KNOWLEDGE AND PRACTICE OF PREVENTIVE SEXUAL AND REPRODUCTIVE HEALTH BEHAVIOURS AMONG MALE CIVIL SERVANTS IN OYO STATE SECRETARIAT, IBADAN, OYO STATE

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DEDICATION

This research work is dedicated to Christ Jesus, the eternal Lover of my soul for His unwavering love towards me, and to my parents, Elder and Deaconess S.E. Adewusi for their support all from the beginning.

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ABSTRACT

Men's leading trend in risky sexual practices, non-utilisation of screening services has been associated with their perceived risk of sexually transmitted infections. Few studies have documented the knowledge, perception and practice of men on preventive sexual and reproductive health behaviour in Nigeria. This study, therefore, assessed the preventive sexual and reproductive health knowledge and practice of male civil servants in Oyo State Secretariat, Ibadan.

The study was descriptive cross-sectional survey that used a four-stage sampling technique to select 272 male civil servants across fourteen selected ministries in the Oyo State Secretariat, Ibadan. A pre-tested semi-structured self-administered questionnaire which contained a 31–point knowledge scale, 33–point perception scale, 17–point practice scale, questions relating to factors affecting the adoption of preventive sexual behaviour and reproductive health among male civil servants was used for data collection. Knowledge scores 0 – 11, > 11 ≤ 21and > 21 were classified as poor, fair, and good, respectively. Perception scores 0 – 17 and >17 were categorised as poor and good perception, respectively and practice scores 0 – 9 and > 9 were categorised as poor and good practice, respectively. The data were analyzed using descriptive statistics, Chi-square test and Fishers exact test at p=0.05.

Respondents' age was 38.0 ± 9.4 years, majority (71.0%) were married and Yorubas (97.8%). Knowledge score was 10.9 ± 5.0; respondents with poor, fair and good knowledge of preventive sexual and reproductive health behaviours were 54.0%, 43.8% and 2.2% respectively. The Perception score was 10.9 ± 5.6 and 87.1% and 12.9% had poor and good perception respectively. The Practice score was 9.3 ± 2.7 and only 49.6% of the respondents had good practice of preventive sexual and reproductive health behaviours. Majority (77.6%) considered lack of adequate knowledge as a factor affecting the adoption of preventive sexual and reproductive health behaviour. Religion/Faith was considered by majority (76.5%) to influence these behaviours, 64.7% agreed that their partners can also affect these behaviours, 67.3% agreed that availability of material support for reproductive health e.g. condom will encourage adoption. Availability of

screening services (65.1%), good attitude of health workers carrying out the screening exercise (69.5%) and trust in healthcare professionals (73.9%) were also considered to influence adoption. The Fishers' exact test showed that there was no significant relationship between the age of the respondents and their knowledge of preventive sexual and reproductive health behaviour but there was significant relationship between their cadre and their knowledge. The test also showed significant relationship between their highest qualification and their knowledge, and also significant relationship between the knowledge and the perception of the respondents. The Chi square test showed that there was no statistically significant relationship between the perception and the practice of the respondents of preventive sexual and reproductive health behaviour.

The respondents' knowledge, perception and practice of preventive sexual and reproductive health behaviour were poor. Inadequate knowledge and religion/faith were major influencing factors. Therefore, trainings to promote good preventive sexual and reproductive health practices of should be designed for the men.

Keywords: preventive sexual and reproductive health behaviours, male civil servants, medical screening, care for reproductive organ, prostate cancer

Word counts: 494

CERTIFICATION

I certify that this work was carried out by Oluwafemi Adewusi in the Department of Health Promotion and Education, Faculty of Public Health, College of Medicine, University of Ibadan, Ibadan, Nigeria.

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TABLE OF CONTENT

		Page
TITLE PAGE		i
DEDICATION		ii
ACKNOWLEDGEMENT		iii
ABSTRACT		iv
CERTIFICATION		vi
TABLE OF CONTENT		vii
LIST OF TABLES		xii
LIST OF FIGURES		xiii
OPERATIONAL DEFINITION OF TERMS		xiv
ACRONYMS		xv
CHAPTER ONE		
INTRODUCTION		1
1.1	Statement of the Problem	2
1.2	Justification of the Study	3
1.3	Research Questions	4
1.4	Broad Objective	5
1.5	Specific Objectives	5
1.6	Research Hypotheses	5
CHAPTER TWO		
LITERATURE REVIEW		6
2.1	Sexual and Reproductive Health	6
2.2	Health Behaviour	7
2.3	Preventive Health Behaviour	9
2.4	Male Gender and Preventive Health Behaviour	10
2.5	Knowledge of Preventive Sexual and Reproductive Health Behaviour	13
2.6	Perception of Preventive Sexual and Reproductive Health Behaviour	14

2.7 Practice of Preventive Sexual and Reproductive Health Behaviour 15

2.8 Factors influencing the adoption of Preventive Sexual and Reproductive Health Behaviour 16

2.9 Theoretical Framework 18

2.10 Application of Health Belief Model to the Knowledge and Practice of Preventive Sexual and Reproductive Health Behaviour among Male Civil Servants 19

CHAPTER THREE

METHODOLOGY 22

3.1 Study Design 22

3.2 Description of Study Area 22

3.3 Target Population 23

3.4 Inclusion Criteria 23

3.5 Exclusion Criteria 23

3.6 Sample Size 23

3.7 Sampling Technique 24

3.8 Instrumentation and Data Collection 31

3.9 Validity of Instrument 31

3.10 Reliability of Instrument 31

3.11 Analysis Procedures 32

3.12 Ethical Approval 33

3.13 Study Limitation 33

CHAPTER FOUR

FINDINGS 34

4.1 Section One: Demographic Characteristics of Respondents 34

4.1.1 Distribution of Respondents based on Age and Marital Status 34

4.1.2 Distribution of Respondents based on Religion and Ethnicity 34

4.1.3 Distribution of Respondents Based on Ministry 35

4.1.4 Distribution of Respondents Based on Highest Educational

	Qualification and Cadre	35
4.2	Section Two: Knowledge of Preventive Sexual and Reproductive Health Behaviours	37
4.2.1	Knowledge of STIs Preventive Behaviour	37
4.2.2	Knowledge of Consumption of Essential Micro-nutrients	37
4.2.3	Prevention of Heavy Elements harmful to SRH	37
4.2.4	Knowledge of Personal Hygiene of the Reproductive Organs	38
4.2.5	Knowledge of Prevention of Pesticides	38
4.2.6	Knowledge of Uptake of Medical Screenings	38
4.2.7	Knowledge of Avoidance of Smoking and Drinking	39
4.2.8	Knowledge of Regular Exercise	39
4.3	Section Three: Perception of the Respondents on Preventive Sexual and Reproductive Health Behaviour	42
4.3.1	Perception of STIs Preventive Behaviour	42
4.3.2	Perception of Consumption of Essential Micro-nutrients	43
4.3.3	Perception of Susceptibility, Detection and Uptake of Medical Screenings	43
4.3.4	Perception of Personal Hygiene of the Reproductive Organs	44
4.3.5	Perception of Prevention of Pesticides and Regular Exercise	44
4.4	Section Four: Preventive Sexual and Reproductive Health Practices of Respondents	49
4.4.1	Practice of STIs Preventive Behaviour	49
4.4.2	Practice of Consumption of Essential Micro-nutrients and Prevention of Pesticides	49
4.4.3	Practice of Uptake of Medical Screenings	49
4.4.4	Practice of Personal Hygiene of the Reproductive Organs and Regular Exercise	50
4.5	Section Five: Perceived Factors Affecting the Adoption of Preventive Sexual and Reproductive Health Behaviours	52
4.6	Relationship between Knowledge and Demographic Characteristics of Respondents	55

4.7 Relationship between Knowledge and Perception of Respondents 58
4.8 Relationship between Knowledge and Practice of Respondents 59
4.9 Relationship between Perception and Practice of Respondents 60
CHAPTER FIVE
DISCUSSION, CONCLUSION AND RECOMMENDATIONS 61
5.1 Socio-demographic characteristics 61
5.2 Knowledge of Preventive Sexual and Reproductive Health Behaviour 61
5.2.1 Knowledge of STIs Preventive Behaviour 61
5.2.2 Knowledge of Consumption of Essential Micro-nutrients 62
5.2.3 Knowledge of Prevention of Heavy Elements harmful to SRH 62
5.2.4 Knowledge of Uptake of Medical Screenings 62
5.2.5 Knowledge of Avoidance of Smoking and Drinking 63
5.2.6 Knowledge of Regular Exercise 63
5.3 Perception on Preventive Sexual and Reproductive Health Behaviour 63
5.3.1 Perception of STIs Preventive Behaviour 64
5.3.2 Perception of Uptake of Medical Screenings 65
5.4 Practice of Preventive Sexual and Reproductive Health Behaviour 66
5.4.1 Practice of STIs Preventive Behaviour 66
5.4.2 Practice of Consumption of Essential Micro-nutrients 67
5.4.3 Practice of Personal Hygiene of the Reproductive Organs 67
5.4.4 Practice of Uptake of Medical Screenings 67
5.4.7 Practice of Avoidance of Smoking and Drinking 68
5.4.8 Practice of Regular Exercise 69
5.5 Perceived Factors influencing the adoption of Preventive Sexual And Reproductive Health Behaviour 69
5.6 Test of Hypotheses 71

5.7 Implication of the Study Findings for Health Promotion and Education 72
5.8 Conclusion 73
5.9 Recommendations 74

REFERENCES 75
APPENDIX 83
Questionnaire 84
Letter of Ethical Approval 90

LIST OF TABLES

Table 3.1: Male distribution in Oyo state secretariat 26

Table 4.1: Demographic Characteristics of Respondents 36

Table 4.2: Knowledge of Preventive Sexual and Reproductive Health Behaviours 41

Table 4.3(a): Perception of Preventive Sexual and Reproductive Health Behaviours 46

Table 4.3(b): Perception of Preventive Sexual and Reproductive Health Behaviours 47

Table 4.3(c): Perception of Preventive Sexual and Reproductive Health Behaviours 48

Table 4.4: Practice of Preventive Sexual and Reproductive Health Behaviours 50

Table 4.5: Factors affecting Adoption of Preventive Sexual and Reproductiv Health Behaviours 53

Table 4.6(a): Relationship between Knowledge of preventive sexual and Reproductive health behaviour and Age of Respondents 54

Table 4.6(b): Relationship between Knowledge of preventive sexual and reproductive health behaviour and Highest Qualification of Respondents 55

Table 4.6(c): Relationship between Knowledge of preventive sexual and Reproductive health behaviour and Cadre 56

Table 4.7: Relationship between Knowledge and Perception of Respondents on preventive sexual and reproductive health behaviour 57

Table 4.8: Relationship between Knowledge and Practice of Respondents on Preventive sexual and reproductive health behaviour 58

Table 4.9: Relationship between Perception and Practice of Respondents on preventive sexual and reproductive health behaviour 59

LIST OF FIGURES

Figure 2.1: Health Belief Model illustrating the factors influencing the practice of Preventive Sexual and Reproductive Health Behaviour 21

Figure 4.1: Knowledge of Preventive Sexual and Reproductive Health 40

Figure 4.2: Perception of Preventive Sexual and Reproductive Health 45

OPERATIONAL DEFINITION OF TERMS

Male Civil Servant: men between the ages of 18 and 60 years employed by the State Government

Preventive Sexual and Reproductive Health Behaviours: include Practice of STIs Preventive Behaviour (abstinence, mutual fidelity, avoidance of multiple sexual partners, use of condom, avoidance of having sex with other men), consumption of essential micro-nutrients, avoidance of heavy elements harmful to SRH, personal hygiene of the reproductive organs, avoidance of pesticides, uptake of medical screenings (screening for STIs/prostate cancer), avoidance of smoking and drinking, regular exercise.

ACRONYMS

HIV: Human Immuno-deficiency Virus

ICPD: International Conference on Population and Development

IEC: Information Education Communication

NBS: National Bureau of Statistics

SRH: Sexual and Reproductive Health

STI: Sexually Transmitted Infection

WHO: World Health Organization

CHAPTER ONE

INTRODUCTION

The International Conference on Population and Development (ICPD) in September, 1994 defines reproductive health as "a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity, in all matters relating to the reproductive system and to its functions and processes. Reproductive health therefore implies that people are able to have a satisfying and safe sex life and that they have the capability to reproduce and the freedom to decide if, when and how often to do so. Implicit in this last condition are the right of men and women to be informed and to have access to safe, effective, affordable and acceptable methods of family planning of their choice, as well as other methods of their choice for regulation of fertility which are not against the law, and the right of access to appropriate health-care services that will enable women to go safely through pregnancy and childbirth and provide couples with the best chance of having a healthy infant" (UNFPA 1994b:7.2).

The developing countries including Nigeria face many health challenges. Health indicators especially in sexual and reproductive health are still poor in Nigeria. Diseases such as prostate cancer, Sexually Transmitted Infections including HIV/AIDS kill several hundred thousands of Nigerians each year (NBS, 2014). The National Agency for the Control of AIDS (NACA) in Nigeria also estimated in 2010 that there are about 3,229,757 HIV infected persons in the country making Nigeria, the country with the second highest burden of HIV in the world, only after South Africa.

"Men in Nigeria suffer the highest burden from prostate cancer with an estimated annual age-adjusted incidence and mortality rates of 22.7 and 18.6 per 100,000, respectively. This accounts for 18.2% and 17.7% respectively, of all cancer-related diagnoses and deaths, in men in this region. Given that Nigeria is the most populous country in Africa with an estimated population of 160 million in 2012, the rates and percentages above translate to an enormous burden in absolute numbers of men affected by Prostate Cancer" (Nigeria Prostate Cancer Research Symposium, 2014).

Findings consistently show that men seek help less often than women and underutilize medical and health services (Mansfield et al., 2003). Masculine gender socialization in the society has been argued to explain underutilization and decreased help-seeking in men (Addis & Mahalik, 2003; Benett & Rosalind, 2006).

Studies have also shown that black men suffer a disproportionately higher burden of disease than any other ethnic and racial group in the world (ICC, 2004). Black men in particular have been labeled an "endangered species" due to health, socio-economic, political, and psychological issues affecting this group (Braithwaite, 2001).

Reports are beginning to reveal high risk, susceptibility and prevalence of non-gender specific diseases among men in comparison to women in Nigeria. Reports suggest men are more at risk of developing tuberculosis (TB) than women. A study carried out by Jumbo and his colleagues (2013) in TB referral centers in Bayelsa, Delta and Rivers states in Nigeria revealed that out of a total of 2625 HIV negative TB patients, 1612 (61.4%) were males while 1013 (38.6%) were females . Tuberculosis is commoner in men than women and this sex differences in prevalence begin to appear between ages 10 to 16 and remain higher for males than females. This confirmed several other studies where men are more represented than females due to non-utilization of medical services, negligence on their health status and non-adoption of preventive health practices.

1.1 Statement of the problem

Men have generally been reported to show lackadaisical attitude in taking care of their sexual and reproductive health. However, living healthy by the men is not only essential for them but also for the entire nation since they are leaders in the family and community acting as husbands, uncles, religious leaders, government officials (United Nation, 1992; Galdas et al, 2004; European Commission, 2011).

As noted by Jeanfreau (2011), male-focused preventive or health promoting care is usually not provided. For instance, the National Demographic Health Survey (NDHS), a national health document in Nigeria which contains many preventive sexual and reproductive health variables such as current use of contraceptives, high risk fertility behaviour, access

to health care, nutritional and diet behaviour are targeted towards women and children, neglecting the men population.

Some of the available indicators reported in the NDHS in 2013 show that the men folk are highly at risk of diseases due to the exhibition of negative health behaviours such as sexual risky practices, smoking and tobacco use, non-engagement with preventive care, poor uptake of health care services.

For example, a much larger proportion of men (13%) than women (1%) reported having two or more sexual partners and the prevalence of self-reporting of STIs among men is unacceptably low at 2% (NPC and ICF International, 2014). Although 71% of men know a place where they can get an HIV screening services however, 78% of them have never been tested for HIV (NPC and ICF International, 2014). The report also revealed that tobacco use, a bad preventive practice for reproductive health is only common among the males and that the majority of women in Nigeria do not use tobacco.

