THE INTERNATIONAL JOURNAL OF HUMANITIES & SOCIAL STUDIES

Social-cultural Determinants of Gender Differential in Access and Utilisation of Reproductive Health Services among Male and Female Youths in Ndeiya Division, Limuru Sub-County, Kenya

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Abstract:
Gender differential in access and utilisation of Reproductive Health Services (RHS) among young women and men is a major challenge in ensuring healthy youthful population. Differential access and utilisation of Reproductive Health Services is determined by many factors among them social-cultural factors. The objective of the study was to explore the social-cultural determinants that affect differential access and utilisation of Reproductive Health Services by the male and female youth in Ndeiya Division. The study was guided by the Social Cognitive Theory. Descriptive survey design was adopted to collect numerical and non-numerical information. The target population consisted of 5621male and 5733 female youth aged between 15-24 years. The study solicited information from a sample size of 386 individuals which comprised of 190 males and 196 females. Convenience sampling was employed to select the youths whose data were collected using questionnaires. In addition, five health officers from the two public health facilities within Ndeiya division were selected using census survey. Numerical information was collected using questionnaires while qualitative data was collected using key informant interview guide. Statistical software (SPSS), version 20 aided in analysing the primary data. The study established that more young women accessed and utilised Reproductive Health Services as compared to young men though the differential access was not very large. Study recommended the empowerment of young men through training programs to create awareness on the need of seeking RHS without being influenced by gender stereotype notions and young women to be empowered to make their personal decisions on issues of Reproductive Health (RH).

Keywords: *Social-Cultural, Gender Differential, Access and Utilisation, Reproductive Health Services, Male and Female Youths*

1. Introduction

According to United Nations Population Fund (UNFPA, 2011), young people make up around 18% of the global population, with approximately 90% living in less developed nations. The present generation of youth is the largest ever in history (UNFPA, 2011).UNFPA (2011) indicates that, as the youth develop, they are hugely vulnerable to risks involving theirreproductive health (RH)e.g. STI's and HIV and AIDS, unintended or early pregnancy and childbirth as well as unsafe abortion.This is because of the youth's behaviour which includes experimentation, risk taking on sexual activities and inadequate information on Reproductive Health (RH). In an effort to provide a solution to this, UNFPA, UNFPA, championsfor and supports effective dispatch of comprehensive, youth responsive reproductive health care package for the youth by all the nations. This was endorsed during the International Conference on Population and Development (ICPD) of 1994 in Egypt. The Abuja convention, held in Nigeria in 2008, had the same recommendations as the ICPD conference, but in addition, the former emphasized more on provision of gender sensitive and friendly reproduction health services (RHS) to the young people.

Gender has been found to be a significant indicator in theuptake of RHS such as HIV/STI testing and treatment as well as contraception. Both young and adult men are more likely than their female counterparts to report psychological deterrents to the uptake of these services. This results in gender inequality in the uptake of RHS by men and women of all ages (Sherr*et. al*., 2007; WHO, 2009; Soai, 2012). Although the youth's sexual and RH as well as how they acquire and utilise RHS has received global attention from the researchers, research studies on determinants of differential access and

utilisation of RHS by the male and female youth have not been adequately explored and documented.In South East Asian countries such as India, Indonesia and Bangladesh, nearly one third of the population are young men and women aged 10-24years.This group faces great challenges in reproductive health such as high STI, HIV infection, early/unintended pregnancy (Santhya & Jejeebhoy, 2007). According to Santhya and Jejeebhoy (2007), young people and especially young men continue to be poorly educated on matters of sexual and RH. As a result young men, tend to participate less than young women in accessing and utilising reproductive health services. Caselli (2006) observes that, reproductive health care services have been directed mostly to both married adult and young women with very little of male involvement which is evidenced by the infrequent use of male methods of birth control, low level of reproductive health information, lower STI and HIV testing and treatment among adult and young men. Women continue to be the linchpins of the Reproductive Health programs in South East Asian countries (Baumle, 2013). In India, in 2009, the uptake of HIV test was found to be higher in young women (27.2%) than in young men (18.8%).

According to Sayeh (2013), Sub-Saharan Africa (SSA) is one the fastest growing region in the world with half of the population in these countries being younger than 18 years. Despite the youth in this region facing several reproductive health challenges, access to RHS is the lowest and especially among young men (Ringheim and Gribble, 2010). According to the latter,existing studies showvery low levels of HIV and STI analysis among the youth and particularly the males. Similar sentiments are shared by Ilene and Stephanie (2001) and Okonofua (2013).In South Africa, in 2004, just 15% of the young married men said they sought HIV test in variation to 25% of the young married ladies (Mandisa, 2010).Kenya National Bureau of Statistics (2010), points out that, the population of the youth (15 -24 years) constitute 36% of the Kenyan total population. The Youth in Kenya face many reproductive health challenges which include STI's, HIV/AIDS, teenage pregnancy, unsafe abortions (Kenya Demographic &Health Survey, 2003&Njonjo, 2010).The youth, face significant barriers in accessing both information and services in reproduction health and they have limited knowledge about sexual and RH and risks associated with early or premarital unprotected sex (Madise, 2007). According to Kenya Aids Epidemic Update (2011), young females in Kenya have a significantly higher chance of being tested for HIV and STI's than young men.

Among the youth who are sexually active, there's high level of knowledge of contraception methods (99.2%) and a positive attitude towards contraception methods. However, the contraception use is relatively lower (57.5%) with young men reporting lower condom use, relative to their knowledge of the role of condoms in preventing pregnancy, spread of STI's and HIV (Adam and Mutungi, 2007). Youth friendly services which are meant to inspire the young men and women to seek RHS only exist to a small extent. According to Kenya Essential Services Provision Assessment [KESPA] (2010), only 7% of Kenyan health facilities offer these services. In order to mitigate the reproductive health issues encountered by the adolescents, the Kenyan government, introduced adolescent reproductive health and development policy (2003) and Kenya National Youth Policy (KNYP, 2006). The policies recommended for the provision of youth friendly RHS in all public health facilities and establishment of youth friendly centres to provide the same. In 2005, the Ministry of Health provided overall procedures for provision of adolescent& youth responsive RH services in Kenya. Unfortunately, the policies from the government are not gender sensitive as they have not spelt out on how the health care providers ought to handle male youth and female youth separately given their different needs and rights.

