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Timing of First Pregnancies and Associated Factors among Women in the Reproductive Age in Kajiado County, Kenya

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ABSTRACT

The maternal age during pregnancy has a health impact on both the mother and fetus. Pregnancy related health risks can occur at any maternal age. However, delaying the first pregnancy until at least the age of 18 years, reduces the chances of deaths and complications associated with pregnancy and childbirth. Various factors influence when the first pregnancy occurs among women of reproductive age. The main objective of the study was to investigate the factors associated with timing of first pregnancies among women in the reproductive age attending maternal and child health clinics in Kajiado Central Sub- County. The study employed a cross-sectional analytical study design that used a quantitative approach for data collection. A total of 248 systematically selected women attending maternal and child health clinics participated. The Chi-square test was used to analyze the association between the independent and dependent variables; $p < 0.05$ was considered significant. In addition, a cross tabulation was applied on the factors with a significant association $p < 0.05$, to establish the underlying relationship. Data was analyzed based on the USAID recommendation that, to prevent the adverse maternal and child health outcomes, women should delay the first pregnancy until at least the age of 18 years. The study reported 33.6% of all first pregnancies occurred before the age of 18 years. In addition, factors associated with timing of first pregnancies were found to be; study participant's formal education level ($\chi^2 = 47.493$; df = 4; p = 0.000), spouse formal education level ($\chi^2 = 39.399$; df = 4; p = 0.000), study participant's occupation ($\chi^2 = 22.966$; df = 6; p = 0.000), spouse occupation ($\chi^2 = 16.429$; df = 5; p = 0.006), female genital mutilation ($\chi^2 = 22.757$; df = 1; p = 0.000) and spouse approval for use of contraceptives ($\chi^2 = 15.234$; df = 1; p = 0.000). In conclusion, majority of the study participants had good timing of their first pregnancies. However, there were individual and sociocultural factors associated with when women had their first pregnancies. Therefore, there's need to consider addressing these factors when designing and planning reproductive health interventions that focus on preventing early pregnancies so as to improve the wellbeing of women and children.

Key words: Reproductive Health, Child Health, Maternal Health, Timing of Pregnancy

I. INTRODUCTION

Young maternal age at pregnancy is associated with adverse maternal and child health outcomes (UNICEF, 2020). The Unites States Agency for International Development (USAID), recommended that women should delay the first pregnancy until at least the age of 18 years, to avert adverse maternal and child health risks (USAID, 2012). Maternal deaths have been on the decline globally. However, maternal deaths remain highest among the adolescent girls. Girls aged 10 to 14 years old have the highest risk of complications and death due to pregnancy (WHO, 2019).

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Adolescent girls are twice likely to die of complications related to pregnancy and childbirth, as compared to other older cohorts (UNFPA, 2020). The global Adolescent Birth Rate (ABR) was approximately 44 births per 1000 girls, this translates to approximately 15% of women globally that gave birth before the age of 18 years (UNICEF, 2020). Despite the adverse health risks associated with early pregnancies, they are likely to occur more in low- and middle-income countries (WHO, 2020). Majority of the births that occurred to young women happened mainly in low- and middle-income countries. The UNFPA (2020), estimated that, 20,000 births occur annually among adolescent girls aged below 18 years in developing countries. The Eastern Asia and Western African regions contributed the highest number of adolescent births totaling to 95,153 and 70,423 respectively. The high birth rates in the two regions were associated with low formal education levels among the adolescent girls, inadequate employment opportunities and high levels of poverty (WHO, 2016).

