

UNMET NEED FOR FAMILY PLANNING IN
SOUTH AFRICA 1998 MALAWI 2000

BY

TSHEGOFATSO QUEEN MOLEBATSII

Unmet need for family Planning in South Africa 1998 and Malawi 2000



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A RESEARCH PROJECT SUBMITTED IN
PARTIAL FULLFILMENT OF THE REQUIREMENTS FOR
THE MASTER OF SOCIAL SCIENCE
IN POPULATION STUDIES

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FEBRUARY 2013

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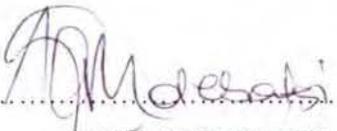
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DECLARATION

I, **Queen Molebatsi**, declare that this dissertation for the Masters Degree of Population Studies at the North-West University hereby submitted, is my own work, and has not previously been submitted by me for a degree at this or any other University. All the design and execution in this study is my own and all materials contained herein have been dully acknowledged.

Signature..........
QUEEN MOLEBATSI

ACKNOWLEDGEMENTS

This is for the remembrance of my late beloved Mother, Onica Morubane who was very supportive during my years of study. May her soul rest in peace. My special gratitude goes to my Heavenly Father who gave the strength throughout to complete the programme. Praise is to Him in the highest. Special thanks to Dr Martin Palamuleni my supervisor, who sacrificed his time to give a hearty guidance and support to the end of this programme. It was not easy but he kept on instilling hope in me for the benefit of the programme. Not forgetting my colleague, Philemon Selemela, who was very much supportive and encouraging. To my two kids, Tsholofelo and Nonofu whom I neglected for some time during the hard times of this programme but who still encouraged me and gave me the opportunity to complete the programme.

ABSTRACT

Introduction: Unmet need for family planning is high in most African countries including South Africa and Malawi as witnessed by high levels of teenage pregnancies, unwanted births and unsafe abortion. As such unmet need for family planning was added to the fifth Millennium Development Goal (MDG) as an indicator for tracking progress on improving maternal health.

Objective: The primary objective of the study is to determine the correlates of unmet need for family planning among women of reproductive age in South Africa and Malawi.

Data and Methods: The study used the 1998 South African Demographic and Health Survey (SADHS) and the 2000 Malawi Demographic and Health Survey (MDHS). Univariate, bi-variate and multi-nominal regression was used to determine the correlates of unmet need for spacing and limiting.

Results: The results showed that unmet need for spacing birth in South Africa is 4.7% whereas unmet need for limiting births is 10.3% and the total unmet need for family planning is 15.0% in 1998. In the case of Malawi, unmet need for spacing births was 19.7%, whereas unmet need for limiting births was 13.9% and total unmet need for family planning was 33.5% in 2000. Unmet need for family planning in both countries varies by socio-economic variables. The results for multinomial logistic regression for South Africa indicate that age of the respondents; population group, marital status and children ever born were found to be determinants of unmet need of family planning for spacing. Age, region, marital status, educational level, ideal number of children and children ever born were found to be unmet need of family planning for limiting in South Africa. In the case of Malawi multinomial logistic analyses indicate that age, type of place of residence, number of children ever born, ideal number of children, the husband's approval of family planning, discussion of family planning with the partner and reading news of family planning in the newspaper are significantly related to unmet need of family

planning for spacing and age and approval of family planning by a partner are found to be significantly related to unmet need of family planning for limiting.

Conclusion: The findings have important policy implications. It is therefore, recommended that raising the status of women through education and skills development, increasing participation of men in sexual and reproductive health, promoting communication between couples are of prime importance in eradicating barriers to the use of contraceptive methods.

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LIST OF ABBREVIATIONS

AIDS	Acquired Immune Deficiency Syndrome
CPR	Contraceptive Prevalence Rate
DHS	Demographic and Health Survey
DOH	Department of Health
HIV	Human Immunodeficiency Virus
HSRC	Human Sciences Research Council
ICPD	International Conference on Population and Development
IPAS	International Pregnancy Advisory Services
IUSSP	International Union for the Scientific Study of the Population
MDHS	Malawi Demographic and Health Survey
MDG	Millennium Development Goals
NGO	Non Governmental Organisations
NRC	National Research Council
PMTCT	Prevention of Mother-to-Child-Transmission
RHRU	Reproductive Health Research Unit
SA	South Africa
SABSM	South African National HIV Prevalence, HIV incidence, Behaviour and Communication Surveys
SADHS	South African Demographic and Health Survey
TFR	Total Fertility Rate
UK	United Kingdom
UN	United Nations
UNDP	United Nations Development Programme
UNFPA	United National Fund for Population
USAID	United States Agency for International Development
WHO	World Health Organisation

CHAPTER 1: INTRODUCTION

1.1 Background of the study

Unmet need for contraception can be understood as a rights-based measure of family planning, that is, the degree to which individuals are able to translate their fertility preferences into action by ensuring that births occur by voluntary and informed choice. Reducing unmet need has been a priority in all the developing countries since the 1994 International Conference on Population and Development (ICPD) in Cairo and countries has made major gains over time in the use of contraceptives, leading to a large and rapid decline in fertility after 1994.

Unmet need of family planning is the result of among others, service delivery constraints such as insufficient or poor drug supply to the health facilities, poor access to the health facility, poor knowledge or lack of information of both the health professionals and the user of the service, inadequate financial support and poor service delivery by the government. Services must be appropriate according to both health standards and client expectation. Therefore, the method and choice must be demand-driven rather than supply-driven.

Availability of the method of contraception plays an important role in the usage of contraceptives. A case study of Contraceptive needs in South Africa, in 1998, reported about young women visiting facilities that used contraceptives and were distributed by trained Nurses. In this particular study, some service points permitted these women greater flexibility of method choice, even offering IUDs to young clients who had already given birth (Maharaj, 2006).

When women lack accurate information, and measures to prevent exposure to reproductive health problems are inadequate, they will be less likely to seek timely professional medical help and more likely to undertake dangerous self-treatment (WHO, 1989). Because of lack of accurate information and adequate services, women face the risk of early, frequent or unwanted

pregnancy. This includes increased morbidity in mothers and their children, as well as the spread of sexually transmitted infection (STI) including HIV and AIDS (Westoff, 2002).

The location of facility and the time of services is one of the most important factors in facilitating child bearing women to use family planning services as indicated by studies from Africa and Asia. Studies in Africa, Kamau (2006) found that women used services because they were near home, school and church. Similarly, in Asia, Poonkhum (2003) found that women wanted services to be conveniently located in town and be near destinations such as shopping malls and department stores. Premises located near bus routes were reported to be all favoured by women (Maharaj, 2006).

1.2 Problem Statement

In recent years, 63% of women in developing countries use a method of family planning. In 1960, that number was just 10%. Despite this dramatic increase, about one out of six married women still has an unmet need for family planning. That is, she wants to postpone her next pregnancy or stop having children altogether but, for whatever reason, is not using contraception. As a consequence, 76 million women in developing countries still experience unintended pregnancies each year, and 19 million resorts to unsafe abortions (UN, 2008).

In South Africa, the high rate of teenage pregnancies has far reaching consequences, especially for Africans and coloureds that are the poorest and most disadvantaged groups in the country. The majority of these pregnancies are neither planned nor wanted. The father of the child seldom acknowledges or takes responsibility for the financial, emotional and practical support of the child. The mother often leaves school, thus ending her opportunities for personal development, making her vulnerable to poverty, exploitative sexual relationships, violence as well as low self-esteem.

The maternal mortality rate reflects on the availability, accessibility and quality of health-care services for pregnant women. The reduction of the maternal mortality rate by three-quarters is one of the Millennium Development Goals,

which South Africa has committed to achieve by 2015. Health experts list South Africa as one of the African countries performing poorly in efforts to reduce maternal and child mortality. The findings were reported in a survey issued by Countdown to 2015, an initiative of the UN, governments and NGOs.

The statistics show that the KwaZulu-Natal province had the highest number of maternal deaths over a three-year period (1999 - 2001) compared to all other provinces. In 2001, KwaZulu-Natal had 243 maternal deaths (highest). The Northern Cape and Western Cape were the two provinces with the lowest number of maternal deaths: 27 and 42 respectively in the same year. The Free State, Gauteng and KwaZulu-Natal were the only three provinces which had increases in the number of maternal deaths from the year 2000 to 2001. All the other provinces showed a slight decrease in the number of maternal deaths from 2000 to 2001.

Ninety-five percent of women use the services of antenatal care in South Africa and more than 85% of women are delivered by a skilled attendant in a facility and yet the country is still having increasing maternal mortality and increasing child mortality (Kaufman, 2004). This indicates that the country has this gap: people are coming to the services, but they're not given the quality health services. Most affected are remote areas and poor rural villages where there are not enough health facilities (Kaufman, 2004).

Women of child bearing age in South Africa are greatly impacted by the HIV/AIDS pandemic. But this is even more the case during these ages (15-19 years) or even earlier than 15 years of age, as children are likely to become sexually active during this stage of development. The outcome of which could be detrimental to their well-being if safe sexual behaviour is not practiced. Knowledge of the status of teenage pregnancy is thus crucial if we are to begin to look at advancing adolescent health. Factors that can contribute to the number of teenagers who fall pregnant are, for example, gender power imbalances, lack of bargaining power concerning the use of contraceptives, lack of access to quality contraceptives and family planning services, and even inadequate information on sexual reproductive health.

Contraception is already having an important effect on reducing the number of infants with HIV infections. This contribution could be strengthened by additional efforts to provide contraception to HIV- infected women who do not wish to become pregnant. Moreover, the effect of contraception can be achieved at a cost savings compared with PMTCT services.

In South Africa, the Choice of Termination of Pregnancy Act, which allows abortion on request up to 20 week's gestation, has been legalized. Since its legalization in 1996, only about 529 410 legal abortions have been performed (IPAS, 2009). This shows that there are still unwanted and unintended pregnancies in the country that need to be attended to in order to reduce the burden caused by them.

1.3 Study Rationale and Justification

Malawi is a new comer in the area of family planning, and South Africa being there in the era of family planning, the two countries are still experiencing high fertility rates. The study was conducted to confirm whether the two countries are having the same determinants of unmet need for family planning.

Current circumstances present a critical opportunity to reconsider the importance of family planning and to revisit and update program strategies. In recent years, new political, financial, and health-system challenges have emerged that complicate addressing women's unmet needs. At the same time, in 2006, unmet need for family planning was added to the fifth Millennium Development Goal (MDG) as an indicator for tracking progress on improving maternal health (WHO, 2008). A recent analysis concluded that family planning is among a handful of feasible, cost-effective interventions that can make an immediate impact on maternal mortality in low-resource settings. Family planning can reduce maternal mortality by reducing the number of pregnancies, the number of abortions, and the proportion of births at high risk. As contraceptive use increases in a population, maternal mortality decreases. It has been estimated that meeting women's need for modern contraceptives

would prevent about one quarter to one-third of all maternal deaths, saving 140,000 to 150,000 lives a year (WHO, 2008).

It would also prevent a similar proportion of the injuries, infections, and long-term disabilities that result from pregnancy, childbirth, and abortion and affect an estimated 15 million women annually. Family planning offers a host of additional health, social, and economic benefits as it can help reduce infant mortality, slow the spread of HIV/AIDS, promote gender equality, reduce poverty, accelerate socio-economic development, and protect the environment. For example, a recent analysis in sub-Saharan Africa found that investing in family planning services would prevent more births of children with HIV than spending the same amount on prevention of mother-to-child-transmission (PMTCT) programmes that offer antiretroviral drugs to pregnant women with HIV (WHO, 2008). Investing in family planning takes on additional urgency because it can help to reduce global inequities in health, a fundamental element of the MDG agenda. Some individuals are far more likely than others to suffer unwanted pregnancies and their consequences, which range from possible death and disability to the personal and financial burdens of raising more children than a family wants or can afford.

Disparities in unmet need contribute to even wider gaps in maternal mortality rates. They also violate women's and men's fundamental human rights to control their own fertility and choose the number and timing of their children a right endorsed by 179 countries at the ICPD. Reducing these inequities is as important a goal for health systems as effectiveness, efficiency or quality care (Ahmadi et al, 2005). Since some of the unmet needs are due to the lack of services, investigation on unmet need can be considered as an evaluation of family planning programmes. Identifying the causes and factors that contribute to unmet need can be an important step in improving family planning services and promoting the acceptance of contraceptives (Ahmadi et al, 2005). Lastly, the study will serve as an evaluation tool to government's intention of taking the family planning services to the disadvantaged communities in South Africa.

1.4 Objectives of the Study

1.4.1 Main Objective

The primary objective of this study is to determine the correlates of unmet need for family planning among women of reproductive age in South Africa and Malawi.

1.4.1.1 Specific Objectives

The specific objectives of the study are:

- 1) to determine the levels of unmet need for Family Planning in South Africa and Malawi;
- 2) to examine the relationship between selected social, demographic and economic factors and unmet need for family planning in South Africa and Malawi;
- 3) to Identify factors that influence the unmet need in South Africa and Malawi; and
- 4) to suggest appropriate strategies for reducing unmet need for family planning in South Africa and Malawi.

1.5 Organization of the Study

The study comprises of five chapters. Chapter one serves as a general introduction of the study, describing the purpose, objectives and significance of the research. Chapter Two provides a literature review of topics related to this study whilst Chapter Three describes the methodology utilized in the study including the sources of data and the applicable statistical analysis techniques used. Chapters Four and five presents the findings of the study for South Africa and Malawi respectively. These two chapters are organised in three main parts as follows: descriptive data analysis highlighting the characteristics of the respondents, bivariate analysis presenting the relationship between unmet need and selected background variables and results of multinomial logistic regression. Lastly, Chapter Six focuses on summary of the results, discussions, conclusion and recommendations emanating from the study.

CHAPTER 2: LITERATURE REVIEW

2.1 Introduction

This chapter reviews studies on unmet needs for contraception paying attention to some of the studies in sub-Saharan Africa. In both South Africa and Malawi very few studies have been conducted in this area. As such most of the studies reviewed in this chapter have been conducted in other developing countries.

2.2 Concept of unmet need for family planning

The basic objective of the concept of unmet need is to estimate the proportion of women not using contraception who either want to cease further childbearing (unmet need for limiting) or who want to postpone the next birth at least two more years (unmet need for spacing) (Westoff, 2006). The concept of "unmet need" describes the condition of fecund women of reproductive age who do not want to have a child soon or ever but are not using contraception. In other words, women with unmet need includes all fecund women who are married or living in union and thus presumed to be sexually active who are not using any method of contraception and who either do not want to have any more children (unmet need for limiting births) or want to postpone their next birth for at least two years (unmet need for spacing births). Married pregnant women whose pregnancies are unwanted or mistimed and who became pregnant because they were not using contraception as well as those who recently gave birth but are not yet at risk of becoming pregnant because they are pregnant or amenorrhoeic and their pregnancies were unintended, are also considered to have unmet need (Westoff, 2006).

The standard formulation does not consider unmet need among unmarried women, including unmarried women and unmarried young adults who are sexually active and at risk of unintended pregnancy. Because there is much unmet need among unmarried sexually active women, this is a serious

limitation if the conventional definition of unmet need is used (Dixon-Mueller and Germain, 1992). When only women who are married or living in union, rather than all sexually active women, are considered as the basis for measuring unmet need, the implication may be that other women do not need contraception. Other researchers have modified the concept to include men (Ngom, 1997), unmarried women (Dixon-Mueller and Germain, 1992), couples (Bankole and Ezeh, 1999), and all women (Ayad and Rathayuth, 2009). This study looks at unmet need in South Africa and Malawi among all women.

To estimate unmet among never-married women, Westoff et al (2006), examined data from 19 sub-Saharan African countries, where the DHS asked the never married women about their reproductive attitudes, sexual activity and contraceptive use. They considered the never married women who reported to have unmet need and were sexually active within the month before the survey and reported that they do not desire pregnancy but they are not using contraception, or, are pregnant unintentionally or amenorrheic after an unintended pregnancy.

2.3 Levels and Trends of unmet need

Unmet need for family planning varies from one area to another. In general unmet need for family planning is higher in developing countries than in developed countries. Globally unmet need for family planning is highest in Sub-Saharan Africa. Variation is also observed in Sub-Saharan Africa. For example, in West Africa unmet need for family planning ranges from 16% to 34%, whereas in East and Southern Africa it ranges from 13% to 38% (Westoff, 2006). The demand for family planning in East and Southern Africa averaged 57% and West Africa averaged 42% (Westoff, 2006). Moreover, studies indicate that in developing countries, women with unmet need for family planning constitute a significant fraction of all married women of reproductive age (Westoff, 2006). Data from the Demographic and Health Surveys showed that among currently married women, 36.9% in Rwanda and 35% in Senegal had unmet need for family planning during the period 1990-2000. In Ethiopia nationwide, it was 36% in 2000 and 33.8% in 2005 (Assefa et al, 2011).

2.4 Importance of unmet need for family planning

Meeting the unmet need for family planning may play an important role in slowing the pace of population growth, improving maternal and child health, and minimizing problems with natural resources and the environment that prevail in South Africa or countries with unmet need of family planning. In many countries, targets of population policies, i.e.; increasing contraceptive use and decreasing fertility levels, could be achieved by eliminating the unmet need for family planning.

2.5 Reasons for not using family planning

There are a number of reasons why individuals do not use family planning methods and services. In their study, the potential demographic significance of unmet need, Westoff et, al (1988) indicate that lack of information about family planning, opposition to family planning, and ambivalence about future childbearing were the principal factors responsible for unmet need for family planning (Korra, 2002).

