

CHAPTER 9. REPRODUCTIVE HEALTH

This chapter presents the 2007 RMIDHS findings on the general state of reproductive health. It covers women's utilization of antenatal, delivery, and postpartum care – that is, the findings from several areas of importance to reproductive and women's health: antenatal, delivery, and postnatal care, and general access to health services.

Information on antenatal, delivery, and postnatal care is of great value in identifying subgroups of women who do not utilize such services, and is useful in planning for improvements in service delivery. Information on antenatal care (ANC) is shown according to the number of ANC visits made, the stage of pregnancy at the time of the first visit, the type of provider, and the specific services and information provided during antenatal visits, including whether tetanus toxoid was received. Similarly, delivery services are described according to the place of delivery, the type of person assisting the delivery, and the rate of caesarean section. Information on postnatal care is shown by whether a woman delivered in a health facility or elsewhere, and describes the time since delivery of the first postnatal care and from whom it was received. This information helps identify population groups who are underserved with maternity care services. Selected general health information for women is also presented in this chapter: namely, their access and barriers to use of health services.

The results of the 2007 DHS are very important in evaluating reproductive health programs and their achievements based on the action plan agreed upon at the 1994 International Conference on Population and Development in Cairo, Egypt. The findings also provide an evaluation of interventions by other sectors to improve quality of care, service utilization, and the health of mothers.

9.1. ANTENATAL CARE

The major objective of ANC is to identify, treat, and prevent problems during pregnancy, such as anemia, infections, and potential life-threatening conditions. It is during an ANC visit that screening for complications and advice on a range of issues, including place of delivery and referral of mothers with complications, occur. In the RMIDHS, interviewers recorded the source of ANC and the person who provided that care for women's most recent births. If a woman received ANC from more than one provider, the provider with the highest qualifications was recorded. Table 9.1 shows the background characteristics of women who had live births in the five years preceding the survey according to the type of ANC provider.

The results indicate that 95 percent of women received ANC from a skilled provider. Most women sought care from a doctor (70 percent), 14 percent received care from a health assistant/personnel, and 12 percent received care from a nurse or midwife. Less than 1 percent (0.3 percent) of women received ANC from a traditional birth attendant (TBA) as their most qualified provider. About 5 percent of women who gave birth in the five years preceding the survey received no ANC.

Data in Table 9.1 further indicate that the choice of ANC provider varies slightly by the mother's age. Mothers aged 35–49 are less likely than younger mothers to receive ANC from a skilled provider (87 percent compared with 96 percent for mothers younger than 20). First- to third-order births are most likely to receive ANC, while fourth- and higher-order births are least likely to receive ANC.

Almost all women in both urban and rural areas receive ANC from a skilled provider (95 percent). Mothers in urban areas are more likely than mothers in rural areas to receive ANC from a doctor (80 percent compared with 50 percent).

In RMI, ANC coverage is not strongly associated with a woman's education. Better-educated women are almost equally likely to have ANC as less educated women; however, they are more likely to be attended to by a doctor than less educated women are. Eighty-nine percent of women who have attained 'more than secondary' education receive ANC from a doctor; the corresponding proportion for women with no or

primary education is 64 percent. Further to this, 3 percent of women with no education receive no ANC compared with only 1 percent who have ‘more than secondary’ education.

Table 9.1. Antenatal care

Percent distribution of women aged 15–49 who had a live birth in the five years preceding the survey by ANC provider during pregnancy for the most recent birth and the percentage receiving ANC from a skilled provider for the most recent birth, according to background characteristics, Marshall Islands 2007

Background characteristic	Doctor	Nurse/ midwife	Health assistant/ personnel	Traditional birth attendant	Other	No one	Total	Percentage receiving ANC from a skilled provider ¹	Number of women
Mother's age at birth									
<20	69.5	11.1	15.1	0.0	0.0	4.3	100.0	95.7	125
20–34	69.1	12.4	14.2	0.4	0.1	3.7	100.0	95.7	568
35–49	72.4	7.9	7.0	0.0	1.9	10.9	100.0	87.3	82
Birth order									
1	73.1	11.7	11.1	0.0	0.0	4.1	100.0	95.9	186
2–3	69.8	11.5	15.5	0.0	0.0	3.2	100.0	96.8	292
4–5	64.8	12.2	14.3	1.2	0.8	6.8	100.0	91.2	193
6+	71.3	11.4	11.4	0.0	0.6	5.3	100.0	94.1	103
Residence									
Urban	80.3	14.1	0.5	0.3	0.2	4.6	100.0	94.9	502
Rural	49.6	7.3	37.7	0.2	0.5	4.6	100.0	94.7	272
Mother's education									
No education/ primary	63.8	12.9	19.9	0.0	0.7	2.7	100.0	96.6	178
Secondary	68.4	12.1	13.1	0.5	0.2	5.8	100.0	93.6	515
More than secondary	89.4	6.4	3.2	0.0	0.0	1.0	100.0	99.0	81
Wealth quintile									
Lowest	52.0	7.8	33.5	0.3	0.7	5.7	100.0	93.2	189
Second	61.4	12.4	21.4	0.0	0.0	4.8	100.0	95.2	188
Middle	79.0	15.1	1.4	0.0	0.6	4.0	100.0	95.4	150
Fourth	80.9	12.3	0.0	0.0	0.0	6.8	100.0	93.2	132
Highest	85.9	11.9	0.0	1.5	0.0	0.7	100.0	97.8	116
Total	69.5	11.7	13.6	0.3	0.3	4.6	100.0	94.8	774