The Sub-Saharan Africa region contributed the highest Adolescent Birth Rate at 103 births per 1000 girls in comparison to other regions (UNICEF, 2020). The overall prevalence of adolescent pregnancy in Africa was 18.8% while the Sub-Saharan region had 19.3%. Within the Sub-Saharan region, adolescent pregnancy prevalence was highest in East Africa region at 21.5%, followed by 20.4% in South Africa, then, 17.7% in West Africa and 15.8% in Central Africa and lowest prevalence was 9.2% in North Africa. High adolescent pregnancy rates in Sub-Saharan Africa region were associated with; early marriages, lack of formal education, rural back ground, lack of education for mother and father, lack of parental engagement on sex education and reproductive health gaps (Kassa et al., 2018). In Kenya, Adolescent pregnancy prevalence rate was at 18% according to the demographic health survey conducted in 2014. Adolescent pregnancy was high among Counties with high poverty levels, rural context and low education levels (KNBS, 2015). In addition, the Kenya Reproductive, Maternal, Neonatal, Child and Adolescent Health Investment Framework (KRMNCAH) cited, access to quality focused reproductive health services, population dynamics, geographic limitations and economic barriers as demand and supply challenges in addressing adolescent pregnancy nationally (GoK, 2016). According to World Vision (2018), maternal and child mortalities and morbidities could be significantly reduced if women delayed pregnancy until at least the age of 18 years.

II. The Problem Statement

Health risks associated with young maternal age at pregnancy range from; preterm delivery, risk for cesarean section birth, gestational diabetes mellitus, risky abortions and pre-eclampsia among women. Similarly, adolescent girls' infants have risks of low birth weight, intensive care unit admission and being born before term (Karatash et al., 2019 & Lakew et al., 2017). In addition, there is risk of neonatal intra-ventricular hemorrhage, puerperal endometritis, systemic infections and obstetric fistula. Socially, early pregnancies predispose the adolescent girls to early marriages, gender-based violence, rejection, stigma and depression (Londero et al., 2019 & UNICEF, 2020). Despite the negative health and social

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effects of women having pregnancies at a young age, Kajiado County was ranked 15th (20.2%) nationally in comparison to other Counties in relation to the adolescent pregnancy prevalence rate and 16th (4%) in relation to adolescents who had their first pregnancy at the time of the survey. In addition, the County had a high rate of adolescent girls engaging in sex at 42.7% (KNBS, 2015 & Obare et al., 2016). Furthermore, Kajiado central had the second highest teenage pregnancy rate of 44.6% in comparison with the five Sub-counties that make up Kajiado County (DHIS - Kajiado, 2019).

III. Objectives of the Study

- To identify the first pregnancies' timing pattern among women in the reproductive age visiting maternal and child health clinics in Kajiado County, Kenya.
- To investigate the individual, institutional and sociocultural factors associated with timing of first pregnancies among women in the reproductive age visiting maternal and child health clinics in Kajiado County, Kenya.

IV. Literature Review

According to the United States Agency for International Development (2012), women should delay the first pregnancy until at least the age of 18 years. This denotes the concept of healthy pregnancy timing. Early pregnancies are a global health concern. These pregnancies not only negatively affect the health of mothers and their children but also have negative social impacts (Ndabumviyubusa & Yadufashije, 2016). Young women below the age of 15 years have the highest risk of pregnancy and childbirth complications (WHO, 2019). Many studies have found an association between early pregnancies and adverse maternal and child health. In Ethiopia, stillbirths were highly associated with young women compared to other older cohorts (Lakew et al., 2017). Similarly, in Ghana, the risk of undergoing a cesarean section birth for adolescents that were pregnant was 80% for both first births and successive births. In addition, the adolescents' newborns had a 30% risk of death compared to older cohorts (Yussif et al., 2017). Furthermore, an assessment of the effects of adolescent pregnancies in Kenya found that the adolescents experienced, social stigma, inadequate mental support, difficulty in adapting to the physiological changes, lack of access to health care services and depression (Kumar et al., 2018).

There several factors that determine when pregnancies occur among women in a community. Among adolescents, the sociodemographic and socioeconomic factors that led to early pregnancies were identified in a study to establish the cost and benefits of meeting the contraceptive needs of adolescents use as; poverty, living in rural areas, living in slum setups and being married early (Darroch et al., 2016). Individual factors associated with early pregnancies included; abuse of substance, lack of self-awareness and access to technology without guidance by guardians and myths on pregnancy prevention (Yakubu & Salisu, 2018). Health care system challenges identified included; lack of adolescent focused reproductive health services and weak health care systems (Darroch et al., 2016).