In 2000, Govindasamy and Boadi (2000) used data collected in the Ghana Demographic and Health Surveys that were conducted in 1988 and 1998 to assess reasons for not using contraceptive methods among Ghanaian women. The results showed that a significant number of women mentioned fertility-related reasons including infrequent sex, menopausal/ sub fecund, postpartum/breastfeeding and wanting more children, as principal reasons for non-use. Method related reasons, particularly fear of side effects for method use, were also given as reasons for non-use (Korra, 2002). A review of literature on male attitudes and behaviours concerning family planning and male initiatives in Africa indicated that men often have positive attitudes toward family planning, but women believe that their husbands disapprove of family planning. The report further noted that spousal communication was positively associated with family planning method used. However, another study conducted by Ezeh (1993) in Ghana showed that spousal influence, rather than being mutual or reciprocal, is an exclusive right of the husband (Korra, 2002).

The study conducted by Rudranand et al (2000) in India's rural Bihar state, indicated that improved access to services, expanded choice of available methods, and increased knowledge of family planning were important for the acceptance of contraception. However, opposition from husbands and in-laws, the desire for at least two sons, and lack of trust of voluntary health workers from a different caste or religion were obstacles to the acceptance of contraception (Korra, 2002).

Women with unmet need are less likely to talk to their husbands about contraception. The reason might be that they perceive that their opinions differ and therefore discussion would lead to spousal conflict. Lack of communication between wives and husbands create barriers in communication. These barriers come into existence because either wife frequently misperceive their husband's attitudes or husbands are more strongly opposed to contraception than their wives (Ahmadi et al, 2005).

From a study which was conducted on unmet need for contraception in Ghana, Govindasamy et. al (2000) find that in general, the unmet need for spacing declines with age whilst the unmet need for limiting increases up to age 44 and then declines. Unmet need is highest among young women age 15-19, with one in two women having a need for family planning, an increase from one in three in 1988, mostly as a result of an increased need for spacing. There was only a small increase in unmet need among these women between 1993 and 1998. Unmet need is lower among women age 45-49, the oldest age group included in the surveys. One in five women in this age group has an unmet need for contraception, and this proportion has not changed over the decade (Govindasamy et. al, 2000).

Table 1: Reasons for not using contraceptives South Africa and Malawi

Reason for non use	South Africa	%	Malawi	%
Wants more	381	15.2	175	3.0
No pregnancy risk	649	26.0	909	15.6
Oppose	472	18.9	221	3.8
No knowledge	118	4.7	55	0.9
Fear of side effects	395	15.8	455	7.8
Others	490	19.6	4011	68.8
	2505	100.1	5826	100.0

Source: calculated by author using data from 1998 SADHS 2000 MDHS.

Table 1 and figure1 show the reasons for not using contraceptives in South Africa 1998 and Malawi 2000. About 15.2% of women in South Africa did not use contraception because they wanted to have more children and only 3.0% of women in Malawi were not using contraception for the same reason of wanting more children. 26% of Women in South Africa were not using contraception because they had no pregnancy risks while in Malawi they were about 15.6%. About 18.9% of women in South Africa opposed the use of contraceptives and in Malawi those who opposed the use of contraceptives were only 3.8%. Women who did not use contraceptives because they had no knowledge of the use of contraceptives in South Africa were 4.7% and in Malawi only 0.9% did not use contraceptives because they had no knowledge of using contraceptive. 15.8% of women In South Africa did not use contraceptives because they feared the side effects and in Malawi these women were only 7.8%. Women who were having other reasons for not using contraceptives were 19.6% in South Africa and 68.8% in Malawi.

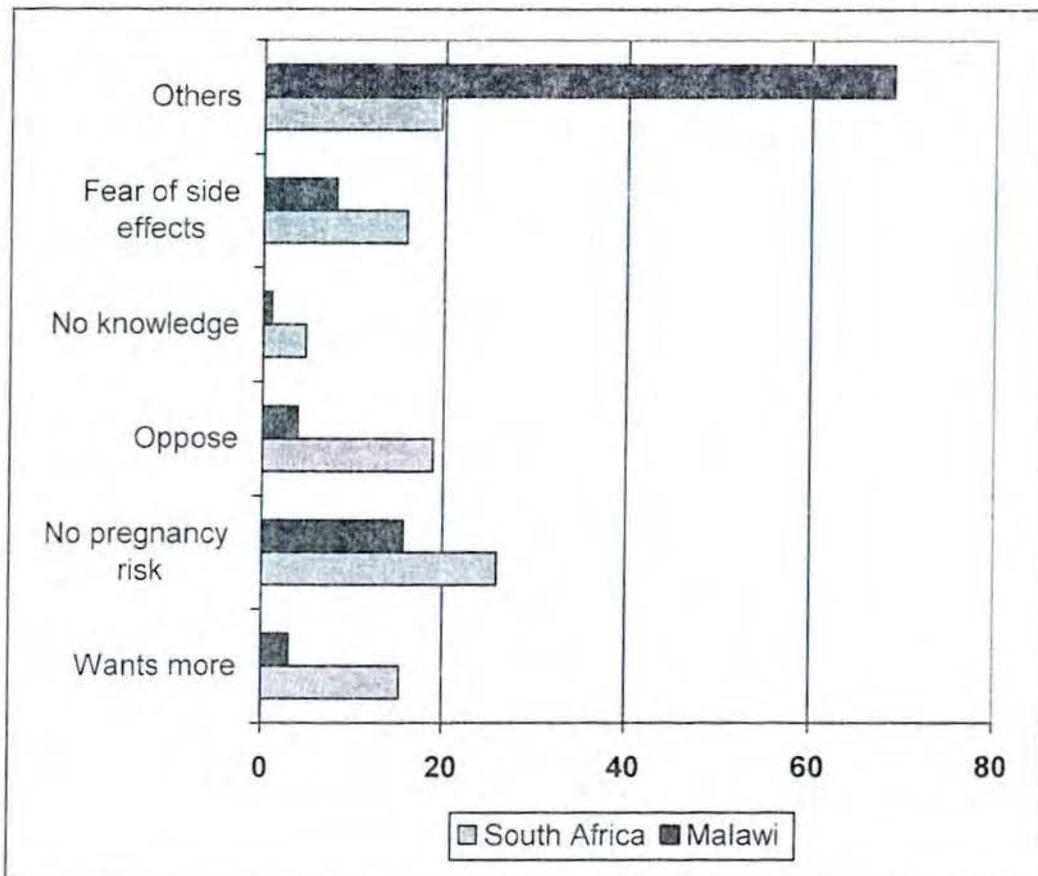


Figure 1: Reasons for non use for South Africa and Malawi

2.6 Family Planning in South Africa

The history of reproductive control and family planning in South Africa is tightly bound with the policies and laws that entrenched social and economic inequality by race (Kaufman, 2001). Family planning services were available as early as the 1930s in South Africa through beneficent welfare societies, but these were intended to cater for poor whites; FP services at that time were considered appropriate only for the "improvement" of the white race, not as a means to curb population growth (Kaufman, 2001).

In 1974 South Africa's National Family Planning Programme was introduced. Rising black joblessness, urbanization and growing opposition and repression characterized the decade. South African Family Planning politics were intricately interwoven with apartheid, the numerical relation of population groups being at its heart (Wolff, 2005).

In 1984, state-provided family planning was eventually put in a larger framework of development, and the Family Planning Programme was incorporated in the National Population Development Programme. When introduced, Family Planning was promoted as a means for improving mothers' and children's health, and only secondary to control the population growth rate. The programme was officially aimed at women of all races, and services were free (Wolff, 2005). However, there were differences in the treatment of white and black women. No attempts were made to include men in the programme. The exclusion of men from family planning services has immense consequences. The government undoubtedly missed an opportunity to initiate a tradition of male concern with contraception, and hand in hand, the prevention of sexually transmitted diseases, which would facilitate the prevention of HIV/AIDS (Wolff, 2005).

By 1993, contraceptive injectables were the most used contraceptive in South Africa. Family planning nurses generally recommended injectable. One of the reasons for this was that many women did not have the possibility to return regularly to a place where service was offered, so that a three-month round was convenient for both mobile services and the women. Another reason was that this is a very safe contraceptive. Many women preferred injectable, because they were hiding their use of contraceptives from their family. Unlike a packet of pills, it did not require them to touch their genitals, which many were comfortable to do (Wolff, 2005).

According to Kaufman (2001), some African women were not offered an alternative at all by the family planning nurses. On the other hand, many white women did not even know about injectable, which suggest that there existed two kinds of family planning with the perception that certain contraceptives

methods were “unfit” for white women. In the 1980s, African women in South Africa were generally given an injection just after they had delivered, sometimes without explanation. There are unconfirmed reports that factory and farm owners were putting the women who worked for them under pressure, saying that they would be dismissed if they were not willing to have an injection (Wolff, 2005). Sterilization was desirable in terms of government because it is the most effective way to prevent unwanted pregnancies. In a context of power relations, as they were in South Africa in the 1980s, suspicion arises that sterilizations could have been done without the patients consent, or that the patient could have been put under pressure to let her or himself sterilized.

The 2009 review of South Africa’ implementation of the programme of action had yielded several recommendations, including the need for more research on teenage fertility and contraceptive use, for efforts to remove barriers hampering young people’s access to contraception or other reproductive health services, for addressing unmet needs in the area of family planning, and for promoting responsible, healthy reproductive lifestyles among high risk groups including the youth (UN, 2011).

2.7 Contraceptive use in South Africa

Contraceptive use represents a significant area of progress among youth in SA and has been partly credited with the first signs of decline in HIV among youth and overall declines in teenage fertility. The 2003, the RHRU survey reported that over half of sexually active women (52.2%) aged 15-24 years were currently using contraception. Two thirds (66.6%) reported using hormonal methods only, under a third (26.5%) used condoms only and fewer than 10% (6.8%) used dual methods (condoms and hormones). Contraceptive use, particularly condom use, has increased significantly since the 1998. SADHS reported that 28.5% of 15-19 year olds and 57.2% of 20-24 year olds used the pill (3.5%, 9.6%), an IUD (0.1%, 0.4%), injectable (22.9%, 42.5%) or condoms (2.0%, 3.5%) (DOH, MRC & Measure DHS, 2002). For additional information on contraceptive use see Table 1.

Condom use has increased dramatically since the 1990s. The 1998 SADHS reported that only 7.6% of sexually active females aged 20-24 years used a condom at last sex. This increased to 47% in the 2002 SABSMM survey and to 55.7% by the 2005 SABSSM survey. Similarly, the 2003 RHRU survey showed that 52% of youth who reported ever having had sex had used a condom at last sex. The proportion had increased to 62% in the 2006 Kaiser/SABC survey.

While reports of condom use have increased for both males and females, rates of use are still almost 20% lower among females than among males. Rates among young men increased from 57.1% in 2002 SABSMM survey to 72.8% in 2005 SABSMM survey. Using the 2003 RHRU survey, Harrison (2008) showed that condom use in fact peaks at a young age for women (16 years) but declines thereafter. Rates of condom use among men remain consistently high until about 21 years where after it declines. While condom use has increased over time, low condom use during sexual debut and inconsistent condom use significantly increases the risk for unplanned pregnancy and HIV. Under half of young people (46%) reported using a condom during sexual debut in the 2003 RHRU survey, and only a third reported always using a condom with their most recent partner.

2.8 Unmet need of family planning in South Africa

The overall decline in fertility in South Africa has run a long course of almost 50 years but at differential rates for the population groups. To date, SA has the lowest fertility rate in mainland sub-Saharan Africa (DoH, 2002). Even though there is low fertility rate in South Africa, unmet need for family planning is still a problem. Unmet need for family planning is inversely related to level of education: the percentage of women with no formal education who have an unmet need for family planning is six times higher than the percentage of women at the highest level of education who show such a need. (Du Plessis, 1996). This further emphasizes the fact that the majority of South African women have not yet achieved satisfactory control over their reproduction.

Contraceptives are widely available free at public health facilities in South Africa, but rates of unintended pregnancies are still high. Some parts of the country with the problem are: Mpumalanga (25 percent), Northern Province (20%), and Eastern Cape (18%), rural African women (21%), coloured women (19%). These findings suggest that a more focused and targeted approach may be necessary (DOH, 1999).

Ten percent of women and 15% of married women reported unmet family planning needs. The greatest need for family planning services were reported by those under 25 and those between 45-49 years of age. The unmet need is highest in rural areas (2 times that of urban areas), 6 times higher among those with no formal education compared to those with post basic education and highest in the Northern Province and Eastern Cape. Clearly, strategies need to focus on increasing access of segments of the population of family planning services (DOH 1998).

The types of contraceptive methods used and their rates of use in SA differ by the demographic characteristics of users. According to the 1998 SADHS, the prevalence of contraceptive use was highest among Western Cape residents (74%), urban dwellers (64%), White and Asians South Africans (76 and 80 % respectively), married women (56%), and those with an educational level at or above standard 9 (79%) (Wolff, 2005). In contrast, contraceptives were used much less often in the Kwazulu Natal, Limpopo and Mpumalanga provinces, (less than 60%) in rural areas (45 %), among black and African women, (69 and 59 %, respectively) and among those with no education (35 percent). Key informants judged contraceptive use among male youths to be low, mostly because family planning services were thought to be friendly to men. In addition, they noted that most men viewed contraception as their partners' responsibility and indicated that the notion of "joint" responsibility for contraceptive practice was not yet popular among South African men and youth (Wolff, 2005). Overall, the 1998 SADHS indicated that contraceptive methods used often were injectable (30% of the population) and even higher among rural women, followed by oral contraceptives (13%) and female sterilization (12%). Condoms, IUCDs and male sterilization were rarely used

(each by < 2.5%) (Wolff, 2005). Generally, the low rates of use for some contraceptives, such as IUDs and sterilization, reflect geographic, financial and technological barriers to their use. The major exception is condoms, which are widely available, free and easy to use but are being used by only 2.3% of the population, according to the 1998 SADHS. The use of condoms may be the reflection of primary use for HIV/AIDS prevention rather than for contraception (Wolff, 2005).

2.9 Family Planning in Malawi

Malawi is a relatively new comer in the area of family planning. The national family planning programme was introduced in the late 1960s in Kenya, early 1970s in Ghana and mid 1970s in South Africa (Chimbwete, Watkins & Zulu, 2005). Although the initial attempts to introduce family planning in Malawi were in the early 1960s, the programme was banned in the late 1960s due to public misconceptions about its intent (Chimbwete, Watkins and Zulu, 2005). In 1982, government approved and established the national child spacing programme following nearly two decades of dialogue on the need to revive the family planning programme.

Since then, there have been a number of improvements in the provision of family planning services in Malawi. First, an increasing number of institutions are involved in the provision of family planning in Malawi. Family planning service provision is an integral part of maternal and child health services of the Ministry of Health and some private and mission hospitals. In addition, some Non Governmental Organizations and private companies such as Banja La Mtsongolo (BLM), Family Planning Association of Malawi (FPAM), ADMARC, Limbe Leaf Tobacco Company operates family planning clinics. Second, non-prescriptive contraceptives are also distributed through commercial outlets (say, pharmacies) and Community Based Distributors of contraceptives (field workers). Third, an enabling environment for family planning provision has been established by formulating appropriate policy guidelines and providing basic and refresher courses to family planning

providers (Solo, et. al. 2005). The policy guidelines which were first developed in 1992 and revised in 1996 removed barriers of spousal consent, age and parity and allowed a wider range of cadres to offer various services.

So far the family planning programme in Malawi seems to have succeeded in narrowing the gap between the knowledge and ever use of contraceptives. However, the success in reducing the level of fertility is limited (ACQUIRE Project, 2005). Total Fertility Rate (TFR) has marginally declined from 6.7 children per woman in 1992 to 6.4 children per woman in 2000 and 6.0 children per woman in 2004 (Malawi Government, 1994, 2002, 2006). The 2010 Demographic and Health Survey estimate TFR to be 5.6 children per woman (Malawi Government, 2010). These estimates indicate a decline of 1.1 children in 18 years. The contraceptive prevalence rate (CPR) has increased six-fold, from 7% in 1992 to 22% in 2004 and 46% in 2010 (Malawi Government, 1994, 2002, 2006). Given the minimal impact of contraception on fertility in Malawi, a number of questions come to mind: Why has fertility not declined by the same magnitude as the increase in contraceptive use? Are women using effective methods? What should be done to encourage Malawian men and women to use contraceptives with the aim of realising their fertility desires and goals? A number of studies have been conducted in Malawi to investigate the correlates of contraceptive use in Malawi (Cohen, 2000; Kalipeni and Zulu, 1993; Kishindo, 1995; Madise and Diamond, 1993; Kalanda, 2010). However, the studies have focussed on small areas (Kalanda, 2010) or have made use of earlier data sets conducted in the initial stages of the family planning programme. For instance, Cohen (2000) used the 1992 MDHS whereas Kalipeni and Zulu (1993) and Madise and Diamond (1993) relied on the study that was conducted in 1988 by the university of Malawi. Given the availability of new data sets and the fact that contraceptive use is one of the indicators of the millennium development goals, there is a need to re-examine the correlates of contraceptive use in Malawi.

