ORIGINAL RESEARCH ARTICLE

An examination of postpartum family planning in western Kenya: *"I want to use contraception but I have not been told how to do so"*

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Abstract

Postpartum family planning (FP) in Kenya is low due to inadequate sensitization and awareness among women, particularly in rural areas. This paper identifies most widely used types of FP, intent and unmet needs among women, FP counseling and barriers to FP uptake. Focus group discussions with providers, traditional birth attendants (TBAs) and mothers, as well as in-depth interviews identify key themes including preferred postpartum FP, limits to existing FP counseling and barriers to FP uptake. Postpartum FP is common including injectable contraceptives, oral contraceptives, coils, condoms, and calendar methods. FP counseling is provided by peers, friends, TBAs and formal health providers. FP practices are associated with family support, literacy, access to FP information, side effects, costs and religion. In conclusion, changes in service provision and education could encourage increase in postpartum FP use in Kenya. (*Afr J Reprod Health 2013; 17[3]: 44-53).*

Résumé

La planification familiale du post-partum (PF) au Kenya est faible en raison de la sensibilisation insuffisante et la sensibilisation des femmes, en particulier dans les zones rurales. Ce document identifie les types les plus répandus de la PF, l'intention et les besoins non satisfaits chez les femmes, la consultation de la PF et les obstacles à l'adoption de la PF. Des discussions à groupe cible avec les prestataires de services, les accoucheuses traditionnelles (AT) et des mères, ainsi que des entrevues en profondeur dégagent les principaux thèmes, y compris la PF du post-partum préféré, les limites de la consultation de la PF en cours et les obstacles à l'adoption de la PF. La PF du Post-partum est commune, y compris les contraceptifs injectables, les contraceptifs oraux, les bobines, les préservatifs et les méthodes de calendrier. La consultation de la PF est prodiguée par des pairs, les amis, les accoucheuses traditionnelles et les prestataires officiels de santé. Les pratiques de la PF sont associées avec le soutien de la famille, l'alphabétisation, l'accès à l'information sur la PF, les effets secondaires, les coûts et la religion. En conclusion, les changements dans la prestation de services et de l'éducation pourraient encourager la hausse de l'utilisation de la PF du postpartum au Kenya. (*Afr J Reprod Health 2013; 17[3]: 44-53).*

Keywords: Kenya; Postpartum family planning; Family planning counseling; Family planning barriers; Traditional birth attendants

Introduction

The Millennium Development Goals (MDGs) represent a collective global commitment to address poverty and health issues, including low incidence of antenatal care visits and modest use of skilled attendants for labor and delivery. But while the emphasis of MDG 4 and 5 is on reproductive health prior to birth, it is also important to address critical issues in postpartum care[1-2]. Thoughtful and consistent postpartum care plays a critical role in decreasing the morbidity and mortality of mothers and babies[3]. The promotion of the use of postpartum family planning (FP) represents one avenue to address high mortality rates, as well as population growth in sub-Saharan Africa. The promotion of FP as part of a comprehensive public health approach that is complemented by economic development may lead to a reduction in the number of people

living in poverty, improved maternal and child mortality figures, greater empowerment of women and better environmental sustainability[4].

FP promotion has improved uptake of contraception and a reduction of fertility rates in industrialized countries; the same has not, however, held true for developing nations – in sub-Saharan Africa in particular. The continent continues to experience high fertility rates, despite considerable identification of the unmet needs for FP in both rural and urban locales. Fertility issues remain topics of considerable debate, even in forums and conferences having little to do with reproductive health[4,5]. Beyond the stated goals of the MDGs with respect to FP, addressing those unmet needs would represent a cost-effective way to help the continent's women take control of their reproductive health while also contributing to a reduction in terminations of pregnancy and a potential decline in obstetric complications. [4]Child spacing remains essential to maternal and infant wellbeing, and proper use of FP can help achieve that[6].