Many research studies have been carried out on reproductive health challenges faced by the Kenyan youth and how they access and utilise RHS as a homogenous group, but there's scanty literature on determinants of differential access and utilisation of RHS by the youth as a heterogeneous group. This therefore, makes the study very timely. According to Kiambu District Strategic Plan (Kiambu, 2010), Kiambu County, just likeother counties in Kenya has documented greatreproductive health challenges among the youth. The county has few standalone youth friendly facilities. Although the youth friendly services are available, the Kiambu District Strategic Plan (from 2005 to 2010), pointed out, that there was scanty access to inexpensive and quality RHS and RHinformation by the youth (NCAPD, 2005). A Study carried out in the county by Obonyo (2009) revealed that there were low levels of HIV and STI testing among both young males and females but particularly among the males. According to (Obonyo, 2009)and (Kamau, 2006), fewer young men are likely to accept HIV&STI testing and treatment. However, gender differences on access and utilisation of RHS by the youth and the determinants for the differences are not well documented as such there's dearth of literature on the same.According to Kiambu West District Development plan 2008-2012 (GoK, 2012), the youth in Kiambu West District, which Ndeiya Division is part of, face reproductive health challenges like the rest of the youth in Kiambu County. The situation in Ndeiya division is further compounded by the fact that Ndeiya has the highest poverty and illiteracy levels in the Kiambu West District. The Limuru Sub-county Public Health Nurse (2011), identifies the access to HIV testing and STI testing and treatment among individuals aged 15-49 years at 55% and 53% for females compared to 42% and 45% for the males respectively. This results to unequal access and utilisation of RHS between male and female youth. It's out of this concern that the current study was carried out to examine the determinants of gender differential in the access and utilisation of RHS among the youth in Kiambu County. At the same time, there's very scanty information as concerns any studies conducted in Ndeiya Division on determinants of gender differential in access and utilisation of RHS by the male and the female youth. The current study therefore sought to investigate the determinants of differential access and utilisation of RHS by the male and female youth in this region, with a view of suggesting interventions that can be put in place to enhance gender equity and equality in the uptake of RHS by the male and the female youth.

1.1. Statement of the Problem

In response to the reproductive health difficulties encountered by the youth as raised by the Kenya Demographic Health Survey (2003), the Government developed Adolescent Reproductive Health & Development Policy in 2003 and

Kenya National Youth Policy in 2007. Both policies recommended for the provision of youth friendly RHS in all public health facilities. In 2005, the MoH provided the national procedures for the provision of these youth friendly RHS. In line with these government recommendations, at least one public health facility out of the three is offering integrated YFRHS in Ndeiya Division.

Despite all these efforts made, studies (Kenya Aids Epidemic Update, 2011; Shueller*et al.*, 2006 &Godia, 2010**)**indicate that the uptake of RHS is not equal between the male and the female youth, with the male youth participating less in the uptake of the services. The Limuru Sub-County Public Health Nurse (2012), identifies the access to HIV testing among individuals aged 15-49 years at 55% for females and 42% for males, while that for STI testing stands at 53% for females and 45% for male. It's out of this concern on the gender differences in the uptake of RHS by the male and female youth that this study endeavoured to investigate the socio-cultural determinants of the gender differential in access and utilisation of RHS by the male and the female youths in Ndeiya Division of Limuru Sub-County, Kiambu County.

1.2. The Specific Objective of the Study

The specific objective of the study was to assess the social-cultural factors that influence gender differential in access and utilisation of RHS by male and female youth in Ndeiya division, Limuru Sub-County.

1.3. Research Question

The study aimed at answering the following question:What are the social-cultural factors that determine the gender differential in access and utilisation of RHS by male and female youth in Ndeiya division, Limuru Sub-County?

2. Literature Review

According to WHO (2009), Social-cultural determinants are major forces in cultures and societies that influence feelings, and conduct of persons.The control ofsexual and reproductive lives among people and options to make, is moulded by gender connected beliefs describing manhood and femininеness. These cultural gender morals and norms progress through a process of socialization beginning from an early phase of infancy. According to Hawkes &Buse (2013), news media are constantly reporting on how every day's activities can destroy our health. However, the global health risks that originate from gender norms have far reaching effect, yet so much neglected.The norms, reinforce risky or unhealthy behaviour such as delayed health seeking in case of men as this is associated with masculinity.Studies on how social-cultural factors determine gender differential access to and utilization of RHS have only been explored to very small extent in both developed and developing countries, however, in depth information on how these factors influence gender differences in access and utilization of RHS has not been adequately covered. Under social-cultural factors, gender socialisation (gender roles training, gender stereotypes), and decision making power have been discussed.

2.1. Gender Socialization

Society expects different attitudes and behaviour from boys and girls, men and women. Gender socialization is the propensity for boys and girls to be socialized in diverse ways (Mahalik& Addis 2003). According to WHO (2013),Socialisation of males implies that they may not request for HIV services due to stigma and discrimination, possibility of being sacked and being labelled as weak and a coward. Barker & Ricardo (2005) Observe that, by using diverse ways, e.g. jokes, mockery and Insinuations, a man is educated of what the community anticipates from him.Numerous tasks linked with requesting for assistance from health professionals such as dependency on significant others, acknowledging a necessity for support, distinguishing and tagging a sensitive issue, conflict with the message young men obtain about the need for self-sufficiency, physical robustness and emotional independence. Young males may fear that yielding to their personal health will portray them as weaker rather than strong. From young ages, boys are conditioned and socialized to be more daring, rough and live up to 'macho man' standard. According to Barker and Ricardo (2005), this socialization of their behaviour carries over their risky sexual behaviour. As a consequence of gender socialization, young women perceive more symptoms and take them more seriously once they are aware of them. Young ladies could therefore assume it calmer than young males to ask for assistance in health linked issues since females are customarily dependent, yielding and accommodating. Barker & Ricardo's research study explored gender socialisation and it's implication on general health seeking behaviour in young males and females in African context. However, this investigation seeks to specifically examine whether gender socialisation can account for gender differential in access to and utilisation of RHS by male and female youth in Ndeiya division only.

2.2. Gender roles Training

Ashcraft & Lee (2005), notes that gender issues are behaviours and prospects linked with both gender and what it means to be male or ladylike. Gender roles are learned through female and males socialisation**.** Gender roles are internalized early in life, when boys and girls internalize that people have diverse anticipations from everyone. Masculinity encompasses a stringent fixed norm that affects males' sexual and RH behaviour and attitudes (Ashcraft & Lee, 2005). Loyalty to male-controlled masculine characteristics, such as dominance, individuality and self-reliance, may also act as an obstacle to men gaining and utilising health services (UNFPA, 2011).

Mac Naughton (2006) *&*Courtenary (2000), observe that, male role socialization sees men as less susceptible to illness than females, they thus have less knowledge on health matters. This explains their poorer copying mechanism on the same. They thus tend to block feelings, fail to declare symptoms and treatment side effects, fail to request for assistance in health matters generally because they do not want to be seen as unmanly. Even when ill, they delay seeking health care and only do so when the disease is in advanced stage. Because of gender roles training, women have clear cut

sense of future thus responsible about their health anxieties. They are apt to use health services more often and receive more preventive care than men. Based on traditional gender roles socialization, some health behaviours that women reveal in life are a result of traditional roles of being perceived to be in need of assistance and being the nurturer of the household.

As opposed to the fore mentioned studies, the current study, seeks to investigate on determinants of gender differential in access and utilisation of RHS by male and female youth in the study area. Sullivan (2011), investigated implications of male gender role socialisation on men's mental health and psychological health demanding behaviour among 434 adult men in United Kingdom. He concluded that men's attitude toward seeking mental and emotional assistance were closely related to traditional masculine beliefs. As opposed to Sullivan's study, the focus for the current study is on impacts of gender differential in access and utilisation of RHS by the male and female youth in the study area.

