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POLITICS & INTERNATIONAL RELATIONS | RESEARCH ARTICLE

Masculinity and men's health-seeking behaviour in Nigerian academia

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Abstract: The nexus between masculinity and men's health-seeking behaviour is a multifaceted global discourse which has been quite enlightening when viewed from varying perspectives. Remarkably, cultural and patriarchal norms continually impact the chauvinistic character of men with regards to their health. It is in line with this that the study investigates men's health-seeking behaviour in the Nigerian academia by identifying factors that impede their acceptability of and accessibility to available healthcare facilities. More specifically, the study examined the extent to which gender/masculinity influences the health-seeking behaviour amongst men and how this invariably affects their rights to health enshrined in goal 3 of the SDGs. The Courtenay's relational theory of gender and men's health is the most suitable theory that puts the discourse in proper perspective. Data was obtained via in-depth interviews conducted with male staff of Covenant University. A convenient sample of 8 respondents were purposively and randomly selected from across the various ranks of the population of the study. The interview results identified and outlined

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PUBLIC INTEREST STATEMENT

The study of men's health-seeking behaviour is quintessential as it gives a vivid and broad understanding of men's overall health issues and the extent to which masculinity expedites the underutilization of health care services. It also elaborates on how the culture of patriarchy makes men reluctant to seeking and accessing relevant health care services for the improvement of their health. Furthermore, it reveals how men find it convenient to resort to self-medication or the consultation of alternative means of health-care. It is however pertinent to note that this research probes deeper and further into possible ways to address the factors that hinder men from accessing available healthcare services and makes adequate recommendations on how men's poor attitude to health care can be improved.

themes on the health-seeking behaviour amongst men in the academia. The paper argues that despite high educational attainments, masculinity and cultural norms remain major influencers of men's health-seeking behaviour. This study concludes that there is a need for health education, sensitization and campaigns in other to enhance health-seeking behaviour amongst men in the academia.

Subjects: Gender Studies; Health Sciences; Masculinity; Sociology; Psychology

Keywords: gender; masculinity; men's health; patriarchy; seeking-behaviour; Nigeria

1. Introduction

There is a direct relationship between the future of any nation and the health of her citizens. The health of citizens is advantageous for the development and growth of the nation (Adaramaja & Ogunsola, 2014). In other words, health is an essential aspect of the wellbeing of all humans, nations and the world in general. Health issues remain highly sensitive, predominantly when it concerns the male gender and associated with the perception of masculinity. This is in line with the sustainable development goal (SDG) 3 which advocates “healthy lives and promote well-being for all at all ages.” Put differently, it is crucial in achieving universal health coverage which includes access to quality and indispensable healthcare services, financial risk protection, access to effective, safe, affordable essential medicines and quality vaccines for all. To effectively explore the intricacies of this study as it relates with health, gender, masculinity, health-seeking behaviour and the right to health, it is imperative to discuss some concepts such as health, masculinity and health-seeking behaviour that are germane to this study. Agbeko (2010) defines health as an optimal personal fitness for a full fruitful creative living. Hausmann-Muela, Riberia, and Nyamongo (2003) avowed that health involves psychosocial, cultural, spiritual and economic aspects, where decisions related to health can have moral consequences regarding illness aetiology, possible treatment approaches as well as the outcome. According to the World Health Organization (WHO, 1974, p. 100), health is “the state of complete physical, mental and social well-being and not merely the absence of disease.” Evidently, this definition portrays health from a holistic view which includes social determinants and not just biological factors only.

Health-seeking behaviour is a process or action taken by any individual to sustain the state of physical well-being and fitness which allows such individual to manage the social, physical and biological environments to his or her gratification (Adaramaja & Ogunsola, 2014). It is also an act of making decisions from available options and the easiness with which humans can make certain choices over others (Shehu, 2005). Health is improved and maintained not only by the improvement and implementation of health science but also through the efforts of individuals and their intelligent behavioural choices which at times is influenced by societal norms (Brabers, Dijk, Groenewegen, & Jong, 2016). Put differently, health is moulded by dynamics not exclusively medical. Demographic factors or socio-economic characteristics of a population such as gender, age, educational qualification, marital status, income level, occupation, birth rate, religion, size of the family and death rate affects health-seeking behaviour (Shehu, 2005).