Kenya's launch of a national FP program in 1967 was largely ignored; it was not until the 1984 approval of a series of population policy guidelines that implementation of the program was begun. Those guidelines were modified in 2000[7].

Limited progress initially made by Kenya in decreasing fertility rates and increasing use of contraception has stagnated since the late 1990s. By 2003, 20% of births in Kenya were unwanted and 25% of pregnancies were untimed.[8] Currently 45 % of married Kenyan women are using some method of contraception while 26% of married women have an unmet need for FP. Uptake of FP services is highest among urban, well-off, educated women, and lowest among those in remote rural areas with little education or income[9]. Factors identified in the 2008-2009 Kenya Demographic and Health Survey (DHS) as inhibitors of FP uptake include fears of side effects, health concerns, religious opposition and opposition from a husband or partner[9].

It is possible that better promotion of FP could respond to these inhibitors and help to reach the more than 68% of Kenyan women who have unmet needs for FP postpartum[6]. The DHS notes that only 5% of women who identified themselves as not using FP had been visited by a fieldworker who shared information about different FP methods. Nor was FP discussed during the majority of health facility visits (88%) by postpartum women surveyed by the DHS[9]. Such negligence represents a significant loss of opportunity to impart promotion, education and wellness messages to rural populations.

As part of a wider examination of labor and birth practices in western Kenya, including the use of skilled delivery attendants, this study aimed to understand the barriers to uptake of postpartum FP in both rural and urban Kenya. The use of focus group discussions to understand the challenges faced by health promoters was complemented by additional conversations with women who have expressed a need, as yet unmet, for postpartum FP.

Methods

Study design and population

Qualitative methods were used to achieve four specific objectives: To identify types of FP commonly used by women; to establish whether women popularly plan to use contraceptives after delivery; to describe the FP counseling rendered; and to explore facilitators and barriers to FP uptake. The study was conducted in both a rural and an urban setting to assess whether location influenced the factors, beliefs and perceptions that inhibited or encouraged uptake of FP. Port Victoria, a fishing village in Busia District, has a district hospital that serves some 70,000 people in the area, the majority of whom are of the Luhya ethnicity. Eldoret, Kenya's fifth largest city at an estimated population of 300,000 was the urban site chosen. Its ethnic makeup is diverse and it is home to the national Moi Teaching and Referral Hospital: Kenya's second largest public medical facility.

Twenty focus group discussions (FGDs) were conducted in all, ten at each site. The participants at each site were divided into groups as follows: two groups of health care providers: trained nurses, trained nurse midwives, clinical officers and doctors; two groups of traditional birth attendants (TBAs): providers of delivery services who are not associated or recognized by the

Kenyan Ministry of Health; three groups of women who had received the recommended baseline of four antenatal care (ANC) visits and given birth within the past three years in a health facility; and three groups of women who had received ANC and given birth in the last three years at home. The inclusion of both service users and service providers in the focus groups ensured that multiple perspectives were available to provide a comprehensive picture of the FP environment in western Kenya. Researchers also conducted in-depth interviews with three mothers at each site, representing age cohorts of 18-25, 26-32 and 33 and older, in order to gain greater insight into what could be considered a typical reproductive experience.

Participants in the service user focus groups conducted at Eldoret were identified by employees of the Riley Mother Baby Hospital and Moi Teaching and Referral Hospital. All were over age 18 and had experienced at least one pregnancy with a live birth outcome. The two facilities also identified health providers in the formal health structure, while outreach workers from the Academic Model Providing Access to Healthcare (AMPATHplus) assisted with the recruitment of TBAs. In Port Victoria, health care workers from the District Hospital and the Mukhobola Health Centre aided in the recruitment of women who had delivered and formal healthcare workers. World Vision staff assisted in the recruitment of TBAs.

Data collection and analysis

FGDs and interviews were led by trained research assistants. Mothers who participated in the FGDs were asked a series of demographic questions, including identifiers such as age, ethnic group, relationship status, level of education and employment status. Questions centered on the following: types of FP used; intent to use contraception after delivery; reasons for and/or against FP use; and availability of FP counseling. Women who participated in in-depth interviews were asked questions about their opinions on postpartum FP; types of FP information or counseling received in the past; sources of FP information; their intentions to use contraception after delivery; and considerations they made when deciding about FP.

