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Situation Analysis of Children in Kiribati

December 2017

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The report was commissioned by UNICEF Pacific, which engaged Coram International, at Coram Children's Legal Centre, to finalize the Kiribati Situation Analysis.

The Situational Analyses were managed by a Steering Committee within UNICEF Pacific and UNICEF EAPRO, whose members included Andrew Colin Parker; Gerda Binder (EAPRO); Iosefo Volau; Laisani Petersen; Lemuel Fyodor Villamar; Maria Carmelita Francois; Settasak Akanimart; Stanley Gwavuya (Vice Chair), Stephanie Kleschnitzki (EAPRO); Uma Palaniappan; Vathinee Jitjaturunt (Chair); and Waqairapoa Tikoisuva.

Suggested citation. United Nations Children's Fund, *Situation Analysis of Children in Kiribati*, UNICEF, Suva, 2017

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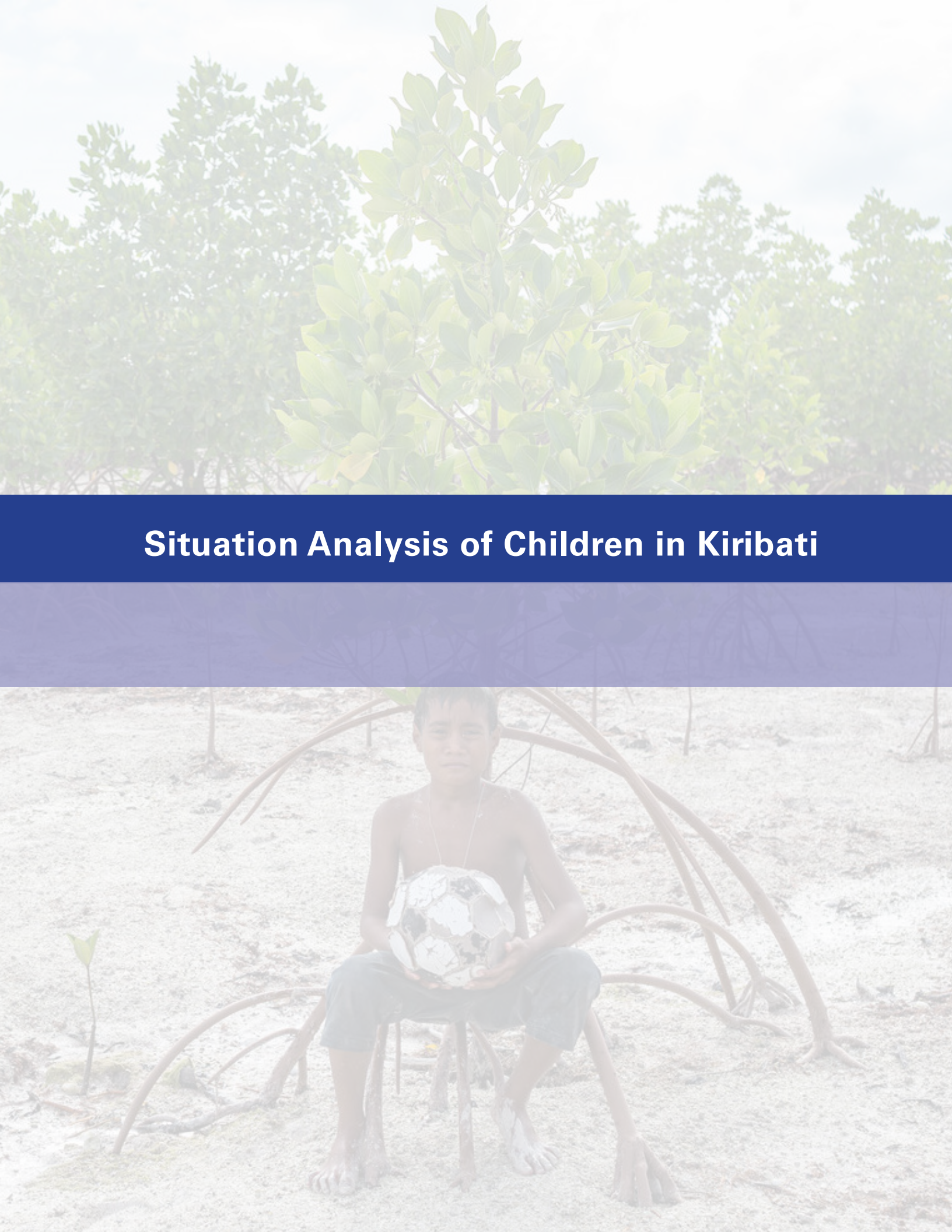

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Executive Summary

Introduction

This report presents a comprehensive assessment and analysis of the situation of children and women in Kiribati. It is intended to present an evidence base to inform decision-making across sectors that are relevant to children and women. In particular, it aims to contribute to the development of programmes and strategies to protect, respect and fulfil the rights of children and women in Kiribati.

Kiribati is an independent republic located in the Micronesian region of the Pacific. It comprises 33 islands, 21 of which are inhabited. Kiribati had a population of 110,136 as per 2015 census, with around 40 per cent below the age of 18 years. Tarawa is the most populated island of Kiribati, with around 41.5 per cent of the population living on the atoll. Rising sea levels threaten the existence of Kiribati as a nation, and the government has begun adapting and responding to this existential threat, for example by buying nearly 6,000 acres of land in neighbouring Fiji, as a potential refuge and a source of fresh-water and food supplies.

This report covers the child outcome areas of health and nutrition, water, sanitation and hygiene (WASH), education, child protection (including child justice) and social protection. By assessing and analysing the situation for children and women in relation to these outcomes and the relevant Sustainable Development Goals (SDGs), it seeks to highlight trends, barriers and bottlenecks in the realization of children's and women's rights in Kiribati.

Key barriers and bottlenecks

The following key barriers and bottlenecks were identified from the full situation analysis of children in Kiribati.

Climate change and disaster risks: Of all the Pacific Island nations, Kiribati is thought to be one of the most vulnerable to the impacts of climate change, as rising sea levels threaten the mere existence of its islands, none of which reaches more than 6 metres above sea level. A key finding of this report is that climate change have a considerable impact on all sectors in relation to the realization of children and women's rights.

Financial and human resources: Kiribati continues to rely heavily on external development aid and declining revenue from fishing licences, and the country is plagued by high unemployment rates. This leads to a lack of available resources across nearly all sectors and a resultant lack of financial resources for the delivery of services and systems for children, but is also linked to a lack of human resources (training and expertise) in several sectors, including health, WASH, education, child protection and justice.

The **geography** of Kiribati creates significant barriers to the realization of children's and women's rights, given remoteness and transportation constraints.

Equity: Children and women living in rural areas enjoy, on the whole, lesser outcomes and access to basic services than those who live in urban areas. The urban–rural divide in access to improved sanitation facilities is one of the largest in the region. Access to improved drinking water sources is also significantly more restricted in Kiribati's rural areas. Furthermore,

pupil–teacher ratios are more advantageous in urban areas compared with rural areas. However, increased drift from rural to urban areas (especially South Tarawa) is placing children at risk, not only because urban settlements lack services and infrastructure but also because children are removed from informal community-based protection mechanisms that might otherwise support them.

The **impacts of poverty** are significant in Kiribati and children and families are highly exposed to risk and economic shocks. Lack of comprehensive social protection and other social welfare services is a significant gap and limits the ability of the government to lift vulnerable persons out of poverty and support economic growth. Lack of opportunities, for young people in particular, perpetuates cycles of poverty.

Cultural norms and approaches: Cultural norms, attitudes and traditions frequently act as barriers (but, in some cases, also as enablers) to the realization of children and women's rights in several sectors in Kiribati. The erosion of traditional community care, and the limitations of community care in urban areas, means children are more exposed to child protection concerns than before. At the same time, traditional attitudes that are permissive of violence, and lack of community planning around child protection, also expose children to risk. Traditional gender roles support and facilitate violence against women and girls, and marginalized groups, including children with disabilities. Traditional norms also underlie key behavioural risk factors associated with negative health outcomes, such as high smoking prevalence among young people.

Data availability: There are useful data sources in some sectors in Kiribati. However, this report has identified several data gaps, and the absence of these data is, in itself, a key finding. There are no up-to-date estimates of child stunting and wasting rates in Kiribati. Furthermore, there is a lack of data about children with disabilities, other vulnerable groups and out-of-school-youth. There is also a lack of data on specific types of child rights violations, such as child labour and sexual exploitation, and on disparities between different population groups, such as gender disparities.

Snapshot of outcome areas

Health	Kiribati faces significant challenges in relation to child and maternal health. It has the highest child mortality rates in the PICTS group, and has not been able to meet international child mortality reduction targets. Kiribati has significant gaps in immunization coverage for eight out of 12 universally recommended vaccines, and the highest TB prevalence in the whole Pacific region, with an estimated 748 cases per 100,000 population. Kiribati has an adjusted maternal mortality ratio of 90 deaths per 100,000 live births, which is still significantly above international development targets. Antenatal coverage for at least one visit stands at 88 per cent. The majority of pregnant women give birth in the presence of a skilled health professional (80 per cent); however, only slightly more than half of all deliveries take place in a health facility (60 per cent). At 22 per cent, contraceptive prevalence is among the lowest in the PICTS region. Religious norms appear to play an important role in suppressing demand for family planning. Data on the prevalence of HIV/AIDS and sexually transmitted infections are extremely poor. 31 per cent of school children aged 13–15 report having attempted suicide, which suggests mental health problems among adolescents are a significant concern.
Nutrition	Information on childhood wasting and stunting in Kiribati is not available, which representes a significant data gap. Aneamia rates are high among pregnant women (38 per cent) and pre-school children (37 per cent). Low birthweight prevalence stands at 8 per cent, which is the third lowest in the PICTS group. While obesity and associated non-communicable diseases are a significant health burden among Kiribati's adult population, childhood obesity is not a major problem. Only 8 per cent of school children aged 13–15 were found to be obese – one of the lowest rates in the PICTS group. 69 per cent of children receive exclusive breastfeeding for the first six months after birth, which is the third highest rate in the PICTS group and above the 50 per cent World Health Organization target for 2025. However, an estimated 50 per cent of children aged 6–23 months are not fed often enough.
WASH	Kiribati has one of the least developed WASH sectors in the Pacific region. Improved water coverage stands at only 67 per cent nationally, and drops to an even lower 51 per cent in rural areas. Only 40 per cent of the population uses improved sanitation facilities. Further, the country has one of the largest rural–urban disparities in access to improved sanitation in the whole PICTS region. Open defecation is still practised by 36 per cent of the population. Fresh-water lenses in South Tarawa, the most urbanized area of Kiribati, are polluted – a situation exacerbated by rising sea levels.

Education	Early childhood education (ECE) in Kiribati is provided exclusively by non-governmental organizations such as churches and community groups. The subsector was recently (2017) formalized, as such few data exist on the accessibility and quality of ECE in Kiribati. The proportion of children enrolling in primary school with prior ECE experience is estimated to stand at around 70 per cent as of 2014. The net enrolment ratio (NER) for primary education is estimated to stand at 98.6 per cent as of 2016, and the NER for secondary education at a lower 77.3 per cent. However, reported enrolment rates for Kiribati should be interpreted with caution, given anomalies in the population data.
Child protection	Corporal punishment is widespread in Kiribati. 81 percent of adults report using violent discipline against children in their household. Nearly one in five women aged 15–49 report experiencing child sexual abuse before the age of 15. Despite a relatively robust legal framework, children were found to be working in the informal sector and engaged in commercial sexual exploitation, especially in the fishing industry. Birth registration (now at 94 per cent) has improved substantially since 2009, when Kiribati had one of the lowest birth registration rates in the Pacific.
Social protection	Up-to-date data on poverty rates are lacking for Kiribati. However, estimates from 2006 suggest that up to 22 per cent of the population lives below the basic needs poverty line. Households with children are particularly at risk of poverty in Kiribati. Basic needs poverty rates are highest in the capital of South Tarawa. A recent assessment of Kiribati's social protection system ranks it on the lower end of the range within the PICTS group in terms of comprehensiveness and impact. In contrast with most other PICTS, the vast majority of Kiribati's social protection expenditure is on social assistance, compared to social insurance. While the amount of assistance provided to beneficiaries is relatively high, the number of beneficiaries receiving benefits is relatively low (in comparison with other countries in the PICTS region).

Acronyms

ADB Asian Development Bank
AIDS Acquired Immune Deficiency Syndrome
ART Antiretroviral Therapy
AusAID Australian Agency for International Development
CEDAW Convention on the Elimination of All Forms of Violence Against Women
CRC Convention on the Rights of the Child
CRPD Convention on the Rights of Persons with Disabilities
CSEC Commercial Sexual Exploitation of Children
DHS Demographic and Health Survey
EAPRO East Asia and Pacific Regional Office
ECCE Early Childhood Care and Education
ECE Early Childhood Education
EFA Education For All
ESSP Education Sector Strategic Plan
EU European Union
FAO Food and Agriculture Organization of the United Nations
FSM Federated States of Micronesia
GADRRRES Global Alliance for Disaster Risk Reduction and Resilience in the Education Sector
GDP Gross Domestic Product
GER Gross Enrolment Ratio
GPI Gender Parity Index
GSHS Global School-Based Health Survey
HIES Household and Income Expenditure Survey
HIV Human Immunodeficiency Virus
HQ Headquarters
ICESCR International Covenant on Economic, Social and Cultural Rights
ICT Information and Communications Technology
ILO International Labour Organization
IPU Inter-Parliamentary Union
ISF Institute for Sustainable Futures
JMP UNICEF/WHO Joint Monitoring Programme for Water Supply, Sanitation and Hygiene
JSS Junior Secondary School
KEMIS Kiribati Education Management Information System
KIRIWATSAN Kiribati Water and Sanitation for Outer Islands
KNSO Kiribati National Statistics Office
KTC Kiribati Teaching College
MDG Millennium Development Goal
MFED Ministry of Finance and Economic Development
MHM Menstrual Hygiene Management
MLHRD Ministry of Labour and Human Resource Development
MoE Ministry of Education

MoH Ministry of Health
MP Member of Parliament
MWYSA Ministry of Women, Children and Social Affairs
NAPA National Adaptation Programme of Action
NCD Non-Communicable Disease
NER Net Enrolment Ratio
NGO Non-Governmental Organization
NMDI National Minimum Development Indicator
OCHA United Nations Office for the Coordination of Humanitarian Affairs
OCS Officer in Command of Station
ODA Official Development Assistance
OECD Organisation for Economic Co-operation and Development
OHCHR Office of the United Nations High Commissioner for Human Rights
PacLII Pacific Islands Legal Information Institute
PEDF Pacific Education Development Framework
PICTS The 14 Pacific Island Countries and Territories that are the subject of the Situational Analyses
PNG Papua New Guinea
SABER Systems Approach for Better Education Results
SDG Sustainable Development Goal
SitAn Situational Analysis
SOP Standard Operating Procedure
SOWC State of the World's Children
SP Strategic Programme
SPC Secretariat of the Pacific Community
SPI Social Protection Indicator
SSS Senior Secondary School
STAKI Standardized Test for Achievement in Kiribati
STEPS STEPwise Approach to Chronic Disease Risk Factor Surveillance
STI Sexually Transmitted Infection
TB Tuberculosis
TVET Technical Vocational Education and Training
UN United Nations
UNCTAD United Nations Conference on Trade and Development
UNDP United Nations Development Programme
UNESCAP United Nations Economic and Social Commission for Asia and the Pacific
UNESCO United Nations Educational, Scientific and Cultural Organization
UNFPA United Nations Population Fund
UNICEF United Nations Children's Fund
UNICEF SitAn Procedural Manual UNICEF's 'Guidance on Conducting a Situation Analysis of Children's and Women's Rights' (March 2012)
UNISDR United Nations International Strategy for Disaster Reduction
UPR Universal Periodic Review
US United States
USP University of the South Pacific
WASH Water Sanitation and Hygiene
WHO World Health Organization

1. Introduction

1.1. Purpose and scope

This report presents a comprehensive assessment and analysis of the situation of children in Kiribati. Its intent is to offer an evidence base to inform decision-making across sectors that are relevant to children and instrumental in ensuring the protection and realization of children's rights. It is, in particular, intended to contribute to the development of programmes and strategies to protect, respect and fulfil the rights of children in the Pacific Island Countries and Territories (PICTs).

In accordance with the approach outlined in UNICEF's Procedural Manual on 'Conducting a Situational Analysis of Children's and Women's Rights' ('UNICEF's SitAn Procedural Manual'), the specific aims of this Situation Analysis (SitAn) are as follows:

- To improve the understanding of all stakeholders of the current situation of children's rights in the Pacific, and the causes of shortfalls and inequities, as the basis for developing recommendations for stakeholders to strengthen children's rights;

- To inform the development of UNICEF programming and support national planning and development processes, including influencing policies, strategies, budgets and national laws to contribute towards establishing an enabling environment for children that adheres to human rights principles, particularly with regard to universality, non-discrimination, participation and accountability;

- To contribute to national research on disadvantaged children and leverage UNICEF's convening power to foster and support knowledge generation with stakeholders; and

- To strengthen the knowledge base to enable assessment of the contribution of development partners, including UNICEF and the UN, in support of national development goals.[1]

This SitAn report focuses on the situation of children (persons aged under 18 years old), adolescents (aged 10–19) and youth (aged 15–24).[2] In addition, it includes an assessment and analysis of the situation relating to women, to the extent that it relates to outcomes for children (e.g. regarding maternal health).

1.2. Conceptual framework

The conceptual framework is grounded in the relationship between child outcomes and the immediate, underlying and structural determinants of these outcomes, and is adapted from the conceptual framework presented in UNICEF's SitAn Procedural Manual. A rights-based approach was adopted for conceptualizing **child outcomes**, which this SitAn presents according to rights categories contained in the UN Convention on the Rights of the Child (CRC). These categories also correspond to UNICEF's Strategic Programme (SP) Outcome Areas. Child outcomes are therefore grouped into Health and nutrition; Water, sanitation and hygiene (WASH) ('survival rights'); Education ('development rights'); Child protection; and Social protection ('protection rights').

The aim of the **child outcomes assessment** component of this SitAn was to identify trends and patterns in the realization of children's rights and key international development targets; and any gaps, shortfalls or inequities in this regard.

A number of analytical techniques were employed in the effort to **analyse** immediate, underlying and structural causes of child outcomes. These included:

- **Bottlenecks and barriers analysis:** A structured analysis of the bottlenecks and barriers that children/groups of children face in the realization of their rights, with reference to the critical conditions/determinants[3] (quality; demand; supply and enabling environment) needed to ensure equitable outcomes for children).

The analysis is also informed by:

- **Role-pattern analysis:** The identification of stakeholders responsible for/best placed to address any shortfalls/inequities in child rights outcomes; and

- **Capacity analysis** – to understand the capacity constraints (e.g. knowledge; information; skills; will/motivation; authority; financial or material resources) on stakeholders who are responsible for/best placed to address the shortfalls/inequities.

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1 UNICEF, 'Guidance on Conducting a Situation Analysis of Children's and Women's Rights', March 2012, pp. 5–6, on http://www.unicefinemergencies.com/downloads/eresource/docs/Rights%20based%20equity%20focused%20Situation%20Analysis%20guidance.pdf [30.01.17].

2 These are the age brackets UN bodies and agencies use for statistical purposes without prejudice to other definitions of 'adolescence' and 'youth' adopted by Member States.

3 Based on the 10 critical determinants outlined in Table 3 on page 20 of UNICEF's SitAn Procedural Manual.

The analysis did not engage in a comprehensive causality analysis, although immediate and underlying causes of trends, shortfalls or inequities are considered throughout.

The analysis was deliberately risk-informed and took an equity approach. An **equity approach** seeks to understand and address the root causes of inequality so that all children, particularly those who suffer the worst deprivations in society, have access to the resources and services necessary for their survival, growth and development.[4] In line with this approach, the analysis included an examination of gender disparities and their causes, including a consideration of the relationships between different genders; relative access to resources and services; gender roles; and the constraints facing children according to their gender.

A **risk-informed analysis** requires an analysis of disaster and climate risks (i.e., hazards; areas of exposure to the hazard; and vulnerabilities and capacities of stakeholders to reduce, mitigate or manage the impact of the hazard on the attainment of children's rights). This is particularly relevant to the PICTS where climate change and other disaster risks are present. A risk-informed analysis also includes an assessment of gender and the vulnerabilities of particular groups of children to disaster and climate risks.

A rights-based framework was developed for measuring child outcomes and analysing role-patterns, barriers and bottlenecks. This incorporates the relevant rights standards and development targets (in particular the Sustainable Development Goals, SDGs) in each of the child outcome areas.

Table 1.1: Assessment and analysis framework by outcome area

Outcome area	Assessment and analysis framework
Health and nutrition	- CRC (particularly the rights to life, survival and development and to health) - SDGs (particularly SDG 3 on ensuring healthy lives and promoting well-being) - Global Strategy for Women's, Children's and Adolescents' Health (2016–2030) - WHO's Global Nutrition Targets (child stunting; anaemia; low birthweight; obesity/overweight; and breastfeeding)
WASH	- CRC (Article 24) - SDGs (particularly SDG 6 on ensuring availability and sustainable management of water and sanitation for all)

4 UNICEF NYHQ, 'Re-focusing on Equity: Questions and Answers', November 2010, p. 4.

Education	- CRC (Articles 28 and 29) - Article 13 of ICESCR - SDGs (particularly SDG 4 on ensuring inclusive and quality education for all and promoting lifelong learning) - Comprehensive School Safety Framework[l]
Child protection	- CRC (Articles 8, 9, 19, 20, 28(2), 37, 39 and 40) - SDGs (particularly SDGs 5, 8, 11 and 16)
Social protection	- CRC (Articles 26 and 27) - ICESCR rights to social security (Article 9) and adequate standard of living (Article 11) - SDG target 1 (end poverty in all its forms everywhere)

1.3. Methods and limitations

This SitAn includes a comprehensive review, synthesis and examination of available data from a variety of sources. The assessment of child outcomes relied primarily on existing datasets from household surveys; administrative data from government ministries and non-governmental organizations (NGOs); and other published reports.[5] Key datasets were compiled from the UNICEF Statistics database (available on https://data.unicef.org/) and the Secretariat of the Pacific Community's (SPC's) National Minimum Development Indicators (NMDI) database (available on https://www.spc.int/nmdi/).[6] The 2016 State of the World's Children (SOWC) report was utilized as it offered the latest available reliable data (available on https://www.unicef.org/sowc2016/). SPC's NMDI database also compiles data produced through national sources.[7] Other institutional databases, such as those of the World Bank, the UNICEF/World Health Organization (WHO) Joint Monitoring Programme for Water Supply, Sanitation and Hygiene (JMP), WHO and the UNESCO Institute of Statistics were also found to be relevant.

The analysis phase required a synthesis and analysis of secondary data and literature, including small-scale studies and reports. It also included a mapping and analysis of relevant laws, policies, and government/SP Outcome Area strategies.

One of the limitations of the methodology is the lack of recent, quality data in relation to some of the areas the analysis covers. Gaps in the availability of up-to-date, strong data are noted throughout the report. The analysis of causes and determinants of rights shortfalls relied heavily

5 These datasets were reviewed and verified by UNICEF.

6 Data from national sources and other reputable sources are compiled and checked for consistency before being registered in the UNICEF Statistics database and used for the annual State of the World's Children Report (SOWC).