1.2 Justification of the study

The American Public Human Service Association (APHSA) in a pathway policy brief noted that prevention, early identification, and behavioural health intervention strategies are integral components of a holistic health and human service delivery system serving individuals across the lifespan. Although preventive health behaviour has great benefits, constituting not only a major means to increased life expectancy but also an improved quality of life for men, little is known about their knowledge, perception and practice of these sexual and reproductive preventive health behaviour and hence the focus of this study.

To say that improvement in the health of the work force is an improvement in the socio-economic development of a nation is not an overstatement because an ill worker cannot be a productive worker. It is only a healthy labour force that can be a productive one, thus leading to socio-economic growth and hence the rationale for this study among the civil servants. Also, the NDHS (2013) revealed that only about 2 out of 10 men in Oyo state

have been tested for HIV and men in the secretariat represent the men in the state and hence the rationale for this study among the men in the secretariat.

Cultural and societal beliefs and expectations tend to make men responsible for making sexual and reproductive health decisions that is, deciding when, where and how sex will take place. This heightens not only men's but also women's vulnerability to HIV/AIDS and other sexually transmitted infections (Asanaenyi, 2014). Therefore, even though women bear the heaviest burden of sexual and reproductive health challenges, men are critical in determining the extent of this burden.

This study therefore will contribute to knowledge by not only assessing the knowledge, perception and practices of male civil servants in Oyo state on how to prevent sexual and reproductive health diseases but also highlight factors influencing them on the adoption of preventive behaviours. The result of this study will provide insight into factors to be considered in health policies formulation, health programming and evaluation especially for the men.

1.3 Research questions

The study had the following research questions:

1. What is the knowledge of the male civil servants on preventive sexual and reproductive health behaviours?
2. What is the perception of the male civil servants towards preventive sexual and reproductive health behaviour?
3. What are the preventive sexual and reproductive health practices among the male civil servants?
4. What are the factors affecting the adoption of preventive sexual and reproductive health behaviour?

1.4 Broad objective of the study

The broad objective of this study is to investigate the knowledge and practice of preventive sexual and reproductive health behaviour among male civil servants in Oyo State secretariat, Ibadan, Oyo State.

1.5 Specific objectives

The specific objectives of this study were as follow:

1. To assess the knowledge of male civil servants on preventive sexual and reproductive health behaviour.
2. To determine the perception of male civil servants towards preventive sexual and reproductive health behaviour.
3. To examine the preventive sexual and reproductive health practices among the male civil servants.
4. To identify factors affecting the adoption of preventive sexual and reproductive health behaviour among male civil servants.

1.6 Research hypotheses

Ho_1: There is no significant relationship between the socio-demographic characteristics of the male civil servants and their practice of preventive sexual and reproductive health behaviours.

Ho_2: There is no significant relationship between the knowledge of the male civil servants on preventive sexual and reproductive health behaviours and their practices.

Ho_3: There is no significant relationship between perception of the male civil servants on preventive sexual and reproductive health behaviours and their practices.

CHAPTER TWO

LITERATURE REVIEW

2.1 Sexual and Reproductive Health

Sexual and reproductive health is a broad concept encompassing health and well-being in matters related to sexual relations, pregnancies, and births. It relates to the health and well-being of individuals, families, and society, and is increasingly part of international and national development discourse (PRB, 2008).

Reproductive health care is defined as the "constellation of methods, techniques, and services that contribute to reproductive health and well-being by preventing and solving reproductive health problems. Reproductive health care also includes sexual health, the purpose of which is the enhancement of life and personal relations, and not merely counseling and care related to reproduction and sexually transmitted infections" (UNFPA, 1994).

As defined by the World Health Organization (2000), sexual health is "enjoyment of sexual relation without exploitation, oppression or abuse; safe pregnancy and child birth and avoidance of unintended pregnancies; absence of sexually transmitted infections including HIV". Sexual health and reproductive health is in close connection with and, in addition to supporting normal body functions such as pregnancy and childbirth, aim to reduce adverse outcomes of sexual activity and reproduction. They are also about empowering everyone, including adolescents and those older than the reproductive years, to have safe and satisfying sexual relationships by tackling obstacles such as gender discrimination, inequalities in access to health services, restrictive laws, sexual coercion, exploitation, and gender-based violence (WHO, 2015).

Poor sexual and reproductive health has complex and far reaching effects on individuals as well as relationships in the community. These could include unintended pregnancies, sexually transmitted infections including HIV, genital and gynecological cancers, sexual violence.

Globally, more than one billion people are infected with one STI or the other and every year, 1.7 million die from these infections (WHO, 2012; WHO, 2014). About one million men and women aged 15–49 contract one of four major curable STIs: gonorrhea, syphilis, chlamydia and trichomoniasis daily (WHO, 2012). In developing countries, an estimated 204 million women of reproductive age contract one of these four STIs each year (WHO, 2012). Report also indicate that sexually active men and women may also be at risk of contracting viral STIs—including hepatitis B, genital herpes, HPV and HIV—which are not curable but can be managed through treatment.

Estimates for 2014 revealed that sexual and reproductive health services fall well short of needs in developing regions including the sub-Saharan Africa. About 225 million women who want to avoid a pregnancy are not using an effective contraceptive method. STIs other than HIV receive relatively little attention but take an enormous toll on the peoples reproductive health. In developing regions each year, an estimated 204 million women have one of the four major curable STIs (chlamydia, gonorrhea, syphilis or trichomoniasis), but 170 million (82%) do not receive STI services (UNFPA, 2014). The HIV and AIDS epidemics still remain a major setback for development in many African countries. The continent has been reported as one of the regions with the largest percentage of People Living with HIV and AIDS (between 15-49 years) globally. In Sub-Saharan Africa, for example, about 22.5 million people are living with HIV and AIDS (NACP, 2011).

2.2 Health Behaviour

According to the Encyclopedia of Public Health, health behaviour or health-related behaviour refers to "any action that is related to disease prevention, health maintenance, health improvement, or the restoration of health. The actions of individuals, groups and organizations, as well as the determinants, correlates and consequences of these actions – which include social change, policy development and implementation, improved coping skills, and enhanced quality of life".

According to Mechanic, (1978), "health behaviour include activities engaged in and modalities used by the individual, voluntary and in specific instances under threat of sanction by society, to (a) prevent; (b) detect disease, defect, injury and disability; (c) promote and enhance health; and (d) protect the individual and the group from risk of actual disease, defect, injury and disability".

In his own working definition, David Gochman defined health behaviour as "those personal attributes such as beliefs, expectations, motives, values, perceptions, and other cognitive elements; personality characteristics, including affective and emotional states and traits; and overt behaviour patterns, actions and habits that relate to health maintenance, to health restoration and to health improvement" (Gochman, 1997). He proposed health behaviour to include not only observable, overt and outward actions but also mental events and emotional states that can be reported and measured. It stressed the link between the actions and health of the individuals. This implies that health behaviour include actions which are intentionally aimed at individual's health and actions which are not intentionally aimed at the health (Gochman, 1997).

"Health-related behaviour is one of the most important elements in people's health and well-being". The last twenty years have witnessed much effort in reduction of morbidity and mortality through changes in health-related behaviour especially changes in lifestyle habits and involvement in screening programmes. Although there has been increase in awareness the disease aetiology, healthy and risky behaviour, this has not always led to healthier behaviours with experience from studies on HIV/AIDS (Encyclopedia of Public Health). Health behaviours have fundamental consequences for determining both the quality and longevity of life by influencing disease outcomes.

Kasl and Cobb (1996) classified health behaviours into three;

(a) Preventive Health Behaviour: "any activity undertaken by a person who believes himself or herself to be healthy for the purpose of preventing or detecting illness in an asymptomatic stage".

(b) Illness Behaviour: "any activity undertaken by individuals who perceive themselves to be ill for the purpose of defining their state of health, and discovering a suitable remedy".

(c) Sick-role Behaviour: "any activity undertaken by those who consider themselves to be ill for the purpose of getting well".

2.3 Preventive Health Behaviour

In a seminar by Kasl and Cobb (1996), it was reported that preventive health behaviour could include self-protective behaviour, also known as cautious behaviour, which is an action intended to confer protection from potential harm such as wearing a helmet when riding a bicycle, using seat belt or wearing a condom during sexual activities. They observed that responses to these health behaviours are quite different compared to those developed to treat diseases that have already been diagnosed through symptoms, tests or medical opinion. Therefore, the decision to adopt preventive health behaviour is based on other factors which are less objective than those symptoms or formal diagnoses given by a doctor.

Preventive services are those performed on a person who has not had the preventive screening done before and does not have symptoms or other abnormal studies suggesting abnormalities; or has had screening done within the recommended interval with the findings considered normal; or has had diagnostic services results that were normal after which the physician recommendation would be for future preventive screening studies using the preventive services intervals; or has a preventive service done that results in a therapeutic service done at the same encounter and as an integral part of the preventive service (e.g. polyp removal during a preventive colonoscopy), the therapeutic service would still be considered a preventive service.

Werle, (2011) observed that several preventive health behaviours present advantages not easily accessible in the short term (like the effects of a balanced diet in cholesterol levels, obesity and heart disease prevention), while its costs impact the consumer's life directly (i.e., the control of sugar or fat consumption through following a balanced diet).

2.4 Male Gender and Preventive Health Behaviour

Kehler (2004) pointed out that gender is an increasingly important concept in explaining how men and women experience and respond to health prevention or promotion programs and interventions and their outcomes. Exploring the social construct of gender in the context of health and help-seeking in ethnocultural visible minority populations is vital to effective provision of services are culturally and gender acceptable.

Nigeria runs a patriarchal system like most of the African culture where men are placed to fulfill societal constructs of masculinity such as playing roles of breadwinner, protection and maintaining the integrity of the family, exercising authority in all matters and covertly permitting male promiscuity amongst others (Jeanfreau, 2011).

The Men's Health Forum (MHF) in a policy development paper "Getting It Sorted" (MHF, 2004) defined male health issue as "one arising from physiological, psychological, social or environmental factors which have a specific impact on boys or men and/or where particular interventions are required for boys or men in order to achieve improvements in health and well-being at either the individual or the population level"

White (2006) stated in a paper presentation that "the first challenge facing those of us working in the field of men's health is to recognize that it is a "field." It has its own developing theory base, it covers a distinct subject area, and there are a growing group of academics, practitioners and organizations working in the area. As with any new field, it needs to be researched, debated, and campaigned for".

Many studies have shown that there are health disparities and clear inequalities in gender, age and social class. Even though there are researches conducted on the preventive health behaviours of males, many of these researches were conducted in the developed countries which have dissimilar characteristics with their developing counterparts such as Nigeria. In a study on the preventive health practices in Barcelona in 2006, it was discovered that, the number of people who adopted preventive practices such as anti-smoking advice, blood pressure measurement and flu vaccination in health centres is greater in public health services (Daban et al., 2007). However, there is a wide gap in comparing the health

of African men in the sub-saharan region with their white counterparts in the developed countries. According to report, the health of African American men is dire when compared to their white counterparts. "African-American men have a higher prevalence and incidence of disease such as diabetes, HIV infection and heart diseases" (Scott, 2011, p. 282).

According to Robertson and his colleagues (2008), there has not been much evidence on how to improve men's uptake of health services. This may probably be due to insufficient data and reports on their knowledge of the intrinsic and extrinsic benefits of this practice; non-assessment of their perceptions based on their contextual exposure in the community which consequently influence their attitudes and practices of these important preventive behaviour.

Investigation of men's health-related preventive health behaviour has great potential for improving men and consequently the families' lives and reducing national costs through the development of responsive and effective intervention. Health promotion and education interventions must be targeted at these men to enlighten and empower them in making healthy choices. In his report, Jeanfreau (2011) stated that the health of men is critical to the family in that the family may eventually live in poverty as a result of being left without the father's income, especially in the patriarchal culture found in Africa where the man is the breadwinner.

Men play powerful roles in the society. They are fathers, husbands, uncles, religious leaders, doctors, policy makers, local and international leaders, etc. Addressing men's shared responsibility and promoting their active involvement in sexual and reproductive health and behaviour including safe sex, family planning, responsible parenthood, parental, maternal and child health has long been identified as a means to achieving positive national development (United Nation, 1992: 27). Ushie and his colleagues (2011) however noted that information on reproductive behaviour is usually given during antenatal, postnatal clinics, attended typically by women. Implicit in this is that the males are excluded.

In their report, Greene, Mehta, Pulerwitz, Wulf, Bankole and Singh stated that there are disparities in male sexual and reproductive behaviour even among social and ethnic groups within a single country across the developing world and, some broadly similar patterns across regions do emerge. In almost about thirty nine developing countries, the majority of men between 20-24 years reported having had sexual intercourse before their 20th birthday and a substantial proportion first had sex before their 15th birthday. A range of 2 to 6 in 10 had more than one partner in the past year of the report among unmarried men aged 15–24 who have ever had sex,. However, despite these high levels of youthful sexual activity in most Sub-Saharan African region, fewer than half of sexually active men 15–24 practise the use of contraceptive method or rely on their partner's contraception.

In a qualitative study conducted among men in Botswana by Rakgoasi and Odimegwu (2013), it was observed that, while both men and women were at risk of HIV infection, men were not taking full advantage of HIV prevention and treatment services. Some of the men attributed this reluctance to ignorance resulting from the fact that men were left out of the sexual and reproductive health discourse from the start. So they perceive male involvement as an attempt to use men in order to affirm and empower women.

It was also reported that many of the men generally have good knowledge of the risks and undesirability of multiple sexual partnerships and that they do not need more than one partner to prove their manhood. However, many excused themselves to engage in multiple sexual partnerships, just to hold on to their masculinity especially against the "empowered women" (Rakgoasi and Odimegwu, 2013).

Rakgoasi and Odimegwu, (2013) revealed that many men are willing to challenge some of the culturally held masculine beliefs in favour of holding masculine roles that emphasize equality, and health seeking outcomes. However more research was suggested so as to provide the evidence base needed for understanding and dealing with the context specific factors that give rise to certain types of masculinities. Such research will engage men and masculinities, and thus supporting the evidence base needed to design sexual and reproductive health policy and programmes in order to address men's sexual and

reproductive health needs in the context of HIV prevention (Rakgoasi and Odimegwu, 2013).

2.5 Knowledge of Preventive Sexual and Reproductive Health Behaviour

The UNAIDS (2008) noted that the first step to take in the battling the HIV pandemic is improving the general knowledge on HIV and efforts from local and international interventions, including extensive HIV prevention programs, have succeeded in improving HIV knowledge and awareness around the globe. At least every seven men out of ten men in Nigeria know that a healthy-looking person can have HIV and that using condoms consistently and correctly and limiting sexual intercourse to one uninfected partner can reduce the risk of HIV infection (NPC and ICF International, 2014). A research conducted in Malawi by Ntata, Muula, Siziya and Kayambazinthu in 2009 showed that many young men in the university have high level of HIV knowledge.

However, other studies have documented low knowledge about condom use among men. Daniel Yaw Fiaveh (2012) noted that despite several interventions, the overall awareness and use of condoms remains low and efforts at increasing condom use among people who are sexually active is still a challenge. In Nigeria, the National Demographic Health Survey in 2013 acknowledged that the overall awareness about HIV prevention and treatment among men has increased only by 1% since 2008 despite government's efforts to increase awareness of HIV prevention and treatment.

Moreso, several studies show little effect on the use of condom with increased knowledge of its protective benefits (Williams, Taljaard, Campbell, et al., 2003; Essien, Mgbere, Monjok, Ekong, Abughosh and Holstad, 2010). The National Demographic Survey in Nigeria in 2013 revealed that the fact that the knowledge about HIV transmission and prevention is high among men has not caused significant increase in the practice of preventive sexual and reproductive behaviour. The report revealed that although seven out of every ten men in Nigeria know where HIV screening can be done, as much as 78% of them have never been tested for HIV.

