



BEYOND AWARENESS: MULTILEVEL DETERMINANTS OF PREVENTIVE HEALTH-SEEKING BEHAVIOUR



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Abstract

Preventive health-seeking behaviour remains central to reducing the global burden of non-communicable diseases and strengthening health systems. However, despite widespread awareness of preventive measures, uptake of screening, monitoring, and lifestyle-based interventions remains inconsistent across populations. This review addresses the problem of the persistent gap between awareness and action in preventive health behaviour. The objective is to synthesise empirical and theoretical evidence on multilevel determinants and explain why knowledge does not consistently translate into sustained preventive practices. The study is guided by the Health Belief Model, Andersen's Behavioural Model of Health Services Use, and the Social Ecological Model. A narrative review design was adopted, drawing on peer-reviewed literature published between 2020 and 2025 and analysed using thematic synthesis. Findings indicate that preventive health-seeking behaviour is shaped by cognitive, socio-economic, cultural, institutional, and structural determinants operating across multiple levels. While perceived susceptibility and self-efficacy influence motivation, enabling resources such as income, insurance coverage, and service availability determine actual utilisation. Organisational pressures, cultural expectations, and health system limitations further constrain engagement. The review concludes that preventive behaviour is structurally conditioned rather than purely individual. It recommends integrated interventions combining health education, systemic reform, workplace health support, and strengthened health service delivery to improve sustained preventive engagement.

Keywords: Preventive health-seeking behaviour, health service utilisation, non-communicable diseases, multilevel determinants, health systems

Introduction

Preventive health-seeking behaviour describes deliberate action taken before illness becomes clinically evident. It includes routine medical examination, screening for hypertension, diabetes and cancer, vaccination, health counselling, blood pressure and blood glucose monitoring, physical activity, dietary regulation, tobacco avoidance and reduction of harmful alcohol use. Unlike curative health-seeking behaviour, which usually begins after pain, discomfort or visible symptoms appear, preventive behaviour requires people to respond to risk before the body signals danger. For this reason, preventive engagement depends not only on knowledge, but also on perceived personal risk, trust in health information, household resources, service accessibility, cultural beliefs and the organisation of health systems.

The relevance of preventive health-seeking behaviour has become more pronounced because non-communicable diseases continue to place heavy pressure on families, communities and health systems. The World Health Organization reported that non-communicable diseases caused at least 43 million deaths in 2021, representing 75% of non-pandemic-related deaths globally, while most of these deaths occurred in low- and middle-income countries (World Health Organization, 2025). Similarly, the Global Burden of Disease Study 2021 showed that

behavioural, metabolic, environmental and occupational risk factors continue to contribute substantially to global morbidity and mortality (GBD 2021 Risk Factors Collaborators, 2024). These findings make prevention an essential public health priority, since early detection and sustained risk reduction can reduce avoidable complications, improve quality of life and limit the long-term cost of care.

Preventive health services also provide a practical route for strengthening primary healthcare. Haque et al. (2020) argued that primary healthcare can support the prevention and control of long-term non-communicable diseases, especially in low- and middle-income countries where hospital-based services often face pressure from late presentation and costly complications. This position aligns with wider health system evidence showing that prevention, primary care access and early intervention remain important for improving efficiency and reducing avoidable disease burdens (OECD, 2023). Prevention, therefore, should not be treated as an optional supplement to curative medicine. It should be understood as a central part of sustainable health system planning.

Despite this importance, the use of preventive services remains inconsistent. Many individuals understand the value of routine checks, screening and healthy lifestyle practices, but they do not always translate such awareness into regular action. Peker et al. (2025), in a qualitative study involving community members and family physicians, found that preventive health services for non-communicable diseases were underused partly because people had limited knowledge of available services, misunderstood the purpose of routine checks and often associated check-ups with paid private healthcare. This pattern shows that awareness of disease risk does not automatically produce preventive engagement, especially when people lack clear guidance on where to go, what services are available and why action matters before symptoms appear.

