

SUMMARY OF FINDINGS

The 2007 RMI Demographic and Health Survey (DHS) is a nationally representative survey of 1,625 women aged 15–49 and 1,055 men aged 15+. The 2007 DHS is the first for the country and one of the four DHSs conducted in the Pacific as part of the Asian Development Bank (ADB)/Secretariat of the Pacific Community (SPC) Pacific Demographic and Health Surveys Pilot Project. The primary purpose of the RMIDHS is to furnish policy-makers and planners with detailed information on fertility; family planning; infant, child and maternal health; nutrition; and knowledge of HIV and other sexually transmitted infections.

FERTILITY

Survey results indicate that the total fertility rate (TFR) for the country is 4.5 births per woman. The TFR in urban areas is much lower than in rural areas (4.1 and 5.2 children respectively).

Education and wealth have a marked effect on fertility, with less educated mothers having more children on average than women with more than secondary-level education and women in the lowest wealth quintile having two more children than women in the highest wealth quintile.

Childbearing starts early and is nearly universal. Marshallese women have an average of 2.4 children by their late twenties and more than five children by the time they reach 50 years.

The initiation of childbearing in the Marshall Islands has not changed much over time, although it seems that there has been a slight increase in age at first birth in recent years. The median age at first birth in Marshall Islands is 20.7 years for women aged 25–29 – the youngest cohort for which a median age can be estimated. The findings further show that women in the highest wealth quintile, urban women, and women who have more than secondary-level education tend to have their first child at a later age than other women. Women with secondary education start having children at least two years later than those with less education (20.3 and 18.6 years respectively).

Marriage patterns are an important determinant of fertility levels in a population. The age at first

marriage for women appears to be slowly increasing in the Marshall Islands. The median age at first marriage has increased from 19.1 years of age among women aged 40–44 to 20.2 years among women aged 25–29. Marshallese women tend to initiate sexual intercourse about two years before marriage, as evidenced by the median age at first intercourse among women aged 20–49 of 17.3 years compared with the median age at first marriage of 19.7 years. Like age at first marriage, age at first sex appears to be very slowly increasing among women in the Marshall Islands. While the percentages of women who had sexual intercourse by exact age 15 are the same or similar among younger cohorts of women and older women, the percentage of women who first had sexual intercourse by exact age 18 is lower among younger cohorts of women than older women.

Men, in contrast, tend to marry several years later than women and initiate sexual activity several years before marriage. The median age at marriage among men aged 20–49 is 22 years, while the median age at first intercourse is 16.5 years. The age at first sex for men has remained relatively constant over the years.

Almost two-thirds of non-first births in the Marshall Islands (32 percent) occur at least 24 months after the birth of the previous sibling, while 72 percent occur within 36 months. The overall median birth interval is 30 months. Birth intervals vary by place of residence: urban women have slightly shorter intervals between births than rural women (29.3 months compared with 31 months).

FAMILY PLANNING

Overall, knowledge of family planning is very high in the Marshall Islands, with 97 percent of all women and 99 percent of all men aged 15–49 having heard of at least one method of contraception. Pills, injectables, condoms and female sterilization are the most widely known modern methods among both women and men.

Sixty-three percent of currently married women have used a family planning method at least once in their lifetime. The modern methods commonly used for family planning by married women are female sterilization, injectables, and pills, with

withdrawal as the most commonly used traditional method.

Modern methods are more widely used than traditional methods, with 59 percent of currently married women using a modern method and 14 percent using a traditional method. The most popular modern method is female sterilization. Married women in urban areas are less likely to use contraception (43 percent) than women in rural areas (48 percent).

Almost all (94 percent) currently married women obtain methods of contraception from public medical sources, while 6 percent obtain their method from other facilities, including private medical services, where 0.5 percent of women obtain their contraceptive method.

Overall, 8 percent of currently married women have an unmet need for family planning services. The need for spacing (3 percent) is lower than the need for limiting (5 percent). If all currently married women who say they want to space or limit the number of children were to use family planning, the contraceptive prevalence rate in the Marshall Islands would increase from 63 percent to 71 percent. Currently, only 45 percent of the demand for family planning is being met.

MATERNAL HEALTH

Ninety-five percent of women who had a live birth in the five years preceding the survey received antenatal care (ANC) from a skilled health professional for their most recent birth. Over three in four (77 percent) women make four or more ANC visits during their pregnancy. The median duration of pregnancy for the first antenatal visit is 4.3 months, indicating that Marshallese women start ANC at a relatively late stage in pregnancy.