7 The database is updated as new data become available.

on existing published reports and, therefore, some areas in the analysis were not subject to robust and recent research; again, gaps are highlighted as necessary.

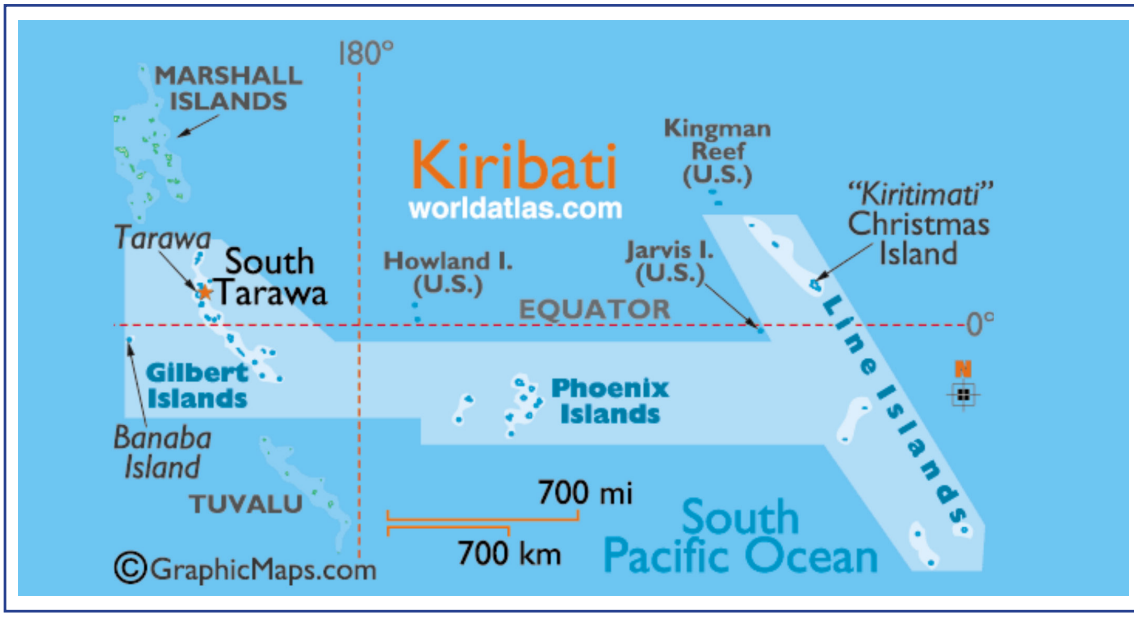
A further limitation was the tight timeframe and limited duration of this SitAn process. This required the authors to make determinations as to priority areas of focus, which entailed the exclusion of some issues from the analysis. This also led to limitations in the extent of, for example, the causality analysis (which was conducted but does not include problem trees), and the role-pattern and capacity gap analyses, for which information is presented but which were not necessarily performed for all duty-bearers in a formal manner.

1.4. Governance and validation

The development and drafting of this SitAn was guided by a UNICEF Steering Committee (comprising Andrew Colin Parker; Gerda Binder; Iosefo Volau; Laisani Petersen; Lemuel Fyodor Villamar; Maria Carmelita Francois; Settasak Akanimart; Stanley Gwavuya [Vice Chair], Stephanie Kleschnitzki; Uma Palaniappan; Vathinee Jitjaturunt [Chair] and Waqairapoa Tikoisuva), which supported the assessment and analysis process by providing comment, feedback and additional data and validating the contents of this report. This governance and validation the Steering Committee provided was particularly important given the limitations in data-gathering and sourcing set out above.

2. Context

Figure 2.1: Map of Kiribati



Source: World Atlas[8]

2.1. Geography and demographics

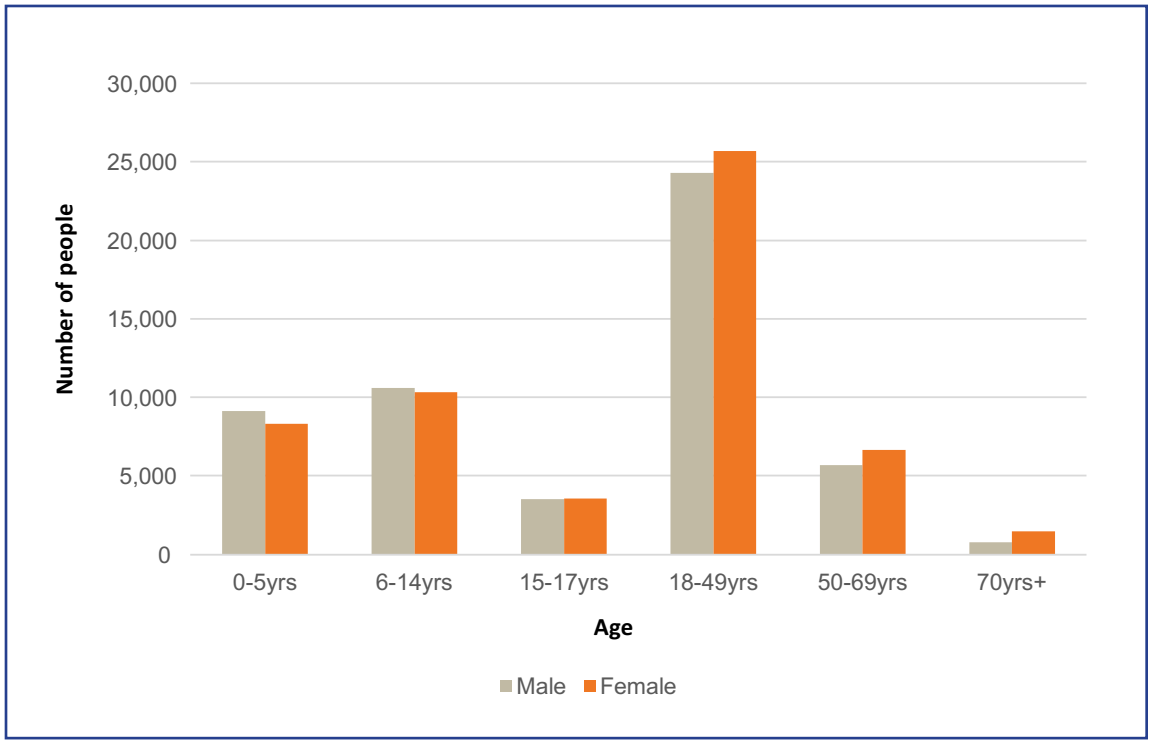
Kiribati (pronounced *Kiribas)* is a Micronesian independent republic that consists of 33 islands, 21 of which are inhabited. The islands are dispersed over 3 million km^2 of the Pacific Ocean, with a total land surface area of around 811 km^2. The islands are divided into three groups: the

8 http://www.worldatlas.com/webimage/countrys/oceania/ki.htm [04.09.17].

Gilbert Islands, the Phoenix Islands and the Line Islands, and are spread over all four of the earth's hemispheres. The capital of Kiribati, Tarawa, is an atoll in the Gilbert Islands and is located north of the equator.[9]

The 2015 Kiribati Population and Housing Census recorded a total population of 110,136 (50.9 per cent female, 49.1 per cent male), with 41.3 per cent under the age of 18.[10] The UN reported the 2016 population at 114,000.[11] Figure 2.2 gives a more detailed breakdown of the population. The 2015 census shows that Tarawa is the most populated island of Kiribati, with 45,687 (41.5 per cent) of the population living on the atoll, 40.2 per cent of whom are below the age of 18. The population of under-18s on Tarawa makes up 40.3 per cent of all the children of Kiribati.

Figure 2.2: Population by age and gender



Source: 2015 census

According to the 2015 census, the majority of the population on Kiribati belongs to the ethnic group I-Kiribati, at 96.2 per cent. This is followed by I-Kiribati/Tuvalu (0.9 per cent), I-Kiribati/European (0.5 per cent), New Zealand (0.61 per cent), I-Kiribati/Chinese (0.4 per cent), Tuvalu (0.2 per cent), Chinese (0.11 per cent), Australian (0.04 per cent), Fijian (0.06 per cent), European (0.08 per cent) and Other (0.9 per cent). The official languages of Kiribati are English and Gilbertese. The 2015 census recorded Roman Catholicism as the major religious denomination in Kiribati, followed

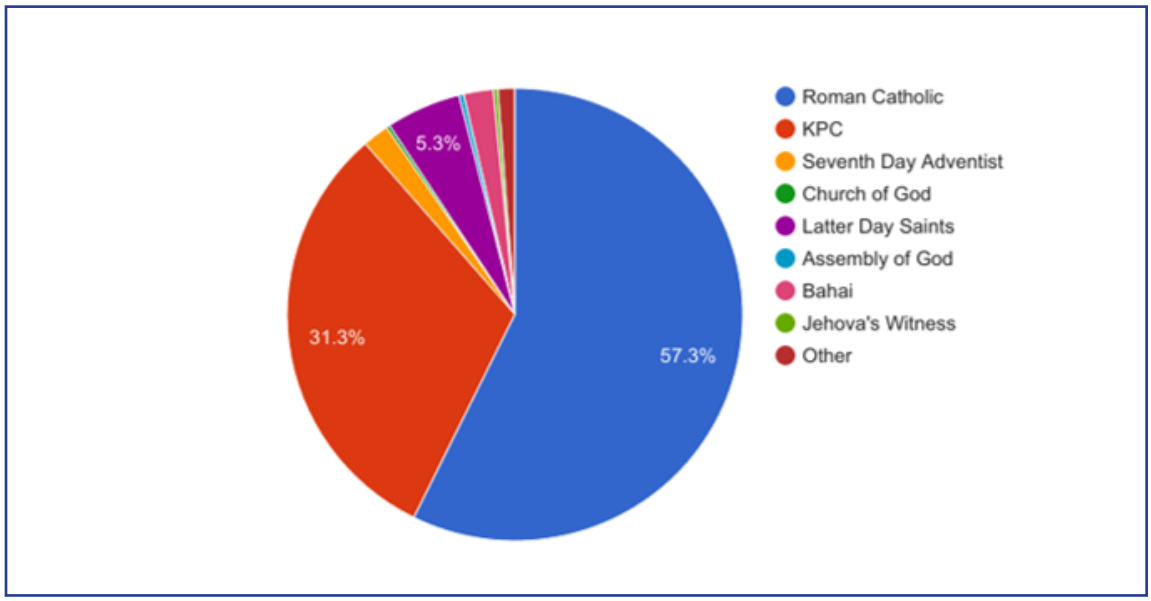
9 See Government of Kiribati, 'About Kiribati', on http://www.kiribatitourism.gov.ki/aboutkiribati [04.09.17].

10 KNSO, 'Kiribati Statistics', on http://www.mfed.gov.ki/statistics/ [04.09.17].

11 UNdata, 'Country Profile, Kiribati', on http://data.un.org/CountryProfile.aspx?crName=kiribati [04.09.17].

by Kiribati Protestant Church and Latter Day Saints, as seen in Figure 2.3. Other religions include Bahai (2.1 per cent), Seventh-day Adventist (1.9 per cent), Church of God (0.3 per cent), Assembly of God (0.3 per cent), Jehovah's Witness (0.3 per cent) and Other (1.2 per cent).

Figure 2.3: Religious make-up of Kiribati



Source: 2015 census

2.2. Main disaster and climate risks

The impacts of climate change on the future of Kiribati are perhaps the greatest challenge facing the nation. In response to this challenge, Kiribati developed a National Adaptation Programme of Action (NAPA) in 2007 and a National Framework for Climate Change and Climate Change Adaptation in 2013.[12] The 2013 framework sets out a number of steps related to improving energy efficiency and the use of renewable energy, and includes a plan to integrate climate change adaptation into national-level planning and institutional capacity-building. Furthermore, considering the impact of rising sea levels on Kiribati, the framework sets out a strategy for the overseas resettlement of people affected by climate change.

With few natural resources, and given its low-level islands, Kiribati is often overwhelmed by minor emergencies. The storm season between November and April brings strong winds and rainfall varies from island to island: some experience droughts of up to 16 months. The location of Kiribati in an area of high seismic activity makes it vulnerable to tsunamis generated by undersea earthquakes.[13]

12 http://www.president.gov.ki/wp-content/uploads/2014/08/National-Framework-for-Climate-Change-Climate-Change-Adaptation.pdf [25.04.17].

13 OCHA, 'Country Profiles, Kiribati', on http://www.unocha.org/pacific/country-profiles/kiribati [04.09.17].

Kiribati has been affected by a number of natural disasters over the past decade, most recently by Tropical Cyclone Pam in 2015, which affected 1,500 people. Severe flooding has also had impacts on the country in recent years; in 2008, Kiribati experienced severe sea swell floods, which affected 85 people; in 2014, king tides affected 220 people directly.[14]

There has been increasing attention paid to the effects of climate change on Kiribati, with the Intergovernmental Panel on Climate Change highlighting the threat of rising sea levels to the infrastructure and livelihoods of many Pacific Island communities. Of all the PICTS, Kiribati is thought to be the most vulnerable to the impacts of climate change, as the population has limited land on which it can recourse. With most of the islands of Kiribati reaching no higher than 6 metres above sea level and being less than 2 km wide, some scientists have even suggested that the islands of Kiribati, as well as Tuvalu, are at risk of disappearing by the middle of the century.[15]

Kiribati has a hot and humid tropical climate, and maximum temperatures in Tarawa have increased by approximately 0.18 degrees Celsius per decade since 1950. This increase is consistent with the worldwide pattern of global warming. As well as rises in sea levels, acidification of the ocean has increased as a result of a rise in carbon dioxide emissions. The reaction of the gas with sea water increases its acidity, affecting the balance of the tropical reef ecosystems.[16]

At the UN General Assembly in 2005, the Kiribati president at the time, Anote Tong, mentioned the need to seriously consider relocating as a form of adapting to climate change, stating that it may be too late for the nation of Kiribati to consider other forms of adaptation.[17] In 2014, the government under Anote Tong purchased around 25 km^2 of land in Fiji, as a possible resettlement area.[18]

2.3. Government and political context

Kiribati is an independent republic within the Commonwealth of Nations. The nation gained its independence from the British Empire in 1979, becoming a sovereign democratic republic with a unicameral legislature, or a single legislative chamber called the Maneaba ni Maungatabu.[19] The assembly has 44 members elected for four years, and the 2016 elections saw three women voted in as new MPs. The 2016 national election saw a total standing of 133 candidates, 18 of whom were women – an increase from the five women who registered for the 2011 elections.[20]

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14 CRED database.

15 Loughry, M. and McAdam, J., 'Kiribati – Relocation and Adaptation, Forced Migration Review, 2008: 51–2, on http://www.fmreview.org/climatechange/loughry-mcadam.html [04.09.17].

16 Changing Climate, 'Kiribati Climate Change', on http://www.climate.gov.ki/changing-climate/ [04.09.17].

17 Loughry and McAdam, 'Kiribati – Relocation and Adaptation'.

18 Ellsmoor, J. and Rosen, Z., 'Kiribati's Land Purchase in Fiji: Does It Make Sense?' Development Policy Centre Blog, 11 January 2016, on http://devpolicy.org/kitibatis-land-purchase-in-fiji-does-it-make-sense-20160111/ [04.09.17]; ADB, 'Asian Development Outlook 2016 Update', on https://www.adb.org/sites/default/files/publication/197141/ado2016-update.pdf [04.09.17].

19 The Commonwealth, 'Kiribati: Constitution and Politics', on http://thecommonwealth.org/our-member-countries/kiribati/constitution-politics [04.09.17].

20 Pacific Women in Politics, 'Kiribati', on http://www.pacwip.org/future-elections/kiribati/ [04.09.17].

Unlike in many PICTS that have adopted the Westminster system, the electoral system in Kiribati is dependent on the majority vote of its citizens. Parliamentarians in Kiribati must receive more than 50 per cent of the votes, and run-off elections are held if popular support is not received in the first round of voting.[21]

The Kiribati National Youth Council, an umbrella organization for youth organizations in Kiribati, was founded in 2007. It aims to give 'more visibility, commitment and impact for the young people in Kiribati'.[22]

2.4. Socio-economic context

> *Kiribati's current national development plan is the Kiribati Development Plan 2016–2019, which has a vision 'Towards a better educated, healthier, more prosperous nation with a higher quality of life' and a mission 'To promote better education, better health and inclusive sustainable economic growth and development through the implementation of higher education standards, the delivery of safe, quality health services and the application of sound economic policies.'*[23]

Kiribati is a lower-middle-income country, with a gross domestic product (GDP) per capita of US$ 1,424.[24] It uses the Australian dollar as a currency. Banaba, a Gilbert Island, was once home to the phosphate industry, run by the British Phosphate Commission. Mining at the time accounted for 80 per cent of exports and 50 per cent of government revenue. The mines were exhausted in 1979, the year of independence, and the loss of this industry caused a drop in GDP.[25] Presently, around 90 per cent of Kiribati's income comes from fishing licence fees from its large economic zone.[26]

According to the Asian Development Bank (ADB), growth in Kiribati is expected to be moderate in 2016, at 1.8 per cent, and is forecast to decrease to 1.5 per cent in 2017, as a result of depressed fishing in its exclusive economic zone.[27] This is said to be a result of El Niño, which is the phenomenon of warming of surface ocean waters in the eastern tropical Pacific.[28] Climate-related disasters have encouraged the current government of Kiribati to move away from depending on

21 Aqorau, T., 'Political Intrigues in the Pacific Islands – the Dire Need for Political Stability', Development Policy Centre Blog, 9 February 2016, on http://devpolicy.org/political-intrigues-in-the-pacific-islands-the-dire-need-for-political-stability-20160210/ [04.09.17].

22 Youth Policy, 'Factsheets, Kiribati', on http://www.youthpolicy.org/factsheets/country/kiribati/ [04.09.17].

23 http://www.mfed.gov.ki/sites/default/files/Kiribati%20Development%20Plan%202016%20-%2019.pdf [01.08.17].

24 World Bank, 'GDP Per Capita (Current US$), Kiribati', on http://data.worldbank.org/indicator/NY.GDP.PCAP.CD?locations=KI [04.09.17].

25 The Commonwealth, 'Kiribati: Economy', on http://thecommonwealth.org/our-member-countries/kiribati/economy [04.09.17].

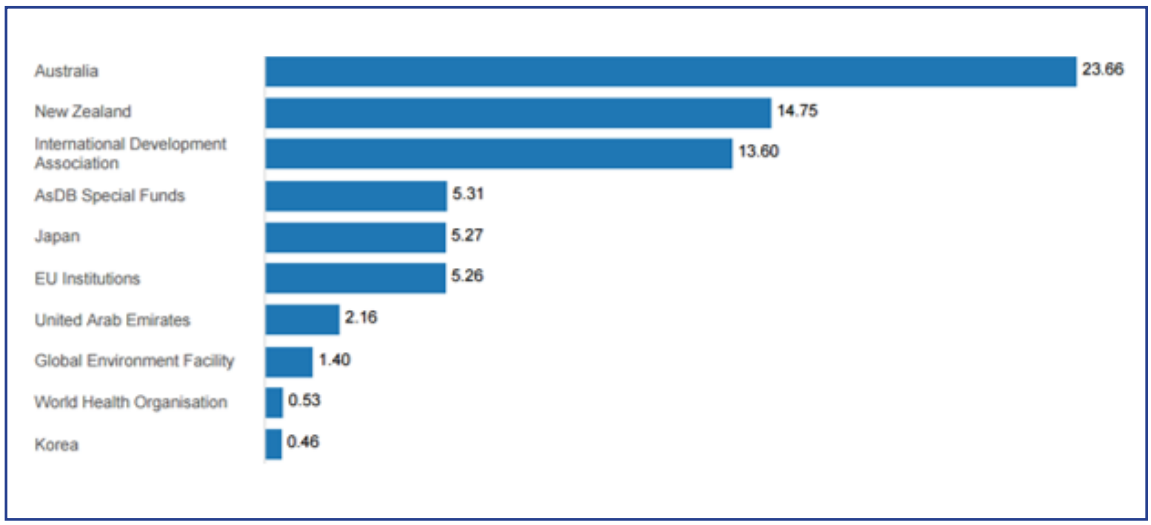
26 Global Partnership for Effective Development Co-operation. 'Monitoring Profile, Kiribati', October 2016, on http://effectivecooperation.org/wp-content/uploads/2016/10/Kiribati_4.10.pdf [04.09.17].

27 ADB, 'Kiribati: Economy', on https://www.adb.org/countries/kiribati/economy [04.09.17].

28 OCHA, 'El Niño in the Pacific', on http://www.unocha.org/el-nino [04.09.17].

the revenue from licensing fees by improving the Revenue Equalization Reserve Fund.[29] The fund was created in 1956, before Kiribati's independence, through the taxation of phosphate mining as well as overseas investment. It is a sovereign wealth fund and is used to finance fiscal deficits.[30] The government has used the revenue to replenish fund resources, and has adopted a more conservative policy regarding asset allocation.[31]

Figure 2.4: Top 10 donors of gross ODA for Kiribati 2014–2015 (US$ million)



Source: OECD Aid Charts at a Glance 2014–2015[32]

The 2014–2015 average of official development assistance (ODA) received by Kiribati amounted to US$ 72.4 million, with most of the aid (US$ 23.66 million) coming from Australia. The remaining ODA donors of ODA can be seen in Figure 2.4. Figure 2.5 gives an outline of the distribution of bilateral ODA received by Kiribati, with 33.1 per cent going to education.

Most of the population of Kiribati lives a subsistence lifestyle, though the country has few natural resources and relies heavily on imports. Lack of land, droughts and infertile soil on the coral islands prohibit large-scale agriculture.[33] The 2015 census recorded a total population of 71,698 of age 15 and above, with 53.1 per cent living in South Tarawa. A total of 60.7 per cent of the 15 and older population was recorded as not employed; 39.3 per cent of this population was recorded as 'actively seeking work'. Figure 2.6 shows the work status of working age population.

29 ADB Asian Development Outlook Update.

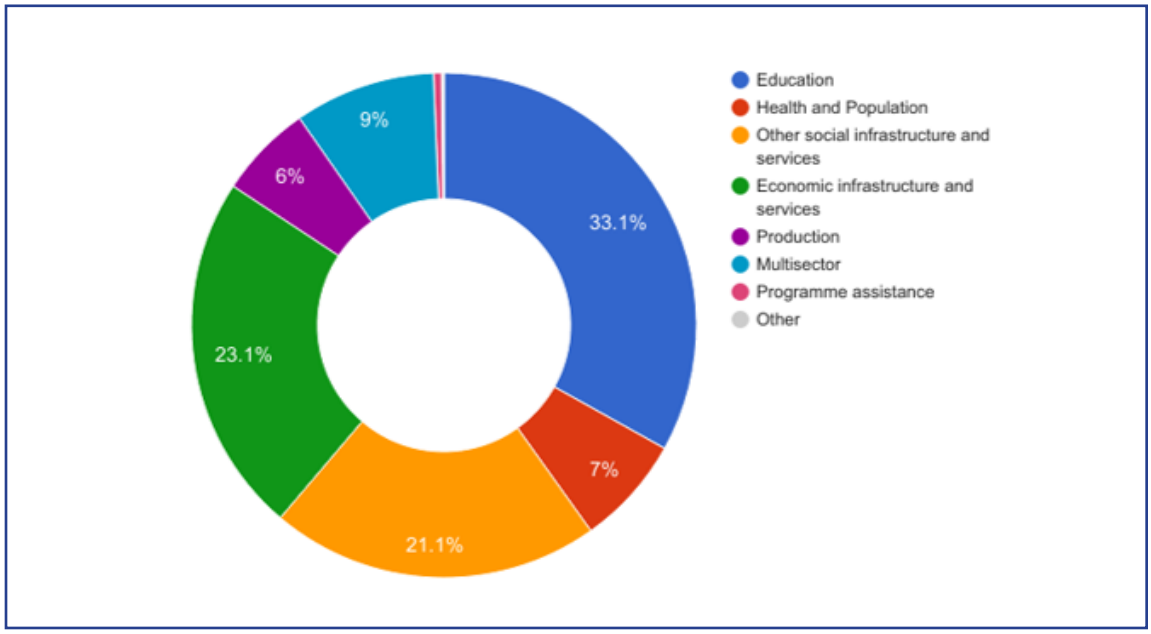
30 Save Kiribati, 'Economy', on http://savekiribati.com/economy.php [04.09.17].