In addition, in a study on the practice of healthy timing and spacing of pregnancies, it was found that lack of access to contraceptives contributed to unhealthy timing of pregnancies (Agida et al., 2016). Sociocultural factors associated with early pregnancies were found to be; child marriages, imbalanced gender relations, lack of mentorship and inappropriate leisure activities (Yakubu & Salisu, 2018). In Kenya the demand and supply challenges identified to have contributed to early pregnancies included; low education levels, poverty, rural settings, female genital mutilation, child marriages, vast distances to health facilities, cost of healthcare, lack of awareness of the reproductive health services being offered at health facilities, inadequate facilities, attitudes of health workers, lack of specialists, poor workforce alignment, inadequate funding, gaps in supply chain and poor quality data generated at the health facility level (KNBS, 2015 & GoK, 2016).

The health and social benefits of reduced health risks associated with pregnancy and child birth are numerous. These benefits cuts across all age groups and gender as a whole (Ndabumviyubusa & Yadufashije, 2016). According to Agida et al., (2016), when pregnancies are healthy nations benefit from women's contribution to the County's economy after their uninterrupted education. Moreover, the resources that had been allocated to address negative effects of early pregnancies would be freed to address other systemic gaps in health care or non-health care sectors. Mortalities and morbidities associated with poorly timed pregnancies could be greatly reduced if women are supported by the community and health care service providers to delay pregnancy until at least the age of 18 years (World Vision, 2018). Enforcement of the law and enhancement of access to reproductive health by all women in the reproductive age provides a window of opportunity to address occurrence of poorly timed pregnancies and their associated health and social impacts.

V. METHODOLOGY

Research design

The study used a cross-sectional analytical study design and quantitative approaches to determine the factors associated with timing of first pregnancies among women in the reproductive age attending maternal and child health clinics.

Study area

The study was carried out in 7 health facilities within Kajiado Central Sub- County in Kajiado County, Kenya. All the 5 administrative wards within the Sub-County were represented in the study. Kajiado County lies between latitude 01°53' south and longitude 36°48' east.

Study Population

About 248 women aged 15 -49 years who attended maternal and child health clinics at the sampled health facilities and gave consent to participate in the study.

Sampling Procedure

The stratified two stage random sampling technique was used. Health facilities were stratified according to the Ministry of Health service delivery levels. Thereafter, 7 health facilities were randomly selected from 22 health facilities. Study participants were proportionately distributed in the 7 health facilities depending on the average monthly attendance of the maternal and child health clinics. This was followed by systematic random sampling at an interval of 10 women in the reproductive age that met the sampling criteria.

Study Variables

The dependent variable was 'Timing of first pregnancy'; this referred to the maternal age when first pregnancy occurred irrespective of whether the pregnancy was carried to term or not. The rationale for looking at the first pregnancy only was based on the USAID recommendation for prevention of adverse maternal and child health outcomes during pregnancy whereby; women should delay the first pregnancy at least until the age of 18 years (USAID, 2012). While the independent variables were categorized into three: Individual factors; age, religion, marital status, respondents formal education level, spouse formal education level, respondents main occupation and spouse main occupation, institutional factors; affordability and availability of commodities to support healthy pregnancy timing, health care workers attitude, advocacy on good pregnancy timing, distance to health facilities, infrastructural access to health facilities, antenatal and postnatal attendance and sociocultural factors; female genital mutilation, child marriages, social group approval for use of contraceptives and spouse approval for contraceptive use.

Data analysis

The timing of first pregnancies pattern was based on the USAID recommendation that women should delay their first pregnancies until at least the age of 18 years to prevent adverse maternal and child health impacts. Proportions of poorly timed first pregnancies comprised pregnancies that occurred when the study participants were less than the age of 18 years, while good timing of first pregnancies consisted of all pregnancies that occurred to the study participants at the age of 18 years and above (USAID, 2012). In addition, the data was analyzed using the SPSS software version 22. Chi-square test was used to test the significance of association between the independent variables and the dependent variable. $P < 0.05$ was considered a significant association. Furthermore, the factors with a significant association of $P < 0.05$, were cross tabulated in SPSS to establish the underlying relationship.