2.3. Gender Stereotypes

According to Barker and Ricardo (2005), gender stereotypes are beliefs and attitudes about masculinity and femininity. From an early age, young boys are socialized that men should be strong and invincible and that they should never acknowledge feeling unwell, whether mentally or physically. They are socialized that to be ill is a sign of weakness for a man or it's simply unmanly but it's acceptable for a woman. Men are therefore reluctant to go for STI/ HIV testing compared to women. As the boys grow into young men, they internalise that the risk taking and aggressive behaviour is characteristic of masculinity. In reproductive health, a major stereotype is that contraception is a woman's responsibility, therefore men in steady or marriage relationships, believe that the issue of contraception is the partner's responsibility, hence they don't feel like they have to think about the issue neither discuss it with their partners (Barker & Ricardo, 2005). Another gender stereotype is that health clinics are meant for women and children, hence, men will hardly want to visit or be seen at such places. This explains their low participation in accessing and utilising health services of all kind, (Barker & Ricardo, 2005). WHO, the World health Report, Shaping the future (2003) observes that, males are previously excluded from information about mother and child'shealth, which is an important entry point on source of information about HIV and STI for females. In addition, to having limited access to health services, men have the perception that real men don't get sick (WHO,2003). Galdas (2005) investigated general health seeking behaviour among adult men in United Kingdom. He observed that, they delayed in seeking health care services and only did so when the disease was quite advanced. Some of the reasons the men cited for the behaviour were that the health clinics were 'women and children spaces' and would hardly want to frequent such places. The men also believed that 'real men' did not get sick. As opposed to Galdas study, the current study seeks to investigate on the gender determinants of differential access and utilisation of RHS by the male and female youth in the study area

According to Hawkes and Buse (2013),there is irresistible evidence that gender stereotypes and prospects can unfavourably impact on health, yet gender related health problems have essentially been disregarded or misconstrued with worldwide health organisations often directing gender precise efforts to girls, women or, even more scarcely, to mothers. The current researcher concurs with the findings of Hawkes &Buse, that there's dearth of literature on gender related health issues. Where studies have been done on the same, the focus has been on women& girls and to a smaller extent, on the mothers. There's therefore the need to research on the determinants of differential access and utilization of RHS by both male &female youth in the study area.

2.3.1. Decision Making Power

WHO (2003) and Mertus (2010) notes that in many settings,women compared to men have limited decision making authority surrounding their lives and health. Limited control over resources among women,in many settings compounds their limited decision making power, making them socially and economically dependent on their partners and husbands. However, in settings where women have economic independence, they have adequate decision-making authority and are thus able to protect themselves by seeking treatment in case of sickness (Mertus,2010). According to WHO (2003) over 90% of Yoruba women, inEkiti, Nigeriais well known for their economic independence and are thus involved in decision making to seek treatment for themselves in case of reproductive tract infections and other gynaecological disorders. According to Mertus (2010), there's a strong correlation between a woman's financial position and her decision-making power in reproductive health. As opposed to the by WHO (2003) and Mertus (2010), the current study seeks to investigate whether decision making power has any influence on differential access and utilization of RHS by the male and female youth in Ndeiya division.

2.4. Theoretical Framework

This enquiry is anchored on social cognitive theory as propounded by Albert Bandura (1986). The theory is a modification of social learning theory by Bandura and Walters (1963). The social learning theory regards gender identity and roles as a set of behaviours that are learned from the environment. According to social learning theory the main way that gendered behaviour are learned is through the process of observational learning. Boys and girls observe people around them behaving in various ways; they then relate the observed behaviour to a particular gender. For instance through observational learning boys and girls learn to associate domestic work with women and girls, while herding livestock is a preserve for men and boys.

Boys and girls pay attention to some of these people (role models) and encode their behaviour. At a later time, they may imitate the behaviour they have observed. They may do this regardless of whether the behaviour may discriminate against one gender or not. However, this theory has difficulty explaining how children's understanding of

gendered behaviour changes over times during development. These findings suggest that cognitive processes play a greater role in the learning of gender than social learning theory allows. For this reason, the Social Cognitive Theory (Bandura, 1989), will be more appropriate for the current study.

The social cognitive theory provides a framework for understanding, predicting and changing human behaviour. The theory identifies human behaviour as an interaction of personal factors, behaviour and environment. The theory argues that people can also through fore-thought, self-reflection and self-regulatory processes; exert substantial influence over their own outcomes and environment more broadly. An interaction also occurs between the environment, behaviour and psychological characteristics (Bandura, 1989). During this process, human expectations, beliefs and cognitive competences are developed and are then modified by social influence and physical structures within the environment.Human beings can also learn by observing others in addition to learning by direct personal participation. This is called vicarious learning/observational learning. The information obtained is coded into symbols which are then used as a guide for future action. Observational learning is important in that it enables human beings to form patterns of behaviour quickly and avoid mistakes. This theory is important in matters of reproductive health as it explains how young men and women are socialized by various socializing agents to accept standards, values and norms of their society. Social learning theory by Albert Bandura had been applied in previous studies. Perry (2010) suggested that factors regarding differences in gender reproductive health disorders management can lead to disaffection. Mesina (2010) also carried out a study titled mass media exposure on family planning: effect on contraceptive use among married youth in the Philippines. This study used Albert Bandura's social learning theory in explaining how the mass media has taken the role of educating the youth on family planning. Results from multivariate logistic regression show that both radio and television have an effect on contraceptive use. Women who are exposed to television are more likely to use contraceptives than male counterparts.

In relation to this study, the theory was applicable in reproductive health seeking behaviour of male and female youth. Young men perceive themselves to be tough, strong, and aggressive and in control hence they behave in a way to confirm the belief. Accessing and utilising reproductive health services by young men and women is regarded as seeking help in reproductive health matters. Young men view it as sign of weakness, being out of control; hence chances are that such an individual will not seek these services. On the contrary, young women through the process of gender socialization are perceived to be traditionally dependent, always in need of help, submissive and compliant. Therefore young women will behave in such a way to confirm the belief, thus they more likely than their male counter parts to access and utilise reproductive health services, which is regarded positively as seeking help in matters of reproductive health. It therefore emerges that due to their socialization process, young men seek help on reproductive health matters at a lower rate than young women.

2.5. Conceptual Framework

A conceptual framework describes the association between the independent variables and the dependent variables. Figure 1 presents determinants of differential access and utilization of reproductive health services by male and female youth.

