Buana Gender: Jurnal Studi Gender dan Anak
ISSN: 2527-810X (e) I 2527-8096 (p)
2024, Vol. 9, No. 2, page 71-83
https://ejournal.uinsaid.ac.id/index.php/buana-gender

Gender Power Relations on Sexual and Reproductive Health Services among Youth in Southwest Nigeria

Christopher Taiwo Oluwadare[1]
Oluwatumininu Akerele[2]
Nelson Akerele[3]
Kayode Emmanuel Igbekoyi[4*]

[1]Department of Sociology, Ekiti State University, Ado Ekiti, Ekiti State
[2,3]Balm in Gilead Foundation for Social Development (BIGIF-NGO), Trinity Estate, Adehun, Ado-Ekiti
[4]Department of Peace and Security, Bamidele Olumilua University of Education, Science and Technology, Ikere-Ekiti, Ekiti State

**Correspondence*: igbekoyi.emmanuel@bouesti.edu.ng

ABSTRACT

Reproductive health 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. This study investigated gender power dynamics and sexual and reproductive health (SRH) services among youth in Southwest Nigeria, using Connell's Theory of Gender and Power to explain the study. The study employed descriptive research design, in which multistage sampling techniques was adopted and questionnaire was used to gather information from 1200 respondents made up of youths aged 15 and 35 in Ekiti, Osun, and Ondo. Results: The findings from the study revealed a concerning lack of understanding of SRH services among youth, with knowledge often rooted in social myths and misconceptions. For example, 59% believed people with HIV always appear unhealthy. While most understood major SRH components like contraception and sexual violence, only 29% of males were familiar with periodic abstinence, preferring condoms. The study found low SRH service uptake among males, attributed to service-related barriers. Interestingly, while 78% agreed that either party can initiate condom use, 34% of males perceived a girl's suggestion as distrustful. Urgent policy reforms are recommended including establishing youth-friendly SRH centers, educational campaigns, and promoting equitable decision-making to empower youth and improve SRH service access. A gender disparity emerged, with females showing higher awareness of various contraceptive methods, potentially reinforcing traditional gender roles. This aligns with previous findings indicating greater HIV awareness compared to other SRH aspects. Societal norms dictate gender-specific risk-taking behaviors, particularly among males, impacting women's health. These behaviors include avoiding condoms, substance abuse, and reluctance to seek HIV testing and treatment. This can lead to issues like violence, STIs, and unintended pregnancies. Based on the findings, the study concluded that the gender disparity in the utilization of reproductive health services with females reporting higher usage compared to males. The study therefore recommends that there

ARTICLE INFO

Keywords:
Gender, Gender Power Relation, Youth Sexual and Reproductive Health, Contraceptive Use

Article History:
Received: September 22, 2024
Revised: November 12, 2024
Accepted: November 14, 2024
Published: November 24, 2024

* Corresponding author: Kayode Emmanuel Igbekoyi igbekoyi.emmanuel@bouesti.edu.ng
https://doi.org/10.22515/bg.v9i2.9962

should be comprehensive and targeted educational programs that specifically address gaps in knowledge concerning sexual and reproductive health.

Introduction

Sexual and reproductive health constraints are influenced by gendered roles and relationships which have enormous direct and indirect consequences for youths' health, wellbeing and life options. They also hinder the achievement of broader development goals, including gender equality, economic opportunity, fertility reduction, and social inclusion (WHO, 2014). Gender power relation is the control, authority or influence of one gender over the other. This power is given by the society through cultural, religion, social and political belief of a set of people or society which also forms their values and norms. Gender power is defined as the ability of a particular gender to be able to coerce, oblige, command, direct, or influence the lives of the other can only exist in relations that involve two or more different gender and it is not constant as it differs in societies and changes with time, orientation, education and globalization. Having gender power is being able to have access to and control over resources and to be able to control Decision-making over the other gender. In many societies, the gender power is given to the male over the female which is termed patriarchy. It is quite disheartening that after twenty-six years of Beijing Conference in China, unequal gender power still affects sexual and reproductive health rights in developing countries especially Nigeria. Women and girls are still not in control of their sexual and reproductive health rights (Yusuff, 2020).

Gender power relations is obvious as a woman's lack of access or control of fund, lack of autonomy and decision-making power, lack of women centered reproductive health services, disrespect of women by healthcare provider, lack of male involvement at health facilities, and attitude of men towards fatherhood. Several studies have been conducted on sexual and reproductive health services and some of these studies has described the expressions of power and how it affects sexual reproductive health (SRH) (Shimpuku et al. 2013), (Sia et al., 2014), (Morgan et al., 2017) and some tries to find out how power dynamics shaping SRH can be shifted (Schaaf, et al., 2021). Study of Kapilashrami (2020) shows how interaction of social divisions of gender creates inequalities in the distribution of SRH. According to Conroy et al [2021], documents from the public health research on the impact of gender relations on sexual and reproductive health has largely framed gender relations on sexual and reproduction of hegemonic, masculinities rooted in patriarchy, male dominance over vulnerable women resulting to poor sexual and reproductive health outcome. For example, according to the study of Desany et al, it was reported that 72% female affirmed that they and their husband made decision about how many children they want to have, 74% female claimed that childbearing was not solely a woman's concern (Desany et al., 2021).