Society generally is polarized into the female and male sexual categories. Persons, whether males or females falling into either side of the classification profoundly have different societal roles and responsibilities. Most African societies, Nigeria inclusive, are highly patriarchal. “Males” are more often than not highly valued than “females”. Connell and Messerschmidt (2005, p. 832) argue that masculinity is the array of practices that allow the continued dominance of males over females. Masculinity entails multifarious hierarchies of socially-constructed narratives or discourses of masculine identity. This, therefore, posits that masculinity is not a fixed or steady, biologically-based phenomenon, rather it is complexly tied to gender, including power dynamics and power relationships. In everyday life, women and men are opened to a variety of dissimilar factors that can intensely affect their well-being both negatively and positively. However, the different roles expected of men and women imposed on them by society significantly impacts

on their health. Scholars such as Amoo (2018) and Amoo et al. (2017) opine that masculinity shapes the character of society and influences health-seeking behaviours. In fact, Craig et al. (2008) avowed that the nexus between masculinity and health-seeking behaviour is evident in men's utilisation of primary health services in some countries. Men continue to lag behind women despite the geographical, financial and cultural accessibility of men to communities' healthcare. In other words, men visit public healthcare facilities much less frequently than women. One of the major reasons why men lack the required confidence to seek health care is that they are socialised into the health culture from an early age (Amoo et al., 2018). Additionally, socio-economic, cultural and political factors accompanied by gender socialisation and gender dynamics affect their decisions making to seek health care.

Courtenay's relational theory of gender and men's health is the most suitable theoretical framework that put this discourse in proper perspective. This theory postulates that men's health seeking-behaviours and philosophies are demonstrations of their masculine identity and dependent on their adherence to contemporary prevailing masculine ideals (Courtenay, 2000). Put differently, Courtenay (2000) speculates that the masculine identities of men continuously experience shifts but when it comes to their beliefs and behaviours regarding health issues, they are adversely predisposed by their constructions of patriarchy/masculinity. It is important to note that, Courtenay's (2000) theory, originates from a societal constructionist and feminist perspective, which also recognizes Connell (1995) theory of dominant hegemonic masculinity that is referenced by other masculinity formations. Most importantly, Courtenay (2000) states that health-related behaviours and opinions are identifiable strategies of constructing and validating gender. Nevertheless, unlike other gender demonstrations, such behaviours can strongly influence the health and life-span of an individual (Das, Angeli, Krumeich, & van Schayck, 2018; Galdas, Cheater, & Marshall, 2005).

Unfortunately, as stated by Courtenay (2000), masculinity is demonstrated through avoidance or negligence of health care and promoting unhealthy behaviours. In societies where traditional masculinity remains the dominant identity for men, healthcare is strictly seen as a feminine construct where females who are usually being described as weaker vessels, require health services regularly while men are resilient and do not need health care services or are not often referred to as "fallen ill" (Seidler, Dawes, Rice, Oliffe, & Dhillon, 2016). Remarkably, it is imperative to note that, men may also authenticate masculinity differently. As Courtenay (2000) states, this may be included but not limited to the following; educational background, ethnicity, age, sexual orientation, economic status, and religion amongst others. It is against the aforementioned that this study therefore seeks to examine the extent to which masculinity affects men's health-seeking behaviour despite literacy and level of educational qualification. It also investigates the possible barriers to men's under-utilization of health services. In order to enhance the existing body of literature on the broad discourse of health-seeking behavior, the study is particularly concerned with the effects and influence of masculinity and gender on the health-seeking behaviour of male academics in Nigeria, as well as their acceptability of existing healthcare facilities.

2. Methods

This study adopts the case study research design. This design allows researchers to do in-depth investigations into specific issues or situations within an identified sample. The design enabled this study to narrow down masculinity within the context of men's health-seeking behaviour. The data obtained for this study were the first of its kind with the groups that constituted the population of this study. The researchers recruited male faculty from Covenant University, a private higher institution in Ogun State, Nigeria as participants for the study. The institution was chosen because it is the fourth in Africa and widely adjudged to be the best in Nigeria according to Times Higher Education 2020 ranking (Times Higher Education, 2019). Based on in-person recruitment, the researchers determined a total of 8 individuals selected to participate in the study (Moore & Willis, 2016). The small number of the participants was due to the limited number of people that consented to participate in the study. Participants were volunteers. Besides, previous studies such as Amoo et al. (2017) have also used limited or small numbers of participants that are manageable

and that could provide sufficient data. Recruitment of participants and the conduct of interviews spanned about seven (7) weeks beginning from July 10, 2018 to August 29, 2018. The participants due to their spread across various academic cadres may help to establish the healthcare orientation amongst the academic staff of Covenant University which would frame health care policies and programmes as well as improve the health-seeking behaviour for both male and female genders in the academia.