The problem is deeper than inadequate information. Recent evidence indicates that preventive behaviour is shaped by social, psychological and structural conditions. In a representative adult study, Ausserhofer et al. (2025) found that age, sex, education, health literacy, patient activation and mistrust of professional health information influenced preventive health behaviour. Zeng et al. (2025), in a scoping review of preventive healthcare access among rural immigrant populations, also showed that affordability, accessibility, language, transport, policy restrictions and cultural relevance shaped preventive service use across different levels of influence. These studies suggest that the gap between awareness and action cannot be explained by individual attitude alone. It reflects the combined effect of personal perception, social context, institutional practice and health system design.

In many low- and middle-income settings, including African health systems, these barriers are intensified by out-of-pocket payment, weak insurance coverage, distance to facilities, uneven service quality and limited preventive health infrastructure. Individuals may know that screening is beneficial but still postpone it because the cost competes with immediate household needs. Workers may intend to attend routine checks but lack time, workplace permission or convenient service points. Others may avoid preventive services because of fear of diagnosis, poor previous encounters with healthcare workers or cultural beliefs that normalise care-seeking only after illness has become severe. Such conditions sustain a reactive pattern of healthcare utilisation, where people seek help when symptoms become disruptive rather than when risk can still be managed early.

This narrative review addresses this awareness-action gap by examining the multilevel determinants of preventive health-seeking behaviour. It asks three related questions: what

individual, socio-economic, cultural, institutional and structural factors influence preventive engagement; how do these determinants explain the failure of awareness to produce sustained preventive action; and what implications do they hold for public health policy and health system strengthening? The review draws on contemporary empirical evidence and established behavioural thinking to explain why prevention must be understood as more than a matter of individual choice.

The significance of this review lies in its attempt to organise scattered evidence into a coherent account of preventive health behaviour. By examining cognitive, social and structural determinants together, the review supports a more realistic approach to intervention design. It can assist public health practitioners, policymakers, researchers and health institutions to move beyond awareness campaigns alone and design prevention strategies that are accessible, affordable, culturally responsive and supported by functional health services. Such an approach is necessary if health systems are to reduce avoidable disease burdens and promote sustained preventive engagement across different population groups.

Literature Review

Preventive health-seeking behaviour has increasingly been conceptualised as a complex and layered public health phenomenon shaped by the interaction of psychological dispositions, socio-economic positioning, institutional arrangements, cultural expectations, and broader policy environments. Contemporary narrative review scholarship consistently challenges the assumption that awareness of disease prevention naturally leads to action. Instead, it demonstrates that the pathway from knowledge to behaviour is frequently disrupted by structural and systemic constraints that limit individuals' capacity to act on health information (World Health Organization, 2023; OECD, 2023; GBD 2021 Risk Factors Collaborators, 2024). This shift in understanding has encouraged a move away from narrowly individualistic explanations towards more integrated models that account for both personal agency and structural conditions.

The Health Belief Model (HBM) remains one of the most enduring psychological frameworks for explaining preventive behaviour. Originally articulated by Rosenstock (1974), the model proposes that health-related actions are shaped by perceived susceptibility, perceived severity, perceived benefits, perceived barriers, cues to action, and self-efficacy. Within preventive health contexts, this framework has been widely applied to explain why individuals choose to engage in screening, vaccination, and lifestyle modification. However, more recent empirical studies suggest that its explanatory power is partial rather than comprehensive. Wong et al. (2021) demonstrated that while perceived susceptibility and perceived benefits strongly predicted vaccine uptake, perceived barriers significantly reduced compliance, particularly in uncertain health environments. Similarly, Yang et al. (2024) observed that although individuals with higher health literacy showed stronger preventive intentions, these intentions were not consistently translated into action where systemic barriers were present. These findings highlight a recurring limitation of the HBM, namely that it privileges cognitive readiness while underestimating the role of structural constraint.

A broader narrative synthesis of recent literature reinforces this limitation by demonstrating that behavioural intention is frequently disrupted by material and contextual barriers. Lau et al. (2025) reported that uptake of preventive health checks remained low even among individuals with positive health attitudes when logistical difficulties, cost burdens, and service inaccessibility were present. In a related analysis, Dhingra et al. (2025) showed that socio-economic status significantly shaped preventive behaviour, indicating that individuals' capacity to act is closely tied to their position within broader economic structures. Zeng et al.

(2025) further extended this argument by demonstrating that preventive healthcare access among marginalised populations is constrained by intersecting barriers, including policy restrictions, cultural factors, and weak service integration. Collectively, these studies suggest that intention is continuously mediated by structural realities that either enable or inhibit preventive action.

