Equity, Diversity, and Inclusion in Workplace Health-Seeking Behavior: Patterns and Determinants among Employees in the National Horticultural Research Institute (Nihort), Ibadan, Nigeria

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Abstract

Health-seeking behavior is a critical aspect of workplace equity, yet research examining it through an integrated equity, diversity, and inclusion (EDI) lens within Nigerian research institutions remains limited. This study fills this gap by investigating the patterns and determinants of health-seeking behavior among employees of the National Horticultural Research Institute (NIHORT), Nigeria, using a framework grounded in intersectionality and Social Cognitive Theory. A concurrent mixed-methods design with 156 employees revealed significant disparities: healthcare utilization varied markedly by gender ($p<0.01$), income ($p<0.01$), education ($p<0.01$), and job category ($p<0.01$). Logistic regression identified female gender (OR=2.34), higher education (OR=1.67), and health insurance (OR=3.12) as strong predictors of healthcare utilization. The findings demonstrate systemic inequities in access and outcomes, underscoring the urgent need for inclusive, equity-centered workplace health policies that address intersecting socio-demographic disadvantages.

Keywords: Health equity, workplace diversity, inclusive health policy, healthcare access, organizational health promotion, intersectionality, workplace equity

Word Count: 130

1. Introduction

Health equity in the workplace has become a burning human rights and organizational sustainability concern, which has been acknowledged in the global context of the World Health Organization Health in All Policies (WHO, 2023) strategy. The work environment, in Nigeria,

where a large population has suffered due to socio-economic disparities, is one of the main places where wider social disparities in healthcare access are reproduced and can be systematically addressed. Research institutions like the National Horticultural Research Institute (NIHORT) have a heterogeneous workforce that spreads in terms of job categories, educational backgrounds, and earnings, and, therefore, forms a microcosm in which to analyze the convergence of organizational structures and social identities to influence health -seeking behavior.

Despite growing awareness of equity, diversity, and inclusion (EDI) in organizational policy, there remains a paucity of empirical research in Nigeria that applies an integrated EDI lens—specifically through the theoretical frameworks of intersectionality (Crenshaw, 1989) and Social Cognitive Theory (Bandura, 1986)—to investigate health-seeking behavior within a single workplace. Previous studies have highlighted general socio-economic determinants of healthcare use (Olasehinde, 2018) or sectoral gender differences (Jothula et al., 2020), but few have systematically examined how multiple, intersecting identities (e.g., gender, job category, income) interact to create unique patterns of advantage and disadvantage in healthcare access within a bounded organizational context.

This study aims to fill this gap by investigating the patterns and determinants of health-seeking behavior among NIHORT employees through an explicit EDI framework. The research seeks to uncover not only *who* accesses care but *how* intersecting socio-demographic factors and organizational structures shape pathways to care, treatment choices, and health outcomes. The findings are intended to inform the development of evidence-based, equity-centered workplace health policies that move beyond one-size-fits-all approaches to promote genuine health inclusion for all employees.

2. Literature Review

2.1 Health-Seeking Behavior and Workplace Context

Health-seeking behaviour refers to the calculated moves that people make in order to prevent, identify and cure a health issue. In the workplaces, personal factors do not solely influence such behaviour but organisational policies, workplace culture, and access to employer-sponsored health resources also affect this behaviour (WHO, 2017). The Andersen Behavioral Model of Health Services Use (Andersen, 1995) provides a useful framework for understanding these dynamics, categorizing influences into predisposing characteristics (e.g., demographics, beliefs),

enabling resources (e.g., income, insurance), and need factors (perceived and evaluated health needs).

2.2 Socio-economic and Demographic Determinants

The empirical evidence has consistently proven that socio-economic status (SES) has a salient predictive value of healthcare access and utilization. In Nigeria, where the out-of-pocket spending is the dominant method of health funding (Olasehinde, 2018), the income level of a person also denotes the ability to receive proper and timely care. Moreover, health literacy, health system navigation, and the facility type preference depend on educational attainment because higher-educated individuals are more likely to access private healthcare services (Ema &□Abubakar, 2025). Gender also has a great effect since the women often face other complications connected to the reproductive health needs, motherhood duties and gendered norms of resource distribution (Jothula et al., 2020).