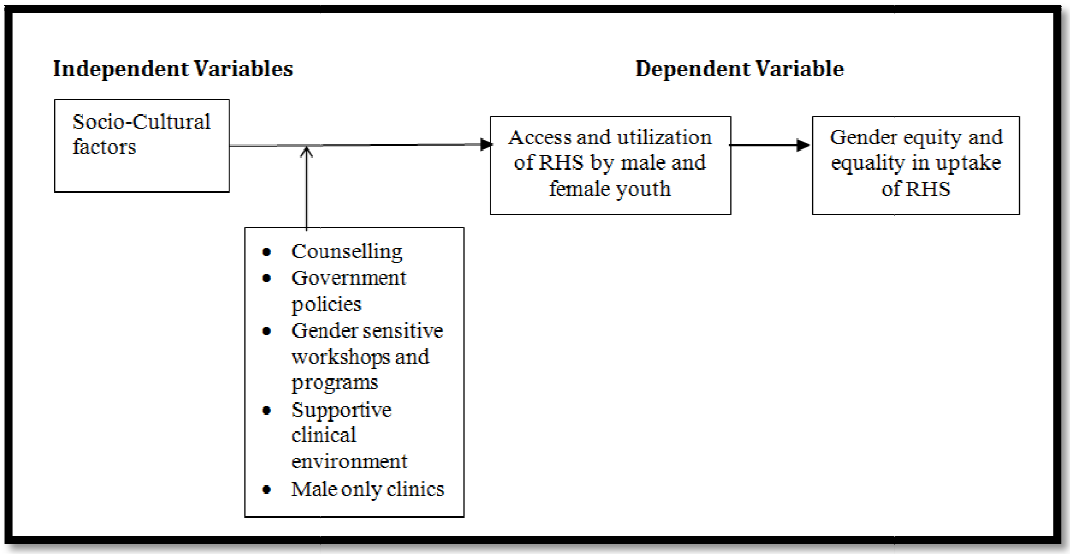

Figure 1: A Conceptual Framework

In the conceptual framework shown above, various social-cultural factors (determinants) are hypothesized to influence differential access to and utilization of reproductive health services (RHS) by the male and the female youth in the study area. The reproductive health services under discussion here are: HIV testing and treatment, STI testing &treatment as well as contraception. The independent variable is social-cultural factors while the dependent variable is the differential access and utilization of RHS by the male and female youth. These factors can promote or inhibit access to and utilization of (RHS) by the male and the female youth. If interventions such as gender sensitive workshops and programs are initiated, supportive clinical environment is enhanced, male only clinics are established, more health

facilities offer youth friendly reproductive services and more youth friendly centres are created there will be increased access and utilization of RHS. This will enhance gender equity and equality in the uptake of RHS.

3. Methodology

The research was guided by descriptive survey design. Descriptive approach was preferred as it provides a good framework for gathering a large amount of data that depicts the male and female youth's opinions, attitudes and ideas on the uptake of RHS within a short duration of time (Oso, 2009). As such questionnaires and interview schedules and were utilized to identify and assess the social cultural variables that impact on gender differential access and utilization of RHS by the male and female youth in the study area.The study was conducted in Ndeiya Division, which is located in Limuru Sub-County in Kiambu County. Documented in KNBS demographic profile of 2014, the ratio of male to females in Kiambu County is 1: 1.02 (KNBS, 2010). Based on this ratio, the population of males and female'syouthinNdeiya Division is 5621 and 5733 respectively.The locale for the study was chosen in Limuru Sub-County (with six wards- Ndeiya, Ngecha, Tigoni, Bibirioni, Limuru Central and Limuru East Wards) as a unique study area because statistics indicate that the uptake of RHS is low and in addition not equal between the male and the female youth, with the male youth participating less in the uptake of the services. For instance, Limuru Sub-County has Contraceptive Prevalence Rate (CPR) of 51% (KDHS, 2014). However, there were variations in patterns of utilization of RHS among young males and females in Ndeiya, Ngecha, Tigoni, Bibirioni, Limuru Central and Limuru East Wards. Limuru East Ward had the highest proportion (56%) of the female and male youths utilizing RHS, while Ndeiya Ward (47%) had the lowest RHS intake. There was also gender variations in the overall uptake of RHS in Ndeiya Ward, with the proportion of female youth utilizing RHS being higher than those of male youths (49% and 45%, respectively). Further, no documented evidence has emerged in Ndeiya Ward that has investigated the access and utilisation of RHS by the male and the female youth. All males (5621) and females (5733) youth living in Ndeiya Division in Limuru Sub County aged between 15-24years constituted the population. The frame of sampling was linked to all the youths aged 15-24 years from youth groups in the following social places: registered church youth groups, registered Boda Bode operators, registered outdoor and indoor games such as football, darts and NyumbaKumi initiative records in Ndeiya Division in Limuru Sub -County. The study also targeted the only five health officers from the public health centres in Ndeiya division since it was expected that they would provide first hand and relevant information on health services provided by the sampled health facility. See Table 1.

Respondents	Number
Youths of age -group 15-24 years	11354
Health service providers	5
Total	11356

Table 1: Target Population

The study targeted a total of 11356 respondents. Stratified and simple random technique sampling sufficed to identify participants (youths) from sample sizes. The population of 11,354 representing male and female youths in Ndeiya Division was represented by a sample size of 386 at significance level of 5% or margin of error of 0.05 for categorical data.The social places were grouped into four strata namely; registered church youth groups, registered BodaBoda operators, registered outdoor and indoor games such as football, darts and NyumbaKumi initiative. Simple randomized method was then applied to identify the specific participants from each stratum of social groups in NdeiyaDivision.Since the target population of public health officers was small, sample selection was based on census survey sampling technique targeting the whole population since it was manageable to seek data from the five health officers (Gay, 1976). Thus, the public health officers were selected from the only three public health facilities, Ndeiya, Thigio and Rwamburi.This information in Table 2.

Category	Population		Sample	
	Females	Males	Females	Males
Church Youth Groups	2964	2912	106	101
BodaBoda Operators	200	651	7	15
Games	943	689	28	32
Nyumba-Kumi Initiative	1624	1369	55	42
Health Officers	3	2	3	2
Total	5736	5622	199	192

Table 2: Sample Size

In this study, 391 respondents were selected. The current study applied two research tools to gather data from respondents. The Male and Female Youths' Questionnaire collected primary data/information from the male and female youths as these groups are presumably literate. Interviews guides administered to health officers gathered quick and in-depth information about the cases of interest for the study. To ensure the validity of the research questionnaires, content validity was addressed in this study. The reliability of the instrument was tested using Cronbach's Alpha coefficient which is used to assess the internal consistency or homogeneity among the research instrument items. A Cronbach's coefficient alpha of .70 or higher was deemed adequate in this study to allow the instrument for data collection (Drost,

2011).Quantitative (numerical) data was obtained using the questionnaires while qualitative data were obtained through the use of the interview schedule. Quantitative data was analysed using descriptive statistics such as means, mode, median and standard deviations and were used to summarize results and explain the population and sample involved. Qualitative data comprised answers to items in the subjective parts of the tools and the interview schedule. Narratives and interpretive reports were written to depict the situation as it was on the ground. In addition the chi-square test was used to determine whether an independent variable is a factor influencing the dependent variable or not (Mugenda, 2014). This test was used for each of the predictor variable over the criterion variable. The Software SPSS assisted in data analysis.

