress (19, 20).

Numerous factors contribute to this deficient help-seeking behaviour among medical professionals. Mental health stigma remains a formidable barrier, particularly in healthcare environments where workers fear being perceived as weak, incompetent, or professionally inadequate upon disclosing psychological struggles (21, 22). Additional significant obstacles include concerns regarding confidentiality, fears of discrimination, limited awareness of available mental health services, and the time constraints imposed by demanding work schedules (23, 24). In many instances, healthcare workers opt for self-management strategies or rely on informal support networks rather than accessing professional mental health services.

Conversely, specific enabling factors can facilitate help-seeking behaviour among healthcare workers. Supportive workplace policies, encouragement from supervisors and peers, access to confidential mental health services, stress management programs, and enhanced mental health literacy have all been linked to an increased willingness to seek help (22, 25). Organisational initiatives aimed at promoting mental health awareness and cultivating psychologically safe work environments are therefore pivotal in improving access to mental health support for healthcare personnel (26, 27).

Although extensive research has examined occupational stress, burnout, and psychological distress among healthcare workers globally, there is a paucity of empirical evidence regarding how perceived stress, perceived barriers, and enabling factors collectively influence help-

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seeking behaviour among primary healthcare workers in Nigeria. Existing Nigerian studies have predominantly focused on prevalence estimates of stress, burnout, anxiety, and depression (28, 29, 30), paying relatively little attention to the behavioural processes that determine whether healthcare workers seek assistance during periods of psychological distress. Comprehending these relationships is vital for designing effective workplace mental health interventions and bolstering workforce resilience within primary healthcare settings.

This study is grounded in the Health Belief Model (HBM), originally formulated by Becker (31) and subsequently expanded by Rosenstock (32). The HBM asserts that health-related behaviours are shaped by individuals' perceptions of health threats, the perceived benefits of taking action, the perceived barriers to action, and cues that trigger behavioural responses. This model has been extensively utilised to explain preventive health behaviours and patterns of healthcare utilisation. Within the context of this investigation, perceived stress can be understood as an individual's recognition of psychological strain and vulnerability to adverse mental health outcomes. Healthcare workers who perceive higher levels of occupational stress may be more inclined to recognise the necessity for professional support. Perceived barriers, such as stigma, confidentiality concerns, and time constraints, may deter help-seeking despite the acknowledgement of need. Conversely, enabling factors or cues to action, including workplace mental health programs, supervisor recommendations, peer support, and accessible confidential services, may motivate healthcare workers to seek appropriate assistance. Thus, the HBM offers a robust framework for understanding how stress perceptions, barriers, and enabling factors interact to influence help-seeking behaviour among healthcare workers (31, 32). Given the escalating burden of occupational stress and the critical imperative of maintaining a healthy healthcare workforce, this study investigates the relationship between perceived stress, perceived barriers, enabling factors, and help-seeking behaviour among primary healthcare workers. The findings from this study are anticipated to provide evidence for developing targeted workplace mental health interventions and policies aimed at enhancing psychological well-being and promoting timely help-seeking among healthcare professionals.

Materials and Methods

Study Design

This study utilised a descriptive cross-sectional quantitative design to examine occupational stress, help-seeking behaviour, perceived barriers, and enabling factors among primary healthcare workers in Ogun Central Senatorial District, Nigeria. This design was selected to allow the simultaneous assessment of variables at a single point in time and to facilitate the examination of relationships and predictors of help-seeking behaviour.

Study Area

The study occurred in Ogun Central Senatorial District, Nigeria, covering six LGAs including the capital, Abeokuta. Public primary healthcare centres here, managed by the state board, provide essential services to urban and rural populations. Like many Nigerian facilities, these centres face workforce shortages, high patient loads, and resource limitations, conditions likely contributing to significant occupational stress among healthcare workers.

Study Population

The population consisted of primary healthcare workers in public facilities across the six LGAs. Eligible participants included nurses, midwives, community health officers, community health extension workers, medical officers, and health attendants directly involved in patient care. These frontline workers are routinely exposed to demands influencing stress and help-seeking behaviours.