TBAs were asked a series of demographic questions prior to joining the FGD. They included identifiers such as age, ethnicity, level of education, years of experience as a TBA, the type of training they received, and if they had any other means of income generation aside from assisting births. Focus groups for TBAs covered the following: how often they counsel their clients on postpartum FP; how this counseling is done; the kind of FP advice given to their clients; and barriers to FP and suggestions for increasing uptake of FP postpartum. Health care providers were asked questions in three main domains: FP counseling practices; FP advice provided to clients; barriers to uptake of FP and ideas about how to remove those barriers.

Prior to initiation of research activities, ethical clearance was sought at George Washington University, USA, and Moi University, Eldoret. Each study participant completed a consent form prior to participation. Participants received transport reimbursement and were given light refreshments during the discussions. Interviews and FGDs were all digitally recorded. The FGDs were conducted largely in Swahili and English although Luhya (local language) was used for one FGD in Port Victoria. Each FGD had 7-12 participants and took on average 1.5 hours. The data was collected at both sites between May and July 2010.

Demographic data were analyzed using STATA to generate descriptive statistics. The qualitative data were first transcribed and then translated from Swahili/Luhya into English as necessary. Once the transcripts were completed, four of the investigators coded and analyzed the data for thematic content. To illustrate participants' responses, verbatim quotations have been used.

Results

Demographic data

There were 175 participants, with 94 FGD participants in Port Victoria and 81 in Eldoret. The overall breakdown of participants was as follows: 31 health care providers, 32 TBAs and 112 mothers who had delivered in the past three years.

Due to purposive sampling, results of the demographic surveys are not generalizable at the population level.

The 32 TBAs who participated in the study ranged in age from 25 to 71 (mean=53). A third of all TBAs had no formal education. The TBAs from Eldoret achieved slightly higher levels of education but overall there was little difference. Most of the TBAs (N=18) reported at least 15 years of experience, with only two reporting less than one year of experience. The majority were trained by a family member. More than half (N=19) reported generating income from activities in addition to assisting births, including small enterprise, farming, poultry husbandry and casual work. The mothers ranged in age from 18 to 39 (mean=26 years). Ethnic diversity was greater among the Eldoret FGD participants, with a total of seven ethnic groups - Kikuyu, Luhya, Kalenjin, Luo, Kisii, Kamba and Meru - represented. The Port Victoria population only reported Luhya and Luo ethnic groups.

At both sites, nearly 80% of the women were married and more than 90 % lacked formal employment. Only six did not attend school. Nearly 20% (N=22) completed secondary school and four completed a university degree. As expected, education level among urban Eldoret participants was on average higher than in Port Victoria[9].

Sources of family planning information

Similar themes emerged from both groups with respect to how women receive information about family planning. Sources for postpartum FP information include the Catholic Church (the calendar/natural method), from public media such as radio or television, and health providers – either during ANC visits or daily education sessions provided at health facilities. Most women who receive FP education share it with others.

Postpartum family planning counseling and topics covered

Health care providers' (HCPs) counseling

The HCPs use a client-centered approach including history taking, medical assessment and consultation with fellow health providers or experts as necessary. HCPs said they advise on the following issues (beginning with the most popularly reported topics): when to use FP; the importance of child spacing; the need to minimize to a manageable number of children; types of FP methods and their advantages/disadvantages; advice on breast feeding; the liberty to change an FP method; compatibility of a method and fertility plans; compatibility of a method with the user's health conditions; each method's possibility of failure; the use of dual methods to increase FP success; importance of STI prevention; demystification of myths about FP; the wisdom of delaying the first child; danger signs associated with FP methods; and the need to seek help in case of danger signs.