Note: If more than one source of ANC was mentioned, only the provider with the highest qualifications was considered in this tabulation.

¹ Skilled provider includes doctor, nurse, midwife, and health assistant/personnel.

Women in the highest wealth quintile are slightly more likely to receive ANC from a skilled provider (98 percent) than women in the lowest wealth quintile (93 percent). They are especially more likely to receive ANC from a doctor: 86 percent compared with 52 percent of women in the lowest wealth quintile.

9.1.1. Number of antenatal care visits and timing of the first visit

In line with World Health Organization (WHO) guidelines, the RMI Ministry of Health recommends that a woman who is having a normal pregnancy attend four ANC visits, the first of which should take place during the first trimester. Information on ANC visits and the stage at which pregnant women seek ANC is presented in Table 9.2. More than 70 percent of women (77 percent) attend four or more visits for ANC; thus, more than three-quarters attend the number of ANC visits recommended by WHO standards.

Table 9.2 further shows that a high proportion of pregnant women (43 percent) attend their first visit during the first three months of pregnancy. Twenty-nine percent of women make their first ANC visit during the fourth or fifth month of pregnancy, while 19 percent make their first visit during the sixth month of pregnancy or later. The median gestational age at which women make their first visit is 4.3 months, when the opportunity may have passed to diagnose problems early, provide treatment, or prevent further complications.

Table 9.2. Number of antenatal care visits and timing of first visit

Percent distribution of women aged 15–49 who had a live birth in the five years preceding the survey by number of ANC visits for the most recent live birth and by the timing of the first visit, and among women with ANC, median months pregnant at first visit, according to residence, Marshall Islands 2007

Number and timing of ANC visits	Residence		Total
	Urban	Rural	
Number of ANC visits			
None	4.6	4.6	4.6
1	0.9	4.1	2.0
2–3	12.7	11.7	12.3
4+	76.6	78.1	77.1
Don't know/missing	5.3	1.5	3.9
Total	100.0	100.0	100.0
Number of months pregnant at time of first ANC visit			
No antenatal care	4.6	4.6	4.6
<4	43.0	42.4	42.8
4–5	30.4	25.7	28.8
6–7	18.7	19.6	19.0
8+	2.3	7.6	4.2
Don't know/missing	1.0	0.1	0.7
Total	100.0	100.0	100.0
Number of women	502	272	774
Median months pregnant at first visit (for those with ANC)	4.3	4.4	4.3
Number of women with ANC	479	260	739

9.1.2. Quality of antenatal care

The Sexual and Reproductive Health Policy Guidelines for RMI (MOH 2006) provide details of what is to be done by a health service provider during ANC. Some health workers have been trained to offer this package. Table 9.3 shows the percentage of mothers who received ANC by content of ANC and background characteristics. The results show that not all women received the minimum package. Over two-thirds of women (71 percent) who gave birth in the five years preceding the survey took iron tablets or syrup during their last pregnancy. Over 9 out of 10 women (92 percent) who received ANC for their most recent birth in the past five years had their weight measured during the pregnancy. Over 90 percent (93 percent) had their blood pressure measured, and over half (53 percent) received information on how to recognize signs of problems during pregnancy. A urine sample was taken from 85 percent of women with

ANC while a blood sample was taken from the same proportion of women (85 percent). Meanwhile, a small percentage (5 percent) were given drugs for intestinal parasites.