Good sexual and reproductive health is a state of complete physical, mental and social well-being in all matters relating to sexuality and the reproductive system. All individuals have a right to make decisions governing their body and to access services that support that rights (Starrs et al., 2018). Reproductive health 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 (WHO, 2021). Reproductive rights'' are the rights of individuals to decide whether to reproduce and have reproductive health. This may include an individual's right to plan a family, terminate a pregnancy, use contraceptives, learn about sex education in public schools, and gain access to reproductive health services (Finlay et al., 2020).

Several scholars have conducted studies relating to gender power relationship on sexual and reproductive health from different perspectives. Studies on gender inequality from the global perspective has focused on the determinant factors at individual level such as the age at marriage or literacy, household level like decision making and at the society level such as access to services Global report from Unicef Data (2023), claimed that unwanted pregnancies were about 48%. This report supported a striking result which shows that 57% women were unable to make decisions on their own regarding sexual and reproductive health. What this implies is that women were denied of their own body and healthcare. According to Ssebuny et al. (2022) 777,000 birth from adolescents were recorded, with 58% of this figure were from Africa, Asia nations with 28%, Latin America with 14%. This study further affirmed that 67% increase in an unmet family planning was recorded, as a result of reduction to access to sexual and reproductive health, in also which could have increased in 42% of unwanted pregnancies in Philippines. In Sub-Saharan Africa, survey has shown that more than half of women especially in the rural areas between the age of 15-24 were pregnant before the age of 18 years (George, 2020). The study of Onahid et al (2023) stressed that restriction in gender power relationship as resulted to stigmatization and negative affect the health seeking behavior of female towards accessing sexual and reproductive health services. The study further state that 27% women from developing nations gave birth before the age of 18 years.

Gender based inequality in patriarchy societies like Nigeria means differences in access to health services and treatment. Because the unequal gender power relations, men have more access to structural and institutional power which domicile in the form of access to education, health, political participation and economic resources and opportunities (Marx, 2018). In Southern Nigeria, the intricate interplay of gender power relations poses significant challenges to the knowledge acquisition and attitudes of youths towards sexual and reproductive health (SRH) services. The prevalence of pregnancies among teenagers is not far-fetched especially in Southwest, Nigeria. According to a study by Oluwadare et al (2023) in Ekiti State, shows that 75% awareness of teenage pregnancy, cum the fact that access to healthcare service was a major challenge for the pregnant teenager. Despite various interventions aimed at improving SRH outcomes, persistent disparities exist in youths' access to and utilization of SRH services due to gender-based barriers. Also, it is as a result of power relations that structure how societies are organized or ideologies are shaped. Based on this, because there is little or no grounded empirical study that compare two or more areas makes the study relevant and germane.

Literature Review

Feminist scholars have made significant contributions to conceptualizing gender relations as a set of relationships to address critiques of static and binary constructions of gender and to re-establish gender as socially constructed and relational. They have also advanced understandings of the complex diversity within and across genders by incorporating analysis of other social relationships including class, ethnicity and radicalization, and their impact at various ages to acknowledge and anchor the context-specific influences that underlie gender dynamics. One of the most influential voices in theorizing gender relations has been that of the Australian sociologist Raewyn Connell who developed the Theory of Gender and Power**.** The theory was developed as a collection of writings on the theories of sexual inequality and gender and power imbalances. Connell identified the critical components of these existing theories and developed an integrative theory of gender and power. According to Connell (1987), three major structures characterize the gendered relationships between men and women: the sexual division of labor, the sexual division of power, and the structure of cathexis. Both the sexual division of labor and the sexual division of power had been identified from previous research as two fundamental structures that partially explain gender relations (Wingood and DiClement, 2000).

Method

Research Design

This study adopted a descriptive survey design. The study adopted a quantitative method in which questionnaire was used to collect information from respondents. The study area for this study is Southwestern part of Nigeria. The study population will consist of the general populace in the States including male and female, and adopted the definition of youth according to the Africa Youth Charter (2006) to be a person between the ages of 15 and 35 for this study. The States in Southwest, Nigeria include; Ekiti, Ibadan, Lagos, Ogun, Ondo, and Osun States. However, a multistage sampling technique was employed to select respondents from three States in Nigeria. The first stage adopted purposive sampling in selecting Ekiti and Ondo State. The justification for selecting Ekiti State was that it was recorded based on the fact that it has the highest prevalence of teenage pregnancy and sexual violence in Southwest, while Ondo State recorded the lowest States with contraceptive use in Southwest, Nigeria as reported by NDHS 2018 data (2018). The second stage adopted in this study is a simple random sampling technique in selecting Osun State from the remaining States (Ibadan, Lagos, and Ogun State). The justification for selecting Osun State is to enable three States represented in the Study. Finally, respondents using either house to house random sampling or exit visits interviews. 1200 respondents using the Taro Yamane sample size determination formulae, to select respondents from the three sample States in the southwestern region of Nigeria.