Inclusion and Exclusion Criteria

Inclusion required employment in selected facilities for at least six months, age 18+, active duty status, English proficiency, and voluntary informed consent. Exclusions applied to those employed for less than six months, on leave or transfer, non-clinical administrative staff, and individuals with severe illness or cognitive impairment affecting participation.

Sample Size Determination

The sample size calculation relied on the single population proportion formula for cross-sectional studies as outlined by Kish (33). In the absence of a documented prevalence rate for help-seeking behaviour among primary healthcare workers in the specific study area, a conservative prevalence of 50% was assumed to maximise variability and ensure adequate statistical power. With a 95% confidence level and a 5% margin of error, the initial calculation yielded 384 participants. However, given that the total population of eligible workers in the six LGAs was 1,249, a figure below 10,000, a finite population correction was applied, adjusting the sample size to 293. To account for potential non-response, an additional 10% was added, resulting in a final target sample size of 322 participants.

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Sampling Technique
A multistage sampling technique was employed. First, all six LGAs were included for geographical representation. Second, public facilities were selected via simple random sampling from health authority lists. Third, the sample of 322 was proportionately allocated across LGAs based on workforce size. Finally, workers were stratified by professional cadre and selected via simple random sampling using staff lists from facility management.

Instrument for Data Collection
Data were collected using a structured, self-administered questionnaire with five sections: sociodemographic characteristics; perceived stress (eight items); help-seeking behaviour (six items); perceived barriers (eight items); and enabling factors/cues to action (seven items). The supplied questionnaire specifies four response categories for each section. Perceived-stress and help-seeking items use frequency anchors (1 = rarely, 2 = sometimes, 3 = often, 4 = very often); barrier items use agreement anchors (1 = strongly disagree to 4 = strongly agree); and enabling-factor items use likelihood anchors (1 = very unlikely to 4 = very likely).

Validity and Reliability of the Instrument
The study underwent face and content review by public-health and behavioural-science experts and a pilot involving 30 workers in Sagamu LGA, whose data were excluded from analysis. Reported Cronbach's alpha coefficients were 0.82 for perceived stress, 0.79 for help-seeking behaviour, 0.84 for perceived barriers, and 0.81 for enabling factors. These reliability estimates are retained as reported; the underlying pilot records and analysis were not available for independent verification.

Data Collection Procedure
Following ethical approval and administrative permissions, eligible participants were approached in their facilities. They were informed of the study's purpose and voluntary nature, and written informed consent was obtained. Questionnaires were administered privately to ensure confidentiality and retrieved immediately to minimise data loss.

Measurement of Variables
Perceived stress was assessed with eight items scored from 1 to 4; the summed score therefore ranges from 8 to 32, with higher scores indicating more frequent perceived stress experiences. Scores from 8-16 were measured as low, 17-24 as moderate, and 25-32 as high. Help-seeking behaviour was assessed with six source-of-help items scored from 1 (rarely) to 4 (very often); the summed score ranges from 6 to 24, with higher scores indicating more frequent reported help-seeking across the listed sources. Scores from 6-12 were measured as low, 13-18 as moderate, and 19-24 as high. The scale includes both formal sources (doctor, mental health specialist, and professional counsellor) and informal sources (family, friends/colleagues, and religious leaders); the total score should therefore not be interpreted as formal mental-health-service use alone. Perceived barriers comprise eight items scored from 1 (strongly disagree) to 4 (strongly agree), giving a possible total of 8–32. Scores from 8- 16 were measured as low, 17-24 as moderate, and 25-32 as high. Enabling factors comprise seven items scored from 1 (very unlikely) to 4 (very likely), giving a possible total of 7–28.

Data Analysis
Data were analysed using SPSS version 27. Descriptive statistics summarised demographics and variables. Pearson's correlation examined relationships among stress, barriers, enabling factors, and help-seeking behaviour. Multiple linear regression identified independent predictors, including stress, barriers, enabling factors, and socio-demographics. Statistical significance was set at $p < 0.05$.

Ethical Considerations
Ethical approval was granted by the Ogun State Health Research Ethics Committee (OGHREC/467/2026/1011/APP). Administrative permission was obtained from the Ogun State Primary Health Care Development Board and relevant LGAs. Participation was voluntary with written informed consent. Anonymity, confidentiality, and the right to withdraw were assured. No personal identifiers were collected, and data were securely stored for research purposes only.