There are several occasions at the health facility when FP education is provided. The most popular is during ANC and as mothers are discharged after delivery. Most women receive these messages only once because of the high volume of patients seen by health care providers, which mean they do not have the time to reinforce messaging. Some women receive the messages more than once, both during ANC visits and in post-delivery discharge counseling.

Counseling frequency aligns with the frequency of visits to a health facility, according to participants in one of the Eldoret FGDs. There were missed opportunities for FP counseling, a position reinforced by the service users in the other FGDs. For instance, a 28-year-old mother from Port Victoria did not receive any advice on FP. Although she achieved the recommended four visits proscribed by the World Health Organization, she never received any advice about postpartum FP from the health facility. This means that everything she knows about FP she learned second-hand, from friends. As she stated in her interview: *'I want to use but I have not been told how to use them…I only used for one year but I was not given any advice. I just used on my own.'*

Traditional birth attendants' (TBAs) counseling

TBAs advise mothers on several FP issues including: the importance of managing family size; types of FP methods and their advantages/disadvantages; the need to involve male partners in FP matters; importance of spacing children; when to use FP; the need to seek help in

case of danger signs; the liberty to change an FP method, compatibility of a method with the user's health conditions; warnings against use of expired contraceptives; and the vital role of a woman as the initiator of FP in her home.

Some of the Eldoret-based TBAs said that delivery counseling included information about postpartum FP. FP methods discussed includes the natural/calendar method and female condoms are, although the later remains an unpopular choice. Sometimes Port Victoria TBAs also recommend use of herbal contraceptives. Some TBAs in Eldoret and Port Victoria also recommend the natural method to couples.

TBAs usually advise couples to consider male-oriented methods when the FP methods used by women result in a barrage of side effects:

"When they [women] *come complaining, 'I am having a backache, this part of the body is aching and so forth,' you will advise them on the new methods for the men. Yes, because they are now available…If he really cares about the health of his wife, he should try and use it. It does not have any side effect…you just talk with him and convince him to use it so that the woman can also rest and take care of the children for a while"* (TBAs, Eldoret, FGD 1).

TBAs educate their own families about FP, providing guidance to their female relatives and encouraging them to share that information with their own friends and peers. They actually counsel 'any woman or girl' in the community on FP, especially those who are noticeably pregnant. TBAs from both sites sometimes voluntarily

choose to visit (without an invite) and gently counsel a woman that delivers annually, or one who has many children and is living in absolute poverty and sickness. Occasionally, some of the Port Victoria TBAs consider coercive approaches such as encouraging mothers to go to the health facility for FP: *"We mock others saying, 'Whatever you are doing is a shame! Just go to hospital and have FP"* (TBAs, Port Victoria, FGD 2). Even so, it is not always easy for TBAs to prompt and encourage FP in their communities. For instance, one Port Victoria group noted that some mothers are opposed to FP due to their partners' resistance. As such, the TBAs feel obliged to limit their FP counseling.

Due to their limited knowledge on contraceptives, TBAs routinely refer community members to the health facilities for FP education. Sometimes, they also escort the mothers to the health facilities for FP counseling and initiation. One case is illustrative:

"For me, I would truly say that one woman happened to have been sent to me by her husband that I take her to the hospital so that she could start using family planning. The truth is that, I actually took her to a health facility and she was issued with a family planning method. I am not quite sure what that doctor did, and it was there at the district hospital. You know, it happened that the woman conceived and so the husband sent her back to me. When I saw this, I again took her back to the doctor" (TBAs, Eldoret, FGD 1).

TBAs may be selective when they consider which health facility to refer mothers to because some of the private clinics do not provide comprehensive guidance to FP seekers. This example emerged from one of Eldoret's largest low-income neighborhoods: *"There are* [private] *clinics that we have here, and many women prefer to go there because they are not asked questions…They will not talk to you or explain or give you advice to guide you …If you reach there at the clinic and say, 'I need injection* [injectable contraceptive]*,' they inject you. If you say it is drugs, they will tell you these are the drugs. Usually they don't test you or explain to you the dangers involved in using family planning. They are concerned with the money. So we advise them* [women] *to go to district hospital or come to MTRH"* (TBAs, Eldoret, FGD 2).