Table 9.3. Components of antenatal care

Among women aged 15–49 with a live birth in the five years preceding the survey, the percentage who took iron tablets or syrup and drugs for intestinal parasites during the pregnancy of the most recent birth, and among women receiving ANC for the most recent live birth in the five years preceding the survey, the percentage receiving specific antenatal services, according to background characteristics, Marshall Islands 2007

Background characteristic	Among women with a live birth in the last five years, the percentage who during the pregnancy of their last birth:		Number of women with a live birth in the last five years	Among women who received ANC for their most recent birth in the last five years, the percentage with selected services:					Number of women with ANC for their most recent birth
	Took iron tablets or syrup	Took intestinal parasite drugs		Informed of signs of pregnancy complications	Weighed	Blood pressure measured	Urine sample taken	Blood sample taken	
Mother's age at birth									
<20	73.7	4.3	125	52.1	88.9	88.6	83.3	83.5	119
20–34	71.8	5.3	568	53.8	92.7	93.1	84.5	85.0	547
35–49	58.1	6.4	82	52.6	93.5	95.1	88.5	86.9	73
Birth order									
1	74.1	3.7	186	56.7	91.8	91.8	86.8	88.0	178
2–3	76.4	4.4	292	54.4	91.5	90.5	84.0	83.5	283
4–5	63.1	5.7	193	48.9	92.4	94.9	83.9	84.6	180
6+	62.4	9.4	103	53.2	94.6	95.8	84.6	83.9	98
Residence									
Urban	62.3	6.0	502	59.0	99.0	98.7	98.8	99.5	479
Rural	86.1	3.8	272	43.2	79.6	81.2	58.8	58.0	260
Mother's education									
No education/primary	69.5	4.2	178	50.6	88.8	91.5	76.6	77.2	173
Secondary	70.3	5.5	515	54.8	92.4	92.1	85.6	85.7	486
More than secondary	75.8	5.6	81	51.2	98.4	97.5	96.7	96.7	80
Wealth quintile									
Lowest	78.2	2.2	189	48.4	77.5	80.0	58.6	57.9	178
Second	67.6	7.6	188	42.7	91.1	90.9	79.8	80.7	179
Middle	74.6	7.7	150	57.1	100.0	100.0	99.3	99.3	144
Fourth	55.2	5.8	132	63.5	98.5	97.5	99.1	99.1	123
Highest	75.9	2.4	116	62.6	100.0	100.0	99.1	100.0	115
Total	70.7	5.2	774	53.4	92.2	92.6	84.7	84.9	739

The differences in the content of ANC by background characteristics are shown in Table 9.3. In general, the majority of women who received ANC services with their most recent births tended to get only three of the ANC interventions. Women in urban areas were much more likely to receive all of these key ANC services than rural women, with the exception of iron tablets or syrup, which rural women were more likely to take (86 percent compared to 62 percent). In general, women with 'more than secondary' education and those in higher wealth quintiles were also more likely than other women to receive key ANC services.

9.1.3. Tetanus toxoid immunization

Neonatal tetanus is a leading cause of neonatal death in developing countries where a high proportion of deliveries are conducted at home or in places where hygienic conditions may be poor. Tetanus toxoid (TT) immunization is given to pregnant women to prevent neonatal tetanus. If a woman has received no previous TT injections, for full protection a pregnant woman needs two doses of TT during pregnancy. However, if a woman was immunized before she became pregnant, she may require only one or no TT injections during pregnancy, depending on the number of injections she has ever received and the timing of the last injection. For a woman to have lifetime protection, a total of five doses is required.

Table 9.4. Tetanus toxoid injections

Among mothers aged 15–49 with a live birth in the five years preceding the survey, the percentage receiving two or more tetanus toxoid injections during the pregnancy for the last live birth and the percentage whose last live birth was protected against neonatal tetanus, according to background characteristics, Marshall Islands 2007

Background characteristic	Percentage receiving two or more injections during last pregnancy	Percentage whose last birth was protected against neonatal tetanus ¹	Number of mothers
Mother's age at birth			
<20	13.4	23.6	125
20–34	20.3	40.4	568
35–49	26.2	38.2	82
Birth order			
1	16.1	21.1	186
2–3	22.2	44.5	292
4–5	16.1	41.5	193
6+	26.7	39.3	103
Residence			
Urban	25.8	47.1	502
Rural	8.8	19.7	272
Mother's education			
No education/primary	16.4	26.5	178
Secondary	21.1	40.6	515
More than secondary	19.4	41.7	81
Wealth quintile			
Lowest	7.7	20.7	189
Second	12.9	27.7	188
Middle	28.2	47.7	150
Fourth	31.0	46.6	132
Highest	27.0	56.9	116
Total	19.8	37.5	774

¹ Includes mothers with two injections during the pregnancy of their last birth, or two or more injections (the last within three years of the last live birth), or three or more injections (the last within five years of the last birth), or four or more injections (the last within 10 years of the last live birth), or five or more injections prior to the last birth

The 2007 RMIDHS collected data on whether or not women received at least two TT injections during pregnancy and whether or not the pregnancy was protected against neonatal tetanus for women's most recent live birth in the five years preceding the survey. Table 9.4 shows that only one in every five (20 percent) pregnant women received two or more TT injections during her last pregnancy. However, over one-third (38 percent) of women had their last pregnancy protected against neonatal tetanus due to their previous immunization history.