Table 2: Contraceptive use by Method for South Africa and Malawi

	South Africa	Malawi
Female Sterilization	2.5	4.8
Pill	9.6	1.5
IUD	0.01	0.4
Injectable	42	13.9
Implants	0.0	0.3
Male Condom	3.5	1.7
Traditional	0.4	0.0
Rhythm	0.0	0.4
Withdrawal	0.0	1.5
Other	6.8	1.3

Source: calculated by author using data from 1998 SADHS and 2000 MDHS

Table 2 and figure 2 show the levels of contraceptive use by method for South Africa and Malawi. Female Sterilization in South Africa is 2.5% and in Malawi is 4.8%. The use of pill in South Africa is higher (9.6%) than Malawi (1.5%). The use of IUD in South Africa is 0.01% and in Malawi is 0.4%. Injectable are highly used than any other method. In South Africa the use of injectable is 42% and in Malawi is 13.9%. Implants in South Africa are not used and the use of them in Malawi is 0.3%. The use of male condoms in South Africa is 3.5% and in Malawi is 1.7%. The use of traditional method in South Africa is 0.4% and in Malawi traditional method was not used. Rhythm and withdrawal methods in South Africa are not in use and in Malawi the use of rhythm method is 0.4%. The use of withdrawal method in Malawi is 1.5%. Other use of contraceptives for South Africa is 6.8% and in Malawi is 1.3%.

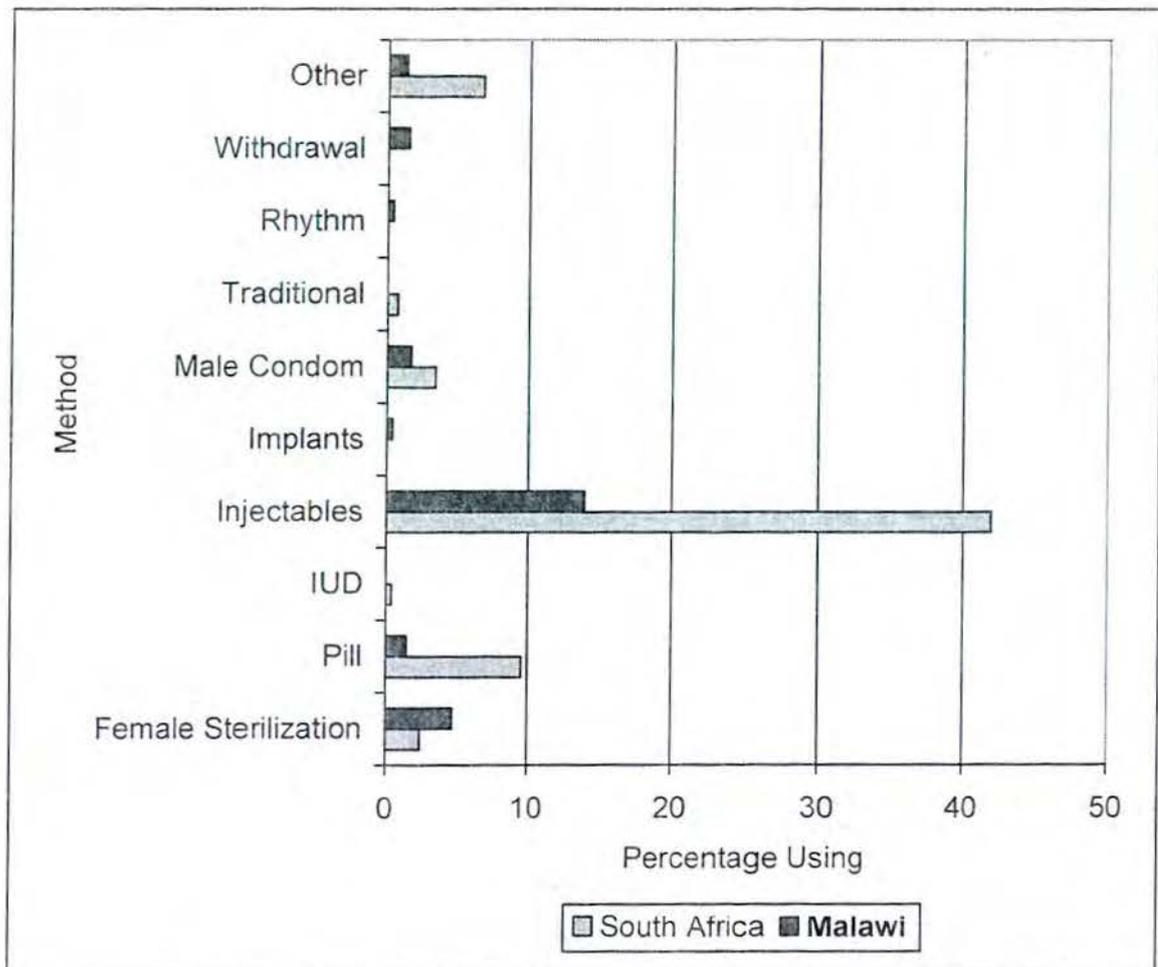


Figure 2: Contraceptive use by method for South Africa and Malawi

2.10 Determinants of unmet need for Family Planning

A number of socio-economic characteristics are associated with unmet need among married women. In the subsequent paragraphs some of these factors will be discussed.

2.10.1 Women's Age

A number of studies indicate that contraceptive use varies by age of the woman (Omwango and Khasakhala, 2001). Findings from a study conducted in 1991 in Kenya found that age is related to contraceptive practice (Omwango and Khasakhala, 2001). Individuals and/or couples are thought to

be less likely to practice contraception when they are young (age groups below 25) or when they are old (age groups above 35 years). This is the case because the former are still young and have not yet achieved their fertility desires whereas the older age, fecundity is low with the low frequency of sexual contact. Using the data of seven developing countries Perbley (1996) finds that women 45 years and older are less likely get pregnant, or they do follow existing tradition of society and therefore, do not want to try anything new (Njogu, 1991).

It is also noted that almost everywhere, clear relationships emerge between women's age and the level of unmet need when unmet need is divided into spacing and limiting components. Contraceptive use among younger women is used for limiting births because older women have had as many children as they want, and often more. Unmet need for limiting typically peaks among women in their late thirties and early forties and then declines in the 45-49 age groups (Khouangvichit et al, 2002).

2.10.2 Ideal number of children

Available literature indicates that in developing countries almost all married women want to have children, and they want them soon after marriage. Thus, among childless married women there is almost no unmet need for spacing or limiting births. Once women have had their first child, however, unmet need for spacing in some countries decreases with each additional child. In most sub-Saharan countries, unmet need for limiting births increases with each additional child that a woman has. Overall, the trend for limiting and the trend for spacing cancel each other out. As a result it is stated that there is no apparent relationship between number of children and the overall level of unmet need. Women who had achieved or exceeded their ideal family size were about twice as likely to be current users as were women who had not yet reached their ideal number of children (Belachew, 2007).

In a study on desired number of children and the impact of population policies, Pritchett (1994) explains that the increase of contraceptive availability could affect the desired number of children. Likewise, the change in desired number of children or desire family size leads to change in contraceptive prevalence, as people use more contraception to achieve their fertility target. According to this explanation it reflects that desired number of children is the main motivation of contraception use for limiting or spacing (Degraff et al, 1997).

2.10.3 The level of Education

Various studies has identified that increasing access to education among women is one of the main reasons for the increase use of contraception since the 1970s (Caldwell 1982, Bankole and Ezeh 1999, Udjo 2003). One of the greatest achievements since democracy in SA is the massive expansion in access to education, especially in the enrolment of African youth and women. Access to primary schooling is universal (104%) and secondary school enrolment (80%) is high (Schindler, 2008). A study in Kenya explains that education of women is seen as a vehicle by which people use to learn more about family planning, which may lead to demand for fewer children Caldwell, 1982). This will consequently contribute to the use of contraceptives to prevent or to space childbirth (Khouangvichit et al, 2002). Education may affect fertility control including education facilities for acquisition of information about family planning; it increases husband-wife communication and increases couple income potential, making a wide range of contraceptives methods affordable (Weinberger, 1987).

Bertrand et al. (2001) found that the differential of contraceptive practice rate is greater between women who have no education and those who have attended primary school and also there are differences in the prevalence of contraceptive use between women with some primary education and those with some secondary school or higher education (Khouangvichit et al, 2002). The report from information program stated that there are two patterns of unmet need related to women's education. Outside sub-Saharan Africa better educated women have somewhat less unmet need than women with little or

no education, as in Turkey. In contrast, in most sub-Saharan countries, such as Ghana, levels of unmet need are about the same regardless of women's education levels (Khouangvichit et al, 2002)..

These patterns suggest that outside Africa, although many women at all education levels want to avoid pregnancy, less educated women face more obstacles to using contraception than more educated women. In sub-Saharan Africa, however, women with more education are more interested in avoiding pregnancy than other women but face the same obstacles as other women (Khouangvichit et al, 2002). In the study on the impact of women's employment and education on contraceptive use and abortion in Kinshasa, Zaire, which was conducted by Shapiro and Tambashe, in 1994, it was found that women's employment and education are strongly linked to contraceptive use and abortion, and differences in the incidence of abortion by schooling and employment status appear to play an important role in contributing to corresponding observed differences in fertility (Khouangvichit et al, 2002).

Modern contraceptives and induced abortion appeared to be used as complementary fertility control strategies in Kinshasa, and the analysis of the findings suggested that better educated women employed in the modern sector are most likely to be in the forefront of the contraceptive revolution. (Bertrand et al.1993, Richter & Udjo, 2006).

2.10.4 Rural /Urban Residence

Results from studies conducted in sub-Saharan countries indicated that in most countries unmet need is greater in rural areas than in urban areas (National Research Council, 1993). In some countries, for example: Senegal, Kenya, Nigeria and Parkistan, their unmet need is either greater in urban areas or about the same as in rural areas (Gwatkin, 2009). The pattern of unmet need by residence probably reflects both the greater interest in avoiding pregnancy among urban residents and the limited availability and acceptability of contraception, even in cities. Also, within cities everywhere,

slum or squatter neighbourhoods are likely to have higher levels of unmet need than elsewhere. (World Bank, 2005).

Data from the 1990 Contraceptive Prevalence Survey in Bangladesh were analyzed to identify and facilitate understanding of the factors responsible for urban- rural differentials in contraceptive use (NRC, 1993). The information was collected nationally and representative samples of ever married women under 50 years were analysed. The results of this study showed that the oral contraceptives were the most popular method of contraception in both urban and rural areas. The popularity of other methods also varied from urban and rural residents. (National Research Council, 1993). Women in rural areas were found to have used contraception at a lower rate than in urban women at all ages groups. Younger women and older married women were less likely to have ever used contraception than women aged 20-39 years. In rural Bangladesh, more educated women and women who were employed with cash payment were found to be more likely than other women to have ever used family planning. Women who never attended school were least likely to practice family planning, 34% in urban areas and 30% in rural areas (National Research Council, 1993).

2.10.5 Women' labour force participation

Most researchers support the notion that a direct negative relationship exists between married women's labour force participation and fertility behaviour, yet female employment shows no consistent, general relationship with declining fertility at individual and societal levels (Miah et al; 1992). The study was conducted in Bangladesh to explore specific conditions under which employment lowers fertility (Miah et al; 1992). The multivariate analysis for the study revealed that women's modern and traditional occupation significantly lowers their fertility and that modern contraceptives and husbands' occupations in traditional and modern sectors have significant positive effects on fertility (Miah et al; 1992). The correlation between higher fertility and contraceptive use may be due to women's delay in practicing family planning until reaching desired parity and or high mortality driving women to cease

practice in order to replace lost offspring. The results show that women who are employed may not have unmet need for contraception (Miah et al; 1992).

2.10.6 Knowledge of contraceptive methods

Lack of information is another important reason for unmet need. Women who are aware of many contraceptive methods, know where they can be obtained, understand their side effects, and know how to use them, are less likely to have unmet need.

Whether or not a woman knows of just one contraceptive method makes little difference to unmet need. Lack of awareness of any contraceptive method is most likely to explain unmet need in countries with little contraceptive use, as in sub-Saharan Africa. This is because, if a woman does know about contraception, she cannot cite other reasons for not using it, such as lack of availability or side effects.

Along with other reasons, lack of sufficient knowledge may contribute to more than two-thirds, of all unmet need as Bongaarts and Bruce (1995) have estimated from DHS data for 12 countries. The researchers created a "knowledge index" consisting of three items: mentioning a modern contraceptive method without being prompted, being aware of its source and having an opinion about side effects. In general, the level of unmet need is lower in countries where this knowledge index is higher (Swanepoel, 2008).

To use contraception, women must not only know about the existence of contraception itself but also what services are offered, where and when (Swanepoel, 2008). Results from a study titled: Trends and differentials in knowledge, indicates contraception use in rural Bangladesh in 2001 and showed that knowledge of contraceptives tended to be positively and moderately to respondent's educational levels, non-agricultural occupation and number of living children (Swanepoel, 2008).

In a study of knowledge and attitude of married Turkish men regarding family planning, results showed that the use of family planning was approved by

78.9% of men, but a contraceptive method was actually applied by only 65.6%, whereas 27.6% of the high school and university graduates had five or more children, as many as 67.4% of the men with lesser educational levels had a large offspring (Cutis et al, 1996) Nearly 60% of the men had been given information about family planning by healthcare professionals. It was concluded that education has a greater impact on knowledge and attitudes about family planning (Cutis et al, 1996)

2.10.7 Source of information

In Ghana a study was conducted in 2000 to examine the attitudes toward and use of knowledge about family planning among Ghanaian men. The findings indicated that demographic factors such as education, religion, types of marital relationships and exposure to mass-media education have significant effects on the participants' increased knowledge, changing attitudes, and practices of family planning and reproductive decision making (Gyimah et al, 2008). The most common knowledge they had about family planning was that the practice of family planning helps to space and limit the number of children couples want to have and it enabled families to plan and cater for a small family (Gyimah et al, 2008).

The mass media were credited as the main source of knowledge about family planning methods and services. 62% of the participants identified newspaper, television and radio as their source of knowledge. About 26% of the participants mentioned family planning and health service providers as another source of their knowledge. 13% of participants mentioned churches, their wives, friends and neighbours as sources of their knowledge about family planning services (Gyimah et al, 2008). It is evident that decisions to use of family planning could also be initiated by significant others including spouses, relatives, friend and neighbours, thus social networks play a crucial role in fertility decision making (Swanepoel, 2008).

2.10.8 Discussing Family Planning with spouse

Decisions about using family planning practices and fertility control measures (limiting the number of children a woman should have) are not entirely individual decisions. Communication between a husband and wife has been found to be a prime indicator of the extent of knowledge and acceptance of family planning practices that couples will be willing to adopt and use (Sharon & Valente, 2002).

The participants in the study of attitudes towards and use of knowledge about family planning, among Ghanaian men in 2000, were involved in discussions about their inter-spousal communication patterns concerning family planning (Gyimah et al, 2008). According to most of the participants, the discussion of the number of children a couple should have is considered a taboo and culturally unacceptable. The participants believed that children are gifts from God and their numbers should not be negotiated (Gyimah et al, 2008).

However, it appeared that a higher percentage of men were willing to discuss contraception use than the number of children they want to have with their wives. For example, it was indicated that communication among spouses with regard to the number of children to have and the use of contraceptives increased progressively with professionals and business occupations (Gyimah et al, 2008). Inter-spousal communication was more common among participants who were Christians and those in monogamous relationships and it indicated that 29% of participants with secondary and post-secondary education, 37% of those in monogamous marital relationship and 31% of those who claimed to be Christian indicated that they talked to their spouses about the number of children they wanted to have (Gyimah et al, 2008).

Concerning contraceptive use, 51% of men in monogamous relationship, 40% of the educational participants, and 42% of Christians also indicated that they discussed the use of contraceptives with their spouses. It is obvious that spousal communication is a key factor in the adoption and sustained use of family planning because such discussions allow couples to exchange new

ideas and clarity information, which might change some wrong beliefs about the use of some family planning devices. Open communication between couples about family planning also provides couples with an opportunity to discuss family size preferences and the means to achieving them (Swanepoel, 2008).

2.11. Conceptual Framework of Unmet Need for Family Planning

Figure 1 lays the conceptual framework for this study. Two groups of variables are used to examine factors influencing unmet need for family planning. The independent variables, which influence the unmet need for family planning of the study population, are subdivided into three sets. The first two are the underlying factors that are indexed by some important demographic and socio-economic variables. The third group of independent variables is the proximate determinants that are indexed by various indicators of women's knowledge, attitudes, and perceptions.

For this particular study, one dependent variable is considered (unmet need: limit/ space). Demographic and socio-economic factors are assumed to be the underlying determinants of unmet need for family planning. That is, the effect of underlying factors is expected to reach the ultimate dependent variable, unmet: limit/space through the assumed proximate variables, namely, knowledge, attitudes, and perceptions concerning family planning.