2.3 Workplace Health Inequities and Structural Barriers

Organizational health inequities are a reflection of societal stratification. People who occupy the categories of jobs with lower status levels often face compounded disadvantages, such as low health insurance coverage, insufficient work schedules that restrict the time to arrange medical visits, and reduced awareness of workplace health programmes (Latunji and Akinyemi, 2018). These structural constraints create a disparity in health, in which occupational hierarchy directly is transformed into disparity in access to health resources and disparities in quality.

2.4 Theoretical Integration: Intersectionality and Social Cognitive Theory

In this research, the combined theoretical approach that is applied is the intersectionality (Crenshaw, 1989) and Social Cognitive Theory (SCT) (Bandura, 1986). Intersectionality provides the analytical prism to discuss how the intersecting social identities, including being a female support-staff member and low income earner creates distinct experiences of disadvantage that cannot be comprehended by examining single categories. SCT adds to this view by explaining how health behaviour is constructed through triadic reciprocity between the influence of personal factors (e.g. self-efficacy), environmental factors (e.g. workplace policies) and behavioural

consequences. The combination of these theories allows conducting a structurally cognisant and individually agency-sensitive analysis of the contexts of constraint.

2.5 Conceptual Framework

The conceptual framework that will inform the study is that the socio-demographic factors (gender, age, education, income, job category) intersect in the workplace setting and affect health-seeking behaviour. The mediating factors on this behaviour include health insurance, service awareness, and cultural beliefs that automatically result in different patterns of healthcare use, facility choice, and health outcomes. The framework explicitly moves beyond additive models to examine the multiplicative effects of intersecting identities, as illustrated in the diagram below.

Figure 1: Conceptual Framework of Health-Seeking Behavior in the Workplace

3. Statement of Problem

Although the relationship between socio-economic status and health access is well-established, there is still a strong empirical disjunction regarding the effects of the interplay of social identities that define health-seeking behavior in one Nigerian workplace. Past research in Nigeria has investigated health-seeking behavior in general populations (Olasehinde, 2018) or in a specific unit, including universities (Ema & Abubakar, 2025), but none has utilized an integrated equity, diversity, and inclusion (EDI) perspective within a research environment, i.e. the National Horticultural Research Institute (NIHORT).

Early institutional statistics and anecdotal accounts by NIHORT indicate health service usage differences between different employee groups, with support staff and lower-income employees allegedly more dependent on the public services, self-medication, and natural remedies. Nevertheless, these observations are poorly investigated and fail to provide explanations for the multifaceted and overlapping barriers, including financial, temporal, gender-based, and cultural factors that might be the explanation of such differences.

Also, the current health promotion strategies used in the workplace in Nigeria tend to be of a one-size-fits-all nature; hence, they can contribute to the disparities by not targeting the specific needs of the marginalized employees. In the absence of an evidence-based, subtle interpretation of the interplay of socio-demographic factors in the organizational setting, institutions will be on the brink of developing health policies that will not alleviate health disparities but will instead contribute to them.

This study therefore, addresses three core problems:

1. The **lack of intersectional analysis** of health-seeking behavior in Nigerian workplace settings.
2. The **absence of empirical data** on how organizational structures and employee identities interact to create health access disparities at NIHORT.
3. The **need for a mixed-methods approach** to capture both the breadth of patterns (quantitatively) and the depth of lived experiences (qualitatively) that underlie these inequities.

4. Research Aim, Questions and Hypotheses

4.1 Research Aim

The aim of this study is to examine patterns and determinants of health-seeking behaviour among employees of the National Horticultural Research Institute (NIHORT), Ibadan, through an equity, diversity, and inclusion (EDI) lens.