Older women and women pregnant with higher-order births are more likely to receive two TT injections during their pregnancy. The likelihood of having a pregnancy that is protected against neonatal tetanus

does not decline with mother's age at birth, and women who are pregnant with their first child are actually less likely to have their pregnancy protected against neonatal tetanus than women with higher-order pregnancies. Previous pregnancies as well as increasing age may expose women to opportunities to receive TT injections that also contribute to protecting their later pregnancies. Therefore, older and higher-parity women may be less likely to require two TT injections during pregnancy in order for their pregnancies to be protected against neonatal tetanus.

Women in urban areas are more likely to have their last pregnancy protected against neonatal tetanus than rural women (47 percent versus 20 percent). The proportion of women *who received two or more injections during their last pregnancy* was higher in urban areas than rural areas (26 percent compared to 9 percent). The likelihood of having the last pregnancy protected against neonatal tetanus increases with educational attainment. Likewise, the likelihood of having the last pregnancy protected against neonatal tetanus increases with the level of household wealth.

9.2. CHILDBIRTH CARE

Some of the factors associated with birth outcome include the place where the mother delivers the baby, the disinfection practices used there, the equipment available, and the skills and performance of those who assist the woman. Table 9.5 shows the percent distribution of live births in the five years preceding the survey by place of childbirth and by background characteristics of the mother.

Overall, 85 percent of births occurred at health facilities; only 13 percent of births took place at home. According to Table 9.5, births to younger women and low-order births are more likely to take place in a health facility than births to older women and higher-order births. For example, 81 percent of births to mothers aged 35–49 took place at a health facility, whereas the corresponding figure for births to women under 20 years old is 83 percent. Similarly, 89 percent of first-order births occurred at health facilities, compared with 80 percent of sixth- and higher-order births.

ANC attendance is related to place of childbirth. Births to women who make four or more ANC visits are more likely to occur in a health facility than births to women who do not attend ANC (85 percent and 74 percent).

Table 9.5. Place of delivery

Percent distribution of live births in the five years preceding the survey by place of delivery and percentage delivered in a health facility, according to background characteristics, Marshall Islands 2007

Background characteristic	Health facility		Home	Other	Missing	Total	Percentage delivered in a health facility	Number of births
	Public sector	Private sector						
Mother's age at birth								
<20	78.6	4.2	14.5	1.8	1.0	100.0	82.8	212
20–34	82.8	3.2	12.7	1.0	0.3	100.0	86.0	864
35–49	81.3	0.0	16.0	2.7	0.0	100.0	81.3	97
Birth order								
1	84.7	4.1	7.9	2.3	1.0	100.0	88.9	317
2–3	80.8	2.7	15.4	1.0	0.1	100.0	83.5	449
4–5	81.8	3.7	14.2	0.0	0.3	100.0	85.5	273
6+	79.3	0.9	17.4	2.4	0.0	100.0	80.2	134
Residence								
Urban	90.3	4.4	3.4	1.4	0.4	100.0	94.7	751
Rural	67.1	0.8	30.8	0.9	0.3	100.0	67.9	422
Mother's education								
No education/primary	74.3	1.1	24.1	0.5	0.0	100.0	75.4	271
Secondary	83.9	2.9	11.2	1.5	0.6	100.0	86.7	794
More than secondary	87.0	10.1	1.2	1.7	0.0	100.0	97.0	108
Antenatal care visits¹								
None	74.3	0.0	25.7	0.0	0.0	100.0	74.3	36
1–3	84.5	5.1	10.4	0.0	0.0	100.0	89.6	111
4+	81.3	3.9	13.2	1.5	0.0	100.0	85.2	597
Don't know/missing	(84.3)	(0.0)	(15.7)	(0.0)	(0.0)	100.0	(84.3)	31
Wealth quintile								
Lowest	66.7	1.2	31.6	0.0	0.5	100.0	67.9	298
Second	83.1	0.0	16.1	0.6	0.2	100.0	83.1	286
Middle	92.0	2.7	2.8	2.2	0.4	100.0	94.7	234
Fourth	91.7	4.1	2.6	0.8	0.8	100.0	95.9	189
Highest	82.0	11.3	2.7	4.0	0.0	100.0	93.3	165
Total	81.9	3.1	13.3	1.3	0.4	100.0	85.1	1,173

Note: Figures in parentheses are based on 25–49 unweighted cases.

¹ Includes only the most recent birth in the five years preceding the survey

The proportion of births occurring in a health facility is much higher in urban areas (95 percent) than in rural areas (68 percent). Meanwhile, births to mothers with ‘more than secondary’ education are more likely to occur in a health facility than births to women with no or primary education (97 percent and 75 percent). A woman’s wealth status also has a direct relationship with the place she gives birth to her baby. In general, the proportion of births in a health facility increases incrementally with each rising wealth quintile.