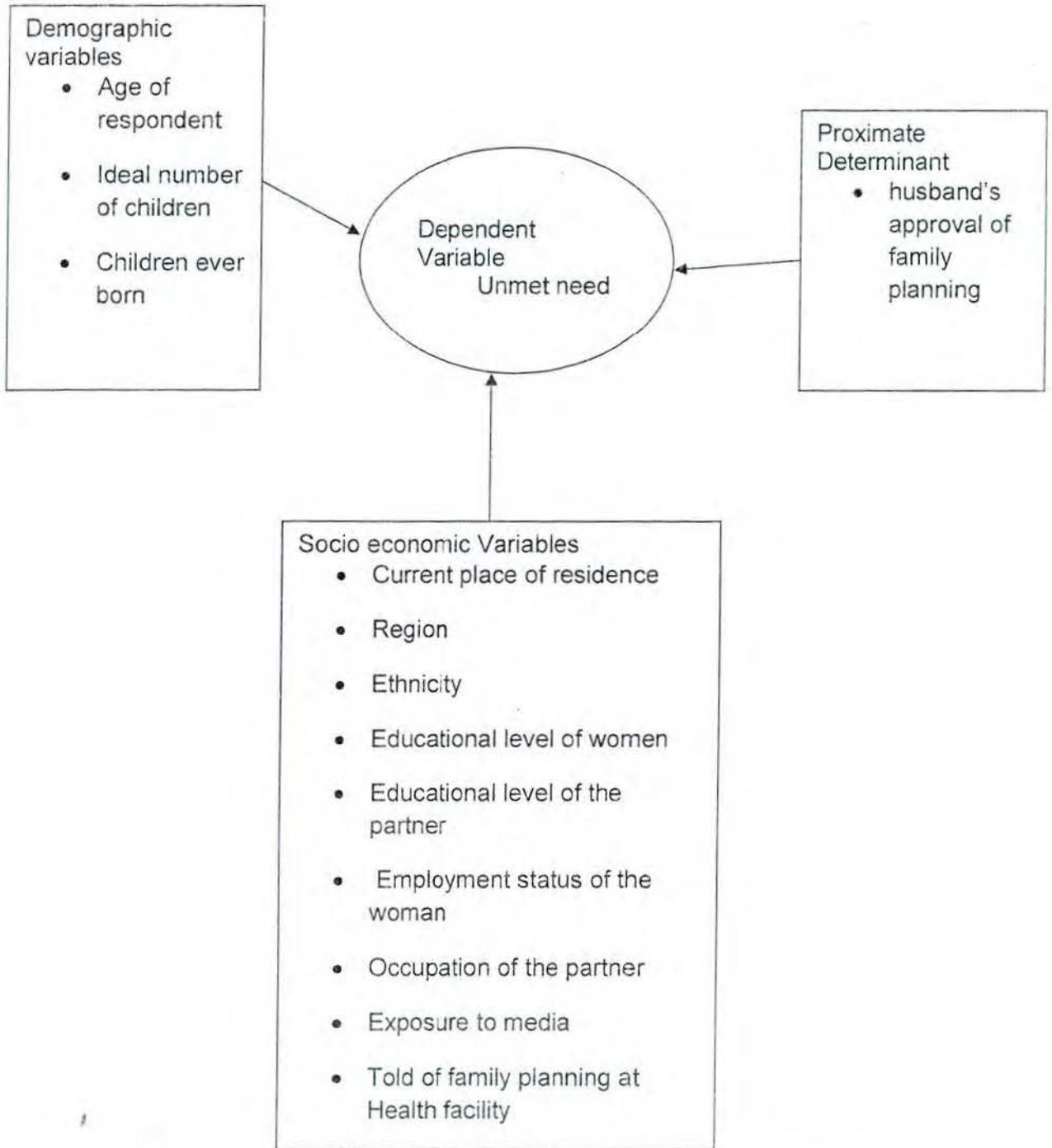


Figure 3: conceptual frame work of unmet need for family planning

2.12. Summary

While unmet need for family planning has been investigated at an international level, little has been done to investigate this phenomenon in the case of South Africa and Malawi. Available information indicates that South Africa has low unmet need whereas unmet need is high in Malawi. Unmet need is influenced by various social, economic and demographic factors.

CHAPTER 3: METHODOLOGY

3.1 Introduction

The chapter describes the study area, the populations of Malawi and South Africa, sources of data to be used in the study, methods of analysis and finally the limitations of the study.

3.2 Description of the Study Areas

3.2.1 South Africa

South Africa is situated on the Southern tip of Africa and has a total land area of 1,219,080 square kilometres. It has the Atlantic Ocean in the West, the Indian Ocean in the East and shares borders with Namibia, Zimbabwe, Botswana, Mozambique and Swaziland, while the Kingdom of Lesotho forms an enclave within South Africa.

When apartheid ended in 1994, the South African government had to integrate the formerly independent and semi-independent Bantustans (namely, Bophutswana, Transkei, Ciskei, Venda, etc.) into one political structure of South Africa. It abolished four former provinces which were the Cape Province, Orange Free State, Natal and the Transvaal and replaced them with the nine fully integrated Provinces which are: Northern Cape, North-West, Gauteng, Limpopo, Mpumalanga, Kwazulu-Natal, Eastern Cape, Free State and Western Cape.

The population of South Africa according to the census 2001 was 44.8 million and presently it is estimated to 49.9 according to the mid 2010 estimates from Statistics South Africa. Ethnic composition of South Africa consists of Black (79.5%), White (9.2%), Coloured (8.9%) and Asian (2.5%). South Africa's economy is one of the most developed economies on the African continent. However, the country suffers from high levels of poverty and unemployment. The 2003 Human Development Report for South Africa indicates that

approximately 50% of the South African population lives below the poverty line (UNDP 2003). The Gini coefficient is the third highest in the world: In 1995 it was 0.596 and even increased to 0.72 by 2006 (UNDP 2003, SSA 2008).

3.2.2 Malawi

Malawi is 901 kilometres in length and ranging from 80 to 161 kilometres in width. It lies between latitudes 9 and 17 degrees south of the equator; longitudes 33 and 36 degrees East; and is located in South-East Central Africa. It is bordered by the United Republic of Tanzania in the North and North-East; the Republic of Mozambique in the East, South and South-West; and the Republic of Zambia in the West.

For administrative purposes, Malawi is divided into three regions: Northern, Central and Southern; twenty-seven districts: six in the North, nine in the Centre and twelve in the South. Each district consists of a number of chief's (Traditional Authority) areas that are further subdivided into various villages. Coincidentally, these divisions, particularly at regional level, sub divide the country into more or less distinct physical, cultural, social and economic zones.

Malawi's social and demographic indicators are among the worst in the world. The 2009 Human Development Report ranks Malawi 163 out of 171 countries (UNDP, 2009). Relative to other countries in the region, Malawi has always had high fertility and mortality rates. For example, although the infant mortality rate has declined from 176s per 1000 in 1976 to 151 per 1000 in 1987 and to 135 per 1000 live births in 1998 (National statistical Office, 1984, 1994), Malawi has the highest infant mortality rate in the SADC region. Moreover, the risk of Malawian women dying due to pregnancy and related factors is very high and worsening. Maternal mortality ratio has increased from 620 per 100,000 live births to 1120 per 100000 live births (Malawi Government, 1992, 2001). Similarly, expectation of life at birth of estimated to be 48 years in 1998 is believed to have declined to 40 years and is among the lowest in the world. The decline in expectation of life at birth is largely attributed to HIV/AIDS epidemic. It is estimated that HIV/AIDS prevalence rate is 14%. Furthermore,

studies have shown that the major factors contributing to the poor health status in the country are: poverty, high illiteracy rates, especially among women, too early, too many, too frequent and too late pregnancies and high fertility. Total Fertility Rate (TFR) in Malawi is still high though it has declined somewhat over the past few decades. TFR has declined from 7.6 children per woman in 1977 to 7.4 children per woman in 1987 to 6.4 children per woman in 1998 (National statistical Office, 1984, 1994). The decline in fertility could be attributed to an increase in contraceptive prevalence rate. Contraceptive prevalence rate has increased from 7% in 1992 to 26% in 2000 (Malawi Government, 1992, 2001). There are, however, differences in demographic parameters (mortality, fertility, migration, population density) and socio-economic indicators among regions and districts in the country. For instance, fertility is the highest in the central region, followed by the Northern region and lowest in the Southern region. Mortality is highest in the Southern Region, followed by the Central Region and lowest in the Northern Region.

3.3 Sources of Data

The data used for this study are from Demographic and Health Surveys (DHS) that were conducted by Macro International/MEASURE. The DHS (now DHS+) program has conducted over 170 nationally representative surveys in about 70 countries throughout Africa, Asia, the Near East, Latin America, and the Caribbean. The DHS program is funded by USAID and implemented by Macro International, Inc. DHS typically have large sample sizes of between 5000 and 30,000 households. These surveys provide data for a wide range of monitoring and impact evaluation indicators in the areas of population, health, and nutrition. In particular, in the case of South Africa, the 1998 SADHS was used whereas for Malawi the 2000 MDHS was utilized (Malawi Government, 2002).

Both surveys involved the use of three basic questionnaires. Firstly, a household questionnaire that recorded information on all household members. Secondly, the male questionnaire was similar to that of the individual women questionnaire but excluded the birth history and maternal and child health

sections. Thirdly, a questionnaire on individual women that recorded detailed information on eligible women who were identified from the household questionnaires. The women questionnaire collected information on the respondent's background characteristics, reproductive history, knowledge and practice of family planning, breast-feeding practices, marriage, fertility preferences etc., as well as on her husband's background characteristics. The main focus of the present study is on a number of specific questions asked of women about their most recent pregnancy and live birth in the five years preceding the survey. Women were specifically asked: (i) if they were checked by a trained health professional (doctor, nurse, or midwife) at least once during pregnancy, i.e. antenatal care; and (ii) if they were attended by a trained health professional during their delivery, i.e. professionally-assisted delivery. The 1998 SADHS collected data from 11723 women and the 2000 MDHS collected data for 11698 women of in the same age range.

3.4 Data Analysis

In this study, women were divided into those having met or unmet need, and no need for family planning. Those with met or unmet need can be further categorized into those who want to limit their family size- that is, to prevent all future births- and those who want to space births by delaying the next birth. For the purpose of addressing the research aims and objectives, the following three statistical methods were employed, namely, the uni-variate, bi-variate and multivariate methods. Descriptive uni-variate analyses were performed to inspect the frequency distributions of the variables. Bivariate analysis was employed to examine the relationships of the independent variables and unmet need of family planning.

Lastly the association between unmet need was modelled, using multinomial logistic regression. Multi-nomial logistic regression is used when a categorical dependent variable has more than two categories. The multinomial regression model allows for multiple outcomes that are nominal in nature, rather than ranked in some meaningful ways. The multinomial regression model breaks the regression up into a series of binary regressions,

comparing each group to a baseline group. In this study, the dependent variable, unmet need for family planning, has three categories: all other women, unmet need for spacing and unmet need for limiting. All other women are set to be the reference group. Multi-nomial regression will assess the odds of unmet need for spacing versus all other women, and unmet need for limiting versus all other women. The multi-nomial regression model would have two sets of results and relative risk ratio (RRR), very similar to odds ratio would predict the odds of using modern methods as compared to non use of contraceptives. It is like performing two binary logistic regressions where the first binary regression will treat the general model for multi-nominal regression and is denoted by:

$$\ln\left[\frac{P_g}{P_1}\right] = \ln\left[\frac{P_g}{P_1}\right] + B_{g1} + B_{g2} + \dots + B_{gz}$$

$$\ln\left[\frac{p_g}{p_1}\right] = \ln\left[\frac{P_g}{P_1}\right] + \chi\beta$$

Where p_g is the probability that an individual with values X_1, X_2, \dots, X_p is in group g , P_g is the prior probabilities of group membership and β_{gi} is the regression coefficients that are to be estimated from the data. Group one is the reference group. The regression coefficients β for the reference group are set to zero. Even though the choice of the reference group is arbitrary, it is usually the largest group or a control group to which the other groups are to be compared. This leaves $g-1$ logistic regression equations in the multi-nomial logistic model. If Y has three unique values A B and C, where C is the reference group, logistic regression model consists of two equations:

$$\ln\left[\frac{P_g}{P_1}\right] = \ln\left[\frac{P_g}{P_1}\right] + B_{g1} + B_{g2} + \dots + B_{gz}$$

$$\ln\left[\frac{p_g}{p_1}\right] = \ln\left[\frac{P_g}{P_1}\right] + \chi\beta$$

The third model examined the relationship of unmet need and socio-economic variables. All the statistical analyses were conducted using Statistical Package for Social Sciences (SPSS) version 1

3.5 Description of Variables

3.5.1 Dependent Variable

In this study, all women were divided into those having met or unmet need, and no need for family planning. Those with met or unmet need can be further categorized into those who want to limit their family size- that is, to prevent all future births and those who want to space births by delaying the next birth. All other women, including non-sterilized women, who are in fecund, are defined as having no need for family planning and were therefore excluded from analysis.

The dependent variable unmet need was therefore categorized as women with unmet need to space, women with unmet need to limit and all other women. Unmet need for spacing includes pregnant women whose pregnancy was mistimed, amenorrhoeic women whose last birth was mistimed, and women who are neither pregnant nor amenorrhoeic and who are not using any method of family planning and say they want to wait two or more years for their next birth. Also included in unmet need for spacing are women who are unsure whether they want another child or who want another child but are unsure when to have.

Unmet need for limiting refers to pregnant women whose pregnancy was unwanted, amenorrhoeic women whose last child was unwanted and women who are neither pregnant nor amenorrhoeic and who are not using any method of family planning and who want no more children unmet need for limiting is coded 1 and unmet need for spacing is coded 2.

3.5.2 Independent Variables

The independent variables used in this study include: age of the respondent, maternal education, respondents occupation, number of living children, ethnicity, place of residence, region, partner's educational level partner's occupation and respondent's occupation. These independent variables were included based on their observed relationship with unmet need. Past studies show that most of these factors are imperative explanatory variables of unmet need for family planning (see Westoff & Bankole, 1995; Robey et al., 1997; Casterline et al., 1997; Stash 1999; Ezeh and Bankole, 1999).

Women's age: Age has been collected from all sexually active women as a scale variable in a month and year of birth format. A cross reference question has been included to state how old the person was at his last birthday. This was recorded in completed years. For analysis, purpose grouping of age is necessary. Age refers to the age group of the women; this variable is divided into 7 groups of age 15 - 19 yrs is coded 1; 20 - 24 is coded 2; 25-29 is coded 3 30-34 is coded 4, 35-39 is coded 5, 40-44 is coded 6 and 45-49 is coded 7.

Women's Education: The level of education is classified into 3 categories: No education is coded "0", primary education is coded 1, secondary education is coded 2 and tertiary education is coded 3. Women who completed sub A until those who completed grade 7 are classified as those that completed primary education. Secondary education is those who completed grade 8 to grade 12.

Women's Occupation: Women's occupation is classified into five categories: not working is classified as 0, managerial and professional is classified as 1, small business and salesman is classified as 2, lower senior is classified as 3 and unskilled manual is classified as 4.

Place of Residence: Place of residence refer to the place that women live. This is classified as urban and non-urban. The classification is based on the sample of 690 urban primary sampling units and 282 non-urban primary

sampling units. (DoH, 1998:285). Further disaggregation of place of residence is based on the 9 province.

Husband's Education: This variable refers to the level of education of the husband. No education is coded "0", Primary education is coded 1, secondary education is coded 2 and tertiary education is coded 3. Men who completed grade 1 until those who completed grade 7 are classified as those that completed primary education. Secondary education is those who completed grade 8-12.

Husband 's Occupation: Men's occupation is classified into five categories: not working is classified as 0, managerial and professional is classified as 1, small business and salesman is classified as 2, lower senior is classified as 3 and unskilled manual is classified as 4.

Exposure to Media: The two main media channels are electronic and print media. The electronic media include radio, television, social networks and others. The DHS survey concentrated on two, radio and television. The questions asked are: In the last few months have you heard about family planning on radio, on the television, in the news paper, from the poster or from leaflets? The respondents could answer either *Yes* or *No* on this multiple response question.

Ideal number of Children: A DHS question on the ideal number of children is asked to all women. The question probes for numeric responses. The field workers have been trained in such a way that they could obtain numeric answers from the respondents. Respondents who had no children were asked: "If you could choose exactly the number of children to have in your whole life, how many would that be?" Respondents, who had children in turn, were asked: "If you could go back to the time you did not have any children and could choose exactly the number of children to have in your life, how many would that be?" This includes current pregnancy.

Children ever born: Women were asked on children ever born. The question probes for numeric responses. The field workers have been trained in such a way that they could obtain numeric answers from the respondents.

Knowledge about Family Planning: The respondents were asked about the knowledge of any method of family planning. The answers were rated as follows: knows no method is 0, knows only folkloric is 1, knows only traditional method is 2, and knows modern method is 3.

Husband's approval of FP: The respondents were asked about the husband's approval of family planning. The answers were rated as 0 is disapproves, 1 as approves and 8 as don't know.

Couple's discussion about FP: Married women were asked how often they had discussed family planning with their husbands in the past year. Respondents were further asked if their husbands share the same ideal number of children with them. Three responses were that the couple never discusses or the couple discusses once or twice or the couple discusses more often.

Table 3: Description of study variables

Variable	Description for South Africa	Description for Malawi
Unmet need for family planning	0= all other women 1= women with unmet need to space 2= women with unmet need to limit	The same as SA
Age	1= 15-19 2= 20-24 3= 25-29 4= 30-34 5= 35-39 6= 40-44 7= 45-49	The same as SA
Education	0=no education 1=primary, 2= secondary, 3= higher	0=no education 1= primary 2=secondary 3=higher
Place of residence	1= urban 2= rural	The same as SA
Province of residence/ Region	1= Western Cape, 2= Eastern Cape, 3= Northern Cape, 4= Free State, 5=Kwa-Zulu Natal, 6= North West, 7= Gauteng, 8= Mpumalanga, 9= Limpopo	1=Northern Region 2= Central Region 3= Southern Region
Population group/ Ethnic group	1= Africans/Blacks 2= Coloureds 3=Whites, 4= Asians/ Indians.	1=Chewa 2=Tumbuka 3=Lomwe 4=Tonga 5=Yao 6=Sena 7=Nkonde 8=Ngoni 9=Amanganja/Anyanja 10=Other
Marital status	0=never married 1=currently married 2=formerly married	The same as SA
Educational level	0= No education 1= Primary education 2=Secondary education 3= Higher education	The same as SA
Currently working	0=no 1=yes	The same as SA
Partner 's education	0= No education 1= Primary education 2=Secondary education 3= Higher education	The same as SA
Partner's	1=professional, technical, manager	The same as SA

occupation	2=clerical, sales, services 3=agricultural, crafts, trade, domestic, manual	
Ideal number of children	0 = 0 1 = 1 child 2= 2 children 3= 3 children 4= 4 and more children	The same as SA
CEB	0 = 0 1 = 1 child 2= 2 children 3 =3 children 4 = 4 and more children	The same as SA
Spousal approval about fp	0=disapproves 1=approves	The same as SA
Heard of fp-radio	0=no 1=yes	The same as SA
Heard of fp-TV	0=no 1=yes	The same as SA
Heard of fp-news paper	0=no 1=yes	The same as SA
Heard of fp planning - posters	0=no 1=yes	Visited by FP worker
Heard of fp - brouchers	0=no 1=yes	Visited health facility in the past 12 months
At health facility told of fp	0=no 1=yes	The same as SA

3.6 Limitations of the Study

The sample sizes were only limited to women of childbearing age (15-49 years). It does not tell anything about women outside the specified groups (especially very young sexually-active female adolescents).