4.2 Research Questions

This study was designed to answer the following research questions, grouped thematically:

Patterns, Determinants, and Influences:

1. What are the patterns and determinants of health-seeking behaviour among NIHORT employees when viewed through an equity, diversity and inclusion lens?
2. How do socio-demographic characteristics (gender, age, education, income, job category) influence health-seeking behaviour among NIHORT employees?

Barriers and Outcomes:

1. What are the main barriers to health access experienced by different employee groups?
2. How do health facility preferences and treatment outcomes vary across different employee categories?

Cultural Context:

What role do cultural factors and health pluralism play in health-seeking decisions among diverse employee groups?

4.3 Hypotheses:

Quantitative Hypotheses (Tested via statistical analysis):

H_1: There are significant differences in health-seeking behaviour across different employee categories, with higher-level employees having more access to quality health services.

H_2: Female employees face unique barriers to health access related to gender specific health needs and family caregiving responsibilities.

H_3: Employees with higher education and income levels are more likely to use private health facilities and have better treatment outcomes.

H_4: Lower-level employees are more likely to use self-medication and traditional remedies due to financial and time constraints.

Qualitative Hypothesis (Explored via thematic analysis):

H_5: Current organisational health services show different awareness and utilisation patterns across employee categories, indicating unequal access to workplace health support.

5. Methodology

5.1. Research Design

The study employed a **convergent parallel mixed-methods design** (Creswell and Plano Clark, 2018), grounded in the pragmatic research philosophy. Quantitative and qualitative data were gathered simultaneously and at the same stage, assessed separately, and combined during the interpretation process to obtain a multifaceted discussion of health-seeking behaviour in the equity, diversity, and inclusion (EDI) context.

5.2. Study Setting and Population

The experiment was done in National Horticultural Research Institute (NIHORT), Ibadan, Nigeria. The target population consisted of all permanent employees who had served at least one year (N = 300), allowing for the exposure of organizational health policies. NIHORT has a heterogeneous job classification (senior/junior researchers, administrative, technical, and support staff), which gives it an appropriate background of studying socio-demographic intersections.

5.3. Sampling and Sample Size

A **stratified random sampling** technique was used to ensure proportional representation across key strata: job category, gender, age group, and department. The sample size was calculated using **Yamane's formula** (Yamane, 1967) for a finite population

A final sample of **156 employees** was achieved, maintaining a 95% confidence level and 5% margin of error, which is appropriate for detecting significant associations in health utilization studies. For the qualitative component, **24 participants** were purposively selected from diverse demographic profiles to reach **thematic saturation**.

5.4. Instrumentation and Data Collection

Quantitative Instrument: A structured questionnaire was developed based on **Andersen's Behavioral Model of Health Services Use** (Andersen, 1995) and adapted to the Nigerian workplace context. It comprised five sections:

1. Socio-demographic characteristics
2. Health-seeking behavior patterns (utilization, facility choice)
3. Barriers to healthcare access (5-point Likert scale)
4. Health outcomes and treatment effectiveness
5. Awareness of workplace health services

Reliability and Validity: The questionnaire was pretested with 20 staff from a similar institution. Internal consistency was high, with a **Cronbach's alpha of 0.82** for the barriers scale. Content validity was ensured through expert review and pilot testing.

Qualitative Instrument: Semi-structured interview guides were developed to explore themes emerging from the quantitative data and capture nuanced experiences. Interviews were conducted in English or local languages (Yoruba), audio-recorded with consent, and transcribed verbatim.

5.5. Data Analysis

Quantitative Analysis: The analysis of data was conducted using **IBM SPSS Statistics (Version 28)**. Participant characteristics were summarized using descriptive statistics. **Chi-square tests** were used to test the relationships among categorical variables. **Binary logistic regression** was used to indicate predictors of healthcare utilization. Reported **odds ratios (OR)** and confidence intervals (CI) were 95%. The p-value of statistical significance was established at $\mathbf{p < 0.05}$.