2.1. Study population and data collection protocol

A total of eight in-depth interviews were conducted in the English Language amongst the faculty and staff of Covenant University. The respondents were selected via the purposive sampling approach. This is because the sampling technique enabled the researchers to reach the target sample quickly and due to specific characteristics required that they must be male faculty and agree to participate. Participants resided in Sango, Ota, Ogun State, southwestern Nigeria. In addition, the technique provided the opportunity to make a generalization from the sample that is being studied in a logical and analytical manner. With the use of convenient sampling, participants with similar criteria were chosen. In accordance with the philosophies of qualitative research, homogenous and moderately small sample size was preferred in order to prevent the loss of vital information during analysis (Brocki & Wearden, 2006). In order to adequately reflect the demographic profile of the study area, the sample was stratified into four groups demarcated by rank, which are the professorial cadre (PC), senior lecturer cadre (SLC), the “others” cadre (OC) constituting the lower category made up of Graduate Assistant, Assistant Lecturers and Lecturer 2 while the non-teaching staff category was represented with (NTS) for descriptive analysis. Just two respondents were selected from each of the categories which gave a total of 8 respondents in all. Informed consent was acquired from the study participants and none of the respondents was coerced into participating in the interview sessions. Participants had the freedom to opt-out during the process. The names, addresses, telephone numbers and other personal details of participants were not collected, thus, there was no need to obtain ethical approval for the study. Eligibility criteria for participation in the interview included that they were from 20 years and above and they have been in the employment of the University in the last 5 years.

2.2. Socio-demographics

The socio-demographic variables and inclusion criteria of the selection of participants are age, academic status, religion, occupation, location of residence (whether on or off campus), marital status and financial status. Age was split into three categories (30–49, 50–69 and 70+) for descriptive analysis. Financial status or structure was split into four categories between 350, 000 to 500, 000 for the professorial cadre, between 250, 000 to 349, 000 for the senior lecturer cadre, between 105, 000 and 249, 000 for the others category and between 40 and 104, 000 for the staff category. All the respondents were Christians because the institution under study is a Christian school. 7 of every 8 respondents are married while 1 of every 8 was engaged. 1 of every 8 respondents have been in the academia for between 5 to 10 years, 3 of every 8 participants have spent between 11 and 20 years, while 1 of every 8 had spent over 48 years in the academia.

2.3. Data analysis procedures

For the study, the researchers conducted in-depth semi-structured interviews with an interview guide adapted from the work of Ntokozo (2013). During each interview session, the respondents responded to the demographic form and also provided answers to a series of questions in the interview guide. The interview took place in a location that participants selected as convenient and relaxing for them to adequately express themselves and provide the data needed for the study. The locations however include participants’ homes and office. Each participant participated in a 30–60 minutes interview session which was recorded and transcribed verbatim. The transcripts were individually coded. Qualitative analysis, as well as the elucidation of themes, followed the processes of Thematic Analysis (TA). The semantic thematic approach which involves categorizing themes at a descriptive level of simple meaning buttressed by excerpts from the data was adopted for this study (Boyatzis, 1998; Braun & Clarke, 2006). Afterwards, the thematic analysis was taken further to an interpretative level to place the analysis within broader interpretations and meanings pertinent to available literature (Patton, 1990).

This procedure brought about the adoption of global themes that were drawn from the basic themes using identifiers from the data that are necessary for analysis. In other words, the thematic approach drew on the associations between the data set, while exploring likely contradictions, tensions and inconsistencies between and within the data obtained from the individual participant. After this, themes for thematic analysis and presentation of data were developed. The analysis of this study consisted of various parts. The first describes the characteristics of the population described by the socio-demographics of the respondents. Thematic analysis was presented and labelled with the category of the groups. Respondents within each category were identified with numbers 1 and 2.

2.4. Credibility and transferability

As it relates to qualitative research methods, the trustworthiness, credibility and transferability or generalization of results are important concepts. The credibility of this study was ensured via note-taking and reflections. To ensure transferability, the researchers situated the data within existing extant literature and made inferences on various ways in which the data from this study could be applied to the larger society specifically as it relates to masculinity and men's health, the availability, accessibility, acceptability of healthcare services within the academia as well as the quality of available healthcare.