9.2.1. Assistance during childbirth

In addition to place of birth, assistance during childbirth is an important variable that influences the birth outcome and the health of the mother and the infant. This is because the skills and performance of the birth attendant determine whether or not he/she can manage complications and observe hygienic practices. Table 9.6 shows the percent distribution of live births in the five years preceding the survey by person providing assistance, according to background characteristics.

Overall, 94 percent of births were assisted by a skilled provider during delivery. Just half of all births (45 percent) were delivered with the assistance of a doctor, 41 percent were assisted by a nurse/midwife, and 8 percent were assisted by a medical assistant/clinical officer. Only about 2 percent of births were assisted by a TBA, while under 1 percent were assisted by relatives or friends. For 0.6 percent of births, the mother did not receive any assistance during childbirth.

Births to younger women and low-order births are more likely to receive assistance during childbirth from a skilled provider than births to other women. Almost all births (97 percent) to urban women were attended by a skilled provider, compared with 90 percent of births to rural women. Women of lower educational backgrounds and in poor wealth quintiles were less likely to receive assistance during childbirth from a skilled provider. Use of a TBA is highest among births to women in the lower quintiles.

Table 9.6. Assistance during delivery

Percent distribution of live births in the five years preceding the survey by person providing assistance during delivery, percentage of birth assisted by a skilled provider and percentage delivered by caesarean section, according to background characteristics, Marshall Islands 2007

Background characteristic	Person providing assistance during delivery							Percentage delivered by C-section	Number of births		
	Doctor	Nurse/ midwife	Health assistant/ personnel	Traditional birth attendant	Relative/ other	No one	Don't know/ missing			Total	Percentage delivered by skilled provider ¹
Mother's age at birth											
<20	45.2	39.8	8.5	2.5	0.9	0.7	2.4	100.0	93.5	9.7	212
20-34	45.4	40.7	8.4	2.0	0.9	0.7	1.9	100.0	94.5	9.7	864
35-49	39.2	49.2	3.0	0.0	0.0	0.0	8.6	100.0	91.4	5.7	97
Birth order											
1	51.0	39.8	5.7	1.9	0.3	0.8	0.6	100.0	96.4	13.5	317
2-3	41.3	42.4	8.7	3.0	1.4	0.6	2.7	100.0	92.4	9.0	449
4-5	46.8	36.7	10.9	1.3	0.6	0.6	3.3	100.0	94.3	5.8	273
6+	38.5	50.3	5.0	0.0	0.9	0.5	4.8	100.0	93.8	7.9	134
Place of delivery											
Health facility	49.8	44.0	5.2	0.1	0.1	0.0	0.8	100.0	98.9	11.0	997
Elsewhere	17.5	26.4	24.1	12.6	4.7	2.2	12.4	100.0	68.0	0.0	171
Residence											
Urban	51.3	45.2	0.2	0.6	0.7	0.7	1.4	100.0	96.7	10.9	751
Rural	33.4	34.2	21.8	4.3	1.2	0.6	4.5	100.0	89.5	6.6	422
Mother's education											
No education/ primary	37.6	41.2	10.5	4.2	1.1	0.1	5.2	100.0	89.3	4.3	271
Secondary	45.5	41.5	8.0	1.4	0.7	0.9	1.9	100.0	95.0	10.5	794
More than secondary	58.4	39.4	1.4	0.0	0.8	0.0	0.0	100.0	99.2	13.7	108
Wealth quintile											
Lowest	32.6	35.2	20.2	3.7	1.4	0.3	6.5	100.0	88.0	5.5	298
Second	35.9	46.0	11.6	2.9	0.4	0.5	2.7	100.0	93.6	7.7	286
Middle	53.5	43.4	0.0	1.5	1.2	0.4	0.0	100.0	96.9	10.4	234
Fourth	57.6	39.0	0.0	0.0	1.0	1.2	1.1	100.0	96.6	9.7	189
Highest	55.6	43.4	0.0	0.0	0.0	1.0	0.0	100.0	99.0	17.1	165
Total	44.9	41.3	8.0	1.9	0.8	0.6	2.5	100.0	94.1	9.3	1,173

Note: If the respondent mentioned more than one person attending during delivery, only the most qualified person is considered in this tabulation. Total includes five births with missing information on the place of delivery, which are not shown separately.

¹ Skilled provider includes doctor, nurse, midwife and health assistant/personnel.

