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Adolescent Motherhood in Kenya

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Abstract
This paper sought to find out the factors associated with adolescent motherhood in Kenya. Bivariate and multivariate analyses were carried out on the 2008/09 Kenya demographic and health survey women file. Out of the 1,767 women adolescents, 301were already mothers at the time of the survey. Results of bivariate analysis showed that motherhood in Kenya begins as early as age 13, and that it is high among girls of primary education qualifications, rural residents, those from low wealth index households, and who have never used contraception. Majority of the fathers to these children (80 percent) are aged between 20 and 29. Logistic regression analysis revealed that girl's educational qualification, type of place of residence, household wealth index, region of residence, ever use of contraception and the partner's education qualification are statistically related to adolescent motherhood in Kenya. There is need therefore to invest substantial efforts to understand the individual social and cultural factors affecting adolescents' reproductive health outcomes and design policies that address them appropriately.
Keywords: adolescent, motherhood, Kenya, contraceptive use

1. Introduction

Most adolescents have no idea of what they are getting themselves into when they engage in unprotected sex and then later discover that they are pregnant. They are thrown into panic not knowing who to turn to for fear of rejection. When the man who fathered the baby, a lot of time five or so years older than the girl, discovers that the girl is pregnant, they disown the pregnancy and claim innocence. In some cases, the girl is thrown out of home or is shipped to some hide out till she delivers as she has now become an eye sore for the family. At such ages, these girls are not prepared for motherhood: proper motherhood is trying, requiring both physical and emotional maturity on the part of a woman (Izugbara et al. 2011). A proper mother provides social and emotional nurturance to her child and cares for the household, she shows compassion and love to her child, and makes sacrifices for the child.

Every day, 20,000 girls below age 18 give birth in developing countries while they occur on a much smaller scale in the developed world. Girls under 15 account for two million of the 7.3 million births that occur to adolescent girls under 18 every year in the developing world. This is such a worry considering the projection by the 2013 State of the World Population that in sub-Saharan Africa, births to girls under 15 are projected to nearly double by 2030. Girls who become pregnant before 18 are often unable to enjoy or exercise their rights, such as their right to education, to health and an adequate standard of living, and thus denied these basic rights. When a girl becomes pregnant or has a child, her health, education, earning potential and her entire future may be in jeopardy, trapping her in a lifetime of poverty, exclusion and powerlessness. The impact on a young mother is often passed down to her child, who starts life at a disadvantage, perpetuating an intergenerational cycle of marginalization, exclusion and poverty. The costs of early pregnancy and child birth extend beyond the immediate sphere of the girl, taking a toll on her family, the community, the economy and the development and growth of her nation (UNFPA 2013b). Adolescent pregnancy is also accompanied by adverse maternal, newborn and child health outcomes. Literature document that approximately one in two girls in developing countries has nutritional anaemia which can increase the risk of miscarriage, stillbirth, premature birth and maternal death (Pathfinder International 1998; Ransom and Elder 2003). Most of the adolescent mothers become pregnant within two years of menarche and when their pelvis and birth canals are still developing, and this heightens their health problems. The risk of a newborn surviving after the mother dies due to maternal complications remains dismal.

Adolescent pregnancies yielding to adolescent motherhood are a consequence of many factors such as widespread poverty, communities' and families' acceptance of child marriage, and inadequate efforts to keep girls in school. Some mothers stay silent on seeing their girls pregnant in the name of that being a good test for their girls' fertility. Taking into account the role of their partners (age, employment status and educational qualification), this study seeks to examine the factors associated with adolescent childbearing in Kenya. Apart from availing literature for academic researchers, the findings herein are important in informing policy on adolescent reproductive health and safe motherhood.

2. Literature Review

Young people are more sexually active now than before. This exposes them not only to the risk of becoming