This study is based on data from 1998 SADHS and 2000 MDHS. These data sets are 11 and 13 years old respectively. It is possible that the family planning situation in the countries may have changed contrary to the situation presented in this study. If this is the case the results may not be as enlightening to policy and decision makers as one would have expected. However, if the situation has changed this study should be seen as providing a basis for comparisons for similar studies in future.

Just like other source of demographic data, the Demographic and Health Surveys has its own limitations. A major limitation of the data is that it does not cover some important possible predictors about the utilization of reproductive health services, for example, distance to health facilities, transportation services, the price and quality of care and respondent's belief concerning health practices. It also excludes cultural variables which are important in influencing use of reproductive health services.

Another problem that was encountered relate to the fact that although 1998 SADHS and 2000 MDHS used similar sampling methods and survey instruments to collect data, there are some differences in the information collected. For example, the variable ethnicity is defined rather differently in the two data sets. In the case of South Africa ethnicity refers to population groups whereas in Malawi it refers to "tribal" groupings. Whereas in Malawi information on belonging to the various religious groups was collected in South Africa this information was not collected at all. Malawi is divided into three regions (Northern, Central and Southern Regions) whereas South Africa has nine provinces. These differences made comparison difficult.

CHAPTER 4: UNMET NEED IN SOUTH AFRICA

4.1 Introduction

This chapter consists of the following sections, section 4.2 which describes selected socio-economic background characteristics of women in reproductive age for South Africa 1998. Section 4.3 examines the relationship between the background variables and unmet need of family planning in South Africa and section 4.4 presents the results of multi-nomial logistic regression describing the determinants of unmet need in South Africa.

4.2 Background characteristics of the Respondents in South Africa

Table 4 gives the summary statistics of the South African study population.

Age

The results show that the largest proportion of childbearing women was in the age groups 15-19 with 19% and 17.7% in 20-24 age groups. The smallest percentage of childbearing women was in age group 45-49 with 8.3%.

Place of residence

The results shows that the majority of women 60.2%, were residing in urban areas and 39.5% were residing in rural areas. The figures are suggesting that more participants in the 1998 survey were from the urban areas.

Racial groups

The largest proportion of the participants was Africans, 77.9% and 10.2% were coloureds, 7.8% were Whites and only 3.5% were Asians. This suggests that majority of the respondents in this survey were Africans, and this is supported by the report of 2001 census which indicated that 80% of South African population is Blacks/Africans.

Province of residence

Table 4 indicates that 10.2% of women interviewed in the survey were from Western Cape, 13.2% of women were from Eastern Cape. North-West had 7.7% of women participated in the survey followed by Mpumalanga with 7.0% and 11.2% of women were from Limpopo. The largest proportion of women interviewed was from Gauteng with 21.7% followed by KwaZulu-Natal with 20.1%. Free State and Northern Cape were less represented by women with 6.5% and 2.2% respectively.

Respondent's marital status

With the marital status, results indicate that 48.3% of the respondents were never married, 43.3% were married while 8.5% were formerly married.

Respondent's level of education

For the total population, the majority of women had secondary education (60.5%), 24.8% had primary education and only 6.8% had no education.

Current employment status

The largest proportion of women who participated was currently not working (67.2%) and only 32.3% of women were working.

Partner education

Results also indicate that women whose partners were having secondary education were about 24.5% and 14% their partners had primary education, while only 4.4% of the women their partners had higher education.

Partner occupation

The majority of the participants (34.2%), reported that their partners were doing Agricultural, Crafts, Trade and Domestic Manual, while 9.7% of participants reported that their partners were doing Clerical, Sales and Services and the least reported that their partners were doing professional, technical and managerial occupations.

Partner approves family planning

About 30.2% of women who participated in the survey indicated that their partners approved family planning and only 9.1% of the participants reported that their partners did not approve family planning.

Ideal number of children

The highest proportion of women (58.0%) wanted to have two children, followed by 23.5% of women who wanted to have 3 children. The least, which is 2.9%, wanted no children.

Children ever born

With children ever born the results show that about 30.2% of participants reported that they had 2 children, while 29.5% reported that they never had children, 21% of participants reported that they had 1 child and only 6.3% of women reported that they had more than 4 children. This shows that the majority of participants had 2 children and this was followed by those who had no children at all.

Exposure to family planning messages in the media

Exposure to media includes radio, TV, news papers, posters and brochures. Table 4 indicates that the highest proportion of women (65.7%) heard family planning messages on radio and only 34.2% never heard of family planning on the radio. 40% of participants heard of family planning messages on TV and about 50% never heard of family planning messages on TV. Those who read about family planning in newspapers were 41.3% and the majority, which is 58.5% never, read of family planning messages in the newspapers. About 39% of participants heard about family planning on posters and 60.4% of women who participated in the survey never read of family planning messages on the posters. Those who heard of family planning on brochures were about 34% only and 65.3% of participants never heard of family planning messages in brochures.

At health facility told of family planning

Results in table 4 also indicate that 26.4 % of respondents were never told of family planning at the health facility and only 15.7% were told of family planning at the health facility.

Table 4: Selected socio-economic background characteristics of women in South Africa

Variables	N	%
Age		
15-19	2249	19.2
20-24	2075	17.7
25-29	1857	15.8
30-34	1654	14.1
35-39	1636	13.9
40-44	1294	11
45-49	970	8.3
Total	11735	100
Place of residence		
Urban	7095	60.5
Rural	4640	39.5
Total	11735	100
Population group		
African	9147	77.9
Coloured	1201	10.2
White	916	7.8
Asian	406	3.5
Total	11669	99.4
Province		
Western Cape	1193	10.2
Eastern Cape	1566	13.3
Northern Cape	253	2.2
Free State	763	6.5
KwaZulu Natal	2364	20.1
North West	909	7.7
Gauteng	2552	21.7
Mpumalanga	819	7
Limpopo	1316	11.2
Total	11735	100
Marital Status		
Never Married	5665	48.3
Currently Married	5077	43.3
Formerly Married	993	8.5
Total	11735	100

Educational level		
No education	804	6.8
Primary	2916	24.8
Secondary	7103	60.5
Higher	912	7.8
Total	11735	100
Currently working		
No	7889	67.2
Yes	3795	32.3
Total	11685	99.5
Partner education level		
No education	682	5.8
Primary	1685	14.4
Secondary	2877	24.5
Higher	516	4.4
Total	5760	49.1
Partner Occupation		
Professionals, Technical and Managerial	490	4.2
Clerical, Sales and Services	1135	9.7
Agricultural, Crafts, Trade, Domestic, Manual	4011	34.2
Total	5636	48
Partner approves FP		
Disapproves	1067	9.1
Approves	3548	30.2
Total	4615	39.3
Ideal number of Children		
0	335	2.9
1	1003	8.5
2	6801	58
3	2754	23.5
4+	657	5.6
Total	11550	98.4
CEB		
0	3465	29.5
1	2477	21.1
2	3547	30.2
3	1504	12.8
4+	741	6.3
Total	11735	100
Heard of FP – radio		
No	4009	34.2

Yes	7710	65.7
Total	11719	99.9
Heard of FP – TV		
No	5957	50.8
Yes	5755	49
Total	11712	99.8
Heard of FP- newspaper		
No	6861	58.5
Yes	4849	41.3
Total	11710	99.8
Heard of FP- poster		
No	7086	60.4
Yes	4625	39.4
Total	11711	99.8
Heard of FP - broucher		
No	7669	65.3
Yes	4044	34.5
Total	11713	99.8
At health facility told of FP		
No	3103	26.4
Yes	1842	15.7
Total	4945	42.1

4.3 Relationship between unmet need and background variables in South Africa

Table 5 shows the relationship of the background variables and the unmet need to limit and to space, while Figure 4 shows the levels and patterns of unmet need in South Africa in 1998. Unmet need to space in South Africa is 4.7% in 1998 and unmet need to limit in South Africa is 10.3%. Total unmet need in South Africa was 15.0%.

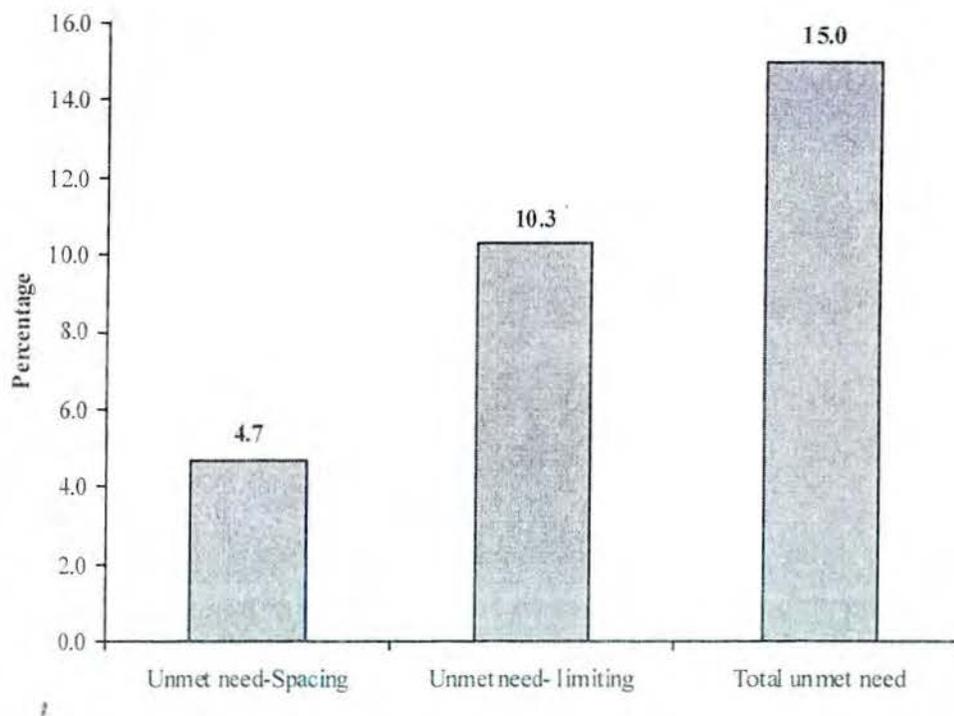


Figure 4: Levels of Unmet need for family planning in South Africa

4.3.1 Spacing

Unmet need for spacing decreases with age. Unmet need for spacing was 4.1% in age group 15-19 increases to 5.6% in age group 20-24 and 5.1% in age group 25-29 and starts declining to 3.5% in age group 30-35 declining further to 0.7% in age group 45-49. Unmet need for spacing is highest in the rural areas (5.0%) than in urban areas (2.7%). African groups had higher unmet need to space (4.1%) than other racial groups. Unmet need to space is lowest in Coloureds (0.2%).

Unmet need for spacing differ per province. Unmet need to space is high in Limpopo (6.5%), followed by Mpumalanga (5.9%), then Kwa-Zulu Natal (3.9%), followed by Gauteng (3.3%), Eastern Cape (3.2%), then Northern Cape (2.4%) followed by Western Cape and North-West (1.9%) respectively. Free State has the lowest unmet need to space compared to all the provinces (1.8%). Married women had high unmet need to space (4.7%) than the women who never married (3.1%) and the formerly married (0.50%).

Unmet need to space is high in women who are not working (4.3%) than those who are working (2.2%). Women with no education had high unmet need to space (4.1%) followed by those with primary education (4.1%) then by those with secondary education (3.5%) and declined in those with higher education (1.4%). Women whose partners had no education (5.9%) has high unmet need to space, followed by those whose partners had primary education (4.6%) declined in those whose partners had secondary education (4.0%) and further declined in those whose partners had higher education (1.4%).

Unmet need to space is higher in women whose partners perform agricultural, crafts, trades, domestic and manual labour (4.5%) than those whose partners are performing clerical, sales and services labour (3.6%) and those whose partners are professionals, technical and managerial (0.4%). Unmet need to space was 5.0% in women who wanted to have 3 children, followed by 4.6 % of those who wanted to have 4+ children and 3.3% of those who wanted to have 1 child and 3,1% of those who want to have 2 children. Unmet need to space is lower in women who do not want to have children (2.4

Unmet need to space decreases with the number of children. The less the number of children ever- born the more the unmet need to space. Women with 0-1 children has more unmet need 4.1% than those who had 2-3 children (3.2%) and lower in those who had 4 and more children (2.2%). Women whose husbands disapprove of family planning had more unmet need to space (9.5%) than those whose husbands approves of family planning (3.3%).

Unmet need to space is high on women who had never heard of family planning on media. Women who were never told of family planning at health facility (3.7%) had high unmet need for spacing than those who were told of family planning at health facility (3.5%).

4.3.2 Limiting

Unmet need for limiting increases with age. Table 5 shows that unmet need for limiting was 1.2% in age group 15-19 increasing to 10.5% in age group 35-39 and increasing further to 12.3% in age group 45-49.

Unmet need for limiting was more in the rural area (8.1%) than in the urban areas (4.9%). High unmet to limit was found to be more on African group (7.1%), followed by Coloured group (3.2%), then Asians (3.00%). Lower levels of unmet need to limit were found in the Whites (2.9%).

Unmet need to limit was high in Eastern Cape (8.6%) followed by Mpumalanga (7.1%), then Kwa-Zulu Natal (7.0%). Limpopo had unmet need to limit of 6.5%, North-West had unmet need to limit of 6.3%, unmet need to limit for Gauteng was 6.3% followed by Free State (3.8%) then Northern Cape (3.6%) and low unmet need to limit was found to be in Western Cape (1.6%). Married women had high unmet need to limit (10.3%) than those women who are formerly married (5.2%) and last those never married were 2.5%. High levels of unmet need to limit were in women who were not working (6.5%) and less in women who were working (5.4%).

Table 5 shows that women with no education had high unmet need to limit (15.0%) followed by those who had primary education (9.7%), decreasing in women with secondary education (4.2%), and those with higher education (2.2%).

Levels of unmet need to limit is high in women whose partners had no education (15.0%), followed by those whose partners had primary education (11.4%), and decreasing in women whose partners had secondary education (7.9%) and in those women whose partners had higher education (4.5%). Unmet need to limit is high in women whose partners are one agricultural, crafts, trade, domestic and manual labour (10.7%), followed by those whose partners are on clerical, sales and services. Lower levels of unmet need to limit are on women whose partners are professionals, technical and managerial (5.2%).

Unmet need to limit increases with the high number of children the women desire. The more the number of children the woman desires the higher the unmet need to limit. Unmet need to limit is 4.2% in women who wanted to have no children and increases in women who wanted to have 3 children (9.5%) and in women who wanted to have 4 and more children (11.6%).

Unmet need to limit increases with the number of children the women has. The more the number of children the woman has the higher the unmet need to limit. Unmet need to limit was 1.2% in women who had no children and 3.7% in women who had 1 child and starts to increase in women who had 3 children (11.8%) and 22.3% in women who had 4 and more children. Unmet need to limit is higher in women whose husbands disapprove of family planning (9.0%) than women whose husbands approve of family planning (5.5%). Almost all women who have heard about family planning on the media have unmet need to limit.

4.3.3 Total unmet need in South Africa, 1998

In this section total unmet need by selected characteristics of childbearing age women in South Africa in this will be explained.

The higher the age, the higher the probability of having unmet need of family planning. The lower the age, the less chances of having unmet need of family planning. The results in table 2 show that women age 15-19 has total unmet need of 5.3% followed by women aged 20-25 (8.5%), and starts to increase in age group 35-39 (12.5%) and the total unmet need for family planning in age group, 45-49 is higher than all other age groups (13.0%).

Total unmet need is more on women residing in rural areas (13.1%) than those living in urban areas (7.6%). Provincially, total unmet need is more in Limpopo (13.1%), followed by Mpumalanga (13.0%), then Eastern Cape (11.7%). In Kwa-Zulu Natal total unmet need for family planning is 10.9 % followed by Gauteng (9.6 %). North-West had total unmet need of 8.3%.

Regarding population groups, the total unmet need is more in Africans (11.1%) than all racial groups in South Africa, followed by Whites (4.1%) and Asians (3.7%), and less in Coloureds group (3.4%). The results in table 2 below shows that 15.0% of women who were currently married had high levels of total unmet need, and 5.7% of both were never married and the formerly married had low levels of total unmet need of family planning respectively.

Table 5 shows that the total unmet need is more on the unemployed women (10.8 %) than those who were employed, and high level of total unmet need is found in women whose partners were doing agricultural, crafts, trade, domestic and manual work (15.2%), followed by those whose partners were on clerical, sales and services (11.2%). Women whose partners are professionals, technical and managerial have relatively low level of total unmet need for family planning. Results continue to show that 19.3% of women who had no education had high levels of total unmet need followed by 13.8% of women who had primary education.

Table 5 also shows that 20.8% of women whose partners had no education had high total unmet need of family planning, followed by 15.9% of those whose partners had primary education. Total unmet need was low in women whose partners had higher education (5.9%). Total unmet need is high on women whose partners disapprove family planning (18.5%) than those whose partners approved of family planning (8.8%).