Andersen's Behavioural Model of Health Services Use provides a more structurally grounded explanation of preventive health behaviour by categorising determinants into predisposing characteristics, enabling resources, and need factors. Andersen (1995) argues that utilisation of health services is not solely determined by individual motivation but is strongly influenced by the availability of enabling resources. Empirical research supports this position. Gopalan et al. (2021) found that insurance coverage, income level, and geographic proximity to healthcare facilities were more significant predictors of preventive service use than demographic variables alone. Similarly, Reibling et al. (2022) demonstrated that differences in national healthcare system organisation significantly influenced preventive service uptake, reinforcing the importance of macro-structural design in shaping health behaviour. These findings suggest that preventive engagement is highly sensitive to system-level accessibility and financial protection mechanisms.

Evidence from sub-Saharan Africa further strengthens this structural interpretation. Ameh et al. (2022), in a systematic review, identified affordability, availability of services, perceived quality of care, and trust in health systems as central determinants of preventive service utilisation. Importantly, their findings show that awareness alone is insufficient in contexts where health systems are under-resourced or unevenly distributed. Ogunrinde and Aluko (2024) similarly observed that in Nigerian settings, individuals often adopt a reactive approach to healthcare, seeking services only after symptoms become severe. Peker et al. (2025) added that limited awareness of available preventive services further compounds low utilisation, even in contexts where services technically exist. These studies collectively demonstrate that structural deficiencies persist even in environments where health information is increasingly accessible.

The Social Ecological Model (SEM) broadens this analysis by locating preventive behaviour within multiple interacting levels of influence, including individual, interpersonal, organisational, community, and policy domains (Bronfenbrenner, 1977; McLeroy et al., 1988). Rather than isolating behaviour at the individual level, this framework emphasises relational and environmental influences. Zhao et al. (2022) demonstrated that community norms and structural conditions significantly moderate preventive health behaviour, suggesting that individual intention is shaped by surrounding social expectations. Smith et al. (2023) similarly found that workplace organisational culture and institutional policies strongly influence participation in preventive screening, even after controlling for individual risk perception. These findings reinforce the argument that preventive behaviour is socially embedded and institutionally conditioned.

At a broader structural level, global health evidence highlights the influence of inequality and health system performance on preventive outcomes. The Global Burden of Disease Study reports that behavioural, metabolic, and environmental risk factors remain major contributors to global mortality, with substantial variation across healthcare systems and socio-economic contexts (GBD 2021 Risk Factors Collaborators, 2024). The World Health Organization (2022; 2023) further documented that disruptions to essential health services during the COVID-19 pandemic significantly reduced preventive service utilisation worldwide, exposing vulnerabilities in health system resilience. OECD (2023) also reports persistent

inequalities in preventive care access, even in high-income countries, indicating that structural barriers are not confined to resource-limited settings.

Occupational and institutional environments further complicate preventive engagement. Smith et al. (2023) found that high workload intensity, time scarcity, and organisational pressure reduce participation in routine health screening among employees. This suggests that even when preventive services are available, structural demands within workplaces may inhibit engagement. Rata Mohan et al. (2025) also reported gender differences in preventive behaviour, with women more likely than men to utilise preventive services. These differences are often linked to variations in health socialisation, care-seeking norms, and interaction with health systems, highlighting the role of social identity in shaping behaviour.

Evidence from policy and health economics further demonstrates the importance of financial design in shaping preventive uptake. The Medical Care Research and Review (2021) highlight that elimination of cost-sharing significantly increases preventive service utilisation, particularly among low-income groups. This finding reinforces the argument that financial barriers operate not merely as external constraints but as central determinants of behavioural decision-making in preventive health contexts.

Across the literature, a consistent pattern emerges: preventive health-seeking behaviour is shaped by the interaction of cognitive, structural, and ecological determinants rather than any single explanatory factor. The Health Belief Model explains motivational processes, Andersen's model explains access and enabling conditions, and the Social Ecological Model explains environmental embedding. However, none of these frameworks alone adequately captures the complexity of preventive behaviour. Their integration provides a more complete and analytically robust explanation of how preventive behaviour is produced and constrained.

