



Self-Perception and Health Locus of Control as Predictors of Preventive Health Behaviour among Academic Staff of Selected Universities in Ondo State, Nigeria

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Abstract

This study examined the extent to which self-perception, and health locus of control predicted preventive health behaviour among university academic staffs selected from three Universities in Ondo State, South-western Nigeria. A cross-sectional survey design with a multi-stage sampling technique was used to select a total of 606 participants (360 Males and 210 Females) from three Universities in Ondo-State, Nigeria. Data were collected with self-report questionnaires. Preventive health behaviour was measured using the Preventive Health Behaviour Scale, by Jayanti RK, et al. Self-perception was also measured using, Self-perception Scale, by Jayanti RK, et al. and health locus of control was measured using the Multidimensional Health Locus of Control Scale, by Wallston KA, et al. Three hypotheses were tested with multiple regression analysis. The result showed that self-perception significantly predicted preventive health behaviour [$\beta = .28$; $F = 4.99$]. Also, internal locus of control ($\beta = .33$, $F = 31.29$) predicted preventive health. The findings demonstrated that self-perception, health locus of control played important roles in preventive health behaviour among academic staff. The researcher therefore recommends based on these findings suggest that stakeholders in university administrations should integrate psychological factors implicated in this study when designing behavioural interventions to promote preventive health behaviour among academic staff.

Keywords: Self-Perception; Health Locus of Control; Academic Staff; Preventive Health Behaviour

Abbreviations: NUC: National Universities Commission; PHBS: Preventive Health Behaviour Scale; MHLCS: Multidimensional Health Locus of Control scale Self-perception Scale.

Introduction

Preventive health behaviour has become a central objective of public health interventions over the last half decade, as

the influence of prevention within the health services has increased [1]. All human beings generally desire to live up to old age with a life free of disease and illness but this desire is not realized for a significant percentage of human population probably because their lives presumably were cut short by premature death or incapacitated by one disease or another Dennis DU, et al. [2]. Preventive health is an important component of several theories of health behaviour [1]. These theories state that once people perceive themselves as being

susceptible to health risks, they form intentions to take preventive actions or to give up risky health behaviour [2].

Over the years, the focus of public health movement has shifted from the management and treatment of infectious diseases, which was the preoccupation of the first half of the twentieth century, to modification of life style into preventive health behaviours [1]. Today, world leaders are focusing on preventive healthcare rather than curative medicine. This notion has provided a platform for a paradigm shift in healthcare practice [2]. The attendant consequences of this has entailed a shift by public health physicians from research on how to control different diseases, to preventive health behaviour and the need to form alliance with experts in preventive behaviour [1].

From an academic standpoint, it is important to understand the factors which lead people to develop preventive health behaviors [3]. Many health conditions are caused by lifestyle choices, such as problem drinking, substance use, smoking, reckless driving, overeating, or unprotected sexual intercourse [2]. The key question in health behaviour research is how to predict and modify the adoption and maintenance of health behaviours [1]. Fortunately, human beings have, in principle, control over their conduct. Health-compromising behaviours can be eliminated by self-regulatory efforts and health-enhancing behaviours can be adopted instead, such as physical exercise, weight control, preventive nutrition, dental hygiene, condom use, or accident prevention [3].

In general terms, preventive health behaviour refers to the actions of individuals, groups, and organizations and to those actions, determinant, correlates, and consequences, including social changes, policy development and implementation, aimed at improving coping skills and enhanced quality of life [2]. Scientific literature has identified three types of health behaviour: preventive health behaviour, illness behaviour, and sick-role behaviour. Preventive health behaviour is any activity undertaken by an individual who believes to be healthy for the purpose of preventing or detecting illness in an asymptomatic state [4]. Preventive health behaviours are typically identified as having salutary effects on physical and mental well-being, and it is conceptualized as wellness maintenance activities and avoidance of risk behaviours [4]. Preventive health behaviour generally follows from a belief that such behaviour will benefit health. An obvious example is quitting smoking to reduce the chances of early morbidity and mortality. It does not follow, of course, that all beliefs on which preventive behaviours are based are well founded, nor that the resulting behaviours will have the desired outcomes [2].