4. Findings and Discussions

The study targeted a sample size of 386 youths for the study but only 300 respondents were available for the study. The study therefore administered 300 questionnaires that constituted 77.7% of the target population of 386. Out of 300 questionnaires administered, 290 were found to be valid for analysis. In addition, the study collected information on different demographic characteristics that included age, sex, marital status, whether the respondent was a student or not and finally the religion of the respondents. About 137 (47.2%) of the respondents were between 15 and 17 years of age followed by the ages of 18-20 at 104 (35.9%) while the least number was in the age of 21-22 at 15 (5.2 %). It is observed that majority of the sampled youths, (146) 50.3% were males as compared to females (144)49.7%. On marital status, majority 226(78%) of males and females respondents' were single as compared to only 64(22.1%) males and females who were married. The result implies that because majority of sampled youths were not married, they were likely to engage in sex before marriage and also engage multiple partners, a result of which may require reproductive health services in Ndeiya Division. The results also showed that majority 275(94.8%) of the respondents were in school as compared to 15(5.2%) who were not in school. This partly explain why most women 126(43.3%) and men 102(35.0%) who were involved in this study had access to reproductive health services. On religion, majority 284(97.9%) of the respondents were Christians, 4(1.4%) were Muslims while 2(0.7%) did not profess to any religion. One of the health officers interviewed had the following to say:

".....Some youths who were deeply religious shy away from seeking RH services. They view such behaviour as an indication that an individual had engaged in immoral act. However, those who were less religious view seeking RH services as a normal way of life at their age and in the digital era where there's free flow of information. As such they didn't shy away from it. In some religious groups and sects there are reservations on the use of contraceptives and other RHS (Oral Interview [O.I] 3rd April 2016).

The objective of the study was to establish social-cultural variables that impact on the access and utilization of reproductive health Services of the male and youth in Ndeiya Division of Limuru Sub County. The study interrogated wide range of social cultural factors like gender socialization, decision making power among others that are likely to have influenced access and utilisation of RHS to the youth. The enquiry examined the kind of family set-up in which participants could have been brought up in. Studies have shown that the family set-up influences the decision making within the family and amongst individuals.

	Single parent	Divorced	Widowed	Extended	Nuclear	Total
Male	13(4.5%)	8(2.8%)	8(2.8%)	13(4.5%)	104(35.9%)	146(50.3%)
Female	10(3.4%)	1(0.3%)	2(0.7%)	12(4.1%)	119(41.0%)	144(49.7%)
Total	23(7.9%)	9(3.1%)	10(3.4%)	25(8.6%)	223(76.9%)	290(100.0%)

Table 3: Family Set-up

These findings imply that majority of the young women and men in Ndeiya Division had both their parents as the socialising agents at the family level. Socialising agents such as parents and siblings have an influence on decision making power necessary for accessing and utilising reproductive health services by young men and women. This assertion is supported by (Bandura, 1986)who argues that Human beings can learn by observing others (family members) in addition to learning by direct personal participation. This is called vicarious learning/observational learning. In addition, the study sought to determine differential chores subjected to siblings of opposite sex. This was necessary to determine if the differential chores impacted on access and utilisation of RHS among youths of different gender.

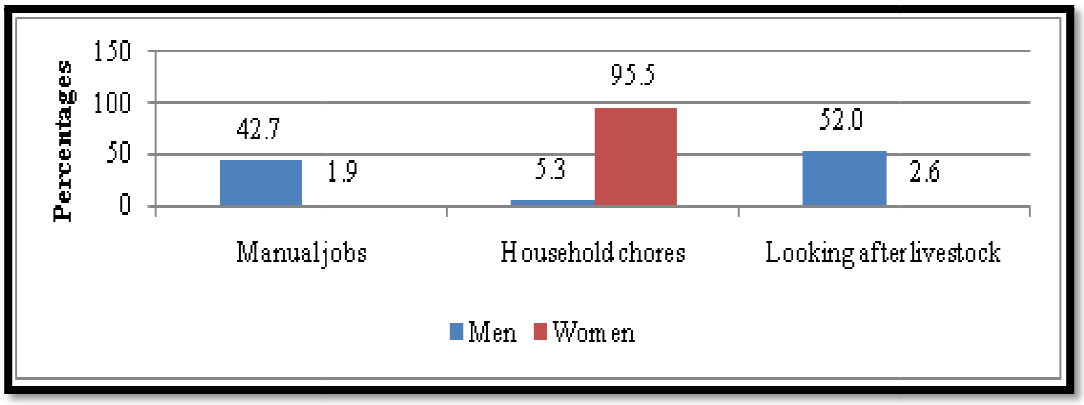

Figure 2: Gender Specific Chores

Chi-square test between gender of youth and type of chores performed had significant results at .05 level ($\chi 2=22.00$, DF=4, p=.000). The results show that gender was a factor in chores performed by the youth within the family.

These findings imply that tasks performed are gender specific. The socialization process at family level has dictated the nature of the duties young men and women performed. This view anchors well with Social Cognitive Theory which states that young men perceive themselves to be tough, strong, and aggressive and in control hence they behave in a way to confirm the belief. These results are in agreement with Mahalik (2003), who established that there is tendency for boys and girls to be socialized differently. Men are brought up with the belief that they are hardy as compared to women and a as result heavy manual tasks are given to them as compared to women who are usually given light domestic duties. The multiple household chores given to the girls and young women are very involving. However, this had not deterred the young women from seeking reproductive health services. Further, the study enquired if the respondents had received information on RHS. This was vital in order to establish if they had received information on HIV, STI testing, treatment and use of Contraceptives. The findings are presented in Figures 3.

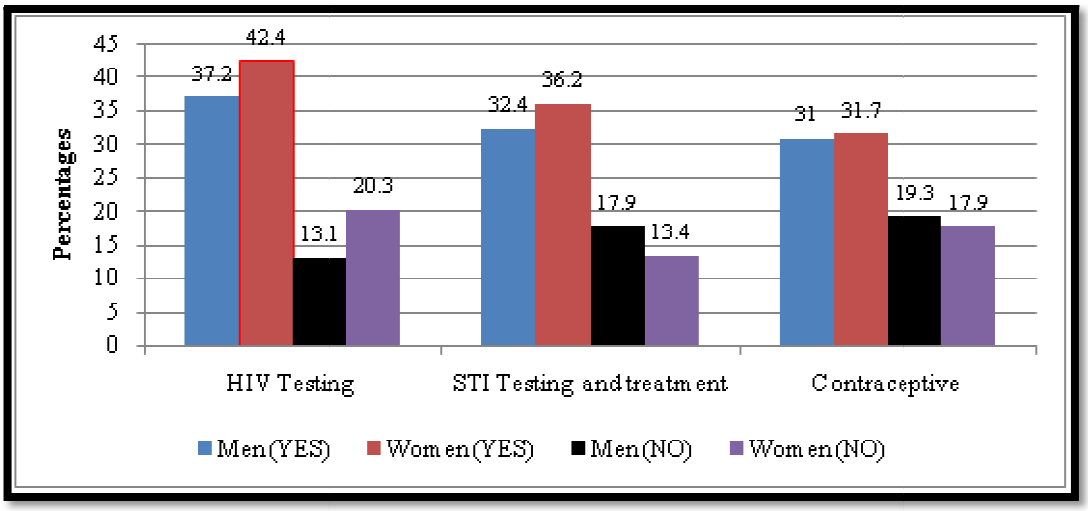

Figure 3: Information on Reproductive Health Services

In summary, more young women than men had received information on the three reproductive health services. Chi-square test of independence between information on reproductive health services received by either gender indicated a significant link at p=0.05 levels (χ^2= 32.3, DF=4, p=.000). The above findings imply that fewer men may seek reproductive health services as compared to women due to lack of information. These revelations are in agreement with the study findings by Magadi (2011) in a reserarch on gender difference in HIV infection across sub-Saharan Africa countries which established that more women than men had adequate information on HIV infection. An interview with one of the health worker responsible of VCT in one of the health centres in the study area revealed the following;

"….. Young men are the minority visitors to our Voluntary Counselling and Testing (VCT) unit as compared to young women. However, when we enquire on their awareness on HIV, they exhibit more knowledge as compared to their counterparts. This could be attributed to the fact that boys are more adventurers while seeking information on any subject. They would clearly and succinctly explain the source of their information. Most of their information is obtained from their peers and internet. It's worth noting that the availability of knowledge on the reproductive health services available in a medical facility doesn't always translate to seeking the said services". (O.I. April 4th 2016).