VI. RESULTS

Sociodemographic characteristics of study Participants

Majority of the study participants were aged between 20 and 24 years 54(21.8%) while the least cohort was that of women aged 45 years and above at 3(1.2%). The study participants were mainly

Christians 221(89.1%). More than half of the study participants 178(71.8%), were married. A large proportion comprising of 53.7% (133) of the study participants, had a secondary level of education and above however, 18.1% did not have any formal education. A majority, consisting of a proportion of 66.9% (166), had a source of income while 33.1% did not have a source of income. Regarding the spouses; all 197(100%), had a source of income however, majority were in business comprising of 62 (31.5%), and a majority representing a proportion of 50.5% (95), had a secondary school level of education and above. On the other hand, 19.4% did not have any formal education.

Table 1: Socio-demographic Characteristics of Study Participants

Variable	**Category**	**n (%)**
Age (Completed Years)	15-19	32(12.9%)
	20-24	54(21.8%)
	25-29	53(21.4%)
	30-34	51(20.6%)
	35-39	37(14.9%)
	40-44	18(7.3%)
	45-49	3(1.2%)
Religion	Christianity	221(89.1%)
	Islam	27(10.9%)
Marital status	Single	43(17.3%)
	Cohabiting	16(6.5%)
	Married	178(71.8%)
	Separated	5(2.0%)
	Widow	6(2.4%)
Age at which respondent started cohabiting or got married	<=15	24(11.7%)
	16-18	50(24.4%)
	>=19	131(63.9%)
Level of formal education	None	45(18.1%)
	Primary 1- 8	70(28.2%)
	Secondary Form 1-4	80(32.3%)
	College	42(16.9%)
	University	11(4.4%)
Occupation	Livestock keeping	41(16.5%)
	Agricultural Farmer	3(1.2%)
	Casual Laborer	29(11.7%)
	Handicraft	1(0.4%)
	Businesswoman	52(21.0%)
	Housewife	82(33.1%)
	Employed	40(16.1%)
Spouse's level of formal education	None	38(19.4%)
	Primary 1- 8	59(30.1%)
	Secondary Form 1-4	40(20.4%)
	College	35(17.9%)
	University	24(12.2%)
Spouse's Occupation	Livestock keeping	43(21.8%)

	Agricultural Farmer	8(4.1%)
	Casual Laborer	31(15.7%)
	Handicraft	1(0.5%)
	Business	62(31.5%)
	Employed	52(26.4%)

Timing of the first pregnancies pattern

In relation to when the first pregnancies occurred among the study participants, figure 1 below shows timing of the first pregnancies pattern. Less than half 33.6%, of first pregnancies were poorly timed; the pregnancies occurred to the study participants while younger than 18 years of age. While 66.4% of the first pregnancies occurred in good timing; at the age of 18 years or older.