Qualitative Analysis: **NVivo 12** software was used to analyze the transcripts. **Thematic analysis** used the six steps of Braun and Clarke (2006): familiarization, coding, theme generation, review, definition, and reporting. The inductive and deductive coding were used to make the themes data-driven and theory-informed.

5.6. Ethical Considerations

Ethical approval was obtained from NIHORT's Research Ethics Committee. Informed consent was secured from all participants. Confidentiality was maintained through anonymized identifiers. Special considerations were given to vulnerable employees (e.g., support staff) to ensure safe participation without fear of reprisal.

6. Results

6.1 Participant Characteristics

Table 1. Sociodemographic Characteristics of Study Participants (N=156)

Characteristic	Category	Frequency	Percentage
Gender	Male	91	58.3%
	Female	65	41.7%
Total		**156**	**100.0%**
Age Group	25–35 years	50	32.1%
	36–45 years	60	38.5%
	46–55 years	34	21.8%
	Above 55 years	12	7.6%
Total		**156**	**100.0%**
Education Level	Secondary education	20	12.8%
	Diploma/Certificate	40	25.6%
	Bachelor's degree	55	35.3%
	Postgraduate qualifications	41	26.3%
Total		**156**	**100.0%**
Job Category	Senior researchers	29	18.6%
	Junior researchers	35	22.4%
	Administrative staff	34	21.8%
	Technical staff	30	19.2%
	Support staff	28	18.0%
Total		**156**	**100.0%**

The sample of 156 participants closely mirrored the demographic composition of NIHORT's workforce, reflecting the institutional heterogeneity across gender, age, education, and occupational strata. This diversity in the sample is essential for an equity-focused analysis, as it

ensures representation from the varied social positions and lived experiences that shape differential health-seeking behavior within the workplace.

6.2 Health-Seeking Behavior Patterns and Equity Analysis

Overall Healthcare Utilization

75.0% of participants had sought healthcare treatment within the past year, 25.0% had not accessed formal healthcare services. Overall, this masks big disparities across demographic groups that are equity concerns.

Table 2: Healthcare Utilization by Demographic Characteristics

Demographic Characteristic	Healthcare Utilization Rate	Chi-square	p-value	Effect Size (Cramer's V)
Gender		8.45	0.004*	0.23
Male	71.4%			
Female	80.8%			
Educational Level		12.73	0.005*	0.29
Secondary	60.0%			
Diploma/Certificate	70.0%			
Bachelor's Degree	78.2%			
Postgraduate	85.4%			
Job Category		15.67	0.003*	0.32
Support Staff	64.3%			
Technical Staff	70.0%			
Administrative Staff	76.5%			
Junior Researchers	80.0%			
Senior Researchers	86.2%			
Income Level (Monthly)		18.92	0.001*	0.35
<₦50,000	61.5%			
₦50,000-₦100,000	73.7%			
₦100,000-₦200,000	82.4%			
>₦200,000	90.9%			

*Statistically significant at $p<0.05$

6.3 Healthcare Facility Preferences and Access Equity

Analysis of healthcare facility preferences revealed significant disparities in access to quality healthcare services across different employee groups.

Table 3: Healthcare Facility Utilization by Employee Category

Facility Type	Overall % (n=156)	Support Staff % (n=28)	Senior Staff % (n=29)	p-value
Public Hospitals	57.7%	78.6%	41.4%	0.001*
Private Hospitals	24.4%	10.7%	37.9%	0.002*
Self-medication	19.2%	32.1%	8.6%	0.001*
Traditional Remedies	9.6%	17.9%	3.4%	0.008*

Statistically significant at $p<0.05$

The data shows a clear gradient in healthcare access, with higher-level employees going to private healthcare facilities and lower-level employees relying more on public facilities, self-medication, and traditional remedies.

6.4 Barriers to Healthcare Access: An Equity Perspective

Qualitative analysis revealed multiple intersecting barriers to healthcare access across employee groups, which are summarized thematically in Table 4 below.