Data Management

The questionnaire was used to collect the quantitative data. The questionnaire was drafted to explain the objectives of the study. In order to get in-depth information about the subject matter, nine focus group discussions were organized with a total of nine groups; male and female specific groups in each senatorial district of the sample state. Each group was made up of at least five to nine male and female participants between the ages of 13-35 years (married and unmarried) in both rural and urban communities of the sample states. Quantitative data from the questionnaire was analyzed using Statistical Package for Social Sciences (SPSS 21.0) and results were interpreted through descriptive analysis.

Result

Table 1: Social Characteristics of Survey Respondents by Gender

Variables	Gender		Total
Age	Male (N=504)	Female (N=670)	Total (N=1,174)
15-19	22.4	23.6	
20-21	47.4	57.3	
25-29	17.7	17.7	
30-35	12.8	12.8	
Marital Status			

Monogamous	75.6	75.5	75.6
Polygamous	24.4	24.5	24.4
Religion			
Christian	74.6	77.9	76.5
Islam	22.0	19.1	20.4
Indigenous Religion	2.8	2.8	2.8
Others	0.6	0.1	0.3
Educational Background			
No Formal Education	5.4	3.7	4.4
Primary	3.6	2.7	3.1
Secondary	24.8	31.6	28.7
Post-Secondary	63.1	58.2	60.3
Others	3.2	3.7	3.5
Occupation			
Government Work	11.7	7.9	9.5
Self-Employed	24.8	20.3	22.2
Artisan	4.4	4.3	4.3
Private Salary Employed	13.7	9.4	11.2
Average Monthly Income in Naira			
Less than 30,000	26.6	25.7	26.1
30,001-60,000	24.2	21.3	22.6
60,001-90,000	38.1	40.3	39.4
Above 90,000	11.1	12.7	12.0

Source: Fieldwork, 2023

This section presents the research findings and results from the analysis of the data as well as the discussion. Table 1 showed the description of participants in terms of their socio-demographic characteristics, which include, age, marital status, religion, educational level by sex of respondents.

Age across sexes shows that the majority (53%) of the respondents were aged 20-24 years comprising 47% and 57% of males and females respectively. This data reveals that the largest proportion of respondents falls within the younger adult age range of 20 to 24 years. The representation within this age group is slightly higher among female respondents compared to male respondents. This age distribution might suggest that younger adults, especially those in their late teens to late twenties, were more likely to participate in the survey or study. Understanding the demographics of respondents provides insights into the perspectives and beliefs of this specific age cohort regarding sexual and reproductive health, which can be valuable for tailoring health programs, interventions, or services that cater to the needs of this demography. The marital status of respondents shows that about 77% male are in a monogamous marriage, while 24.4% male respondents are into polygamous marriage. On the part of the female, 75.5% of them are into monogamous marriage while 24.5% female are into polygamous marriage. Therefore, an overwhelming proportion (75.6%) of both male and female respondents are involved in monogamous marriage. This is a major social dysfunctionality which calls for further study on factors that promotes this among the youth because it can lead to other social vices and affect the overall wellbeing of young people in the society.

There are more Christians across gender, 75% of males and 78% of females were Christians. Information on religion shows that 77% of respondents were Christian in which 75% were male while 78% were female. Educational level shows that the majority (60%) of respondents had tertiary education in which 63% were male while 58% were female. Also, 29% had secondary education in which 25% were male while 32% were female, 4% had no formal education in which 5% and 4% were male and female respectively. This clearly revealed that more male respondents are more educated than female, which could also be responsible for imbalance, inequality and power dynamics between both sexes. The distribution of occupation type shows that close to half of respondents (49%) of respondents were unemployed (42% of male and 55% of female). This implies that the economic power of the youth is averagely low which could impact accessibility and uptake of SRH services. Also there is a significant gap between unemployed male and female i.e. more female respondents are unemployed than male. This is followed by the 22% self-employed respondents (25% of male and 20% of female).

Gender Power Relation on Sexual Reproductive Health Services

Table 2: Gender Power Relation on Decisions about Sexual Reproductive Health.