Among women who received ANC, over half (53 percent) report that they were informed about how to recognize signs of problems during pregnancy. Weight and blood pressure measurements were taken for 92 percent and 93 percent of women respectively. Urine and blood samples were taken from 85 percent of women. Only 20 percent of women received two or more tetanus toxoid injections during their most recent pregnancy. In the case of an additional 38 percent of women, the baby was protected against neonatal tetanus because of previous immunizations the woman had received.

Over 8 in 10 births occur in a health facility. Overall, 94 percent of births are delivered with the assistance of a trained health professional – that is, a doctor, nurse, midwife, medical assistant, or clinical officer – while only 2 percent are delivered by a traditional birth attendant (TBA). Less than 1 percent (0.8) of births are attended by a relative or some other person, while 0.6 percent of births are delivered without any type of assistance at all.

Postpartum care is extremely high in the Marshall Islands. Only 21 percent of women who had a live birth in the five years preceding the survey received no postnatal care at all, and 64 percent of mothers received postnatal care within the critical first two days after delivery. Seventy-three percent of women received first postnatal care from trained health professionals, while 3 percent were cared for by a TBA.

Concern that there was no female care provider available, no care provider available, and no drugs available were the common problems cited in accessing health care in the Marshall Islands.

CHILD HEALTH

Thirty-four percent of children aged 12–23 months were fully vaccinated at the time of the survey: about 70 percent had received the BCG vaccination and 54 percent had been vaccinated against measles. Because DPT and polio vaccines are often administered at the same time, their coverage rates are expected to be similar. However, differences in coverage of DPT and polio result in part from stock-outs of the vaccines. Over 70 percent of children received the first doses of DPT and of polio. However, only 48 percent of children received the third dose of DPT and only 46 percent received the third dose of polio.

The occurrence of diarrhea varies by age of the child. Young children aged 12–23 months are more prone to diarrhea than children in other age groups. There is not much variation in the prevalence of diarrhea by child's sex. Diarrhea is more common among children who live in households with a non-improved or shared toilet facility than among children who live in households with improved, not shared facilities. Surprisingly, diarrhea is common among children who live in households with an improved source of drinking water. Although there is not much

difference, rural children are more likely than urban children to get sick with diarrhea (10 percent versus 9 percent). The pattern of prevalence of diarrhea by mother's level of education is not clear, while the prevalence of diarrhea generally decreases as wealth quintile increases – however, this is not clear.

Almost three in four (70 percent) children with diarrhea were treated with some kind of oral rehydration therapy (ORT) or increased fluids. About 4 in 10 children (38 percent) were treated with oral rehydration salt (ORS) prepared from an ORS packet, 13 percent were given recommended home fluids, and 43 percent were given increased fluids.

ORPHANHOOD

Over 4 in 10 Marshallese households included one or more children who stayed with neither their natural father nor their natural mother. A higher percentage of households with foster children was found in rural areas than in urban areas (50 percent compared with 44 percent). Only 1 in 10 Marshallese households contains orphans. There are more households with single orphans (8 percent) than with double orphans (1 percent). No major variations exist between rural and urban households regarding households with orphans.

About 6 out of 10 (56 percent) Marshallese children aged less than 18 years live with both parents, while 13 percent live with their mother and not with their father even though the father is alive somewhere. Female children aged 0–9 years living in rural areas are more likely to be found living with their mothers.

Marshallese children not living with either parent constitute about a quarter (23.2 percent). They are likely to be aged 2–17 years, living in rural areas and in the lowest to the middle wealth quintile households. There is very little variation by sex.

Overall, one-quarter (25 percent) do not live with their biological parents; this percentage increases as the age of the child increases and is greater in rural areas. Meanwhile, 4 percent of these Marshallese children have either one or both parents dead.

BREASTFEEDING AND NUTRITION

Breastfeeding is nearly universal in the Marshall Islands, with 95 percent of children born in the five years preceding the survey having been breastfed at some time. There is very little difference in whether children were ever breastfed by most background characteristics except place of residence and wealth status. There is an obvious difference in the proportion ever breastfed between rural and urban, where the practice is almost universal (97 percent) in rural areas compared to 93 percent in urban areas. Similarly, the proportions of children being breastfed are likely to be higher among mothers in lower wealth quintile households than mothers in richer households.

The median duration of breastfeeding is 15.4 months, while the median duration for exclusive breastfeeding is 0.7 months and the median duration for predominant breastfeeding is 0.9 months. In contrast, the mean duration is longer, with overall mean duration of breastfeeding 18.1 months, mean duration for exclusive breastfeeding 2.3 months, and mean duration for predominant breastfeeding 2.8 months. There is little difference in the duration of breastfeeding by sex of the child. Rural children are breastfed for a slightly longer duration than urban children (19.9 months compared to 14.2 months). Mothers with secondary education breastfeed their children for a shorter duration than mothers with less education.