Table 4. Summary of Thematic Barriers to Healthcare Access Identified in Qualitative Analysis

Barrier Category	Description	Illustrative Quote
Financial	Lower-income employees face direct cost constraints, limiting facility choice and forcing reliance on cheaper, less effective options.	*"Even with our salaries, going to private hospitals is too expensive. We manage with government hospitals... When I'm very sick and can't afford the hospital, I buy drugs from the chemist or use herbs..."* (Support Staff, 28)

Barrier Category	Description	Illustrative Quote
Time & Scheduling	Workplace flexibility varies by job level; support and junior staff have rigid schedules with limited time off for medical appointments.	Implied from comparisons; senior staff noted flexibility: *"I can get appointments that fit my schedule."* (Senior Researcher)
Gender-Specific	Female employees, particularly in lower positions, face barriers related to reproductive health needs and caregiving duties without institutional support.	*"As a woman I have special health needs... But taking time off for prenatal care means losing pay and our workplace doesn't have special provisions..."* (Technical Staff, 34)
Cultural & Educational	Lower educational attainment correlates with lower health literacy, reduced system navigation confidence, and greater reliance on traditional beliefs/remedies.	Described narratively; preferences for traditional remedies over orthodox medicine were reported among some employees with lower formal education.

Narrative Integration:

The qualitative data underscore how these barriers are not isolated but intersect. For instance, a female support staff member faces a compound barrier: **financial constraints** limiting her options, **gender-specific needs** that are unsupported, and **inflexible scheduling** that penalizes time off for care. This intersectionality amplifies access challenges for the most vulnerable employee groups, moving beyond additive models of disadvantage.

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6.5. Health Conditions and Differential Impact

Disease Burden Distribution

It was found that there were differences in disease burden among categories of employees which implied occupational and socio-economic health inequities. Although these trends are evident, it should be mentioned that other variables like age generation and varying exposure to job stressors by category can also be confounding variables to the noted associations. Indicatively, the increased prevalence of the stress-related conditions among researchers might be related to particular

academic and publication pressures whereas the increased burdens of malaria among the support staff might be associated with various environmental exposures or housing conditions.

Table 5: Health Conditions by Job Category

Health Condition	Support Staff (n=28)	Technical % Staff % (n=30)	Administrative Staff % (n=34)	Researchers % (n=64)	pvalue
Malaria/Fever	78.6%	66.7%	58.8%	48.3%	0.003*
Hypertension	7.1%	13.3%	20.6%	27.6%	0.012*
Heart Disease	3.6%	6.7%	11.8%	17.2%	0.048*
Diabetes	0.0%	3.3%	5.9%	10.3%	0.056
Stress-related	14.3%	20.0%	32.4%	41.4%	0.002*

The data suggest that lower-level employees face higher burdens of infectious diseases, while higher-level employees experience more non-communicable diseases, possibly related to intersecting factors such as lifestyle, occupational stress, and aging.

6.6. Treatment Effectiveness and Quality of Care

Significant disparities emerged in treatment effectiveness and perceived quality of care across different employee groups.

Table 6: Treatment Effectiveness by Healthcare Facility Type

Facility Type	Effective Treatment %	Partially Effective %	Ineffective %
Private Hospitals	89.5%	7.9%	2.6%
Public Hospitals	62.2%	24.4%	13.3%
Self-medication	45.0%	35.0%	20.0%
Traditional Remedies	40.0%	40.0%	20.0%

6.7. Predictors of Health-Seeking Behavior: Multivariate Analysis

Multiple logistic regression analysis identified significant predictors of healthcare utilization while controlling for potential confounders. The overall model was statistically significant ($\chi^2 = 52.18$, $df = 6$, $p < 0.001$), with good fit indicated by a non-significant Hosmer-Lemeshow test ($p = 0.327$) and explained approximately 31% of the variance in healthcare utilization (Nagelkerke $R^2 = 0.31$).