3. Results

3.1. Sample

The researchers interviewed eight men for the study. The participants' age ranged between 31 and 75 years. The length of the time for the interviews varied. Ranging between 30 minutes and 1 hour. After the approval of the interview guide, the researchers selected 8 men for this study, 2 participants each from the Professorial cadre, Senior Lecturer cadre, non-teaching staff and other cadres in the academia. Participants were assured of the protection of their confidentiality.

3.2. Emerging themes of the study

The overriding research question was "does masculinity influence the health-seeking behaviour of men in the academia"? In this study, a number of themes emerged. The major ones are: The use of internet for health consultations; Awareness about health issues peculiar to men; Nature of the Sickness; Perception of knowing their own Body System; Men's level of conformity to masculinity beliefs and health-seeking behavior; Relationship with Medical personnel; Acceptance of alternative methods of healthcare; Perception towards Preventive health care and medical screening; Treatment for others but not self; and Challenges that affects Men's health-seeking behavior.

3.2.1. Awareness about health issues peculiar to men

There is generally limited knowledge of diseases peculiar to men. The diseases mentioned bordered on diabetes, prostate cancer, and blood pressure whereas there are other diseases such as bladder stones, Peyronie's Disease, Testicular Cancer, Male Breast Cancer, Binge-Eating Disorder, Runner's Hematuria, Varicoceles which were not mentioned by all participants. Below are some excerpts from the interviews:

I know quite a few of them ... you know the prostate thing is very peculiar to men, high blood pressure, diabetes (sugar level) are some other health issues peculiar to men (PC, 1).

Diseases peculiar to men are Blood pressure and sugar levels (NTS, 2).

3.2.2. The use of the internet for health consultations

Technology plays an important part in people's lives. Since the development of the internet and its expansion globally, it has been a majorly adopted global platform for the dissemination and retrieval of information across the various field of human endeavours including health. Gathered health information is often for various purposes, including preparations for or following a medical consultation, to gain information regarding medication prescribed and for self-diagnosis purposes,

or for help with managing a long-term condition. Despite the potential of the internet in ensuring good health, it could also encourage poor health behaviour such as self-medication, overdoes and delay in getting medical help. Below is an excerpt:

Well, I believe that one should actually try some things out before you seek for medical attention for prescription ... these days, what I do is that I ask Google health questions (PC, 1).

3.2.3. Nature of the sickness

Respondents' perception about the nature of the sickness influences and determines their decisions as to whether they will visit medical facilities or not. The "nature of the sickness" centres on respondents demarcation between normal (common and less severe sicknesses) and severe sicknesses. In other words, respondents categorized sicknesses as common when they are used to them, and others as complex ones when or because they often do not experience them, which influence their health-seeking behaviour. Some thematic excerpts are stated below:

When I feel some kind of uneasiness that is unusual, maybe as a result of work-related stress, I may want to quickly seek for medical attention because it appears unusual than I normally feel (PC, 1).

I look at the nature of that sickness ...to know if it is serious enough or worth seeking medical attention for (OC, 1)

Actually, it is not every time that you need to go to the hospital for medication. If you have a kind of sickness or symptom that you are used to or that you know, and you have been to the hospital for; and for which medical practitioners have recommended certain treatments to you before, I think you can take the same medication on your own. But if you know that the sickness is not normal, then you should go to the hospital (SLC, 2).

I seek professional healthcare only when there is a major problem (NTS, 2).

My visit to health facilities depends on the nature of the sickness. When I know that what is wrong with my health is similar to old symptoms that I have known overtime, I know how to address it. But if it is new or it persists, I believe that that is where self-medication should stop (PC, 2).

Basically, I mostly just try to check the symptoms. If they are the usual things that I am used to, I just rest (OC, 2).

It is necessary to mention that the dichotomy discussed about the nature of sickness and health-seeking habit is underpinned by participants' perception of self-medication. Here are some excerpts:

Self-medication is a good thing ... I appreciate it probably because it has always worked for me, but I usually tell people that once you stay on self-medication and it doesn't work for you for two ds, or after two days, it will be better you get medical attention (OC, 1).

Respondents that claimed to have a cordial relationship with care providers argued that:

I don't really buy the idea of self-medication, it is not a good thing to do, if anybody is doing that, you are simply damaging your health. It is better to seek help from professionals (NTS, 1).

3.2.4. Perception of knowing their own body system

The "I know my body syndrome" is a major cause of self-medication. 1 of every 2 respondents referred to knowing their own body as having a strong impact on their health-seeking behaviour.

They argued that they did self-medication because they knew their body systems and the medication that works for them. Some excerpts are presented below:

Once you know your body system and discover some particular symptoms, you know the kinds of drugs to get (OC, 1).