Between the ages of six months and 23 months, children consume foods made from grains more often than any other food group. Ninety-three percent of breastfeeding children and 99 percent of non-breastfeeding children in this age group ate foods made from grains in the day and night preceding the interview. The next most commonly consumed food group is 'meat, fish, poultry and eggs'. Around 83 percent of breastfeeding children and 94 percent of non-breastfeeding children ate meat, fish, poultry and/or eggs. The third commonly consumed food group is fruits and vegetables, which are rich in vitamin A and were consumed by 61 percent of breastfeeding children and 69 percent of non-breastfeeding children.

Ninety-one percent of youngest children aged 6–23 months living with their mother received breast milk or other milk or milk products during the 24-hour period before the survey; 83 percent

had a minimally diverse diet (i.e. they had been fed foods from the minimum number of food groups depending on their age and breastfeeding status); and 65 percent had been fed the minimum number of times appropriate for their age. In summary, over half (55 percent) of Marshallese children aged 6–23 months met the minimum standard with respect to all three infant and young child feeding (IYCF) practices.

Ninety-three percent of youngest children aged 6–35 months living with their mother consumed foods rich in vitamin A in the 24-hour period before the survey. Consumption of foods rich in vitamin A increases from 72 percent among children aged 6–8 months to 97 percent of children aged 12–35 months.

The staple diet of mothers of young Marshallese children consists of foods made from grains (96 percent) and food from the group meat, fish, shellfish, poultry, and eggs (96 percent). Almost three in four women (71 percent) consume fruits and vegetables rich in vitamin A whereas 82 percent of women consume *other solid or semi-solid food*. Forty-two percent of mothers drink milk, while 71 percent drink tea and coffee and 93 percent drink other liquids.

Seventeen percent of the children who were tested for swelling on top of their feet had a dent remaining in the skin: there is no clear pattern by age of children but there are certainly variations, with the lowest observed among 6–11-month-olds (13 percent) and the highest among children aged less than six months (19 percent). The biggest difference is among urban and rural residents, where 23 percent of the children in urban areas had dents remaining in the skin after testing compared to only 3 percent in rural areas.

Eight percent of children who were observed aged 0–5 years had hair that was thinly spread on their head, while 5 percent had sparsely growing hair and 2 percent had yellow-colored hair, indicating malnutrition. These observed abnormalities, particularly the thinly spread hair growth, are likely to be found in children who are aged less than 6–23 months, children in rural areas, children whose mothers have no or only primary education, children born to mothers whose age at the child's birth is less than 35 years, and children born to mothers who are in the lowest to the

middle wealth quintile households. Similar background characteristics are observed for those with the abnormalities of sparsely growing hair and yellow-colored hair.

The results of observations made during the 2007 RMIDHS concerning thinness and wastage among children aged 0–5 for whom wasting was observed for selected parts of their bodies show that almost 1 in 10 children 0–5 years of age (7 percent) were observed to have low weight for age, indicating thinness in the children's head. Interestingly, among the children whose weight for age was observed for selected parts of the body, about the same proportion had thinness in the observed body parts. The results indicate that about 10 percent of children aged 0–5 years have very low weight for their age. These Marshallese children are more likely to be aged 12–35 months, be male, live in rural areas, have mothers with no or only primary-level education, have mothers who were aged less than 20 years at the time of the children's birth, and be in the poorest households than other children.

The results of the observed overall nutritional status for children aged 0–5 years at the time of the survey show that over 8 in 10 (83 percent) children aged 0–5 years were observed to be well nourished while 13 percent were observed to be malnourished after the various tests and targeted observations.

HIV/AIDS AND STIs

Knowledge about AIDS is almost universal among the adult Marshallese population. A very high proportion of both women and men have heard of the virus (96 percent and 97 percent respectively). The results also show that the level of knowledge is quite high for both women and men at different ages and in different marital status categories, places of residence, education levels and household wealth quintiles.

Men and women were specifically asked if one can reduce the risk of acquiring HIV through consistently using condoms, limiting sexual intercourse to one uninfected partner who has no other sex partners, and abstaining from sexual intercourse. The results show that 73 percent of women and 90 percent of men agree that using a condom at every sexual intercourse can reduce the risk of getting HIV, while 86 percent of women

and 92 percent of men agree that limiting sexual intercourse to one uninfected partner is a way to avoid contracting HIV.