Total unmet need is high on women who wanted to have 4 or more children (16.2%), followed by women who wanted to have 3 children. Those who wanted no children had less total unmet need (6.6 %). Women who wanted to have 1-2 children also had low levels of total unmet need for family planning. Results also show that total unmet need is more on women who had 4 or more children (24.4%), followed by women who had 3 children (15.1%) and also more on women who wanted to have 2 children (10.2%). The results in table 5 shows that total unmet need is found to be more on all women who had at least heard about family planning on the radio, TV, newspaper, posters and brochures.

Table 5: Relationship between background characteristics and unmet need in South Africa, 1998

Variables	Spacing	Limiting	Total	Chi-square	p-value
Age				368.94	0.000
15-19	4.1	1.2	5.3		
20-24	5.6	2.9	8.5		
25-29	5.1	5.0	10.1		
30-34	3.5	7.1	10.6		
35-39	2.0	10.5	12.5		
40-44	1.8	10.4	12.2		
45-49	0.7	12.3	13.0		
Place of residence				268.94	0.000
Urban	2.7	4.9	7.6		
Rural	5.0	8.1	13.1		
Population group					
African	4.1	7.1	11.2	98.62	0.000
Coloured	0.2	3.2	3.4		
White	1.2	2.9	4.1		
Asian	0.7	3.0	3.7		
Province				149.00	0.000
Western Cape	1.9	1.6	3.5		
Eastern Cape	3.2	8.6	11.8		
Northern Cape	2.4	3.6	6.0		
Free State	1.8	3.8	5.6		
KwaZulu Natal	3.9	7.0	10.9		
North West	1.9	6.4	8.3		
Gauteng	3.3	6.3	9.6		
Mpumalanga	5.9	7.1	13.0		
Limpopo	6.5	6.5	13.0		
Marital status				338.26	0.000
Never Married	3.1	10.3	13.4		
Currently Married	4.7	10.3	15.0		
Formerly Married	0.5	5.2	5.7		
Currently working				37.7	0.000
No	4.3	6.5	10.8		
Yes	2.2	5.4	7.6		
Educational status				249.57	0.000
No education	4.8	15.0	19.8		
Primary	4.1	9.7	13.8		
Secondary	3.5	4.2	7.7		
Higher	1.9	2.2	4.1		
				73.08	0.000

Partner education					
no education	5.9	15.0	20.9		
Primary	4.6	11.4	16.0		
Secondary	4.0	7.9	11.9		
Higher	1.4	4.5	5.9		
Partner occupation				0.0	33.04
Professionals, Technical and Managerial	0.4	5.2	5.6		
Clerical, Sales and Services	3.6	7.7	11.3		
Agricultural, Crafts, Trade, Domestic, Manual	4.5	10.7	15.2		
Ideal no of children				150.06	0.000
0	2.4	4.2	6.6		
1	3.3	4.5	7.8		
2	3.1	4.7	7.8		
3	5.0	9.5	14.5		
4+	4.6	11.6	16.2		
Children ever born				600.08	0.000
0	4.1	1.2	5.3		
1	4.1	3.7	7.8		
2	3.2	7.0	10.2		
3	3.2	11.8	15.0		
4+	2.2	22.3	24.5		
Partner approves FP				99.05	0.000
Disapproves	9.5	9.0	18.5		
Approves	3.3	5.5	8.8		
Heard of FP – radio				94.75	0.017
No	3.1	6.5	9.6		
Yes	3.8	7.0	10.8		
Heard of FP – TV				8.03	0.018
No	4.5	5.3	9.8		
Yes	2.7	7.3	10.0		
Heard of FP- newspaper				59.47	0.000
No	4.2	4.5	8.7		
Yes	2.7	7.2	9.9		
Heard of FP – poster				49.01	0.000
No	4.1	4.6	8.7		
Yes	2.8	6.9	9.7		
Heard of FP – broucher				35.50	0.000
No	4.1	4.8	8.9		
Yes	2.7	5.9	8.6		
At health facility told of fp				2.25	0.324
No	3.7	4.9	8.6		
Yes	3.5	4.9	8.4		

4.4 Determinants of unmet need in South Africa

This section analyses the determinants of unmet for family planning in South Africa. Table 6 shows the results of multinomial logistic regression of the effects of socio-demographic, economic and partners' characteristics on unmet need for family planning for spacing and limiting among South African women in 1998.

4.4.1 Spacing

Table 6 indicates that age, population group, marital status and children ever born are significantly related to unmet need to space in South Africa.

Age of the respondents is positively related to unmet need for spacing births. Women in the age group 15-19 are 13.4 times more likely to have unmet need for spacing than women in age group 45-49. Women in age group 30-34 are 7.8 times more likely to have unmet need for spacing than women in age group 45-49. The odd ratios decrease with increasing age of the respondent implying that as the age of the respondent increases, there is less likelihood of reporting unmet need for spacing. Marital status is also positively related to unmet need to space. The never married are 6.5 times more likely to have unmet need than the formerly married. Women who are married are 10.8 times more likely to have unmet need to space than women who were formerly married. Population groups are positively related to unmet need to space. Africans are 5.5 times more likely to have unmet need than Asians.

Another variable that is influencing unmet need for spacing in South Africa is number of children ever born. Women with no children ever born are 3.8 times more likely to have unmet need for spacing than women with four or more children. Women with one child are 1.6 times more likely to have unmet need for spacing than women with four or more children in age group 45-49. But the result is not statistically significant. Women with three children are 1.1 times more likely to have unmet need for spacing than women with four or more children in the age group 45-49.

4.4.2 Limiting

Age, region, marital status, educational level, ideal number of children and children ever born were found to be the most important determinants of unmet need to limit. Women in age group 20-24 are 0.382 less likely to have unmet need than women in age 45-49. Women in age 25-29 are 0.319 less likely to have unmet need to limit than women in age 45-49. Women in age group 35-39 are 0.403 less likely to have unmet need limit than those in age group 45-49.

Another important variable for unmet need to limit is region. Women in Eastern Cape are 2.2 less likely to have unmet need to limit than those women in Limpopo and women in Mpumalanga are also 2.2 less likely to have unmet need to limit than women in Limpopo. Women who are never married are 0.490 less likely to have unmet need to limit than women who were formerly married. Women who are currently married are 2.1 less likely to have unmet need to limit than those who are formerly married.

Table 6 also shows that women who intends to have 1 child are 2.8 less likely to have unmet need to limit than women who desire to have 4 children or more. This means that the more desire to have less children, the more the need to limit. Women who has 1 child are 0.460 less likely to have unmet need to limit than women who has 4 or more children and women who has 2 children are 0.518 less likely to have unmet need to limit than women who has 4 or more children.

Table 6: Multi-nominal logistic Regression on unmet need for family planning for spacing and limiting among South African women in 1998

Age	Spacing			Limiting		
	Odds Ratio	LB	UB	Odds Ratio	LB	UB
15-19	13.380*	1.206	148.423	0.545	0.052	5.695
20-24	13.322*	1.811	97.975	0.382*	0.146	0.995
25-29	11.699*	1.672	81.889	0.319*	0.155	0.655
30-34	7.837*	1.140	53.889	0.403*	0.218	0.745
35-39	4.054	0.565	29.112	0.847	0.502	1.429
40-44	3.095	0.395	24.231	0.639	0.360	1.135
45-49						
Place of residence						
Urban	0.792	0.407	1.541	0.815	0.518	1.281
Rural [®]						
Provinces						
Western Cape	1.191	0.265	5.352	.374**	0.100	1.395
Eastern Cape	0.882	0.385	2.021	2.234*	1.108	4.504
Northern Cape	1.366	0.205	9.102	0.870	0.218	3.465
Free State	0.54	0.163	1.791	1.441	0.618	3.356
Kwa-Zulu Natal	1.19	0.575	2.462	1.370	0.698	2.692
North-West	0.481	0.094	2.465	1.475	0.577	3.769
Gauteng	0.856	0.319	2.291	2.296*	1.106	4.766
Mpumalanga	1.325	0.549	3.199	1.981	0.919	4.269
Limpopo [®]						
Marital status						
Never married	6.557*	2.634	16.32	0.490*	0.354	0.678
Currently married	10.845*	4.369	26.919	2.193*	1.634	2.942
Formerly married [®]						
Population group						
Africans/ Blacks	5.555*	0.645	47.851	1.956	0.691	5.534
Coloureds	1.314	0.096	17.932	2.030	0.598	6.898
Whites	2.994	0.282	31.754	0.931	0.289	2.996
Asians [®]						
level of education						
No education	5.220**	0.643	42.395	2.980*	0.969	9.167
Primary	6.167	0.870	43.739	2.647*	0.982	7.133
Secondary	4.605	0.710	29.884	2.584*	1.058	6.308
Higher [®]						
currently working						
No	1.386	0.794	2.418	1.008	0.698	1.457
Yes [®]						
Partner's education						

No education	0.679	0.134	3.449	.436**	0.149	1.277
Primary	0.988	0.226	4.324	0.446	0.172	1.156
Secondary	1.317	0.333	5.207	.543**	0.233	1.264
Higher [®]						
Partner' Occupation						
Professional , Technical and Managerial	0.656	0.183	2.353	0.722	0.326	1.599
Agriculture,	0.650	0.340	1.240	0.861	0.546	1.357
Crafts, Trade, Domestic and Manual [®]						
Ideal no of children						
0	0.000	0.000	0.000	1.481	0.312	7.022
1	0.303	0.071	1.295	2.866*	0.998	8.232
2	0.404	0.171	0.952	1.653**	0.827	3.305
3	0.589	0.278	1.248	2.149*	1.144	4.035
4+ [®]						
Children ever born						
0	3.775**	0.773	18.438	.114**	0.024	0.546
1	5.093*	1.289	20.126	.460*	0.211	1.001
2	2.373	0.652	8.628	.518*	0.288	0.931
3	3.288	0.933	11.587	0.926	0.549	1.562
4+ [®]						
Partner approves FP						
Disapprove	2.610	1.602	4.251	1.813	1.228	2.678
Approves [®]						
Heard of FP - radio						
No	1.051	0.612	1.805	0.987	0.652	1.494
Yes [®]						
Heard of FP - TV						
No	2.210	1.239	3.941	1.146	0.765	1.716
Yes [®]						
Heard of FP - newspaper						
No	0.890	0.468	1.692	0.711	0.452	1.118
Yes [®]						
Heard of FP - poster						
No	1.707	0.768	3.792	1.744	0.992	3.069
Yes [®]						
Heard of FP - broucher						
No	0.841	0.364	1.945	0.831	0.469	1.473
Yes [®]						
At health facility told of FP						
No	1.073	0.652	1.767	0.907	0.632	1.304
Yes [®]						

** = p<0.05

4.5 Summary

This chapter has examined the pattern and trends of unmet need for family planning among women in South Africa. Unmet need for spacing births in South Africa is 4.7% whereas unmet need for limiting births in South Africa is 10.3%. Total unmet need for family planning in South Africa was 15% in 1998. The results presented in this chapter indicate that unmet need for family planning varies by socio-economic variables. The multi-variate analyses indicate that age of the respondents, population group of the respondents, educational level of the respondents, marital status of the respondent, children ever born and ideal number of children were found to be the determinants of unmet need for family planning (space and limit) in South Africa.

CHAPTER 5: UNMET NEED IN MALAWI

5.1 Introduction

In this chapter the findings for Malawi are presented and discussed. The chapter consists of the following sections: section 5.2 which describes some of the background characteristics of women in reproductive age for Malawi based on 2000 MDHS; section 5.3 examines the relationship between the background variables and unmet need in Malawi whereas section 5.4 presents the results of multi-nomial logistic regression.

5.2 Background characteristics of the respondents in Malawi

Table 7 gives the summary statistics of the Malawian study population.

Age Group

The results show that the largest proportion of women (27.9%) were in age-group 20-24, followed by women in age group 23.4%. Women in the age group 30-35 were about 14.0% and those in age group 35-39 were 11.9% followed by those in age group 15-19 (11.3%). The lowest were women in the age group 40-44 (7.4%) followed by those in age group 45-49 (4.2%).

Place of residence

The majority of the respondents in Malawi lived in rural areas (79.7%). The 2000 Malawi Population Census states that the percentage of the population living in urban areas is 20.3% (Malawi Government, 2008). This means that the urban population is over represented in the study population in 2000.

Region of residence

The majority of the respondents were in the Southern Region (49% in 2000), followed by Central Region and then Northern Region. The 2008 Malawi Population Census indicates that the highest population is in the Southern Region (46.9%), followed by Central Region (35.8%) and lowest in the Northern Region (17.3%) (Malawi Government, 2008). This finding is

consistent with the distribution of the population at the national level where the Southern Region is home to almost half of the population.

Education

The majority of the study population have primary education (61%), followed by no education (30%), then secondary education (8%). A similar pattern is also observed among partners in that 64% of the respondents reported that their husbands had primary education, 23% had secondary and higher education and 13% had no education. Less than one percent of the respondents reported that they did not know their husbands level of education.

Respondent's marital status

Most of the respondents in Malawi were married (82%). Only 13.8% of the respondents were never married and 3.8 percent were formerly married.

Current employment status

The largest proportion of women who participated in the study was working. Table 7 indicates that 56% of the respondents were working and 54% of the women were not working. The same can be said of the spouses. However, the majority of the spouses worked in Agriculture, crafts, trade, domestic and manual.

Partner approves family planning

Table 7 shows that most respondents reported that their husbands approved family planning. Nearly 76% of women who participated in the survey indicated that their partners approved of family planning and only 16% of the participants reported that their partners did not approve of family planning.

Ideal number of children

The majority of the respondents (68%) reported that they wanted to have four or more children. Less than 1% of the women indicated that they wanted no children.

Children ever born

The majority women, 37.3% reported to be having 4 children. Nineteen point six percent of women reported that they never had children. About 15.8% of women reported to be having at least 1 child, 14.7% of women had 2 children and 12.6% reported to be having 3 children.

Exposure to family planning messages in the media

Table 7 indicates that 70.8% of Malawian women in 2000 heard family planning messages on radio and only 29.2% never heard of family planning on the radio. Only 6% of the women in Malawi heard FP on TV whereas the most of the women (94%) never heard FP on TV in the last months. The low numbers of women reporting that they heard FP on TV may partly be attributed to the fact that TV were introduced in Malawi in 1999 and at the time of the survey most of the women interviewed, did not have TV sets.

Table 7 indicates that 80.5% of Malawian women in 2000 read about family planning in newspapers and 19.5% never read of family planning in the newspapers. Results also indicate that 38.4% of Malawian women in 2000 reported that they were never visited by FP worker in the last 12 months and only 61.6% reported that they were visited by FP worker. According to table 7, 13.1% did not visit a health facility in the last 12 months and 86.9% visited a health facility in the last 12 months.

At Health facility told of family planning

According to table 1, 63.6% of respondents were never told of family planning at the health facility and only 36.4% were not told of family planning at the health facility.

Table7: Selected socio-economic background characteristics of women in Malawi 2000

	N	%
Age		
15-19	2123	21.2
20-24	2587	25.8
25-29	2032	20.3
30-34	1223	12.2
35-39	1038	10.4
40-44	652	6.5
45-49	366	3.7
Total	10021	100.0
Region		
North	1730	17.3
Central	3575	35.7
South	4716	47.1
Total	10021	100.0
Place of residence		
Urban	2222	22.2
Rural	7799	77.8
Total	10021	100.0
Ethnic group		
Chewa	2831	28.3
Tumbuka	1021	10.2
Lomwe	1827	18.2
Tonga	229	2.3
Yao	1409	14.1
Sena	361	3.6
Nkonde	337	3.4
Ngoni	1074	10.7
Amanganja/Anyanja	548	5.5
Other ¹	378	3.8
Total	10015	100.0
Marital Status		
Never married	1385	13.8
Currently married	8257	82.4
Formerly married	379	3.8
Total	10021	100.0
Currently working		

No	4397	43.9
Yes	5620	56.1
Total		
Partner education		
No education	1152	13.3
Primary	5495	63.6
Secondary	1862	21.6
Higher	97	1.1
Don't know	29	0.3
Total	8635	100.0
Partner occupation		
Professionals, Technical and Managerial	509	5.9
Clerical, Sales and Services	1935	22.5
Agricultural, Crafts, Trade, Domestic, Manual	6172	71.6
Total		
Heard FP – Radio		
No	2929	29.2
Yes	7092	70.8
Total	10021	100.0
Heard FP – TV		
No	9417	94.0
Yes	602	6.0
Total	10019	100.0
Heard FP – Newspaper		
No	8059	80.5
Yes	1953	19.5
Total	10012	100.0
Visited by FP worker		
No	8703	86.9
Yes	1317	13.1
Total	10020	100.0
Visited health facility in the last 12months		
No	3848	38.4
Yes	6172	61.6
Total	10020	100.0
At health facility told of FP		
No	2246	36.4
Yes	3921	63.6
Total	6167	100.0
Children ever born		
0	1964	19.6
1	1585	15.8

2	1474	14.7
3	1262	12.6
4+	3736	37.3
Total	10021	100.0
Ideal number of children		
0	11	0.1
1	161	1.7
2	1341	13.8
3	1589	16.3
4+	6628	68.1
Total	9730	100.0
Education		
No education	2438	24.3
Primary	6351	63.4
Secondary	1215	12.1
Higher	17	0.2
Total	10021	100.0
Partner approval of FP		
Disapproves	1323	16.0
Approves	6263	75.9
Don't know	667	8.1
Total	8253	100.0

5.3 Relationship between unmet need and background variables

Table 8 shows the levels and patterns in the unmet need for family planning by selected characteristics of women in Malawi. The results reveal that the levels of unmet need for family planning increases with the age of women and the levels of unmet need to limit births appear to increase with the age of women.