Results
Table 1 outlines the socio-demographic characteristics of the 322 primary healthcare workers surveyed in Ogun Central Senatorial District. The workforce is predominantly female (86.6%), with the largest age group falling between 40 and 49 years (40.4%). Most participants are married (68.9%) and Christian (69.9%). In terms of professional composition, Nurses/Midwives (33.5%) and Community Health Extension Workers (CHEWs) (29.5%) constitute the majority, while Medical Officers represent a small fraction (1.9%). Regarding experience, the sample is seasoned, with over half (56.8%) having more than 11 years of service, suggesting a stable and experienced workforce.

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Table 1: Socio-Demographic Profile of Primary Healthcare Workers in Ogun Central Senatorial District: Distribution of Age, Sex, Professional Cadre, Experience, and Religion (n = 322)

Variable	Category	Frequency (n)	Percentage (%)
Age Group (years)	20–29	40	12.4
	30–39	82	25.5
	40–49	130	40.4
	≥50	70	21.7
Sex	Male	43	13.4
	Female	279	86.6
Marital Status	Single	80	24.8
	Married	222	68.9
	Divorced/Separated	11	3.4
	Widowed	9	2.8
Professional Category	Nurse/Midwife	108	33.5
	CHO	42	13
	CHEW	95	29.5
	Medical Officer	6	1.9
	Health Attendant	71	22
Years of Experience	<1 year	6	1.9
	1–5 years	63	19.6
	6–10 years	70	21.7
	11–15 years	84	26.1
	>15 years	99	30.7
Religion	Christianity	225	69.9
	Islam	97	30.1

Table 2 presents the composite scores reported for the 322 participants. Mean perceived stress was 20.52 ± 3.62 (range 10–30), help-seeking behaviour was 12.23 ± 2.45 (range 6–20), perceived barriers were 21.23 ± 3.74 (range 10–32), and enabling factors were 19.28 ± 3.85 (range 7–28).

Table 2: Descriptive Summary of Composite Scores for Occupational Stress, Help-Seeking Behaviour, Perceived Barriers, and Enabling Factors among Primary Healthcare Workers in Ogun Central Senatorial District (n = 322).

Variable	Number of Items	Range	Mean ± SD	Minimum	Maximum
Perceived Stress	8	8–32	20.52 ± 3.62	10	30
Help-Seeking Behaviour	6	6–24	12.23 ± 2.45	6	20
Perceived Barriers	8	8–32	21.23 ± 3.74	10	32
Enabling Factors	7	7–28	19.28 ± 3.85	7	28

Table 3 shows that stressful workplace conditions had the highest mean stress-item score (2.89 ± 0.95), followed by time demands (2.72 ± 1.02). For the help-seeking items, mean scores were higher for family members (2.38 ± 1.10) and friends/colleagues (2.35 ± 1.11) than for professional counsellors (1.72 ± 0.85) and mental health specialists (1.73 ± 0.88).

Table 3: Occupational Stress Burden and Help-Seeking Behavioural Patterns among Primary Healthcare Workers: Descriptive Analysis of Item Responses and Composite Scores (n = 322)

Domain/Item	Rarely n (%)	Sometimes n (%)	Often n (%)	Very Often n (%)	Mean ± SD
Occupational Stress Experiences					
Workplace conditions are stressful	35 (10.9)	61 (18.9)	132 (41.0)	94 (29.2)	2.89 ± 0.95
I feel overwhelmed by workload	53 (16.5)	86 (26.7)	110 (34.2)	73 (22.7)	2.63 ± 1.00
I have little control over work-related decisions	55 (17.1)	88 (27.3)	105 (32.6)	74 (23.0)	2.61 ± 1.01
I feel pressure from time demands	51 (15.8)	80 (24.8)	101 (31.4)	90 (28.0)	2.72 ± 1.02
I feel emotionally drained because of my work	94 (29.2)	86 (26.7)	74 (23.0)	68 (21.1)	2.36 ± 1.11
Job responsibilities interfere with my personal/family life	69 (21.4)	97 (30.1)	84 (26.1)	72 (22.4)	2.49 ± 1.06
I feel frustrated because of work organisation	92 (28.6)	100 (31.1)	79 (24.5)	51 (15.8)	2.28 ± 1.03