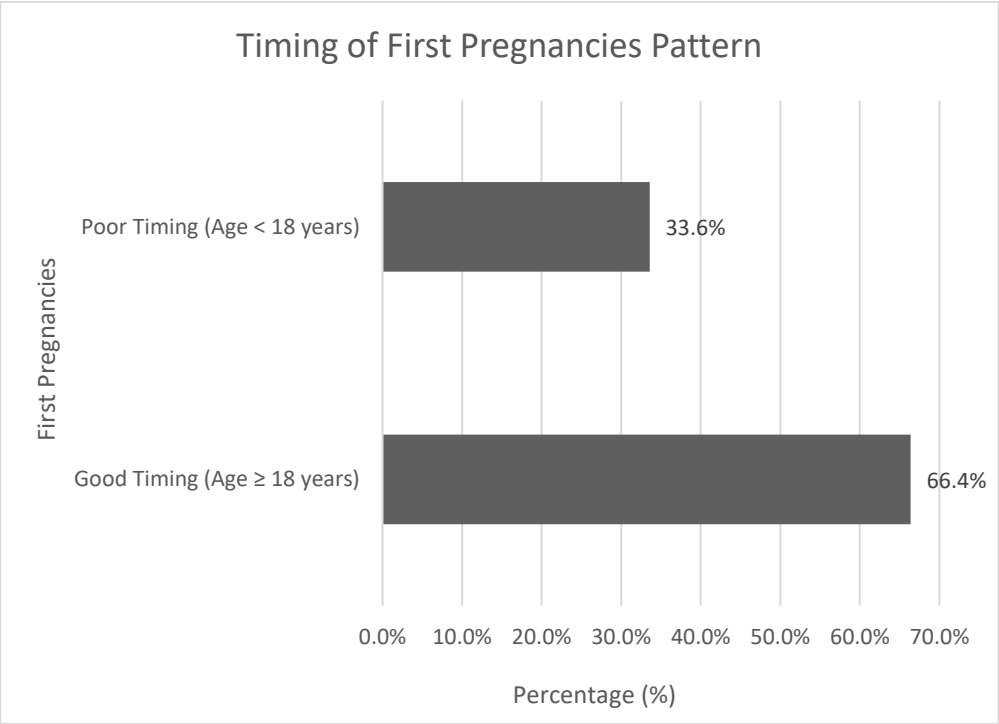

Figure 1 Timing of first pregnancies pattern

Individual factors associated with timing of the first pregnancies

Table 2 shows the association between individual factors and timing of first pregnancies. Formal education level of the study participants ($\chi^2 = 47.493$; df = 4; p = 0.000), spouse's formal education level ($\chi^2 = 39.399$; df = 4; p = 0.000), main occupation of study participants ($\chi^2 = 22.966$; df = 6; p = 0.000) and spouse's main occupation ($\chi^2 = 16.429$; df = 5; p = 0.006) were significantly associated with timing of first pregnancies ($p < 0.05$). The cross tabulated analysis of individual factors with a statistically significant associations found that a large proportion comprising 77.2% of study participants and spouses consisting of 81.2% with low formal education level, of below secondary school education,

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had poorly timed first pregnancies. Similarly, regarding occupation, the highest proportion of 38%, of study participants with poorly timed first pregnancies were housewives.

Table 2 Individual factors associated with timing of the first pregnancies

Variable	Category	First Pregnancy Timing		Chi – Square
		Poor n (%)	Good n (%)	
Age	15-19	15(48.4%)	16(51.6%)	χ^2= 9.518 P=0.146 df=6
	20-24	19(38.0%)	31(62.0%)	
	25-29	13(26.5%)	36(73.5%)	
	30-34	12(24.0%)	38(76.0%)	
	35-39	14(40.0%)	21(60.0%)	
	40-44	4(23.5%)	13(76.5%)	
	45-49	2(66.7%)	1(33.3%)	
Religion	Christianity	68(32.2%)	143(67.8%)	χ^2= 2.257 P=0. 133 df=1
	Islam	11(47.8%)	12(52.2%)	
Marital Status	Single	13(38.2%)	21(61.8%)	χ^2=6.289 P=0. 179 df=4
	Cohabiting	1(6.7%)	14(93.3%)	
	Married	63(35.6%)	114(64.4%)	
	Separated	1(33.3%)	2(66.7%)	
	Widowed	1(16.7%)	5(83.3%)	
Respondent's education	None	28(65.1%)	15(34.9%)	χ^2= 47.493 P=0. 000 df=4
	Primary 1- 8	33(48.5%)	35(51.5%)	
	Secondary Form 1-4	13(17.6%)	61(82.4%)	
	College	5(12.5%)	35(87.5%)	
	University	0(0.0%)	10(100.0%)	
Spouse's education	None	23(62.2%)	14(37.8%)	χ^2= 39.399 P=0. 000 df=4
	Primary 1- 8	29(49.2%)	30(50.8%)	
	Secondary Form 1-4	5(12.8%)	34(87.2%)	
	College	5(14.3%)	30(85.7%)	
	University	2(9.1%)	20(90.9%)	
Main occupation	Livestock keeping	18(51.4%)	17(48.6%)	χ^2=22.966 P=0. 000 df=6
	Agricultural Farmer	0(0.0%)	3(100.0%)	
	Casual Laborer	10(38.5%)	16(61.5%)	
	Handicraft	1(100.0%)	0(0.0%)	
	Businesswoman	18(36.7%)	31(63.3%)	
	Housewife	30(37.0%)	51(63.0%)	
	Employed	2(5.3%)	36(94.7%)	
Spouse's main occupation	Livestock keeping	22(51.2%)	21(48.8%)	χ^2= 16.429 P=0.006 df=5
	Agricultural Farmer	4(57.1%)	3(42.9%)	
	Casual Laborer	8(26.7%)	22(73.3%)	
	Handicraft	0(0.0%)	1(100.0%)	
	Businessman	22(36.1%)	39(63.9%)	
	Employed	8(15.7%)	43(84.3%)	