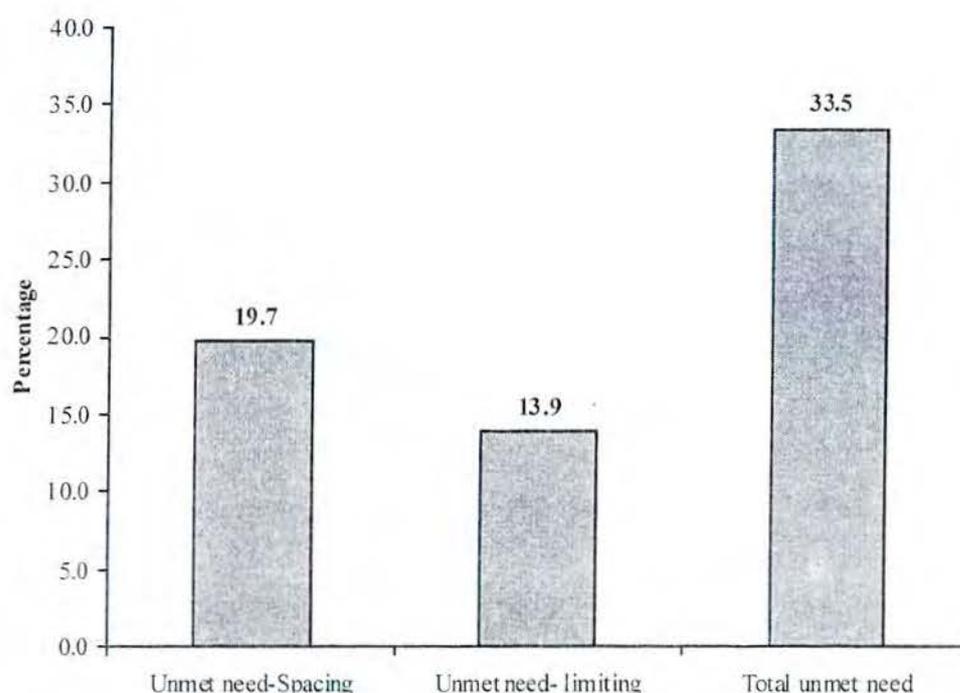


Figure 5: Unmet need for family planning in Malawi

5.3.1 Spacing

Unmet need for spacing in Malawi was 23.5% in age group 20-24, decreased to 21.1% in age group 25-29, and in age-group 44-49 it was 17.4%. In age group 30-34, unmet need to space starts to decline to 16.9% and goes further to decline to 15.3% in age group 15-19. Low unmet need to space was found in age-group 40-44 by 6.1% and in age group 45-49 unmet need to space was about 4.4%. This indicates that the lower unmet need to space, the higher the age of a woman.

Unmet need for spacing is highest in the Central Region (17.7%) closely followed by Southern Region (17.6%) and then Northern region (16.5%). Unmet need for spacing is higher in rural areas (18.5%) than urban areas (13.8%).

Table 8 shows that unmet need for spacing is more in Tonga and Lomwe with 18.8%, respectively. In Nkonde unmet need for spacing is 17.5%, Tumbuka has unmet need for spacing of 17.4% followed by Ngoni with unmet need to space of 17.3% at Nkonde. Anyani region has unmet need to space of 17.2%. Chewa has unmet need of 17.1%. In other regions unmet need for spacing was found to be 14.0%. The results show that unmet need for spacing differ within regions.

With the marital status in Malawi, unmet need to space was found to be higher in the currently married (19.7%), followed by the never married (7.4%). Unmet need for spacing was very low in the formerly married women (5.0%). Women who were not currently working have a higher unmet need to space (17.7%) than those who were currently working (17.3%). Women, whose partners have primary education have higher unmet need (19.6%), followed by those whose partners had no education (19.3%). Women whose partners had secondary education had lower unmet need to space (18.0%) and those who did not know the educational status of their partners had low unmet need to space (10.3%). Women whose partners had higher educational level had the lowest unmet need to space (8.2%).

Women whose partners who are on clerical, sales and services occupations had very high unmet need to space of 20.2% followed by women whose partners are on agricultural, crafts, trade and domestic manual (19.1%). Women whose partners were professionals, technicians and managers had the lowest unmet need to space (13.6%). Those women who heard of FP from the radio had higher unmet need to space (17.5%) than those who never heard of family planning on the radio (17.2%). Women who never heard of FP from TV had a higher unmet need to space (17.9%) than those who heard about FP on the TV (10.5%).

Women who never heard of FP from the newspaper had a higher unmet need to space (17.8%) than those who read about FP in the newspaper (15.8%). Women who were never visited by FP Worker had higher unmet need to space (17.4%) than those who were visited by FP Worker heard about FP (17.3%) Women who visited health facility in the last 12 months had unmet need to space of 19.2% and those who never visited health facility in the last 12 months had an unmet need to space of 14.7% which is lower than those who had visited the health facility. Results also show that women who were told of FP at health facilities have a higher unmet need to space of 19.6% than those who were never told of unmet need to space (18.4%).

Women who had 1 child had the highest unmet need to space (26.2), followed by those who had 2 children (23.8%). Women who had 3 children (22.5%) had a high unmet need to space. Those who had more than 4 children had lower unmet need to space (13.7%) followed by those who had no children (9.4%). Higher unmet need for spacing is higher in women who desired to have more than 4 children (18.2%), followed by women (17.7%) who desire to have 3 children. Unmet need for spacing decreased in women (15.0%) who desired to have 2 children followed by those who have 1 child (8.7%), and those who desire to have no children have no unmet need to space.

Women who had no education had a higher unmet need to space (18.8%) than women who had primary education (17.6%) and secondary education (14.0%). Women who had higher educational levels had no unmet need to space. Women whose partners had disapproved family planning had a higher unmet need to space (24.9%), followed by those who do not know whether their husbands approve family planning (24.7%). Women whose partners approve family planning had lower unmet need to space (18.0%).

5.3.2 Limiting

Unmet need for limiting increases with age. Unmet need for limiting was 2.4% in age group 15-19 increasing to 23.7% in age group 35-39 and increasing further to 34.2% in age group 45-49. Unmet need for limiting is more in the Central Region with 13.9% and lower in both North and South regions. Table 8 shows that rural areas have high unmet need for limiting of 12.5% and while urban areas have unmet need for limiting of 9.3%. Unmet need for limiting was found to differ with type of ethnic groups. The Chekwa group has unmet need for limiting of 13.3%, followed by the Ngoni with 13.2% and the Anyanja with unmet need for limiting of 13.0%. Lower unmet need for limiting was found in the ethnic group of the Sena with 6.6%.

Women who are currently married had a high unmet need for limiting of 13.9% and the formerly married had unmet need for limiting of 7.4% while the never married were found to have a low unmet need of 0.9%. Women who were currently working had a high unmet need for limiting of 12.5% and those who were not working had low unmet need of 11.0. Unmet need for limiting in partner education was found to be high in those women who do not know their partners' educational level with 20%, followed by those who had no education with 16.0%. Low unmet need for limiting of 6.2% was found in women with higher educational levels. Unmet need for limiting also differs with the type of employment the partner is working. Unmet need for limiting was found to be high with 14.1% on women whose husbands' occupations were in agricultural, crafts, trade and domestic manual, followed by those whose husbands were on clerical, sales and services (12.8). Women whose husbands were professionals, technicals and managerial had low unmet need for limiting of 9.6%. †

Women who never heard of FP on the radio had higher unmet need for limiting of 13.5% and those who heard of FP on the radio had lower unmet need for limiting of 11.2%. Women who never heard of FP on the TV had a high unmet need for limiting of 12.0% while those who heard of FP on the TV had lower unmet need of 8.7%. Women who never heard of FP on newspapers had unmet need for limiting of 12.6 and those who heard of FP

from newspapers had lower unmet need for limiting of 8.7%. Those women who were visited by FP Worker had high unmet need for limiting of 12.5% and those who never visited by FP Worker had low unmet need for limiting of 11.7%. Women who visited health facility in the past 12 months had unmet need for limiting of 11.8% while those who had visited health facility in the past 12 months had unmet need for limiting of 11.9%. Results showed that women who had been told of FP at health facility had unmet need for limiting of 11.9% and those who were never told of FP at health facility had unmet need for limit of 11.5%.

Women who had born 4+ children had high unmet need for limiting of 22.7%, followed by those women who had born 3 children having unmet need for limiting of 10.7% while the women who never had children had a low unmet need for limiting of 1.6%. Unmet need to limit is more on women who desire to have 1 child with 16.1% followed by women who desire to have more than 4 children with 12.5%. Women who desire 2 children and 3 children have a low unmet need for limiting of 9.5% and 9.4% respectively. Women who desire no children have no unmet need for limiting. Unmet need for limiting is more on women who have no education with 16.1, followed by women who have primary education with unmet need of for limiting of 11.4%. Unmet need for limiting is lower in women with secondary education (5.7%) and those with higher education (5.9%). Women whose partners disapprove of FP have a high unmet need for limiting of 19.2%, followed by women who do not know whether their partners approve or disapprove of FP with 14.2%. Women whose partners approve of FP have a lower unmet need for limiting of 12.7%.

5.3.3 Total unmet need in Malawi

In this section total unmet need by selected characteristics of childbearing age women in Malawi will be explained below.

The higher the age, the higher the probability of having total unmet need of family planning. The lower the age, the less chances of having unmet need of family planning. The results in table 8 show that women age 15-19 have a

total unmet need of 17.6% followed by women aged 20-24 (29.6%) and starts to increase in age group 25-29 (31.6%). The total unmet need for family planning in age group 45-49, is higher than all age groups (38.5%). Total unmet need is higher in the Central Region with 31.6%, and then followed by the South Region with 28.2%, and the North Region has a total unmet need of 27.4%. Women residing in the rural areas have a high total unmet need of 31.0% and urban areas have a total unmet need of 23.1%. Regarding ethnic groups, the total unmet need is higher in the Tonga group with 31.4%, followed by the Anyanja group. Almost all the ethnic groups in Malawi have a high total unmet need and the lowest total unmet need of 23.0% and are found in the Sena group.

Women who are currently married have a 33.5% total unmet need and this is higher than in the formerly married (12.4%) and the never married (8.4%). Women who are currently working had total unmet need of 29.7% which is higher than the total unmet need of women not working (28.7%). With education of the partner, the total unmet need is 36.0% in women whose partners have no education, followed by 33.6% of women whose partners have primary education, women who do not know the level of their partners education have total unmet need of 31.0% and women with secondary education have lower total unmet need of 28.4%. The lowest total unmet need (14.4%) is found on women whose partners have higher education.

Table 8 also shows that the total unmet need for family planning (33.2%) is high on women whose partners are on agriculture, crafts, trade, domestic and manual, followed by those whose partners are on clerical, sales and services (33.0%) and lower total unmet need of 23.3%, and is found on women whose partners are in professional, technical and managerial occupations. The total unmet need (30.7%) was high on women who never heard of FP on radio, and lower total unmet need (28.7%) was found on women who heard of FP on the radio. The total unmet need of 29.9% was found on women who never heard of FP on the TV and it was higher than on women who heard of FP on TV (18.9%). Women with a high total unmet need was found in women who never heard of FP from the newspapers (30.4%) and low total unmet need

(24.5%) was found on women who heard of FP from the newspapers. Total unmet need is found to be high (29.8%) in women who was visited by family planning Worker and lower (29.2%) on women who was never visited by family planning Worker. Higher total unmet need for family planning (30.9%) is found on women who visited health facility in the past 12 months and low total unmet need (26.6%) on women who never visited health facility in the past 12 months. Those who heard of FP at health facility had total unmet need of 31.5%, higher than of 29.9% of those who never heard of FP at health facility.

Results in table 8 shows that total unmet need in children ever born was high in women who had more than 4 children (36.4%) followed by women who had 3 children (33.1%). Total unmet need was 31.0% in women who had 2 children and the lowest total unmet need of 11.0 is found on women who never had children. Women who desired to have more than 4 children had a total unmet need of 30.7% than those who desired to have 3 children (27.2%). Those who desired to have 1 child and 2 children had a total unmet need of 24.8% and 24.5%, respectively. Those women who desired no children had no total unmet need for family planning.

Total unmet need is high in women who had no education (34.9%), followed by 29.0% of those who had primary education. Women who had secondary education have lower total unmet need of 19.7% and those who had higher education has the lowest total unmet need of 5.9%. Women whose partners disapprove of FP had a higher total unmet need of 44.1% followed by total unmet need of 39.0% for women who did not know whether they approved of FP or not. Women whose partners approve family planning had a total unmet need of 30.7%.

Table 8: Relationship between background variables and unmet need in Malawi 2000

	Spacing	Limiting	Total	Chi-square	p-value
Age					
15-19	15.3	2.4	17.6	933.6	0.000
20-24	23.5	6.1	29.6		
25-29	21.1	10.5	31.6		
30-34	16.9	16.7	33.6		
35-39	11.9	23.7	35.6		
40-44	6.1	28.8	35.0		
45-49	4.4	34.2	38.5		
Region					
North	16.5	10.9	27.4	26.4	0.000
Central	17.7	13.9	31.6		
South	17.6	10.6	28.2		
Place of residence					
Urban	13.8	9.3	23.1	51.8	0.000
Rural	18.5	12.5	31.0		
Ethnic group					
Chewa	17.1	13.3	30.4	21.2	0.027
Tumbuka	17.4	11.4	28.8		
Lomwe	18.8	10.6	29.4		
Tonga	18.8	12.7	31.4		
Yao	17.3	11.5	28.8		
Sena	16.3	6.6	23.0		
Nkonde	17.5	9.8	27.3		
Ngoni	17.3	13.2	30.5		
Anyanj	17.2	13.0	30.1		
Other	14.0	9.8	23.8		
Marital Status					
Never married	7.4	0.9	8.4	432.7	0.000
Currently married	19.7	13.9	33.5		
Formerly married	5.0	7.4	12.4		
Currently working					
No	17.7	11.0	28.7	4.83	0.089
Yes	17.3	12.5	29.7		
Partner education					
No education	19.3	16.8	36.0	49.68	0.000
Primary	19.6	14.0	33.6		
Secondary	18.0	10.4	28.4		
Higher	8.2	6.2	14.4		
Don't know	10.3	20.7	31.0		

Partner occupation					
Professionals, Technical and Managerial	13.6	9.6	23.2	39.49	0.001
Clerical, Sales and Services	20.2	12.8	33.0		
Agricultural, Crafts, Trade, Domestic, Manual	19.1	14.1	33.2		
Heard FP – Radio					
No	17.2	13.5	30.7	10.53	0.005
Yes	17.5	11.2	28.7		
Heard FP – TV					
No	17.9	12.0	29.9	33.61	0.000
Yes	10.5	8.5	18.9		
Heard FP – Newspaper					
No	17.8	12.6	30.4	31.26	0.000
Yes	15.8	8.7	24.5		
Visited by FP worker					
No	17.4	11.7	29.2	0.57	0.752
Yes	17.3	12.5	29.8		
Visited health facility in the past 12 months					
No	14.7	11.9	26.6	33.8	0.000
Yes	19.2	11.8	30.9		
At health facility told of FP					
No	18.4	11.5	29.9	1.72	0.422
Yes	19.6	11.9	31.5		
Children ever born					
0	9.4	1.6	11.0	1002.7	0.000
1	26.2	4.2	30.3		
2	23.8	7.2	31.0		
3	22.5	10.6	33.1		
4+	13.7	22.7	36.4		
Ideal number of children					
0	0.0	0.0	0.0	44.23	0.0000
1	8.7	16.1	24.8		
2	15.0	9.5	24.5		
3	17.7	9.4	27.2		
4+	18.2	12.5	30.7		
Education					
No education	18.8	16.1	34.9	119.9	0.0000
Primary	17.6	11.4	29.0		
Secondary	14.0	5.7	19.7		
Higher	0.0	5.9	5.9		
Partner approval of FP					
Disapproves	24.9	19.2	44.1	101.43	0.000
Approves	18.0	12.7	30.7		
Don't know	24.7	14.2	39.0		

** = p<0.05

5.4 Determinants of unmet need in Malawi

This section looks at the determinants of unmet need for family planning in Malawi. Table 9 shows the results of multi-nomial logistic regression of the effects of socio-demographic, economic and partners' characteristics on unmet need for family planning for spacing and limiting among Malawian women in 2000. Two variables, namely, visited by health worker and currently working were not included in the multi-variate analysis. Only the variables that were found to be significant based on chi square test were included in the multi-nomial logistic regression.

5.4.1 Spacing

The results for unmet need to space indicate that age, type of place of residence, partner education, husband's approval of family planning, discussion of family planning and heard of family planning on TV are significantly related to unmet need for spacing births in Malawi.

Age of the respondents is positively related to unmet need for spacing births. Women in age group 15-19 are 6.8 times more likely to have unmet need for spacing than women in age group 45-49. Women in the age group 20-24 are 5.6 times more likely to have unmet need for spacing than women in the age group 45-49. Women in age group 25-29 are 4.7 times more likely to have unmet need for spacing than women in age group 45-49. Women in age group 30-35 are 4.1 times more likely to have unmet need for spacing than women in age group 45-49. The odd ratios decrease with increasing age of the respondents implying that as the age of the respondent increases, the less likelihood of reporting unmet need for spacing.

Another important determinant of unmet need for spacing births is the type of residence. Women residing in rural areas have higher unmet need for spacing than women residing in urban areas. The results in Table 9 indicate that urban women are 0.7 times less likely to have unmet need for spacing than rural women.