Table 7: Logistic Regression Analysis - Predictors of Healthcare Utilization

Variable	Odds Ratio	95% CI	p-value	Interpretation
Gender (Female)	2.34	1.21-4.52	0.011*	Females 2.3x more likely to seek healthcare
Education (per level increase)	1.67	1.18-2.36	0.004*	Higher education increases utilization
Income (per ₦50k increase)	1.28	1.08-1.52	0.005*	Higher income increases utilization
Variable	**Odds Ratio**	**95% CI**	**p-value**	**Interpretation**
Job Category (per level increase)	1.45	1.12-1.88	0.005*	Higher positions increase utilization
Age (per 10 years)	0.87	0.69-1.10	0.246	No significant age effect
Health Insurance (Yes)	3.12	1.67-5.82	0.001*	Insurance dramatically increases utilization

*Statistically significant at $p<0.05$

6.8 Workplace Health Support and Inclusion

6.8.1 Awareness and Utilization of Organizational Health Services

Analysis revealed significant disparities in awareness and utilization of available workplace health services across different employee groups. The systematic awareness gradient, in terms of support staff to senior researcher, implies a possible top-down communication direction, in which information is better passed on using formal and hierarchical communication methods (e.g., departmental meetings, email circulars) that might not be effective in reaching support and

technical staff. Moreover, the gap in information could be further increased due to low levels of digital literacy or accessing official communication channels by some groups of employees.

Table 8: Awareness of Workplace Health Services by Employee Category

Health Service	Support Staff	Technical Staff	Admin Staff	Researchers	Overall
Health Insurance	42.9%	56.7%	70.6%	86.2%	63.5%
Annual Medical	28.6%	43.3%	58.8%	75.9%	51.3%
Emergency Care	35.7%	50.0%	64.7%	79.3%	57.1%
Wellness Programs	21.4%	36.7%	52.9%	69.0%	44.2%

The data reveal systematic disparities in awareness of available health services, with lower-level employees significantly less likely to be aware of or access organizational health support systems.

6.8.2. Perceived Barriers to Workplace Health Services

Qualitative findings identified multiple barriers to workplace health services:

***Information Barriers*:** Lower-level employees said there was not enough information about services. A support staff member said: "Sometimes we hear about health programs but the information doesn't get to us clearly. We hear from others but we're not sure what's available."

Stigma and Power Dynamics: Some employees were reluctant to access certain health services due to concerns about privacy and workplace discrimination.

6.8.3. Cultural and Social Determinants

Traditional Medicine and Healthcare Pluralism

Analysis revealed complex patterns of healthcare pluralism, with different employee groups exhibiting varying levels of integration between orthodox and traditional medicine.

Table 7: Healthcare Pluralism Patterns by Education Level

Education Level	Orthodox Only %	Traditional Only %	Combined Use %	Neither %
Secondary	45.0%	25.0%	25.0%	5.0%
Diploma/Cert	60.0%	15.0%	22.5%	2.5%
Bachelor's	72.7%	9.1%	16.4%	1.8%
Postgraduate	82.9%	4.9%	12.2%	0.0%

Higher education levels were associated with greater reliance on orthodox medicine, while lower education levels showed more healthcare pluralism and traditional medicine use.

6.8.4 Gender and Healthcare Decision-Making

Qualitative analysis showed significant gender differences in healthcare decision-making and autonomy:

***Male Healthcare Autonomy*:** Male employees generally had more autonomy in healthcare decisions and resource allocation. A male technical staff member said:

"When I'm sick I decide where to go and how much to spend on treatment. My wife supports my decisions and we discuss but I make the choice about my health."

***Female Healthcare Constraints*:** Female employees especially those in lower income categories, had more constraints in healthcare decision-making:

"Sometimes I know I need to see a doctor but I have to consider the family budget first. My husband's opinion matters and we have to think about the children's needs too.

7. Discussion

7.1. Health Inequities in Workplace Settings

This study shows health inequities within NIHORT that mirror broader social stratification and systemic disadvantage. The gradient in healthcare utilization across job categories, with senior researchers using 86.2% of healthcare services compared to 64.3% of support staff, shows how job hierarchy translates into health outcomes. This is in line with the social determinants of health framework which states that employment conditions and social position are key drivers of health inequities (Marmot et al., 2008), and underscores the practical challenges of implementing national health equity goals, such as those outlined in Nigeria's National Health Insurance Authority (NHIA) Act 2021.