pregnant but also to risks of HIV and sexually transmitted and other venereal diseases. Years before, girls have been perceived to fear pregnancy more than infections of HIV and other venereal diseases. Adolescent pregnancy is also associated with increased risk of conditions such as haemorrhage, fistula and mental disorders such as depression, as well as poor birth outcomes, including high neonatal mortality as such mothers have limited exposure to reproductive health services. Adolescents are also major contributors to maternal deaths that arise from pregnancy complications such as pre-eclampsia, eclampsia and cephalopelvic disproportionality, all of which they are less likely to be prepared to deal with. These risks are elevated in cases where the adolescent does not attend antenatal clinics and gives birth at home with no skilled birth attendant. In the vast Rift Valley region of Kenya, women have reportedly preferred giving birth at home than in health facilities for the fear of being attended to by men and that the health facilities are cold, and have raised beds. The social costs are also high: many pregnant adolescents have to leave school, affecting the long term prospects of themselves and their families, and they experience increased risk of exploitation and abuse. Much as 212,467 girls were enrolled in form one in the year 2009, only 188,198 girls managed to school till form four in the year 2012 (Statistical Abstract 2013), a dropout rate of 11.42 percent. This might be alluded to various factors, among them, natural attrition, but we cannot escape to say that a sizeable proportion dropped out to enter motherhood at such an early age.

Education prepares girls for jobs and livelihoods, raises their self esteem and their status in their households and communities, and gives them more say in decisions that affect their lives. Education further reduces their likelihood of child marriage and delays childbearing, eventually leading to healthier birth outcomes. Higher literacy rates among women aged 15 to 19 are associated with significantly lower birth rates (UNFPA 2013a). An analysis of 39 countries found that, with the exception of Mali and Benin, unmarried girls aged 15 to 17 who attend school are considerably less likely to have had premarital sex as compared to their out-of-school peers (Biddlecom et al. 2008; Lloyd 2010). These findings underscore the protective effect that an education may confer against adolescent pregnancy and its adverse outcomes. Dropping out of school because of pregnancy leads to the evaporation of the girl's job prospects, and her vulnerabilities to poverty, exclusion and dependency multiply (UNFPA 2013b) and enhance prospects for more pregnancies even though some adolescent mothers drop out of school because of getting in unions majorly cohabitations or first marriages.

Nonetheless, education in some cases affects adolescent pregnancy through other pathways. Especially in rural areas and in areas with abject poverty, day-school girls are likely to be baited with lifts to school and a few coins for basic needs in exchange with sex which in most cases is unprotected. Also, while at school, girls are under intensive and strict care from parents and teachers. To most girls, this stops after graduating from secondary school leaving them with the option of adventuring in sex that yields in pregnancies.

Girls from ethnic minorities and marginalized groups lack opportunities in life, and have limited or no access to sexual and reproductive health, including contraceptive information and services putting them at higher pregnancy risks (UNFPA 2013b). Some communities marry off young girls as early as age 10 to men old enough to be their parents. At such tender ages, these girls have no exposure to any form of sexual education and have no clue of what their husbands expect from them. They become baby-making machines that subject them to the elevated risks of maternal, newborn and child health complications. Also, women from more developed regions tend to start child bearing later than their counterparts in the less developed regions as the majority would be educated and have more opportunities for career development outside the household (Ikamari 2005).

Adolescents who become pregnant tend to be from low-income households and are nutritionally depleted. Poverty forces girls to sell their bodies for material gains and to the extreme, as an income source in support of the family's basic needs. Adolescents from rich families are able to afford and access contraceptives which prevent them from conceiving. However, some people still hold on beliefs that modern contraception specifically contraceptive injection can make a woman permanently infertile and that family planning encourages sexual promiscuity. Others still believe that contraceptives reduce sexual urges in women and results in deformed children.

Adolescent girls who give birth have much higher risks of dying from maternal causes compared to women in their 20s and 30s. These risks increase greatly as maternal age decreases, with adolescents under 16 facing four times the risk of maternal deaths as women over 20 (WHO 2008). Furthermore, babies born to adolescents face significantly higher risks of death compared to babies born to older women. About 19 percent of young women in developing countries become pregnant before age 18 (UNFPA 2013a). KNBS and ICF Macro (2010) reported that 18 percent of girls aged 15-19 in Kenya have begun childbearing. Especially for adolescents younger than 15 years of age, pregnancies are not a result of a deliberate choice, but a result of absence of choices and of circumstances beyond the girl's control. Early pregnancies reflect powerlessness, poverty and pressures from partners, peers, families and communities, and they are a lot of time a result of sexual violence or coercion. At such ages, these girls have little autonomy that makes them to have little say about whether or when they should become pregnant (UNFPA 2013b).