Preventive actions can help reduce, but not entirely eradicate, the chances of contracting a disease or illness [4]. The strength of the cause and effect relationship between

certain behaviour and the health problem one is trying to prevent will determine the impact performing the behaviour will have on reducing the risk [2]. A variety of psychosocial factors account for individual differences in the propensity to undertake preventive health behaviours, including; demographic factors, social factors, emotional factors, perceived symptoms, personality factors and cognitive factors [4].

Many researches have shown that self-perception is the main determinant of preventive health behaviours [5]. According to this paradigm, self-perception is a function of expectations about the outcomes that will result from one's engaging in health behaviour and expectations about one's ability to engage in or execute the health behaviour. Thus "outcome expectations" consist of beliefs about whether a given health behaviour will lead to given outcomes, whereas "efficacy expectations" consist of beliefs about how capable one is of performing the behaviour that leads to those outcomes. It is emphasized that both outcome and efficacy expectations reflect a person's beliefs about capabilities and behaviour-outcome links [1]. Perceived self-perception represents one core aspect of social-cognitive theory [6]. While outcome expectancies refer to the perception of the possible consequences of one's action, perceived self-perception refers to personal action control or agency. A person who believes in being able to produce a desired effect can conduct a more active and self-determined life course. Health specific self-perception is a person's optimistic self-belief about being capable to resist temptations and to adopt a healthy lifestyle [5].

Bandura A, et al. [6] argues that perceived self-perception influences all aspects of behaviour, including the acquisition of new behaviours (e.g., a sexually-active young adult learning how to use a particular contraceptive device), inhibition of existing behaviours (e.g., decreasing or stopping cigarette smoking), and dis-inhibition of behaviours (e.g., resuming sexual activity after a myocardial infarction). Self-perception also affects people's choices of behavioral settings, the amount of effort they will expend on a task, and obviously, perceived self-perception predicts degree of therapeutic change in a variety of settings [7]. Weinstein (1983) cited in, Bandura A, et al. [7] posit that individuals ignore their own risk increasing behaviour (I drink lots of alcohol but that's irrelevant) and focus on a risk reducing behaviour (but at least I don't smoke). Another personality trait often associated with preventive health behaviour is locus of control.

Locus of control is one such generalized expectancy in Rotter's social learning theory [8]. It refers to the person's belief as to whether control over valued reinforcements is internal or external to the person. (Locus is the Latin

word for 'place'.) A person with an internal locus of control orientation believes that reinforcements are a consequence of either some action (or set of actions) in which the person engages, or of some relatively enduring characteristic (or set of characteristics) of the actor and a person with an external locus of control orientation believes that reinforcements are the result of forces outside of the person, either the situation itself or the action(s) of other people. Also included under 'external' locus of control is the belief that reinforcements are only determined by fate, luck or chance. An external belief orientation is typically equated with a perception of lack of control over reinforcements [8].

Ihinmoyan T, et al. [8] stressed that, health locus of control arise from a person's belief concerning his/her health, whether control over his or her health is controlled by internal or external factors. Internal factors involve the individual belief of responsibility and control of anything that happens to him or her, while external involves ascribing the control and responsibility to external factor. When individual beliefs responsible for certain behavioural change that happen or that are about to happen he/she can easily engage in preventive behaviour, this refers to internal loci of control, and when the individual perceive that he or she been controlled by external factors and that he/she cannot do anything to change the situation, this situation refers to external loci of control.

Statement of the Problem

In Africa, approximately 7.5 million avoidable medical and surgical procedures are performed annually (African Center for Disease Control and Prevention, 2003), while approximately 18.9 million people around the world are hospitalized unnecessarily. With staggering reports as those cited above, the need for alternatives to curative medicine cannot be over emphasized. Medical researchers have postulated a number of alternatives including but not limited to herbal treatments, yoga techniques, acupuncture and preventive healthy lifestyle regime [1].

Of the stated alternatives, preventive health behaviour have garnered immense interest across healthcare fields and several lifestyle behaviours have been suggested which includes but not limited to exercising, dieting, healthy behaviours like non-smoking have been encouraged in the last century in a bid to stem curative medical practices which are expensive [2]. Hence, the necessity to understand and sustain preventive healthy behaviour becomes the bane of most contemporary medical researches (Centers for Disease Control and Prevention, 2003).