2.6 Perception of Preventive Sexual and Reproductive Health Behaviour

HIV risk perception has been identified as an important predictor for one's adoption of preventive behaviour against the infection (Macintyre, 2004). Misperceptions on HIV ways of transmission may lead to wrong preventive actions. Despite the increase in HIV prevention knowledge, people still engage in risky sexual behaviour, even in countries with high HIV prevalence (Judith Lammers, Sweder van Wijnbergen and Daan Willebrand, 2013). A systematic analysis of condom use in four different cities in sub-Saharan Africa showed no significant increase of condom use even among populations with higher HIV prevalence rates (Lagarde E, Auvert B, Chege J, et al, 2001).

This, according to Judith Lammers, Sweder van Wijnbergen and Daan Willebrand (2013) is less surprising if people are unaware of the level of risk of contracting HIV or other STIs when having unprotected sexual intercourse, i.e. knowing how to reduce risk may not change behaviour if the risk perception is low. The degree of risk perception of unprotected sex is not often addressed in HIV prevention campaigns and neither are evaluations on the relation between risk perception and preventive behavior widely incorporated in the empirical research on condom use. Daniel Yaw Fiaveh, (2012) concluded that although the majority of men who have ever had sexual intercourse have the knowledge that condom protect against HIV, a substantial number of them think that having sex with the use of a condom is inferior because it reduces sexual pleasure.

Studies across Nigeria show differences in the knowledge of HIV/AIDS transmission and prevention, risk perception among men. A study by Ekanem and colleagues (2005) among intra-city male commercial drivers and motor park attendants in Lagos reported that while 96.4% had proper perception of being at risk of HIV/AIDS infection, 74.3% still engaged in high risk sexual practices and only 11.6% consistently used condom during sex with casual partners. However, Awosan, Ibrahim, Arisegi and Erhiano (2014) reported low risk perception of HIV among male drivers in Sokoto.

2.7 Practice of Preventive Sexual and Reproductive Health Behaviour

Generally, males across all ages have greater incidence of serious health problems and higher rates of death than do females for all the leading causes of death including sexual and reproductive health. Much of the explanation for these outcomes lies in the greater involvement of men in highly risky health behaviors. The traditional male gender role encourages risk-taking behaviors as acceptable male conduct (Nicholas, 2000). For example, excessive alcohol and tobacco use are greater in men than in women, and these are detrimental to sexual and reproductive health. Nicholas (2000) opined that men are more likely than women to delay seeking medical care as a result of ignoring cancer symptoms.

In a survey in Canada, the results show that 46.4% of individuals had one partner during the last twelve months preceding the survey while 21.9% had two or more partners. The survey also reported that thirty four percent of the men used condom the last time they had sexual intercourse and this utilization was more frequent in younger people, the 15 to 29 years old group, than in respondents aged 30 years and over. Chandra, Mosher, Copen and Sionean (2011) reported that the median number of opposite-sex partners in lifetime for males ranges between five and seven, with three to four opposite-sex partners.

Similarly, in a research conducted among male sexual workers in Thailand Thirty-five percent of the men reported ever having been tested for HIV while about one-fifth of them reported they had received counseling and/or advice, and eight stated they had received STI diagnosis and treatment. However, many of them reported to have accessed sexual health services at a hospital or clinic in the past one year. Trustworthiness and credibility were the most common criteria reported by the men in choosing a sexual health venue (UNESCO, 2012).

A report by Drinkware (2013) shows that there has been a similar pattern of drinking for young and adult men in the United Kingdom. Up to 67% of adult men were reported to take alcohol in 2011 while 52% of men aged 16-24 years take alcohol in 2011.

Odejide (2006) stated that although there were no rules in black and white prohibiting females and adolescents from drinking in the traditional Nigerian society, alcohol consumption is synonymous with male adults. Production and intake of alcohol in the modern Nigeria is on the increase (Chikere and Mayowa, 2011) and the volume is highly unrecorded due to illegal and local productions (Jernigan & Obot, 2006).

According to the NDHS in 2013, thirteen percent of men in Nigeria were reported having two or more sexual partners in the 12 months preceding the survey and men have a mean of 4.1 lifetime sexual partners. Also, five in every hundred men reported ever paying for sexual intercourse within the last one year of the survey. However, two in three men who reported engaging in paid sex used a condom the last time they paid for sex. The practice of condom use by men who paid for sexual intercourse is highest among those age 20-24 years. It was also reported that the proportion of men reporting that they used a condom the last time they paid for sex increases with increasing wealth.

Another vital preventive sexual and reproductive health practice is accessing medical screening for HIV and other STIs. Among men in Nigeria, only twenty percent of them have ever gone for an HIV screening. Likewise, as low as two out of every ten men reported having an STI in the past 12 months of the survey while 45 percent seek advice or treatment from a health facility or health professional and twenty percent of men did not seek advice or treatment (NPC and ICF International, 2014).

2.8 Factors influencing the adoption of Preventive Sexual and Reproductive Health Behaviour

In a research conducted among male sexual workers in Thailand, some of the factors that affect the practice of preventive sexual and reproductive health behavior include inconvenient service hours by the health facilities providing some of these preventive sexual **a**nd reproductive health services, long waiting hours at the facilities and lack of trust in the confidentiality and privacy in the services. Other identified factors are disrespectful and judgmental attitude of service providers/health workers (UNESCO, 2012).

According to Rakgoasi and Odimegwu (2013), men were not accessing HIV prevention and treatment services and this was as a result of ignorance resulting from the fact that men were left out of the sexual and reproductive health discourse from the start. Adegoke (2010) reported that knowledge and awareness of the damaging effects of health compromising behaviours are factors influencing the adoption of preventive sexual and reproductive health. He admitted that this is evident in the number of men who claimed to abstain from cigarette smoking and alcohol consumptions. Also, the consumption habit of men is largely dependent on their knowledge of the nutrients of foods consumed (Adegoke, 2010).

In addition, religion and culture were reported as factors affecting the adoption of preventive sexual and reproductive health behaviour. For example, majority of men who neither smoke nor drink alcohol do not do so because their religions preach against it and the fact that health beliefs influence health behaviour is an indication that culture is one of the broader social factors affecting human behaviours (Adegoke, 2010).

UNFPA (2014) reported that determinants of sexual and reproductive health where improvements are needed include provision of accurate information and education, provision of a range of modern methods, logistics to ensure a continuous flow of supplies, training for health workers, availability and adequacy of service sites, supply of community-based workers, and availability of counseling on methods, stigma and gender inequality.

2.9 Theoretical Framework

Using the Health Belief Model (HBM) which was developed in the 1950s by psychologists working in the U.S. Public Health Service (Hochbaum, Rosenstock, Leventhal, and Kegeles) as a way to explain why medical screening programs offered by the United States Public Health Service, particularly for tuberculosis, were not very successful (Hochbaum, 1958). The underlying concept of the Health Belief Model is that health behaviour is determined by personal beliefs or perceptions about a disease and the strategies available to decrease its occurrence (Hochbaum, 1958). Individual perception of health services is influenced by the several interpersonal factors affecting health behaviour. The HBM has four constructs: perceived susceptibility, perceived seriousness, perceived benefits and perceived barriers. Each of these perceptions individually or in combination can be used to explain the preventive health-seeking behaviour of the male civil servants considering their knowledge, perception, practices and factors influencing their practices.

Perceived susceptibility or personal risk can be considered as one of the most powerful perceptions in prompting people to adopt healthier behaviour and seek health services because the greater the perceived risk by an individual, the greater the likelihood of engaging in behaviours to decrease the risk, prevent the disease and the greater the likelihood of seeking health services.

Perceived severity refers to an individual's belief or perception about the seriousness or severity of a disease. McCormick-Brown (1999) stated that while the perception of seriousness is often based on medical knowledge or information, it may also come from beliefs a person has about the difficulties a disease would create or the effects it would have on his or her life in general.

Perceived benefit is a person's opinion of the value or usefulness of a new behaviour or health services in decreasing the risk of developing a disease. Perceived benefits play an important role in the adoption of secondary preventive behaviours such as screenings.

Perceived barrier is an individual's own evaluation of the obstacles in his or her way of adopting new health behaviour or accessing a health service. Janz and Becker (1984) believed that perceived barrier is the most significant in determining behaviour change. The Centers for Disease Control and Prevention (2004) opined that in order for a new behaviour to be adopted, a person needs to believe that the benefits of this new behaviour outweigh the consequences of continuing the old behaviour.

The HBM also recognized modifying factors such as sex, age, culture, religion, socio-economic status, educational status, motivation, past experience and other socio-demographics as determinants in adopting new sexual and reproductive preventive health behaviours or accessing health services.

The HBM also suggests that behaviour is also influenced by cues to action. These are events, people, or things that move people to change their behaviour. Examples include illness of a family member, media reports (Graham, 2002), advice from others, reminder postcards from a health care provider (Ali, 2002) or health warning labels on a product.

In 1988, self-efficacy was added to the beliefs of HBM (Rosenstock, Strecher, & Becker, 1988). Self-efficacy according to Bandura (1978) is the belief in one's own ability to do something.

2.10 Application of Health Belief Model to the Knowledge and Practice of Preventive Sexual and Reproductive Health Behaviour among Male Civil Servants

Perceived susceptibility: When men perceive that they may become infected with STIs during unprotected sexual intercourse or believe they have engaged in risky sexual behaviours, they will adopt preventive sexual and reproductive health behaviours such as condom use and increase their medical screening services uptake. However, poor perception such as "I can never be infected with STIs", "HIV is only contracted by women", "prostate cancer affects only wealthy men" or that smoking and alcohol consumption cannot affect their sexual performance will limit the likelihood of adopting positive sexual and reproductive preventive behaviour.

Perceived severity: Belief that sexually transmitted infections can cause infertility which causes social stigma or that prostate cancer can cause great pain and even untimely death will influence their decisions to adopt preventive measures.

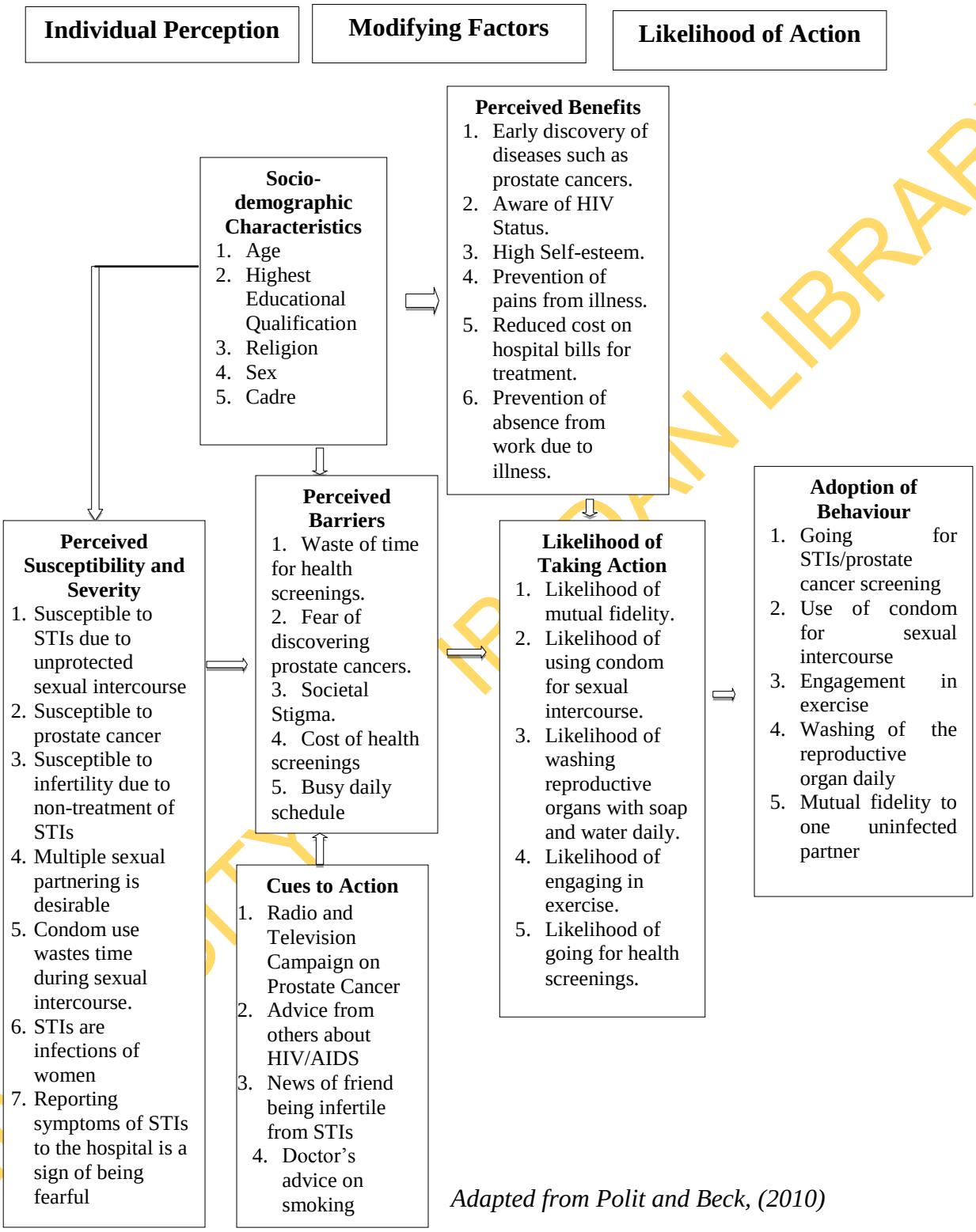
Perceived benefit: When men believe that there are benefits in going for health screenings such as early prostate cancer treatment which may prevent death. Also, beliefs that condom is protective enough to prevent STIs infection will affect their use of it.

Perceived barrier: Men who are always busy at work, faced with societal stigma of not being masculine enough when they report abnormal signs in their reproductive organs to the hospital and even fear of discovering prostate cancer will likely not go for medical screenings. The cost of screening services and purchase of condoms, the complexity of hospital registration process can also be perceived barriers to adopting these preventive behaviours.

Modifying factors: The age, religion, educational qualification and cadre may also influence how much can be paid for the cost of adopting these preventive health practices.

Cues to action: Some factors can prompt the men to adopt preventive sexual and reproductive health behaviour. For example, knowing a friend who died of AIDS or prostate cancer, or who suffers from infertility due to non-treatment of STIs will prompt the men to adopt preventive health behaviours.

Self-efficacy: Men do not try to do something unless they think they can do it. This implies that adopting preventive health behaviours by these men is only possible when they believe in themselves as being capable of doing so.



Adapted from Polit and Beck, (2010)

Figure 2.1 Health Belief Model illustrating the factors influencing the practice of Preventive Sexual and Reproductive Health Behaviour

CHAPTER THREE

METHODOLOGY

3.1 Study Design

This study was a descriptive cross-sectional research. It is a behavioural diagnostic study that identifies knowledge, perception, practices and factors affecting sexual and reproductive preventive health behaviour of male civil servants. The study utilized quantitative method of data collection using structured self-administered questionnaire and the major variables in the questionnaire are the socio-demographics; knowledge of male civil servants on sexual and reproductive preventive health behaviour; perception of male civil servants towards sexual and reproductive preventive health behaviour, sexual and reproductive preventive health practices and the factors affecting the adoption of this behaviour.

3.2 Description of Study Area

The study area is Ibadan, the capital of Oyo state which is located within the Southwest of Nigeria. Ibadan is the largest city in West Africa with an estimated population of 1,338,659 (NPC, 2006). It lies roughly on latitude 7^{o}N and 4^{o}S and occupies a total land area of 9,756km^{2}. It is located at the boundary between the rain forest and the grassland region of the southwestern part of Nigeria. Ibadan city is bounded by Lagelu LGA on the northern and eastern sides, Akinyele LGA on the northern and western sides and Oluyole LGA on the south and south western sides.

Oyo State Secretariat is located in Ibadan. It consists of nineteen (19) ministries. These ministries are Ministry of Agriculture and Natural Resources, Ministry of Industry, Applied Science and Technology, Ministry of Economic Planning and Budgeting, Ministry of Education, Ministry of Environment and Habitat, Ministry of Establishment and Training, Ministry of Finance, Ministry of Health, Ministry of Information and Orientation, Ministry of Justice, Ministry of Lands and Housing, Ministry of Local Government and Chieftaincy Matters, Ministry of Physical Planning and Urban, Development, Ministry of Special Duties, Ministry of Trades, Investment and

Cooperatives, Ministry of Water Resources, Ministry of Women Affairs, Ministry of Works and Transport, Ministry of Youth and Sports.