I do self-medication because I know my body (NTS, 2).

I have never had any major problem except muscular sprains from sports, headaches, malaria and these are things that I know how to address myself (PC, 2).

Because I know my body, I self-medicate. But after self-medication of one or two days without any changes or improvement, I resort to medical help (PC, 1).

3.2.5. Men's level of conformity to masculinity beliefs and health-seeking behaviour

The man factor as reflected in hegemonic masculinity has been a risk to men's health-seeking behaviour. Hegemonic masculinity built into the society's classification of men as the stronger sex and women as the weaker sex is an influencer of men's health care. For men, seeking medical help challenges the norm of being strong. 7 of the 8 participants argued that men conform to the belief of masculinity identity in seeking health care when feeling ill. Men express some form of masculinity and sentiments that men should not be sick. Below are some excerpts in support of the submissions above:

The number one challenge to men's health seeing behaviour is this mentality of "I am strong". Men tend to be overconfident, maybe that is why men die more or earlier than women (PC, 1).

Cultural norms are the major problems for men as expressed in masculinity and the patriarchal African society. There are certain things we men believe people should not know us for. Most of the time if you are not feeling alright, you charge or motivate yourself to be strong because your wife and children are observing you. You would not want to present yourself as a sickler because the whole family would be agitated. It is not a thing of pride for the head of the family to be going to the hospital or complaining. It is a sign of weakness ... so we pretend as if nothing is happening (SLC, 2).

On the contrary, one in every 8 respondents argued that masculinity is not a determinant of health-seeking behaviour. An excerpt buttressing this is stated below:

My masculinity does not affect my health-seeking behaviour negatively but positively because being a man notwithstanding, I do seek medical attention whenever I feel my state of health demands me to (NTS, 1).

Additionally, it was also observed that there is often resentment amongst men about being treated by women when they need professional medical intervention. The masculinity factor also reflects in the rejection of medical help because of the feeling that being treated by women who are seemingly labelled "the weaker sex" is a taboo. This is also because culturally, there are certain matters that men are not expected to discuss with women. However, males visit to health centres impede on this norm as most of the health care providers are females. Below is an excerpt:

Masculinity prevents me from going to hospitals. You will go, then a woman will be attending to you as a man. No oh! (SLC, 2).

3.2.6. Relationship with medical personnel

Men seek medical help only out of necessity and due to the nature of their relationship with healthcare providers. As observed from the in-depth interviews, the relationship between healthcare providers and patients can be categorized as non-existent, cordial and distant. 1 of every 2

respondents avowed that their relationship with healthcare providers is distant. 1 of every 2 respondents also argued that their relationship with their health care providers is cordial, while 1 of every 8 respondents stated that such relationship is non-existent. Some excerpts are stated below:

I do not have a good relationship with them because I don't really go there ... therefore, most times, my relationship or contact with healthcare providers is strictly based on necessity. Asides that, I don't go to the hospital (PC, 1).

Perception about self-medication is another common reason for the distant relationship with health care providers. This often makes visits to the hospital a last resort. Below are some excerpts:

I don't normally go to the hospital or consult for anything. I usually examine myself and self-medicate. I do it a lot ... The moment the health challenge goes beyond what I expect and I cannot manage it again, I go to the hospital (SLC, 2).

My relationship with health practitioners is distant. I believe that one should actually try some things out before seeking medical help from health facilities (PC, 1).

My relationship with health care providers is very cordial. I don't just take drugs anyhow. I love to go there to see a physician that will give me the right prescription after conducting some tests on me (NTS, 1).

Another propeller of self-medication and poor relationship between men in the academia and health care providers is the influence of the transferred medical knowledge their acquaintances have gotten from healthcare providers. An excerpt is presented below:

I have always seen my wife as my pharmacist. She does not have any background in medicine or pharmaceutical practice but her mother does. So, each time her mum talks about drug prescription, she writes it down. So, she has her own diary for that. She knows the drugs to prescribe once there is any ailment, be it headache, runny stomach or stomach ache etc. So, once I observe anything, I consult her and then we just go to the pharmacy or medicine store to buy whatever drugs is needed to address the situation. So, because of that, my relationship with healthcare providers is quite distant (OC, 1).

3.2.7. Acceptance of alternative methods of healthcare

There are perceptions of the acceptance and usage of alternative methods of health care. The challenges, however, centres on hygiene and prescription problems amongst other issues. Here are some excerpts:

Occasionally, I use agbo (herbs) only for malaria, but not for any other thing (PC, 1).