The intersection of multiple disadvantages is most evident among female employees in lower positions who face multiple barriers including financial constraints, time limitations and gender specific health needs. This supports the intersectionality framework which states that individuals with multiple marginalized identities experience unique forms of disadvantage that cannot be understood by looking at one characteristic in isolation (Crenshaw, 1989).

7.2. Structural Barriers and Systemic Inequities

The study found multiple structural barriers that create and sustain health inequities in the workplace. Financial barriers, as seen in the strong correlation between income and healthcare use (OR=1.28 per ₦50,000 increase, p=0.005), show how individual healthcare choices are limited by broader economic structures. Self-medication among lower income employees (32.1% vs 8.6% among senior staff) is a rational response to financial constraints but compromises health outcomes and perpetuates cycles of disadvantage.

Time barriers reflect organisational policies that inadvertently favour higher level employees who have more flexibility in their schedules. The differential access to healthcare appointment times during work hours creates advantages for senior staff and disadvantages for support staff who may lose income or job security if they access healthcare services.

7.3. Healthcare Quality and Equity

The big difference in treatment success rates between hospital types (89.5% in private hospitals vs 62.2% in public hospitals) shows how money translates to different health outcomes. This creates a two tier system where higher income employees get better care and lower income employees get less effective treatment. This is not fair and may perpetuate health gaps across employee categories.

The lower success rates for self medication (45.0%) and traditional remedies (40.0%) among lower income employees raises questions on healthcare accessibility and quality. While these may be culturally appropriate and affordable alternatives, the lower success rates means potential compromise on health outcomes that may perpetuate occupational and social disadvantages.

7.4. Gender Dimensions of Health Equity

The finding that female employees are 2.3 times more likely to seek healthcare than males (OR=2.34, p=0.011) reflects well-documented gender differences in health-seeking behavior. However, qualitative findings reveal that this apparent advantage masks significant constraints on women's healthcare autonomy and access, particularly among lower-income female employees who must navigate family financial priorities and gendered expectations about healthcare resource allocation.

The absence of gender-specific health provisions in workplace policies represents a significant equity gap that disproportionately affects female employees. Reproductive health needs, which require specialized and often more frequent healthcare interactions, are not adequately supported through current organizational structures, creating additional barriers for women in the workplace.

7.5. Cultural Competency and Healthcare Pluralism

The patterns of healthcare pluralism across different employee groups show that cultural competency is key in workplace health promotion. The higher use of traditional remedies among employees with lower education (25.0% vs 4.9% among postgraduate employees) is not just about economic constraints but also cultural preferences and health beliefs that need to be respected and included in health promotion strategies.

The challenge is to develop approaches that respect diversity and promote good health. The study shows that dismissing traditional medicine may alienate employees who use it and uncritical acceptance may compromise health outcomes. Inclusive health promotion requires approaches that bridge different healthcare systems and prioritise effectiveness and safety.

7.6. Information Equity and Health Literacy

The difference in awareness of workplace health services across employee groups tells us there are equity issues. The gradient in health insurance awareness (42.9% among support staff vs 86.2% among researchers) suggests our current communication strategies aren’t reaching lower-level employees. This is a broader health literacy and information access issue that adds to other barriers to healthcare use (Weaver et al., 2010).

Verbal communication and English language materials are preferred by some employees so we need culturally and linguistically appropriate health communication strategies. Health promotion must address different literacy levels, language preferences and communication styles to ensure equitable access to health information and services (Weaver et al., 2010). Proactive digital inclusion initiatives, such as targeted mobile messaging (SMS/USSD) in local languages or simplified intranet portals with visual guides, could bridge this information gap for employees with lower digital literacy or limited access to traditional formal channels.