Previous studies conducted among the civil servants in Oyo state secretariat have shown that men adopt less of preventive health behaviour and are at higher risk than their female counterparts. Ibrahim (2011) reported that females are very slightly better in fruit consumption, a preventive healthy practice than males and hence the rationale for focusing this study on the men population in the secretariat.

3.3 Target Population

The target population of this study were male civil servants who are currently engaged in active service with the state ministries inside the Oyo State Secretariat. This site was selected because it is a workplace with large number of men and with the assumption that the population has some level of education which varies from one another.

3.4 Inclusion Criteria

Males within the age range of 18 – 60 years currently with the Oyo State Government in the State Secretariat and willing to give an informed consent was included in the study.

3.5 Exclusion Criteria

Male casual workers at the state secretariat and female workers were excluded in the study.

3.6 Sample Size

The sample size for the study would be a total of 272 male civil servants. This sample size was calculated using this formula by Lesley Kech (1978):

$$n = \frac{Z^2 (pq)}{d^2}$$ where n = minimum sample size

Z = 1.96 (Confidence Interval at 95%)

d = (0.05 Level of Precision)

p = 19.9% (Prevalence of men who have been tested for HIV in Oyo State)

q = 80.1% (1-p)

$$n = \frac{1.96^2 \times 0.199 \times 0.801}{0.05 \times 0.05} = 244.9 \approx 245$$

Adjusting the sample size for 10% non-response rate:

$$n_f = \frac{n}{1-NR}$$

Where:

n_f = Adjusted sample size due to non-response

NR = Non-response rate of 10%

$$n_f = \frac{245}{1-10\%} = 272.2 \approx 272$$

3.7 Sampling Technique

Multi-stage sampling technique was employed in recruiting the participants for this study.

First Stage: A simple random sampling (balloting) was carried out to select 14 ministries out of the 19 ministries (75%). This was to ensure adequate representation of the entire ministries in the secretariat. The Ministries selected are;

1. Agriculture and Natural Resources
2. Economic Planning and Budgeting
3. Education
4. Establishment and Training
5. Finance
6. Health
7. Justice
8. Industry, Applied Science and Technology

9. Information and Orientation
10. Local Government and Chieftaincy Matters
11. Physical Planning and Urban, Development
12. Special Duties
13. Works and Transport
14. Youth and Sports

Second Stage: Proportionate sampling (from the total number of men in each of the selected ministry) was used to determine the number of men to be selected from each of the fourteen (14) ministries.

Third Stage: A systematic sampling was used to select the number of offices in each of the departments. The number of offices in each selected ministry was counted and intervals were calculated for each ministry based on the number of offices in the ministries and the number of men to be selected from the ministry. Simple random selection (casting coin) was done between the first and the second office and the interval was thereafter applied in selecting the offices in each ministry.

Fourth Stage: A simple random sampling (balloting) was used to select the calculated eligible participants where there is more than one man in the office.

Below is the table showing the estimated male population in the sampled ministries and the proportionate sampled number of participants.

Table 3.1: Male distribution in Oyo state secretariat

S/N	List of Ministry	Estimated Male Population	Proportionate Male Sampling Calculation	List of Departments	Number of men/Ministry
1.	Agriculture and Natural Resources	495	$\frac{495}{2357} \times 272 = 57.12$	Administration and Supplies	
				Finance and Accounts	
				Rural Development	
				Rural Community Development Centre	
				Agricultural Engineering	
				Livestock	
				Veterinary Services	
				Produce Services	
				Crops and Farm Settlement	
				Planning Research and Statistics	
				Forestry	
				Enforcement	
				Fisheries	57
2.	Economic Planning and Budgeting	74	$\frac{74}{2357} \times 272 = 8.54$	Administration and Supplies	
				Finance and Accounts	
				Budget	
				Planning	
				Monitoring and Evaluation	9
3.	Education	425	$\frac{425}{} \times 272 = 49.05$	Administration and Supplies	49

			2357	Finance and Administration	
				Science, Maths and Technology	
				Higher Education	
				Curriculum Development	
				Evaluation	
				Schools	
				Planning Research and Statistics	
4.	Establishment and Training	48	48 x 272 = 5.54 2357	Administration and Supplies	
				Finance and Accounts	
				Establishment	
				Pension and Training	
				Management Planning and Services	6
5.	Finance	47	47 x 272 = 5.42 2357	Administration and Supplies	
				Finance and Accounts	
				Revenue	
				Control and Expenditure	5
6.	Health	158	158 x 272 = 18.23 2357	Finance and Accounts	
				Primary Health Care	
				Food & Lab Service	
				Secondary Health Care	
				Pharmaceutical Services	18

				Nutrition	
				Nursing Services	
				Planning Research and Statistics	
7.	Justice	64	64 x 272 = 7.39 2357	Administration and Supplies	
				Public Prosecution	
				Litigation and Advisory Services	
				Mediation Centre	
				Legal Drafting and Parliamentary Counseling	
				Administrator General And Public Trustee	
				Planning Research and Statistics	
				Counselling	7
8.	Industry, Applied Science and Technology	43	43 x 272 = 4.96 2357	Administration and Supplies	
				Finance and Accounts	
				Project Analysis and Implementation	
				Industry	
				Applied Science and Technology	5
9.	Information And Orientation	52	52 x 272 = 6.0 2357	Administration and Supplies	
				Finance and Accounts	
				Public Grassroots Enlightenment	6

				Photography	
				Camera Recording	
				Information	
				Graphics	
				Planning Research and Statistics	
10.	Local Government and Chieftaincy Matters	36	$\frac{36}{2357} \times 272 = 4.15$	Administration and Supplies	
				Finance and Accounts	
				Local Government Affairs	
				Local Government Inspectorate	
				Chieftaincy	4
11.	Physical Planning and Urban, Development	332	$\frac{332}{2357} \times 272 = 38.31$	Administration and Supplies	
				Finance and Accounts	
				Development Planning	
				Development Control	
				Urban and Rural Development	
				Urban-Rural Environment Management	38
12.	Special Duties	8	$\frac{8}{2357} \times 272 = 0.92$	Administration and Supplies	
				Finance and Accounts	1
13.	Works and Transport	542	$\frac{542}{2357} \times 272 = 62.55$	Administration and Supplies	
				Finance and Accounts	
				Mechanical and Electrical	63

				Highway	
				Fire Services	
				Building	
				Planning Research and Statistics	
14.	Youth and Sports	33	33 x 272 = 3.81 2357	Administration and Supplies	
				Finance and Accounts	
				Sport Administration	
				Sport Facilities	
				Youth Development	
				Planning Research and Statistics	4
TOTAL		**2357**	**272.0**		**272**

Source: Staff Gender Nominal Roll: Ministry of Finance, Oyo State (July, 2015)

3.8 Instrumentation and Data Collection

A pre-tested semi-structured self-administered questionnaire consisting of five sections was used. The first section was to elicit socio-demographic information while knowledge of male civil servants on preventive sexual and reproductive health behaviour; perception of male civil servants towards preventive sexual and reproductive health behaviour; preventive sexual and reproductive health practices and the factors affecting the adoption of this behaviour among the male civil servants make up sections two, three, four and five respectively. Two research assistants were trained to assist in the collection of data from the male civil servants in the secretariat.

Permission to collect data from the ministries was collected from the Office of the Head of Service after which the researcher and the two trained research assistants visited the selected ministries within three weeks to first seek consent, followed by administration of the questionnaires. The researcher and the research assistants approached the male civil servants in their offices to fill the questionnaires. The team waited for the men to complete the questionnaires and sections not clear to them were clarified upon their request. The completed questionnaires were then retrieved from them. However, some of the respondents could not fill it that same day so the team retrieved the questionnaires the following day.

3.9 Validity of Instrument

The questionnaire was critically examined by experts within and outside of the Department of Health Promotion and Education. The technical inputs of supervisor and other professionals was sought to ascertain the face and content validity of the developed instrument.

3.10 Reliability of Instrument

The reliability of the instrument was ensured by conducting a pre-test among 27 male civil servants (10% of minimum sample size) in Ondo State Secretariat, Akure (a setting with similar characteristics) with a draft of the questionnaire to determine its internal

consistency and accuracy. A revision was made based on the analysis of the results of the pre-test. Cronbach Alpha statistical test was carried out on the pre-test study which gave a coefficient of 0.7. The instrument was accepted as reliable because the coefficient was greater than 0.5.

3.11 Analysis Procedures

Descriptive statistics such as frequency counts, percentages, means and standard deviation was used to clean the data and analyze the research questions. Statistical Package for Social Sciences (SPSS) version 20 was employed for bivariate analysis utilizing Chi-square test statistics employed to describe associations between two categorical variables and compare proportions with p-value set at < 0.05 at a confidence interval of 95%. Fisher's exact test was used to analyse categorical variables less than 5 and the p-value was also set at < 0.05 at a confidence interval of 95%.

A 31 – points knowledge scale was used to assess the knowledge of the respondents; scores between 0 – 11 indicated **poor knowledge** while scores greater than 11 but less or equal to 21 indicated **fair knowledge** and scores greater than 21 indicated **good knowledge** of preventive sexual and reproductive health behaviour. 1, 2 and 3 was used to code poor, fair and good knowledge of preventive sexual behaviour and reproductive health respectively.

Score 0 – 11 = Poor Knowledge

> 11 ≤ 21 = Fair Knowledge

> 21 = Good Knowledge

Also, a 33 – points perception scale was used to assess the perception of the respondents; scores between 0 – 17 indicated **poor perception** and scores greater than 17 indicated **good perception** of preventive sexual and reproductive health behaviour. 1 and 2 was used to code poor and good perception of preventive sexual and reproductive health behaviour respectively.

Score 0 – 17 = Poor Perception

> 17 = Good Perception

In addition, a 17 – points practice scale was used to assess the practice of the respondents; scores between 0 – 9 indicated **poor practice** and scores greater than 9 indicated **good practice** of preventive sexual and reproductive health behaviour. 1 and 2 shall be used to code poor and good practice of preventive sexual and reproductive health behaviour respectively.

Score 0 – 9 = Poor Practice

> 9 = Good Practice

3.12 Ethical Approval

Ethical approval for the study was obtained from the Oyo State Ministry of Health Ethical Review Committee. Permission was taken from the Head of Service, Permanent Secretaries and Directors of the departments. Privacy, anonymity and confidentiality was ensured for the participants and verbal informed consent was also be obtained from respondents before administering the questionnaires.

3.13 Study Limitation

Some of the male civil servants could not fill the questionnaire immediately because of their busy schedule but promised to return it the following day. However, some of the questionnaires could not be recovered due to misplacement by these respondents.

Also, the study is limited in that it was carried out only among male civil servants in the ministries although there are other Ministries, Departments and Agencies (MDAs) in the state secretariat such as commissions, boards, printing press and so on, thereby making the research participants very selective. Any generalization of the results of this study must be made with caution.

CHAPTER FOUR

FINDINGS

This chapter presents the result of this study. This presentation is done in the following sections; section one shows the demographic characteristics of respondents; section two represents the respondents' knowledge on preventive sexual and reproductive health behaviours while section three shows the perception of the respondents on preventive sexual and reproductive health behaviour. Section four describes the preventive sexual and reproductive health practices of respondents and section five elicits the factors affecting the adoption of these behaviours.

4.1 Section One: Demographic Characteristics of Respondents

The socio-demographic characteristics of the respondents help to understand the social and demographic conditions under which the data was collected.

4.1.1 Distribution of Respondents Based on Age and Marital Status

The age distribution of the respondents indicates that the respondents ranged from 19 to 61 years with the mean age as 38.0 ± 9.4 years. Fifty-five respondents (20.2%) were between ages 18-29 years while 114(41.9%) were in age range 30-41 years. Eighty-nine respondents (32.7%) were of 42 years and above (See table 1). Majority of the respondents are married 193 (71.0%) while 76(27.9%) are single and only 2(0.7%) are divorced. One of the respondents (0.4%) is separated.

4.1.2 Distribution of Respondents Based on Religion and Ethnicity

More than half of the respondents are Christians 177(65.1%) while 94(34.6%) are Muslims and only one respondent (0.4%) is a traditionalist. Almost all the respondents are Yorubas 266 (97.8%) while only 3(1.1%) are Igbos and one respondent is of the Edo tribe 1(0.4%).

4.1.3 Distribution of Respondents Based on Ministry

Forty-nine (18.0%) of the respondents were from the ministry of Agriculture and Natural Resources while 9(3.3%) were from Economic Planning and Budgeting, 47(17.3%) from Education, 10(3.7%) from Establishment and Training, 10(3.7%) from Finance, 20(7.4%) from Health, 10(3.7%) from Industry, Applied Science and Technology, 6(2.2%) from Information and Orientation, 10(3.7%) from Justice, 4(1.5%) from Local Government and Chieftaincy Matters, 36(13.2%) from Physical Planning and Urban Development, 2(0.7%) from Special Duties, 53(19.5%) from Works and Transport and 6(2.2%) from Youth and Sports.

4.1.4 Distribution of Respondents Based on Highest Educational Qualification and Cadre

More than half of the respondents had a first degree 140 (51.5%) while 63(23.2%) had NCE/OND and 33(12.1%) had SSCE. 28(10.3%), 6(2.2%), 1(0.4%) had Masters education, Primary education and no formal education respectively. One hundred and sixty-three respondents (59.9%) were senior staff while 107(39.3%) were of the junior cadre.

Table 4.1: Demographic Characteristics of Respondents

(n = 272) **Variables**		**Frequency**	**Percentage**
Age	18-29 years	55	20.2
	30-41 years	114	41.9
	42 and above	89	32.7
	Non Response	14	5.2
Marital Status	Single	76	27.9
	Married	193	71.0
	Divorced	2	0.7
	Separated	1	0.4
Religion	Christianity	177	65.0
	Islam	94	34.6
	Traditional	1	0.4
Ethnic Group	Yoruba	266	97.8
	Igbo	3	1.1
	Edo	1	0.4
Ministry	Agriculture and Natural Resources	49	18.0
	Economic Planning and Budget	9	3.3
	Education	47	17.3
	Establishment and Training	10	3.7
	Finance	10	3.7
	Health	20	7.3
	Industry, Applied Science and Technology	10	3.7
	Information and Orientation	6	2.2
	Justice	10	3.7
	Local Government and Chieftaincy Matters	4	1.5
	Physical Planning and Urban Development	36	13.2
	Special Duties	2	0.7
	Works and Transport	53	19.5
	Youth and Sports	6	2.2
Highest Educational Qualification	No Formal Education	1	0.4
	Primary School Certificate	6	2.2
	SSCE	33	12.1
	N.C.E/O.N.D	63	23.2
	H.N.D./B.Sc/B.Ed/B.A	140	51.4
	M.Sc/M.Ed/M.A	28	10.3
	Non Response	1	0.4
Cadre	Senior Staff	163	59.9
	Junior Staff	107	39.3
	Non Response	2	0.8

4.2 Section Two: Knowledge of Preventive Sexual and Reproductive Health Behaviours

4.2.1 Knowledge of STIs Preventive Behaviour

Findings in this study reveal that more than half of the respondents 152 (55.9%) knew two sexually transmitted infections while 83(30.5%) can only mention one of the STIs and 37(13.6%) do not know any of the STIs at all. Similarly, 125(46.0%) of the respondents knew two of the preventive sexual behaviours that can be practised while 96(35.3%) knew one of the behaviours and 51(18.8%) do not know any at all.

As high as 174(64.0%) of the respondents cannot mention at least one sexual risky behaviour while 55(20.2%) can only mention one and only 43(15.8%) can mention two sexual risky behaviours. However, it is surprising to note that 134(49.3%) can mention two ways of preventing sexually transmitted infections while 86(31.6%) can mention only one way of preventing STIs and 52(19.1%) cannot mention any way to prevent STIs. Every 7 man out of 10 (70.2%) had the knowledge of the advantages of condom, while only 24(8.8%) had no knowledge of the advantages of condom and 57 (21.0%) can mention only one advantage of condom use.