Figure 9.1. Level of assistance by skilled provider during childbirth

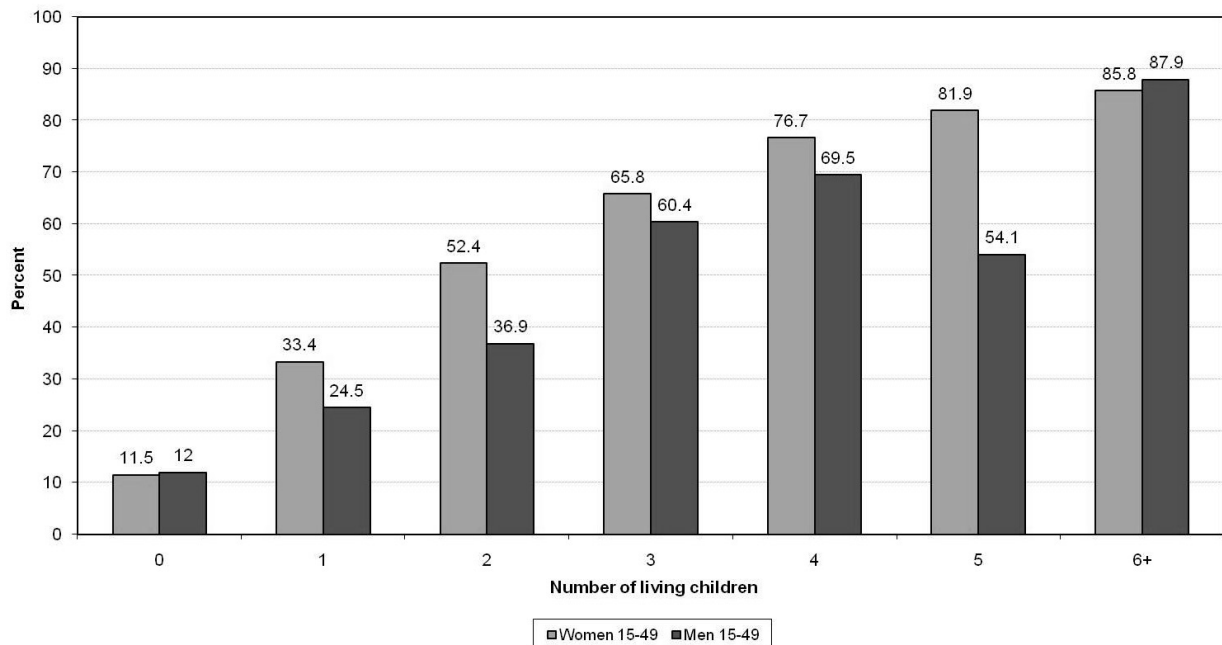


Figure 9.1 shows that women who have attained ‘more than secondary’ education are more likely to be assisted at childbirth by a skilled provider than women with no or primary education (99 percent compared with 89 percent). The likelihood of receiving skilled attendance at birth increases with wealth quintile, from 88 percent of births in the lowest quintile to 99 percent in the highest.

Table 9.6 also presents data on prevalence of births by caesarean section. Overall, 9 percent of births were delivered by C-section. C-sections were more common among first births, births to women in urban areas, and births to women with higher education. The results show inequity across wealth quintiles in access to C-section, with 6 percent of births to women in the lowest wealth quintile occurring by C-section compared with 17 percent of births to women in the highest wealth quintile.

9.3. POSTPARTUM CARE

Postpartum care is important for both the mother and the child to treat complications arising from the delivery as well as to provide the mother with important information on how to care for herself and her child. The postpartum period, also known as the puerperium, is defined as the time between delivery of the placenta and 42 days (six weeks) following delivery. The timing of postpartum care is important. The first two days after delivery are critical, since most maternal and neonatal deaths occur during this period. The RMI MOH recommends that a mother should attend postpartum care during the puerperal period to check complications that may arise in her health. Through provision of integrated services, the MOH recommends that mothers receive postpartum care when they bring their infants for immunization.

In the 2007 RMIDHS, the timing of the first postpartum checkup was assessed among women who gave birth in the five years preceding the survey. Table 9.7 shows the timing of the first postpartum checkup by background characteristics. The table indicates that 21 percent of women did not receive postpartum care. Sixty-four percent of women received postpartum care within the first two day. Women in the age group 20–34, women with higher-order births, rural women, less educated women, and those in the highest wealth quintile are more likely to get postpartum care than other women.

Table 9.7. Timing of first postnatal checkup

Among women aged 15–49 giving birth in the five years preceding the survey, the percent distribution of the mother's first postnatal checkup for the last live birth by time after delivery, according to background characteristics, Marshall Islands 2007