Knowledge of family planning methods and their benefits

There are a number of FP methods known to mothers in Eldoret and Port Victoria. Table 1 enumerates the most familiar: Injectable contraception, oral contraception (pills), coil, con calendar/natural method.

Table 1. Popular family planning methods among mothers in Eldoret and Port Victoria Kenya

FP methods known to mothers	Source focus group discussions
Injectable contraceptive	All FGDs
Oral contraceptive	All FGDs
Coil	All FGDs except WDHF, Eldoret, FGD 1
Condoms	All FGDs except WDH, Eldoret, FGD 3 & Port Victoria, WDHF, FGD 1
Calendar or natural method	All FGDs except WDHF, Port Victoria, FGD 1 & WDH, Port Victoria, FGD 2
Traditional methods/herbs	WDHF, Eldoret, FGDs 2, 3; WDH, Eldoret, FGDs 1, 2, 3; WDHF, Port Victoria, FGDs 1, 2, 3; WDH, Port Victoria, FGD 2
Norplant	WDHF, Eldoret, FGDs 1, 2, 3; WDH, Eldoret, FGDs 1, 2, 3; WDHF, Port Victoria, FGDs 1, 3
Tubal ligation	WDHF, Eldoret, FGDs 2, 3; WDH, Eldoret, FGDs 1, 2; WDHF, Port Victoria, FGDs 2, 3
Breastfeeding eight hours a day	WDH, Port Victoria, FGDs 1, 2
Vasectomy	WDHF, Eldoret, FGDs 2, 3
Chinese tablets (taken monthly)	WDHF, Eldoret, FGD 3
Withdrawal method	WDHF, Eldoret, FGD 1

WDHF= Women who delivered at a health facility; WDH= Women who delivered at home

Table 2. Reasons for postpartum uptake of family planning in Eldoret and Port Victoria Kenya

Reason for using a FP method	Source focus group discussions
To space their children	WDHF, Eldoret, FGD 2; WDHF, Port Victoria, FGDs 2; WDH, Port Victoria, FGDs 1, 2, 3
To have a financially manageable family	WDHF, Eldoret, FGD 2; WDH, Eldoret, FGD 1; WDH Port Victoria, FGDs 1, 3
To avoid pregnancy	WDHF, Eldoret, FGD 2; WDHF, Port Victoria, FGD 1; WDH, Port Victoria, FGD 1
When they have had desired number of children	WDHF, Eldoret, FGD 2; WDH, Port Victoria, FGD 2
Conception maybe antagonistic to a mother's medical condition	WDHF, Eldoret, FGD 3; WDH, Port Victoria, FGD 1
To avoid weakening a HIV infected body through pregnancy	WDHF, Port Victoria, FGD 2
Presence of an irresponsible husband	WDH, Port Victoria, FGD 3
Nature of a mother's employment	WDH, Port Victoria, FGD 2

WDHF= Women who delivered at a health facility; WDH= Women who delivered at home

Whether FP uptake is considered immediately after delivery or postponed for a few months, mothers associated several benefits with FP (Table 2). The top three reasons listed by the FGD participants were: child spacing, financial management of the household, and to avoid pregnancy.

Opinions on postpartum family planning

Findings revealed that despite knowledge of the different methods and their benefits, women were still not using FP consistently. A few hesitated to pursue any postpartum FP because they had never used FP even before becoming pregnant. Others postponed FP uptake for a determined period of time or when menses resumed. Other reasons cited by FGD participants included: the assumption that breastfeeding provides adequate protection against conception; disagreement with spouses; and fear of diverse negative physical effects associated with contraceptives.

Nonetheless, the norm is to take up a FP method. Those who do begin using FP consider it necessary, as illustrated by one 36-year-old mother in Eldoret: *"A wise woman who is intelligent will make up her mind and say, 'These children are*

enough and I need to look for ways of looking after them.'"