Variable	Sex		
	Male (N=504)	Female (N=670)	Total (N=1,174)
Agree that a girl can initiate use of condoms			
Yes	404(80.2)	516(77.0)	920(78.4)
No	100(19.8)	154(23.0)	254(21.6)
Agree that a boy can initiate use of condoms			
Yes	406(80.6)	516(77.0)	922(78.5)
No	98(19.4)	154(23.0)	252(21.5)
Agree that condoms are suitable for steady relationship			
Yes	351(69.6)	488(72.8)	839(71.5)
No	153(30.4)	182(27.2)	335(28.5)
Agree that it would be too embarrassing to buy condoms			
Yes	308(61.1)	444(66.3)	752(64.1)
No	196(38.9)	226(33.7)	422(35.9)

Source: Fieldwork, 2023

Table 2 shows the percentage description of gender attitudes of youth about sexual reproductive health issues. Seventy-eight percent (78%) agreed that a girl can initiate use of condoms in which 80% were male while 77% were female. Majority (79%) agreed that a boy can initiate use of condoms in which 81% were male while 77% were female. The data suggests that there's a considerable consensus among both males and females that both genders can take the initiative in using condoms. Interestingly, while the overall agreement percentages are relatively similar between males and females in both scenarios, there's a slightly higher agreement percentage among males for both statements. This data is essential in understanding societal perceptions regarding gender roles in sexual health and contraception. Furthermore, seventy-seven percent (77%) agreed that condoms are suitable for casual relationships in which 73% were male while 79% were female. Again, a sizable proportion (72%) agreed that condoms are suitable for steady relationships in which 70% were male while 73% were female. Sixty-four percent (64%) agreed that it would be too embarrassing to buy condoms in which 61% were male while 66% were female.

Figure 1. Responses to "Contraception is Girls Responsibility".

Figure 1 below shows the percentage distribution of the respondents who believed that contraception is a girl's responsibility. Moreover, fifty percent (50%) of the respondents, 49% of male and 51% of females believe that contraception is a girl's responsibility. This data reveals that a significant portion of both males and females hold the perception that the responsibility for contraception primarily falls on girls or women. The slightly higher agreement percentage among females compared to males suggests that a slightly larger proportion of females may perceive contraception as their responsibility within relationships or sexual encounters.

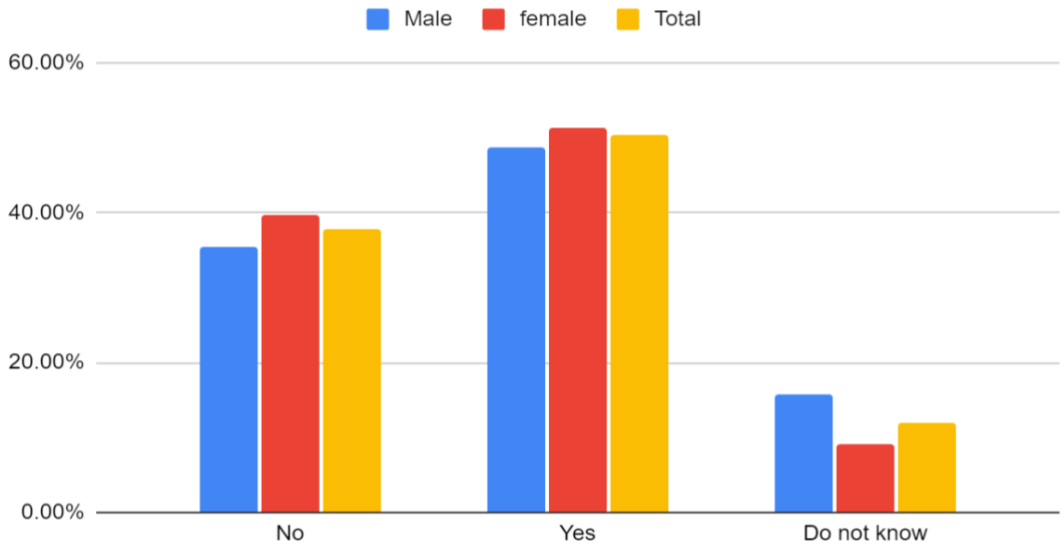

Figure 2: Does Men Need Sex More?

Figure 2 below shows the percentage distribution of the respondents who believed that a man need more sex than a woman. Majority (55%) of respondents consisting of 58% of male and 53% of females believe that men need more sex. This data reveals that a majority of respondents, both male and female, hold the belief that men require more sex than women. The higher percentage among male respondents compared to female respondents suggests that a slightly larger proportion of males perceive a greater sexual need in men than females do. Interpreting this data, it's important to note that this belief reflects traditional and often stereotypical notions about gender and sexuality, which might not necessarily align with individual preferences or realities.