Age differences within unions influences adolescent pregnancy rates: the greater the difference the

greater the chances are that the girl will become pregnant before age 18 (United Nations 2011). In most cases where women tend to marry at young ages, the difference between the singulate mean age at marriage (SMAM) between males and females are generally large. This is highly depicted in some communities in Kenya, for example, the Masaai, the Turkana, the Samburu and the Pokot where a girl is forced into marriage based on the highest bidder in terms of the amount of bride price, which is measured by the number of heads of cattle, paid and not love. Such a girl has to divorce schooling and get married, a lot of time, in an already polygamous marriage in which her major role is to baby-make.

Summarily, it is likely that the social and health disadvantages of early motherhood are particularly concentrated among very young mothers who give birth before the age of 16. There is certainly evidence that neonatal mortality increases as the age of the adolescent mother decreases (WHO 2008) and research also suggests that girls giving birth before the age of 15 are five times more likely to die during pregnancy or delivery as women in their 20s, partly as a result of physical immaturity. Older adolescents are twice as likely to die during pregnancy and delivery as women in their 20s (UNFPA 2007). However, this study limits itself to adolescents aged 15-19 as it uses Kenya Demographic and Health Survey data. Demographic and Health Surveys do not collect information on people aged less than 15 for ethical reasons revolving around sexuality and pregnancies, and that some may not be sure of their responses. As mentioned by Chong et al. (2006), researchers shy away from covering sensitive topics with individuals under the age of 15 either because of social norms concerning age-appropriate behaviours, ethical concerns regarding potentially harmful effects of the research, or doubts about the validity of young adolescents' responses. Further, some researchers question whether very young adolescents have the cognitive ability to answer questions requiring a thoughtful assessment of the barriers they face or of potential consequences of future actions. Others believe that the stigma surrounding premarital sexual activity for girls is too high to obtain accurate information.

3. Methodology

Data used in the analyses was drawn from the 2008/09 KDHS. In order to ensure that the estimates were as current as possible, the study used respondents aged 15-19 in its analysis. Out of the 8,444 women interviewed during the survey, 1,767 (21 percent) were aged under 20, herein referred to as adolescents. 301 of the 1,767 adolescents were already mothers at the time of the survey, representing a percentage of 17. These 301 adolescent mothers form the unit of analysis. Data on them was transformed in a manner that each adolescent mother constituted a unit of observation.

Bivariate analysis was done to examine the characteristics of adolescent mothers based on various background factors. Multivariate analysis involving logistic regression modelling was done to analyse the factors behind adolescent motherhood. Logistic regression analysis aimed at bringing out the likelihood of an adolescent girl entering motherhood based on the study covariates. The regression model allows for the estimation of the occurrence of an outcome due to the effect of several explanatory variables by fitting data to a logit function logistic curve.

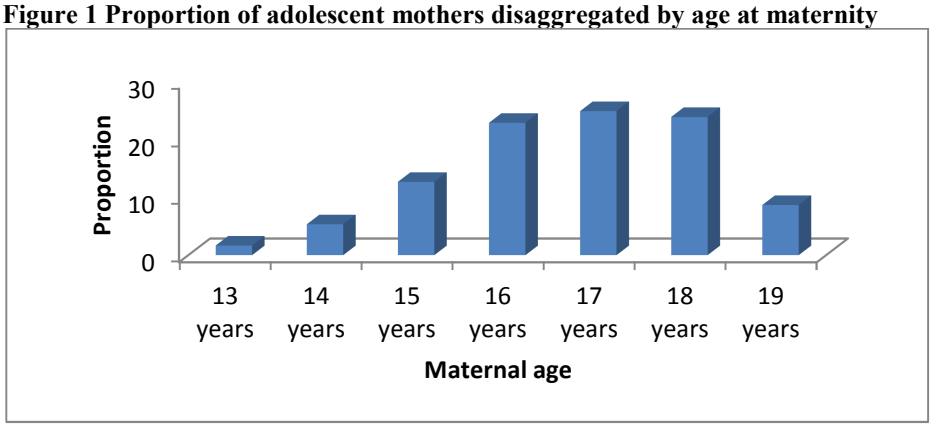
Two models were developed: model I focussing on the influence of women-related factors on adolescent motherhood, and model II focussing on the influence of all factors on adolescent motherhood. Demographic and health survey data is weighted so as to adjust for the differences in probability of selection between cases in a sample. It is common for samples to be selected to expand the number of cases in certain areas (example, urban areas) where estimates are needed.