A persistent awareness–action gap is evident across both high-income and low- and middle-income contexts. Individuals frequently recognise the importance of preventive care, yet fail to act due to financial constraints, limited-service availability, institutional inefficiencies, occupational pressures, and weak health system organisation (World Health Organization, 2023; OECD, 2023; Ameh et al., 2022). This pattern suggests that preventive health behaviour is not simply a matter of individual decision-making but a socially and structurally produced outcome shaped by broader systems of inequality and access.

Overall, the literature supports an integrated interpretive position in which preventive health-seeking behaviour operates across multiple interacting levels. Its determinants span psychological, socio-economic, institutional, occupational, cultural, and policy domains. This reinforces the need for multilevel interventions that extend beyond awareness creation to include structural reform, health system strengthening, workplace redesign, and equitable policy implementation aimed at enabling sustained preventive engagement.

Methodology

A narrative literature review design was adopted to synthesise and critically interpret evidence on preventive health-seeking behaviour. This design is particularly appropriate for topics characterised by conceptual diversity and methodological heterogeneity, as it enables the integration of empirical findings with theoretical perspectives while preserving analytical depth. Unlike systematic reviews that focus on quantifiable aggregation, a narrative approach allows for a more interpretive engagement with literature, particularly where the aim is to understand relationships between behavioural, structural, and contextual determinants across varied health systems and populations (Ferrari, 2015; Green et al., 2022). In this study, the

approach facilitated a coherent synthesis of how preventive health behaviour is shaped across psychological, socio-economic, institutional, and policy environments.

The literature search was conducted using major academic databases, including PubMed, Scopus, Web of Science, and Google Scholar. These databases were selected due to their broad coverage of public health, behavioural science, and health systems research. A combination of controlled and free-text search terms was applied to capture relevant studies. Key terms included “preventive health-seeking behaviour”, “preventive health service utilisation”, “screening uptake”, “health behaviour determinants”, and “multilevel determinants of health”. Boolean operators were used to refine search sensitivity and improve relevance. Peer-reviewed studies published between 2020 and 2025 were prioritised to ensure contemporary relevance, while seminal theoretical works were retained to support conceptual framing and interpretation.

Eligibility criteria were defined to ensure conceptual consistency and analytical focus. Studies were included if they examined determinants of preventive health-seeking behaviour or related preventive health service utilisation among adult populations. Particular attention was given to studies exploring socio-economic, psychological, cultural, institutional, occupational, and structural determinants, as these dimensions align with the multilevel orientation of the review. Studies focusing exclusively on acute or curative healthcare, or those unrelated to preventive health behaviour, were excluded to maintain conceptual clarity. In addition, non-peer-reviewed opinion pieces and editorials without empirical or theoretical grounding were not considered for inclusion.

The analytical process followed a thematic narrative synthesis approach. This involved systematic extraction of relevant data from each study, including research design, population characteristics, geographical context, theoretical framework, and key findings related to determinants of preventive behaviour. The extracted data were then organised into analytically meaningful categories guided by established behavioural and ecological frameworks, particularly the Health Belief Model, Andersen’s Behavioural Model of Health Services Use, and the Social Ecological Model. This process enabled comparison across studies while preserving contextual nuance and theoretical coherence.

Interpretive synthesis was subsequently undertaken to identify recurring patterns, divergences, and explanatory mechanisms across the literature. Rather than merely summarising findings, the analysis examined how different determinants interact across levels of influence and how these interactions shape the observed awareness–action gap in preventive health behaviour. Particular attention was given to the relationship between individual cognition and structural constraints, as well as the ways in which institutional and policy environments either facilitate or inhibit preventive engagement. This layered analytical approach ensured that the synthesis moved beyond description towards a more integrated understanding of preventive health-seeking behaviour as a socially embedded and structurally conditioned phenomenon.

Results

The synthesis of evidence across the reviewed literature indicates that preventive health-seeking behaviour is not determined by a single factor, but rather by an interconnected system of cognitive, socio-economic, cultural, institutional, and health system influences. When organised analytically using a synthesis matrix approach, the findings reveal a consistent multilevel structure in which determinants operate simultaneously and reinforce

one another across different contexts (GBD 2021 Risk Factors Collaborators, 2024; World Health Organization, 2023).