Barriers associated with uptake of postpartum family planning

Numerous barriers discourage uptake of FP in Eldoret and Port Victoria. They include personal, social, economic, facility level, and medical factors. Ranked from most inhibiting to least, the barriers included: concern about side effects; lack of support from spouses and extended family; rumors, myths and misconceptions about FP; fear of infertility; religious beliefs; costs of FP methods and non-adherence issues; illiteracy among mothers; and failure of FP methods in the past.

Tables 3 and 4 provide a summary of the barriers discussed by HCPs and TBAs. Health care providers identified rumors and misconceptions about FP, religious beliefs, and lack of support from spouses and extended family as the three main barriers to FP uptake. Other identified barriers include side effects, access to the diverse methods, conflicting health interests for mothers, and illiteracy.

TBAs identified side effects; rumors, myths and misconceptions about FP; lack of support from spouses and extended family; and fear of fertility complications as the most common barriers to uptake of FP.

Table 3. Barriers to postpartum family planning in Eldoret and Port Victoria Kenya: Health care providers' (HCPs) perspectives

Barrier to uptake of FP services	Source focus group discussions
Rumors, myths and misconceptions about FP	All HCP FGDs
Religious beliefs	All HCP FGDs
Lack of support from spouses and extended family	All HCP FGDs
Side effects	Mixed HCPs, Port Victoria, FGD 1; Mixed HCPs, Port Victoria, FGD 2
Inaccessibility and unavailability of some FP services	Nurses, Eldoret, FGD 1; Mixed HCPs , Eldoret, FGD 2
Conflicting health interests when considering FP options for clients	Mixed HCPs , Eldoret, FGD 2; Mixed HCPs, Port Victoria, FGD 1
Illiteracy	Nurses, Eldoret, FGD 1; Mixed HCPs , Eldoret, FGD 2
Cost	Nurses, Eldoret, FGD 1
Patronizing staff attitude towards youthful clients	Nurses, Eldoret, FGD 1
Lack of supplies	Nurses, Eldoret, FGD 1
Limited competence among the staff	Nurses, Eldoret, FGD 1
Language barrier	Mixed HCPs , Eldoret, FGD 2
Minimal male involvement	Nurses, Eldoret, FGD 1
Conflicting provider-user view points	Mixed HCPs, Port Victoria, FGD 2
Non-adherence	Mixed HCPs, Port Victoria, FGD 2
Fear of HIV testing	Mixed HCPs, Port Victoria, FGD 1
Limited training of providers	Mixed HCPs, Port Victoria, FGD 1

Table 4. Barriers to postpartum family planning in Eldoret and Port Victoria Kenya: Traditional birth attendants' (TBAs) perspectives

Barrier to uptake of FP services	Source focus group discussions
Side effects	All TBA FGDs
Rumors, myths and misconceptions	TBAs, Eldoret, FGD 1, 2; TBAs, Port Victoria, FGD 2
Lack of support from spouses and extended family	TBAs Port Victoria FGDs 1, 2
Fear of infertility	TBAs, Eldoret, FGD 1; TBAs, Port Victoria, FGD 2
Competing herbal and 'supernatural' FP alternatives	TBAs, Eldoret, FGD 2
Religion	TBAs, Eldoret, FGD 2
Cost	TBAs, Eldoret, FGD 2
Ignorant and adamant mothers' wish for more children	TBAs, Port Victoria, FGD 2
The wish to deliver and culturally name children after family members	TBAs, TBAs, Eldoret, FGD 2

Inaccessibility and unavailability of some FP services	TBAs, TBAs, Eldoret, FGD 2
Known FP failure	TBAs, Port Victoria, FGD 1
Fear of HIV testing	TBAs, Port Victoria, FGD 2
Quack providers	TBAs, Eldoret, FGD 1

Table 5. Participants' suggestions for increasing family planning (FP) practices in Kenya

Demand-side	**Supply-side**
Include men in FP issues	Ensure FP methods are available and affordable
Disseminate information on FP side effects	Create adolescent-friendly services
Increase FP counseling and awareness about all FP methods	Use interpreters to overcome language barriers
Consider TBA role in FP counseling and referral to health facilities	

Ideas for increasing uptake of postpartum family planning

All of the care providers, both formal and informal, shared ideas on how to improve FP uptake, both among nulliparous women and postpartum. (Table 5).