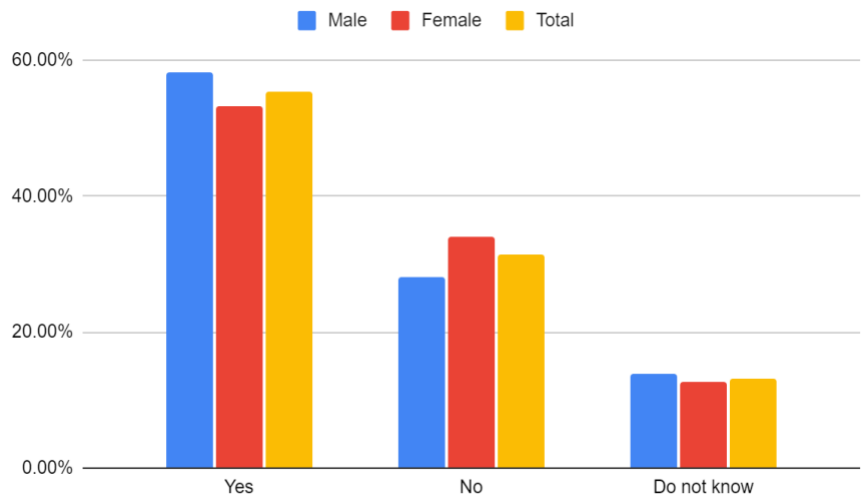

Table 3 Gender Role and Accessibility and Uptake of SRH services

	Sex		
Variable	**Male (N=504)**	**Female (N=670)**	**Total (N=1,174)**
Do males go for reproductive health services			
Yes	276(54.8)	412(61.5)	688(58.6)
No	60(11.9)	116(17.3)	176(15.0)
Do not know	168(33.3)	142(21.2)	310(26.4)
Do females go for these services			
Yes	274(54.4)	426(63.6)	700(59.6)
No	63(12.5)	100(14.9)	163(13.9)
Do not know	167(33.1)	144(21.5)	311(26.5)

Source: Fieldwork, 2023

Gender Role and Accessibility and Uptake of SRH services

The gender disparities of sexual and reproductive health services has been attributed to several factors such as low quality services at inconvenient hour of service especially in Botswana, Nigeria, and Uganda. In the case of Nigeria, social factors like level education, ethnicity, marital status, and religion contribute to the power relationship and awareness in sexual and reproductive health services in Ekiti State (Oluwadare et al., 2023). It is based on this that Table 3 shows the percentage description of respondents by their accessibility to sexual and reproductive health and services, males go for health services, females go for health services. More than half (60%) of the respondents, 54% of male and 64% of females, agreed that females should go for health services. These findings indicate that a majority of respondents believe that females should seek out health services. Interestingly, females themselves seem to hold this belief more strongly than males do. 59% of the respondents comprising 55% of male and 62% of females agreed that males go for health services. This data reveals that a majority of respondents, both male and female, believe that males do seek sexual and reproductive health services. The slightly higher percentage among females compared to males suggests that more females hold the belief that males seek these services. It's worth noting that the agreement rate among males themselves is notably lower than among females.

Discussion

The study revealed that the largest proportion of respondents falls within the younger adult age range of 20 to 24 years. The representation within this age group is slightly higher among female respondents compared to male respondents. This age distribution might suggest that younger adults, especially those in their late teens to late twenties, were more likely to participate in the survey or study. Understanding the demographics of respondents provides insights into the perspectives and beliefs of this specific age cohort regarding sexual and reproductive health, which can be valuable for tailoring health programs, interventions, or services that cater to the needs of this demography. It is also necessary to note that youths hardly discuss their sexual power relations with their parents and seek advice (Odewusi, 2020). Revealing from the study shows that an overwhelming proportion (75.6%) of both male and female respondents are involved in monogamous marriage. Finding from the study revealed that 77% of respondents were Christian in which 75% were male while 78% were female. Also revealing from the study is that the majority (60%) of respondents had tertiary education in which 63% were male while 58% were female. This clearly revealed that more male respondents are more educated than female, which could also be responsible for imbalance, inequality and power dynamics between both sexes. The distribution of occupation revealed that close to half of respondents (49%) of respondents were unemployed (42% of male and 55% of female). This implies that the economic power of the youth is averagely low which could impact accessibility and uptake of SRH services. Also there is a significant gap between unemployed male and female i.e. more female respondents are unemployed than male. This is followed by the 22% self-employed respondents (25% of male and 20% of female).

The issues regarding the decision-making it was found in the study of Desany et al which plays a major role in gender's health outcomes, and condoms and contraceptives outcomes had a robust relationship with gender indicators. It was reported that women able to make their own health decision were 1.57 times more likely to use condoms. Also, seeking care at the health facility is associated with women's autonomy for making major household purchase (OR:1.35, 95% CI: 1-13, 1.62).