At the individual level, preventive behaviour is primarily shaped by cognitive appraisal processes. Across studies, perceived susceptibility and perceived severity consistently emerge as important motivators of preventive action, particularly in relation to screening and early detection behaviours. Individuals who recognise personal vulnerability to disease are more likely to express intention to engage in preventive care. However, intention alone is not sufficient to guarantee action. Self-efficacy emerges as a critical moderating factor, influencing whether individuals feel capable of navigating health systems and sustaining preventive routines. Empirical evidence supports this pattern, with Wong et al. (2021) demonstrating that perceived risk and perceived benefits significantly predict preventive uptake, while Yang et al. (2024) show that behavioural consistency declines when structural barriers override cognitive readiness.

When examined through a synthesis matrix lens, cognitive determinants function primarily as initiating conditions rather than determining factors of sustained behaviour. This indicates that motivation is necessary but not sufficient, particularly in environments where structural constraints limit access.

Socio-economic determinants represent the second major analytical cluster and consistently demonstrate stronger predictive power over actual preventive behaviour than cognitive factors alone. Income level, employment stability, and insurance coverage directly shape individuals' ability to access preventive services. In contexts where out-of-pocket payments dominate healthcare financing, preventive care is frequently deprioritised in favour of immediate economic needs. This pattern is strongly supported in the literature, where Gopalan et al. (2021) identify enabling resources as more influential than demographic characteristics, while Reibling et al. (2022) demonstrate that health system organisation significantly determines preventive service utilisation across countries.

Within this synthesis cluster, socio-economic constraints operate not merely as background conditions but as active determinants that shape decision-making thresholds. Lau et al. (2025) further reinforce this pattern by showing that even when attitudes towards preventive care are positive, uptake remains low when financial and logistical barriers persist. Similarly, Dhingra et al. (2025) highlight that socio-economic status moderates preventive behaviour, reinforcing inequality in access and utilisation.

Cultural and social determinants form a third synthesis domain, operating through shared meanings, norms, and collective expectations regarding health and illness. In several contexts, illness is interpreted through fatalistic or spiritually determined frameworks, reducing perceived personal control over health outcomes. This weakens preventive orientation and shifts behaviour towards reactive care-seeking patterns. Zeng et al. (2025) provide evidence that cultural and structural constraints jointly limit preventive healthcare access among marginalised populations, while Ogunrinde and Aluko (2024) demonstrate that in Nigerian contexts, care-seeking behaviour is often delayed until symptoms become severe.

From a synthesis perspective, cultural determinants interact strongly with cognitive factors, particularly perceived control and self-efficacy. Where cultural beliefs reduce perceived agency, even high health literacy may not translate into preventive action.

Institutional determinants, particularly workplace conditions, constitute a fourth analytical cluster in the synthesis matrix. High workload intensity, limited flexibility, and occupational

stress consistently reduce opportunities for preventive engagement. Smith et al. (2023) demonstrate that workplace organisational culture significantly influences screening uptake independent of individual-level risk perception, indicating that institutional environments shape behavioural feasibility. Within this cluster, preventive health behaviour is often subordinated to occupational demands, creating a structural tension between productivity expectations and health maintenance.

In contrast, institutions that embed structured wellness programmes or provide workplace-based screening opportunities tend to facilitate higher preventive uptake. This indicates that institutional design functions as an enabling or constraining mechanism depending on organisational priorities.

Health system determinants represent the final and most structurally influential synthesis domain. Across studies, the availability, accessibility, and perceived quality of services consistently shape preventive engagement. Weak health systems characterised by long waiting times, limited diagnostic capacity, and poor service responsiveness reduce trust and discourage routine utilisation. Reibling et al. (2022) emphasise that system design significantly determines preventive uptake, while OECD (2023) highlights persistent inequalities in access even within well-resourced systems.

The World Health Organization (2022; 2023) further demonstrates that disruptions such as those caused by the COVID-19 pandemic significantly reduced preventive service utilisation globally, exposing the fragility of preventive health systems under stress. In this synthesis cluster, health system performance operates as a foundational determinant that shapes all other levels of influence.