Several authors Dennis DU, et al. [2]; Ihinmoyan T, et al. [8] have pointed out that preventive health behaviours may have

a positive impact on quality of life via delaying the onset of chronic disease and extending active lifespan. Human behaviour, especially health behaviour, is complex and not always readily understandable. It may also not be related to health per se, since motivation for health behaviour is dynamic and not static. Most people are aware that if they smoke they will have an increased risk of getting lung cancer [2]. Some people who do not smoke get lung cancer, of course, but the numbers are small. Similarly, wearing a seat belt reduces the chance of dying in an automobile crash, yet it does not guarantee that the individual involved will not be seriously hurt.

This study intends to provide links and associations by examining the predictive roles of self-perception and health locus of control as predictors of preventive health behaviour among academic staff of selected Universities in Ondo State Nigeria. Exploring preventive health behaviour from this angle might help promote preventive health behaviour in Nigeria. It would be pertinent to ask some relevant questions:

- Would self-perception predict preventive health behaviour?
- Would health locus of control predict preventive health behaviour?
- Would self-perception and health locus of control would jointly predict preventive health behaviour?

Purpose of the Study

This study mainly examined personality factors, self-perception, comparative optimism and health locus of control as predictors of preventive health behaviour among academic staff of selected Universities in Ondo-state, Nigeria. Based on the research questions above, the specific purpose of this study was to;

- Determine whether self-perception predict preventive health behaviour of Universities Academic Staff.
- Assess whether health locus of control predict preventive health among academic staff of selected Universities in Ondo State, Nigeria.
- Examine the joint effect of all the predictor variables (health locus of control, comparative optimism, and self-perception) on preventive behaviour of Universities Academic Staff.

Hypotheses

- Self-perception will significantly predict preventive health behaviour among academic staff in selected Universities in Ondo State.
- Health locus of control will significantly predict preventive health behaviour among academic staff in selected Universities in Ondo State.
- Self-perception and locus of control will significantly

predict preventive health behaviour among academic staff in selected Universities in Ondo State.

Methods

Research Design

A cross-sectional survey design was adopted in the study. Moreover, variables of this study were not actively manipulated. The dependent variable is preventive health behaviour while the predictor variables are self-perception and health locus of control.

Participants

The participants for the study were pooled from both government and privately owned universities in Ondo State, South-West Nigeria. The participants for the study were selected from a pool of academic staff from one State University (Adekunle Ajasin University, Akungba-Akoko), one Federal University (Federal University of Technology, Akure) and a privately owned University (Achievers University, Owo) all situated in Ondo State. There were more

males (65%) than females (35%). Majority of participants were between the ages of 31-50 years (69%). Majority of participants were also in the senior lecturer and lecture I cadre (61%) with very few participants being professors (6%), assistant lecturers (7%) and graduate assistants (9%). Data on job tenure showed that 42% of the samples have spent 6-10 years in the University while only 7% have spent more than 15 years. Lastly, majority of participants had Ph.D. degrees holders (68%) while the remaining had either MSc. or BSc. degrees.

Sampling Techniques

A multi-stage sampling technique was adopted for the study. The choices of universities for the study were made using convenient sampling technique. While purposive sampling technique was used to select academic staff in the selected universities because of the schedule of duties and the nature of meetings that academic engage. However, each of the respondents was accessed using snowballing sampling technique; as a result, respondents gave referrals to others that are interested in participating in the study (Table 1).

Respondents	Number of Available Staff	Gender		Confidence Interval 95%	Required Sample
		Male	Female		
The State University	359	223	136	2.69	180
The Federal University	768	460	308	2.03	384
The Private University	84	54	30	2.01	42

Table 1: Showing Respondents, Number of Available Staff, Confidence Level and Sample Needed.

Based on this, the analysis of the number of questionnaires distributed among the 3 selected tertiary institutions is presented below:

- The State University = 50% of 359 = 179.5 (180)
- The Federal University = 50 % of 768 = 384
- The Private University = 50% of 84 = 42

Gender of the participants sampled from the three Universities were; 396 Males and 210 Female participants. Total number of Participants = 342 + 180 + 42= 606.