The study shows the percentage description of gender attitudes of youth about sexual reproductive health issues. The study revealed that 78% agreed that a girl can initiate use of condoms in which 80% were male while 77% were female. Majority (79%) agreed that a boy can initiate use of condoms in which 81% were male while 77% were female. The data suggests that there's a considerable consensus among both males and females that both genders can take the initiative in using condoms. Interestingly, while the overall agreement percentages are relatively similar between males and females in both scenarios, there's a slightly higher agreement percentage among males for both statements. This result also buttresses the finding of Mkwananzi (2022) that majority of female (77%) and male 84% male youth justified the fact that wife is to ask husband to use condom. This data is essential in understanding societal perceptions regarding gender roles in sexual health and contraception. However, the study Davids et al (2021) conducted in Western Cape, South Africa, shows the reasons for both genders to initiate the idea of using condom by stating that the decision-making for condom use was shaped by the concern about their future and lack of stability in their lives. Also, Friedman (2018) stress that 1 out of 5 reported that both genders initiate the idea of using condoms. That is, condoms involve both genders, but the female play more action role in initiating the idea of using condoms. This can be attributed to fear of pregnancy, parenthood, and sexually transmitted diseases.

Also revealing from the study 77% agreed that condoms are suitable for casual relationships in which 73% were male while 79% were female. Again, a sizable proportion (72%) agreed that condoms are suitable for steady relationships in which 70% were male while 73% were female. This is in support of Looze et al (2019) that there is a gender equality was positively associated with contraceptive use among both genders. This is

because the results show that for every 0.1 point increase the equality scale and the likelihood of condoms use at last intercourse rose the odds ratio, 2.1 for females. In contrary, 85% respondents claimed that condom use is 2 times suitable in causal relationship than 36% respondents who claimed it is suitable in a committed relationship (Indo Asian News Service, 2020). Also revealing 64% agreed that it would be too embarrassing to buy condoms in which 61% were male while 66% were female. The study of Winterman (2012) corroborates the finding of this study by stating that more than half (56%) of the total respondents feel embarrassed in buying condoms, in which 54% were male and 57% were female. Dahl et al. (1998) confirmed that youth do feel embarrassed about purchasing condom, and as a result, affecting access to preventive behaviors against sexually transmitted infections and unwanted pregnancy.

The study revealed the percentage distribution of the respondents who believed that contraception is a female responsibility. Based on this, half (50%) of the total respondents, in which 49% were male and 51% respondents were females believe that contraception is a female responsibility. This data reveals that a significant portion of both males and females hold the perception that the responsibility for contraception primarily falls on girls or women. This is because most of the responsibility to obtain contraceptives, and the use of it in gender power relation on sexual healthcare continues to fall or rely on female. The fact remains that some of the imbalances are related to cases of women being the ones that are actually pregnant and give birth (Cox, 2024). Though, this is regarded as outdated gender roles that assume women are the ones who take care of children. The study of Wigginton et al reported that nearly 90% of female affirmed that contraceptive responsibility should be shared with their sexual partner, while 50% reported shared responsibility was a reality for them. The slightly higher agreement percentage among females compared to males which suggested that a slightly larger proportion of females may perceive contraception as their responsibility within relationships or sexual encounters (Wigginton et al., 2018).

Revealing from the study shows the percentage distribution of the respondents who believed that men need more sex than women. It revealed that more than half (55%) of the total respondents consisting of 58% of male and 53% of females believe that men need more sex. Studies have corroborate this findings, that because there is higher testosterone level in men, makes them do think more of sex, seek it more actively and get turned on more easily (Shaw, 2024). This data reveals that a majority of respondents, both male and female, hold the belief that men require more sex than women. The higher percentage among male respondents compared to female respondents suggests that a slightly larger proportion of males perceive a greater sexual need in men than females do. This report is in line with the finding of Eric (2022) which stated that women were quite satisfied with the amount of sex they had , but the men on the avreage wishes for 50% increase. In reality, men have more interest in sexual relationship than women. This as reported that 51% men would love to have sex at least everyday compare to 7% women (Forst, 2013). Interpreting this data, it's important to note that this belief reflects traditional and often stereotypical notions about gender and sexuality, which might not necessarily align with individual preferences or realities.

The study further revealed the percentage description of respondents by their accessibility to sexual and reproductive health and services, males go for health services, females go for health services. More than half (60%) of the respondents, 54% of male and 64% of females, agreed that females should go for health services. These findings indicate that a majority of respondents believe that females should seek out health services. These results can be attributed to the findings of Nyalela and Dlungwane (2023) in which they outline the factors contributing to male poor access to sexual and reproductive health SRH, which include; lack of access and availability of SRH services, poor health-seeking behavior, and SRH facilities not conceived as male-friendly sphere. But the study of Singh et al (2024) contradicted the report by stressing that male were 2.5 times more likely to

utilize SRH services than the female (AOR=2.5, 95% CI=1.4-4.2). Interestingly, females themselves seem to hold this belief more strongly than males do. 59% of the respondents comprising 55% of male and 62% of females agreed that males go for health services. This data reveals that a majority of respondents, both male and female, believe that males do seek sexual and reproductive health services. The slightly higher percentage among females compared to males suggests that more females hold the belief that males seek these services. It's worth noting that the agreement rate among males themselves is notably lower than among females.