When integrated across the synthesis matrix, the findings demonstrate clear interaction effects between levels. Cognitive motivation initiates intention, socio-economic conditions determine feasibility, cultural norms shape perceived control, institutional environments influence opportunity structures, and health systems define accessibility and trust. These layers do not operate independently but interact dynamically to produce the observed patterns of preventive behaviour.

A key cross-cutting pattern emerging from the synthesis is the persistent awareness–action gap. Across both high-income and low- and middle-income contexts, individuals often demonstrate adequate awareness of preventive health practices but fail to translate this awareness into sustained action. This gap is consistently attributed to structural constraints rather than informational deficits (World Health Organization, 2023; OECD, 2023; Ameh et al., 2022). Ameh et al. (2022) in particular highlight that in sub-Saharan Africa, affordability, access barriers, and weak system trust remain dominant constraints, even when awareness is present.

Overall, the synthesis matrix demonstrates that preventive health-seeking behaviour is best understood as a multilayered system of interacting determinants rather than a linear behavioural process. The evidence strongly suggests that interventions focused solely on awareness creation are insufficient. Instead, effective strategies must address structural barriers, strengthen health system capacity, reform institutional environments, and enhance socio-economic access in order to produce sustained preventive engagement.

TABLE 1: Synthesis Matrix of Multilevel Determinants of Preventive Health-Seeking Behaviour

Level of Determinant	Key Determinants Identified	Theoretical Alignment	Empirical Evidence Base	Synthesis Interpretation
Individual (Cognitive)	Perceived susceptibility; perceived severity; self-efficacy; health literacy; risk perception	Health Belief Model (Rosenstock, 1974)	Wong et al. (2021); Yang et al. (2024); Lau et al. (2025)	Awareness and risk perception initiate preventive intention, but do not guarantee action when structural barriers exist
Socio-economic	Income level; employment stability; insurance coverage; affordability of care	Andersen Behavioural Model (Andersen, 1995)	Gopalan et al. (2021); Dhingra et al. (2025); OECD (2023)	Economic capacity determines whether preventive intentions are practically feasible
Cultural and Social	Fatalism; gender norms; health beliefs; social expectations; trust in health information	Social Ecological Model (McLeroy et al., 1988)	Zeng et al. (2025); Ogunrinde & Aluko (2024); Rata Mohan et al. (2025)	Cultural meanings and social norms shape perceived control over health and influence preventive orientation
Institutional / Occupational	Workplace culture; workload; time constraints; organisational health policies	Social Ecological Model (Bronfenbrenner, 1977)	Smith et al. (2023); Rata Mohan et al. (2025)	Organisational environments can enable or restrict preventive engagement depending on flexibility and policy support
Health System / Structural	Service availability; accessibility; waiting time; quality of care; trust in health system	Andersen Model + Health Systems Framework	Reibling et al. (2022); WHO (2022; 2023); Ameh et al. (2022)	Health system design is a major determinant shaping access, utilisation, and continuity of preventive care
Policy / Macro-structural	Health financing; inequality; governance; service disruption; system resilience	Social Determinants of Health Framework	GBD 2021 Risk Factors (2024); OECD (2023); WHO (2023)	Policy environment defines overall preventive opportunity structure and system responsiveness

Discussion

The findings of this narrative review provide a refined understanding of preventive health-seeking behaviour as a multilevel and structurally mediated phenomenon. Across the

literature, a persistent awareness–action gap is evident: individuals frequently demonstrate adequate knowledge of preventive health practices and express positive intentions, yet this rarely translates into sustained preventive action. The synthesis indicates that this gap is not a result of informational deficit alone but reflects the interaction of cognitive, socio-economic, cultural, institutional, and systemic determinants that jointly shape behavioural outcomes (World Health Organization, 2023; OECD, 2023).

A critical reading of the evidence shows that cognitive determinants, while important, are insufficient in isolation. Within the Health Belief Model framework, perceived susceptibility and perceived severity are consistently associated with preventive intention. However, their predictive power weakens when structural barriers are introduced. Wong et al. (2021) demonstrate that perceived risk significantly predicts preventive uptake, particularly in vaccination contexts, while Yang et al. (2024) report that health literacy improves intention but not sustained behaviour where access constraints persist. In contrast, Lau et al. (2025) show that even strong positive attitudes towards preventive care do not translate into utilisation when logistical and financial barriers are present. This contrast suggests that intention-based models tend to overestimate behavioural compliance because they insufficiently account for real-world constraints.