4. Characteristics of Adolescent Mothers

Bivariate analysis was carried out on the 301 respondents aged under 20 who were already mothers at the time of survey. Results are presented in Figures 1 through 8.

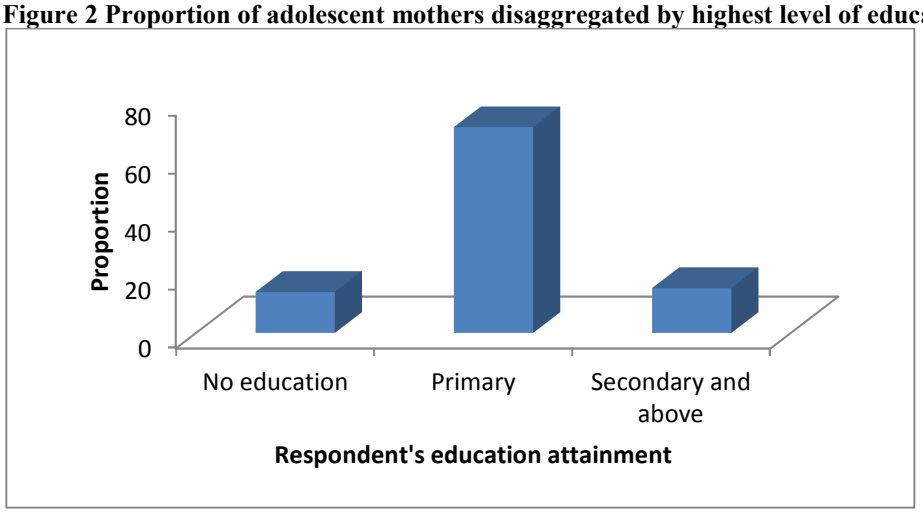
Motherhood in Kenya commences at the age of 13, Figure 1 showing that 2 percent of adolescent mothers were aged 13. This is at the backdrop of the reported fact that the youngest grandmother in Kenya is a 23 year old woman in Migori County, an implication that she likely conceived at the age of 11 and gave birth to a daughter who, like the mother, conceived at the age of 11 too. A greater proportion of adolescents give birth between the ages of 16 to 18 years.

Figure 1 Proportion of adolescent mothers disaggregated by age at maternity



From Figure 2, we learn that the largest proportion (71precent) of adolescent mothers have primary school education qualifications, followed by those with some secondary education (15 percent) and then those with no education at all (14 percent). This implies that much as many girls might have graduated from primary school with good marks to take them to secondary schools, the role of mothering their babies deprives them such a chance. As aforementioned, dropping from school due to motherhood affects the long term prospects of these girls and their families, and they experience increased risk of exploitation and abuse.

Figure 2 Proportion of adolescent mothers disaggregated by highest level of education



A big chunk of adolescent mothers are of rural residence, from low wealth index households, and have never used contraception. Surprisingly, households of high wealth index also produce a substantial proportion of adolescent mothers with households of average wealth index producing the least proportion. Majority of those women who reported having ever used contraception mentioned having used modern contraception (data not shown).

The role of men who father the children cannot be overlooked. Results of bivariate analysis show that majority of these men (62 percent) have primary school education qualifications, with those that have either no education or at least secondary education forming 19 percent each. Furthermore, most of these men are aged between 20 and 29 years (79.5 percent), followed by those aged at least 30 (17 percent) and lastly those aged under 20 (3.5 percent). This is a clear indicator that “old” men go for such young girls and that the age differences between the girls and their partners are wide apart.

Figure 3 A divided circle showing distribution of adolescent mothers based on type of place of residence

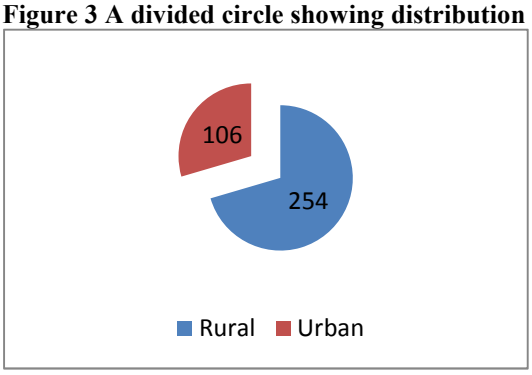


Figure 4 A divided circle showing distribution of adolescent mothers based on wealth index