4.2.2 Knowledge of Consumption of Essential Micro-nutrients

More than half of the respondents 185(68.0%) did not know at least one of the essential micro-nutrients required for good reproductive health in men while 72(26.5%) knew just one of the micro-nutrients. This is a gap revealed by this study. However, 125(46.0%) of respondents mentioned 2 food items which can provide these micro-nutrients and 104(38.2%) could not mention any.

4.2.3 Knowledge of Prevention of Heavy Elements harmful to SRH

Almost all the respondents 257(94.5%) did not know at least one of the heavy elements found in environmental chemicals that can affect reproductive health. However, 12(4.4%) can mention one of the elements while 3(1.1%) mentioned two of those heavy elements.

This distribution shows that there is very low knowledge on this area of sexual and reproductive health. Two hundred and thirty-four men (86.0%) said they did not know at all how they can be exposed to the heavy elements found in environmental chemicals while 33(12.1%) mentioned one way of exposure to these chemicals and only 5(1.8%) mentioned correctly two ways of exposure to these chemicals.

4.2.4 Knowledge of Personal Hygiene of the Reproductive Organs

One hundred and seventy-five (64.3%) of the men did not know why it is unhealthy for men to put on tight underwear while only 97(35.7%) of the men know why it is unhealthy. In addition, more than half of the total respondents 161(59.2%) did not know any personal hygiene practice for the male reproductive organs that can prevent infections while 72(26.5%) knew only one personal hygiene practice and only 39(14.3%) knew two personal hygiene practices for the male reproductive organs so as to prevent infections.

4.2.5 Knowledge of Prevention of Pesticides

Also, as high as 224(82.4%) did not know any effect of pesticides on male reproductive health while only 39(14.3%) knew just one of the effects and 9(3.3) knew two effects of pesticides on male reproductive health.

4.2.6 Knowledge of Uptake of Medical Screenings

More than half of the total respondents 145(53.3%) knew at least one place to do HIV screening while 66(22.4%) know more than a place to carry out the test and only 61(22.4%) did not know where HIV screening can be done. Out of all the men, only 12(4.4%) gave two correct reasons why it is important to go for HIV screening while 105(38.6%) gave only one reason and 155(57.0%) did not know the reason why it is important to go for HIV screening. Majority of the respondents 214(78.7%) did not know at what age a man should go for prostate cancer screening while 58(21.3%) know at what age a man should go for prostate cancer.

4.2.7 Knowledge of Avoidance of Smoking and Drinking

Also, majority of the men 203(73.5%) did not know why smoking and drinking are unhealthy for men's sexual and reproductive health and only 69(25.4%) knew why they are bad.

4.2.8 Knowledge of Regular Exercise

As high as 230 (84.6%) of the total respondents did not know the benefit of exercise on sexual performance while only 42(15.4%) knew the benefits of exercise on sexual performance.

Summarily, 147 (54.0%) had poor knowledge of preventive sexual and reproductive health behaviours while 119 (43.8%) had fair knowledge of them and only 6 (2.2%) had good knowledge of them. However, the average knowledge of preventive sexual and reproductive health behaviours was poor with Knowledge score at 10.9 ± 5.0.

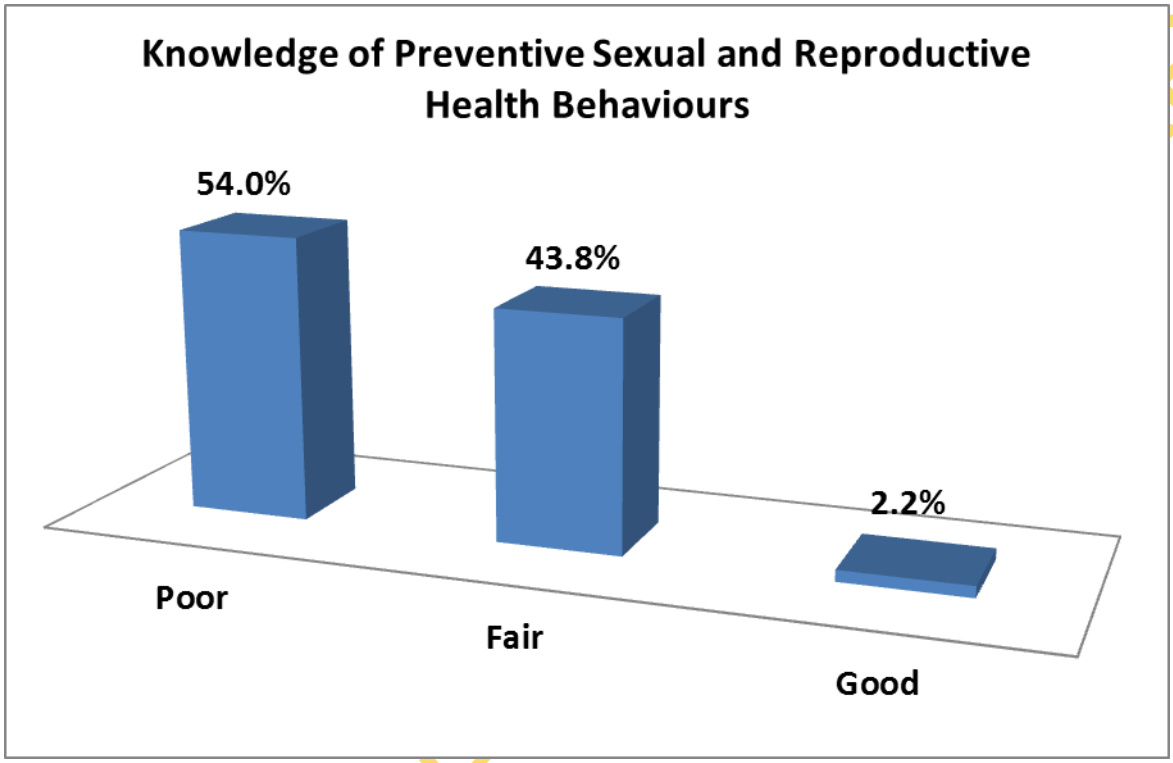


Figure 4.1: Knowledge of Preventive Sexual and Reproductive Health

Table 4.2: Knowledge of Preventive Sexual and Reproductive Health Behaviours

Knowledge Questions *n = 272*	Responses Incorrect (%)	Partially Correct (%)	Correct (%)
Mention 2 infections that can be acquired through sexual intercourse.	37 (13.6)	80 (29.4)	155 (57.0)
Mention any 2 preventive sexual behaviours that you know.	51 (18.8)	94 (34.6)	127 (46.7)
List 2 advantages of using condom during sexual intercourse.	24 (8.8)	57 (21.0)	191 (70.2)
Mention 2 essential micro-nutrients required for good reproductive health in men	185 (68.0)	72 (26.5)	15 (5.5)
Mention 2 food sources rich in these nutrients	103 (37.9)	44 (16.2)	125 (46.0)
List 2 heavy elements found in environmental chemicals that can affect reproductive health	257 (94.5)	12 (12.4)	3 (1.1)
Mention 2 ways men can be exposed to these chemicals?	233 (85.7)	34 (12.5)	5 (1.8)
Mention 2 effects of pesticides on male reproductive health.	224 (82.4)	39 (14.3)	9 (3.3)
Mention 2 personal hygiene practices that can prevent reproductive organs infection.	158 (58.1)	72 (26.5)	42 (15.4)
Mention 2 places where HIV screening can be done.	61 (22.4)	145 (53.3)	66 (24.3)
	Incorrect (%)	**Partially Correct (%)**	**Correct (%)**
List 2 risky sexual behaviour	170 (62.5)	55 (20.2)	47 (17.3)
Mention 2 ways to prevent Sexually Transmitted Infections	52 (19.1)	83 (30.5)	137 (50.4)
Give 2 reasons why it is important to go for HIV screening.	155 (57.0)	105 (38.6)	12 (4.4)
	Incorrect (%)		**Correct (%)**
Give one reason why men should not wear tight underwear.	174 (64.0)		98 (36.0)
At what age should a man go for prostate cancer screening?	212 (77.9)		60 (22.1)
Give 2 reason why smoking and drinking alcohol are bad for men's sexual and reproductive health	200 (73.5)		72 (26.5)
Mention one benefit of exercise on sexual performance.	230 (84.6)		42 (15.4)

*Non-responses were excluded

4.3 Section Three: Perception of the Respondents on Preventive Sexual and Reproductive Health Behaviour

4.3.1 Perception of STIs Preventive Behaviour

Findings in this study reveal that 172(63.2%) of the respondents felt that preventing sexual and reproductive health diseases is better than treating them while 93(34.2%) disagreed with it. More than half of the men 146(53.7%) disagreed with the fact that STIs affect only women while as much as 124(45.6%) still agreed that the infection affect women alone. Looking at the perception of STIs been caused by witches; 144(52.9%) disagreed with the fact that the infections can be caused by witches while 121(44.5%) agreed that STIs can be caused by witches. The study shows that 141(51.8%) of the respondents disagreed with the perception that STIs will go if not treated while 124(45.6%) agreed with it.

A high proportion of the respondents 240(88.2%) agreed that that condom use can prevent pregnancy while 29(10.7%) disagreed with and 3(1.1%). Similarly, 244(89.7%) agreed that condom is not difficult to use while 24 (8.8%) disagreed with it. In the same vein, almost all the respondents 259(95.2%) agreed that condom is readily available to buy while only 7(2.6%) disagreed with it. However, the figure of respondents who agreed that condom has side effects on their body rose to 114(41.9%) while those who disagreed with that are 149(54.8). Similarly, 139(51.1%) of the respondents disagreed with the fact that trying to use condom can be time wasting during sexual intercourse while 127(46.7%) agreed that it can be time wasting. Approximately half of the respondents 137(50.4%) disagreed with the belief that using condom can limit sexual pleasure while 127(46.7%) agreed that it can. More than half of the total respondents 152(55.9%) disagreed with the perception that herbal concoction is more effective in treating STIs than conventional drugs while 102 (37.5%) agreed with it.

As high as 116(42.6%) of the men agreed that having sex with other men is more enjoyable while 143(52.6%) disagreed with it. Considering self-efficacy in terms of perception towards ability to be faithful to one sexual partner; 122(44.9%) perceived that it is not possible for them to be faithful to one sexual partner while 147(54.0%) disagreed.

Over half of the respondents 163(59.9%) agreed that it is wrong to have more than one sexual partner while 103(37.9%) did not see anything wrong in having more than one sexual. In addition, 131(48.2%) respondents agreed that knowing their HIV status cannot affect their sexual behaviour while almost the same number of people 130(47.8%) disagreed with that. More than fifty percent of the respondents 139(51.1%) disagreed with the fact that prostate cancer screening is meant only for wealthy men while 119(43.8%) agreed that it is.

4.3.2 Perception of Consumption of Essential Micro-nutrients

Majority of the respondents 244(89.7%) agreed that what they eat can determine their reproductive health while only 20(7.4%) disagreed with it. Still on food consumption impact on reproductive health, 115(42.3%) perceived that their sperm count cannot be reduced even if they smoke or drink alcohol while 1445 (53.3%) disagreed with it.

4.3.3 Perception on Susceptibility, Detection and Uptake of Medical Screenings

One hundred and seventy-three respondents (63.6%) agreed that it is possible for them to develop prostate cancer while 77(28.3%) disagreed. However, only 128 (47.1%) agreed that they are susceptible to STIs or HIV while 138(50.7%) disagreed on their susceptibility to STIs including HIV. Similarly, 238(87.5%) of the respondents agree that prostate or breast cancer will not go except it is treated. Twenty-nine (10.7%) respondents disagreed with the perception that prostate or breast cancer will not go except it is treated. One hundred and thirty-eight respondents (50.7%) perceived that late detection of STIs cannot cause infertility while 124(45.6%) perceived that it can.

A little above average of the total respondents 150(55.1%) perceived that going for HIV screening is not a waste of time while 113(41.5%) perceived it as a waste of time and 9 respondents (3.3%) gave no response on it. However, the frequency of those who saw going for prostate cancer screening as a waste of time reduced to 49(18.0%) while those who saw it as not been waste of time increased to 212(77.9%). Similarly, 122(44.9%) of the respondents perceived that reporting every abnormal sign in the reproductive organs to the hospital is a sign of being fearful while 138(50.7%) perceived it is not.

Almost half of the total respondents 119(43.8%) agreed that they are too busy to go for HIV/STIs screening regularly while 142(52.2%) disagreed with that. While 122 (44.9%) respondents agreed that health workers waste their time when they go for HIV/STIs screening and which has discouraged them, 133(48.9%) disagreed with.

4.3.4 Perception of Personal Hygiene of the Reproductive Organs

Majority of the respondents 224(82.4%) agreed that dirty underwear can predispose them to reproductive organ infections while 39(14.3%) disagreed. Close to half of the respondents 120(44.1%) agreed that examining their penis and scrotum daily is unnecessary while a little above half of the respondents 140(51.5%) disagreed with it. One hundred and eighty-two of the respondents (66.9%) agreed that washing the scrotum and penis with soap and water regularly can prevent infection while 79(29.0%) disagreed with it.

Another reproductive health hygiene is the quality of underwear and findings revealed that 120(44.1%) of the respondents agreed that their underwear cannot affect their sperm quality while 140(51.5%) disagreed.

4.3.5 Perception of Prevention of Pesticides and Regular Exercise

Findings on the perception of men revealed that 110(40.4%) perceived that pesticides have nothing to do with their sperm quality while 131(48.2%) perceived otherwise. Majority of the respondents 244(89.7%) agreed that exercise can boost their reproductive health while only 22(8.1%) disagreed.

In summary, majority of the respondents 237 (87.1%) had poor perception on preventive sexual and reproductive health behaviours and only 35(12.9%) had good perception, however, the Perception score of the respondents is 10.9 ± 5.6.