Background characteristic	Timing after delivery of mother's first postnatal checkup					No postnatal checkup ¹	Total	Number of women
	Less than 4 hours	4–23 hours	2 days	3–41 days	Don't know/missing			
Mother's age at birth								
<20	36.3	8.0	14.4	13.2	2.8	25.3	100.0	125
20–34	40.7	3.9	19.7	14.3	2.0	19.4	100.0	568
35–49	44.0	0.8	21.1	9.4	0.0	24.7	100.0	82
Birth order								
1	37.1	6.1	16.1	17.2	2.7	20.8	100.0	186
2–3	39.8	4.3	18.9	12.1	1.3	23.6	100.0	292
4–5	45.0	2.7	19.5	12.8	2.0	18.0	100.0	193
6+	39.3	3.3	23.5	12.6	2.3	19.0	100.0	103
Residence								
Urban	41.8	4.2	15.1	13.8	2.6	22.4	100.0	502
Rural	37.6	4.2	26.2	13.1	0.8	18.1	100.0	272
Education								
No education/primary	36.5	4.3	20.4	13.3	0.7	24.9	100.0	178
Secondary	42.9	4.4	19.3	13.1	1.7	18.5	100.0	515
More than secondary	32.5	2.6	14.3	17.2	6.0	27.3	100.0	81
Wealth quintile								
Lowest	35.8	3.6	22.6	13.0	1.1	23.9	100.0	189
Second	32.4	6.3	20.8	15.7	0.0	24.8	100.0	188
Middle	39.8	3.6	18.6	13.3	4.4	20.4	100.0	150
Fourth	54.0	1.7	15.4	11.6	1.8	15.6	100.0	132
Highest	45.8	5.6	15.0	13.6	3.5	16.5	100.0	116
Total	40.4	4.2	19.0	13.6	1.9	20.9	100.0	774

¹ Includes women who received a checkup after 41 days

9.3.1. Type of provider for the first postpartum checkup

The type of provider for postpartum care was assessed. This is important because the skills of a provider determine the ability to diagnose problems and to recommend appropriate treatment or referral. Table 9.8 shows that 66 percent of women received postpartum care from a doctor, nurse, or midwife, while 7 percent received postpartum care from other cadres of health professionals. Three percent of women received postpartum care from a TBA. Generally, women in the age category 20–34, those who gave birth to their first child, urban women, those with secondary education and above, and those in the highest wealth quintile are more likely to receive postpartum care from skilled professionals. Use of a doctor, nurse, or midwife for postpartum care in rural areas (52 percent) is very much lower than the national average of 66 percent; however, greater use of other health assistants or personnel for postpartum care (19 percent of women) and TBAs (5 percent) in rural areas increases the **proportion of women with any postpartum care** to almost equal the national average.

Table 9.8. Type of provider of first postnatal checkup

Among women aged 15–49 giving birth in the five years preceding the survey, the percent distribution by type of provider of the mother's first postnatal health check for the last live birth, according to background characteristics, Marshall Islands 2007

Background characteristic	Type of health provider of mother's first postnatal checkup				No postnatal checkup ¹	Total	Number of women
	Doctor/nurse/midwife	Health assistant/personnel	Traditional birth attendant	Other			
Mother's age at birth							
<20	62.8	6.0	1.5	1.6	25.3	97.1	125
20–34	66.5	7.9	2.8	0.0	19.4	96.7	568
35–49	65.6	1.5	3.5	0.0	24.7	95.3	82
Birth order							
1	71.6	3.8	1.6	0.5	20.8	98.3	186
2–3	62.9	7.5	2.2	0.4	23.6	96.5	292
4–5	65.4	9.5	4.3	0.0	18.0	97.2	193
6+	64.7	6.5	2.8	0.0	19.0	92.9	103
Residence							
Urban	73.3	0.5	1.3	0.2	22.4	97.7	502
Rural	52.0	18.9	5.2	0.4	18.1	94.6	272
Education							
No education/primary	55.8	8.8	5.4	0.1	24.9	95.0	178
Secondary	68.9	7.4	2.1	0.2	18.5	97.1	515
More than secondary	68.4	0.2	0.0	1.2	27.3	97.1	81
Wealth quintile							
Lowest	46.4	17.3	4.1	0.1	23.9	91.8	189
Second	60.9	9.3	3.0	0.5	24.8	98.6	188
Middle	77.0	1.4	1.3	0.0	20.4	100.0	150
Fourth	73.7	0.0	4.0	0.7	15.6	94.0	132
Highest	82.0	1.4	0.0	0.0	16.5	100.0	116
Total	65.8	6.9	2.7	0.3	20.9	96.6	774

¹ Includes women who received a checkup after 41 days

9.3.2. Problems encountered in accessing health care

The 2007 RMIDHS assessed problems encountered in accessing health care. Table 9.9 shows the percentage of women who reported that they had various types of serious problems in accessing health care. Overall, 84 percent of the women reported that they encountered at least one serious problem in accessing health care. Concern that there are no drugs available and concern that there are no service providers available are two equally common constraints to accessing health care, with 78 percent of each reported. The second common constraint to accessing health care is a concern that no female provider is available, with 56 percent of women perceiving this as a problem. Getting money to pay for treatment is the most commonly reported constraint to accessing health care, with 44 percent of women saying getting money is a serious problem. Having to take transport (42 percent) is considered important, followed by distance to the health facility (40 percent). Lesser-reported problems are not wanting to go alone (35 percent) and getting permission to go for treatment, reported by 22 percent of women.