I really do not believe in traditional medicine. Naturally, I query if traditional medicine works and if it can work for me That is apart from the fact that it is very bitter (OC, 1).

I don't believe in them. I prefer foreign drugs. I have a reservation about the people who sell herbs. (NTS, 2)

I hate traditional medicine because of my experience. I have had a very nasty experience after using it. When I was in school, a friend of mine had just come from home and brought herb tea and told us how to make it. I took some and throughout the night I was purging, and it continued for days, and they had to rush me back to my village. So anything herbs is a no-go area for me (SLC, 2)

Responses from participants revealed that religious beliefs and practices are major alternative methods of cure. Respondents also identified the importance of religion on their health-seeking behaviour and that it plays a major role in making health decisions. In fact, 3 of every 8

respondents mentioned that they engage their faith and trust in God or a supreme being as a cure to sicknesses. Below are excerpts from the in-depth interviews:

I believe one should receive medical attention ... However, for those of us who are Christians, we also tend to want to use faith. I use faith myself too (PC, 1).

The first thing I consider when I am not feeling fine health-wise is to pray to my God, take communion (a liquid Christians take as representing the blood of Jesus Christ), and after that, I will now seek medical help from health practitioners around me (NTS, 1).

As the head of the family, I need to use faith more than the other members of the family to show them spiritual leadership (SLC, 2).

As a Christian, the use of faith is not sinful. There is nothing wrong with that. Usually, I pray when I have some health challenges but when they persist, I get help. If it is minor ailments like headaches, I know I need rest so I just try to do that because I know my body (SLC, 1).

Some responses also reflected a balance between alternative medicines and the use of faith for healing. According to NTS 2, “I mostly rely on my faith. But sometimes I use self-medication and go to hospitals in emergency cases”.

3.2.8. Institutional social structure and perception towards preventive health care and medical screening

The perception of the respondents towards medical screening and preventive health care was very poor. When asked about their attendance in health facilities for medical screening, all the respondents showed that they never visited any medical facility exclusively for health screening although they were aware that the facilities existed. They had the perception that visit to medical centres should be when there is a major sickness that they cannot address with self-medication and alternative medicines. Most of the respondents avowed that they do not want to do any medical screening and preventive health care. Most of the respondents prefer not to know their medical status due to the pressure that the results would put them under psychologically. Other reasons include the fear of being stigmatized and reprimanded from work as well as a lack of confidence about the confidentiality of the health care providers. Some reasons for poor perception towards preventive health care and medical screening are presented thematically below:

For people that have a sickness that they know can attract stigmatization, they may not want to go to the hospital because if they do, they are going there to announce themselves. But those that don't have anything to fear can go (SLC, 2).

People were actually scandalized because of the last general medical checkup we had in this institution. At a point, people were being detained and hospitalized. Even before getting to that place, my blood pressure was already high because I was scared of being hospitalized (OC, 1).

Medical care/attention is necessary. But I believe that those who run away from it do so out of fear of discovery of what is wrong with them. Some would rather prefer not to know what is wrong with them. They do not want to subject themselves to anxiety and fear of knowing what ailments they have (PC, 2).

Another challenge is that negative organizational response to medical reports also induced fear of being laid off from their jobs. An excerpt is stated below:

Management needs to assure people that even when you are tested positive to an ailment, the outcome or aftermath effect should not be resignation, sack or downsizing. This will stimulate and motivate people to freely submit themselves to go for medical checkups (OC, 1).

Workplace policy has influenced men's health-seeking habit positively. It was noted that attending medical check-ups is more of a forceful exercise amongst the participants. All the respondents do not go for medical check-up willingly unless when asked to do so by the management of their institution. Find some excerpts below:

Apart from the one (medical check-ups) we have here yearly, and the check-up I underwent at my point of entry into this institution, I have not had any encounter of medical check-up(s). For me, the last time I went for medicals was when the school management compelled us to go and I just had to go because if I didn't go, my salary may be affected (OC, 1).

I actually get medically checked about twice a year, which is the one that the institution organizes and on a few occasions, my church organizes medical programs. That's all. But I don't go on my own (SLC, 1).

I don't go for check-ups except that which the school management does for us once a year (PC, 1).

3.2.9. Treatment for others but not self

One of the common themes that were observed is men's treatment of other members of their families such as their children and wives but not themselves. This shows that men's responsibility of taking care of the home transcends to ensuring their medical health. Below are some excerpts:

A man that has a family will think more of how to take care of his family first and cater for pressing needs or responsibilities at home. So with those pressures, we men tend to neglect ourselves healthwise while taking care of others. So we pay the price of sacrifice with our health in order to fend for the family (PC, 1).