Generally, most women and men are aware of reducing the chance of getting HIV through these specified prevention methods: limiting sex to one uninfected partner (86 percent and 92 percent respectively), abstaining from sex (85 percent and 89 percent), using a condom (73 percent and 90 percent) and using a condom and limiting sex to one uninfected partner (67 percent and 87 percent).

Sixty-seven percent of women and 72 percent of men know that a healthy-looking person can have the virus that causes AIDS. Knowledge that people cannot get the AIDS virus by sharing food with a person who has AIDS is lower (61 percent of women and 65 percent of men) than knowledge that the AIDS virus cannot be transmitted by supernatural means (80 percent of women and 81 percent of men). That is, respondents were also asked if they thought that people could get the AIDS virus because of witchcraft or other supernatural means, and the majority of respondents rejected this idea.

One in three women (33 percent) and 45 percent of men have comprehensive knowledge of HIV and AIDS. Women in urban areas are more likely to have comprehensive knowledge than their rural counterparts (39 percent compared with 21 percent). Married women with more than secondary-level education and those in the fourth and highest wealth quintile are more likely to have comprehensive knowledge than other women. As for women, comprehensive knowledge is more common among men in urban areas who are currently married, men with higher education, and men in the fourth and higher wealth quintile.

Eighty-two percent of women and 78 percent of men know that HIV can be transmitted from a mother to her child by breastfeeding. A very low proportion of women (18 percent) and an even lower percentage of men (12 percent) know that there are special drugs that a doctor or nurse can give to a pregnant woman infected with the AIDS virus to reduce the risk of transmitting the virus to the baby. About 1 in 10 women and men (15 percent and 11 percent respectively) aged

15–49 know that HIV can be transmitted through breastfeeding and that the risk of transmission can be reduced by special drugs.

Most women and men express positive attitudes and opinions toward family members who have AIDS. For example, 74 percent of women and 72 percent of men report that they would not want to keep secret that a family member has the AIDS virus, while over half (56 percent) of the women and two in three men (66 percent) are willing to care for an HIV-infected family member. In contrast, only 28 percent of women and 21 percent of men report that they would buy vegetables from a shopkeeper who has the AIDS virus.

Almost all men (95 percent) in the age group of 15–49 years agree that a wife is justified in refusing to have sexual intercourse with her husband if she knows that the husband has a sexually transmitted disease. The same proportion of men also agree that the wife is justified in refusing sexual intercourse or asking the husband to use a condom.

Most adult women and men agree that children aged 12–14 years should be taught about using condoms to avoid getting HIV. Nine in 10 women and men (91 percent of women and 90 percent of men) support the idea of educating children about condom use to prevent HIV.

Most Marshallese women and men believe that the best way to raise HIV and AIDS awareness is through radio programs. About 62 percent of women and 53 percent of men suggest that HIV and AIDS awareness programs are best carried out through radio services.

An equal proportion of women and men believe that health workers are the best people to discuss HIV and AIDS with (93 percent). The results obviously show that almost all Marshallese women and men are more likely to trust health workers to discuss HIV- and AIDS-related issues, which is an indication of a perception that HIV and AIDS are health issues and not socioeconomic or development issues.

Among women and men who had sexual intercourse in the past 12 months, 3 percent of women had multiple partners compared to 9 percent of men. Having multiple sexual partners is

more likely among younger women and men who are either 'never married' or divorced, separated or widowed than among other groups. Meanwhile, 18 percent of women compared to 39 percent of men had higher-risk sex during the same 12-month period. Among those women and men who had higher-risk sex in the past 12 months, twice as many men as women used condoms (20 percent compared to 10 percent).

The results show that most Marshallese women and men are likely to know where to go for an HIV test (90 percent and 89 percent respectively). Even though most people know where to get tested, only a little over one in three had the courage to get an HIV test (39 percent of women and 37 percent of men) compared to over half the women and men who had never had an HIV test. Almost an equal proportion of women and men were tested for HIV in the 12 months before the DHS (22 percent and 21 percent respectively). Of these who were tested in the last 12 months, 67 percent of women and 56 percent of men received counseling with the test.

Forty-one percent of women received HIV counseling during antenatal care, 48 percent were offered an HIV test during ANC, and 40 percent were tested for HIV during ANC. Overall, 24 percent of women were counseled, offered an HIV test and received an HIV test, while almost three in four women (72 percent) reported that they received postnatal counseling. These results show that fewer than half of all women were tested for HIV during ANC visits, while 7 in 10 women received postnatal counseling.

Ten percent of women and 3 percent of men reported that they had a sexually transmitted infection (STI) or symptoms of an STI in the 12 months preceding the survey. Women aged 25–29 and men aged 15–29 have the highest likelihood of reporting symptoms of an STI. Never-married women and married men are less likely to report symptoms of an STI. Women and men in rural areas are more likely to report symptoms of an STI than their counterparts in urban areas.