Involvement of significant others in FP matters and deliberate encouragement of women to visit health facilities accompanied by their spouses should increase couple counseling and joint decision making. Persistent awareness about FP through the mass media, community health workers, and general community involvement remains important. HCPs mentioned the need to maximize the FP message in medical camps, church campaigns, and at chiefs' mabaraza (community meetings). Other suggestions included door-to-door visits and seminars or workshops that provide easy-to-understand information about the importance of FP and the different methods available. TBAs also suggested taking advantage of the diverse social groups that women usually attend and using them as a FP education forum. Both TBAs and formal HCPs mentioned ways of improving and promoting health services through use of interpreters to overcome language barriers, making FP methods affordable and available, and encouraging the development of youth-friendly centers. Increased training of HCPs on FP was also highlighted.

HCPs from both sites mentioned a need for the Kenya government to actively support FP and explore diverse incentives that can encourage FP. TBAs considered promotion of abstinence after delivery as a natural FP method. They argued that this approach had worked well for many past generations. Unsurprising, TBAs from both sites discussed benefits of engaging trained and remunerated TBAs to help promote FP in their communities (Table 5). They are willing to encourage FP in their catchment areas but they need more information in order to effectively counsel mothers/couples who come to them for advice.

Discussion

Study findings suggest that there is general FP awareness and some postpartum utilization of FP in both Eldoret and Port Victoria. This can be attributed to the inclusion of postpartum women who attended the recommended number of ANC visits, where they were more likely to be exposed multiple times to health messaging including information about FP. However, this is not representative of the norm in Kenya, as uptake of ANC is also a major challenge in most of the country. Injectable and oral contraceptives were the most popular forms of postpartum FP among the women included in the FGD, which reflects the national uptake of FP, according to the KDHS (2008-9), in which modern methods (95%) were more widely used than traditional ones (69%)[9] . FP information is available at health facilities, churches, social forums, and in public media, although the study showed that there were considerable missed opportunities for sharing FP information at health facilities. An overwhelming majority of Kenyan women who do not use FP

(88%) have never been in contact with a health care professional for discussions about its use[9].

Correct and more easily accessible information about the rationale for FP, advantages of FP, and how to use the methods is needed. Counseling and FP information should be routinely disseminated at every possible interaction between an HCP and female clients. Further, training HCPs on postpartum FP services is key to FP uptake[10, 11]. Such training will make HCPs more likely to discuss FP with postpartum women, and consequently, result in substantial improvements in postpartum FP. There is evidence from Kenya suggesting once women get informed about FP, uptake goes up and unmet need drops[10]. The country's health care sector should also consider expanding the use of other vehicles for FP information dissemination, such as periodic medical camps, church campaigns, health promotion by community health workers, and Chiefs' *mabaraza* (community meetings).

FP advocacy and improved FP services in health facilities should be matched by investment in ensuring that products are available. For example, a common reason noted for discontinuation of some contraceptives in Kenya is stock outs and this requires immediate attention[12]. The Kenyan ministries of health and relevant development partners should thus address FP service issues.

While the use of TBAs for delivery is being discouraged as part of the sector's formal policy, they remain vital links to the community; those relationships should be cultivated but framed towards health promotion, with FP and ANC among the top issues. Enlisting TBAs as community health workers to spread valid and credible information about FP would be an effective way to bring services to those living in hard-to-reach areas. Indeed, a study in Malawi, Ghana, and Zambia discovered that FP outreach programs can raise awareness of FP.[13] In addition, practical ways of increasing involvement of significant others in FP decision making are needed. Inadequate spousal FP discussion and support has been noted in other African nations.[14] Male involvement is clearly crucial for increased and persistent FP use in Kenya[12].