31 ADB Asian Development Outlook 2016 Update.

32 OECD, Top Ten Donors of Gross ODA for Kiribati, on http://www.oecd.org/countries/kiribati/aid-at-a-glance.htm#recipients [04.09.17].

33 Save Kiribati, 'Agriculture', on http://savekiribati.com/agriculture.php [04.09.17].

Figure 2.5: Bilateral aid by sector for Kiribati



Source: OECD Aid Charts at a Glance 2014–2015[34]

A total of 42.5 per cent of the employed population is female and 57.5 per cent is male; 38.2 per cent of the employed population works within the agriculture, fishing or mining industries and 10.4 per cent within the education and health sectors. Male workers dominate the agriculture, forestry and mining industry (4,929 compared with 1,054 female workers); female workers dominate the health sector (545 compared with 239 male workers). The 2015 census also shows that 16.9 per cent of the working population is aged between 15 and 24, with 60.3 per cent of this group being male and 39.7 per cent female. The 2010 census provided a figure of 54 per cent for youth unemployment.[35]

According to the National Youth Policy 2011–2015, only around 400–600 paid jobs are available to the over 2,000 students leaving school each year. This highlights a lack of opportunity for the younger population in the country.[36]

In the 2015 Human Development Index, Kiribati was ranked 137th out of the 188 participating countries.[37] In the same year, the UN Committee for Development Policy decided not to recommend Kiribati's graduation from least developed country status, largely because of its economic vulnerability. The situation will be reviewed again in 2018.[38]

34 OECD, 'Bilateral ODA Received by Sector for Kiribati', on http://www.oecd.org/countries/kiribati/aid-at-a-glance.htm#recipients [04.09.17].

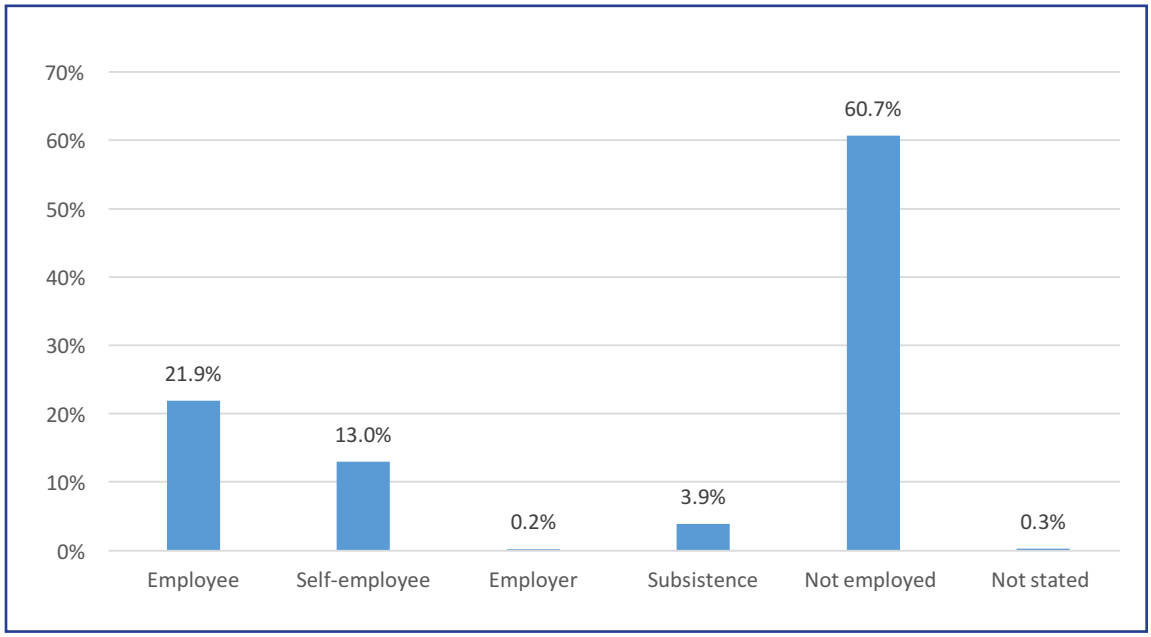
35 KNSO, 'Report on the Kiribati 2010 Census of Population and Housing', August 2012, on http://www.mfed.gov.ki/sites/default/files/Census-Report-2010-Volume-1_3.pdf [04.09.17].

36 http://www.youthpolicy.org/national/Kiribati_2011_National_Youth_Policy.pdf [04.09.17].

37 Global Partnership for Effective Development Co-operation, 'Monitoring Profile, Kiribati'.

38 Kiribati Development Plan 2016–2019.

Figure 2.6: Work status of population age 15 years and above (N=71,698)



Source: 2015 Census

Kiribati has not outright achieved any of the Millennium Development Goals (MDGs); however, according to FAO, the country has reached one of the three targets in relation to eradicating extreme poverty. Food security milestones were reportedly achieved prior to the global 2015 deadline. Promoting gender equality and empowering women is also on track to be achieved, with high proportions of women in the public sector and executive positions.[39] The number of individuals living below the national poverty line is recorded to be 21.8 per cent, which is actually the second lowest poverty rate among PICTS.[40]

Gini coefficient figures indicate low levels of inequality in the country, in comparison with other PICTS, with a national coefficient of 0.39, and 0.35 for South Tarawa. Inequality is reported to be 17 per cent lower in South Tarawa than in the rest of the Gilbert Islands.[41]

2.5. Legislative and policy framework

The Cabinet of Kiribati is the top decision-making body of the government and currently consists of 14 members, including the President. The president appoints members of the Cabinet, from among the MPs, and only Parliament can undo a Cabinet decision.[42] The president also appoints

39 MFED, 'Millennium Development Goals: Kiribati'. June 2015, on http://www.mfed.gov.ki/publications/millennium-development-goals-kiribati-june-2015 [04.09.17].

40 Global Partnership for Effective Development Co-operation, 'Monitoring Profile, Kiribati'.

41 UNCTAD, 'Vulnerability Profile of Kiribati', December 2014, on http://www.un.org/en/development/desa/policy/cdp/cdp_news_archive/2015-cdp-plen-pre-6b.pdf [04.09.17].

42 Republic of Kiribati Presidential Web Portal, 'Cabinet', on http://www.president.gov.ki/cabinet/ [04.09.17].

the head of the judiciary, known as the chief justice, under advice from the Cabinet as well as in consultation with the Public Service Commission. This process adheres to Section 81 of Chapter 6 of the Constitution of Kiribati.[43]

The judiciary of Kiribati consists of the Privy Council (UK), the Court of Appeal, the High Court and the magistrates' courts. The magistrates' courts have jurisdiction within the limits of the district in which they are situated. The High Court appears to have unlimited original jurisdiction in civil and criminal cases. The Court of Appeal has jurisdiction to hear civil and criminal appeals as of right from any High Court decision on a question of law. The Privy Council has jurisdiction from any High Court decision involving the interpretation of the Constitution where application to the High Court was made in concordance with Chapters 3 and 9 of the Constitution of Kiribati.[44]

Kiribati ratified the CRC in December 1995. Twenty years later, it ratified both Optional Protocols to the CRC (on children in armed conflict and on the sale of child prostitution and child pornography).[45]

In 2015, it was reported that Kiribati had passed a new Juvenile Justice Bill, to ensure the protection and respectful treatment of children and youth with charged or alleged offences. The Act will focus on keeping children out of adult prisons, and provide opportunities for the community to participate in the rehabilitation and reintegration of youth offenders. A separate Juvenile Court will be established, to ensure children do not have to go through regular courts set up for adults.[46]

Chapter 2 of the Constitution of Kiribati is dedicated to the 'protection of fundamental rights and freedoms of the individual'. This chapter states that 'Every person in Kiribati is entitled to the fundamental rights and freedoms of the individual… whatever his race, place of origin, political opinions, colour, creed or sex.' The chapter contains many rights and freedoms, including protection of the right to life and personal liberty and from slavery and forced labour.

Kiribati reports a reasonably high rate of human rights literacy. The 2015 census asked the population (aged six years and over) whether they had heard of 'human rights'; out of 92,660 people, 82.2 per cent said they had, whereas 17.5 per cent said they had not.

In September 2013, Kiribati ratified the Convention on the Rights of Persons with Disabilities (CRPD).[47] In its 2014 Universal Periodic Review (UPR), Kiribati was recommended to amend Article 15 of the Kiribati Constitution, which prohibits discrimination on the grounds of race, place of origin, political opinions, colour or creed, to include disability. The UPR also encouraged the government of Kiribati to harmonize existing domestic laws with the CRPD.[48]

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43 Republic of Kiribati Judiciary, 'Kiribati Annual Court Report 2012, 2013, 2014', on www.fedcourt.gov.au/__data/assets/pdf_file/0012/30810/Kiribati-Annual-Court-Report-2012-2014.pdf [04.09.17].

44 PacLII, 'Kiribati Courts System Information', on http://www.paclii.org/ki/courts.html [04.09.17].

45 OHCHR, 'Ratification Status for Kiribati', on http://tbinternet.ohchr.org/_layouts/TreatyBodyExternal/Treaty.aspx?CountryID=40&Lang=en [04.09.17].

46 UNICEF, 'Kiribati Passes Juvenile Justice Bill to Ensure Safety of Children in Contact with the Law', 31 August 2015, on https://www.unicef.org/pacificislands/1852_24592.html [04.09.17].

47 OHCHR, ' Ratification Status for Kiribati'.

48 UNESCAP, 'Universal Periodic Review Second Cycle – Kiribati – Reference Documents', 13 June 2014, on http://www.ohchr.org/EN/HRBodies/UPR/Pages/UPRKIUNContributionsS21.aspx [04.09.17].

Kiribati ratified the Convention on the Elimination of All Forms of Discrimination against Women (CEDAW) in March 2004,[49] and in 2011 it established the National Approach to Eliminating Sexual and Gender-Based Violence in Kiribati along with a Policy and National Action Plan (2011–2021). The Plan outlines the strategies and activities that will be implemented in a 10-year timeframe to achieve a more sustainable change towards ultimately eliminating violence against women and children.[50] The government hopes to eradicate all forms of violence against women, at local, national, regional and international levels, through policy commitments such as strengthening and improving preventive, protective, social and support services.

2.6. Child rights monitoring

In general, Kiribati has not kept up with its reporting requirements in relation to international human rights treaties, as Table 2.1 illustrates.

Table 2.1: Kiribati's treaty-body reporting requirements[51]

	Status	Past reports	Next report due
CRC	11 December 1995 (A)	22 August 2005	Consolidated 2nd, 3rd and 4th reports, overdue since 2011
CRC OP1	16 September 2015 (A)	-	-
CRC OP2	16 September 2015 (A)	-	-
CEDAW	11 March 2004 (A)	-	Initial, 2nd and 3rd reports overdue since 2005, 2009 and 2014, respectively
CRPD	27 September 2014 (A)	-	-

49 OHCHR, 'Ratification Status for Kiribati'.

50 http://www.mfed.gov.ki/publications/sexual-and-gender-based-violence [04.09.17].

51 OHCHR, 'Reporting status for Kiribati' on http://tbinternet.ohchr.org/_layouts/TreatyBodyExternal/Countries.aspx?CountryCode=KIR&Lang=EN [04.09.17]

3.

Health and Nutrition

The situation analysis of child and maternal health in Kiribati is framed around the CRC (particularly the rights to life, survival and development and to health) and the SDGs, in particular SDG 3 on ensuring healthy lives and promoting well-being. The following assessment and analysis covers the following broad areas: child mortality, child health, immunization/communicable diseases, maternal health and adolescent health. Furthermore, the situation of child and maternal nutrition in Kiribati is analysed regarding the six thematic areas described in WHO's Global Nutrition Targets: childhood stunting; anaemia; low birthweight; obesity/overweight; breastfeeding; and wasting/acute malnutrition. The respective sub-sections set out the specific international development targets pertaining to each thematic area.

Key Health and Nutrition-related SDGs

SDG	Target	Indicator
2.2	By 2030, end all forms of malnutrition, including achieving, by 2025, the internationally agreed targets on stunting and wasting in children under 5 years of age, and address the nutritional needs of adolescent girls, pregnant and lactating women and older persons	Prevalence of stunting (height for age <-2 standard deviation from the median of the World Health Organization (WHO) Child Growth Standards) among children under 5 years of age
		Prevalence of malnutrition (weight for height >+2 or <-2 standard deviation from the median of the WHO Child Growth Standards) among children under 5 years of age, by type
3.1	By 2030, reduce the maternal mortality ratio to less than 70 per 100,000 live births	Maternal mortality ratio
		Proportion of births attended by skilled health personnel

3.2	By 2030, end preventable deaths of newborns and children under 5 years of age, with all countries aiming to reduce neonatal mortality to at least as low as 12 per 1,000 live births and under-5 mortality to at least as low as 25 per 1,000 live births	Under-5 mortality rate
		Neonatal mortality rate
3.3	By 2030, end the epidemics of AIDS, tuberculosis, malaria, and neglected tropical diseases and combat hepatitis, water-borne diseases, and other communicable diseases	Number of new HIV infections per 1,000 uninfected population, by sex, age and key populations
		TB incidence per 1,000 population
		Malaria incidence per 1,000 population
3.7	By 2030, ensure universal access to sexual and reproductive health care services, including for family planning, information and education, and the integration of reproductive health into national strategies and programs	Proportion of women of reproductive age (aged 15–49 years) who have their need for family planning satisfied with modern methods
		Adolescent birth rate (aged 10–14 years; aged 15–19 years) per 1,000 women in that age group

The analysis here takes a 'health systems approach'. A country's health system includes 'all organisations, people and actions whose primary intent is to promote, restore or maintain health'.[52] According to WHO/UNICEF guidance, the following six building blocks make up a country's health system: 1) leadership and governance; 2) health care financing; 3) health workforce; 4) information and research; 5) medical products and technologies; and 6) service delivery.[53] The analysis of underlying causes of shortcomings and bottlenecks in relation to child (and maternal) health and nutrition in Kiribati takes these building blocks of the health system into account (where relevant). Furthermore, cross-references to other relevant parts of the SitAn (e.g. WASH) are made where necessary, given that the causes of shortcomings in health systems are often multifaceted and interlinked with other areas covered in the SitAn.

3.1. Child mortality

Neonatal mortality (0–28 days), infant mortality (under one year) and under-five mortality have been declining since the early 1990s. However, despite this progress over the past decades, Kiribati has not been able to meet international development goals related to child mortality, and has the second-highest under-five child mortality rate in the PICTS group, with only Papua New Guinea (PNG) reporting a higher rate.[54]

52 UNICEF and WHO, 'Building Block, Nutrition Integration, and Health Systems Strengthening', 2016, on https://www.unicef.org/supply/files/GLC2_160615_WHO_buildling_blocks_and_HSS.pdf [02.03.17].

53 Ibid.

54 NMDI data, on https://www.spc.int/nmdi/vital_statistics [25.04.17].

According to the latest national estimates summarized in the 2016 SOWC dataset, the under-five child mortality rate in Kiribati stands at 56 deaths per 1,000 live births as of 2015, which represents a 42 per cent reduction since 1990. The 56/1,000 average rate means Kiribati is far from the SDG 3.2 target on under-five child mortality – that is, a reduction to at least 25/1,000 by 2030. However, in light of Kiribati's progress over the past decades, it is quite likely the country will reach the SDG target of 25/1,000 by 2030. Note that the under-five mortality rate in Kiribati remains somewhat higher for boys (61/1,000) than for girls (51/1,000).

The majority of the under-five deaths occur before the age of one. The infant mortality rate (for under one year olds) was estimated in the SOWC 2016 dataset to stand at 44/1,000 as of 2015, which represents a 36 per cent reduction from 69/1,000 in 1990. The SDGs do not include an explicit target linked to infant (under-one) mortality, but instead focus on under-five and neonatal mortality. Neonatal mortality in Kiribati is estimated to stand at 24 deaths per 1,000 live births in the SOWC dataset. This means Kiribati has also not yet met the SDG 3.2 target for neonatal mortality, which aims for a rate of 12/1,000 by 2030. Regional data from the NMDI database also suggest Kiribati's infant mortality rate is the second highest in the Pacific Islands region, with (again) only PNG having a higher rate than Kiribati.[55]

While child mortality rates in Kiribati have experienced an overall decline since 1990, they have also fluctuated heavily in this period. For example, Kiribati's 2015 MDG Progress Report notes that, while the infant mortality rate had fallen to a low 1/1,000 in 2007, rates increased again significantly to 37/1,000 in 2010, reversing previous progress.[56]

Aggregate figures also hide important differences *within* Kiribati. For example, a 2013 UNICEF report on maternal and child survival in Kiribati suggests child mortality rates are significantly higher in Kiribati's remote outer islands. The report also indicates that child mortality is higher among poorer households and among mothers with lower levels of education.[57]

Causes-of-death estimates that most deaths in under-five children in Kiribati, as of 2015, owed to pneumonia (17 per cent of all deaths in under-five children), followed by pre-term complications (15 per cent), intra-partum complications (13 per cent), congenital diseases (10 per cent) and diarrhoea (9.5 per cent). It is notable that unspecified 'other causes' make up the largest category of all causes of death in under-five year olds in Kiribati (18 per cent), suggesting classification problems in the country's health information system (see Figure 3.1).

Worryingly, it appears that more than 50 per cent of all births in Kiribati are in at least one of the recognized avoidable high-risk categories: the mother is older than 34 years, the birth interval is less than two years or the pregnancy is the fourth or more.[58] Based on 2009 Demographic and Health Survey (DHS) data, it is estimated that a birth in such an avoidable high-risk category is twice as likely to result in death as a birth that is not in such a category.[59]

55 Ibid.

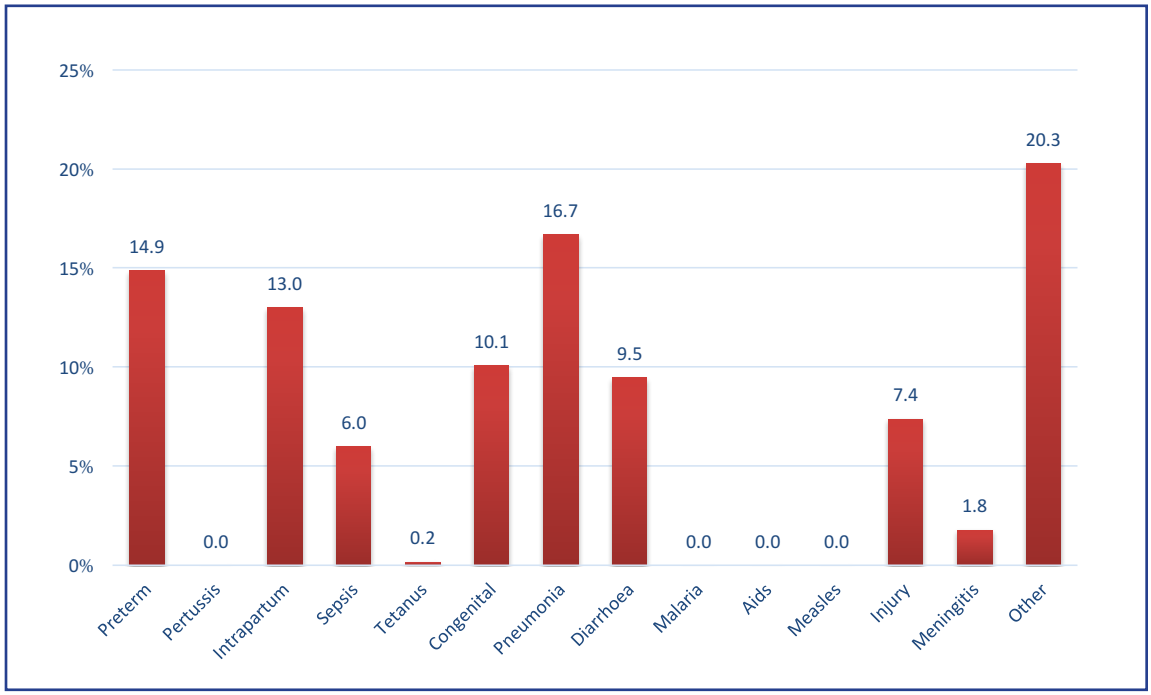
56 Government of Kiribati, 'Millennium Development Goals: Kiribati Progress to June 2015', on http://www.mfed.gov.ki/publications/millennium-development-goals-kiribati-june-2015 [25.04.17].

57 UNICEF, 'Kiribati: Tracking Progress in Maternal and Child Survival. A Case Study Report', 2013, on https://www.unicef.org/pacificislands/14-02-2014_Kiribati_Case_Study_For_Delivery_to_UNICEF_8-29-2013_conversion.pdf [25.04.17].

58 Ibid.

59 Ibid.

Figure 3.1: Causes of death (percentage of all deaths in under-five children)



Source: UNICEF 2016[60]

Many of the underlying causes of the very high child mortality rates in Kiribati relate to poverty, overcrowding, lack of family planning, poor diet and limited access to improved water and sanitation facilities. For example, data from Chapter 4 on water and sanitation shows over one third of Kiribati's of population practice open defaecation, which, combined with a lack of hand-washing habits, leads to the spread of diseases (including diarrhoea), particularly among children.