I would rather take them to the hospital than go there personally for anything. If there is anything (health challenge) I just imagine that it is paracetamol I need. Sometimes, I use my faith and pray about it. But for other members of my family, I ensure they get themselves treated in the hospital (SLC, 2).

3.2.10. Challenges that affect men's health-seeking behaviour

Some challenges affect men's health-seeking behaviour. Fear is a factor that negatively affects men's visit to health facilities. An excerpt is stated below:

Relationship with healthcare providers are non-existence this is because I believe they always put fear in people (NTS, 2).

Relationships with caregivers are also affected by the variance between the patient's perception and diagnostics by health providers. Some excerpts are presented below:

I am usually okay with them. But sometimes, I feel that they try to insist on some things that I may not agree with because I know my body better than they think they do (PC, 2).

My relationship with healthcare providers is quite good. When they ask all kinds of questions, I am generally open to them ... but sometimes I don't really see the need for all the drugs they prescribed (OC, 2).

Financial constraints were also expressed as affecting health-seeking behaviour. 7 of every 8 respondents argued that there is a strong correlation between financial constraints and men's health-seeking behaviour. The cost of receiving health care has severe influence on the decision of men to seek health care. Cost of health care services such as consultation fees, registration fee, medication fees amongst others is a barrier to health-seeking behaviour and make the adoption of alternative health care and self-medication attractive. As a result, men prefer to make do with self-

medication and other alternative health care which are not as costly as getting professional medical help. Below are some excerpts:

I feel finance is a major challenge. When you consider that the cost of taking yourself to the medical centre is exorbitant, then you ask yourself “what is the need” ... then you can as well just go to the pharmacy and get some drugs and you will be fine (OC, 1).

I know generally people consider finance but when you think very well, finance is not something one should be considering when it comes to health because one’s health is paramount (PC, 1).

There was a contrary view to the submissions that finance is a constraint to good health seeking habits. Just 1 of every 8 respondents did not agree that finance constitutes an impediment to health-seeking. An excerpt supporting this stance is stated below:

I don’t really think finance is a barrier. Primary healthcare is affordable. Even if you have the notion that healthcare in Nigeria is expensive, there are government hospitals where their rates are cheaper than the charges in private hospitals. So, healthcare at the initial stage is something affordable for everyone. It is only if one has a number of complicated health issues that finance can or should be an issue (NTS, 1).

Another challenge to health-seeking behaviour amongst men is the level of confidence in health facilities and personnel. Here is an excerpt:

The confidence you also have in the health facilities and practitioners is also a very important factor. For example, I have a health care centre near my house which normally one would think is reputable and offers quality services, but having heard so many stories and having seen certain things there, I don’t want to go to such a place. The main reason why I patronize the health facility I use is because of the confidence I have in his ability and professional practice (PC, 1).

4. Discussion

This study dealt exclusively with men’s health-seeking behaviour with particular samples selected from the academia. Amongst the most significant findings of this study is that men’s health-seeking behaviour is very poor and this is as a result of a number of factors viewed from different angles. It avows that cultural and patriarchal norms/beliefs still play very vital roles in determining the health-seeking behaviours of men despite their educational and professional attainments. In other words, cultural and patriarchal norms/beliefs are major barriers to the attainment of SDG 3 as men in the Nigerian academia have permitted these norms to hinder their access to quality healthcare services. This shows that socially constructed gender norms such as masculinity which often characterize men as being resilient and brave amongst other socially constructed expectations affect the attitude of men and is a common barrier to their unhealthy health-seeking behaviour. The definition of masculinity and gender as it relates to health is very unhelpful because most men tend not to visit medical centres until their ailments deteriorate and sometimes lead to death. This finding was supported by studies of Lubega, Musinguzi, Omiel, and Tumuhe (2015), Men’s Health Forum (MHF, 2008) and Khan (2004).

There was an interface between fear of discovering the challenges with their health, the notion of masculinity and the invasion of privacy. The fear amongst the participants is a result of the psychological awareness of knowing their status and the effects on their employment status which socially, men are not permitted to express. This is opposing the norm of men as being fearless and strong and it is an invasion of the rights of headship. This opposes the findings of Ajayi and Soyinka-Airewele (2018) and Qayum and Ray (2010) in their classification of African men (this could be applicable in other societies) as being brave, fearless, adventurous and born leaders.