Looking at the results by age and birth order, older women and women with more children are more likely to cite getting money, distance to health facility, having to take transport, concern that no provider is available, and availability of drugs as major problems to accessing health care. Younger women and those with fewer children, on the other hand, are more likely to cite getting permission, getting money for treatment, not wanting to go alone, concern that there is no female provider, concern that no provider is available, and concern that no drugs are available as major problems. Divorced, separated, or widowed women are generally more constrained in getting money for treatment than their currently married and never-married counterparts. By employment status, women who are unemployed are most likely to report having each of the problems asked about in accessing health care, except getting permission to go for treatment. Women who are not employed for cash are usually more likely to also report having most of the problems in accessing health care, including getting money to pay for treatment.

Rural women are more likely than urban women to report having each of the problems asked about in accessing health care. They are especially more likely to report that distance to a health facility and having to take transport are serious problems. Less educated women and those in lower wealth quintiles are more likely to report at least one serious problem in accessing health care than other women. Educational attainment has an especially strong association with reporting getting money for treatment, distance to health facility, and having to take transport as serious problems. By wealth quintile, Table 9.9 shows that women in the highest wealth quintile are much less likely than women in other wealth quintiles to report each of the problems asked about in accessing health care. As expected, the probability of reporting getting money as a barrier to care decreases steadily as wealth quintile increases.

Table 9.9. Problems in accessing health care

Percentage of women aged 15–49 who reported that they have serious problems in accessing health care for themselves when they are sick, by type of problem, according to background characteristics, Marshall Islands 2007

Background characteristic	Problems in accessing health care									
	Getting permission to go for treatment	Getting money for treatment	Distance to health facility	Having to take transport	Not wanting to go alone	Concern no female provider available	Concern no provider available	Concern no drugs available	At least one problem accessing health care	Number of women
Age										
15–19	27.2	46.0	41.4	42.7	52.5	66.7	81.0	80.9	86.0	306
20–34	23.6	43.2	38.8	40.0	34.2	53.1	76.5	76.4	83.6	840
35–49	17.1	45.6	41.8	43.8	25.9	52.7	74.2	74.5	82.0	479
Number of living children										
0	22.0	39.3	36.1	35.0	42.6	58.9	75.4	74.5	81.0	419
1–2	24.7	45.1	40.7	43.5	36.7	54.2	77.1	77.2	84.4	496
3–4	22.6	46.1	40.1	42.5	31.4	52.4	76.7	76.6	84.0	370
5+	19.1	47.9	44.5	46.2	28.1	56.7	77.5	78.5	85.1	340
Marital status										
Never married	22.9	42.0	38.6	38.4	43.0	59.2	78.4	77.8	83.1	383
Married or living together	21.9	44.3	40.3	42.4	32.8	54.2	75.9	75.8	83.2	1,145
Divorced/separated/widowed	25.9	55.7	44.3	46.0	32.7	57.2	79.0	82.1	89.8	97
Employed last 12 months										
Not employed	21.4	45.2	40.6	42.6	39.3	59.8	78.1	77.3	84.9	1,117
Employed for cash	24.5	43.4	39.3	40.0	26.4	46.9	74.0	75.9	81.4	479
Employed not for cash	(22.0)	(30.9)	(37.0)	(31.3)	(23.2)	(32.5)	(65.6)	(63.3)	(68.4)	29
Residence										
Urban	15.5	36.9	29.8	31.5	32.0	51.8	72.2	71.8	78.8	1,106
Rural	36.9	60.3	62.3	63.2	42.1	63.4	86.2	87.1	93.7	519
Education										
No education/primary	29.8	53.3	51.7	52.8	43.1	65.7	80.2	79.4	87.0	427
Secondary	20.9	43.1	38.6	41.0	35.0	55.2	77.6	77.9	84.0	1,016
More than secondary	13.0	30.6	22.0	19.1	18.2	33.4	63.3	63.4	73.0	182
Wealth quintile										
Lowest	37.0	62.7	63.1	64.7	47.1	66.6	86.9	86.5	93.9	350
Second	30.4	61.5	52.7	55.8	35.9	61.2	84.0	85.7	91.5	353
Middle	18.9	42.1	35.3	37.3	32.5	53.0	72.4	70.3	80.6	319
Fourth	16.0	35.9	30.7	30.4	36.9	51.7	75.3	77.0	81.4	306
Highest	5.9	14.0	13.3	14.2	21.6	42.3	61.9	60.8	67.5	298
Total	22.4	44.4	40.2	41.6	35.2	55.5	76.7	76.7	83.6	1,625

Note: Figures in parentheses are based on 25–49 unweighted cases.