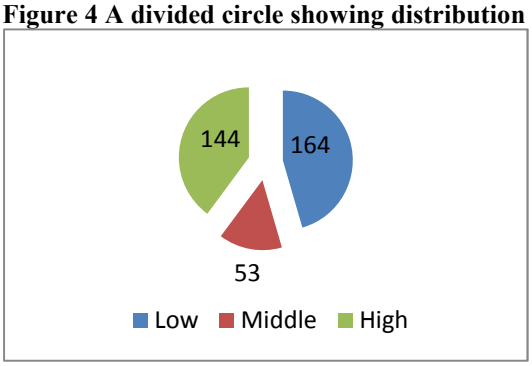
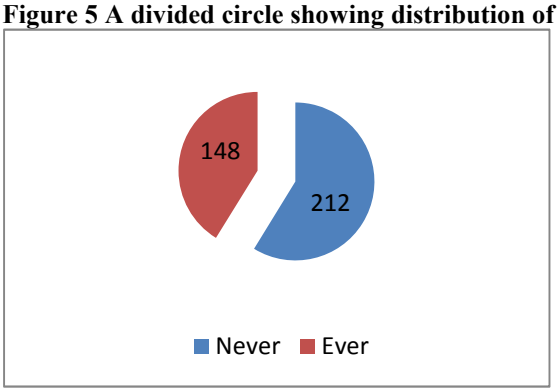


Figure 5 A divided circle showing distribution of adolescent mothers based on ever use of contraception



Based on region, Nyanza (26 percent), Coast and Rift Valley (both at 18 percent) top the list of regions with high proportions of young mothers. Central (4 percent), North Eastern (5 percent) and Nairobi (6 percent) are the regions with the least proportions of adolescent mothers.

Figure 6 Proportion of adolescent mothers disaggregated by partner's educational attainment

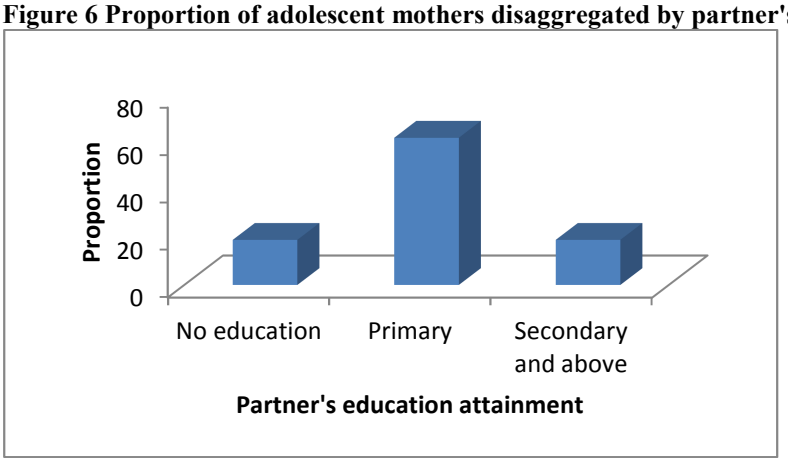


Figure 7 Proportion of adolescent mothers disaggregated by partner's age

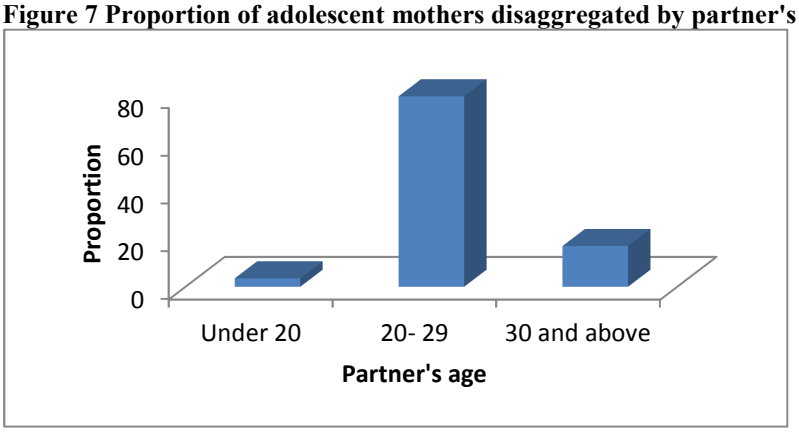
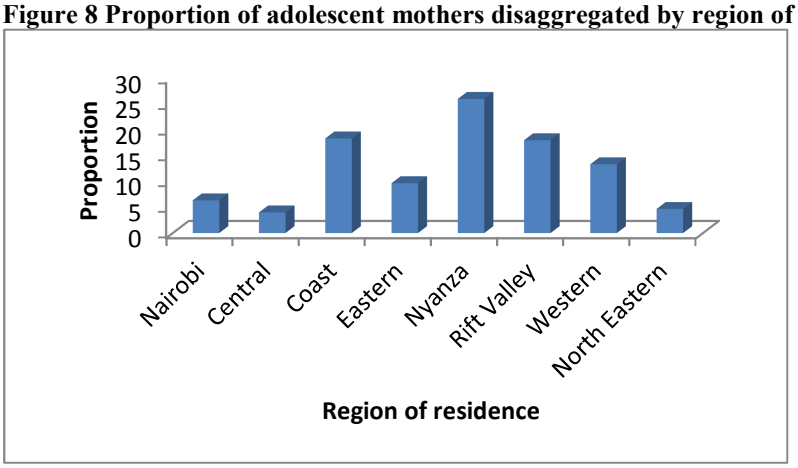