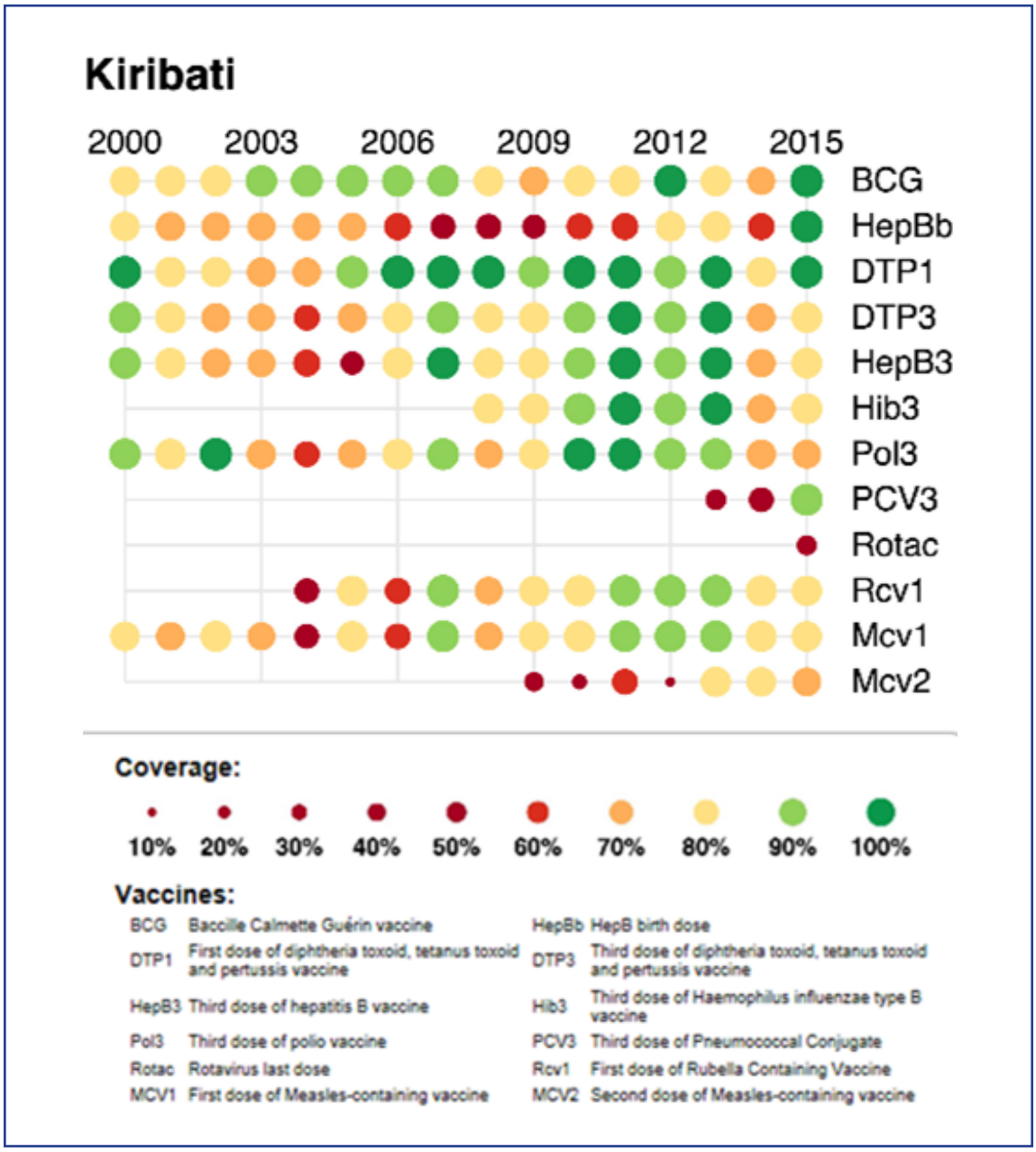
3.2. Child health, immunization and communicable diseases

According to the most recent estimates (the 2016 SOWC dataset), 81 per cent of children under five with suspected pneumonia in Kiribati are taken to a health provider. This rate of access in cases of suspected pneumonia is above the regional average for East Asia and the Pacific (74 per cent). In Kiribati, around 62 per cent of children under five with diarrhoea are estimated to receive oral rehydration salts, which is significantly above the regional average of 47 per cent for East Asia and the Pacific (excluding China). Diarrhoea continues to affect a large number of children in Kiribati, especially young children. For example, according to data from the 2009 DHS, 10 per cent of under-five children had diarrhoea in the two weeks before the survey, and diarrhoea prevalence is highest among those aged 12–23 months.[61]

60 UNICEF 2015. on https://data.unicef.org/topic/child-survival/under-five-mortality/ [05.06.17].

61 UNICEF, 'Kiribati: Tracking Progress in Maternal and Child Survival'.

Figure 3.2: Immunization coverage in Kiribati



Source: WHO Global Health Observatory 2016[62]

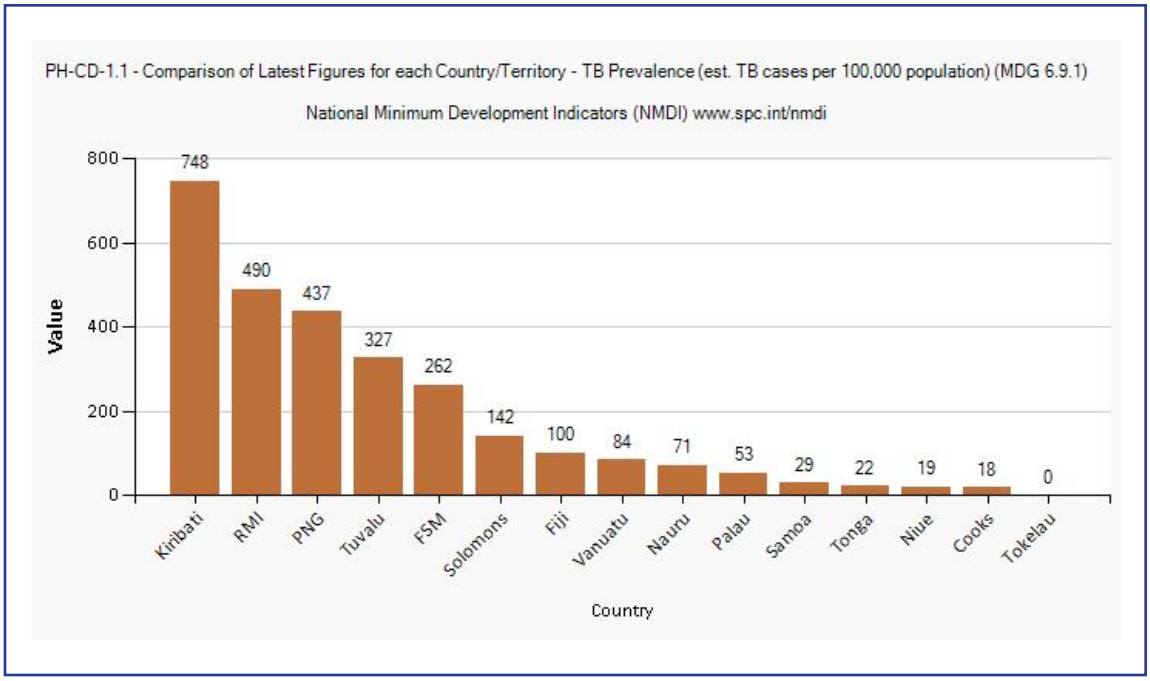
While the above indicators of child health suggest most children in Kiribati have adequate access to health care when needed, significant data gaps in relation to child health remain. For example, there appear to be no data on disparities between urban and rural areas (or wealth quintiles) in relation to diarrhoea treatment in Kiribati.

62 These WHO estimates are based on data officially reported to WHO and UNICEF by UN Member States as well as data reported in the published and grey literature. WHO's immunization coverage data are reviewed and the estimates updated annually. See http://apps.who.int/gho/data/node.wrapper.immunization-cov?x-country=KIR [25.04.17].

Good progress has been made in fighting (at least some) vaccine-preventable diseases in Kiribati. For example, UNICEF/WHO estimates suggest that 95 per cent of under-one year olds in Kiribati are fully immunized against DPT and 91 per cent against measles, both of which are near-universal coverage rates.[63] However, estimates provided by the WHO Global Health Observatory also indicate that Kiribati has significant gaps in immunization coverage for eight out of 12 universally recommended vaccines, for which the country has reached only a less than 80 per cent coverage rate (Figure 3.2).

SDG target 3.3 encourages all countries to eradicate TB by 2030. According to NMDI data, Kiribati has the highest TB prevalence in the whole Pacific region, with an estimated 748 cases per 100,000 population (see Figure 3.3 for regional comparison).[64] On a positive note, the TB detection rate was estimated to stand at 80 per cent as of 2013, which places Kiribati in the middle range of the PICTS group. WHO estimates also suggest TB treatment coverage stood at around 80 per cent, as of 2015, which suggests most TB-positive individuals in Kiribati have access to health care.[65]

Figure 3.3: TB prevalence per country



Source: NMDI 2016[66]

63 UNICEF Statistics, on https://data.unicef.org/country/kir/ [25.04.17].

64 NMDI data, on https://www.spc.int/nmdi/communicable_diseases [25.04.17].

65 WHO TB country profiles, on http://www.who.int/tb/country/data/profiles/en/ [25.04.17].

66 NMDI data, on https://www.spc.int/nmdi/communicable_diseases [25.04.17].

3.3. Maternal health

According to SDG 3.1, all countries should aim to reduce the maternal mortality ratio to less than 70 per 100,000 live births by 2030. According to latest UN estimates of 2015, Kiribati's MMR stands at 90 per 100,000 live births, which is still significantly above the SDG target.[67] However, it is important to note that estimates for Kiribati are quite unstable, given that they are based on a very small number of deaths per year. Overall, the total number of maternal deaths has decreased over the past decades, from six in 1990 to only three in 2015.[68]

The 2013 UNICEF report on child and maternal survival suggests that all of the most recent maternal deaths reported in Kiribati resulted from haemorrhage.[69] However, it is difficult to establish a meaningful causes-of-death 'hierarchy' based on such a small number of cases, as only a few deaths per year can significantly alter the outcome here.

According to the 2009 DHS, estimated antenatal coverage for at least one visit stands at 88 per cent, which indicates that initial care is accessible to most pregnant women in Kiribati. Slightly higher proportion of women in urban areas (91 per cent) received antenatal services compared to women in rural areas (87 per cent). However, antenatal coverage for at least four visits is estimated to stand at a lower 71 per cent, suggesting that families need to be incentivized to make more regular visits to clinics for antenatal checks. Recent data also suggest an overwhelming majority of pregnant women in Kiribati give birth in the presence of a skilled health professional (80 per cent). However, only slightly more than half of all deliveries take place in a health facility (institutional delivery in 60 per cent of cases). Caesarean sections are carried out in 10 per cent of births in Kiribati.

The 2013 UNICEF report on child and maternal survival suggests pregnant women living in rural areas tend to have their first antenatal consultation visit later than urban women, which may indicate that access is more difficult in rural areas, but it is not clear about which data source this statement is based on.[70] The report also suggests that traditional birth attendants still play an important role in the delivery process, especially in the outer islands, and it estimates that traditional birth attendants cater for the needs of 10–30 per cent of women in Kiribati.[71]

3.4. Violence against women and girls

Violence against women and girls is a key public health concern, and the data that exist suggest it is a significant problem in Kiribati. According to the nation-wide Kiribati Family Health and Safety Study, implemented in 2008, 68 per cent of ever-partnered women aged 15–49 had

67 https://data.unicef.org/topic/maternal-health/maternal-mortality/ [03.03.17].

68 Ibid.

69 UNICEF, 'Kiribati: Tracking Progress in Maternal and Child Survival', p. 14

70 Ibid.

71 Ibid., p. 19.

experienced some form of violence (emotional, physical and/or sexual) from an intimate partner. Physical partner violence prevalence alone was found to stand at 60 per cent, and sexual violence prevalence at 46 per cent.[72] A more detailed discussion of violence against women and girls in Kiribati can be found in Chapter 6 on 'Child Protection'.

3.5. Adolescent health

According to 2016 SOWC data, adolescents aged 10–19 years old make up 20 per cent of the total population of Kiribati, which amounts to 23,000 individuals in total. The proportion of adolescents (aged 10–19) in the total population is significantly above the regional average of 13 per cent for East Asia and the Pacific.

3.5.1. Fertility and contraceptive use

Reducing fertility rates and increasing contraceptive use is a critical issue facing Kiribati. The National Framework for Climate Change and Climate Change Adaptation 2013 highlights the urgent need to reach a stable population size of about 120,000 persons by 2025, which it estimates to be the maximum sustainable population size for Kiribati, on the basis of known and estimated land and water resources, and provided that effective climate change adaption measures are put in place.

It appears to be fairly common for women in Kiribati to have children at a relatively young age. According to 2009 DHS data, 21 per cent of surveyed women aged 20 had already given birth to at least one child, with the proportion increasing to 40 per cent at age 22 and 63 per cent at age 25.[73] Underage pregnancies are also fairly common in Kiribati, with SOWC 2016 data suggesting that, by the age of 18, roughly 9 per cent of teenage girls have become mothers. Teenage pregnancies affect young women's educational and economic prospects and those of their children, as children of teenage mothers tend to have poorer health and education outcomes.

According to World Bank estimates from 2015, the adolescent fertility rate in Kiribati stands at 16 (births per 1,000 women aged 15–19), which is below the regional average of 22/1,000 for East Asia and the Pacific. The World Bank data also reveal that the adolescent fertility rate is on the decline in Kiribati, having decreased continuously since the 1960s, when it stood at 72/1,000.[74]

Data on marriage rates among the adolescent population group highlight significant inequities between genders: while the percentage of men in this age group currently married or in union was estimated to be at 5 per cent, the percentage more than tripled to 16 per cent when looking at women in the same age group. The marriage rate for adolescent girls is also significantly higher

72 WHO, 'Measuring and Responding to Violence against Women in Kiribati', 2013, on http://www.wpro.who.int/toPICTS/gender/country_case_measuring_and_responding_to_gender-based_violence_kir.pdf?ua=1 [25.04.17].

73 KNSO and SPC, 'Kiribati Demographic and Health Survey 2009', on http://catalog.ihsn.org/index.php/catalog/4131 [25.04.17].

74 World Bank data, on http://data.worldbank.org/indicator/SP.ADO.TFRT?locations=KI [07.03.17].

than the regional average of 6 per cent for East Asia and the Pacific. Previous research has shown that early marriage reduces the likelihood that married women will have equal decision-making power in relation to family planning and contraceptive use.[75]

It is estimated in the SOWC data that contraceptive prevalence[76] in Kiribati stands at around 22 per cent of the population, which is significantly lower than the regional average of 63 per cent for East Asia and the Pacific.[77] The very low prevalence in Kiribati appears, in part, to result from supply-side constraints. For example, a 2013 UNICEF report on maternal and child survival suggests the supply of contraceptives is Kiribati is not reliable, with repeated stock-outs reported.[78] Data from the 2009 DHS suggest contraceptives are sourced primarily through the public sector, with government hospitals the most common public source (54 per cent), followed by health centres (23 per cent) and family planning clinics (9 per cent). The 2009 DHS also suggests 28 per cent of currently married women in Kiribati have an unmet need for family planning (with unmet need for limiting being roughly the same as unmet need for spacing). The same data source indicates that unmet need is particularly pronounced for the adolescent survey population (15–19 year olds), for whom nearly all demands for family planning are unmet (35 per cent of a total demand of 36 per cent). Unmet need also appears to be somewhat higher among women living in urban areas compared with women living in rural areas of Kiribati.

In addition to supply-side constraints, the existing data highlight demand-side constraints, with reported demand for contraceptives very low in Kiribati. The 2009 DHS data suggest only 50 per cent of all married women have a demand for family planning, whether this demand is met or unmet (this proportion drops to 5 per cent for unmarried women). It appears that dominant social and religious norms are the main underlying factor suppressing demand for contraceptives amongst Kiribati's population. For example, the 2009 DHS found that, among married women aged 15–49, the most commonly cited reason for not intending to use contraception was religion (29 per cent), followed at a much lower level by fear of side effects (11 per cent) and the desire to have as many children as possible (10 per cent). Interestingly, demand for family planning appears to be highest for women in the lowest wealth quintile, which suggests economic considerations (e.g. the need for additional income-earning capacity) also play an important role in determining demand for family planning services in Kiribati.

Finally, social norms that stigmatize sexual activity among (unmarried) adolescents may act as a barrier to accessing family planning services, especially in very small communities in Kiribati's outer islands, where 'There is little confidentiality in the health services, where everyone knows everyone, and young people can risk ridicule or beatings by asking for contraceptives.'[79]

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75 See Plan International, 'Getting the Evidence: Asia Child Marriage Initiative', on https://plan-international.org/publications/getting-evidence-asia-child-marriage-initiative [29.03.17].

76 Contraceptive prevalence is typically defined as the percentage of women of reproductive age who use (or whose partners use) a contraceptive method at a given point in time. Women 'of reproductive age' is usually defined as women aged 15–49. See e.g. http://indicators.report/indicators/i-29/ [21.03.17].

77 The regional average excludes China.

78 UNICEF, 'Kiribati: Tracking Progress in Maternal and Child Survival'.

79 UNICEF Pacific, 'Kiribati Islands. A Situation Analysis of Children, Women and Youth', 2005, p. 50, on https://www.unicef.org/pacificislands/Kiribati_Sitan.pdf [25.04.17].

3.5.2. HIV/AIDS and sexually transmitted infections

Kiribati is experiencing a low-level general HIV epidemic. According to the 2015 Global AIDS Progress Report compiled by Kiribati's Ministry of Health (MoH) in March 2015, there were 57 cumulative cases of HIV between 1991 and 2014.[80] Perhaps as a result of the small overall number of cases, there are no UN-validated estimates for HIV incidence (in children and women), mother-to-child transmission rates, anti-retroviral therapy (ART) treatment coverage or HIV-related deaths in Kiribati.[81] According to the Global AIDS Progress Report, in 2015 there were 23 confirmed AIDS-related deaths, four of which were of children. The report also suggests that high migration rates and high turn-over rates of the HIV clinical core team, combined with poor case management, have made it difficult to establish accurate ART treatment coverage for Kiribati.[82]

Although exact figures are not available, it appears that Kiribati's national AIDS response is heavily dependent on external donor funding, in particular the Global Fund Transitional Funding Mechanism and the New Funding Mechanism. This which raises concerns about the sustainability of existing prevention and treatment programmes.[83]

Data on the prevalence of sexually transmitted infections (STIs) in Kiribati are extremely poor, but the few data that are available suggest STIs are a significant problem. For example, the 2015 Global AIDS Progress Report suggests the prevalence of chlamydia ranges from 5 to 10 per cent, although it notes that the data source is not nationally representative.[84] These relatively high STI rates raise concerns about potential future increases in HIV cases, as they indicate that the underlying behavioural risks for HIV transmission are significant.

3.5.3. Substance abuse

There are limited quantitative data on substance abuse among adolescents in Kiribati. The most important national data source in this respect is the Global School-Based Health Survey (GSHS), which was implemented in Kiribati in 2011, using a representative sample of 1,582 pupils aged 13–15 (in Forms 2–4).[85]

Although the purchase and consumption of alcohol are prohibited by law (Liquor Ordinance of 1973 and Manufacture of Alcohol Act of 1997), it appears that this prohibition is not enforced by any of responsible agencies.[86] The available data suggest alcohol consumption is very common among Kiribati's under-age (under-18) population. According to the GSHS data, two in three pupils (66 per cent) aged 13–15 reported having consumed alcohol before the age of 14 years. A total of 30 per cent indicated that they had consumed alcohol on at least one day during the 30 days

80 MoH, 'Global AIDS Response Progress: Kiribati Country Progress Report 2015', on http://www.unaids.org/sites/default/files/country/documents/KIR_narrative_report_2015.pdf [26.04.17].

81 SOWC 2016 and https://data.unicef.org/country/kir/ [11.04.17].

82 MoH, 'Global AIDS Response Progress: Kiribati Country Progress Report 2015'.

83 Ibid., p. 23.

84 MoH, 'Global AIDS Response Progress: Kiribati Country Progress Report 2015'.

85 See http://www.who.int/chp/gshs/2011_GSHS_FS_Kiribati.pdf?ua=1 [12.04.17].

86 National Youth Policy 2011–2015, p. 17.

before the survey was implemented. Note that these figures are likely to underestimate the true prevalence of alcohol consumption among under-age respondents, as the legal prohibition will have prevented some respondents from accurately reporting their behaviour.

Alcohol consumption appears to be significantly higher among boys (44 per cent) than among girls (19 per cent), according to the GSHS data.[87] The National Youth Policy 2011–2015 attributes these gender differences in alcohol consumption to underlying social norms, according to which young women are expected not to drink.[88] Alcohol contributes to the high rate of traffic accidents in the country, particularly in South Tarawa,[89] and, as mentioned earlier, also contributes to high levels of domestic violence in Kiribati.[90]

As with alcohol consumption, tobacco use is also quite common among Kiribati's youth population. Around 26 per cent of pupils aged 13–15 surveyed in the 2015 GSHS indicated that they had used tobacco products on at least one day during the previous 30 days, with boys more likely to report having used tobacco (34 per cent) than girls (19 per cent). It appears that many children in Kiribati are introduced to tobacco at a very early age, with 76 per cent of pupils who had previously smoked indicating that they had first tried a cigarette before the age of 14 years. Tobacco use is the only risk factor common to all four main non-communicable diseases (NCDs)[91] and exacerbates virtually all other NCDs.[92]

The National Youth Policy 2011–2015 highlights the socio-cultural roots of widespread tobacco use in Kiribati. It suggests that the gift of tobacco (*mweaka*) is a key part of spiritual beliefs in the outer islands, and that, in more urbanized areas, *mweaka* is still considered polite.[93]

In contrast with alcohol and tobacco use, marijuana use does not appear to be a major problem among Kiribati's adolescent population. According to the GSHS data, 4 per cent of surveyed pupils indicated that they had previously consumed marijuana, with boys (again) somewhat more likely to report consuming marijuana (7 per cent) than girls (2 per cent).[94] While these gender differentials in relation to substance abuse may reflect real differences in behaviour between boys and girls, it is important to note that survey findings may also reflect differences in *reporting* between boys and girls, which may be influenced by (gendered) social norms that make substance abuse by boys/young men more acceptable.

87 Note that the 95 per cent confidence intervals do not overlap, so the difference is statistically significant.

88 P. 17.

89 Ibid.

90 WHO, 'Measuring and Responding to Violence against Women in Kiribati'.

91 The four main NCDs are diabetes, cardiovascular disease, cancer and chronic respiratory disease. See World Bank, 'Pacific Possible: Health & Non-Communicable Diseases', on http://pubdocs.worldbank.org/en/942781466064200339/pacific-possible-health.pdf [21.03.17].

92 World Bank, 'Pacific Possible: Health & Non-Communicable Diseases'.

93 P. 17.

94 Note that this difference is not statistically significant at the 95 per cent threshold, as the confidence intervals overlap.

3.5.4. Mental health

Kiribati's mental health legislation, the Mental Health Act 1977, is out-dated and does not reflect the CRPD, given its heavy focus on the institutionalization of mental health patients.[95] As of April 2017, it appears that a badly needed review of the 1977 Act is still under way.[96]

Kiribati's health information system does not allow for the precise quantification of the prevalence of mental disorders (in the general population as well as among adolescents), and a recent situation analysis of mental health in Kiribati highlighted the lack of data.[97] However, existing data suggest adolescent mental health is an area of concern.

The 2011 GSHS collected limited information about adolescent mental health. For example, the data indicate that 31 per cent of all pupils aged 13–15 had attempted suicide during the 12 months before the survey was implemented, which is worryingly high. Male pupils were slightly less likely to report having attempted suicide (30 per cent) than female pupils (31.5 per cent).[98] Beyond the GSHS, there appear to be few quantitative data on the mental health of adolescents and children in Kiribati. As a result, little is known about the mental health of Kiribati's youth outside of the age range of 13–15 and about the mental health of out-of-school youth.