Socio-economic determinants provide a more consistent explanatory pattern across studies, although their interpretation varies. Gopalan et al. (2021) and Reibling et al. (2022) both identify enabling resources such as income, insurance coverage, and health system organisation as strong predictors of preventive utilisation. However, Dhingra et al. (2025) extends this interpretation by showing that socio-economic status does not only affect access but also shapes behavioural orientation itself, influencing both intention and action. This contrasts with studies that treat socio-economic factors solely as access barriers, indicating a more embedded relationship between economic position and health behaviour.

Evidence from sub-Saharan Africa further reinforces the dominance of structural constraints while also introducing cultural variation. Ameh et al. (2022) identify affordability, service availability, and health system trust as primary determinants of preventive utilisation. However, Ogunrinde and Aluko (2024) emphasise cultural interpretations of illness, including fatalistic beliefs and delayed care-seeking norms. The divergence between these findings highlights an important interpretive tension: while structural studies emphasise resource constraints, cultural analyses highlight meaning systems that shape perceived necessity of prevention. Together, they suggest that preventive behaviour is simultaneously materially constrained and culturally mediated.

Institutional and occupational contexts introduce another layer of complexity. Smith et al. (2023) demonstrate that workplace organisation and occupational demands significantly influence screening uptake, even after controlling for individual risk perception. This finding contrasts with studies that prioritise individual cognition, suggesting that institutional environments may override personal intention. In high-demand occupational settings, time scarcity and organisational expectations function as indirect barriers to preventive engagement, reinforcing structural explanations of behaviour.

At the broader system level, Reibling et al. (2022) argue that healthcare system design strongly influences preventive uptake across national contexts. This aligns with OECD (2023) and World Health Organization (2023) reports, which highlight persistent inequalities in preventive service access and disruptions in service delivery, particularly following the COVID-19 pandemic. However, a key contradiction emerges when comparing macro-level

reports with behavioural studies: while system-level analyses emphasise structural inequality as the dominant determinant, individual-level studies continue to prioritise psychological factors. This reflects a tension in the literature between structural determinism and cognitive behavioural explanation.

The Social Ecological Model provides a useful integrative framework for reconciling these contradictions. Zhao et al. (2022) demonstrate that community norms and structural environments significantly moderate preventive behaviour, while Smith et al. (2023) show that organisational culture independently shapes screening participation. However, even within ecological studies, variation persists regarding the relative dominance of each level of influence. Some studies emphasise community norms, while others prioritise institutional structures, indicating that contextual specificity determines which level becomes most influential.

A further consistent contradiction across the literature concerns the role of awareness. While studies such as Wong et al. (2021) present awareness as a strong predictor of preventive behaviour, others, including Ameh et al. (2022) and Lau et al. (2025), demonstrate that awareness alone has limited behavioural impact when structural barriers remain unresolved. This divergence reflects methodological differences, where intention-based studies tend to overestimate behavioural translation, whereas utilisation-based studies reveal the constraining effect of access and affordability.

Despite these inconsistencies, a coherent interpretive pattern emerges across the synthesis. Preventive health-seeking behaviour is not driven by a single determinant but by the interaction of cognitive motivation, socio-economic capacity, cultural meaning systems, institutional structures, and health system performance. Cognitive factors generate intention, but structural and institutional conditions determine whether such intention is feasible. Where these layers are misaligned, the awareness–action gap persists.

In summary, the literature demonstrates that preventive health behaviour is inherently contingent and context-dependent. Contradictions across studies do not weaken the evidence base but instead highlight the importance of multilevel interpretation. The most consistent finding is that structural determinants frequently constrain or override cognitive intention, particularly in resource-limited settings. This reinforces the need for integrated theoretical and policy approaches that move beyond individual-level explanations towards structurally informed models of preventive health engagement.

Conclusion and Recommendations

Preventive health-seeking behaviour remains central to the prevention, early detection, and control of non-communicable diseases. This narrative review has shown that preventive engagement is not determined by awareness alone, even though knowledge of disease risk and the benefits of early detection remains important. The findings demonstrate that preventive behaviour is shaped by the interaction of cognitive, socio-economic, cultural, institutional, occupational, and health system determinants. Individuals may recognise the value of screening, monitoring, vaccination, and lifestyle modification, but they may still be unable or unwilling to act when cost, distance, time pressure, cultural belief, poor service experience, or weak health system support limits access.