About 14 percent of young women and 27 percent of young men in the 15–24 age group had their first sex very early in life, i.e. before the age of 15. About 60 percent of young women and 73

percent of young men had sex before they turned 18. Early sexual initiation is more likely among young adults who know where to obtain condoms than those who do not know a source of condom supply.

WOMEN'S EMPOWERMENT

Data for the 2007 RMIDHS show that 35 percent of currently married women and almost 80 percent of currently married men were employed at some time in the year prior to the DHS. Most of these women and men are likely to be paid in cash (87 percent and 94 percent respectively). Women are more likely to work but not receive payment (3 percent) than men (0.2 percent). Similarly, women are more likely to be paid in cash or in kind than men (9 percent and 5 percent respectively).

Overall, about one in four women (25 percent) mainly decide by themselves how their earnings are to be spent. Almost 6 in 10 women (58 percent) report that they make the decision jointly with their husband/partner, while 15 percent report that the decision is mainly made by their husband/partner.

Regarding the magnitude of a woman's earnings relative to those of her husband/partner, over one in three working women report that their earnings are either more or less than those of their husband/partner (39 percent and 37 percent respectively), and over 1 in 10 (13 percent) report that their husbands or partners do not bring in any money.

The data show that almost one in four (23 percent) Marshallese married women whose husbands receive cash earnings report that their husbands/partners are the main decision-makers on the use of their cash earnings, compared with over one in three married men (38 percent) who report themselves as being so. A larger percentage of women (65 percent) than men (50 percent) report that decision-making is joint between the husband and wife.

Over one in three women (38 percent) are more likely to decide mainly by themselves how their cash earnings are used if their husband/partner has no earnings or did not work in the preceding 12 months, compared to over half (53 percent) who make joint decisions with their husband/

partner. Women are only slightly more likely to make decisions about the use of their earnings on their own if they earn more than their husband/partner (25 percent) than if they earn less (24 percent).

While 19 percent of women say they make decisions regarding daily household purchases on their own, only 7 percent report that they make decisions about major household purchases by themselves. About 2 in 10 (18 percent) married women independently decide on their own health care. Some women report that their husbands/partners are more likely to make independent decisions. Over 20 percent of women report that their husbands/partners make decisions about large household purchases by themselves while almost one in four (24 percent) women report that their husbands/partners make decisions about their health care. In terms of visits to a woman's family or relatives, women are most likely to report that they make these decisions jointly with their husband/partner (64 percent). Women are likely to report that all four decisions are made jointly with their husband/ partner.

Twenty-eight percent of men think that mainly husbands should make decisions about major household purchases and 24 percent think that mainly husbands should make decisions about visits to the wife's family or relatives, compared to 59 percent who think that it should be a joint decision. Almost half of all men (47 percent) think that mainly their wives should make decisions relating to purchases of daily household needs, compared to 37 percent who think it should be a joint decision. Only 14 percent of currently married men believe that the number of children to have should be decided mainly by the husband, while over 8 in 10 men (81 percent) say that it should be a joint decision between husbands and wives.

Data show that most women find violence against women justified in certain circumstances. Over half of all women (56 percent) agree that at least one of the reasons asked about in the RMIDHS is sufficient justification for violence against women. This indicates that Marshallese women generally accept violence as part of male-female relationships, which is not surprising because traditional norms teach women to accept, tolerate, and even rationalize battery.

Men were also asked about their opinions on the justification of violence against women under certain circumstances. Almost 6 in 10 men agree that it is justified for at least one of the specified reasons. It is interesting to note that this is about the same as the percentage of women who agree with at least one of the reasons (56 percent compared to 58 percent).

The data show that over 8 in 10 men believe that a woman has a right to refuse to have sex with her husband for all the specified reasons. Younger men (15-19 years), men who have never married, men who are unemployed, men with no children, men in rural areas, men with no or only primary-level education, and men who are from the poorest households are the least likely to agree with all of the reasons for a wife to refuse sex with her husband.

DOMESTIC VIOLENCE

The 2007 RMIDHS included a module on violence. About 3 in 10 women have experienced physical violence since the age of 15. More than half of these women, or 22 percent of all women, have experienced physical violence in the past 12 months. Four percent of women experience physical violence often, while 18 percent experienced violence occasionally in the past 12 months.

Physical violence is higher among Marshallese women in urban areas than those in rural areas (29 percent compared with 27 percent). Similarly, women in rural areas are more likely to have experienced physical violence in the past 12 months, and to have experienced it often during that time.