According to the National Youth Policy 2011–2015, there were 21 suicides recorded in 2005. The policy document also suggests the majority of youth suicides in the country were linked to relationship disputes, excessive alcohol use and depression.[99]

The 2013 situation analysis on mental health in Kiribati suggests that health professionals receive very minimal training on mental health issues, and laments that there is no separate budget allocation for mental health within government health spending, which, according to the authors, has resulted in inadequate funding for mental health services in Kiribati.[100]

3.6. Nutrition

SDG 2.2 encourages states to end all forms of malnutrition by 2030, including achieving, by 2025, the internationally agreed targets on stunting and wasting in children under five years of age (the WHO Global Nutrition Targets), and to address the nutritional needs of adolescent girls, pregnant and lactating women and older persons.[101]

95 WHO, 'Profile on Mental Health in Development (WHO proMIND): Republic of Kiribati', 2013, on http://apps.who.int/iris/bitstream/10665/85307/1/9789241505673_eng.pdf [10.04.17].

96 See e.g. VSA News, on https://www.vsa.org.nz/blog/news/frangipanis-in-bloom-mental-health-in-kiribati/ [26.04.17].

97 WHO, Kiribati proMIND.

98 Note that 95 per cent confidence intervals overlap.

99 P. 17.

100 WHO, Kiribati proMIND.

101 See Sustainable Development Knowledge Platform, : https://sustainabledevelopment.un.org/sdg2 [10.04.17].

According to WHO's Global Nutrition Targets, Kiribati should, by 2025, aim to, achieve results in relation to stunting, anaemia, low birthweight, childhood overweight, exclusive breastfeeding in the first six months and childhood wasting.[102]

WHO Global Nutrition Targets

	Target	Indicator
1	By 2025, achieve a 40 per cent reduction in the number of children under 5 who are stunted	Prevalence of stunting (low height-for-age) in children under 5 years of age
2	By 2025, achieve a 50 per cent reduction of anaemia in women of reproductive age	Percentage of women of reproductive age (15–49 years of age) with anaemia
3	By 2025, achieve a 30 per cent reduction in low birthweight	Percentage of infants born with low birthweight (< 2,500 g)
4	By 2025, ensure there is no increase in childhood overweight	Prevalence of overweight (high weight-for-height) in children under 5 years of age
5	By 2025, increase the rate of exclusive breastfeeding in the first 6 months up to at least 50 per cent	Percentage of infants less than 6 months of age who are exclusively breastfed
6	By 2025, reduce and maintain childhood wasting to less than 5 per cent	Prevalence of wasting (low weight-for-height) in children under 5 years of age

3.6.1. Child stunting and wasting

There are no up-to-date estimates of child stunting and wasting rates in Kiribati, which represents a significant data gap. This data gap was also highlighted in a recent UNICEF report on maternal and child survival in Kiribati.[103]

3.6.2. Anaemia

Globally, it is estimated that maternal anaemia (low levels of functioning red blood cells) accounts for around 20 per cent of maternal deaths,[104] increasing the risk of blood loss at delivery and post-partum haemorrhage. The nutritional status of the mother during pregnancy and lactation can also affect the health and nutritional status of the child. For example, anaemic mothers are at

102 WHO, Nutrition, on http://www.who.int/nutrition/global-target-2025/en/ [02.03.17].

103 UNICEF, 'Kiribati: Tracking Progress in Maternal and Child Survival', p. 14.

104 Black, R.E. et al. 'Maternal and Child Undernutrition: Global and Regional Exposures and Health Consequences', Lancet, 2008.

greater risk of delivering premature and low-birthweight babies, who also have an increased risk of dying.[105]

According to WHO/FAO estimates, the prevalence rate of anaemia in pregnant women stands at a high 38 per cent, which makes maternal anaemia a serious public health concern.[106] Anaemia prevalence among non-pregnant women of reproductive age is estimated to stand at 20 per cent (as of 2011), and anaemia in pre-school children at 37 per cent (as of 2011).[107] De-worming and iron supplementation can be effective in reducing anaemia in pregnant women as well as children.[108]

3.6.3. Low birthweight and underweight

According to the 2016 SOWC database, around 8 per cent of children in Kiribati are born with low birthweight (i.e. less than 2,500 grams), which is the third lowest prevalence rate in the PICTS group.[109] The 2009 Kiribati DHS found 15 per cent of children under five years to be underweight and 8 per cent to be severely underweight, with little difference reported between urban and rural areas. The combined proportion of children who are underweight or severely underweight places Kiribati well above the WHO threshold of 10 per cent, making child underweight a significant public health issue in the country.[110]

3.6.4. Obesity

According to estimates provided by the Institute of Health Metrics, the leading causes of ill-health and death in Kiribati in 2010 were NCDs (diabetes: 7.7 per cent of years of life lost, stroke: 6.3 per cent, ischemic heart disease: 4.2 per cent, cirrhosis: 2.2 per cent), followed by some communicable diseases (lower respiratory infections: 5.6 per cent), protein-energy malnutrition (2.6 per cent), diarrhoeal diseases (2.5 per cent) and injuries (road injuries: 2.3 per cent, self-harm: 2.2 per cent).[111] While the overall disease burden of injuries, communicable diseases and diarrhoeal diseases has been on the decline since the 1990s, the disease burden of NCDs has increased rapidly, with Kiribati witnessing almost epidemic rises in diabetes and chronic kidney disease.[112]

Many of these NCDs are related to obesity, which has been estimated to affect up to 81 per cent of the adult population in Kiribati.[113] A somewhat out-dated STEPwise Approach to Chronic

105 See e.g. K4Health, 'Anaemia Prevalence, Causes, and Consequences', on https://www.k4health.org/toolkits/anemia-prevention/anemia-causes-prevalence-impact [13.08.17].

106 WHO/FAO, 'Kiribati – Food and Nutrition Security Profiles', 2015, on http://www.fao.org/fileadmin/templates/rap/files/nutrition_profiles/DI_Profile_-_Kiribati_280714.pdf [26.04.10].

107 Food Fortification Initiative, 'Kiribati Country Profile, on http://www.ffinetwork.org/country_profiles/country.php?record=83 [26.04.10].

108 WHO/FAO, 'Kiribati – Food and Nutrition Security Profiles'.

109 Note that data are missing for Cook Islands, Niue, Tokelau and Tonga.

110 UNICEF, 'Kiribati: Tracking Progress in Maternal and Child Survival', p. 14.

111 WHO Country Cooperation Strategy for Kiribati 2013–2017.

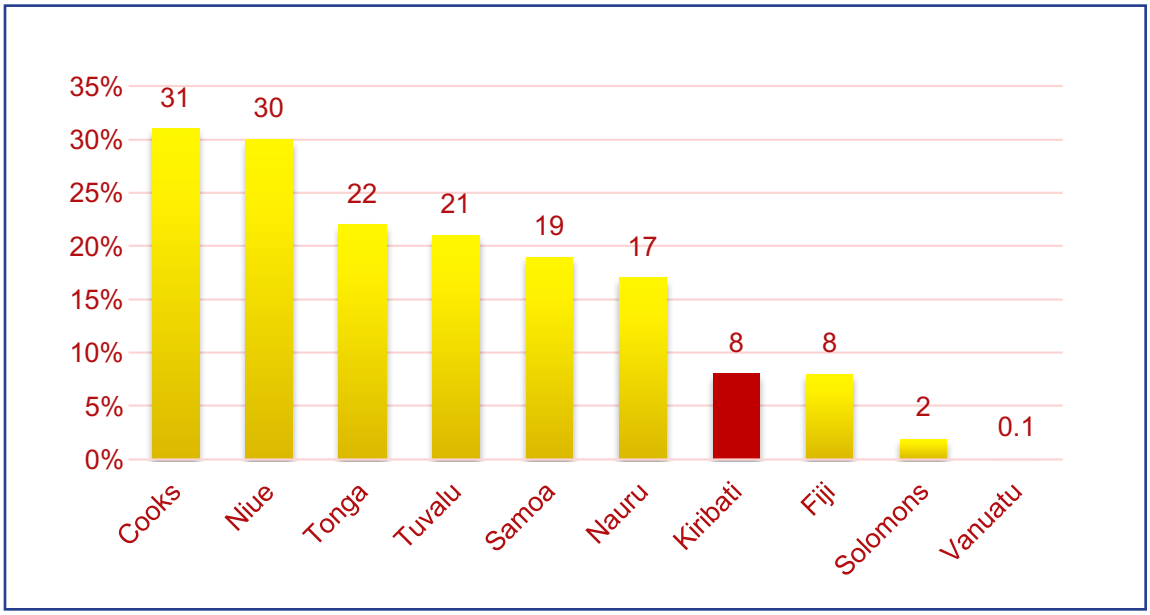
112 Institute of Health Metrics, 'Global Burden of Disease Study 2010. Kiribati Profile', on http://www.healthdata.org/sites/default/files/files/country_profiles/GBD/ihme_gbd_country_report_kiribati.pdf [20.03.17]; see also WHO Country Cooperation Strategy for Kiribati 2013–2017, p. 38.

113 UNICEF, 'Kiribati: Tracking Progress in Maternal and Child Survival', p. 14

Disease Risk Factor Surveillance (STEPS) survey from 2006 suggests obesity affects at least 40 per cent of the population aged 15–64 (so including children aged 15–18), and that at least 72 per cent are overweight, with rates significantly higher among women.[114] High fasting plasma glucose, high body mass index and dietary risks were identified as the three risk factors accounting for most of the disease burden in Kiribati as of 2010.[115] WHO attributes the high rates of obesity and the dramatic increase in the burden of associated NCDs to changing diets, the increased use of tobacco and alcohol and limited public understanding of the associated health risks.[116]

Up-to-date national estimates of obesity prevalence in children and adolescents appear to be very limited. However, 2009 DHS data suggest obesity is prevalent in 5.7 per cent of children under five years, which indicates that childhood obesity is *not* a major problem in Kiribati. The 2011 GSHS data to some extent confirm these findings from the DHS, suggesting that obesity is not a major issue among school children in Kiribati (at least those aged 13–15). According to the GSHS data, only 8 per cent of students aged 13–15 were obese (one of the lowest rates in the PICTS group) (see Figure 3.4), with no significant differences between genders.

Figure 3.4: Obesity prevalence in school children aged 13–15



Source: GSHS 2010–2016

3.6.5. Breastfeeding

WHO recommends that infants are exclusively breastfed for the first six months of life to achieve optimal growth, development and health.[117] Breastfeeding appears to be relatively widespread

114 Kiribati STEPS Survey 2004–2006 Fact Sheet, on www.who.int/chp/steps/2004_Kiribati_FactSheet.pdf [26.04.17].

115 Institute of Health Metrics, 'Global Burden of Disease Study 2010. Kiribati Profile'.

116 WHO Country Cooperation Strategy for Kiribati 2013–2017, p. 38.

117 http://www.who.int/elena/titles/exclusive_breastfeeding/en/ [13.04.17].

in Kiribati. According to the most recent estimates, 69 per cent of children in Kiribati receive exclusive breastfeeding for the first six months after their birth, which is already 19 percentage points above the 50 per cent target set out in WHO's Global Nutrition Targets for 2025. DHS data indicate that in most cases breastfeeding is initiated shortly after birth, with 80 per cent of babies breastfed within one hour of birth and 92 per cent of babies breastfed within one day of birth. DHS data also suggest that the mean duration of breastfeeding is 24 months, but that only one in four children is still exclusively breastfed at the age of six months.[118]

Despite these relatively high breastfeeding rates, it appears that many children in Kiribati do not have a healthy diet or sufficient nutritional intake. For example, it is estimated that 50 per cent of children aged six to 23 months are not fed frequently enough, according to international standards.[119] DHS data also suggest that a large proportion of children (40 per cent) are already introduced to food and liquids other than breast milk at an early age of four to five months after birth, which could contribute to the high prevalence of underweight children in Kiribati.[120]

3.7. Key barriers and bottlenecks

Kiribati's has a well-established, publicly funded, formal health system.[121] While adequate health care is generally accessible for most of Kiribati's population, there are a number of important barriers and bottlenecks to further progress in the area of health, which are described below.

3.7.1. Climate and disaster risks

Climate change and extreme weather increase the threat of both communicable and non-communicable diseases, and can exacerbate existing bottlenecks and create additional barriers for individuals wanting to access health care.[122]

According to a recent WHO assessment report, the key climate-sensitive health risks in Kiribati are vector-borne diseases (e.g. dengue fever), water-borne diseases (causing diarrhoeal illness) and food-borne diseases. In particular, the prevalence of fish-poisoning (ciguatera) is thought to be exacerbated by climate change-induced increases in the oceanic temperature around Kiribati, at least until a critical, higher temperature threshold is reached.[123]

WHO's Country Cooperation Strategy for Kiribati 2013–2017 anticipates that climate-related health problems will be borne disproportionately by certain vulnerable sectors of the population – the very poor, young children, the elderly, persons with disabilities, people with pre-existing

118 Cited in UNICEF, 'Kiribati: Tracking Progress in Maternal and Child Survival', p. 14.

119 Ibid.

120 See Figure 11.4 of the 2009 DHS report.

121 WHO Country Cooperation Strategy for Kiribati 2013–2017, p. 38.

122 WHO Country Cooperation Strategy for Kiribati 2013–2017.

123 WHO, 'Human Health and Climate Change in Pacific Island Countries', 2015, p. 66, on http://iris.wpro.who.int/bitstream/handle/10665.1/12399/9789290617303_eng.pdf [13.03.17].

illnesses (e.g. NCDs) and individuals in certain occupations (e.g. farmers, fishers and outdoor workers).[124]

3.7.2. Transportation

Another challenge facing Kiribati's health system relates to the remoteness of the 33 atolls and reef islands and the difficulties associated with transferring patients in need of specialized health care overseas. For example, WHO's 2012 Health Service Delivery Profile for Kiribati notes that residents of the outer islands often incur high transportation costs to access hospital-level health care, and generally present very late to hospitals (if at all). Infrequent and costly transportation links present a significant risk for patients in need of urgent access to medical care, which may not be available on each island (or even in the capital of Tarawa), especially in the event of medical emergencies.

3.7.3. Health financing

Overall, per capita spending is above WHO's 2001 GDP per capita regression line for lower-income Western Pacific countries[125] but at the lower end of the PICTS range, based on NMDI data from 2013.[126] However, high travel costs and dependence on external donor assistance represent bottlenecks in relation to Kiribati' health financing.

According the 2012 WHO Health Service Delivery Profile, health care provision in Kiribati is almost exclusively publicly funded, with significant overseas donor assistance and minimal out-of-pocket spending, as services are provided free of charge to all Kiribati residents. The total health budget for 2010 was approximately US$ 14.1 million, and funds were used primarily for clinical hospital services and curative care (52 per cent); pharmaceuticals (17 per cent); primary care and public health (16 per cent); and administration (15 per cent). Medical referrals to New Zealand are funded through development assistance, at a cost of US$ 630,000 for 57 patients as of 2010.

Total government spending on health was estimated to stand at around 9 per cent of GDP as of 2011, which is above the WHO-recommended 5 per cent of GDP. Estimates from 2013 suggest government spending on health amounts to roughly 14 per cent of total government spending, which places Kiribati in the upper end of the range of relative government health expenditure compared with other countries in the region.[127]

The primary risk to Kiribati's health budget identified by the WHO's 2012 Health Service Delivery Profile is the potentially high cost of travel for patients referred abroad and/or from the outer islands. WHO also highlights that Kiribati's health funding is heavily reliant on international development cooperation flows, with net flows in recent years at roughly 25 per cent of GDP.

124 P. 12.

125 As cited in WHO, 'Kiribati Health Service Delivery Profile'.

126 https://www.spc.int/nmdi/health_systems [12.04.17].

127 NMDI data, on https://www.spc.int/nmdi/health_systems [12.04.17].

3.7.4. Health workforce

As in many other PICTS, nurses make up the largest group within the health workforce of Kiribati, at 70 per cent of all health sector employees.[128] However, the ratio of nurses to population in Kiribati is below the regional average. According to NMDI data, Kiribati has about 3.2 nurses per 1,000 individuals, compared with the regional average (including PNG) of 3.6. According to estimates from 2010, Kiribati has 0.4 physicians per 1,000 individuals, which is also below the PICTS average (including PNG), of 0.9.[129] While the health worker to population rate is generally quite low in Kiribati, it is also important to highlight rural–urban discrepancies. For example, none of the remote outer islands (except for Kiritimati and Tabiteuea North) have any doctors.[130]

One of the key underlying causes of the health workforce shortage in Kiribati appears to be the out-migration of qualified health workers and the inability of the public health system to retain these professionals. For example, WHO's 2012 Health Service Delivery Profile suggests out-migration of qualified doctors, nurses and medical assistants to larger neighbouring countries remains a pressing concern, contributing to staffing shortages in the health system. Another important underlying cause of the health workforce bottleneck appears to be the compulsory retirement of health workers at age 50. Lastly, it appears that Kiribati's public health system fails to attract a sufficient number of new recruits, with WHO estimating that the current intake of health workers for training is unlikely to meet future requirements.

3.7.5. Decentralization

WHO's 2012 Health Service Delivery Profile also suggests devolution (or decentralization) has negatively affected Kiribati's ability to strengthen and streamline its health care system. It notes that responsibilities devolved to local authorities have not been matched with sufficient funding, and this has resulted in poor service delivery and diminished confidence in public health care.

3.7.6. Service delivery

Comprehensive primary health care services are offered through a network of 75 health clinics and 30 health centres/dispensaries. A central referral hospital in South Tarawa (with 120 beds) provides a range of secondary curative services and is responsible for overseas referrals for specialized secondary and tertiary care. Three other hospitals are operational, in Kiritimati (seven beds), Betio (10 beds) and North Tabiteuea, provide basic surgical, medical and maternity services. Patients requiring specialized secondary and tertiary health care services are referred overseas. [131]

A major challenge facing Kiribati's health service delivery system is the high cost and administrative difficulty of delivering services to a population that is dispersed across many islands that have

128 WHO, 'Kiribati Health Service Delivery Profile'.

129 https://www.spc.int/nmdi/health_systems [20.03.17].

130 WHO, 'Kiribati Health Service Delivery Profile'.

131 Ibid.

minimal infrastructure and transport links. According to the 2012 WHO Health Service Delivery Profile, problematic inequities exist between the outer islands and the main island of Tarawa, with a disproportionate share of health care funding and human resources allocated to the central hospital on South Tarawa.

4.

Water, Sanitation and Hygiene

Ensuring all children have access to safe and affordable drinking water, as well as adequate sanitation and hygiene, is crucial to achieving a whole range of development goals related to health and nutrition as well as education. For example, a lack of basic sanitation, hygiene and safe drinking water has been shown to contribute to the spread of water-related diseases (including diarrhoea), which are in turn a significant cause of under-five child mortality in the Pacific region.[132] Existing evidence also suggests that poor WASH access is linked to growth stunting.[133] Furthermore, there is growing evidence that clean water and sanitation facilities (at home and in schools) can improve school attendance and even learning outcomes for boys and girls.[134] This chapter assesses and analyses the situation in Kiribati regarding children's access to improved water sources and sanitation facilities, as well as children's hygiene practices, using SDGs 6.1, 6.2 and 1.4 as set out in the below table as benchmarks.

The WHO/UNICEF JMP has produced estimates of global progress (WASH) since 1990.[135] The JMP was previously responsible for tracking progress towards MDG 7c on WASH and now tracks progress towards the SDGs' WASH targets.[136] The JMP uses a 'service ladders' system to benchmark and compare progress across countries, with each 'rung' on the ladders representing progress towards the SDG targets.[137] The sub-sections below utilize the relevant service ladders to assess Kiribati's progress towards meeting the SDG targets.

132 WHO, 'Sanitation, Drinking-Water and Health in Pacific Island Countries', 2016, on http://iris.wpro.who.int/bitstream/handle/10665.1/13130/9789290617471_eng.pdf [05.06.17].

133 UNICEF, 'Looking Back, Moving Forward. A Snapshot of UNICEF's work for Pacific Island children 2015–16', 2015.

134 Ibid.

135 WHO and UNICEF, 'Progress on Drinking Water, Sanitation and Hygiene: 2017 Update and SDG Baselines', 2017, p. 6.

136 Ibid.

137 Ibid., p. 2, p. 7.

Key WASH-related SDGs

WASH sector goal[II]	SDG global target	SDG indicator
Achieving universal access to basic services	1.4 By 2030, ensure all men and women, in particular the poor and vulnerable, have equal rights to economic resources, as well as **access to basic services**	1.4.1 Population living in households with access to basic services (including **basic drinking water, sanitation and hygiene**)
Progress towards safely managed services	6.1 By 2030, achieve universal and equitable **access to safe and affordable drinking water** for all 6.2 By 2030, achieve access to **adequate and equitable sanitation and hygiene** for all and end open defecation, paying special attention to the needs of women and girls and those in vulnerable situations	6.1.1 Population using **safely managed drinking water services.** 6.2.1 Population using **safely managed sanitation services**, including a hand-washing facility with soap and water
Ending open defecation	6.2 By 2030, achieve access to adequate and equitable sanitation and hygiene for all and **end open defecation**, paying special attention to the needs of women and girls and those in vulnerable situations	

4.1. Access to improved water sources

In order for a country to meet the criteria for a **safely managed drinking water service, SDG 6.1**, the population should use an improved water source fulfilling three criteria: it should be accessible on premises; water should be available when needed; and the water supplied should be free from contamination. If the improved source does not meet any one of these criteria, but a round trip to collect water takes 30 minutes or less, it will be classified as a **basic drinking water service (SDG 1.4)**. If water collection from an improved source takes longer than 30 minutes, the source is categorized as giving a **limited service**.[138] The immediate priority in many countries is to ensure universal access to at least a basic level of service.[139]

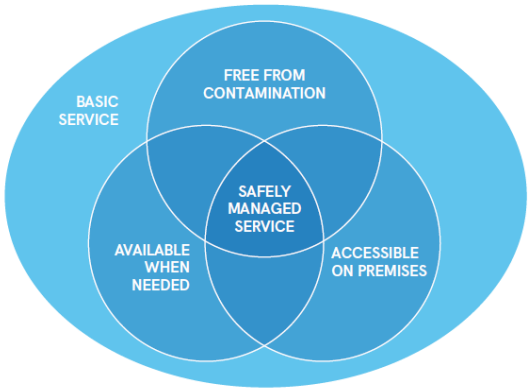
138 Ibid., p. 8.

139 Ibid., p. 10.

Figure 4.1: JMP service ladder for improved water sources

SERVICE LEVEL	DEFINITION
SAFELY MANAGED	Drinking water from an improved water source that is located on premises, available when needed and free from faecal and priority chemical contamination
BASIC	Drinking water from an improved source, provided collection time is not more than 30 minutes for a round trip, including queuing
LIMITED	Drinking water from an improved source for which collection time exceeds 30 minutes for a round trip, including queuing
UNIMPROVED	Drinking water from an unprotected dug well or unprotected spring
SURFACE WATER	Drinking water directly from a river, dam, lake, pond, stream, canal or irrigation canal

Note: Improved sources include: piped water, boreholes or tubewells, protected dug wells, protected springs, rainwater, and packaged or delivered water.



Source: JMP Progress on Drinking Water, Sanitation and Hygiene: 2017 Update and SDG Baselines

As an atoll country, Kiribati sees its potable water drawn exclusively from aquifers and harvested rainwater.[140] No estimate of the proportion of population using safely managed drinking water services is available for Kiribati, as data are not available in relation to the proportion of the population using an improved source that is accessible when needed and the proportion of the population using an improved source that is free from contamination.[141]

According to 2017 JMP estimates, as of 2015 64.4 per cent of the population in Kiribati had access to basic drinking water services – that is, improved water within a 30-minute round trip – with 35 per cent of the population having access only to an unimproved source – that is, more than one third of the population. This means Kiribati is currently quite far from reaching SDG 1.4 in relation to drinking water. Of the Kiribati population with access to an improved drinking water source, 33.4 per cent used a piped source and 31.6 per cent a non-piped source; of those with access to an improved drinking water source, 56.2 per cent had access to an improved supply on premises.[142] As Figure 4.2 shows, these estimates make access to water in Kiribati the most limited across all PICTS.