Instruments

The study made use of a self-reported questionnaire, which comprises of six sections (A-F).

Section A: Socio-Demographic Information. This section includes information on: Age, Sex, Marital Status, Educational Qualification and Job Status of the respondents, Job tenure.

Section B: Self-Efficacy Scale: (SES). Self-Efficacy Scale was used to measure self-perception. The SES was developed by Jayanti RK, et al. [9], a 5-item scale measured on a 5-point scale, ranging from 1-strongly disagree to 5-strongly agree. Examples of the items are 'I usually make an attempt to eat a well-balanced diet' 'I usually make an attempt to exercise

regularly', and 'In the long run, people who take care of themselves stay healthy'. Jayanti RK, et al. [9], reported the reliability ranged from a low of .91 to a high of .92, reflecting acceptable internal consistency. The SES was scored by summing the total number of responses, divided by the total number of items, as such high scores indicate self-perception and low scores indicate lower tendency in self-perception in an individual or group of individuals. The SES was validated by Dennis DU, et al. [2] the concurrent validity of the SES, with academic staff and undergraduates with the Self-perception Scale: (SES), with 5 items to evaluate the presence of self-perception symptoms which has been validated for its use on academic population. The present study reported a Cronbach's Alpha reliability coefficient of .90. The pilot study showed a construct validity of the items of the SES revealed the Kaiser-Myer-Olkin measure of sampling adequacy was KSO-MSA=.87. The SES explained 31.6% of the variance with an eigenvalue of 3.17 and Cronbach's Alpha of .88.

Section C-D: Multidimensional Health Locus of Control Scale: MHLCS: Health locus of control was measured using Multidimensional Health Locus of Control scale developed by Ihinmoyan T, et al. [8]; Wallston KA, et al. [10]. The MHLCS is

an 18-item scale measured on a 6-point scale ranging from 1= Strongly Disagree to 6= Strongly Agree. The scale was a self-report measure intended for use in the general population to assess an individual's internal belief, chance belief and powerful other belief. Sample items for each dimension are: 'if I become sick, I have the power to make myself well again' (Internal Belief), "Often I feel that no matter what I do, if I am going to get sick, I will get sick (Chance Belief) and if I see an excellent doctor regularly I am less likely to have health problems (Powerful others)". Wallston KA, et al. [10] reported a Cronbach Alpha reliability coefficient of .94. Ihinmoyan T, et al. [8] reported a reliability coefficient of .95. This study reported a Cronbach's Alpha reliability coefficient of .95. The present study showed a construct validity of the items of the MHLCS revealed the Kaiser-Myer-Olkin measure of sampling adequacy was KSO-MSA= .89. The MHLCS explained 32.6% of the variance with an eigenvalue of 3.37 and a Cronbach's Alpha of .91 [11].

Section E-F: Preventive Health Behaviour Scale PHBS: Preventive health behaviour was measured using Preventive Health Behaviour Scale (PHBS) developed by Jayanti RK, et al. [9] which was an off-shoot of the modified version of the Preventive Test Inventory scale, originally developed by Moorman and Matulich (1993). The PHBS was designed as a measure of general preventive drive and motivation in individuals. The PHBS is a 3-point scale, where 1 = Never, 2 = Sometimes, and 3 = Always. The PHBS a 17-item scale, which was summated to arrive at a measure of preventive health care behaviours. Sample of item is how often you eat a well-balanced diet. The PHBS has several advantages as a self-report instrument for assessing preventive health behavioural outcomes. The items were stated in simple terms that make it easier for respondents to understand and to respond, the scale is self-administered within a short period of time, the index scores are easily interpreted. The PHBS obtained data on both interviewer-rated and self-rated preventive health dimensions.