Figure 8 Proportion of adolescent mothers disaggregated by region of residence



5. Factors Associated with Adolescent Motherhood in Kenya

Logistic regression analysis was done to bring out the significant factors explaining the likelihood of adolescent motherhood in Kenya. In Model I that considered the influence of women-related factors on adolescent motherhood, the study found respondent's educational attainment, type of place of residence, household wealth index, region of residence, and ever use of contraception to be significantly related to adolescent motherhood. Girls with at least primary educational qualifications were more likely to be mothers than those with no education at a $\rho<0.00$ value. This significance disappears when partner's factors are introduced in the analysis (in Model II). Girls residing in an urban environment and in Nyanza region are 43 percent and 59 percent, respectively, less likely to be mothers compared to girls residing in a rural environment and in Nairobi region in Model I, a statistic significance that disappears in Model II.

Economically, girls from households categorised as "average" in terms of wealth index are 0.49 times more likely to be mothers than those from low wealth index households in Model I. This relationship becomes inverse when partner factors are introduced in the analysis, in that girls from households of average wealth index are 0.02 times less likely to be mothers (in Model II). However, results in the full model indicate that girls from high wealth index households are 13 percent more likely to be mothers at a statistic significance of 0.05.

Table 1 Results of factors associated with adolescent motherhood in Kenya

Variable name	Model I		Model II	
	B	Exp(β)	B	Exp(β)
Respondent's education level				
None	-	1.000	-	1.000
Primary	1.162	3.195*	0.017	1.017
Secondary and above	2.217	9.176*	0.380	1.463
Type of place of residence				
Rural	-	1.000	-	1.000
Urban	-0.559	0.572**	-0.842	0.431
Household wealth index				
Low	-	1.000	-	1.000
Average	0.397	1.488***	0.978	0.978***
High	0.287	1.332	1.126	1.126***
Region of residence				
Nairobi	-	1.000	-	1.000
Central	0.272	1.312	0.778	2.176
Coast	-0.558	0.572	-0.048	0.953
Eastern	-0.093	0.911	-0.183	0.833
Nyanza	-0.903	0.405**	-0.962	0.382
Rift Valley	-0.540	0.583	0.074	1.077
Western	-0.344	0.709	0.353	1.424
North Eastern	0.637	1.891	0.898	2.456
Ever use of contraception				
Never	-	1.000	-	1.000
Ever	-2.022	0.132*	-1.178	0.308*
Partner's age				
Under 20			-	1.000
20- 29			-0.192	0.826
30 and above			-0.001	0.999
Partner's education level				
None			-	1.000
Primary			0.592	1.808
Secondary and above			1.113	3.045***
χ-test		275.634		33.562
-2log likelihood		1337.400		280.643

*ρ<0.001; **ρ<0.01; ***ρ<0.05

Further, girls who have ever used contraception are 0.87 and 0.69 times, in Models I and II respectively, less likely to be mothers compared to their colleagues who have never used contraception, both at a statistic significance of 0.001. Partner's age was not found to be statistically related to adolescent motherhood whereas partners with some secondary education were 2.05 times more responsible for adolescent motherhood than their colleagues with no education (in Model II).