Previous JMP analysis has indicated that water collection from unimproved sources and surface water is more likely to take over 30 minutes, representing a double burden. With women and girls worldwide bearing the responsibility for water collection in eight out of 10 households with water off premises, the limited access in Kiribati is likely put a particular burden on women and girls.[143]

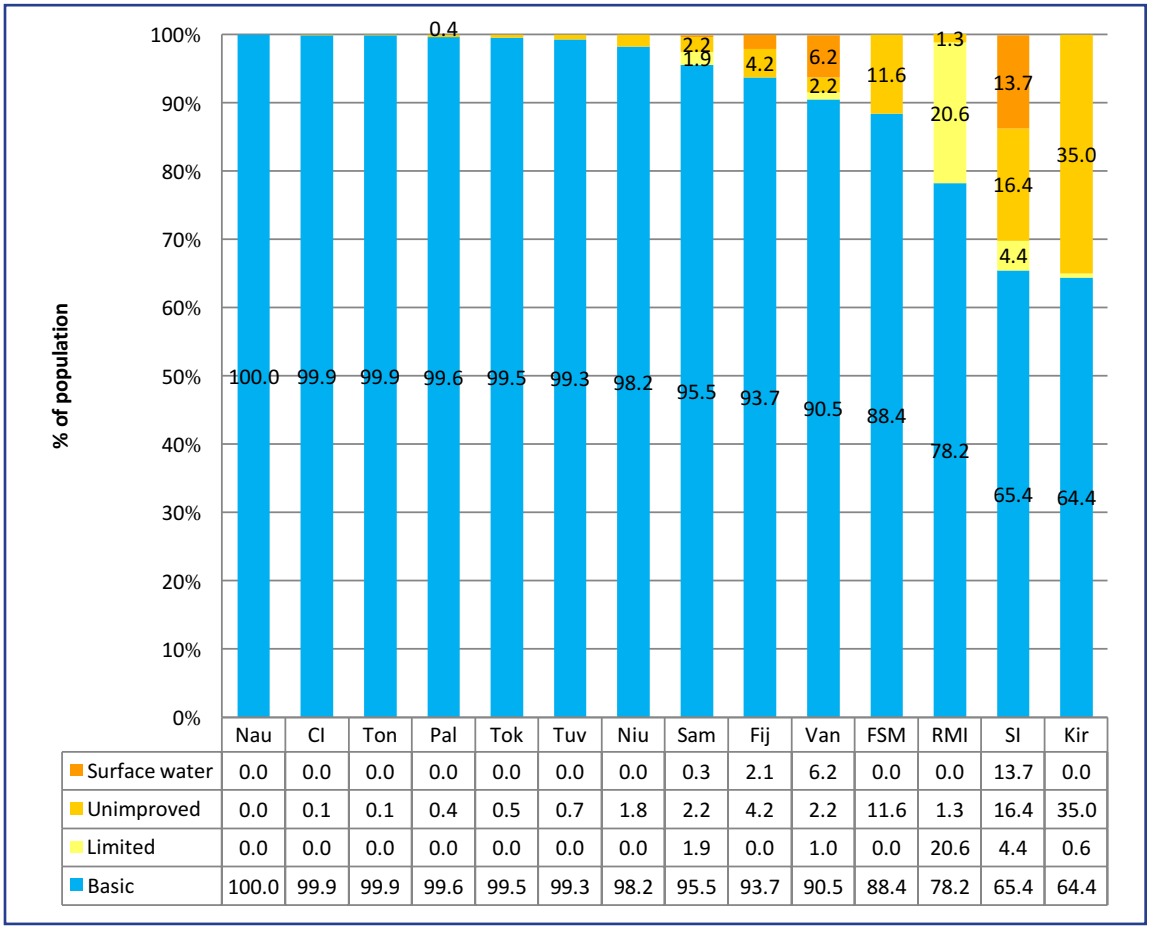
140 McIver, L., Davies, S., Tibwe, T. and Iddings, S., 'Assessment of the Health Impacts of Climate Change in Kiribati', *Int. J. Environ. Res. Public Health* 2014, pp. 5224–40.

141 JMP data for Kiribati available from https://washdata.org/data#!/kir [04.08.17]

142 Ibid.

143 WHO and UNICEF, 'Progress on Drinking Water, Sanitation and Hygiene: 2017 Update and SDG Baselines', p. 11.

Figure 4.2: Provision of drinking water services as per JMP service ladder, 2015 estimates



	Nau	CI	Ton	Pal	Tok	Tuv	Niu	Sam	Fij	Van	FSM	RMI	SI	Kir
Surface water	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.3	2.1	6.2	0.0	0.0	13.7	0.0
Unimproved	0.0	0.1	0.1	0.4	0.5	0.7	1.8	2.2	4.2	2.2	11.6	1.3	16.4	35.0
Limited	0.0	0.0	0.0	0.0	0.0	0.0	0.0	1.9	0.0	1.0	0.0	20.6	4.4	0.6
Basic	100.0	99.9	99.9	99.6	99.5	99.3	98.2	95.5	93.7	90.5	88.4	78.2	65.4	64.4

Source: JMP data[144]

Table 4.1: Provisions of drinking water services, 2017 estimates

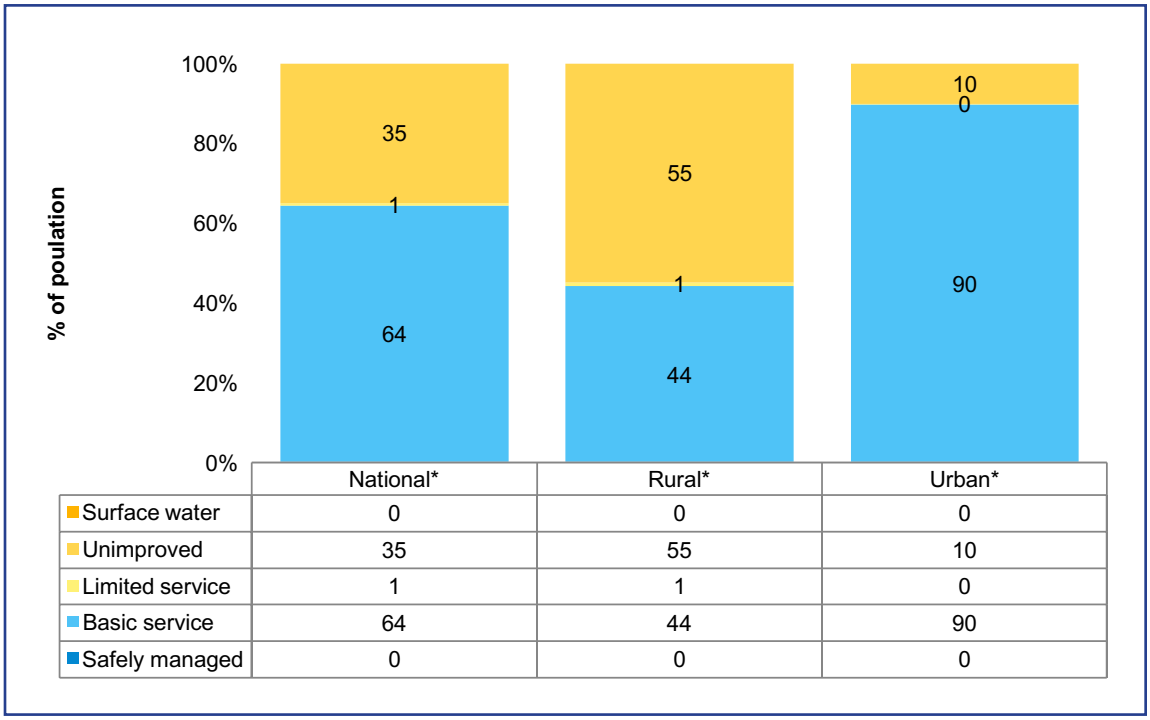
Year	Improved water	Improved within 30 mins	Improved more than 30 mins (limited)	Unimproved water	Surface water	Population using improved sources that are:				
						Piped	Non-piped	Accessible on premises	Available when needed	Free from contamination
2000	61.4	60.8	0.7	38.6	0.0	32.4	29.1	52.4	-	-
2005	62.9	62.2	0.6	37.1	0.0	32.7	30.2	53.9	-	-
2010	64.2	63.6	0.6	35.8	0.0	33.0	31.3	55.4	-	-
2011	64.5	63.9	0.6	35.5	0.0	33.0	31.5	55.7	-	-
2015	65.0	64.4	0.6	35.0	0.0	33.4	31.6	56.2	-	-

Source: JMP data[145]

144 https://washdata.org/data# [01.08.17].

145 Ibid.

Figure 4.3: Provisions of drinking water services in Kiribati, 2017 estimates



	National*	Rural*	Urban*
Surface water	0	0	0
Unimproved	35	55	10
Limited service	1	1	0
Basic service	64	44	90
Safely managed	0	0	0

Source: JMP data[146]

Disaggregated data indicate stark disparities in access to basic drinking water services between rural and urban areas: 89.7 percent of the urban population was estimated to have access to basic services in 2015; in rural areas only 44.2 per cent of the population had access to basic services.

Table 4.1 provides an overview of progress over the past 15 years in Kiribati in relation to improved water coverage. While estimates indicate that basic drinking water coverage has increased from 60.8 to 64.4 per cent, this is rather slow progress in light of the overall low levels of access. Disaggregated data for rural and urban areas indicate that, while access to basic service in urban areas increased by about 12 percentage points between 2000 and 2015, rural areas saw a decrease during the same period of about 4 percentage points (from 48.5 per cent to 44.2 per cent). According to these estimates, Kiribati is still a rather long way from achieving SDG target 1.4, and, with the current pace of progress, would not be able to meet this target by 2030.[147] The same data also indicate that efforts must particularly be targeted towards rural areas.

Data from JMP prior to 2015 cannot be used to estimate coverage as per the service ladder as data for some criteria are not available. Estimates prior to 2017 also used a slightly different definition of improved water. For example, up until 2017, bottled water was generally considered an unimproved source;[148] as of 2017, it is not considered an 'improved' source.[149] Further, data

146 https://washdata.org/data#!/kir [01.08.17].

147 Ibid.

148 Bottled water is considered 'improved' for drinking only when the household uses an improved source for cooking and personal hygiene.

149 UNICEF and WHO, 'Progress on Sanitation and Drinking Water – 2015 Update and MDG Assessment', 2015, p. 52, on http://www.who.int/water_sanitation_health/publications/jmp-2015-update/en/ [04.09.17].

estimates until 2015 drew on 1,982 sources, whereas the 2017 JMP database has more than doubled to include 4,710 data inputs, 3,408 of which are used to produce estimates. Given this, 2015 and 2017 data are not directly comparable. However, keeping these restrictions in mind, considering estimates prior to 2000 can still provide an indication of overall progress over a longer time period.

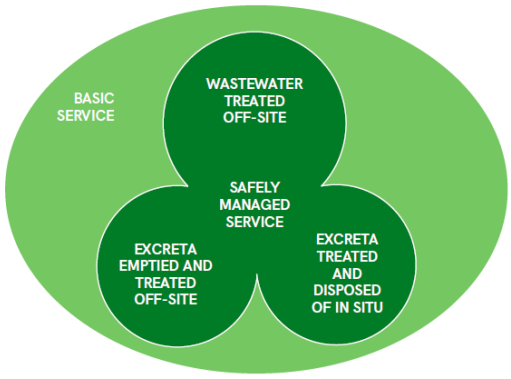
4.2. Access to improved sanitation facilities

In order to meet SDG 6.2 in relation to safely managed sanitation services, Kiribati's population should have access to improved sanitation facilities that are not shared with other households, and the excreta produced should be either treated and disposed of *in situ*, stored temporarily and then emptied, transported and treated off-site or transported through a sewer with wastewater and then treated off-site.[150] If excreta from improved sanitation facilities are not safely managed, people using those facilities will be classed as having access to a basic sanitation service (SDG 1.4); if they are using improved facilities that are shared with other households, this will be classified as a limited service.[151] Under SDG target 6.2, a specific focus is also put on ending the practice of open defecation. While this target aims to progressively raise standard sanitation services for all, the immediate priority for many countries will be to ensure universal access to at least a basic level of service.[152]

Figure 4.4: JMP service ladder for improved sanitation facilities

SERVICE LEVEL	DEFINITION
SAFELY MANAGED	Use of improved facilities that are not shared with other households and where excreta are safely disposed of in situ or transported and treated offsite
BASIC	Use of improved facilities that are not shared with other households
LIMITED	Use of improved facilities shared between two or more households
UNIMPROVED	Use of pit latrines without a slab or platform, hanging latrines or bucket latrines
OPEN DEFECATION	Disposal of human faeces in fields, forests, bushes, open bodies of water, beaches or other open spaces, or with solid waste

Note: improved facilities include flush/pour flush to piped sewer systems, septic tanks or pit latrines; ventilated improved pit latrines, composting toilets or pit latrines with slabs.



Source: JMP Progress on Drinking-Water, Sanitation and Hygiene: 2017 Update and SDG Baselines

150 WHO and UNICEF, 'Progress on Drinking Water, Sanitation and Hygiene: 2017 Update and SDG Baselines', p. 8.

151 Ibid., pp. 8–9.

152 Ibid., p. 10.

No estimate of access to safely managed sanitation service is available for Kiribati, as data on excreta disposal are unavailable. However, JMP estimates show that, also in relation to sanitation, Kiribati is some way from universal provision of basic services. As of 2015, according to estimates, 39.8 per cent of the population had access to basic facilities while 8.4 percent had access to limited services. Further, according to estimates for the same year, 17.2 per cent of the population had access only to unimproved sanitation facilities.[153] As Figure 4.5 shows, of all the PICTS, only Solomon Islands has poorer access to sanitation services.

As Figure 4.6 shows, significant inequities in provision of services exist between urban and rural locations in Kiribati. While estimates for 2015 suggest 49.5 per cent of the rural population had access to basic services, in urban areas this rate was only 32 per cent. However, it is important to note that rapidly urbanizing areas such as South Tarawa also face significant challenges, owing to overcrowding, highly degraded sewage systems and over-extraction of groundwater. For example, in the capital, South Tarawa, according to a 2011 study, only 40 per cent of the population is connected to the public sewerage system and the town has higher diarrheal disease prevalence than any other part of the country.[154]

Table 4.2: Provision of sanitation facilities, 2017 estimates

Year	Improved sanitation	Improved and not shared	Improved and shared (limited)	Unimproved sanitation	Open defecation	Population using an improved and not shared sanitation facility:					
						Latrines and other	Septic tank	Sewer connection	Disposed *in situ*	Emptied and treated	Wastewater treated
2000	36.9	30.3	6.6	14.3	48.8	0.8	19.6	9.9	-	-	-
2005	41.6	34.2	7.3	15.4	43.0	2.4	21.9	10.0	-	-	-
2010	46.2	38.1	8.0	16.7	37.1	6.1	22.0	10.0	-	-	-
2015	48.1	39.8	8.4	17.2	34.6	7.6	22.0	10.1	-	-	-

Source: JMP data[155]

According to SDG target 6.2, Kiribati should aim to end any practice of open defecation by 2030. Most recent JMP estimates suggest open defecation is still practised by as much as 34.6 per cent of the population (see Table 4.2). These estimates indicate that Kiribati is still a long way from achieving this important WASH-related international development target and, further, that, if it continues at the same rate of progress as over the past 15 years, the country will not be able to meet SDG 6.2 by 2013.[156] Disaggregated data for rural and urban areas indicate that large disparities in rates of open defecation exist: the rate in rural areas in 2015 stood at 50.1 per cent while

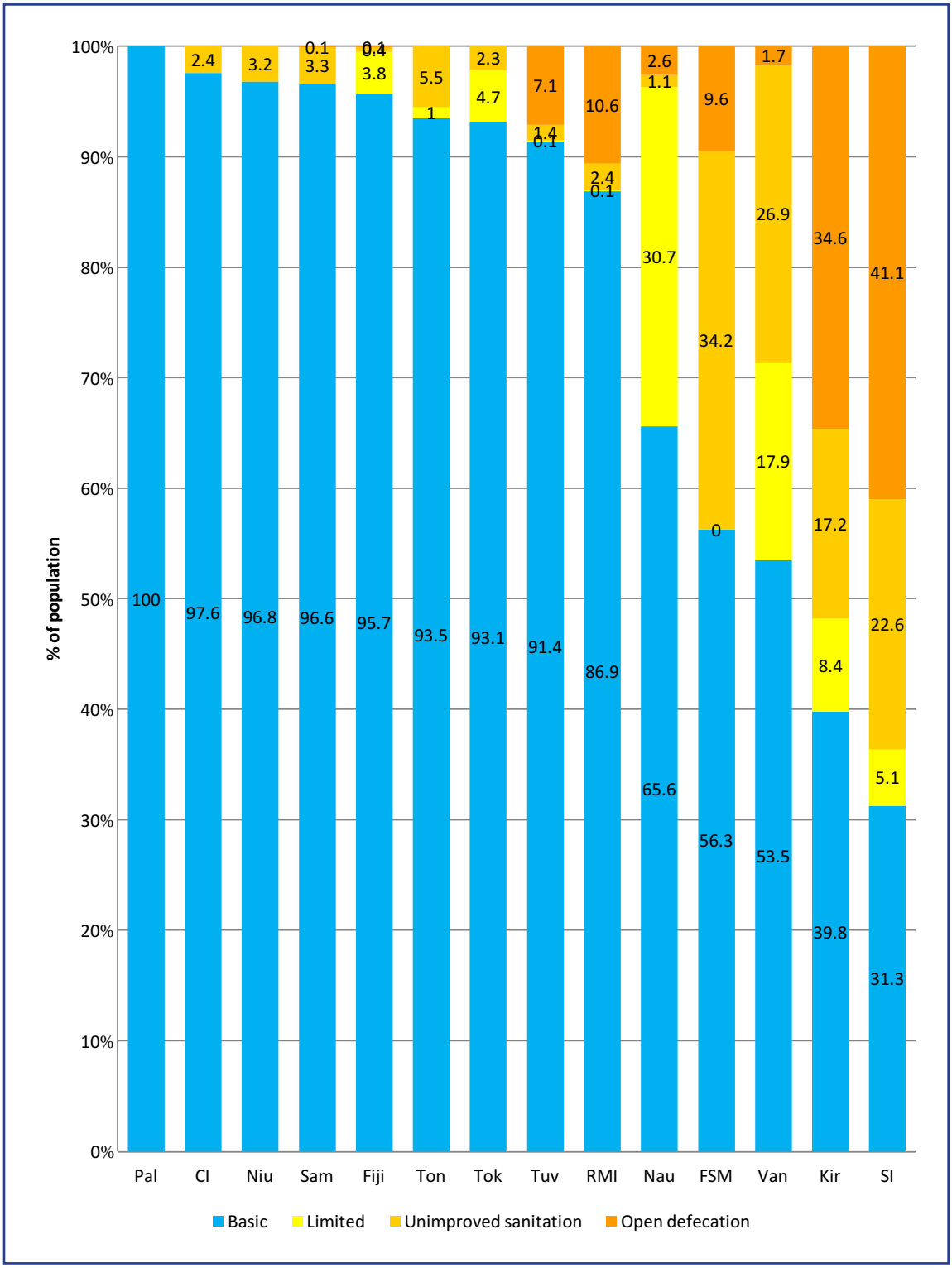
153 https://washdata.org/data#!/kir [04.08.17].

154 ISF, 'Kiribati Water, Sanitation and Hygiene Sector Brief', October 2011, prepared for AusAID.

155 https://washdata.org/data#!/kir [04.08.17].

156 Ibid.

Figure 4.5: Provision of sanitation facilities as per JMP service ladder, 2015

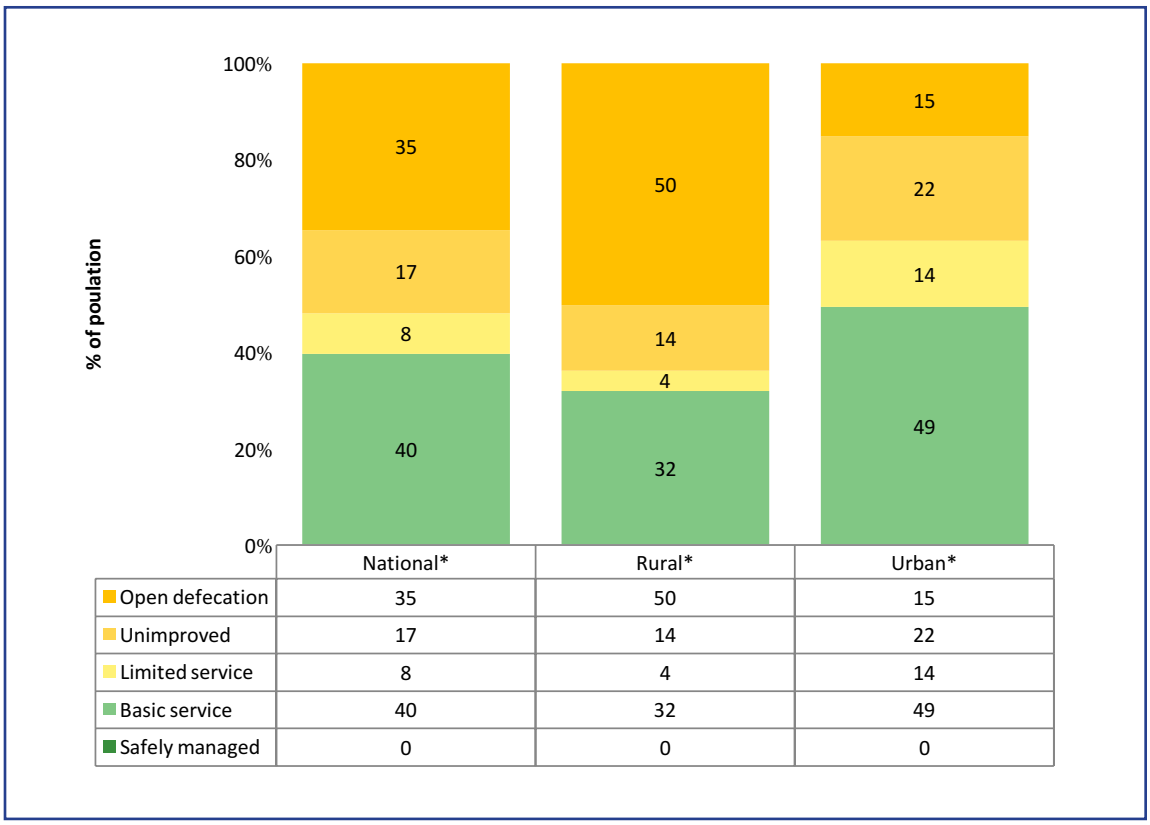


Source: JMP data[157]

157 https://washdata.org/data# [01.08.17].

in urban areas it was only 15.1 per cent. This further indicates that a particular focus should be on reducing open defecation rates in rural areas.