Among women who have experienced physical violence since age 15, 72 percent report that a current husband or partner committed physical violence against them, while 21 percent report that they experienced violence by a former husband/partner. Other perpetrators commonly reported by women are parents or stepparents (20 percent), and sisters and brothers (6 percent).

Women who have ever been pregnant were asked about their experience of physical violence during pregnancy. Overall, 7 percent of Marshallese women have experienced physical violence while

pregnant. Results by background characteristics reveal that the likelihood of having experienced violence during pregnancy decreases with increasing age but increases with the number of living children.

The 2007 RMIDHS investigated women's experience of sexual violence, including a question on whether the respondent's first sexual intercourse was forced. First sexual intercourse forced against their will is much more common among women aged less than 15–29 (8 percent). These women are more likely to have experienced the forced sexual encounter before first marriage or first cohabitation than at the time of first marriage or first cohabitation (9 percent compared to 6 percent).

Marshallese women were asked about six specific acts of control exercised by their husbands or partners. Among ever-married women aged 15–49 whose husband/partner has ever demonstrated specific types of controlling behaviors, 4 in 10 (40 percent) said that their husbands or partners insist on knowing where they are at all times. Similarly, almost 4 in 10 (38 percent) women reported that their husband/partner is jealous or angry if they talk to other men, while a similar proportion (36 percent) of women cited that they are frequently accused of being unfaithful. One in five respondents (20 percent) went on to say that they are not permitted to meet their female friends, and 17 percent said that their husband/partner does not trust them with money.

Respondents were asked about seven specific acts of physical violence, two of sexual violence, and three of emotional violence. The results show that 22 percent of women have experienced physical violence at the hands of their husband or partner, 11 percent have experienced sexual violence, and 15 percent have experienced emotional violence. Overall, almost one-third of ever-married women (30 percent) have experienced violence (physical, sexual, or emotional) by a husband or other intimate partner.

Ninety-three percent of women who have experienced emotional violence by their current or most recent husband experienced such violence in the 12 months preceding the survey, and 22 percent of them experienced emotional

violence often. Similarly, 90 percent of women who have ever experienced physical or sexual violence by their current or most recent husband experienced such violence in the 12 months preceding the survey, and 14 percent have experienced such violence often.

Almost half the women (49 percent) who have ever experienced physical violence by their current or most recent husband/partner suffered the injuries asked about, compared with 33 percent of women who suffered sexual violence and 42 percent of women who suffered physical or sexual violence. For each type of violence, women were most likely to report having experienced cuts, bruises, or aches, followed by eye injuries, sprains, dislocations, or burns. Women were least likely to report having suffered the most severe injuries; nevertheless, more than 1 in 10 women (ranging between 1 and 4 percent) who have ever experienced physical or sexual violence by their husband reported suffering deep wounds, broken bones, broken teeth, or other serious injuries.

Twelve percent of ever-married women report that they have initiated physical violence against their current or most recent husband, while 9 percent say they had committed such violence in the 12 months preceding the survey.

Twenty-six percent of women who have experienced violence seek help, compared to 52 percent who never told anyone and 14 percent who sought help specifically from someone. Women who experience physical violence only or both physical and sexual violence are more likely to seek help than those who experience sexual violence only.

MORTALITY

For the most recent period (i.e. 0–4 years before the survey, reflecting roughly 2003–2007), the infant mortality rate (IMR) is 21 deaths per 1,000 live births. This means that two in every 100 babies born in RMI do not live to their first birthday. Of those who survive to their first birthday, 16 out of 1,000 die before reaching their fifth birthday. The overall under-five mortality is 37 deaths per 1,000 live births, which implies that four in every 100 Marshallese babies do not survive to their fifth birthday.

The first month of life is associated with the highest risk to survival. The neonatal mortality rate is 15 deaths per 1,000 live births, implying that nearly two out of every 100 infant deaths occur during the first month of life. As childhood mortality declines, post-neonatal mortality usually declines faster than neonatal mortality because neonatal mortality is frequently caused by biological factors that are not easily addressed by primary care interventions. In RMI, post-neonatal mortality is six per 1,000 births.

The IMR in rural RMI during the 10 years before the 2007 DHS was 37 deaths per 1,000 births, as opposed to 30 in urban areas. This rural IMR of 37 is above the national average of 33 deaths per 1,000 births. The urban–rural gap in childhood mortality appears to be consistent as the age of children increases, except for post-neonatal mortality, where there is no difference between rural and urban populations, and for child mortality, where the gap is quite small (one death per 1,000). Surprisingly, the probability of dying between the first and fifth birthday for urban infants is 8 percent higher than for rural infants.