The above sentiments implies that although most young men do not seek reproductive health services in health facilities it does not mean they are not equipped with necessary information. Gender socialisation and gender stereotyping plays a major role in encouraging or discouraging young men and women to seek reproductive health services in health facilities. According to Social Cognitive Theory the main way that gendered behaviours are learned is through the process

of observational learning. Boys and girls observe people around them behaving in various ways; they then relate the observed behaviour to a particular gender. Information on who provided the information on reproductive health services is presented in Figure 4.

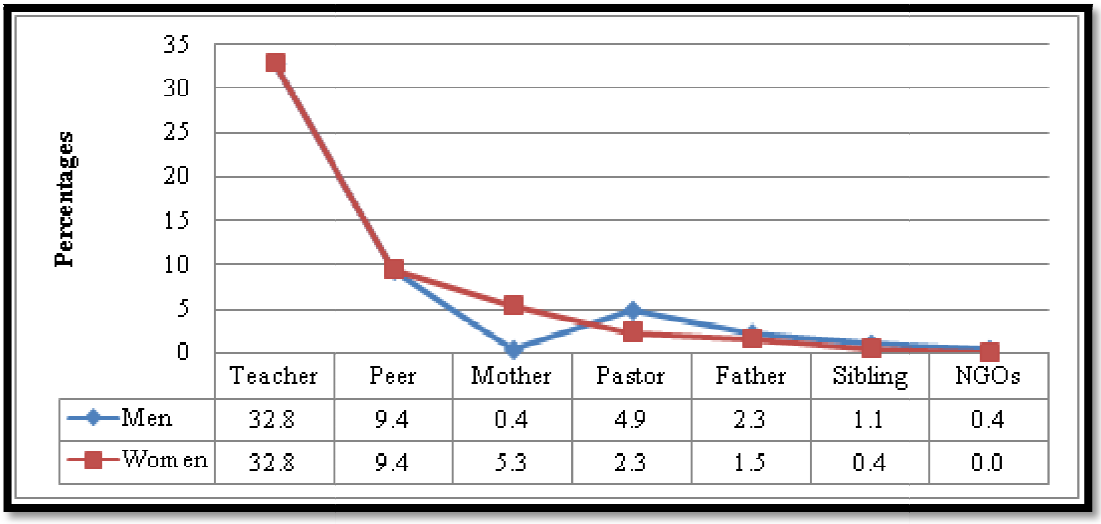

Figure 4: Provider of Information on RHS

The above results imply that teachers and peers play a critical role of disseminating reproductive health information. This can be attributed to the understanding that the youth devote a lot of their time with peers and teachers who act as role models and mentors. The findings are in agreement with the study findings by Gahagan and Rehman (2004) who argued that reproductive health information flows unhindered in education set-ups and through peer to peer forums since there are no age barrier experienced. The low contribution of parents in provision of reproductive health information among the young women and men can be attributed to the breakdown of the African culture and adoption of the western culture. This breakdown has resulted in parents ceding their role of offering advice to young women and men. Consequently, the current African cultural set-up has created cultural barriers where the role of parents as source of reproductive health information is minimal. This observation is supported by the research findings by Mumah, *et.el.*, (2014) in their study on the causes of unintended pregnacies found that the breakdown of traditional African way of living has resulted in un-wanted pregnancies. This was so because the parents have abdicated their traditional role of bringing up the girl child as was the case before the influence of the western and modern cultures.

Culture beliefs and customs plays a critical role in influencing access to RHS in different communities and in different age groups. Studies have shown that cultural beliefs and norms in African societies play a greater hindrance to access and utilisation of reproductive health services as it's a taboo for communities to talk about issues that borders on sexuality and reproductive health to their children. The study results established whether the ways in which young men and women are brought up influence access to and utilization of RHS.

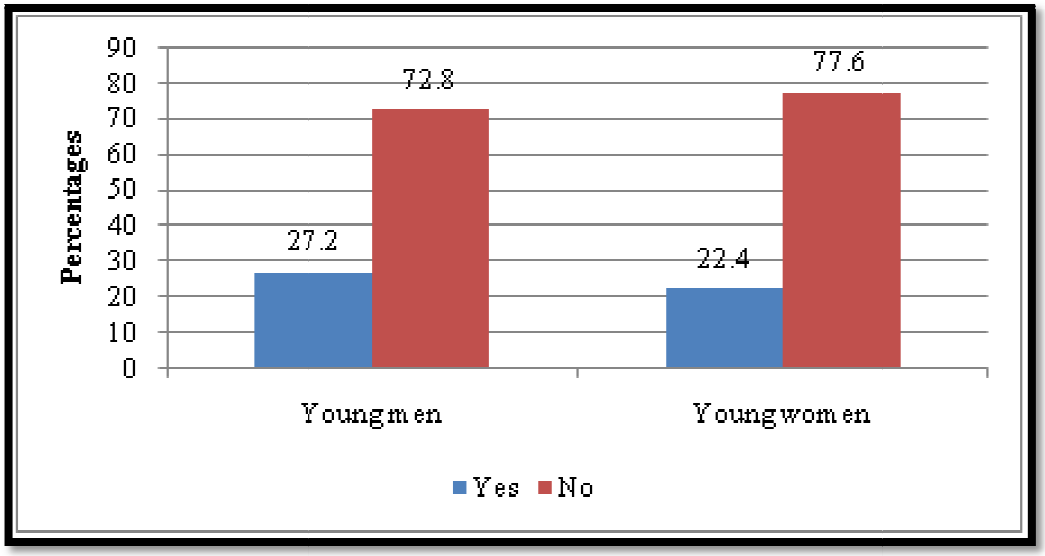

Figure 5: Upbringing and Access to Reproductive Health Services

Chi-square test between the methods of upbringing of the youth and access to reproductive health services was not significant at .05 level (χ^2=21.19, DF=3, p=.079). The above revelations paint a scenario where the upbringing of young

men and women has no influence on access and utilization of RHS in health facilities. However an interview with a medical officer from one of the health facilities had a contrary opinion. The interview established that;

".....although parents and extended families do not directly influence the young women and men to seek reproductive health services, the way they are brought up has some influence. For example the breakdown of traditional African culture has left the young men and women to seek RH information from any source they find accessible. The information may not be necessary correct and adequate. The lack of parental and societal guidance has left the young men and women to seek reproductive health from other sources that are not controlled by the society, cultural beliefs and norms or by the way they were brought up". (O.I April 2016).