Unmet need for spacing births is also influenced by partner's approval of family planning. Women who reported that their partners approved family planning were 0.5 times less likely to have unmet need for spacing than those who did not know whether husbands approved family planning or not. Furthermore, unmet for spacing is also influenced by partner occupation. Women who reported that their partners were professionals, technicians and managers, were less likely to have unmet need for spacing, than women whose partners were on other occupations.

5.4.2 Limiting

The results for unmet need to limit indicate that age, place of residence, number of children ever born, ideal number of children, husbands' approval of family planning and read of family planning in the newspapers, are significantly related to unmet need for limiting births in Malawi.

Age of the respondents is positively related to unmet need for limit childbearing. Women in age group 15-19 are 0.32 times less likely to have unmet need for limiting than women in age group 45-49. Women in age group 20-24 are 0.31 times less likely to have unmet need for spacing than women in the age group 45-49. Women in age group 25-29 are 0.31 times less likely to have unmet need for limiting than those women in the age group 45-49. Those women in the age group 30-34 are 0.41 less likely to have unmet for limiting than women in the age group 45-49. Women in age group the 35-39 are 0.56 are less likely to report unmet need for limiting than those in the age group 45-49. The odd ratios increase with increasing age of the respondent implying that, as the age of the respondent increases, the likelihood of reporting unmet need to limit childbearing also increases.

Another important determinant of unmet need for limiting child bearing is the number of children ever born. The results in Table 9 indicate that women without children are 0.13 times less likely to have unmet need for limiting compared to women with 4 or more children. On the other hand, women with 1 child is 0.23 times less likely to have unmet need for limiting compared to

Women with 4 or more children whereas women with 2 children are 0.36 times less likely to have unmet need for limiting compared to women with 4 or more children. Women with 2 children are 0.66 times less likely to have unmet need for limiting compared to women with 4 or more children.

Place of residence is positively related to unmet need for limiting children. Women living in urban areas are 0.13 less likely to have unmet for limiting than women living in rural areas.

The ideal number of children also influences unmet need to limit childbearing. Desiring fewer number of children makes women less likely to have unmet need for limiting. Women who desire to have 1 child is 4.08 times less likely to report unmet need for limiting than women who desire 4 or more children women who desire 2 children and is 2.08 times less likely to report unmet need for limiting than women who desire 4 or more children. Women desiring 3 children are 1.6 times less likely to report unmet need to limit the number of children than women who desire 4 or more children. The odds ratio increases with the number of desired children, indicating that the more the number of children desired the higher the likelihood to have unmet need to limit childbearing.

Unmet need for limiting births is also influenced by partner's approval of family planning. Women who reported that their partners disapproved family planning were 0.64 times more likely than those who do not know whether their husbands approved or disapprove of family planning to have unmet need for limiting.

Table 9: Multi-nominal Regression on unmet need for family planning for spacing and limiting among Malawian women in 2000

	Odds Ratio	Spacing		Odds Ratio	Limiting	
		LB	UB		LB	UB
Age						
15-19	6.83**	2.81	16.61	0.32**	0.16	0.62
20-24	5.61**	2.37	13.27	0.31**	0.19	0.49
25-29	4.78**	2.04	11.17	0.31**	0.21	0.47
30-34	4.16**	1.78	9.74	0.41**	0.27	0.61
35-39	3.26**	1.38	7.73	0.56**	0.37	0.83
40-44	1.45	0.56	3.71	0.69	0.45	1.06
45-49 ®						
Province						
North	0.74	0.52	1.05	1.07**	0.69	1.66
Central	1.06	0.85	1.32	1.51**	1.15	1.99
South ®						
Place of residence						
Urban	0.73**	0.60	0.89	0.85	0.66	1.09
Rural ®						
Ethnicity						
Chewa	1.10	0.68	1.78	1.36	0.72	2.57
Tumbuka	1.43	0.91	2.23	1.35	0.75	2.45
Lomwe	1.18	0.71	1.95	1.44	0.74	2.80
Tonga	1.45	0.80	2.63	1.32	0.60	2.88
Yao	0.97	0.58	1.62	1.55	0.80	3.03
Sena	0.93	0.51	1.70	0.66	0.27	1.59
Nkonde	1.20	0.70	2.07	1.03	0.49	2.18
Ngoni	1.04	0.63	1.73	1.52	0.79	2.91
Anyanja	0.90	0.51	1.59	1.79	0.87	3.65
Other ®						
Education						
No education	2.14	0.46	9.95	3.54	0.44	28.56
Primary	2.09	0.46	9.62	3.54	0.44	28.22
Secondary	2.06	0.45	9.56	4.03	0.50	32.56
Higher	1.63	0.27	9.61	2.23	0.21	23.44
Don't know ®						
Respondent working						
NO	1.063	0.923	1.224	1.216	1.023	1.445
Yes (R)						
Partner education						
no education	1.911	0.423	8.631	1.922	0.416	8.888
Primary	1.909	0.427	8.530	1.799	0.394	8.209
Secondary	1.799	0.399	8.115	1.955	0.422	9.053
Higher (R)						
Partner Occupation						
Professionals, Technical and Managerial	0.643*	0.461	0.897	0.864	0.591	1.263
Clerical, Sales	1.075	0.912	1.267	1.202	0.979	1.477

and Services						
Agricultural, Crafts, Trade, Domestic, Manual						
Heard of FP – Radio						
No	0.99	0.846	1.18	1.22	1.006	1.49
Yes ®						
Heard of FP- TV						
No	1.90**	1.28	2.80	1.18	0.77	1.82
Yes ®						
Read about FP-news paper						
No	0.96	0.78	1.17	1.04	0.86	1.34
Yes ®						
Visited by FP worker						
No	1.14	0.94	1.38	1.02	0.81	1.28
Yes						
Visited health facility in past 12 moths						
No	0.986	0.851	1.14	1.08	0.907	1.29
Yes ®						
At health facility told						
No	0.98	0.84	1.15	1.04	0.86	1.26
Yes ®						
CEB						
0	0.46	0.29	0.73	0.13**	0.06	0.31
1	1.13	0.85	1.49	0.23**	0.15	0.37
2	1.12	0.87	1.44	0.36**	0.25	0.52
3	1.08	0.85	1.38	0.66**	0.49	0.89
4 ®						
Ideal no of children						
0	0.44	0.24	0.81	0.20	0.07	0.60
1	0.63	0.27	1.47	4.08**	1.86	8.97
2	0.84	0.66	1.06	2.08**	1.54	2.79
3	0.88	0.72	1.08	1.62**	1.25	2.10
4 ®						
Partner approves of FP						
Disapprove	0.84	0.62	1.13	1.27	0.85	1.90
Approve	0.51**	0.39	0.65	0.64**	0.44	0.92
Don't Know ®						

** = $p < 0.05$

5.5 Summary

This chapter has examined the pattern and trends of unmet need for family planning among women in Malawi. Unmet need for spacing births in Malawi was 19.7, whereas unmet need for limiting births in Malawi was 13.9. The total unmet need for family planning in Malawi was 33.5% in 2000. The results presented in this chapter indicate that unmet need for family planning varies by socio-economic variables. The multi-variate logistic analyses indicate that age of the respondent, type of place of residence, number of children ever born, ideal number of children, partner occupation, partner education, husbands' approval of family planning, discussion of family planning with partners and hearing of family planning on TV, are significantly related to unmet need of family planning in Malawi.

CHAPTER 6: RESULTS AND RECOMMENDATIONS

6.1 Introduction

The purpose of this chapter is to present conclusions as far as the main findings of the study are concerned. A brief summary of the results will be presented. The determinants of unmet need for family planning in South Africa and Malawi are discussed and finally, recommendations based on the findings, will be presented.

6.2 Major Findings

One of the objectives of the study was to determine the level of unmet need for family planning among all women of reproductive age who are sexually active in South Africa and Malawi using the 1998 SADHS and the 2000 MDHS. The results showed that the total unmet need for family planning was 15.0% in South Africa and 33.5% in Malawi. These estimates indicate that total unmet need for family planning is higher in Malawi than South Africa. In addition, for each country, the results indicate that the levels of unmet need for family planning were still high. This situation could be due to poor advocacy of family planning programmes in both countries. In South Africa, the statement is supported by the fact that in 1996 the country was concerned about backstreet abortions which contributed to more deaths due to septic abortions (SABSMM 2000). The Act of Termination of pregnancy was formulated; Act no 92 of 1996, now amended Act, Act no1 of 2008. The persistence of high rates of teenage pregnancies also supports the statement that family planning programmes were not supported (DOH, 2000). In Malawi reports shows that there is high risk of Malawian women dying due to pregnancy and related factors and maternal mortality ratio also increased from 620 per 100,000 live births to 1120 per 100000 live births (Malawian Government, 1992, 2001).

The results also show that in South Africa in 1998 unmet need to limit was higher than unmet need to space in South Africa. On the other hand in Malawi in 2000 unmet need to space was higher than unmet need to limit. Unmet need to space in South Africa is 4.7% in 1998 and unmet need to limit in South Africa is 10.3%. Unmet need to space in Malawi is 19.7% and unmet need to limit in Malawi is 13.9%. These statistics suggest that women in South Africa would like to limit childbearing whereas the issue of limiting childbearing is still minimal in Malawi.

Another objective of the study was to examine the relationship between background variables and unmet need for family planning in the two countries under study. The findings of the study indicate that unmet need for family planning varies by background variables. For example unmet need for spacing decreases with age and those limiting births increases with age.

The last specific objective of the study was to identify the determinants of unmet need for family planning in South Africa 1998 and Malawi 2000. This was done using multinomial regression analyses. The results of multinomial regression models show that age of the respondent, population group, respondent's marital status, and children ever born were predictors of unmet need to space among all women of the reproductive age in South Africa, while age, region, respondent's marital status, respondent's educational level, ideal number of children and children ever born were predictors of unmet need to limit. In Malawi, age, approval of FP by partner/husband is the most predictors of unmet need to space. Age, type of place of residence, ideal number of children, husband approval of FP, district and children ever born, are the most predictors of unmet need to limit in Malawi.

6.3 Discussions

Age was identified as an important determinant of unmet need for both South Africa and Malawi (space and limit). Generally, high levels of unmet need to space were found between ages 15-19, 20-24 and 25-29 years. Those in the age group 20-29 were more likely to have unmet need to space when compared with those in the 15-19 age group. Those in age 20-29 are in tertiary institutions and had to concentrate in their education not on child bearing. High level of unmet need to limit was found to be high in age group 30-49. Women in the age-group 45-49 have reached their desired family size so they are more concerned with the use of contraception in order to limit their births.

In both countries, South Africa and Malawi, women in rural areas were found to have high levels of unmet need of family planning (space and to limit). The reason for these results may be that women who reside in rural areas are in the poor, less educated, ignorant and have limited access to health services. This is also supported by studies made in other Sub-Saharan countries that showed that rural women had significantly higher unmet need compared to urban women. For instance, urban-rural disparity was observed in the following countries: Kenya, Lesotho, Tanzania and Uganda (Assefa et al, 2011).

In South Africa unmet need for spacing and limiting was high amongst the Black/African population as compared to other racial groups. The likely reasons are poor access to family planning, attitude to the use of contraception, poverty, low levels of education and cultural beliefs. For instance, most Africans believe that the duty of an African woman is child bearing and child rearing. Unmet need of family planning was also found to be influenced by province/region of residence in both countries. Unmet need was found to be high in all the provinces of the South Africa, except in Northern Cape, where there are low levels of unmet need of both to space and to limit. In Malawi, Central Region was reported to be having high unmet need to limit than in the Northern and Southern Regions. The results are similar to what is

found in other African countries. A study in Kenya found out that unmet need to space and to limit was highest in Western Province, while in 2003, unmet need to space and to limit was high in Nyanza province (Westoff, 2006). This could be related to the differences in the availability and accessibility of family planning facilities including the distance to the health care centre in these areas. Currently married and never married women in South Africa had high levels of unmet need to space and to limit than those who were formerly married. Most of the common reasons given by married women for not using contraception are associated with access to supplies and services. Concerns about side effects, health effects and inconvenience of methods can also be reasons.

The level of education of the women in South Africa has an impact on unmet need for family planning. Both women who had no education and those with primary education were found to have high levels of unmet need to space and to limit. The higher the educational level, the better the attitude toward the uptake of family planning. This was evidenced by the fact that women with higher educational level had low levels of unmet need to space and to limit. Another study which was conducted in Uganda indicated that unmet need for family planning was lower for women with secondary or higher education and higher in women with no education and primary education (Assefa, 1999). A study in Kenya (2008) indicated that women with primary incomplete education were 2 times more likely to experience unmet need for family planning compared to those with primary or higher education (Koorra, 2002). The possible explanation for this could be that women empowered through education have better access to health facilities and information about modern education. In addition, unmet need progressively declined with increasing level of women's education (Hogan et al, 1999).

Regarding the respondent's occupation, women who were employed were significantly less likely to report unmet need for spacing and limiting in South Africa when compared to those unemployed. This may be related to the fact that more time is given to employment responsibilities rather than in the home

environment. In the working environment more information relating to reproductive decision is shared within the working women's networks.

Partner's /husband's education in South Africa also influences the reporting of unmet need for family planning women. Women whose partners/husbands were having higher educational levels were less likely to have unmet need for family planning. Husband's educational status determines the level of understanding during partner discussions concerning the use of contraception. If the husband has clear understanding about the importance of using contraception, the wife will be in a better position to use contraception. Those women whose husbands are less educated will have unmet need for family planning because the husband may refuse her to use contraception because of lack of understanding.

Partner's /husband's approval for family planning significantly influences the reporting of unmet need for family planning among Malawian and South African women. Women whose husbands approved of family planning were less likely to report unmet need for spacing and limiting. This means that partners/husbands and men in general are still relevant in decision-making process regarding the uptake of family planning. Again in a study of Ethiopia, women who believed that their husbands / partners approved of family planning have a lower unmet need than women who believed that their husband disapproved of the use of contraceptives, or women who are unaware of their husband's attitude towards family planning. Use of contraceptives is much higher among women who believe that they have their husband's support (Omrana et al, 2001).

In both Malawi and South Africa, unmet need for family planning is also influenced by the type of employment the partner/ husband is occupying. Unmet need for family planning was highly reported by women whose partners/husbands were in agricultural, trade, domestic and manual in South Africa and in Malawi those women whose partners were in professional, technical and managerial were less likely to report unmet need than women whose husbands were in other occupations.

The ideal number of children and children ever born were found to be determinants of unmet need for family planning in both Malawi and South Africa. Women who wanted to have three or more than four children reported high unmet need to limit, whereas women who had four children were more likely to have unmet need to limit. A study conducted in Ethiopia also revealed that as women's ideal number of children increases, so does their unmet for spacing. Women whose ideal number of children is 3 to 4 and above are twice as likely to have an unmet need for spacing (Koorra, 2002).

Media exposure in Malawi is significant only with respect to the unmet need for spacing. Women who did not hear of family planning on TV were more likely to report unmet need to space than those who heard of family planning on TV. This is also evidenced in an Ethiopian study where women who have been exposed to the media were 80% less likely to have an unmet need for spacing as women with no exposure (Korra, 2002).

6.4 Recommendations

Based on the above findings, interventions aimed at meeting the unmet need for family planning in both countries are required. To achieve this, the following recommendations are made:-

First, age of a woman has been identified as a determinant of unmet need in this study. It is therefore recommended that all women of child bearing age be provided with full access to family planning services as this will be instrumental in reducing unmet need. In this regard barriers that present women of specific age groups should be eliminated. Health workers also play the most important role in educating young people about contraception and pregnancy prevention, this will promote and strengthen youth friendly reproductive health services ensuring a supportive healthcare system for young people.

Secondly, in order to reach larger communities with provision of family planning methods, community based programmes should be employed mostly to the rural areas. This involves community health care workers who will work most of their time in the community. There should be a strong working relationship between the health professionals and the community health care workers. Community health care workers should complement health professionals in providing door-to-door education and distributing short acting methods such as condoms and pills. The community health care workers can also play a role in engaging men in family planning issues. These community health care workers will also identify the defaulters, giving out family planning messages using known languages and identify other barriers to the use of family planning and be taken to health professionals to address them.

Thirdly, education contributes significantly to the quality of women's lives, therefore improving Women's and men's access to education and encouraging continuous and constant exposure would significantly increase use of family planning and reduce unmet need.

Forth, provinces/regions with high total unmet need should benchmark from those provinces/regions that are performing better with respect to access and availability of family planning methods, and also on how they manage the family planning programme. An example is the Western Cape which seems to be doing better when compared to other provinces.

Fifth, men's involvement in family planning decision-making is also important in improving the reproductive behaviour of women. Spousal communication is also important in bridging the gap between met and unmet need.

Sixth, family planning messages should be accessible in all media or be strengthened to reach all women and men. The media should use local languages so that the readers and the listeners can be able to access information. This can also improve the visitation to the health facilities to hear more about family planning. Adult education can also be encouraged to enlighten those who have no education and those with primary education. This can help them to make sound decision-making on their health issues.

Seventh, missed opportunities could be minimised with increased effort on the part of service providers at the institutional level. Service providers have to be encouraged and be provided with the necessary training and motivation to effectively promote family planning in health facilities on a regular basis.

Lastly, more studies should be conducted to investigate the characteristics of women who use and do not use family planning and other reproductive health services. Future studies should not only be multidisciplinary but also qualitative in nature. Qualitative research is the most appropriate method to explore the wide range of views, attitudes, perceptions and experiences of individual's point of view and perspective (Silverman, 2005). Furthermore,

Silverman (2005) noted that "some researchers believe that qualitative method can provide a deeper understanding of social phenomena than would be obtained from purely quantitative data".



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