The review further confirms that the awareness–action gap is best understood as a product of misalignment between individual intention and structural opportunity. The Health Belief Model explains how perceived susceptibility, perceived severity, perceived benefits, perceived barriers, and self-efficacy shape motivation. Andersen’s Behavioural Model of

Health Services Use shows that enabling resources such as income, insurance coverage, service availability, and affordability determine whether preventive intention can become actual utilisation. The Social Ecological Model broadens this understanding by showing that interpersonal influence, workplace culture, community norms, and policy arrangements also shape preventive behaviour. Taken together, these frameworks show that preventive health-seeking behaviour is not a simple personal decision but a socially and structurally shaped practice.

The evidence reviewed also shows that preventive behaviour varies across contexts. In better-resourced settings, psychological motivation and health literacy may play a stronger role because services are more accessible. In low- and middle-income settings, structural barriers such as out-of-pocket expenditure, weak insurance protection, distance to facilities, service delays, and limited diagnostic capacity often weaken preventive uptake. Occupational populations also face distinct constraints, especially where heavy workload, rigid schedules, and organisational expectations leave little time for routine health checks. These findings point to the need for prevention strategies that address both individual motivation and the conditions that make preventive care possible.

This review therefore concludes that improving preventive health-seeking behaviour requires a shift from awareness-centred interventions to integrated, multilevel approaches. Health education remains necessary, but it cannot produce lasting behavioural change when financial, institutional, cultural, and system-level barriers remain unresolved. Sustainable improvement depends on making preventive care affordable, accessible, trustworthy, culturally acceptable, and institutionally supported.

Public health interventions should combine health education with practical access-enhancing measures. Awareness campaigns should move beyond general messages about the importance of prevention and provide clear guidance on available services, screening schedules, risk factors, cost options, and referral pathways. Communication should also be culturally responsive, using trusted community structures, religious institutions, workplaces, and local health actors to reduce fear, fatalism, stigma, and misinformation surrounding preventive care.

Health systems should strengthen preventive service delivery by improving accessibility, reducing waiting time, expanding diagnostic capacity, and enhancing the quality of patient-provider interaction. Preventive services should be integrated more firmly into primary healthcare so that routine screening, health counselling, blood pressure checks, diabetes screening, cancer risk assessment, and lifestyle support become ordinary parts of healthcare contact. Service delivery should be organised in a way that reduces inconvenience for users, especially those in rural areas, low-income communities, and demanding work environments.

Financial protection should be treated as an essential component of preventive health policy. Governments, insurers, employers, and health institutions should reduce out-of-pocket payments for basic preventive services and expand coverage for routine screening and early detection. Where individuals must choose between daily household needs and asymptomatic healthcare, prevention is likely to be postponed. Reducing direct cost barriers will therefore improve equity and increase the likelihood that people will act before illness becomes advanced.

Workplaces should be recognised as important platforms for preventive health promotion. Employers should support routine health checks through on-site screening, flexible medical appointment policies, wellness programmes, health education sessions, and referral linkages

with health facilities. Such measures are particularly important for working adults who may have knowledge of preventive care but lack time or organisational support to access services. Workplace health promotion should not be treated as an occasional activity but as part of organisational responsibility for employee wellbeing.

Policy frameworks should reposition preventive healthcare as a routine and funded part of health system planning. This requires stronger investment in primary healthcare, community-based screening, health workforce capacity, electronic health records, reminder systems, and monitoring of preventive service coverage. Policies should also address inequality by ensuring that vulnerable groups, informal workers, older adults, rural populations, and low-income households are not excluded from preventive services.

Future research should examine how determinants of preventive health-seeking behaviour interact over time and across population groups. Longitudinal and mixed-methods studies are needed to clarify how awareness, intention, access, cultural beliefs, workplace pressures, and health system trust shape preventive behaviour across the life course. More research is also needed on occupational populations, informal workers, and underserved communities, especially in low- and middle-income countries. Future studies should move beyond isolated determinants and examine how combined interventions at individual, institutional, community, and policy levels can produce sustained preventive engagement.

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