5.1 Discussions

This paper examined the factors associated with adolescent motherhood in Kenya using 2008/09 Kenya demographic and health survey data. Results of bivariate analysis indicated that childbearing start at an earlier age of 13 years in Kenya, and that it is high among girls with primary educational qualifications, those of rural residence, residents in households of low wealth index, those who have never practiced contraception, residents of Nyanza region and those whose partners are aged 20-29 years and have primary education qualifications. The early entry into child bearing state signifies more likelihood of getting into marriages earlier than otherwise anticipated. This is because ex-nuptial childbearing is culturally and socially discouraged in most communities in Kenya (Ikamari 2008) and that women with ex-nuptial births have a lower chance of getting married (Ikamari 2005). Such early marriages affects the social networks of the girls, their decision making power, long term sexual and reproductive behaviour and health, ability to negotiate with partners and family over healthy behaviours, and more significantly human rights abuse (Bruce 2007). The births to these women category face a myriad of challenges: they are subjected to elevated risks of infant and child deaths, lower intellectual and academic achievement, health complications, social behaviour problems and problems of self control primarily due to the effects of single parenthood and lower educational qualifications. Majority of adolescent mothers belonging to poor households places both the mothers and their newborns at increased risk of illness, and they

face more challenges in accessing timely and high quality care compared to those belonging to wealthier households. As a result of poverty, many young women are forced to marry at a young age, making them to start child bearing early due to unprotected and increased sexual frequency, and in most cases marry someone who is older than them (Palamuleni 2011).

In the logistic regression results, educational qualification of both the respondent and the partner was found to be significantly related to adolescent motherhood in Kenya. The respondent's educational level was however found significant only in the model that excluded the effects of the partner on adolescent motherhood. Adolescents with some education were found to be more likely to initiate child bearing, with the likelihood increasing from adolescents with primary education to those with at least secondary education. This can be attributed to the ignorance such girls possess, thinking that they know a lot pertaining sexual health than their counterparts with no education at all. Such girls, especially in rural areas and in cases of abject poverty, are lured into sex for gifts and little monies to enable them meet their day-to-day needs considering that majority are school girls. Schools too may fail to offer sexuality education, making the girl-child to rely on information that is often inaccurate from peers about sexuality, pregnancy and contraception. A study by Ikamari (2008) found women with primary education to have a higher statistically significant risk of getting a first birth compared to women with no education. Bledsoe et al. (1999) said that exposure to limited schooling may undermine traditional practices of sexual abstinence while at the same time has not adequately facilitated the acquisition of life skills and related reproductive behaviour such as increased use of contraception and negotiation of sex associated with increased schooling.

Motherhood is more likely among adolescents in rural Kenya than among those in urban Kenya. The less likelihood of urban adolescent being mothers is due to the widespread contraception information in urban settings and the proximity and accessibility to family planning services compared to those in rural areas. Girls who have ever used contraception were 0.69 times less likely to have initiated childbearing at a statistical significance of 0.001 than their colleagues who have never used contraception. Especially with the upward trend in modern contraceptive use, it is expected that unpreparedness for pregnancies will decline in Kenya.

6. Conclusions

Results of bivariate analysis show that motherhood in Kenya begin as early as 13 years of age, and that adolescent motherhood is high among girls with primary school educational qualifications, those of rural residence, low wealth quintile households, residents of Nyanza region, and those who have never used contraception. Just like the girls, majority of their partners have primary school educational qualifications and are aged between 20 and 29 years.

Multivariate analytical findings showed that adolescent motherhood is a consequence of an interlocking set of factors, among them, educational attainment of the woman, type of place of residence, household wealth index, region of residence, ever use of contraception, and partner's educational attainment, all of which were found to be statistically related to adolescent motherhood.

A supportive environment with evidence-informed policies effectively developed, implemented, enforced, monitored and evaluated can ultimately contribute to stopping adolescent pregnancies and achieving safe motherhood in Kenya. Such an environment will improve adolescents' access to quality reproductive health information; enhance their self-esteem and confidence to use existing services. There is need to invest substantial efforts to understand the individual social and cultural factors affecting adolescents' reproductive health outcomes and design policies that address them appropriately. Policy makers especially parliamentarians ought to exhibit strong and visible efforts to prevent adolescent pregnancies including enacting, reforming and enforcing laws that prohibit: marriage of girls before the age of 18, coerced sex and severely punish perpetrators.

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