These findings can be attributed to the breakdown of African culture and adoption of modern and western culture. This breakdown has thus deterred the youthful males and females from accessing data/information on reproductive wellbeing from parents. These research results are supported by Dunne, McIntosh and Mallory (2014) who argued that the social media and internet had enormous impact on access to RHS by the youth. To further this discourse, the respondents were asked to indicate whether cultural beliefs and norms play any part in persuading youthful ladies and men to access and utilise reproductive health services. The findings are presented in Figure 6.

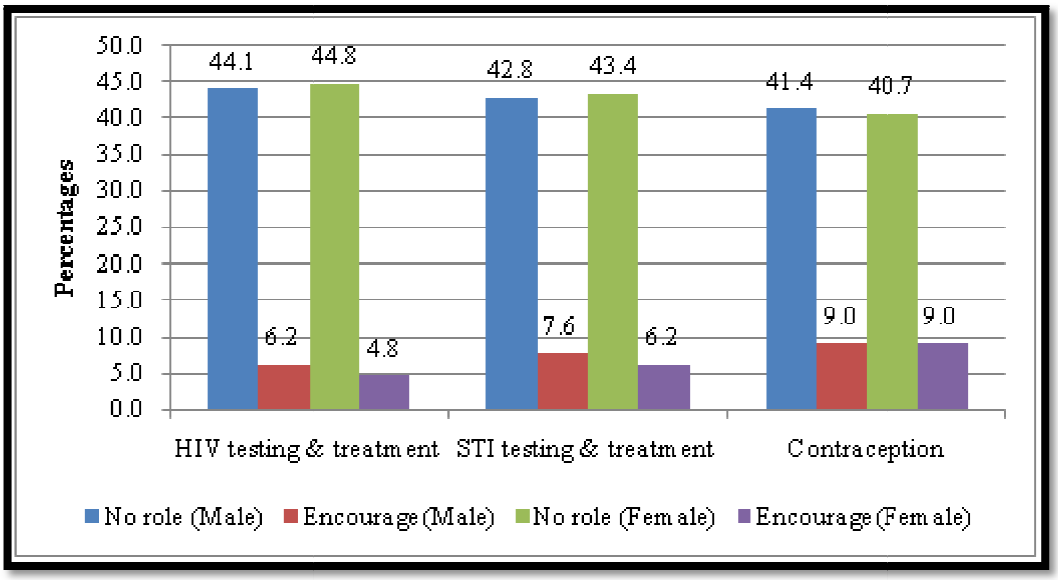

Figure 6: Role of Cultural Beliefs and Norms in Accessing and Utilisation of Reproductive Health

The findings indicated that cultural beliefs and norms have very little effect in impelling youthful ladies and men to access and utilise RHS. Chi-square test of independence between the role of cultural beliefs and access and utilisation of RHS was not significant at p=0.05 level of confidence (χ^2= 39.17, DF=3, p=.217). The minimal role of culture in influencing access and utilization of RHS can be attributed to breakdown of the African culture and adoption of western culture due to a lot of media influence. Any debate about reproductive issues that boarder on sexuality is not openly discussed between parents and children in African society. It's usually frowned upon.

The participants were requested to specify from their opinion whether young men and women had equal access to RHS. These findings are presented in Figure 7.

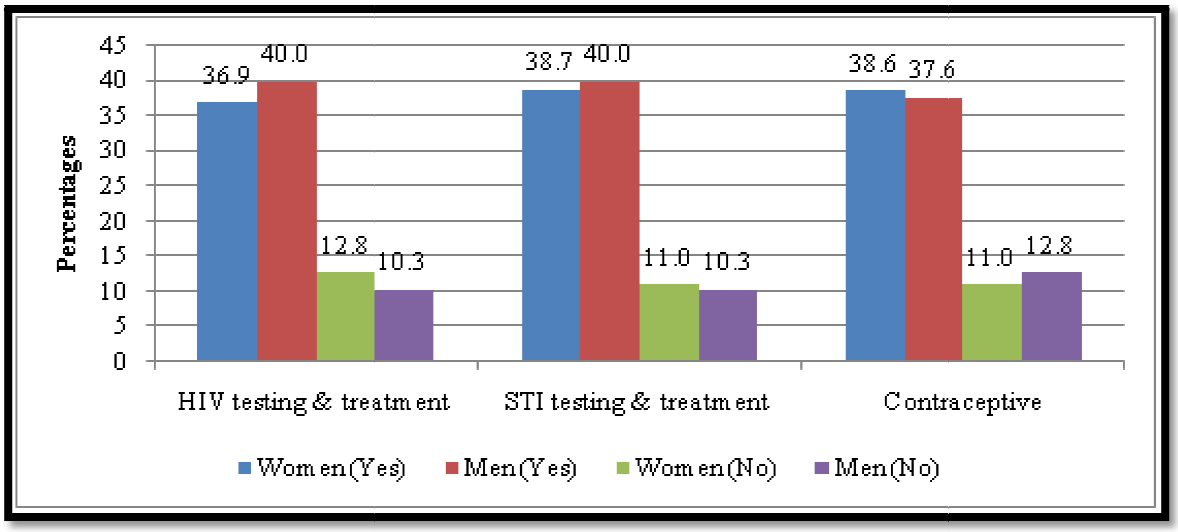

Figure 7: Equal Access to Reproductive Health

As presented in Figure 4, it's clear that despite lack of cultural beliefs and norms affecting access and utilization of RHS, young men and women still had their own ways of accessing the three RHS. These results imply that access to RHS is does not depend on cultural beliefs and norms. These results can be attributed to the role the media has on young men and women in as far as access and utilisation of RHS is concerned. Free advertisements and commercials on reproductive health services available in the media serve to encourage the young men and women to seek Reproductive health services.
On the influence of decision making power on access to reproductive health services, the enquiry endeavoured to find out if the participants were in any relationship as this influenced their decision making power. The findings are presented in Figure 8.