In conclusion, this study sought to identify types of FP commonly used by women in Eldoret and Port Victoria, to establish whether women popularly plan to use any sort of contraceptive after delivery, to describe the FP counseling rendered, and to explore barriers to contraceptive uptake. There is widespread awareness of FP methods and most mothers consider postpartum contraceptives. They also access limited FP counseling on diverse topics provided by fellow mothers, friends, HCPs and TBAs. Nonetheless, there are cultural, social, economic, facility level, and medical factors that hinder optimal FP uptake.

While this study has provided perspectives on issues concerning FP, it has also generated additional questions for further research and suggested alternative pathways to increase postpartum FP. Subsequent research should focus on how diverse stakeholders could work collaboratively to improve the quality and reach of FP services throughout Kenya. More FP dialogues across rural and urban communities can buoy the Kenyan government to play a more active role in making sure user perspectives are 'heard,' FP education is enhanced, and services are made more readily available to all men and women. Further, more research should investigate provider-client interpersonal relations and how they impact FP uptake.

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References

1. http://www.un.org [Internet]. United Nations, Millennium Development Goals [cited 2012 Sept 6]. Available from: http://www.un.org/millenniumgoals/
2. Perkins M, Brazier E, Themmen E, Bassane B, Diallo D, Mutunga A, et al. Out-of-pocket costs for facility-

based maternity care in three African countries. Health Policy and Plann 2009; 24(4): 289–300.
3. Ministry of Health. Safe Motherhood Demonstration Project - Repositioning postpartum care in Kenya. Safe Motherhood Policy Alert, Kenya. Ministry of Health: University of Nairobi and Population Council; 2005.
4. Cleland J, Bernstein S, Ezeh A, Faundes A, Glasier A and Innis J. Family planning: the unfinished agenda. Lancet 2006; 368(9549): 1810–1827.
5. Kaler A, Alibhai A, Kipp W, Konde-Lule J and Rubaale T. Enough children: Reproduction, risk and "unmet need" among people receiving antiretroviral treatment in western Uganda. AJRH 2012; 16(1): p. 133-144
6. Access-FP & USAID. Postpartum contraception: Family planning methods and birth spacing after childbirth. Family planning initiative addressing unmet need for postpartum family planning. USAID: Washington, DC; 2008.
7. Ojakaa D. Trends and determinants of unmet need for family planning in Kenya. Calverton, MD: Macro International; 2008.
8. Ndegwa S, Onduso P and Casey L. Reproductive health and family planning in Kenya: The Pathfinder International experience. Pathfinder International: Nairobi. 2008.
9. Kenya National Bureau of Statistics. Kenya Demographic and Health Survey 2008-9, Government of Kenya: Nairobi; 2010.
10. Mwangi A, Warren C, Koskei N and Blanchard H. Strengthening postnatal care services including postpartum family planning in Kenya. Frontiers in Reproductive Health, ACCESS-FP Jhpiego, Population Council, USAID: Washington, DC; 2008.
11. Mathe JK, Kasonia KK, and Maliro AK. Barriers to adoption of family planning among women in eastern Democratic Republic of Congo. AJRH 2011; 15: 69-77.
12. Burke HM and Ambasa-Shisanya C. Qualitative study of reasons for discontinuation of injectable contraceptives among users and salient reference groups in Kenya. AJRH 2011; 15(2): 67-78.
13. Malarcher S, Family planning success stories in Sub-Saharan Africa. Global Health Technical Briefs, USAID: Washington, DC; 2007
14. Berhane A, Biadgilign S, Amberbir A, Morankar S, Berhane A, and Deribe K. Men's knowledge and spousal communication about modern family planning methods in Ethiopia. AJRH 2011; 15(4): 24-32.