Jayanti RK, et al. [9] reported at the coefficient reliabilities of the PHBS ranged from a low of .89 to a high of .93, reflecting acceptable internal consistency. Dennis DU, et al. [2] reported that direct assessment of reliability was carried out in various centres using test/retest method, simultaneous interviews, interclass correlation coefficient was used to analyse the reliability of item rating and the author reported the range found was 85 to 96 with median of 77 using the statistic Kappa. Reliability over a 2-month period and a 4-month period produced a test-retest coefficient of .93 and internal consistency for adolescent groups ranged from .82 to .93. The construct validity of the PHBS revealed the Kaiser-Myer-Olkin measure of sampling adequacy (KSO-MSA) of .68. The PHBS explained 30.2% of the variance with an Eigenvalue of 3.67 and a Cronbach's Alpha of .76.

Procedure

The study was conducted in academic settings in order to provide ecological validity. Due to the busy schedule of the academic staff that participated in the study, the researcher used snow balling sampling technique so that the desired number of academic staff would be assessed. The purpose of the study was explained to the participants who volunteered as they were also given assurance of confidentiality and anonymity of their identities and responses. In addition, the respondents were told that there is no right or wrong answers, and as such should try to be as honest as possible in their responses. However, below are the inclusion and exclusion criteria, in other to control for outliers within the study.

Inclusion Criteria

- The participant must be a member of academic staff for at least six months as at the time of this study.
- The participant must have the capacity to give informed consent.
- The participant must be ethnically Nigerian.
- The patient must be able to read and understand English language.

Exclusion Criteria

- The participant who has not worked up to six months and a member of academic support staff.
- The participant must not be chronologically older than 60 years of age.
- The participant must not have any form of physical challenge (i.e., blind, lame, deaf and dumb).
- The participant who is non-literate in English language.

Data Analysis

In order to determine the extent and direction of associations among the study variables, Pearson Product Moment Correlation was used to test the extent and direction of study variables used in the study. However, for hypothesis 1, 2 and 3 was tested using multiple regression analysis.

Results

Test of Relationship among the Study Variables Table 2.

Variables	β	t	R	R ²	df	F
Self-perception	0.28	1.35	0.24	0.06	2(586)	8.28**
Health Locus of control	0.33	2.32				

Note: *p.0.01

Table 2: Summary of Correlation Matrix Showing Inter-Variable Relationships among the Study Variables.

From the Table 2 above, the results indicated that self-perception showed significant relationship with preventive health behaviour $[\beta = (588) = -.28, p < .0001]$. Therefore, hypothesis 1 was accepted. In addition, health locus of control $[\beta = (588) = .33, p < .0001]$ was positively significantly related with preventive health. Therefore, hypothesis 2 was accepted. On the contribution of self-perception and health locus of control reported R^2 of 6%. Therefore, hypothesis 3 was accepted.

Discussion

The findings revealed that self-perception significantly predicted preventive health was significantly and negatively related with internal locus of control $[\beta = .28, p < .001]$. Possible explanation for this is that, individuals with increased level of self-perception tend to show behaviours that not inimical to them. This means that, individuals with increased tendency towards preventive health tend to take precautions especially as it bothers around them and those significant to them. Self-efficacious individuals show increased sense of self-awareness and personal hygiene.

The result also revealed that, locus of control $[\beta = .33, p < .001]$ significantly predicted preventive health. This result demonstrates that believing one has control over one's own life, the lesser an individual's tendency to demonstrate preventive health behaviour. The findings of paralleled this assumption that individuals with increased levels of locus of control often engage in adherence behaviour and in turn lead to preventive health behavior [2].

Conclusion

Based on the findings, the study has empirically demonstrated that academic staff self-perception and health locus of control demonstrated higher tendency to exhibit preventive health behaviour, than their counterparts. Moreover, the findings revealed that preventive health was significantly related with locus of control. The result of this study also showed that all the independent variables (self-perception and health locus of control) jointly predicted preventive health behaviour. These results demonstrate that self-perception and locus of control play an important role in preventive health behaviours among academic staff.

Implications of the Findings

Findings of the study have some direct practical implications for academic employees and stakeholders in academic institutions. The findings from this study point out the need for National Universities Commission to design and develop intermediation programmers that can help increase effective preventive health practices for academic employees to help

develop and sustain general wellbeing and development within the academia and educational sector. The findings of this study also have practical implications for reviewing and updating Nigerian tertiary education reforms, specifically in relations to teaching, and training of academics. It is therefore suggested that the National Universities Commission should integrate policies that encourages preventive health measures. Against this background, the study expands knowledge in many ways and focus direction on the gains and cost benefits of preventive health practices. Although earlier studies have linked personality and psychosocial variables with preventive health behaviour, this study was one of the first few attempts to empirically investigate correlates of locus of control and optimism dichotomies among academic staff in Ondo State South-western Nigeria. Also, the study extended health prevention study to often ignored occupational group such as academic staff.