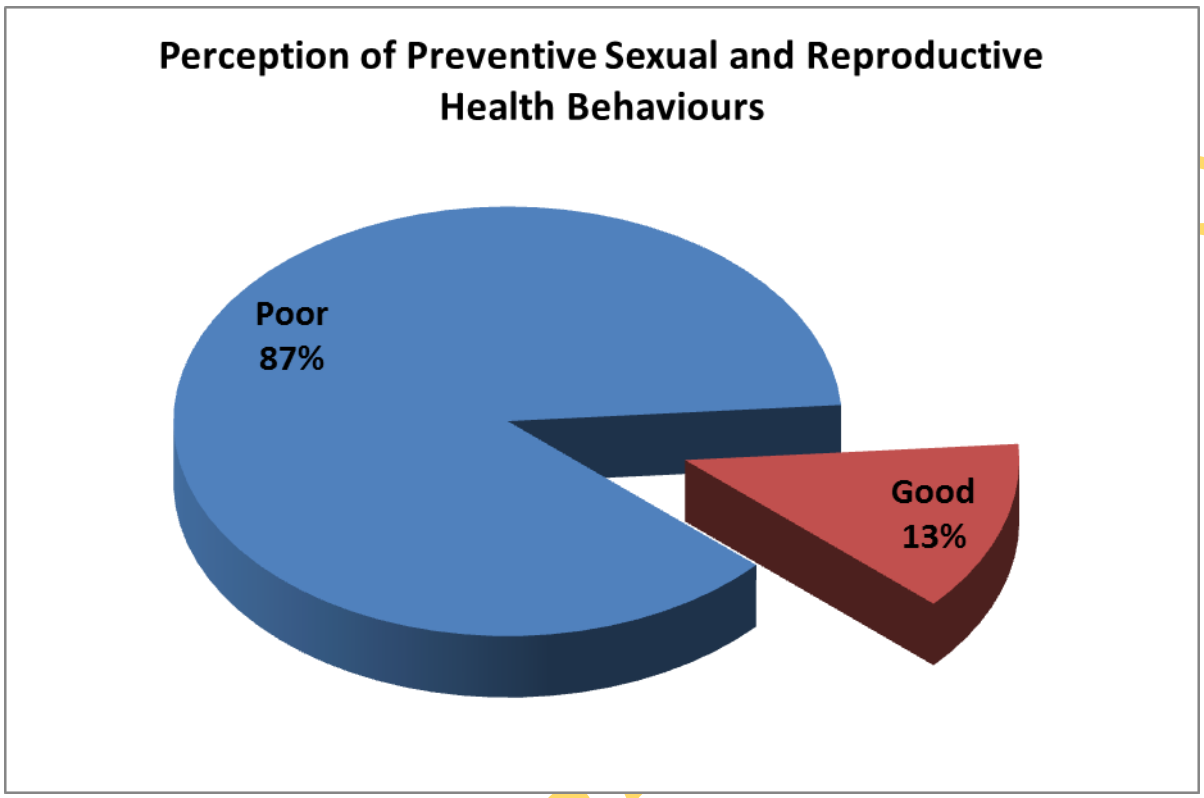


Figure 4.2: Perception of Preventive Sexual and Reproductive Health

Table 4.3(a): Perception of Preventive Sexual and Reproductive Health Behaviours

N = 272 **Perception Statements**	**Agree (%)**	**Disagree (%)**
Treating sexual and reproductive diseases is not better than preventing them.	172 (63.2)	93 (34.2)
Sexually Transmitted Infections (STIs) only affect women.	124 (45.6)	146 (53.7)
Sexually Transmitted Infections can be caused by spiritual attacks.	121 (44.5)	144 (52.9)
STIs will go even if not treated.	124 (45.6)	141 (51.8)
Prostate or Breast Cancer will not go except it is treated.	213 (89.3)	29 (10.7)
Late detection of STIs cannot cause infertility.	124 (44.9)	133 (48.9)
Health workers waste my time when I go for HIV/STI screening and this has discouraged me.	122 (36.3)	172 (63.7)
Use of condom can prevent pregnancy.	240 (88.2)	29 (10.7)
Condom is not difficult to use correctly.	244 (89.7)	24 (8.8)
Condom is readily available to buy.	259 (95.2)	7 (2.6)
Condom use has side effects on my body.	144 (41.9)	149 (54.8)

*Non-responses were excluded

Table 4.3(b): Perception of Preventive Sexual and Reproductive Health Behaviours

n = 272	**Perception Statements**	**Agree (%)**	**Disagree (%)**
	Herbal concoction is more effective in treating STIs than conventional drugs.	102 (37.5)	152 (55.9)
	Using condom can limit sexual pleasure during intercourse.	127 (46.7)	139 (50.4)
	Trying to use condom can waste time during sexual intercourse.	127 (46.7)	139 (51.1)
	I am too busy to go for HIV/STIs screening regularly.	119 (43.8)	142 (52.2)
	Having sex with other men is more enjoyable.	116 (42.6)	143 (52.6)
	Being faithful to one sexual partner is not possible for me.	122 (44.9)	147 (54.0)
	I don't see anything wrong in having more than one sexual partner.	103 (37.9)	163 (59.9)
	It is possible for me to develop prostate cancer.	173 (63.6)	77 (28.3)
	I can never have STIS or HIV.	128 (47.1)	138 (50.7)
	Going for HIV screening can be a waste of time	113 (41.5)	150 (55.1)
	Going for prostate cancer screening is not a waste of time	212 (77.9)	49 (18.0)
	Knowing my HIV status cannot affect my sexual behaviour	131 (48.2)	130 (47.8)
	Prostate cancer screening is only meant for wealthy men	119 (43.8)	139 (51.1)
	Examining my penis and scrotum daily is unnecessary	120 (44.1)	140 (51.5)

*Non-responses were excluded

Table 4.3(c): Perception of Preventive Sexual and Reproductive Health Behaviours

n = 272	**Perception Statements**	**Agree (%)**	**Disagree (%)**
Reporting every abnormal sign in the reproductive organs to the hospital is a sign of being fearful		122 (44.9)	138 (50.7)
Washing the scrotum and penis regularly with soap and water can prevent infections		182 (66.9)	79 (29.0)
My underwears cannot affect my sperm quality		120 (44.1)	140 (51.5)
What I eat can determine my reproductive health		244 (89.7)	20 (7.4)
My sperm count cannot be reduced even if I smoke or drink alcohol		115 (42.3)	145 (53.3)
Exercise can boost reproductive health		244 (89.7)	22 (8.1)
Pesticides have nothing to do with sperm quality		110 (40.4)	131 (48.2)
Dirty underwears can predispose me to reproductive organ infections		224 (82.4)	39 (14.3)

*Non-responses were excluded

4.4 Section Four: Preventive Sexual and Reproductive Health Practices of Respondents

4.4.1 Practice of STIs Preventive Behaviour

One hundred and seven (39.3%) of the total respondents have more than one sexual partners while 159 (58.5%) did not have. One hundred and twenty-five of the total respondents (46%) use condom for sexual intercourse with their other sexual intercourse among the men who has more than one sexual partners, while 88(32.4%) do not use. Half of the respondents do not use condom for sexual intercourse with their regular sexual partner while 130(47.8%) do.

As expected from findings from their perception, as high as 105(38.6%) of the men stated they have sex with other men while 136(50%) did not and 31(11.4%) gave no response on this. Ninety-six of the men (35.3%) use herbal concoction when they see signs of STIs while 154(56.6%) do not use it.

4.4.2 Practice of Consumption of Essential Micro-nutrients and Prevention of Pesticides

Approximately half of the total respondents 137(50.4%) consume vegetables and fruits regularly while 127(46.7%) do not. Only 106(39.0%) of the respondents get exposed to pesticides because they use it regularly while 145(53.3%) do not.

4.4.3 Practice of Uptake of Medical Screenings

Majority of the respondents 212(77.9%) report every abnormal sign in their reproductive organs to the hospital or a doctor while only 52(19.1%) do not. However, 151(55.5%) of the men had not undergone prostate cancer screening in the last one year while 118(43.4%) had undergone it in the last one year. In comparison to their practice on other prostate cancer screening practice, 146(53.7%) had not gone for HIV screening in the last three months while 119(43.8%) had gone.

4.4.4 Practice of Personal Hygiene of the Reproductive Organs and Regular Exercise

A high proportion of the men 231(84.9%) wash their reproductive organs with soap and water daily while only 34(12.5%) do not. One hundred and twenty-nine (47.4%) respondents sometimes wear tight underwear while 135(49.6%) do not. Majority of the respondents 209(76.8%) change their underwear daily while only 51(18.8%) do not. A good number of the men 198(72.8%) examine their scrotum and penis regularly while only 67(24.6%) do not examine theirs regularly. More than half of the men 159(58.5%) said they carry out exercise daily while 103(37.9%) do not.

In summary, 137(50.4%) of the total respondents had poor preventive sexual and reproductive health practices while 135(49.6%) had good practice. The overall Practice score among the respondents is 9.3 ± 2.7 which is poor.

Table 4.4: Practice of Preventive Sexual and Reproductive Health Behaviours

n = 272	**Practice Statements**	**Yes (%)**	**No (%)**
Report every abnormal sign in reproductive organs to the hospital or a doctor		212 (77.9)	52 (19.1)
Had not been screened for prostate cancer in the last one year.		151 (55.5)	118 (43.4)
Had STIs screening within the last one year.		111 (40.8)	156 (57.4)
Personally examine scrotum and penis regularly.		198 (72.8)	67 (24.6)
Have more than one sexual partner		107 (39.3)	159 (58.5)
Don't use condom for sexual intercourse with my regular sexual partner.		136 (50.0)	130 (47.8)
Use condom for sexual intercourse with other sexual partner(s)		125 (46.0)	88 (32.4)
Do have sex with other men.		105 (38.6)	136 (50.0)
Use herbal concoction on having signs of STIs		96 (35.3)	154 (56.6)
Had not gone for HIV test in the last 3 months.		146 (53.7)	119 (43.8)
Wash my reproductive organs with soap and water daily.		231 (84.9)	34 (12.5)
Sometimes wear tight underwear.		129 (47.4)	135 (49.6)
Don't consume vegetables and fruits regularly		127 (46.7)	137 (50.4)
Drink alcohol		119 (43.8)	145 (53.3)
Carry out exercise daily		159 (58.5)	103 (37.9)
Exposed to pesticides because of use.		106 (39.0)	145 (53.3)
Change my underwear every day.		209 (76.8)	51 (18.8)

*Non-responses were excluded

4.5 Section Five: Perceived Factors affecting the Adoption of Preventive Sexual and Reproductive Health Behaviours

Considering the factors that affect the adoption of preventive sexual and reproductive health behaviours; Majority of the respondents 211(77.6%) considered lack of adequate knowledge as a factor while 21(7.7%) do not see it as a factor. Also, 150(55.1%) of the men see culture as a factor contributing to the adoption of these behaviour while 55(20.2%) do not. Religion/Faith was considered by majority of the respondents 208(76.5%) as factor influencing the adoption of these behaviours while only 22(8.1%) considered it as not. The influence of the partner was also identified by 176(64.7%) as a factor while 43(15.8%) do not identify it as a factor.

One hundred and eighty-three respondents (67.3%) considered availability of material support for reproductive health e.g. condom to be a factor affecting the adoption of these practices while 44(16.2%) do not. Availability of screening services was also seen as a factor influencing preventive sexual and reproductive health behaviours by 177(65.1%) but not by 44(16.2%). One hundred and eighty-nine respondents (69.5%) considered the good attitude of health workers carrying out the screening exercise as an important factor to be considered while 40(14.7%) does not consider it as a factor.

However, only 115(42.3%) considered the cost of the screening services to be a factor affecting the adoption of screening behaviour while 95(34.9%) did not consider it as a factor. The absence of stigma was considered to be a factor by only 114(41.9%) while 72(26.5%) considered it not to be a contributory factor. A high proportion of the respondents 201(73.9%) considered trust in healthcare professionals as a factor influencing the utilization of these services while 22(8.1%) do not consider trust in health care professional as a factor. The lack of fear of discovering STIs/cancers was only considered by 127(46.7%) as a factor while 81(29.8%) do not consider it as factor.

Only 116(42.6%) identified lack of complexity of the hospital registration process as a factor affecting the adoption of these behaviours while 99(36.4%) do not identify this as a factor. One hundred and fourteen respondents (41.9%) see less busy daily schedule as a

factor influencing the adoption of these behaviour while 101(37.1%) do not see it as a factor. Affordable cost of health care services was also identified as a factor that can influence the adoption of preventive sexual and reproductive health behaviour by 177(65.1%) while 49(18.0%) do not identify it as a factor. Easy access to the health care services is also important in adoption of preventive sexual and reproductive health behaviours. This factor was considered by 197(72.4%) while 29(10.7%) did not consider it.

Table 4.5: Perceived Factors affecting Adoption of Preventive Sexual and Reproductive Health Behaviours

N = 272	**Factors**	**Yes (%)**	**No (%)**
Adequate knowledge preventive sexual behaviour and reproductive health		211 (77.6)	21 (7.7)
Culture		150 (55.1)	55 (20.2)
Religion/Faith		208 (76.5)	22 (8.1)
Partner's influence		176 (64.7)	43 (15.8)
Availability of material support for reproductive health e.g. condom		183 (39.3)	159 (58.5)
Availability of screening services		177 (65.1)	44 (16.2)
Good attitude of health workers carrying out screening services		189 (69.5)	40 (14.7)
Cost of screening exercise		115 (42.3)	95 (34.9)
Absence of stigma		114 (41.9)	72 (26.5)
Trust in healthcare professionals		201 (73.9)	22 (8.1)
Lack of fear of discovering STIs/Cancers		127 (46.7)	81 (29.8)
Lack of complexity of the hospital registration process		116 (42.6)	99 (36.4)
Less busy daily schedule		114 (41.9)	101 (37.1)
Affordable cost of healthcare services		177 (65.1)	49 (18.0)
Easy access to healthcare services		197 (72.4)	29 (10.7)

*Non-responses were excluded

4.6 Relationship between Knowledge and Demographic Characteristics of Respondents

(a) Table 4.6(a) shows that although the number of men with the knowledge of preventive sexual and reproductive health behaviour rises with age, this was not statistically significant (F = 4.855, p = .530).

Table 4.6(a): Relationship between Knowledge of preventive sexual and reproductive health behaviour and Age of Respondents

N=272	**Knowledge**		
Age (years)	**Poor n(%)**	**Fair n(%)**	**Good n(%)**
18-29 years	36(13.2)	19(7.0)	0(0.0)
30-41 years	59(21.7)	51(18.8)	4(1.5)
≥ 42	45(16.5)	42(15.4)	2(0.7)

(F-Test = 4.855, p= 0.530, Null Hypothesis is Accepted) *Non-responses were excluded

(b) Table 4.6(b) shows that highest qualification of the respondents is significantly associated with their knowledge of preventive sexual and reproductive health behaviour (F = 31.417, p = .001). The knowledge of preventive sexual and reproductive health behaviour increases with increase in educational attainment.

Table 4.6(b): Relationship between Knowledge of preventive sexual and reproductive health behaviour and Highest Qualification of Respondents

N=272	**Knowledge**		
Highest Educational Qualification	**Poor n(%)**	**Fair n(%)**	**Good n(%)**
No Formal Education	1(0.4)	0(0.0)	0(0.0)
Primary School Certificate	6(2.2)	0(0.0)	0(0.0)
SSCE	26(9.6)	7(2.6)	0(0.0)
N.C.E/O.N.D	39(14.3)	24(8.8)	0(0.0)
H.N.D./B.Sc/B.Ed/B.A	66(24.3)	70(25.7)	4(1.5)
M.Sc/M.Ed/M.A	9(3.3)	17(6.2)	2(0.7)

(F-Test = 31.417, p= 0. 001, Null Hypothesis is Rejected) *Non-responses were excluded

(c) Table 4.6(c) shows that the cadre of the respondents is significantly associated with their knowledge of preventive sexual and reproductive health behaviour (F = 13.772, p = .004) with the senior staff having better knowledge on the subject matter than the junior staff.

Table 4.6(c): Relationship between Knowledge of preventive sexual and reproductive health behaviour and Cadre

N=272	**Knowledge**		
	Poor n(%)	**Fair n(%)**	**Good n(%)**
Cadre			
Senior Staff	76(27.9)	83(30.5)	4(1.5)
Junior Staff	71(26.1)	34(12.5)	2(0.7)

(F-Test = 13.772, p= 0. 004, Null Hypothesis is Rejected) *Non-responses were excluded

4.7 Relationship between Knowledge and Perception of Respondents

Table 4.7 shows that the perception of the respondents on preventive sexual and reproductive health behaviour is significantly associated with their knowledge of it (F = 71.076, p = .000). Therefore, we reject the null hypothesis which states that there is no significant association between the knowledge of the respondents and their perception of preventive sexual and reproductive health behaviour.

Table 4.7: Relationship between Knowledge and Perception of Respondents on preventive sexual and reproductive health behaviour

N=272	**Knowledge**		
Perception	**Poor n(%)**	**Fair n(%)**	**Good n(%)**
Poor	147(54.0)	90 (33.1)	0(0.0)
Good	0(0.0)	29(10.7)	6(2.2)

(F-Test = 71.076, p= 0. 000, Null Hypothesis is Rejected) *Non-responses were excluded

4.8 Relationship between Knowledge and Practice of Respondents

Table 4.8 shows that the practice of the respondents on preventive sexual and reproductive health behaviour is significantly associated with their knowledge of it (F = 7.551, p = .019). Therefore, we reject the null hypothesis which states that there is no significant association between the knowledge of the respondents and their practice of preventive sexual and reproductive health behaviour.

Table 4.8: Relationship between Knowledge and Practice of Respondents on preventive sexual and reproductive health behaviour

N= 272	**Knowledge**		
Practice	**Low n(%)**	**Fair n(%)**	**High n(%)**
Poor	79(29.0)	44(16.2)	3(1.1)
Good	68(25.0)	75(27.6)	3(1.1)

(F-Test = 7.551, p= 0. 019, Null Hypothesis is Rejected) *Non responses were excluded

4.9 Relationship between Perception and Practice of Respondents

Table 4.9 shows that although the good practice of the respondents on preventive sexual and reproductive health behaviour improves with better perception, this is not statistically significant (X^2 = .646, df = 1, p = .422). Therefore, we accept the null hypothesis which states that there is no significant association between the perception of the respondents and their practice of preventive sexual and reproductive health behaviour.