In comparing the mortality rates for urban and rural areas, it is important to note that ‘urban’ covers only two islands: Majuro and Ebeye. These two islands are home to over 68 percent of the total population of RMI. Both of the islands are entirely urban and have different socioeconomic environments in terms of general sanitation and nutrition; however, a large proportion of the population is not employed by the formal sector.

For neonatal mortality, 27 deaths per 1,000 births were observed for mothers with secondary-level education compared to 14 per 1,000 for mothers with no education or primary education. In other words, the probability of a baby dying in the first month of life for mothers with secondary education is 46 percent higher than for infants whose mothers have no or primary-level education. This contributes directly to the above-national-average IMR of 35 deaths per 1,000 to

mothers with secondary-level education compared to 28 deaths per 1,000 for mothers with no or primary education.

In contrast, post-neonatal mortality and childhood mortality are higher for mothers with no or primary-level education than for mothers with secondary education. This leads to the observation that the under-five mortality rates for children whose mothers have no or primary education and for those whose mothers have secondary education are the same, at 47 deaths per 1,000. It is worth noting that most of the benefit of secondary education over no or primary education is due to a difference in IMR (28 versus 35). There is virtually no difference between the children of women with secondary education and the children of women with no or primary education in under-five mortality rates.

In RMI, perinatal mortality increases with the level of education of the mother, with the largest difference observed between women with no or primary education and those with more than secondary education (20 pregnancy losses or early deaths per 1,000 pregnancies compared with 25). Perinatal mortality is lowest among women with no or primary education (20 pregnancy losses or early deaths per 1,000 pregnancies).

Twenty-four percent of births in RMI are not in any high-risk category. An additional 21 percent of births are first-order births to mothers aged 18–34 years – considered an unavoidable risk category. The remaining 55 percent of births in RMI are in at least one of the specified avoidable high-risk categories. Over one-third of births (38 percent) are in only one of the high-risk categories (mostly high birth order >3, 18 percent, and 13 percent for short birth interval of <24 months), while 16.9 percent are in multiple high-risk categories. The births in multiple high-risk categories are mostly found in the following combination: birth order higher than three with birth interval <24 months (9 percent of births).

DHS INDICATORS REQUIRED BY INTERNATIONAL AGENCIES

INDICATOR	DIFFERENTIALS		
	NATIONAL	URBAN	RURAL
Millennium Development Goals (MDG)/United Nations Population Fund (UNFPA)			
Net enrolment ratio in primary education (net attendance ratio)	83.2	81.1	87.1
Net enrolment ratio in primary education (net attendance ratio – males)	82.5	80.3	86.5
Net enrolment ratio in primary education (net attendance ratio – females)	83.8	81.8	87.7
Literacy rate of women aged 15–49 years	95.3	96.3	93.2
Literacy rate of men aged 15–49 years	94.4	93.9	95.3
Literacy rate of women aged 15–24 years	96.1	-	-
Literacy rate of men aged 15–24 years	93.6	-	-
	1.02	1.02	1.01
	1.15	1.19	0.98
Ratio of girls to boys in primary, secondary, and tertiary education	-	-	-
Ratio of literate women to men, 15–24 years old	1.03	-	-
Ratio of literate women to men, 15–49 years old	1.01	1.03	0.98
Share of women in wage employment in the non-agricultural sector	58.0	52.0	72.0
Under-five mortality rate	46	44	49
Infant mortality rate	33	30	37
Percent of one-year-old children immunized against measles	6.2	-	-
Percent of children aged 12–23 months immunized against measles	54.1	55.9	50.0
Percent of births attended by skilled health personnel	94.1	96.7	89.5
Contraceptive prevalence rate	45	42.7	48.3
Percent of population using solid fuels	33.6	7.9	95.2
Percent of population with sustainable access to an improved water source, urban and rural	98.4	97.8	99.7
Percent of population with access to improved sanitation, urban and rural	70.7	82.4	52.6