Institutional factors associated with timing of first pregnancies

Table 3 shows a summary of the association between institutional factors and timing of first pregnancies. The study found none of the intuitional factors under investigation associated with timing of first pregnancies ($p > 0.05$).

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Table 3 Institutional factors associated with timing of first pregnancies

Variable	Category	First Pregnancy Timing		Chi²/Fisher's exact
		Poor n (%)	Good n (%)	
Affordability of pregnancy timing	No	51(48.6%)	54(51.4%)	χ^2=1.856
	Yes	0(0.0%)	2(100.0%)	P=0.173
Availability of pregnancy timing	No	47(49.5%)	48(50.5%)	χ^2= 0.114
	Yes	3(42.9%)	4(57.1%)	P=0.735
Health care workers' attitude	No	49(49.0%)	51(51.0%)	χ^2= 0.001
	Yes	1(100.0%)	1(100.0%)	P=0.978
Advocacy on good pregnancy timing	No	16(38.1%)	26(61.9%)	χ^2= 3.076
	Yes	35(55.6%)	28(44.4%)	P=0.079
Distance to health facility	No	40(54.1%)	34(45.9%)	χ^2= 2.734
	Yes	10(35.7%)	18(64.3%)	P=0.098
Infrastructural access to health	No	48(49.5%)	49(50.5%)	χ^2= 0.033
	Yes	2(33.3%)	4(66.7%)	P=0. 442
ANC and PNC attendance	No	50(49.5%)	51(50.5%)	χ^2= 0.590
	Yes	0(0.0%)	1(100.0%)	P=0.271

Sociocultural factors associated with timing of first pregnancies

Table 4 shows a summary of the association between sociocultural factors and timing of first pregnancies. Female genital mutilation (χ^2 =22.757; df = 1; p = 0.000) and spouse approval for use of contraceptives (χ^2 =15.234; df = 1; p = 0.000) were found to be associated with timing of first pregnancies ($p < 0.05$). A cross tabulation analysis of sociocultural factors with significant associations, showed that, majority of study participants, consisting of 78.5% who had undergone female genital mutilation (FGM) and 77.4% who lacked spouse approval to use contraceptives had poorly timed first pregnancies.

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Table 4 Sociocultural factors associated with timing of first pregnancies

Variable	Category	First Pregnancy Timing		Chi²/Fisher's exact
		Poor n (%)	Good n (%)	
Female Genital Mutilation	No	17(17.0%)	83(83.0%)	χ^2= 22.757 P=0.000 df=1
	Yes	62(47.0%)	70(53.0%)	
Child Marriages	13-15	11(45.8%)	13(54.2%)	χ^2= 4.025 P=0.119 df=2
	16-18	19(39.6%)	29(60.4%)	
	19-34	36(27.9%)	93(72.1%)	
Social group approval for use of contraceptives	No	26(29.5%)	62(70.5%)	χ^2= 2.068 P=0.150 df=1
	Yes	9(18.4%)	40(81.6%)	
Spouse Approval for use of contraceptives	No	24(41.4%)	34(58.6%)	χ^2= 15.234 P=0.000 df=1
	Yes	7(10.8%)	58(89.2%)	