Figure 4.6: Provision of sanitation facilities in Kiribati, 2017 estimates



	National*	Rural*	Urban*
Open defecation	35	50	15
Unimproved	17	14	22
Limited service	8	4	14
Basic service	40	32	49
Safely managed	0	0	0

Source: JMP data.[158]

Of the seven PICTS that have not met SDG 6.2,[159] Kiribati has the second highest rate, at 34.6 per cent. In all countries in which open defecation is practised, rates are higher in rural areas than in urban areas – though it is important to note that Kiribati has the highest defecation rate in urban areas, at 15.2 per cent, with Solomon Islands following at 9 per cent.

On a more positive note, Kiribati can point to significant progress in combating the practice of open defecation in some areas. A result of the total sanitation KIRIWATSAN project (funded by UNICEF and the EU) was that North Tarawa became one of the first islands in the whole Pacific region to be declared completely 'open defecation free'.[160] Overall, Kiribati has also reduced its open defecation rate by more than 20 percentage points since 1990, when it stood at 57 percent.[161]

158 https://washdata.org/data#!/kir [04.08.17].

159 FSM, Kiribati, Marshall Islands, Nauru, Solomon Islands, Tuvalu and Vanuatu.

160 UNICEF, 'Kiribati: Tracking Progress in Maternal and Child Survival'.

161 JMP 2015 updated data, on https://www.wssinfo.org/ [25.04.17].

4.3. Hygiene practices

According to SDG target 6.2, Kiribati should, by 2030, also aim to provide access to adequate and equitable hygiene for all, paying special attention to the needs of women and girls and those in vulnerable situations. Hygiene promotion that focuses on key practices in households and schools (washing hands with soap after defecation and before handling food, and the safe disposal of children's faeces) is an effective way to prevent diarrhoea (and other diseases), which in turn affect important development outcomes such as those related to child mortality or school attendance.[162]

The presence of a hand-washing facility with soap and water on premises has been identified as the priority indicator for the global monitoring of hygiene under the SDGs. Households that have a hand-washing facility with soap and water available on premises will meet the criteria for a **basic** hygiene facility (SDGs 1.4 and 6.2). Households that have a facility but lack water or soap will be classified as having a **limited** facility, and distinguished from households that have no facility at all.[163]

Figure 4.7: JMP service ladder for improved hygiene services

SERVICE LEVEL	DEFINITION
BASIC	Availability of a handwashing facility on premises with soap and water
LIMITED	Availability of a handwashing facility on premises without soap and water
NO FACILITY	No handwashing facility on premises

Note: Handwashing facilities may be fixed or mobile and include a sink with tap water, buckets with taps, tippy-taps, and jugs or basins designated for handwashing. Soap includes bar soap, liquid soap, powder detergent, and soapy water but does not include ash, soil, sand or other handwashing agents.

Source: JMP Progress on Drinking Water, Sanitation and Hygiene: 2017 Update and SDG Baselines

No data on hygiene practices are available for Kiribati in the 2017 JMP study and, to our knowledge, the 2011 GSHS for Kiribati represents the most important publicly available, nationally representative, data source on hygiene practices among children in the country. According to these data, about 16 per cent of pupils never or rarely washed their hands after using the toilet or latrine during the 30 days before the survey. Importantly, these data are self-reported, so they do

162 See e.g. UN-Water Decade Programme on Advocacy and Communication, 'Implementing WASH', Information Brief, on http://www.un.org/waterforlifedecade/waterandsustainabledevelopment2015/images/wash_eng.pdf [27.03.17].

163 WHO and UNICEF, 'Progress on Drinking Water, Sanitation and Hygiene: 2017 Update and SDG Baselines', pp. 8–9.

not necessarily capture hygiene *practices,* and are likely to overestimate the proportion of pupils washing their hands after toilet use, owing to social desirability bias. The GSHS data do not reveal a statistically significant difference between boys and girls in relation to reported hand-washing practices after latrine use.[164] Unfortunately, they also capture reported hygiene behaviour only for school children aged 13–15 (in Forms 2–4), so very little is known about children in other age groups and children who do not attend school (i.e. out-of-school youth).

4.4. WASH in schools and MHM

A recent regional report on menstrual hygiene management (MHM) in East Asia and the Pacific examines the situation in four PICTS: Fiji, Kiribati, Solomon Islands and Vanuatu, including in schools. The report suggests that, of these four PICTS, only Solomon Islands has so far made good progress in terms of initiating formative research on MHM. Table 4.8 summarizes the findings of the regional study for each of the four included PICTS. Note that in all four PICTS, no progress has so far been achieved in relation to the provision of teaching and learning materials on MHM, and Kiribati has shown 'progress' only in government leadership on MHM, coordination and MHM in policies.[165]

Figure 4.8: Snapshot of progress on MHM in four PICTS

1 **No progress** 2 **A start has been made** 3 **Reasonable progress** 4 **Good progress**

	Solomon Islands	Fiji	Vanuatu	Kiribati
Government leadership on MHM, coordination and MHM in policies	4	4	1	3
Formative research on MHM	4	1	1	2
MHM in the curriculum	2	1	2	2
Teacher training relevant to MHM	1	1	3	2
Teaching and learning materials on MHM	1	1	1	1
School WASH facilities	3	3	3	1
Stakeholder engagement on MHM	4	3	3	2

Source: UNICEF, 'Supporting the Rights of Girls and Women through MHM', 2016

164 The reported confidence intervals overlap but the level of statistical significance is not reported.

165 UNICEF, 'Supporting the Rights of Girls and Women through Menstrual Hygiene Management (MHM) in the East Asia and Pacific Region: Realities, Progress and Opportunities', 2016, p. 14.

5. Education

Key Education-related SDGs

SDG	Target	Indicators
4.1	By 2030, ensure that all girls and boys complete free, equitable and quality primary and secondary education leading to relevant and effective learning outcomes	Proportion of children and young people (a) in Grades 2/3; (b) at the end of primary; and (c) at the end of lower secondary achieving at least a minimum proficiency level in (i) reading and (ii) mathematics, by sex
4.2	By 2030, ensure that all girls and boys have access to quality early childhood development, care and pre-primary education so that they are ready for primary education	Proportion of children under 5 years of age who are developmentally on track in health, learning and psychosocial well-being, by sex
		Participation rate in organized learning (one year before the official primary entry age), by sex
4.3	By 2030, ensure equal access for all women and men to affordable and quality technical, vocational and tertiary education, including university	Participation rate of youth and adults in formal and non-formal education and training in the previous 12 months, by sex
4.4	By 2030, substantially increase the number of youth and adults who have relevant skills, including technical and vocational skills, for employment, decent jobs and entrepreneurship	Proportion of youth and adults with ICT skills, by type of skill

SDG	Target	Indicators
4.5	By 2030, eliminate gender disparities in education and ensure equal access to all levels of education and vocational training for the vulnerable, including persons with disabilities, indigenous peoples and children in vulnerable situations	Parity indices (female/male, rural/urban, bottom/top wealth quintile and others such as disability status, indigenous peoples and conflict-affected, as data become available) for all education indicators on this list that can be disaggregated
4.6	By 2030, ensure that all youth and a substantial proportion of adults, both men and women, achieve literacy and numeracy	Percentage of population in a given age group achieving at least a fixed level of proficiency in functional (a) literacy and (b) numeracy skills, by sex
4.7	By 2030, ensure that all learners acquire the knowledge and skills needed to promote sustainable development, including, among others, through education for sustainable development and sustainable lifestyles, human rights, gender equality, promotion of a culture of peace and non-violence, global citizenship and appreciation of cultural diversity and of culture's contribution to sustainable development	Extent to which (a) global citizenship education and (b) education for sustainable development, including gender equality and human rights, are mainstreamed at all levels in (i) national education policies, (ii) curricula, (iii) teacher education and (iv) student assessment
4.A	Build and upgrade education facilities that are child-, disability- and gender-sensitive and provide safe, non-violent, inclusive and effective learning environments for all	Proportion of schools with access to (a) electricity; (b) the Internet for pedagogical purposes; (c) computers for pedagogical purposes; (d) adapted infrastructure and materials for students with disabilities; (e) basic drinking water; (f) single-sex basic sanitation facilities; and (g) basic hand-washing facilities (as per the WASH indicator definitions)
4.B	By 2020, substantially expand globally the number of scholarships available to developing countries, in particular least developed countries, small island developing states and African countries, for enrolment in higher education, including vocational training and ICT, technical, engineering and scientific programmes, in developed countries and other developing countries	Volume of ODA flows for scholarships by sector and type of study

SDG	Target	Indicators
4.C	By 2030, substantially increase the supply of qualified teachers, including through international cooperation for teacher training in developing countries, especially least developed countries and small island developing states	Proportion of teachers in (a) pre-primary; (b) primary; (c) lower secondary; and (d) upper secondary education who have received at least the minimum organized teacher training (e.g. pedagogical training) pre-service or in-service required for teaching at the relevant level in a given country

The right to education is a fundamental human right, enshrined in Articles 28 and 29 of the CRC and Article 13 of the International Covenant on Economic, Social and Cultural Rights (ICESCR). According to the United Nations Committee on Economic, Social and Cultural Rights, the right to education encompasses the following 'interrelated and essential features': availability; accessibility; acceptability; and adaptability.[166] The right to education is also contained in the SDGs, which recognize that, 'Quality education is the foundation to improving people's lives and sustainable development'. SDG 4 requires states to 'ensure inclusive and quality education for all and promote lifelong learning'. The SDGs build on the MDGs, including MDG 2 on universal primary education, and UNESCO's Education for All (EFA) goals, which this chapter references throughout where relevant.

In addition to these rights and targets, the UNISDR and the Global Alliance for Disaster Risk Reduction and Resilience in the Education Sector (GADRRRES) Comprehensive School Safety Framework sets out three essential and interlinking pillars for effective disaster and risk management: safe learning facilities; school disaster management; and risk reduction and resilience education. These pillars should also guide the development of the education system in Kiribati, which is vulnerable to disaster and risk.

Kiribati has actively pursued education development plans in recent years. In 2008, the country held a national education summit to discuss the challenges facing the education sector, culminating in the Ministry of Education's (MoE's) Education Sector Strategic Plan (ESSP) for 2008–2011.[167] Following this period, the ESSP 2012–2015 guided Kiribati's education sector development, intended to encourage realization of MDG 2 to provide higher quality and equitable education.[168] Its central goal was for 'All Kiribati children to have access to relevant and quality education by 2020.'[169] Furthermore, the Plan sought to complement Kiribati's regional commitments to the principles of the EFA goals outlined in the Forum Basic Education Action Plan endorsed by the Forum Education Ministers in 2001, and in the Forum Pacific Education Development Framework (PEDF) endorsed by the Forum Education Ministers in 2009.

166 Committee on the Rights of the Child, General Comment No. 13, on the 'The Right to Education', 8 December 1999, para. 6.

167 UNESCO, 'Education For All Report, Kiribati', 2015, on http://unesdoc.unesco.org/images/0023/002314/231490e.pdf [05.09.17].

168 http://www.moe.gov.ki/statistics [05.09.17].

169 MoE, 'Digest of Education Statistics', 2014.

Kiribati's ESSP 2012–2015 set out measures for training and employment, as well as the economic agenda for education. These measures aimed to address the challenges of Kiribati's national economy as well as high unemployment levels among young people in the country. Government expenditure on education as a percentage of total government expenditure has fluctuated over recent years, spanning from a high of 27.4 per cent in 2006 to a low of 10.6 per cent in 2010. The most recent figure available places government expenditure at 18.2 per cent in 2013, marking a 0.52 per cent increase from the previous year (2012).[170] The more recent ESSP, which runs from 2016 to 2019, is reported to contain targets relating to early childhood education (ECE), pointing to the government's attempt to strengthen this sub-sector.

The education system in Kiribati is divided into six stages. The first stage is ECE, provided by the non-government sector, including churches and community groups, for children aged five. Primary education is provided free of charge by the government and is compulsory for all children for six years from the age of six to the age of 11 (Classes 1–6). The following first three years of secondary schooling, Junior Secondary School (JSS), targets children aged 12–14 (Forms 1–3) and are also free and compulsory. Following the completion of JSS, children can take the national examination to determine whether they can progress to Senior Secondary School (SSS). This stage of education consists of four years for young people aged 15–18 (Forms 4–7) and is delivered by both state schools and privately operated church schools. If students wish to continue their education after SSS they must pass examinations in Forms 6 and 7.[171]

The national EFA 2015 report highlights that one of the key issues facing the Kiribati education system is lack of equal physical access to education across the country, particularly at the secondary and tertiary levels, given the geographical dispersal of Kiribati's constituent islands. It notes that only primary schools, and to a lesser extent JSSs, are widely spread throughout the 24 islands of the country, with the majority of SSSs and specialized/technical education facilities located in the urban areas of South Tarawa.

The Committee on the Rights of the Child, in its most recent Concluding Observations (2006), also noted quality of education as a key concern. The Committee noted several barriers contributing to the poor quality of education, including poor infrastructure of educational facilities across the islands and a need to increase investment in teacher training. Details on these barriers are discussed in more detail throughout this chapter.

Set out below is an assessment and analysis of the situation of children's education in Kiribati, including the key barriers and bottlenecks to delivering accessible and quality education for all Kiribati children.

170 NMDI database.

171 Digest of Education Statistics 2014.

5.1. Early childhood education

According to the SDGs, by 2030 states are required to ensure that 'all girls and boys have access to quality early childhood development, care and pre-primary education so that they are ready for primary education'. EFA Goal 1 also requires the expansion and improvement of comprehensive early childhood care and education (ECCE), especially for the most vulnerable and disadvantaged children.

As previously mentioned, ECE in Kiribati is not managed by the MoE, but is instead operationalized by NGOs such as churches and community groups. At present, there is no legal framework in Kiribati governing the development of the ECE sector; however, an ECCE Draft Bill has been developed and is expected to be passed into law in August 2017. Kiribati does have an ECCE Policy,[172] though it was not possible to review this for this SitAn and there are questions about the implementation and availability of prescribed standards for ECE facilities, curricula or teacher qualifications.[173] In 2010, UNICEF prepared a report that sought to guide the formation, acceptance and development of the sub-sector. Recommendations from this to formalize the ECE sub-sector were to be incorporated into the 2014–2015 stage of the ESSP.[174] However, it is not known to what extent steps have been taken to achieve this – although it is understood that, in 2014, the MoE established an ECE Working Group tasked with setting priorities for the sub-sector.[175]

According to a 2010 MoE-led survey conducted on the ECE sub-sector, there were at that time 225 pre-primary schools across the 24 islands of Kiribati, 75 of which were privately run (by churches); the remainder were described as 'community preschools', operated by local community groups.[176]

As a result of this lack of formalization of the ECE sub-sector, few data exist on the accessibility and quality of ECE in Kiribati. The Kiribati Education Management Information System (KEMIS) collects data on whether a child attended ECE previously, but not about ECE itself, which is a barrier to assessing the ECE situation in the country and analysing barriers and bottlenecks to the achievement of SDG 4.2. Some data are available from records collected by the ECE sub-sector coordinator, although the national EFA report for 2015 highlights the need for a well-resourced ECE sub-sector coordinator within the MoE to gather comprehensive statistical information.

Records of the ECE sub-sector coordinator, collected over eight years, from 2005 to 2013, demonstrate a decline in the gross enrolment ratio (GER) from 51 per cent in 2005 to 33 per cent in 2013.[177] Within this, however, in the most recent three years, from 2010 to 2013, there was a relative increase in the GER, suggesting some improvement. The rates indicate nevertheless that significant work is needed to improve the accessibility of pre-primary education. Net enrolment ratio (NER) data for ECE are unavailable.

172 SABER, 'NSA-ECD Country Report 2014', on http://documents.worldbank.org/curated/en/175551468180262002/text/105030-WP-ADD-SERIES-PUBLIC-SABER-ECD-Kiribati-NSA-ECD-CR-Final-2014.txt [1.8.17].

173 Kiribati EFA Report 2015.

174 Ibid.

175 Digest of Education Statistics 2014.

176 Kiribati EFA Report 2015.

177 KEMIS Statistical Digests 2005–2013, cited in Kiribati EFA Report 2015.

The percentage of children entering primary education who were enrolled in ECE has fluctuated significantly in recorded years (from 2005 to 2014). From 2005 to 2008, the number of children enrolling with prior ECE experience dropped from a high 70 per cent to 55 per cent.[178] However, since 2008 the numbers have fluctuated, reaching 70 per cent in 2014 according to the MoE.[179]

From the limited data available, there do not appear to be any significant gender disparities in ECE enrolment, although a more comprehensive assessment would require up-to-date disaggregated NERs, GERs and attendance, survival and drop-out rates. Gender Parity Index (GPI) rankings for the ECE GER over the nine-year period from 2005 to 2013 show a slightly higher proportion of girls than boys enrolled in ECE, the most recent GPI available being 1.03 in 2013.[180] Disaggregated data on transition rates from pre-primary to primary education show that relatively equitable percentages of female and male children progress to primary school from ECE (74 per cent of boys and 76 per cent of girls in 2013, which is the most recent year for which these data were available).[181]

Data on ECE teacher training suggest there is a pressing need to strengthen the quality of ECE education. According to MoE data from 2010, in the EFA Report for 2015, only 28 of the country's 360 pre-school teachers (8 per cent) had received some kind of formal training on ECE teaching. According to the EFA Report, there were no training schools in Kiribati for ECE teachers at the time the of writing,[182] which meant those who wished to teach at ECE level had to leave the country to complete their training abroad in places like Fiji, Australia and New Zealand.

Poor infrastructure and limited facilities have also been identified as a barrier to ensuring access to quality ECE in Kiribati. In 2010, it was recorded that only 75 of the 225 pre-primary schools had classrooms, with the remainder using local community halls, or '*maneaba*'. Furthermore, in 2010 only 38 preschools had toilets, and there were no data on the availability of running water or hand-washing facilities.[183]

The pupil–teacher ratio in ECE in 2010 was 14:2,[184] which is lower than the standard recommended by the World Bank, of 15:1.[185] This raises questions as to the efficiency of the use of ECE teaching time. However, there were significant disparities in the ratio between the islands, with lows of 6:4 in Onotoa and highs of 42:2 in Makin.[186] This suggests significant disparities in the quality of ECE and in efficiency of the use of ECE teaching time across the islands.

178 Kiribati EFA Report 2015.

179 Digest of Education Statistics 2014.

180 Kiribati EFA Report 2015.

181 Digest of Education Statistics 2014; Kiribati EFA Report 2015.

182 Kiribati Teachers College (KTC) stopped training pre-primary training approximately 10 years ago.

183 Kiribati EFA Report 2015.

184 UNICEF Survey, 2010, cited in Kiribati EFA Report 2015.

185 SABER, 'ECD Report for Solomon Islands 2013', p. 19.

186 UNICEF Survey, 2010, cited in Kiribati EFA 2015.

5.2. Primary and secondary education

The EFA goals and SDGs include targets on primary and secondary education. According to SDG 4.1, by 2030 all girls and boys shall complete free, equitable and quality primary and secondary education, leading to relevant and effective learning outcomes. SDGs, MDGs (2.A and 3.A) and EFA Goal 5 require the elimination of gender disparities in primary and secondary education, and EFA Goal 2 requires that children in difficult circumstances and ethnic minorities have access to complete, free and compulsory primary education of good quality.

> *In Kiribati, primary education consists of six years of compulsory schooling for children aged six to 11. JSS consists of three years of compulsory schooling for children aged 12–14, followed by four years of non-compulsory SSS for young people aged 15–18.*[187]

In 2006, the Committee on the Rights of the Child's Concluding Observations highlighted various general barriers to providing equal access to quality primary and secondary education. One of the key challenges is the continued under-development of physical infrastructure across the country as a result of limited resources.[188] The government's National Infrastructure Standards guide the monitoring of school buildings and facilities. Since 2011, as a result of the ESSP 2012–2015, the government has invested in school infrastructure, providing 93 new or renovated classrooms as well as a reported improvement in access to safe water and sanitation.[189] However, a 2014 PEDF indicators report on the formal education sector estimated that 71 per cent of schools had clean water and sanitation.[190]

However, further infrastructural improvements are needed: figures from 2013 indicate that 53 per cent of classrooms are in either fair or poor condition, requiring remedial work. Reports from 2013 highlighted that only seven out of 93 schools were in line with national policy on water supplies (to have water tanks in the absence of running water), with 33 having no water supply at all.[191] Legal requirements reportedly stipulate that toilet facilities are provided at the rate of 1:40 for girls and 1:60 for boys.[192] However, MoE data from 2013 indicate that only seven schools comply with the standard for boys and five schools comply with the standard for girls.[193] There also appear to be significant disparities in relation to school infrastructure across the country – which is a barrier to ensuring equal access to quality education across the country. For instance, while 100 per cent of classrooms in District Central and District South were recorded as having 'adequate' classrooms, the figure was a lower 79 per cent in District North and 50 per cent in Linnix.[194]

187 Digest of Education Statistics 2014.
188 Kiribati EFA Report 2015.
189 Digest of Education Statistics 2014.
190 KEMIS 2015; Digest of Education Statistics 2014.
191 KEMIS 2013, in Kiribati EFA Report 2015.
192 Kiribati EFA Report 2015.
193 KEMIS 2013, in Kiribati EFA Report 2015.
194 Kiribati EFA Report 2015.

5.2.1. Primary education

The NER and GER represent key indicators on the accessibility of primary education; these were 98.6 per cent and 106 per cent, respectively, in 2016.[195] However, caution should be exercised in analysing enrolment rates for Kiribati, given 'anomalies in the population data' that may have had an impact on the enrolment rate indicators.[196] For this reason, the MoE felt it was unlikely that it would meet MDG 2 (universal primary education), and therefore reset its target to 80 per cent enrolment in basic education (which also includes enrolment in JSS).[197] This most likely explains why reported NERs and GERs in a particular year are reported differently.[198]

With this limitation in mind, the MoE nevertheless reported increases in primary enrolment *numbers* in 2014 following an eight-year decline between 2005 and 2013. It found that this increase coincided with various initiatives and reforms instituted by the government to improve primary school enrolments, including the establishment of 93 new or renovated classrooms and improved access to safe water and sanitation in schools, as mentioned above. In addition, the MoE has overseen the implementation of revised curriculums for Classes 1–4 (as of 2012) and increased engagement with local communities on the importance of schooling. The MoE also states that it has implemented Goal 5 of the ESSP 2012–2015 (to ensure that 'All children and young people's rights to education are protected and school sector management is improved by a strengthened legislative framework'), which it considers has strengthened its authority to enforce policies regarding compulsory school attendance.[199]

According to KEMIS data, the survival rate for pupils reaching Class 5 of primary school declined from 90.7 per cent in 2010 to 72.6 per cent in 2013.[200] The MoE states that Class 5 is often regarded as the minimum level that needs to be reached to achieve minimum levels of numeracy and literacy.[201] The fact that almost 30 per cent of children were not reaching this stage of primary schooling in 2013 presents serious concerns.

There are notably gender disparities in the data pertaining to primary school participation. In 2012, the GPI calculated from the gross intake ratio was 1.03, rising to 1.10 in 2013, indicating that more girls than boys are commencing primary school. Furthermore, the GPI calculated from the net intake ratio was 1.12 in 2012, and 1.11 in 2013, indicating a higher proportion of girls than boys in the official age group commencing primary schools. In 2013, the survival rate to Class 6 for girls was greater than that for boys, at 69.8 per cent compared with 62.2 per cent. The MoE notes that cultural perceptions of the value of formal education and a lack of acceptance or understanding of the need to make basic education compulsory may be affecting enrolment rates.[202]

195 www.spc.int/nmdi/education [01.08.17], although it was not possible to verify this figure against its original source.