Conclusion and Recommendations

This study highlights a gender disparity in the utilization of reproductive health services with females reporting higher usage compared to males. This is attributed to several factors, including social and cultural norms, limited access to reproductive information, and unequal power dynamics about sexual relationships. Therefore, there is an urgent need for comprehensive interventions that addresses the knowledge gap, promote gender equality and engage both genders in decision-making regarding sexual and reproductive health services.

i. Government or policy makers should develop interventions targeting gender equality and empowerment. These initiatives should focus on educating both males and females about shared responsibility in sexual and reproductive health decision-making. Encourage community dialogues that challenge harmful gender norms and promote mutual respect and equity in relationships.
ii. Implement policies that promote gender-sensitive approaches within healthcare systems by encourage female empowerment by creating support groups and educational programs tailored to address the challenges faced by young women. Engage males through targeted campaigns to encourage their active involvement in promoting sexual and reproductive health as a shared responsibility.

References

African Youth Charter (2006). The Youth Division. *Retrieved from www.youth.africa.union.org on the 15th of August, 2023*

Connell, R.W. (1987). *Gender and Power*. Stanford, CA: Stanford University Press

Conroy, A. A., Ruark, A., and Tan, J. Y. (2021). Re-Conceptualizing Gender and Power Relations for Sexual and Reproductive Health: Contrasting Narratives to Traditions, Unity and Rights. *An International Journal for Research Intervention and Care. Vol. 22(1).*

Cox, C. (2024). Who is Responsible for Birth Control? *Retrieved on the 25th of July, 2024 from www.webmed.com*

Dahl, D. W., Gorn, G. J., and Weinberg, C. B. (1998). The Impact of Embarrassment on Condom Purchase Behavior. *Canadian Public Health Association. Vol. 89(6):368-370*

Davids, E. L., Zemba, Y., Vries, P. J., Mathews, C., and Swartz, A. (2021). Exploring Condom use Decision-Making among Adolescents: The Synergistics Role of Effective and Rational Processes. *BMC Public Health. Vol.21*

Desany, H. M. S., Wilson, E., Munos, M., Sawdogo-Lewis, T., Maiga, A., Ako, O., Mkuwa, S., Hobbs, A. J., and Morgan, R. (2021). The Role of Gender Power Relations on Women's Health Outcome: Evidence from a Maternal Health Coverage Survey in Simiyu Region Tanzania. *BMC Public Health. Vol. 21*

Eric, B. (2022). Men Really do Want Sex More than Women. *Retrieved from www.bakadesuyo.com on the 25th of July, 2024*

Finlay, J. E, Assefa N, Mwanyika-Sando M, (2020). Sexual and Reproductive Health Knowledge among Adolescents in Eight Sites Across Sub-Saharan Africa. *Tropical Medicine Intern Health. 2020;25(1):44–53.* https://doi.org/10.1111/tmi.13332

Friedman, K. (2018). *Condoms use from a Female Perspective*. Clue's Study with KI-CURT

Frost, R. (2013). It is a Fact, Men have a Higher Sex Drive than Women. Are all Relationship Doomed? *Retrieved from www.benchmarkpsychology.com on the 25th of July 2024*

George, A. S. (2020). Structural Determinants of Gender Inequality: Why they Matter for Adolescent Girl's Sexual and Reproductive Health. BMJ: 368

Indo Asian News Service (2020). People in Casual Relationships More Likely to use Condom. *Retrieved from www.hindustantimes.com on the 3rd of October, 2024*

Kapilashrami, A. (2020). What is Intersecuality and What Promise Does it Hold for Advancing a Right-Based Sexual and Reproductive Health Agenda? *BMJ Sex Reproductive Health. Vol.46(4)*

Looze, M., Madkour, A. S., Huijts, T., Moreau, N. And Currie, C. (2019). Country-Level Gender Equality and Adolescents' Contraceptive use in Europe, Canada and Israel: Findings from 33 Countries. *Perspective Sexual Reproduction Health. Vol. 51(1): 43-53*

Marx, M. F., London, L., and Muller, A. (2018). Missing Knowledge of Gender Power Relations among Non-Governmental Organization Doing Right to Health Worker: A Case Study of South Africa. *BMC International Health and Human Rights. Vol. 18(23)*

Mkwananzi, S. (2022). Gender Differentials of Contraceptive Knowledge and use among Youth-Evidence from Demographic and Health Survey Data in Selected African Countries. *Frontiers Global Women's Health. Vol. 3*

Morgan, R., Tetui, M., Kananura, R. M, Ekirapa-Kiracho, E., and George, A. S. (2017). Gender Dynamics Affecting Maternal Health and Healthcare Access and use in Uganda. *Health Policy and Planning. Vol. 32(5):13-21*

Nigeria Demographic Health Survey (2018). Demographic and Health Survey Key Findings. *Retrieved from www.dhsprogram.com on the 13th of August, 2023*

Nyalela, M., and Dlungwane, T. (2023). Men's Utilization of Sexual and Reproductive Health Services in Low and Middle Income Countries: A Narrative Review. *South African Journal of Infectious Disease. Vol. 38(1):473*