VII. Discussion

Timing of the first pregnancies pattern

The study found that 33.6% of study participants' first pregnancies occurred before the age of 18 years. The proportion of these early pregnancies was within the range of Kenya's Counties' teenage pregnancy rates where, the proportions ranged from 6% to 40% among Counties (KNBS, 2015). In addition, the proportion of early pregnancies was within that of a study conducted in Sub-Saharan Africa where, the prevalence of first adolescent pregnancies was between 7.2% and 44.3% (Ahinkorah et al., 2021). However, this proportion was lower than that of a study conducted in Nigeria where 45.8% study respondents had first pregnancies before the age of 18 years and were also married before the age of 18 years (Agida et al., 2016).

Individual, institution and sociocultural factors associated with timing of the first pregnancies

In relation to individual factors, the level of formal education for study participants and spouses was found to be significantly associated with timing of the first pregnancies; low formal education levels of below secondary school education among study participants and spouses was associated with poorly timed first pregnancies. This finding was similar to a study on determinants of adolescent pregnancies where the absence of free formal education and lack of formal education amongst adolescents was associated with early pregnancies (Yakubu and Salisu, 2018 & Kassa et al., 2018). In addition, a multi country analysis study on associated factors of first adolescent pregnancy in the Sub-Saharan Africa also found respondents with only primary level education had high odds for poorly timed pregnancies (Ahinkorah et al., 2021). Study participants' and spouses' occupation was found to be associated with timing of first pregnancies; poorly timed first pregnancies occurred more among study participants who

had no form of occupation or income. This finding was similar to three studies on early pregnancies in Ethiopia and Zimbabwe were coming from poor wealth quintile and lack of income source contributed to the rise in early pregnancies (Ayele et al., 2018, Geda, 2019 & Mutanana and Mutara, 2015).

None of the institutional factors under the study was found to be associated with timing of the first pregnancies. This finding was similar to a systematic review and meta-analysis study in Africa on determinants of adolescent pregnancy study that found only socioeconomic factors associated with early pregnancies (Darroch et al., 2016). However, this was contrary to a study in Kajiado where few health facilities offered adolescent friendly sexual and reproductive health services were found to be associated with early pregnancies (Gitau et al., 2019). In regards to sociocultural factors associated with timing of the first pregnancies. The study found a statistically significant association with female genital mutilation (FGM) and spousal approval for use of contraceptives. Findings on FGM was similar to a study on the influence of female genital mutilation on girl child education where, 96% of the respondents agreed that girls who had undergone female genital mutilation were prone to early pregnancies compared to those who had not (Mukadi, 2017). In relation to the findings on spouse approval for use of contraceptives, where lack of approval led to poorly timed pregnancies. The finding was similar to a study to determine male partner support for contraceptive use, 23.3% of study respondents mentioned that male partners were responsible for their discontinuation of modern contraceptive use, putting them at risk of pregnancy (Balogun et al., 2016).

VIII. Recommendations and Areas for Further Study

Recommendation

Early pregnancies pose both negative health and social impacts. The study recommends that, future reproductive health designs, plans and interventions consider addressing the factors associated with poorly timed first pregnancies. This may be achieved through support for girls' education, economic empowerment, law enforcement and male involvement in reproductive health programs.

Suggestions for further studies

Conduct a comparative cross-sectional qualitative study at the community level to identify the determinants of pregnancies at advanced maternal ages within the community.

IX. Conclusion

Understanding the factors associated with timing of first pregnancies may help in designing adolescents and reproductive health interventions that support women to have healthy and safe pregnancies. This will require the collaboration of both the reproductive health care providers and the community as a whole. Education and financial empowerment should be supported and encouraged among girls and women in areas with high levels of early pregnancies. Focus should also be in

addressing female genital mutilation which despite being outlawed continues to be practiced. Moreover, raise awareness on reproductive health among men.

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