Limitation of the Study

Like other research studies, this study has some limitations. These limitations have some technical and procedural implications. First, the variables of this study were measured using self-report questionnaire and the responses of this scale can be susceptible to responder bias which may skew the results of the study. This is because self-report responses often provided are not context-specific and thus ambiguous. Another limitation of the study was with regards to questionnaire. The researcher believes that responder bias could be plausible due to social desirability in participants' responses. The questionnaire had a total of 137 questions, which is rather lengthy; this could result in decision fatigue, fatigue effect and/or response bias, thereby affecting the internal validity of the study. This could cause the participants not to respond accurately and may have clicked the average answer. Therefore, in future studies, the questionnaire should be shortened to reduce this bias.

In addition, the study only made use of three tertiary institutions within one geo-political zone in Nigeria out of the six of them, this may not be enough for generalization to other populations and cultures, thus, it is imperative to state here that, the results of this study should be generalized with caution and restraint. Also, through systematic calculated sampling technique the total population of the present study may not account for the general perception of academic community within Nigeria. This situation implicates the generalizability of the study.

Furthermore, this study does not establish cause-effect relationship as the study was descriptive in nature and technically a survey study. Therefore, it will become impossible to establish the causes of preventive health behaviour and establish any possible effect with the result

obtain from the study.

Despite the limitations of the present study, it expands our knowledge in many ways. Although earlier studies have linked personality constructs, comparative optimism, locus control and self-perception with preventive health behaviour among academic staff, this study was one of the few attempts to empirically investigate correlates of preventive health behaviour in Nigeria. Also, the study extended preventive health behaviour study to often neglected occupational group such as employees in the academia. The present findings also demonstrate that preventive health behaviour may also mean the same thing in Nigeria as perceived in other developed Western countries. The study therefore opens opportunity for further research in other parts of Africa and across different occupational groups.

Recommendations

Based on the findings of this study, the researcher recommends as follows:

- The National Universities Commission (NUC) are duty-bound to take adequate steps in policy implementation with the Ministry of Education in Nigeria to inculcate preventive health measures (symposiums, lectures and exercise programmes for employees) that will directly improve the emotional and social aspects of academic staff life to increase the chances of developing and sustaining a viable tertiary education in Nigeria. In other words, lecturers who work in academic environments in Nigeria shall acquire preventive health development possibilities and training in areas of preventive health development and growth, through policy implementation practices by the Nigerian Universities Commission. This will provide affordability uniformity and due representations of employees across the Federation. More so, like those experienced in the United Kingdom (UK), and central Europe who are already reaping the dividends of preventive health practices which has led to decrease in terms of turnover, absenteeism and mortality in those regions.
- Academic staffs are in direct contact with moulding and shaping the lives of young people. As a result, academic staffs possess strong influence among students. The researcher therefore recommends that the Nigeria universities reforms and policies should be reviewed, specifying issues relating to preventive health and training of academic experts in areas concerning the development and promotion of preventive health practices in Nigeria.
- Preventive healthcare practice needs evidence that is proved by research outcomes. Integration of research evidence into factors such as personality characteristics, optimism- pessimism dichotomies, locus of control,

and other psycho-socio variables by academic staff is essential for the optimal performance among academics. It is therefore recommended that psychologist especially clinical psychologists should intensify more on researches in areas of preventive health behaviour for diverse occupational groups.

- Direction for Future Research: It is recommended that future research should incorporate respondents from the other six geo-political zones in Nigeria, in other to make generalizations that could reflect nation-wide recommendation. Also, future studies should conduct experimental or comparative and longitudinal studies in other to establish cause-effect that the present study may not be able to ascertain. Studies with other professionals outside the academia should be conducted especially non-literate populations, military and para-military personnel, media practitioners, entertainers and so on.

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