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I feel exhausted at the end of a typical working day	67 (20.8)	90 (28.0)	86 (26.7)	79 (24.5)	2.55 ± 1.08
Composite Occupational Stress Score					20.52 ± 3.62
Help-Seeking Behaviour					
Doctor	159 (49.4)	94 (29.2)	51 (15.8)	18 (5.6)	1.78 ± 0.91
Mental health specialist	162 (50.3)	101 (31.4)	42 (13.0)	17 (5.3)	1.73 ± 0.88
Professional counselor	159 (49.4)	108 (33.5)	40 (12.4)	15 (4.7)	1.72 ± 0.85
Family members	89 (27.6)	92 (28.6)	72 (22.4)	69 (21.4)	2.38 ± 1.10
Friends/colleagues	94 (29.2)	87 (27.0)	75 (23.3)	66 (20.5)	2.35 ± 1.11
Religious leaders	102 (31.7)	88 (27.3)	75 (23.3)	57 (17.7)	2.27 ± 1.10
Composite Help-Seeking Behaviour Score					12.23 ± 2.45

Table 4 shows that 68.6% agreed with the confidentiality-concern item, while 67.4% agreed that stress is normal and does not need help, and 67.4% agreed that lack of time is a barrier. For enabling factors, 77.0% reported that a clinical error or near miss due to exhaustion would be a cue to seek help, and 76.4% identified worsening physical or mental health as a cue.

Table 4: Perceived Barriers and Enabling Factors Influencing Health Help-Seeking Behaviour among Primary Healthcare Workers in Ogun Central Senatorial District, Nigeria: Item-Level Response Patterns, Mean Scores, and Ranking Analysis (n = 322)

Domain	Item	Disagree n (%)	Agree n (%)	Mean ± SD	Rank
Perceived Barriers	Seeking help is weakness	187 (58.1)	135 (41.9)	2.32 ± 1.05	7
	Fear of being perceived as incompetent	124 (38.5)	198 (61.5)	2.65 ± 0.98	4
	Lack of time	105 (32.7)	217 (67.4)	2.83 ± 0.99	2
	Confidentiality concerns	101 (31.4)	221 (68.6)	2.87 ± 0.96	1
	Handle stress alone	114 (35.4)	208 (64.6)	2.79 ± 1.10	3
	Prefer spiritual help	207 (64.3)	115 (35.7)	2.22 ± 1.06	8
	Stress is normal; no help needed	105 (32.6)	217 (67.4)	2.90 ± 1.02	5
	Do not know where to seek help	137 (42.5)	185 (57.5)	2.65 ± 1.01	6
Enabling Factors	Item	Unlikely n (%)	Likely n (%)	Mean ± SD	Rank
	Advice from colleague/friend	129 (40.1)	193 (59.9)	2.57 ± 0.95	6
	Recommendation from supervisor	108 (33.6)	214 (66.5)	2.78 ± 0.98	4
	Stress management training	137 (42.5)	185 (57.4)	2.57 ± 0.96	7
	Worsening physical/mental health	76 (23.6)	246 (76.4)	3.02 ± 0.84	2
	Confidential mental health services	159 (49.4)	163 (50.6)	2.45 ± 1.01	5
	Clinical error due to stress	74 (23.0)	248 (77.0)	3.06 ± 0.87	1
	Institutional mental health policy	91 (28.3)	231 (71.8)	2.89 ± 0.91	3

Table 5 presents bivariate correlations, not predictors from a multivariable model. Help-seeking behaviour was positively correlated with perceived stress (r = 0.292) and enabling factors (r = 0.540), and negatively correlated with perceived barriers (r = −0.405); the table reports p < 0.001 for these associations. The reported correlations between perceived stress and barriers (r = 0.004, p = 0.943), stress and enabling factors (r = 0.066, p = 0.237), and barriers and enabling factors (r = 0.029, p = 0.607) were not statistically significant. These results describe associations and do not establish that the constructs operate independently in a causal sense.