Table 4.9: Association between Perception and Practice of Respondents on preventive sexual and reproductive health behaviour

N= 272	**Practice**	
	Poor n(%)	**Good n(%)**
Perception		
Poor	112(41.2)	125(46.0)
Good	14(5.1)	21(7.7)

(X^2=0.422, df=1, p= 0. 646, Null Hypothesis is Rejected) *Non responses were excluded

CHAPTER FIVE

DISCUSSION, CONCLUSION AND RECOMMENDATIONS

This study explored the knowledge, perception practice and factors influencing the adoption of preventive sexual and reproductive health behaviours among male civil servants in Oyo state secretariat. This chapter explains the results given in the previous chapter. The demographic characteristics of the respondents, their knowledge, perception and practice of preventive sexual and reproductive health behaviours were investigated. The perceived factors influencing the adoption of preventive sexual and reproductive health behaviours among male civil servants were also determined. Implication of the findings of this study to health promotion and education was also discussed and recommendations were made at the end of this report.

5.1 Socio-demographic Characteristics

The mean age of respondents in this study was synonymous with the study of Ibrahim (2011) among civil servants in the Oyo state secretariat. Seven out of every ten men are married and virtually all the respondents are Yorubas.

The study findings reveal that half of the respondents have a first degree. This is similar to the findings by Ibrahim (2011) who conducted a study on Fruity Response Efficacy and Fruit Consumption among a Group of Civil Servants of Oyo State where almost half of her respondents were graduates. Similarly, the senior staff were more than the junior staff. This is in line with the report of National Bureau of Statistics (2014) where 62.4% were male senior staff.

5.2 Knowledge of Preventive Sexual and Reproductive Health Behaviour

5.2.1 Knowledge of STIs Preventive Behaviour

The findings from this study show that close to three quarter of the respondents had a good knowledge about use of condom as contraceptives and prevention of Sexually

Transmitted Infections). This is supported by the 2013 NDHS where 91% of men were reported to know condom as the modern method of contraceptives.

5.2.2 Knowledge of Consumption of Essential Micro-nutrients

As revealed by this study, more than half of the respondents do not know at least one of the micro-elements required by men for healthy reproductive health. A similar research by Ibrahim (2011) conducted among Oyo state civil servants reports poor fruit consumption behaviour among men males.

5.2.3 Knowledge of Prevention of Heavy Elements harmful to SRH

The respondents possessed a very low level of knowledge of heavy elements found in environmental chemicals that can affect reproductive health and their sources. Only four out of hundred men in the study mentioned heavy metals such as lead, mercury and cadmium. According to Clapp, Jacobs and Loechler, (2008), the bulk of the agents or factors that cause cancer in humans and also pose risk of occurrence are chemicals in the environment and/or work place. These include chlorinated organic pesticides, polychlorinated biphenyls, vinyl chloride, acetochlor and heavy metals such as cadmium, nickel, lead and arsenic which have been specifically implicated in prostate and breast cancer (Ibiba F. Oruambo, Holy Brown and Chimene Okeh, 2014).

5.2.4 Knowledge of Uptake of Medical Screenings

A little more than half of the respondents knew at least one place to do HIV screening. This is in consonance with the 2013 NDHS report which reports that seven out of every ten men know a place where they can get an HIV screening services.

More that three-quarter of the men did not know at what age a man should go for prostate cancer screening. This is comparable to the findings of other studies. A study among males attending a urology clinic in South Africa by Mofolo and colleague (2015) reported that less than a quarter of their total respondents knew the age at which prostate screening becomes important. Similarly, another research conducted in Ilorin, Nigeria by

Abdulwahab, Abdulateef and Olusegun (2010) where almost half of the respondents were civil servants shows that almost all the respondents have never heard of prostate cancer.

5.2.5 Knowledge of Avoidance of Smoking and Drinking

Also, majority of the men did not have the knowledge of why smoking and drinking are unhealthy for men's sexual and reproductive health. This varies with the findings of by Abayomi and Moses (2012) which showed that less than a quarter of their respondents agreed that smoking is good for healthy living. However, the 2013 NDHS revealed that only 8% of the men smoke in Nigeria.

5.2.6 Knowledge of Regular Exercise

Eight out of every ten of the total respondents did not know the benefits of exercise on sexual performance. This is in variance with the study conducted by Abayomi and Moses in 2012 among young adults of college of education in Oyo state where the study showed that majority of the respondents had the awareness that physical activity is one major barrier to short life span in recent years.

Summarily, more than half of the total respondents had had poor knowledge of preventive sexual and reproductive health behaviours. This is in variance with the findings of Uloma Agu, Maurice AGU, Godswill Nnaji and Dennis Ugochukwu (2014) among civil servants in Anambra state, Nigeria who reported that majority of their respondents had good knowledge of Diabetes Mellitus with most of them scoring ≥ 50%.

5.3 Perception on Preventive Sexual and Reproductive Health Behaviour

Central to the current health behaviour theories is the relation between risk perceptions and health behaviour (Renner & Schwarzer, 2003; Weinstein, 2003). It is commonly believed that perceptions of risk encourage people to take preventive actions in order to reduce this risk (Brewer et al., 2004). This implies that lack of preventive behaviour is at least partly attributable to inaccurate risk perceptions, it is vital to examine the factors that influence the accuracy of risk perceptions (Weinstein et al., 1998).

5.3.1 Perception of STIs Preventive Behaviour

A high proportion of the respondents agreed that condom use can prevent pregnancy. In the same vein, a high proportion agreed that condom is not difficult to use and almost all the respondents agreed that condom is readily available to buy. This may be influenced by their high knowledge of the use of condom. This agrees with reports from the NDHS, 2013 where the prevalence of knowledge of the advantages of condom use among men in Nigeria is high.

However, almost half of the men felt that condom can limit sexual pleasure. Similar research conducted among adult men in a West African University population on Condom Myths and Misconception: The Male Perspective, more than half of the men who had ever had sex considered condom use to reduce sexual pleasure (Daniel Yaw Fiaveh, 2012). Men feel strongly that condom reduce sexual pleasure, and marital intimacy, and that they are inconvenient to use. Even women also complain that condoms reduce their sexual pleasure as well. This perception is vital to the acceptance and use of condom by these men as several men have the desire to preserve their sexual pleasure and comfort (Iyaji and Ogbuke, 2011).

More than one-third of the men also believed that condom has side effects after use. This has been identified as a barrier to the use of condom in Nigeria. In their research paper, Iyaji Adejoh and Ogbuke, (2011) noted that beliefs exist that condom can be a source of virginal dryness, inflammation and disease. Some men even describe condom as a coffin, arguing that condom has negative effects on women; condoms could cause them a disease and that the woman's womb could become dry after repeated use. The study shows that almost half of the respondents agree with the perception that STIs will go if not treated. Similarly, only a tenth of the respondents agree that prostate or breast cancer will go if not treated. This figure is low compared to STIs probably because of the perceived severity of cancers compared to STIs by the people.

5.3.2 Perception of Uptake of Medical Screenings

More than one-third of the respondents perceived that reporting every abnormal sign in the reproductive organs to the hospital is a sign of being fearful. Masculinity is a strong factor influencing the uptake of reproductive health services by men. In their qualitative research among men in Malawi Serai Daniel Rakgoasi and Clifford Odimegwu (2014) reported 'The Myth of the Strong Man' where some men believed that their body is strong and that it is only the fragile women that are eager to use HIV and AIDS services. Studies revealed that extent to which a male demonstrates dominant masculine ideals will influence the degree to which he will be perceived as masculine (de Visser et al, 2009). Looking after ones' health has been socially constructed as a feminine endeavor, so any man who challenges these norms runs the risk of being branded 'deviant' (Courtenay, 2000a; Dolan, 2010)

Similarly, quantitative studies indicate an association between masculinities and sexual and reproductive health. The results of a study conducted by Serai Daniel Rakgoasi show that reproductive health programs tend to challenge men's dominance of women's decision on sexuality, and are therefore experienced as a threat to some men's sense of identity (Serai Daniel Rakgoasi, 2010).

Majority of the respondents perceived that they can never have prostate cancer. This is dissimilar to the study conducted in among men in Kenya where only some of the men had poor perception on self-vulnerability to prostate cancer.

In summary, majority of the men had poor perception on preventive sexual and reproductive health behaviours. This is similar to the findings by Igbalajobi, Lawal, Olorunlana (2015) among federal civil servants in Oyo state where the perception risk score of males on HIV is less than average.

5.4 Practice of Preventive Sexual and Reproductive Health Behaviour

5.4.1 Practice of STIs Preventive Behaviour

More than one-third of the total respondents have more than one sexual partner. This relates with other findings where men are shown to engage in multiple sexual partnering. The 2013 NDHS reported that seven out of every ten respondents in the survey in Nigeria have more than one sexual partner and that men have a mean of 4.4 lifetime sexual partners in Oyo State. In their qualitative study, reasons for multiple sexual partnering by men in Botswana include, to "lack of (sexual) satisfaction" within their relationships, means to get back at a partner for refusing to have sex or demanding men to use condoms. Others said it is natural for men to have multiple sexual partnerships because they have a larger "appetite" for sex than women (Serai Daniel Rakgoasi, 2010).

Among the men who have more than one sexual partner, about one-third do not use condom for sexual intercourse with their other sexual partners despite their high knowledge about the use of condom as contraceptives and for prevention of STIs. Studies conducted in many other developing countries gave evidences of similar disparities between high levels of knowledge of HIV/AIDS and awareness of condom and lower use of condoms as a method of disease and pregnancy prevention on the other (Maharaj, 2001; Meekers and Klein, 2001).

As expected from findings from the perception, as high as a third of all the men do have sex with other men while more than one-tenth gave no response on this. This may not be unconnected to the social stigma and criminalization which may lead to arrest. The UNAIDS (2014) reports that there are currently, inadequate data on the prevalence of homosexuals globally especially in Africa to help plan and guide the response to HIV among gay men and other men who have sex with men. Nevertheless, evidence showed that men who have sex with other men are 19 times more likely to be living with HIV than the general population (WHO, 2011).

5.4.2 Practice of Consumption of Essential Micro-nutrients

Almost half of the total respondents consume vegetables and fruits regularly. This is similar to the study findings by Ibrahim (2011) carried out on Fruity response efficacy and fruit consumption among a group of civil servants of Oyo State, Nigeria where their mean fruit consumption score was 2.05 out of 3. Another study by Mathilda and colleagues in 2012 on Intake of Fruit and Vegetables Consumption among Adults in an Urban Community in North Central Nigeria showed that although there was an overall fair knowledge of the nutritional value of fruits and vegetables among majority of the respondents, the practice of fruit consumption was not as high as among women with more women having good practice than men. Similarly, Oyerinde and Owojaiye (2008) reported that there is significant influence of civil servants' knowledge of dietary disease resulting in obesity from their practices in Nigeria

5.4.3 Practice of Personal Hygiene of the Reproductive Organs

Seven out of every ten men in the study examine their scrotum and penis regularly. Dave Hingsburger in The Direct Support Workers Newsletter noted that taking good care of the penis is important in a man's daily routine. Daily thorough washing with warm water and mild soap is necessary. Simple washing with warm water is effective. A mild soap or a non-soap product such as glycerine cream can be used.

A very high proportion of the respondents wash their reproductive organs with soap and water daily. This is probably due to the fact that bathing is customarily perceived as a daily activity.

5.4.4 Practice of Uptake of Medical Screenings

Although only half of the men perceived masculinity construct not to be a barrier in assessing health care, majority of the men report every abnormal sign in their reproductive organs to the hospital or a doctor. This result varied from a study conducted in Malawi among men by Lubega, Musinguzi, Omiel and Tumuhe (2015) where the result showed that many had never thought of taking any kind of medical check-up due to the

'reluctance' tendency stemming from the masculinity construct. As revealed by recent studies, masculinity norm is being challenged by some other factors such as severity of disease, educational status, peer influence, economic strength of men etc, Serai Daniel Rakgoasi (2010) reported that the awareness of the threat of HIV/AIDS is forcing them to privately (re)negotiate their masculinity in order to avoid the obvious danger presented by HIV/AIDS. "They realized for the first time in their history that the blind pursuit of certain idealized masculinity norms, such as multiple partnerships and risk-taking through non-use of condoms, could result in infection and death. So the hegemonic masculine norm necessarily included "being smart" by avoiding HIV infection, not only because of the fear of death, but the primary fear of illness and dependence on other people for care as the latter represents an affront to the idealized masculine image of 'strength, vitality and independence'. So even, seeking to avoid HIV infection was a way of being a man". This increase in practice may be due to their relative higher education exposure. Rakgoasi and Odimegwu, (2013) reported that many men are ready to challenge some of the long standing culturally masculine beliefs and advocate masculine roles that emphasize equality, and health seeking outcomes.

Many of the respondents had never undergone prostate cancer screening and STIs screenings within the last one year. This low uptake of screening services by men is corroborated by other studies. Oladimeji and his colleagues in 2010 reported low uptake of prostate screening among older men in Oyo State and findings by Ajape and his colleagues (2009) among males in Ilorin, Nigeria showed that a large proportion of the men were unaware of prostate cancer screening using the PSA method.

5.4.7 Practice of Avoidance of Smoking and Drinking

Almost half of the men in the study smoke or drink alcohol. This relates with the WHO survey in 2005 in Nigeria where drinking was generally considered as a male behaviour with almost half of the men being current drinkers. This is also similar to the 45% prevalence of alcohol consumption among men in South Africa (Van Heerden and Parry, 2001).

5.4.8 Practice of Regular Exercise

Engagement in exercise has been identified as one of the male capital that is, positive aspects of the masculinity construct (De Visser and McDonnell, 2013). This may account for why more than half of the men carry out exercise daily. However, this is in variance with the study of Abayomi and Moses (2012) where only a few of the young adult respondents actually participate in recommended at least 150 minutes of moderate-intensity aerobic physical activity throughout the week or do at least 75 minutes of vigorous-intensity aerobic physical activity throughout the week or an equivalent combination of moderate- and vigorous-intensity activity. The findings of this study is as dissimilar with the findings of Oyerinde and Owojaiye in 2008 which reveals that civil servants do not participate in physical activities enough to make them healthy.

The study has shown that half of the respondents had poor preventive sexual and reproductive health practices. This stems from their low knowledge and poor perception. This is related to the study conducted by Igbalajobi, Lawal, Olorunlana (2015) where the risk perception of HIV among civil servants in Ibadan was statistically significant to with their mutual agreement on reproductive decision as an adjustment strategy in the context of HIV/AIDS.

5.5 Perceived Factors influencing the adoption of Preventive Sexual and Reproductive Health Behaviour

Health related behaviour depends on knowledge and beliefs about health risks and benefits of taking action (Adegoke, 2010). This suggests why seven out of every ten respondents considered lack of adequate knowledge as a factor which influences the adoption of preventive sexual and reproductive health behaviours. Ogbe (2011) noted in his study that there is a significant relationship between knowledge and practice of STIs and condom use in the prevention of STIs. It suffices to say that people cannot behave or act on what they do not know.

Over half of the men see culture as a factor contributing to the adoption of these preventive sexual and reproductive health behaviours. Adegoke (2010) argued in his

review that the fact that health beliefs influence health behaviour is an indication that culture is one of the broader social factors influencing human behaviours.

Religion/Faith was considered by majority of the respondents as factors influencing their adoption of the preventive sexual and reproductive health behaviours. Similar study on Correlates of Health Behaviour Practices among Literate Adults of Southwest, Nigeria by Adegoke (2010) reiterated that religion is another possible factor which influences health behaviours. According to him, many people abstain from alcohol consumption and cigarette smoking since most religion preach against them and most of the people indicate that they often live by religious principles.

Stigma in the society and health facilities has been identified by several studies as a factor influencing the utilization of reproductive health services. The absence of stigma was considered to be a factor by some of the men. This is comparable to a qualitative study conducted in Malawi where Wirtz and colleagues (2014) reported that the male participants and some health providers believed that one of the barriers preventing positive health seeking behaviour among MSM fears and perceptions of stigma in health facility.