There is generally poor health-seeking behaviour amongst the respondents. Apart from the common screenings such as blood test, blood pressure examinations and other compulsory screenings mandated by workplace organization, it was observed that all the respondents never submitted themselves to self-motivated health screenings. Furthermore, it was also observed that visiting medical facilities for professional health care intervention seemed to be the last option and often sought after self-medication and alternative medicines have failed and the health situation degenerated. Therefore, this study supports the position of Lubega et al. (2015), and Abubakar, Van Baar, Fischer, Bomu, Gona, & Newton (2013) that there ought to be adequate health education on improving health care behaviour, and if possible, that would avoid or even reduce preventable deaths amongst men.

It is worthy to note that, educational status/ranks/attainment do not have significant effects on men's health-seeking behaviour. It was observed that there was no difference in perception on health-seeking behaviour amongst the respondents despite their educational and the employability status. This study, therefore, refutes the finding of Ranstad, Midlöv, and Halling (2017) that socio-economic status is dire determinants of the utilization of health care facilities.

Technology and religious beliefs are major influencers of health-seeking habits such as self-medication and negligent health behaviour. The use of technology via telephone, laptops, and desktops amongst others through internet connectivity for health reasons have attracted ample attention. Conversely, in spite of the possible benefits of the use of the internet in this area, numerous trepidations have been raised by health practitioners, researchers, and scholars. These include uncertainties/fears that it may boost social inaccessibility or seclusion concerns regarding website integrity, as it is an unfettered platform. This is consistent with findings from Bogle (2013), Rains and Karmikel (2009), Larner (2006) and Hardy (1999) who averred that this channel may afford a conduit to non-conventional healthcare services or might result in the discovery of distorted health information, or inappropriate self-medication/diagnosis. Likewise, fears have been raised by Nwosu and Cox (2000) about how the internet poses a serious threat in challenging the tenets and practice of the medical profession. Health-seeking via the use of technology has led to reports from respondents in this study to having a sense of independence and privacy. This is in tandem with studies by Yaya and Ghose (2018), Bogle (2013) and Seckin (2010) who also recounted that the internet can aid users to formulate/concoct medical consultations and make verdicts regarding prescriptions which have and continues to affect doctor-patient relationships.

The place of religion in men's health-seeking behaviour is very controversial and continues to generate heated debate amongst scholars, medical practitioners, religious leaders and the layman about the nexus between healthcare institutions and spiritualism. It was discovered in this study that the majority of the respondents reiterated the importance of their religious beliefs and doctrines as compared to seeking adequate health attention when the need arises. To them, as long as these beliefs are in place, their health status/stability is guaranteed. Although there are reservations on enforced or forced health-seeking behaviour as it induces fear, social stigmatization and fear of loss of job amongst others, institutional enforcement of check-ups seemed to be a promoter of good health seeking habits.

5. Limitations of the study

This study is limited to only men in the academia within the Covenant University context. The researchers did not study the health-seeking behaviour of women. The study did not also consider other variables such as the current health conditions of respondents as well as the effects of leadership positions on health-seeking behaviour amongst men in the academia. However, data obtained from the study achieved the objective of interrogating men's health-seeking behaviour in Covenant University as participants cut across various academic cadres which makes a generalization of the research findings to other research settings possible.

6. Conclusion and recommendation

This study has sufficiently added to the body of knowledge about men's health-seeking behaviour in the academia. It extensively discussed a wide range of factors that affect health-seeking within the purview of masculinity. It specifically investigates whether educational level affects health-seeking attitudes with particular reference to men in a private higher institution in Nigeria. The study has shown that health-seeking behaviour is a complex intersection between individual perceptions about health as well as cultural and social norms commonly practised in various and all societies. Masculinity, cultural values, societal norms and socio-economic factors play very fundamental roles in men's health-seeking behaviour. Furthermore, it found that education has not been a positive propeller for better health-seeking behaviour, rather social norms and social roles have stronger influences on health-seeking behaviour. The study argues that while there are some but little awareness of some of the illness that are peculiar to men, there is an increasing ignorance of the necessity for medical check-ups and preventive health care intervention. This study therefore advocates that health education should be promoted to enhance better health-seeking behaviour amongst men in the academia. This could be done through partnerships between academic institutions and healthcare centres through constant organisation of seminars and programmes that would project the benefits of seeking appropriate health services either when sick or not, as well as provide adequate medical check-ups for their employees at the commencement and end of the year's work.

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