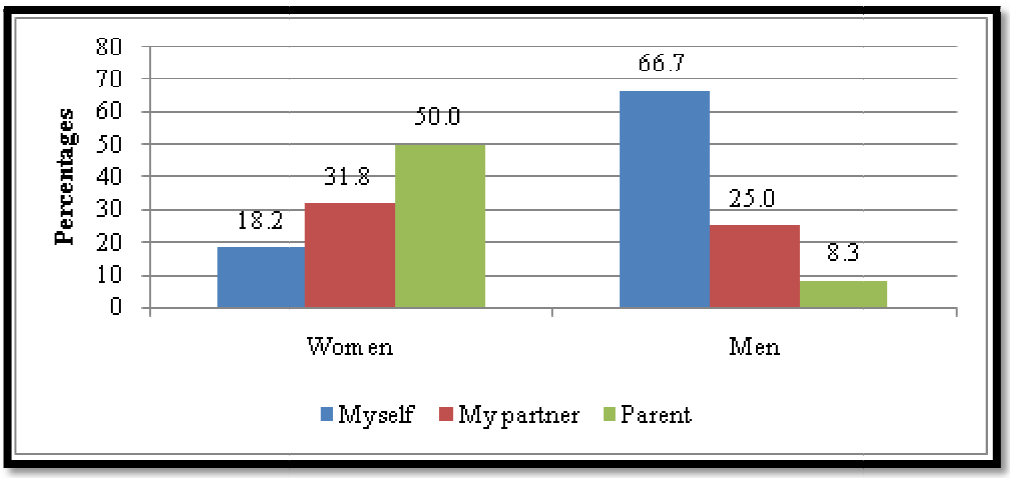

Figure 8: Decision Making and Access to RHS

The findings show that young women had little control of their reproductive health. The study result also shows that young women relied on parents 72(50.0%) and partners 46(31.8%) to make decision on accessing and utilising reproductive health services. Chi-square test of independence between decision making of different gender and access to reproductive health services indicates a significant relation at p=0.05 levels (χ^2= 17.66, DF=4, p=.020). Young men than young women had more control in decision making in as far as accessing and utilising reproductive health services was concerned. The above findings agree with observation by Swiss TPH (Swiss Tropical and Public Health Institute) in a report on teenager and youth sexual and RH survey in Burundi. This documentation established that women (both young and adult ones) especially in the rural areas had little control on their reproductive health.
The investigation also sought to establish the effect of gender stereotypes of young men and women on access and utilization of RHS. The results are shown in Table 4.

	Gender Stereotyping	N	Mean	Std. Deviation
a	The cultural upbringing of men which make them feel invincible and should never acknowledge feeling unwell both mentally and physically has prevented more young men from accessing RHS as compared to young women	290	4.39	.778
b	The society notion that women are generally weak and vulnerable and they often acknowledge feeling unwell has encouraged more young women to seek RHS as compared to young men	290	4.01	.533
c	The perception by the society that contraception is a woman's responsibility has led to many young women seeking RHS(Contraception) as compared to men	290	4.00	.787
d	The feeling that attendance to health clinics is meant for women and children and rarely for men has led to more young women accessing RHS as compared to young men	290	4.01	1.012
e	The perception by the society that 'Real men' never get ill and shouldn't acknowledge feeling unwell has led to fewer young men seeking RHS as compared to young women	290	4.00	.968
f	Reproductive health matters are a preserve of women and to a very small extent to men: A notion that has led to more young women seeking RHS as compared to young men	290	4.11	.911

Table 4.Influence of Gender Stereotypes on Access to Reproductive Health Services
Key: 1- Strongly Disagree, 2-Disagree, 3- Neutral 4- Agree, 5- Strongly Agree

The study established that gender stereotypes associated with young men and women have influence on access to and utilization of RHS in different ways. Chi-square test between gender stereotypes and access to and utilization of RHS indicates a significant relation at p=0.05 levels (χ^2= 9.875, DF=3, p=.000). This shows that there was a difference in the way the youth access and utilizes reproductive health services due to gender stereotypes. The findings above imply that the gender stereotypes assigned to men and women has resulted in differential access and utilisation of RHS. The above results indicate that these gender stereotypes have encouraged more young women compared to young men to access and utilise reproductive health services. The Social Cognitive Theory by Albert Bandura (1989) states that young men perceive themselves to be tough, strong, and aggressive and in control hence they behave in a way to confirm the belief. The above findings are supported by (Macnaughton, 2006)who observed that, male role socialization views males as less susceptible to sickness than females; they thus have less knowledge on health matters. This explains their poorer copying mechanism on the same. They thus tend to suppress emotions, fail to report symptoms and rarely seek for assistance in health matters generally because they do not want to be seen as unmanly. Even when ill, they delay seeking health care and only do so when the disease is in advanced stage. Due to gender roles training, women thus possess a more sharply defined sense of future and thus responsible to their health concern. They are apt to use Reproductive health services more often and receive more preventive care than men. Consequently, as a result of these traditional gender roles socialization some of the health behaviours that women display in life are due to traditional roles of being seen as requiring help, weaker and being the nurturer of the family.

5. Summary

It emerged from the study that majority of the family are in nuclear set-up, thus majority of the respondents had their parents as the socialising agents at family level and there was overall more young women than young men who had received information on Reproductive Health Services accessed. The study also established that more young men had not received contraceptive information as compared to young women. From the study findings, it emerged that information on reproductive health was received at an early age of 1-12 years- a factor attributed to inclusion of reproductive health lessons in primary school curriculum. The study established that majority of young women and men got information on reproductive health from schools. This was followed by health facilities (18.5%) while the NGO's were the least providers at 0.8%. Media which is a powerful tool of disseminating information followed at 11.4%. On the providers of reproductive health information in schools, teachers (65.6%) came first followed by peers (19.8%). It also emerged that pastors (7.1%) were also source of reproductive information. The pastors mainly (4.9%) provided information to young men as compared to 2.3% to young women. The study established that most men performed manual jobs and taking care of livestock while women are responsible for household chores and taking care of children. Chi-square test on gender of youth and type of chores performed was significant at 0.05 level (χ^2=22.00, DF=4, p=.000). The results show that gender was a factor in chores performed by the youth within the family. These roles are as result of gender socialization prevalent in African communities. On decision making on accessing and utilising Reproductive Health Services it emerged that young women had little control over their reproductive health as compared to young men. The parents (50%) made decisions for young women to seek Reproductive Health Services. On the same note 31.8% of young women relied on their partners to make decisions on seeking Reproductive Health Services. On the other hand young men (66.7%) make their own decisions on accessing and utilising the Reproductive Health Services. Parents (8.3%) have little control on young men in decision making to access reproductive health services.

It also emerged that the way the young women and men are brought up and their culture had no influence on differential uptake of Reproductive Health Services. Chi-square test of independence between the role of cultural beliefs and access and utilisation of RHS was not significant at p=0.05 level (χ^2= 39.17, DF=3, p=.217). No gender difference existed in access and utilisation of RHS as a result of influence by cultural beliefs and norms. However, the investigations indicated that gender stereotyping associated with men had deterred them from accessing and utilising Reproductive Health Services. On the contrary gender stereotyping associated with women has positively influenced them to access and utilise Reproductive Health Services.

6. Conclusion

The study concluded that more young women had access and utilisation of Reproductive Health Services as compared to young men which was a point of concern and requires intervention to address the scenario. Chi-square test of independence between utilization of RHS and gender shows a significant association. The study concluded that although the way the young women and men are brought up had no role in influencing access and utilisation RHS, gender stereotyping was found to negatively prevent young men from accessing RHS. The study concluded that lack of ICT integration in RHS provision may have discouraged many male and female youth from accessing and utilising RHS in the health facilities.

7. Recommendations

Based on the findings of this study, the study found that gender stereotyping had negatively influenced young men from seeking RHS. The study therefore recommends for the empowerment of young men through training programs to create awareness on the need of seeking RHS without being influenced by gender stereotype notions. Inaddition, the utilise Reproductive study established that young women have little control on their RH needs because they rarely made personal decisions. This was so because most of them relied on parents and partners to make decisions on their RH issues. This study recommends for young women to be empowered on decision making as concerns their RH needs

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