Kenya's fertility showed a persistent decline from 8.1 births per woman in 1978 to 4.7 in 1998. The decline which was rapid prior to 1998 was supported by an increasing proportion of women who desire no more children and a decline in the ideal number of children (Central Bureau of Statistics (CBS) 1980; National Council for Population and Development (NCPD) *et al.* 1999). However, recent Kenyan fertility trend has been puzzling. Notable among the puzzles is the stalling in the fertility decline between 1998 and 2003, which instead recorded an increase of 0.2 births per woman over the 1998 rate (Anyara and Hinde 2006). The proportion of women who desire no more children fell slightly to 48.6% in 2003 and the mean ideal number of children among married women rose slightly to 4.3 in 2003 (CBS *et al.* 2004). Further, increase in current contraceptive use also stalled in 1998-2003 (NCPD *et al.* 1989, 1994). These changes are pervasive and have been experienced across all parities, age groups type of residence, provinces and educational categories and have generated concern among demographers, researchers and policy makers alike (Westoff and Cross 2006). Recent studies attributed the stalling in the Kenyan fertility decline to faltering in socio-economic development which may have caused deterioration in living standards (Bongaarts 2005, Shapiro and Gebresalassie 2007). Further the stalling in both the use of contraceptive methods and fertility decline in Kenya has also been attributed to a possible faltering in the Kenyan Family Planning Program effort due to inadequate funding especially as a result of the Mexico City Policy (Cleland *et al.* 2006). However, these findings are inconclusive and to some extent speculative. The manner in which economic hardship and social pressure have affected fertility is still obscure and the exact mechanisms by which the family planning program effort has affected the uptake and efficacy of contraceptive methods and fertility in recent times is little known.

Objectives: The objectives of this paper are to demonstrate the extent that fertility levels and changes, from 1978 to 1998 and especially, from 1998 to the present are related to available resources in material goods and time. Second, to determine the availability, quality and accessibility of family planning services and contraceptive methods and show the extent to which they are associated with the stalling of the Kenyan fertility decline. The paper attempts to answer the following questions: What explains the stalling in Kenya's fertility decline? To what extent is it because the

decline in desired fertility has also stalled? To what extent is it because of a failing family planning program effort? Are unintended pregnancies if any since 1998 associated with reduced availability of and access to high quality family planning services?

Data and methods: The study utilizes field data which were collected from Bumula division in Bungoma district in the Western Province, Municipality and Kieni East divisions in Nyeri district in the Central Province and Kibera and Kamukunji divisions in Nairobi district and Province of Kenya between the late 2006 and early 2007. The data were collected using focus group discussions with mostly married women aged fifteen years and above and supplemented with in-depth interviews with key informants. The key informants included senior family planning clinic service providers and managers from the Family Health Options Kenya (FHOK) and Marie Stopes Kenya (MSK). The family planning clinics sampled were located in Nairobi district, Uasin-Gishu district in the Rift Valley Province and in Kisii district in the Nyanza Province of Kenya. The data are analysed using textual and structural approaches guided by the Bongaarts proximate determinants of fertility framework (Bongaarts 1978, 1982) and the Easterline and Crimmins (1985) demand and supply framework (Bongaarts 2005:26).

Findings: The paper presents views expressed by 209 women grouped into 27 groups which divide into twelve n Nairobi district, ten in Nyeri district and five groups in Bungoma district. The majority of discussants were young with either completed primary and/or secondary education and engaged in either small scale peasant farming or small time vending. The data from the focus groups are supplemented by data from four senior family planning clinic service providers and a family planning program director. The findings show that high fertility prior to the onset of the fertility decline in Kenya in 1989, was supported by a friendly economy and climate, large pieces of family land and low prices of basic commodities including on food, health, housing and education. The onset of the decline might have been due to some achievements in socio-economic development. However, the living standards in Kenya have bee deteriorating in the course of the fertility decline forcing couples to prefer a small number of children because of the high cost of basic necessities including food, health care and housing, and the cost of educating the children and further because of the increasing unavailability of land for agricultural use and settlement. Economic

hardship explains excess fertility among some couples, in that, some women get more children outside marriage when fending for their families.

The majority of the women in Nairobi, Nyeri and Bungoma districts rely heavily on the government and local council clinics for family planning services because services in these clinics are affordable than in the private clinics and they are also trustworthy unlike services in the cheap private clinics. The family planning services provided by the FHOK and Marie Stopes clinics have never been interrupted and with exception of implants in the case of FHOK, the clinics of the two organizations have never experienced shortages in the supply of contraceptive methods. The Family Planning Program (FPP) effort managed by the government has deteriorated especially on the side of service delivery. Contraceptive methods have often missed at the clinics since the mid-1990s and more so from the early 2000s. In a notable number of occasions there is no contraceptive method or either no choice of a method or a choice is made between only the pill and the injectable. In most government and less established private family planning clinics medical examination or counselling prior to being given a self-selected contraceptive method is rare and the services are dispensed very fast.

There has been considerable drop out from contraceptive method use since the second half of the 1990s due to method side effects which include the health side effects such as bleeding, backache, headaches and etc., contraceptive method failure and prolonged fertility inhibiting effect of some contraceptive methods after stopping use. Some of the women who stopped using contraceptive methods due to health effects got babies at a close interval. The women who experienced method failure have more children than the number they intended to have and those who have suffered prolonged conception inhibiting effect of a contraceptive method contribute to the proportion of couples who recently expressed a desire for more children. Further the attribution of newly born baby abnormalities to the effects of contraceptive methods, the birth of babies with the copper T IUD on their heads, in addition to the health side effects appear to have scared some potential users of contraceptive methods from contraceptive use. The fear of HIV/AIDS or child mortality due to AIDS was not widely mentioned as either encouraging couples to have more children or promoting

replacement behaviour, however based on some of the views collected it is somewhat difficult to rule out its role in determining recent fertility preferences.

Conclusion,

The constant proportion of current users of contraceptive methods in Kenya in the period 1998-2003 appears to be a net effect of high drop out rate due to method negative side effects and a low uptake by new clients due to the fear of experiencing negative side effects including contraceptive method related prolonged infecundability. The increase in the Kenyan fertility from the late 1990s tends to be due to contraceptive method failure and absence of contraceptive methods which resulted in some women having unintended pregnancies and therefore more children than they expected. Further fertility in excess of the preferences appear to be due to economic hardship and the search for offspring composed of each sex in a case where there is only one sex of children. Therefore the stalling in Kenya's fertility decline is partly explained by economic hardship but more so by a failing family planning program effort which is related to the increase in unintended pregnancies on one hand and a stalling in the decline of desired fertility on the other. However, there is no direct evidence showing that the weakening of the family planning program effort is related to the Mexico City Policy. The prospect for an imminent end to the stalling of the Kenyan fertility decline appears to be dependent on the realisation of substantial improvements in child survival and living standards. Therefore increased funding and efficient management of small-sector high income generating projects and provision of high quality and affordable health and family planning services should be prioritised.