Table 5: Bivariate Associations among Occupational Stress, Perceived Barriers, Enabling Factors, and Help-Seeking Behaviour among Primary Healthcare Workers in Ogun Central Senatorial District (n = 322)

Variables	Help-Seeking Behaviour	Perceived Stress	Perceived Barriers	Enabling Factors
Help-Seeking Behaviour	1	—	—	—
Perceived Stress	0.292* (< 0.001)	1	—	—
Perceived Barriers	-0.405* (p<0.001)	0.004 (p = 0.943)	1	—
Enabling Factors	0.540* (p < 0.001)	0.066 (p = 0.237)	0.029 (p = 0.607)	1

Table 6 confirms that the regression model effectively predicts help-seeking behaviour, explaining 53.5% of its variance (R^2 = 0.535). Enabling factors are the most powerful positive predictor (β = 0.535, p < 0.001), while perceived barriers exert a strong negative influence (β = -

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0.421, p < 0.001). Perceived stress also contributes positively, though to a lesser extent (β = 0.258, p < 0.001). The model's overall significance (F = 121.861, p < 0.001) validates these variables as robust determinants of help-seeking intentions.

Table 6: Multivariable Predictors of Health Help-Seeking Behaviour among Primary Healthcare Workers in Ogun Central Senatorial District: Multiple Linear Regression Model with Unstandardized and Standardised Coefficients, Confidence Intervals, and Model Fit Statistics (n = 322)

Predictor	B	SE	β	t	p-value	95% CI
Constant	7.961	0.863	—	9.221	<0.001	6.262 – 9.660
Perceived Stress	0.174	0.026	0.258	6.721	<0.001	0.123 – 0.225
Perceived Barriers	-0.276	0.025	-0.421	-11.015	<0.001	-0.325 – -0.227
Enabling Factors	0.34	0.024	0.535	13.953	<0.001	0.292 – 0.388

Model Fit (Model Statistics): R = 0.731; R^2 = 0.535; Adjusted R^2 = 0.530; SEE = 1.675; F = 121.861, p < 0.001

Discussion

This study investigated occupational stress, perceived barriers, enabling factors, and help-seeking behaviour among primary healthcare workers in Ogun Central Senatorial District, Nigeria. Results indicate a moderately high stress burden, low-to-moderate help-seeking, substantial barriers, and strong enabling influences. Collectively, these variables explain significant variance in help-seeking, highlighting the complex interplay between psychological strain and contextual determinants.

The study revealed high perceived occupational stress (Mean = 20.52 ± 3.62), with over 70% reporting frequent workload pressure and exhaustion. This aligns with evidence across Nigeria and sub-Saharan Africa where workforce shortages, resource constraints, and rising patient loads drive high job demands (1, 4). Similar findings confirm that Nigerian workers face significant stress from organisational inefficiencies (8). This burden mirrors global trends where burnout increased post-pandemic (6, 34). In African systems, chronic stress is worsened by weak infrastructure and inadequate mental health support (35), contributing to reduced well-being and increased turnover intentions (10, 14).

Despite high stress, help-seeking behaviour was only moderate (Mean = 12.23 ± 2.45). Respondents relied mainly on informal sources like family and religious leaders rather than professional services. This reflects a documented tendency in low- and middle-income countries to prefer informal coping over formal support (36). Low utilisation of professional services aligns with another study that cited stigma, confidentiality concerns, and workload as major barriers (23). Another similar study noted that workers avoid services due to fears of reputational damage and perceived weakness. While informal support offers relief, it may not address clinical stress or burnout (21).

Perceived barriers were high (Mean = 21.23 ± 3.74), with confidentiality concerns, lack of time, and self-reliance beliefs being paramount. Over 68% worried about confidentiality, and 67% believed stress should be handled alone. These findings reflect stigma-related barriers widely reported in the literature (22, 23). In African settings, mental health stigma is entrenched, especially among professionals expected to show resilience (35). Seeking help is often viewed as incompetence. Additionally, heavy workloads limit access to care, perpetuating untreated stress (3, 8). Interestingly, spiritual coping was less dominant (35.7%), suggesting a shift toward recognising psychological stress, though structural barriers remain.