INDICATOR	DIFFERENTIALS		
	NATIONAL	URBAN	RURAL
HIV/UNGASS (United Nations General Assembly Special Session on HIV/AIDS)			
Condom availability and quality			
Adult support of education on condom use for prevention of HIV/AIDS among young people:	90.6	91.5	88.8
Women and men	89.8	91.5	86.3
Knowledge of a formal source of condoms among young people (15–24 years): Women and men	82	82	83
	91	92	88
Accepting attitudes toward those living with HIV – composite of four components			
	4.3	5.1	2.6
	7.4	9.9	1.9
	56.1	60.0	47.5
Willing to care for family member: Women and men	65.7	74.1	47.4
			14.7
	21.3	24.3	17.3
Would buy fresh vegetables from a shopkeeper with AIDS: Women and men	27.9	32.7	
Female teacher who is HIV+ but not sick should be allowed to continue teaching in school: Women and men	14.5	15.9	11.4
	14.2	17.4	7.2
	72.4	72.8	71.3
Not secretive about family member's HIV status: Women and men	73.5	69.0	83.1
	95.8	97.0	93.4
Heard of HIV/AIDS: Women and men	96.6	96.0	98.0
Knowledge of HIV prevention methods: Women and men			
	73.1	76.5	66.0
Use of condoms: Women and men	89.7	90.8	87.1
	85.7	86.2	84.7
Only one/limiting partner: Women and men	91.8	92.2	90.7
	85.4	85.6	84.9
Abstain from sex: Women and men	89.0	88.1	90.8
No incorrect beliefs about AIDS			
	67.4	69.7	62.4
Healthy-looking person can have the AIDS virus: Women and men	72.3	72.1	72.7
	79.8	82.7	73.6
AIDS cannot be transmitted by supernatural means: Women and men	80.9	85.1	71.5
	61.4	68.4	46.6
Cannot become infected by sharing food with someone who has AIDS: Women and men	65.2	69.8	55.1
Knowledge of mother-to-child transmission (MTCT) during pregnancy and through breastfeeding: Women and men			
	15.4	15.9	14.5
	10.5	10.4	10.6
Voluntary counseling and testing			
HIV testing behavior among young people sexually active in the last 12 months: Women and men	26.7	27.3	25.6
	19.4	14.3	29.5
Mother-to-child transmission			
Pregnant women counseled and tested for HIV	23.5	28.3	15.4
Pregnant women counseled for HIV during ANC visit	40.5	50.0	24.3
Pregnant women tested for HIV during ANC visit	40.1	43.4	34.4

INDICATOR	DIFFERENTIALS		
	NATIONAL	URBAN	RURAL
HIV/UNGASS			
Sexual negotiation and attitudes			
Women's ability to negotiate safer sex with husband	94.6	95.8	91.9
Sexual behavior			
Higher-risk sex in the last year: Women and men	18.1	17.2	19.8
Multiple partners in the last year among sexually active respondents aged 15–49: Women and men	39.4	41.6	35.0
	3.3	3.3	3.3
	9.0	8.6	9.8
Condom use at last higher-risk sex			
Last sex with anyone: Women and men	10.3	10.0	10.8
Commercial sex in last year: Men aged 15–49 years	20.3	23.7	12.6
Condom use at last commercial sex, reported by client	0.5	0.5	0.5
Young people's sexual behavior			
Median age at first sex among young women and men aged 20–24 years	17.6	18.1	16.6
	16.5	16.7	16.2
Abstinence of never-married young women and men	19.8	na	na
	16.1	na	na
	13.6	8.7	24.2
Sex before the age of 15: Women and men aged 15–24 years	26.5	24.4	31.1
	60.4	52.5	76.6
Sex before the age of 18: Women and men aged 15–24 years	73.4	70.4	79.2
	45.3	40.1	60.5
Young people having premarital sex in last year: Women and men	66.5	65.6	69.3
	8.1	8.1	7.9
Young people using a condom during premarital sex: Women and men	19.7	24.8	5.3
	7.0	na	na
Young people (15–24 years) having multiple partners in last year: Women and men	13.0	na	na
	8.9	8.0	10.4
Young people using a condom at last higher-risk sex: Women and men	21.7	26.4	11.1
Young people (15–24 years) using a condom at last higher-risk sex of all young people surveyed: Women and men	9.0	na	na
	22.0	na	na
	9.9	10.3	9.2
Condom use at first sex: Young women and men	16.2	21.5	4.7
Age-mixing in sexual relationships: Women			
Young women aged 15–19, non-marital, non-cohabiting partner in the last 12 months	3.8	3.6	4.4
Young women aged 15–24, any partner in the last 12 months	4.7	na	na
Forced sex among young people			
Sex among young people while they are intoxicated: Women and men	9.3	9.5	9.1
Sex with commercial sex workers among young people: Men	38.3	49.3	13.4
	0.6	na	na
Appropriate diagnosis and treatment of STIs			
Seeking treatment for STIs: Women and men	65.3	na	na
	84.8	na	Na
Social impact			
Birth registration	96	96	96
Prevalence of orphanhood under 18 who are orphans (single & double)	4.5	4.9	4.5
Prevalence of orphanhood among children under 15 (single & double)	3.5	na	na

MAP OF THE REPUBLIC OF THE MARSHALL ISLANDS