A high proportion of the respondents considered trust in healthcare professionals as a factor influencing adoption of these services. This is dissimilar with the NDHS which reported that only 2.2% of mothers in the Oyo states cited lack of trust for the health care providers or poor quality of service as their reason for not delivering in a health facility. This region also had the greatest proportion of women whose husbands or family did not allow them to deliver in a health facility. Joe Kalo (2007) also noted that the type and quality of services often received by the clients depend on the knowledge and skills of individual health providers working in these health facilities.

Only four out of every ten respondent considered the cost of screening services to be a factor affecting their adoption of screening behaviour. This was in accordance with the 2013 NDHS reports that the rate of discontinuation of male condoms in Nigeria is 20% and cost accounts for 0.8% of this. This is corroborated by a qualitative study conducted by Doctor and colleagues (2012) which revealed that far distance and high cost of transportation to the health facility discouraged the utilization of reproductive health

services by pregnant women. However, this was different from the findings of Alagbonsi and his colleagues in 2013 where more than three-quarter of the respondents agreed that poor access of patients to medicine and unaffordable costs of healthcare services by patients are part of the causes of poor healthcare services delivery in Kwara state.

The attitude of health care providers towards the men contributes to their utilization of the health care services. Majority of the respondents indicated that good attitude of health workers carrying out screening exercise will motivate them to go for these screenings. Similarly the NDHS reports that the attitude of health workers accounts for 11% of the reasons why women do not access healthcare services. The WHO's report on sexual and reproductive health core competencies in primary care in 2011 stated that an important factor for the future wellbeing of the community is the attitude with which the health worker handles the individuals, as well as his or her knowledge of local norms and taboos, and the services that may be able to assist the client.

5.6 Test of Hypotheses

Findings from the study show that highest qualification of the respondents was significantly associated with their knowledge of preventive sexual and reproductive health behaviour. This is in agreement with the findings of Awosan and colleagues (2014) where there was statistically significant association between the level of education and adequate knowledge of HIV transmission and prevention among drivers in Sokoto, Nigeria. Agyemang, Buor and Tagoe-Darko (2012) also reported that the level of education as a determinant of the knowledge of HIV/AIDS.

Results from the study show that the age of the respondents was not statistically associated with their knowledge of preventive sexual and reproductive health behaviour. This is dissimilar with the findings of Uloma Agu, Maurice AGU, Godswill Nnaji and Dennis Ugochukwu (2014) whose study revealed a significant association between age and knowledge for complications diabetes among civil servants in Anambra state. Results from the study show that the perception of the respondents about preventive sexual and reproductive health behaviour was not significantly associated with their practice of preventive sexual and reproductive health behaviour. This is similar to the findings of

Agweda and Dibua, (2010) where the perception of civil servants on stigmatization towards people living with HIV/AIDS was found to be inversely related to their practice.

5.7 Implication of the study findings for Health Promotion and Education

Health promotion and education do not only provide health education, it also encompasses other components such as developing health skills, creating supportive environment, advocating favourable policies targeted towards helping the individual, community and the nation prevent health problems, promote healthy lifestyles and facilitate access to health services. This study has identified poor knowledge, perception and practice of preventive sexual and reproductive health behaviour among male civil servants with corresponding influencing factors. Addressing these gaps can only be achieved collectively by the men, religious leaders, government, health promoters and other stakeholders as failure to do so do affects the men's health directly and indirectly affect the women, the community and the nation at large.

Educational intervention such as training of the men will effectively address the challenge of low knowledge and poor perception of preventive sexual and reproductive health behaviours. This training should cover knowledge definitions, forms of preventive sexual and reproductive health behaviour, benefits of preventive sexual and reproductive health behaviour and consequences of not practising these behaviours. This can be done by organizing trainings for the men according to their ministry as this study will serve as needs assessment and a post-test will be conducted at the end of the training to assess their increase in knowledge. The training facilitators will be health promoters from the State Ministry of Health and experts from the department of Health Promotion and Education, University of Ibadan will monitor and evaluate the training.

Behavioural change communication (BCC) is essential in passing health information in order to achieve adoption of healthy practices by the people. This ensures awareness and knowledge of preventive sexual and reproductive health behaviour. Television and radio jingles can be used to create awareness and pass information to the men. Information, Education and Communication (IEC) materials such as bill boards, posters, handbills can

also be used in the secretariat to pass information to these men. Key messages for the BCC will include need for consistent and correct use of condom for sexual intercourse, benefits of medical screenings, advantages of consuming fruits and vegetables, avoidance of tight underwear.

In addition, advocacy should be carried out by the health promoter in the state ministry of health to the Head of Service on behalf of the male civil servants as there should be provision of condoms, provision of routine screening services for cancer, HIV and other STIs for them right in the secretariat. This can be done using the lobbying strategy so that provision of commodities and services for the male civil servants can be carried out at least once in every quarter of the year.

To ensure high quality delivery of the above-mentioned strategies, an expert in public health will be required as a consultant to oversee the planning, implementation and evaluation of these strategies as everyone in every step of the implementation needs to be trained appropriately.

5.8 Conclusion

Increasing evidence shows that prevention is effective in reducing costs and alleviating dysfunction that hinders healthy outcomes. The potential benefits for the health of the individual, communities, and the economy of the nation are both achievable and necessary investments. Government and other stakeholders in health system must prioritize resources to institutionalize prevention and early identification practices of behavioural health across the population (Pathway Policy Brief, 2013).

According to the World Health Organization (2006), sexual and reproductive health and well-being are essential if people are to have responsible, safe, and satisfying sexual lives and these require a positive approach to human sexual and reproductive health behaviour and an understanding of the complex factors that influence it. These factors affect whether the expression of sexuality leads to sexual health and well-being or to sexual behaviours that put people at risk or make them vulnerable to sexual and reproductive ill-health.

Findings from this study have revealed poor knowledge of preventive sexual and reproductive health behaviour among male civil servants and this has significantly influenced their perception and consequently resulting into poor practice. Factors considered by these men to influence their adoption of these behaviours include inadequate knowledge about these behaviours, their religion or faith, unavailability of reproductive health commodities and screening services, the attitude of the health workers providing screening services, the cost and accessibility to these screening services.

5.9 Recommendations

In view of the findings of this study, the following recommendations are made:

1. The study revealed a poor knowledge, perception and practice of preventive sexual and reproductive health behaviours among the male civil servants which is mostly influenced by inadequate knowledge of these behaviours. This can be addressed by providing awareness through the use of Information, Education and Communication (IEC) materials such as bill boards, posters and so on carrying information on this issue and pasted in strategic places in each ministry in the secretariat. Preventive sexual and reproductive health seminars and workshops can also be organized for workers in each of the ministry.
2. Since religious beliefs also affect the adoption of these behaviours, advocacies should also be made to the religious leaders so as to encourage their participation in reaching the men with messages on preventive sexual and reproductive health behaviour. Trainings on preventive sexual and reproductive health behaviours should also be conducted for the religious leaders so as to ensure dissemination of correct information to the men.
3. Provision of sexual and reproductive health commodities and screening services at subsidized and affordable cost should be made within the secretariat so as to remove the barrier high cost of screening services.
4. Programmes and interventions that will increase the knowledge and promote the adoption of these behaviours should be designed and implemented by the government and non-governmental organizations and other stakeholders.

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APPENDIX
QUESTIONNAIRE

KNOWLEDGE AND PRACTICE OF PREVENTIVE SEXUAL BEHAVIOUR AND REPRODUCTIVE HEALTH AMONG MALE CIVIL SERVANTS IN OYO STATE SECRETARIAT, IBADAN, OYO STATE

I am a postgraduate student of the Department of Health Promotion and Education, Faculty of Public Health, University of Ibadan and I am conducting a research on the above topic. This questionnaire was designed to gather data and no name is required. All information given will be strictly for research purpose and utmost confidentiality of your identity, response and opinion will be ensured. Please fill appropriately and sincerely, as all information shall be treated as highly confidential.

Can we start now? Yes ☐ No ☐ (If "No", please discontinue)

SECTION A: SOCIO-DEMOGRAPHIC INFORMATION

1. Age: _____ (as at your last birthday)
2. Marital status: Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated ☐
   Others (*please specify*) ……
3. Religion: Christianity ☐ Islam ☐ Traditional ☐ Others (*please specify*) ….
4. Ethnic Group: Yoruba ☐ Hausa ☐ Igbo ☐ Others ☐
5. Which Ministry do you work? ……
6. What department are you? ……
7. What section/unit are you? ……
8. Highest Educational Qualification: No Formal Education ☐ Primary School ☐
   Certificate ☐ S.S.C.E ☐ N.C.E. ☐ H.N.D./B.Sc/B.Ed./B.A ☐
   M.Sc/M.Ed./M.A ☐ Others (*please specify*) ……..
9. Cadre: Senior Staff ☐ Junior Staff ☐

SECTION B: KNOWLEDGE OF PREVENTIVE SEXUAL BEHAVIOUR AND REPRODUCTIVE HEALTH

Instruction: Please provide the answers in the box below

S/N	QUESTION	OPTIONS AND ALLOTTED POINTS	Official Use
10	Mention 2 infections that can be acquired through sexual intercourse.	…… ……	
11	Mention any 2 preventive sexual behaviours that you know.	…… ……	
12	List 2 advantages of using condom during sexual intercourse.	…… ……	
13	Mention 2 essential micro-nutrients required for good reproductive health in men	…… ……	
14	Mention 2 food sources rich in these nutrients	…… ……	
15	List 2 heavy elements found in environmental chemicals that can affect reproductive health	…… ……	
16	Mention one way men can be exposed to these chemicals?	…… ……	
17	Mention 2 effects of pesticides on male reproductive health.	…… ……	
18	Mention 2 personal hygiene practices that can prevent reproductive organs infection.	…… ……	
19	Mention 2 places where HIV screening can be done.	…… ……	
20	Give one reason why men should not wear tight underwear.	…… ……	
21	List 2 risky sexual behaviour	…… ……	
22	Mention 2 ways to prevent Sexually Transmitted Infections	…… ……	
23	Give 2 reasons why it is important to go for HIV screening.	……	
24	At what age should a man go for	…… ……	

	prostate cancer screening?		
25	Give one reason why smoking and drinking alcohol are bad for men's sexual and reproductive health	…… …… ……	
26	Mention one benefit of exercise on sexual performance.	…… ……	

Score Obtained: …….
Code: ……..

SECTION C: PERCEPTION OF PREVENTIVE SEXUAL BEHAVIOUR AND REPRODUCTIVE HEALTH

Instruction: Please read the statements below and tick appropriately

S/N	Statement	Answers	Official Use
27	Treating sexual and reproductive diseases is not better than preventing them.	Agree☐ Disagree☐	
28	Sexually Transmitted Infections (STIs) only affect women.	Agree☐ Disagree☐	
29	Sexually Transmitted Infections can be caused by spiritual attacks.	Agree☐ Disagree☐	
30	STIs will go even if not treated.	Agree☐ Disagree☐	
31	Prostate or Breast Cancer will not go except it is treated.	Agree☐ Disagree☐	
32	Late detection of STIs cannot cause infertility.	Agree☐ Disagree☐	
33	Health workers waste my time when I go for HIV/STI screening and this has discouraged me.	Agree☐ Disagree☐	
34	Use of condom can prevent pregnancy.	Agree☐ Disagree☐	
35	Condom is not difficult to use correctly.	Agree☐ Disagree☐	
36	Condom is readily available to buy.	Agree☐ Disagree☐	
37	Condom use has side effects on my body.	Agree☐ Disagree☐	
38	Herbal concoction is more effective in treating STIs than conventional drugs.	Agree☐ Disagree☐	
39	Using condom can limit sexual pleasure during intercourse.	Agree☐ Disagree☐	
40	Trying to use condom can waste time during sexual intercourse.	Agree☐ Disagree☐	

41	I am too busy to go for HIV/STIs screening regularly.	Agree ☐ Disagree ☐	
42	Having sex with other men is more enjoyable.	Agree ☐ Disagree ☐	
43	Being faithful to one sexual partner is not possible for me.	Agree ☐ Disagree ☐	
44	I don't see anything wrong in having more than one sexual partner.	Agree ☐ Disagree ☐	
45	It is possible for me to develop prostate cancer.	Agree ☐ Disagree ☐	
46	I can never have STIS or HIV.	Agree ☐ Disagree ☐	
47	Going for HIV screening can be a waste of time	Agree ☐ Disagree ☐	
48	Going for prostate cancer screening is not a waste of time	Agree ☐ Disagree ☐	
49	Knowing my HIV status cannot affect my sexual behaviour	Agree ☐ Disagree ☐	
50	Prostate cancer screening is only meant for wealthy men	Agree ☐ Disagree ☐	
51	Examining my penis and scrotum daily is unnecessary	Agree ☐ Disagree ☐	
52	Reporting every abnormal sign in the reproductive organs to the hospital is a sign of being fearful	Agree ☐ Disagree ☐	
53	Washing the scrotum and penis regularly with soap and water can prevent infections	Agree ☐ Disagree ☐	
54	My underwears cannot affect my sperm quality	Agree ☐ Disagree ☐	
55	What I eat can determine my reproductive health	Agree ☐ Disagree ☐	
56	My sperm count cannot be reduced even if I smoke or drink alcohol	Agree ☐ Disagree ☐	
57	Exercise can boost reproductive health	Agree ☐ Disagree ☐	
58	Pesticides have nothing to do with sperm quality	Agree ☐ Disagree ☐	
59	Dirty underwears can predispose me to reproductive organ infections	Agree ☐ Disagree ☐	

Score Obtained: ……
Code: ……

SECTION D: PRACTICE OF PREVENTIVE SEXUAL BEHAVIOUR AND REPRODUCTIVE HEALTH

Instruction: Please read the statements below and tick appropriately

77. Score Obtained: ……

S/N	Statement	Answers	Official Use
60	Report every abnormal sign in reproductive organs to the hospital or a doctor	Yes ☐ No ☐	
61	Had not been screened for prostate cancer in the last one year.	Yes ☐ No ☐	
62	Had STIs screening within the last one year.	Yes ☐ No ☐	
63	Personally examine scrotum and penis regularly.	Yes ☐ No ☐	
64	Have more than one sexual partner	Yes ☐ No ☐	
65	Don't use condom for sexual intercourse with my regular sexual partner.	Yes ☐ No ☐	
66	Use condom for sexual intercourse with other sexual partner(s)	Yes ☐ No ☐	
67	Do have sex with other men.	Yes ☐ No ☐	
68	Use herbal concoction on having signs of STIs	Yes ☐ No ☐	
69	Had not gone for HIV test in the last 3 months.	Yes ☐ No ☐	
70	Wash my reproductive organs with soap and water daily.	Yes ☐ No ☐	
71	Sometimes wear tight underwear.	Yes ☐ No ☐	
72	Don't consume vegetables and fruits regularly	Yes ☐ No ☐	
73	Drink alcohol	Yes ☐ No ☐	
74	Carry out exercise daily	Yes ☐ No ☐	
75	Exposed to pesticides because of use.	Yes ☐ No ☐	
76	Change my underwear every day.	Yes ☐ No ☐	

78. Code: ……

SECTION E: FACTORS AFFECTING ADOPTION OF PREVENTIVE SEXUAL BEHAVIOUR AND REPRODUCTIVE HEALTH

What are some of the things that can make you adopt preventive sexual behaviour and reproductive health?

S/N	Factors (You can tick more than one that applies to you)	Yes	No	Don't know
79	Adequate knowledge preventive sexual behaviour and reproductive health			
80	Culture			
81	Religion/Faith			
82	Partner's influence			
83	Availability of material support for reproductive health e.g condom			
84	Availability of screening services			
85	Good attitude of health workers carrying out screening services			
86	Cost of screening exercise			
87	Absence of stigma			
88	Trust in healthcare professionals			
89	Lack of fear of discovering STIs/Cancers			
90	Lack of complexity of the hospital registration process			
91	Less busy daily schedule			
92	Affordable cost of healthcare services			
93	Easy access to healthcare services			

Thank you for your participation