Odewusi, T. A. (2020). Exploration of Power Relations in the Sexual and Contraceptive Choices of Adolescents in South West, Nigeria. *Retrieved from www.era.ed.ac.uk on the 12th of August, 2024*

Oluwadare, C. T., Igbekoyi, K. E., Ijabadeniyi, O. A., and Olorunfemi, A. A. (2023). Social and Non-Social Factors Influencing Access to Healthcare in Ekiti and Kogi States of Nigeria. *International Journal of Development Research. Vol. 13(5): 62837-62843*

Oluwadare, C. T., Oluwasanmi, L. A., Igbekoyi, K. E., Ibikunle, M. O., Ijabadeniyi, O. A., and Afolabi, C. Y. (2023). Public Perception of Life Chances of Teenage Pregnancy and Mothers in Ekiti State, Nigeria. *Medical and Health Science European. Vol. 7(6):15-30*

Onahid, H., Mansouri, A., Sebbani, M., Nouari, N., Khachay, F. E., Cherkaoui, M., Amine, M., and Adarmouch, L. (2023). Gender Norms and Access to Sexual and Reproductive Health Services among Women in the Marrakech-Safi Region of Morocco: *A Qualitative Study. BMC Pregnancy and Childbirth. Vol. 23*

Schaaf, M., Kapilashrami, A., George, A., Amin, A., Downe, S., Boydell, V., Samari, G., Ruano, A. L., Nanda, P., and Khosla, R. (2021). Unmasking Power Fundamental to Research on Sexual and Reproductive Health and Rights. *BMJ Global Health . Vol. 6(4)*

Shaw, G. (2024). Sex Drive: How do Men and Women Compare? *Retrieved on the 25th of July, 2024 from www.webmed.com*

Shimpuku, Y., Patil, C. L., Norr, K. F., and Hill, P. D. (2013). Women's Perceptions of Childbirth Experience at a Hospital in Rural Tanzania. *Healthcare Women International. Vol. 34(6):461-481*

Sia, D., Onadja, Y., Namdi, A., Foro., A., and Brewer, T. (2014). What Lies Behind Gender Inequalities in HIV/AIDs in Sub-Saharan African Countries: Evidence from Kenya, Lesotho and Tanzania. *Health Policy Plan. Vol. 29(7):938-949*

Singh, D. R., Samita, K. C., Sunuwar, D. R., Shrestha, S., Rajeeb, K. S., Ghimire, S., Khadka, D. B., Sah, L. K., Shah, J. M., and Karki, K. (2024). Accessibility and Utilization of Sexual and Reproductive Health Services among People with Disabilities in Nepal. *Sexuality and Disability. Vol.2(1)*

Starrs, A. M., Ezeh, A. C., Bakers, G., Basu, A., Bertrand, J. T., Blum, R, Coll-Seck, A. M., Grover, A., Laski, L., Rooa, M., Sathar, Z. A., Say, L., Serour, G. I., Singh, S., Stenberg, K., Temmerman, M., Biddlecom, A., Popinchalk, A., Summers, C., and Ashford, L. S. (2018). *Accelerate Progress-Sexual and Reproductive Health and Rights for all: Report of the Guttmarcher*. Lancert Commission. Vol. 391(10140)

Ssebuny, R, N., Boopa, M., Nguyen, D., and Ligon, L. (2022). Disparities in Accessing Sexual and Reproductive Health Services and Rights among Adolescents and Young people during COVID-19 Pandemic: Culture, Economic, and Gender Perspectives. *Current Tropical Medicine and Reproduction. Vol. 9(4):234-242*

UNICEF Data (2023). Equality Childbearing. *Retrieved from www.data.unicef.org on the 3rd of November, 2024*

Wigginton, B., Harris, M. L., Loxton, D., and Lucke, J. (2018). Who Takes Responsibility for Contraception, According to Young Australian Women? *Sexual and Reproductive Healthcare. Vol. 15:2-9*

Wingood, G. M., and DiClement, R. J. (2000). Application of the Theory of Gender and Power to Examine HIV-Related Exposures, Risk Factors, and Effective Interventions for Women. *Health Education and Behavior. Vol. 27(5):539-565*

Winterman, D. (2012). Condoms: Why are we still Embarrassed about using Them? *Retrieved from www.bbc.com on the 25th of July, 2024*

World Health Organization (2014). Sexual and Reproductive Health and Research. *Retrieved on the 2nd of July, 2023 from www.who.int*

World Health Organization (2021). Trends in Maternal Mortality: 1990 to 2015. UNFPA, World Bank. *Retrieved from www.unfpa.org on the 22nd of October, 2023*

Yusuff, O. S. (2020). *Reproductive Rights and Reproductive Choice of Yoruba Women in Southwestern Nigeria. Advance Journal of Social Science.* Vol. 6(1): 138-151