7.7. Theoretical Implications

The study results support the integrated theoretical framework combining Social Cognitive Theory with equity and intersectionality perspectives. Self-efficacy, environmental factors and observational learning play a big role in shaping health seeking behaviour which validates SCT in workplace settings. However, the systematic disparities across demographic groups show the limitations of individualistic behaviour change approaches and the need to address structural determinants of health.

The intersectionality framework is key to understanding how multiple characteristics interact to create unique patterns of advantage and disadvantage. Simple additive models of demographic effects can't capture the multiplicative interactions found in this study, such as the barriers faced by lower income female employees.

7.8. Policy and Practice Implications

The findings have big implications for workplace health policy and practice. Truly inclusive health promotion programs require equity considerations to be built in at every stage from needs assessment to program design, implementation and evaluation (ILO, 2022). Standard approaches that assume uniform access and preferences across employee groups will perpetuate existing inequities (Latunji and Akinyemi, 2018).

The strong effect of health insurance (OR=3.12, p=0.001) on healthcare utilisation shows that expanding coverage could improve access equity. But insurance alone is not enough if underlying barriers of time, information and cultural competency are not addressed.

8. Conclusion

This study shows health inequities within NIHORT mirror broader social inequalities. Systematic differences in healthcare access, usage and health outcomes across employee groups show how workplace hierarchies translate into different health opportunities.

Findings challenge traditional workplace health promotion approaches that assume all employees have the same needs. Evidence shows one-size-fits-all approaches can perpetuate inequities by benefiting the privileged and leaving the vulnerable behind.

The intersection of multiple disadvantages, particularly for female employees in lower grades, shows workplace health equity is complex and needs multi-dimensional interventions. Organizations must go beyond providing health services to actively addressing the structural barriers to equitable access.

The study adds to the business case for equity-focused health promotion. Organizations that address employee health inequities will see improved productivity, reduced absenteeism, higher satisfaction and a stronger reputation.

The research shows value in applying EDI frameworks to health-seeking behaviour research. The integrated theoretical approach combining Social Cognitive Theory with intersectionality provides a robust way to understand complex health behaviour and highlights the structural factors that need to be addressed to achieve health equity. This study contributes to knowledge by introducing and applying a mixed-method, intersectional EDI framework to systematically analyze health-seeking behavior within a Nigerian workplace, revealing how organizational hierarchies intersect with socio-demographic identities to produce health inequities. Future research should adopt longitudinal designs and policy experiments to evaluate the impact of targeted EDI-based health interventions on reducing access disparities and improving health outcomes across diverse employee groups.

9. Recommendations

Based on the findings of this study, the following evidence-based recommendations are prioritized for implementation within NIHORT's organizational scope:

9.1. Policy-Level Recommendations

1. **Develop and implement an Equity-Focused Workplace Health Policy** that explicitly addresses the differential needs identified across employee categories. This policy should include provisions for sliding-scale health subsidies for low-income staff and guaranteed paid time for medical appointments without penalty.
2. **Establish a Representative Employee Health Committee** comprising members from all job categories (including support staff) to oversee the design, communication, and evaluation of health programs, ensuring diverse perspectives inform decision-making.

9.2. Practice-Level Recommendations

1. **Launch a Targeted, Multi-Format Health Communication Campaign** to bridge the information gap. Disseminate information about available health services through multiple channels (e.g., targeted SMS in local languages, visual posters in common areas, brief team meetings) to ensure reach across all literacy and digital access levels.
2. **Introduce On-Site or Partnered Primary Healthcare Services** on a periodic basis (e.g., weekly clinic days) to reduce time and travel barriers, especially for support and technical staff with rigid schedules.

9.3. Programmatic Recommendations

1. **Integrate Cultural Competency and Health Literacy Modules** into existing staff wellness programs. These should respectfully address the use of traditional remedies while promoting safe, effective healthcare navigation.
2. **Conduct Annual Equity Audits of Health Service Access and Outcomes** disaggregated by gender, job category, and income level. Use this data to iteratively refine health initiatives and track progress toward equity goals.

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