Enabling factors were relatively strong (Mean = 19.28 ± 3.85), particularly clinical errors due to stress (77.0%), worsening health (76.4%), and institutional policies (71.8%). Workers are more likely to seek help when stress has tangible consequences or when institutional support is visible. This aligns with the Health Belief Model, where cues to action initiate health behaviour (31, 32). Another study emphasised that workplace interventions and leadership support enhance help-seeking intentions (22). The influence of supervisors and colleagues reflects findings that peer influence and organisational culture shape psychological help-seeking (26).

Correlation analysis showed a positive association between perceived stress and help-seeking (r = 0.292), a negative association between perceived barriers and help-seeking (r = −0.405), and a positive association between enabling factors and help-seeking (r = 0.540). Of these reported bivariate associations, enabling factors had the largest absolute correlation with the outcome. These findings support the Health Belief Model, which posits that barriers and cues outweigh perceived susceptibility (31, 32). Similar patterns exist in Nigeria and other LMICs where enabling environments shape service utilisation (28).

The regression model explained 53.5% of the variance in help-seeking. Enabling factors were the strongest predictor (β = 0.535), followed by

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barriers (β = -0.421) and stress (β = 0.258). This hierarchy suggests structural factors outweigh psychological distress in determining help-seeking. This aligns with Bakker and Demerouti's Job Demands–Resources theory, where job resources (e.g., support) are more influential than demands in shaping coping (2). Global evidence also shows institutional support reduces burnout and improves help-seeking (3).

Findings underscore the need for workplace mental health interventions. Reducing stigma through literacy programs is essential. Institutional policies guaranteeing confidentiality and protected time for mental health services must be implemented. Strengthening supervisory support can aid early identification and referral. Given the high explanatory power of enabling factors, interventions should prioritise structural reforms over individual resilience, especially in low-resource settings with prevalent burnout (1, 4).

Study Limitations

This study used a cross-sectional design, so temporal order and causal relationships cannot be established. The data were self-reported and may be affected by recall or social-desirability bias. The study was conducted among public primary healthcare workers in one senatorial district, which may limit generalisability to other settings or cadres. The questionnaire combines formal and informal help sources in a single help-seeking score, so the total does not isolate professional mental-health-service use.

Conclusion

Overall, the reported results indicate that help-seeking scores were associated with perceived stress, perceived barriers, and enabling factors. Workplace confidentiality, accessible services, and supportive policies are reasonable areas for further consideration, but intervention effects were not evaluated in this cross-sectional study.

List of abbreviations

ANOVA: Analysis of Variance
B: Unstandardized Regression Coefficient
B: Standardised Beta Coefficient
CI: Confidence Interval
CHO: Community Health Officer
CHEW: Community Health Extension Worker
COR: Crude Odds Ratio
DF: Degrees of Freedom
FPC: Finite Population Correction
HBM: Health Belief Model
HSB: Help-Seeking Behaviour
JD-R: Job Demands–Resources Theory
LGA's: Local Government Areas
MLR: Multiple Linear Regression
N: Population Size
n: Sample Size
NBS: National Bureau of Statistics
P: Probability Value (Significance Level)
PHC: Primary Health Care
PHCWs: Primary Healthcare Workers
R: Correlation Coefficient
R^2: Coefficient of Determination
SD: Standard Deviation
SE: Standard Error
SPSS: Statistical Package for the Social Sciences
WHO: World Health Organisation

Declarations

Ethics Approval and Consent to Participate

The manuscript reports approval from the Ogun State Health Research Ethics Committee (OGHREC/467/2026/1011/APP) and written informed consent from participants.

Consent for Publication

All the authors gave consent for the publication of the work under the Creative Commons Attribution Non-Commercial 4.0 license.

Availability of Data and Materials

The datasets generated and/or analysed during the course of this study are not publicly archived but are accessible from the corresponding author upon receipt of a reasonable request.

Conflict of Interest

The authors declare that there are no conflicts of interest, financial or otherwise, that could be perceived as prejudicing the impartiality of the research reported.

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Authors' Contributions

DJM was responsible for the conceptualisation and design of the study, oversaw the data collection process, and played a leading role in drafting the manuscript and performing the statistical analyses. OHA assisted with data gathering, data entry, conducting the literature review, and preparing the manuscript. Both authors have read, reviewed, and approved the final version of the manuscript for publication.

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dedicated efforts were instrumental in the successful execution of fieldwork and data acquisition.

Reference

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