196 Kiribati EFA Report 2015, p. 14; Digest of Education Statistics 2014, p. 26.

197 Kiribati EFA Report 2015, pp. 14 and 24.

198 E.g. Kiribati EFA Report 2015, compared with figures cited on www.spc.int/nmdi/education [12.06.17].

199 Digest of Education Statistics 2014.

200 Kiribati EFA Report 2015.

201 Ibid., p. 23.

202 Kiribati EFA Report 2015.

Gender disparity is also evidenced through repetition rates. Although these saw improvement over the last recorded four years (2009/10–2012/13), the highest rates are consistently found in Classes 1 and 6, with higher percentages of boys repeating the year than girls. For example, in 2013, 4.9 per cent of boys repeated the year, compared with 1.1 per cent of girls. High rates for both boys and girls may indicate a need for greater investment from the MoE in ECE teacher training. The EFA Report for 2015 identifies two key possible drivers for high repetition rates in Class 6. First, while JSS is compulsory and free of charge, children may be dissuaded from progressing beyond primary school by the costs associated with purchasing school books, uniforms and equipment. Second is the limited availability of JSSs to attend on the smaller and more remote islands.203 This highlights the need for equitable access to junior secondary education facilities on all of Kiribati's islands, and not just in larger, more urbanized, areas.

A key indicator of the quality of education delivery is the pupil–teacher ratio; this indicates whether teachers are overburdened and thus unable to provide adequate tuition and supervision. The ratio for primary schools in 2014 was 26.4:1, marking a small increase from 25.0 in 2007–2011.[204]

The 2006 Concluding Observations of the Committee on the Rights of the Child highlighted the need to advance the recruitment and qualifications of all teachers in Kiribati. However, primary school teacher qualifications remain an area for further development. For primary level, teachers are deemed 'qualified' if they have completed Form 5. Encouragingly, in 2014, 96.7 per cent of primary teachers were qualified – an increase of 4.5 percentage points from 2012.[205] However, the EFA Report for 2015 recommends the identification of mechanisms to encourage teachers to gain higher qualifications. As of 2013, no primary school teachers had advanced university qualifications. Further, the report highlights the need also to improve attendance, punctuality and general professional behaviour,[206] which are crucial to ensure the delivery of quality education.

In 2006, the Committee on the Rights of the Child in its Concluding Observations highlighted the need for increased efforts to provide equal educational opportunities for children with disabilities, by offering the necessary support and ensuring teachers are trained to educate children with disabilities within regular schools. In 2014, 207 students in Classes 1–3 across Kiribati were reported as having at least one form of disability.[207] Learning disabilities were recorded as the most common (36.7 per cent) for both sexes, followed by difficulties in communication (speech at 19.8 per cent) and hearing (19.3 per cent). Furthermore, it was recorded that more males than females had a registered disability (3 per cent of all male students in Classes 1–3 versus 1.6 per cent of female students).[208] In Classes 4–6, 127 students were reported as having at least one form of disability (46.5 per cent with learning disabilities, 18.9 with hearing impairments and 10.2 per cent with speech impairments). Disaggregated data put the prevalence of disability at twice as high for males (2.4 per cent of all male students in Classes 4–6 compared with 1.1 per cent

203 Kiribati EFA Report 2015.

204 Ibid., p. 38.

205 Digest of Education Statistics 2014.

206 Kiribati EFA Report 2015.

207 Digest of Education Statistics 2014.

208 2014 Annual Education Census Surveys, in Digest of Education Statistics 2014.

of female students).[209] The MoE launched an Inclusive Education Policy in June 2015, providing a new curriculum package for Class 4 that emphasizes the need for increased awareness of the accessibility issues facing student with disabilities and to create suitable learning environments for all children.

5.2.2. Secondary education

Between 2011 and 2014, there was no significant change in the GERs or NERs for the combined secondary school sector (JSS and SSS). In 2015, the combined GER for secondary education was 72.3 per cent[210] – an increase from 69.5 per cent in 2014. The NER in 2014 was 68 per cent. The GER was consistently 4–5 per cent higher than the NER, suggesting the majority of students enrolled in secondary schools were aged 12–18 years.[211] Figures available through the SPC reflect a 2016 NER and GER for secondary school at 77.3 per cent and 74 per cent, respectively.[212]

Enrolment rates for children in JSS are low considering that this level is compulsory. The JSS NER was 69 per cent in 2013, compared with a significantly higher GER of 97 per cent,[213] indicating that a large proportion of children enrolled in JSS fell outside the official age group. Data suggest there are gender disparities in favour of females concerning access to JSS by children of official JSS age. In 2014, only 75 per cent of males in Forms 1–3 fell within the official age group for their level, compared with 92 per cent of females.[214] Furthermore, the GER for JSS was 97 per cent in 2013, composed of 108 per cent females and 86 per cent males, producing a GPI of 1.26. Additionally, the NER for JSS was 69 per cent in 2013, composed of 78 per cent females and 61 per cent males, with a GPI of 1.28.[215]

Total enrolment figures for senior secondary education have remained relatively constant, fluctuating slightly from year to year, from 7,138 in 2006 to 6,788 in 2014.[216] The GER in 2014 was recorded at 69.5 per cent; however, previous GER data are unavailable. As in JSS, there is a higher female than male GER in SSS, at 81 per cent versus 62 per cent in 2014.[217] Furthermore, the GPI for enrolment numbers increased from 1.32 in 2012 to 1.44 in 2013 before decreasing slightly to 1.40 in 2014. The highest GPI in 2014 occurs in Form 7, at 1.60, compared with 1.34 for Form 6, 1.45 in Form 5 and 1.32 in Form 4.[218] Teachers have reportedly suggested that many boys shun formal education, preferring instead to collect coconuts for money,[219] although the drivers of the gender disparity require further research.

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209 Digest of Education Statistics 2014.

210 MoE Draft Report, 2015.

211 Digest of Education Statistics 2014.

212 www.spc.int/nmdi/education [01.08.17], although it was not possible to verify this figure against its original source.

213 Kiribati EFA Report 2015.

214 Digest of Education Statistics 2014.

215 Kiribati EFA Report 2015.

216 Digest of Education Statistics 2014, p. 22.

217 Digest of Education Statistics 2014, cited on https://www.spc.int/nmdi/education [12.06.14], although it was not possible to verify these figure against their original source.

218 Digest of Education Statistics 2014.

219 Kiribati Education Improvement Program: Evaluation Report, 2014, pp. 36–7, on http://dfat.gov.au/about-us/publications/Documents/kiribati-education-improvement-program-evaluation-report-sept-2014.pdf [05.09.17].

In 2014, 28 students from Forms 1–3 across Kiribati had some form of disability or impairment, or 0.4 per cent of the total number of students in these forms.[220] The domains of disabilities of the majority of these students were unclear, as 71 per cent of them were recorded as having 'other' disabilities.[221] Furthermore, 14 students from Forms 4–7 were reported to have a disability (0.3 per cent of the total number of students in these forms), most of whom were female (11 of the 14). From the data presented above, it appears that the number of children with a registered disability decreases as school years progress. In Classes 1–3, 2.3 per cent have a registered disability; in Classes 4–6, 1.7 per cent; in Forms 1–3, 0.4 per cent; and in Forms 4–7, 0.3 per cent. These decreasing numbers nevertheless do not represent conclusive evidence that children with disabilities are dropping out of school over time. The MoE's 2014 statistical digest highlights the need for further studies to understand the reasons why numbers are decreasing.[222]

The most recently recorded pupil–teacher ratio (2014) for secondary schools (combined JSS and SSS) is 16.1.[223] This marks a decrease from the 20.0 recorded in 2011.[224] While this is considered a satisfactory situation on the whole, disaggregation of these data by geographical location highlights significant disparities that are concerning. District Central and District South demonstrate particularly advantageous pupil–teacher ratios (18.9 and 16.4, respectively, in 2013), while District North has a ratio of 25.7 and Linnix 20.8 (2013). There has been no great variation in ratios over recent years, apart from a recent decline in the ratios for primary schools in Linnix (from 27.7 in 2011 to 20.8 in 2013) and District Central (from 21.9 in 2011 to 18.9 in 2013), as well as a rise in the JSS ratio for District North (from 27.4 in 2011 to 23.5 in 2013).[225] The 2015 EFA Report suggests this pattern may owe to migration to the urban area of South Tarawa[226] in recent years in search of economic and education opportunities.[227]

Data indicate that quality of education requires significant improvement. In 2009, the English literacy rate in Form 4 was 39 per cent and the numeracy rate was 35 per cent.[228] In 2013, female students outperformed male students in English literacy examinations in Form 4; English literacy performance in Standardized Test for Achievement in Kiribati (STAKI) examinations in Form 4 for girls showed that 34.6 per cent were working at or above the expected level, versus 27.2 per cent of boys. Furthermore, numeracy examination results show that 30.4 per cent of girls were working at or above the expected level, compared with 22.0 per cent of boys. Additionally, literacy rates over recent years were significantly higher for Te Kiribati compared with English for both sexes assessed in Form 4.[229] In 2013, 63.4 per cent of female students in Form 4 were

220 Digest of Education Statistics 2014.

221 2014 Annual Education Census Surveys; Digest of Education Statistics 2014.

222 Digest of Education Statistics 2014.

223 Ibid.

224 Digest of Education Statistics 2014, cited on https://www.spc.int/nmdi/education [12.06.14], although it was not possible to verify these figure against their original source.

225 Kiribati EFA Report 2015.

226 South Tarawa's population is growing rapidly, at an annual rate of 4.4 per cent compared with 2.2 per cent nationally; approximately 50 per cent of South Tarawa's population is under 20 years of age (Kiribati EFA Report 2015).

227 Kiribati EFA Report 2015.

228 Data collected for English performance, STAKI, in Form 4; Digest of Education Statistics 2014.

229 Digest of Education Statistics 2014.

performing at or above the expected level in Te Kiribati, compared with 53.6 of male students. These figures are significantly higher than those indicated for English language scores.[230] The literacy rate for 15–24 year olds was 98.5 per cent according to the 2010 census report, although this is significantly out of date.

As previously mentioned, the Committee's on the Rights of the Child's Concluding Observations from 2006 highlighted a need to improve the training and recruitment of teachers in both primary and secondary schools. Teachers with higher-level qualifications are almost exclusively found teaching in secondary schools. A total of 42 per cent of teachers in SSSs hold a Bachelor of Education, compared with 1 per cent in JSS.[231]

The qualification standard in Kiribati for secondary school teachers is the completion of Form 7. A total of 92 per cent of teachers in JSS are qualified, and 66.1 per cent for combined secondary (JSS and SSS) schools, marking a decrease from the 73.7 per cent recorded in 2011.[232]

5.3. Tertiary and vocational education

There are various technical and vocational education and training (TVET) opportunities available to young people and adults in Kiribati. TVET programmes are administered by various ministries, including the MoE and the Ministry of Labour and Human Resource Development (MLHRD). Vocational training options include centres for nursing or fishing, a technological institute, police training, a marine training centre and Kiribati Teaching College (KTC).[233]

Data on enrolment, applications and gender make-up for vocational training can be obtained from MLHRD.[234] These show an unmet demand for vocational training, with only 15 per cent of applicants accepted in 2012–2013 into the Fisheries Training Centre, 9 per cent into the Marine Training Centre and 30 per cent into the Kiribati Institute of Technology.[235] Large numbers applying for TVET programmes are turned away, which means there is a pool of young people who are potentially excluded from both higher education and vocational training. The Committee on the Rights of the Child highlighted this issue as an area of concern in 2006, and it remains a challenge.

While girls are under-represented in some individual programmes,[236] total enrolment rates for TVET programmes are relatively gender-balanced, with female enrolment rising from 42 per cent in 2012 to 51 per cent in 2013.[237]

230 Kiribati EFA Report 2015.
231 Ibid.
232 Digest of Education Statistics 2014.
233 Kiribati EFA Report 2015.
234 E.g. data in Kiribati EFA Report 2015.
235 MLHRD Project Report, in Kiribati EFA Report 2015.
236 For example in the Fisheries Training Centre and the Marine Training Centre; Kiribati EFA Report 2015.
237 MLHRD, in Kiribati EFA Report 2015.

There are insufficient data to be able to conclude whether TVET programmes are leading to increased employment prospects for students, although a future tracer study is reportedly planned to map graduate employment success.[238]

SSS students who wish to continue into tertiary education must qualify through examinations, to enter the University of the South Pacific (USP) or other regional and international universities, such as the Australia Pacific Technical College. The USP Kiribati Campus was opened in 1976; it is located in South Tarawa, offering distance and flexible learning courses as well as on-campus teaching.[239] Students who are unable to access and complete SSS are required to seek formal or informal sector employment or vocational training, in view of the fact that higher formal education is available only to those graduating from Forms 12 and 13.[240]

In order to be able to monitor the country's progress towards meeting SDG 4.3, data concerning the participation rate of youth and adults in formal and non-formal education and training in the previous 12 months, by sex, are necessary. They are currently unavailable.

An area for development highlighted by the Committee on the Rights of the Child was making tertiary education accessible across all the whole country.[241] While the Committee noted that primary schools (and, to a lesser extent, JSSs and SSSs) were widely spread throughout the 24 islands of Kiribati, more senior and specialized education institutions were found in the urban area of South Tarawa only,[242] presenting a significant barrier to children seeking to progress to tertiary education.

238 Kiribati EFA Report 2015.

239 USP Kiribati Campus, on http://www.usp.ac.fj/index.php?id=3646 [05.09.17].

240 Kiribati EFA Report 2015.

241 Committee on the Rights of the Child, Concluding Observations, CRC/C/KIR/CO/129, September 2006.

242 Kiribati EFA Report 2015.

6.

Child Protection

The CRC, its two Optional Protocols and other key international human rights instruments outline the state's responsibility to protect children from all forms of violence, abuse, neglect and exploitation. Whilst the CRC recognizes that parents have primary responsibility for the care and protection of their children, it also emphasizes the role of governments in keeping children safe and assisting parents in their child rearing responsibilities. This includes obligations to support families to enable them to care for their children, to ensure appropriate alternative care for children who are without parental care, to provide for the physical and psychological recovery and social reintegration of children who have experience violence, abuse or exploitation, and to ensure access to justice for children in contact with the law.

The Convention on the Rights of the Child recognize the following rights which are the most relevant to this chapter:

Article 7 – The right to identity and to be registered at birth
Article 19 – The right to protection from all forms of physical or mental violence, abuse or neglect, or exploitation
Article 23 – The rights and special needs of children with disabilities
Article 32 – The right to protection from economic exploitation
Article 33 – The right to protection from illicit use of narcotic drugs
Article 34 – The right to protection from all forms of sexual exploitation and sexual abuse
Article 35 – The right to protection from the abduction, sale and traffic in children
Article 36 – The right to protection from all other forms of exploitation
Article 37 – The right to protection from torture, cruel or inhuman treatment, capital punishment, and unlawful deprivation of liberty
Article 39 – The right to physical and psychological recovery and social integration
Article 40 – The rights of the child alleged as, accused of, or recognised as having infringed the penal law to be treated in a manner consistent with the promotion of the child's sense of dignity

State Parties' obligations to protect children are further guided by: the Optional Protocol on the Sale of Children, Child Prostitution and Child Pornography; the Optional Protocol on the Involvement of Children in Armed Conflict; Convention on the Rights of People with Disabilities; ILO Convention 138 on Minimum Age; ILO Convention 182 on the Worst forms of Child Labour; UN Guidelines for the Alternative Care of Children (2010); UN Standard Minimum Rules for the Administration of Juvenile Justice (1985); UN Guidelines for the Prevention of Juvenile Delinquency (1990); UN Rules for the Protection of Juveniles Deprived of their Liberty (1990); and UN Guidelines for Justice on Child Victims and Witnesses in Criminal Proceedings (2005).

In addition to the CRC, the SDGs sets specific targets for child protection in relation to violence against women and girls (5.2), harmful traditional practices (5.3), child labour (8.7), provision of safe spaces (11.7), violence and violent deaths (16.1), abuse, exploitation, trafficking and all forms of violence against and torture of children (16.2) and birth registration (16.9). The SDGs also promote strengthened national institutions for violence prevention (16.a).

Key Child Protection-related SDGs

SDG	Target	Indicators
5.2	End all forms of violence against women and girls in public and private spheres, including trafficking and sexual and other types of exploitation	Proportion of ever-partnered women and girls aged 15 years and older subjected to physical, sexual or psychological violence by a current or former intimate partner in the previous 12 months, by form of violence and by age
		Proportion of women and girls aged 15 years and older subjected to sexual violence by persons other than an intimate partner in the previous 12 months, by age and place of occurrence
5.3	Eliminate all harmful practices, such as child, early and forced marriage and female genital mutilation	Proportion of women aged 20–24 years who were married or in a union before age 15 and before age 18
		Proportion of girls and women aged 15–49 years who have undergone female genital mutilation/cutting, by age
8.7	Take immediate and effective measures to secure the prohibition and elimination of the worst forms of child labour, eradicate forced labour and by 2025 end child labour in all its forms including recruitment and use of child soldiers	Proportion and number of children aged 5–17 years engaged in child labour, by sex and age
11.7	By 2030, provide universal access to safe, inclusive and accessible, green and public spaces, particularly for women and children, older persons and persons with disabilities	Proportion of persons victim of physical or sexual harassment, by sex, age, disability status and place of occurrence, in the previous 12 months

SDG	Target	Indicators
16.1	By 2030, significantly reduce all forms of violence and related deaths everywhere	Number of victims of intentional homicide per 100,000 population, by sex and age
		Conflict-related deaths per 100,000 population, by sex, age and cause
		Proportion of population subjected to physical, psychological or sexual violence in the previous 12 months
		Proportion of population that feels safe walking alone around the area they live in
16.2	End abuse, exploitation, trafficking and all forms of violence and torture against children	Proportion of children aged 1–17 years who experienced any physical punishment and/or psychological aggression by care-givers in the previous month
		Number of victims of human trafficking per 100,000 population, by sex, age and form of exploitation
		Proportion of young women and men aged 18–29 years who experienced sexual violence by age 18
16.3	Promote the rule of law at the national and international levels and ensure equal access to justice for all	Proportion of victims of violence in the previous 12 months who reported their victimization to competent authorities or other officially recognized conflict resolution mechanisms
		Unsentenced detainees as a proportion of overall prison population
16.9	By 2030, provide legal identity for all, including birth registration	Proportion of children under 5 years of age whose births have been registered with a civil authority, by age

UNICEF's global Child Protection Strategy calls for creating a protective environment 'where girls and boys are free from violence, exploitation and unnecessary separation from family; and where laws, services, behaviours and practices minimize children's vulnerability, address known risk factors, and strengthen children's own resilience'.[243] The UNICEF East Asia and Pacific Region Child Protection Programme Strategy 2007 similarly emphasizes that child protection requires a holistic approach, identifying and addressing community attitudes, practices, behaviours and other causes underpinning children's vulnerability, engaging those within children's immediate environment (children themselves, family and community), and ensuring an adequate system for delivery of holistic prevention, early intervention and response services.

243 UNICEF 20 May 2008, Child Protection Strategy, E/ICEF/2008/5// Rev. 1.

One of the key ways to strengthen the protective environment for children is through the establishment of a comprehensive child protection system. 'Child protection systems comprise the set of laws, policies, regulations and services needed across all social sectors — especially social welfare, education, health, security and justice — to support prevention and response to protection-related risks.'[244] The main elements of a child protection system are shown in Table 6.1.

Table 6.1: Main elements of a child protection system

Legal and policy framework	This includes laws, regulations, policies, national plans, SOPs and other standards compliant with the CRC and international standards and good practices.
Preventive and responsive services	A well-functioning system must have a range of preventive, early intervention and responsive services- social welfare, justice, health and education - for children and families.
Human and financial resources	Effective resource management must be in place, including adequate number of skilled workers in the right places and adequate budget allocations for service delivery.
Effective collaboration and coordination	Mechanisms must be in place to ensure effective multi-agency coordination at the national and local levels.
Information management and accountability	The child protection system must have robust mechanism to ensure accountability and evidence-based planning. This includes capacity for data collection, research, monitoring and evaluation.

Source: Adapted from UNICEF Child Protection Resource Pack 2015

6.1. Child protection risks and vulnerabilities

This section provides an overview of available information on the nature and extent of violence, abuse, neglect and exploitation of children in Kiribati; community knowledge, attitudes and practices relating to child protection; and the drivers underlying protection risks.

6.1.1. Nature and extent of violence, abuse, neglect and exploitation of children

Kiribati has limited quantitative data on child protection, and as a result it is not possible to present a clear picture of the nature and extent of violence, abuse, neglect and exploitation of children. Nonetheless, available information indicates that i-Kiribati children experience various forms of violence, abuse, neglect and exploitation in several contexts, including within the home, in schools and in the community.

244 Ibid.

6.1.1.1. Violence in the home

Children in Kiribati experience relatively high rates of violence in their homes. In a 2009 Child Protection Baseline Study, 81 per cent of adults admitted using violent discipline against children in their household, and 29 per cent of children reported having been physically hurt by an adult in their household within the past month.[245] The main reason given by adults for this violence was discipline or education (80 per cent of responses), with 15 per cent acknowledging that the physical violence was a result of losing their temper. The main perpetrators of all forms of violence against children in the home were reported by child respondents to be siblings (47 per cent) and fathers (25 per cent), with mothers accounting for only 8 per cent of the reported violence.[246]

Exposure to family violence is also a significant issue for i-Kiribati children. A 2010 Family Health and Support Study found that more than 2 in 3 ever-partnered women (68 per cent) had experienced physical and/or sexual violence by an intimate partner.[247] This is significantly higher than the average of 48 per cent for the PICTS for which data are available, and is the highest rate recorded in the region.[248] The Study also highlighted the impact that family violence has on –Kiribati children. Among women who had experienced violence, 19 per cent reported that their children had repeated a year of school (compared to 9 per cent of women who had not experienced violence), and 11 per cent reported that their child(ren) had dropped out of school (compared to a 6 per cent drop-out rate amongst children who had not been exposed to violence).[249]

6.1.1.2. Violence in schools

Children in Kiribati are also exposed to violence in their schools. Of the school-attending children who participated in the Child Protection Baseline Study, 29 per cent reported being physically hurt by a teacher in the month before the study took place, and 40 per cent of key informants from the education sector admitted 'Teachers in this school hit, smack, pinch, kick, flick or pull or twist children's ears.'[250]

Peer violence and bullying are also cause for concern in Kiribati. A 2011 Global Student Health Survey found that 35.3 per cent of Kiribati students aged 13 to 15 had been engaged in physical fights in the 12 months before the survey, and 58.3 per cent had been seriously injured. In addition, 36.8 per cent of students reported being bullied in the past 30 days. These rates are lower than the regional averages (for countries with data)[251] of 49.5 per cent for fighting and 45.4 per cent for bullying (Table 6.3).

245 UNICEF Pacific, 'Protect Me with Love and Care, Kiribati', Child Protection Baseline Study 2009. p. 112.

246 Ibid., p. 27.

247 MISA 2010, Kiribati Family Health and Safety Study, p. 79.

248 Cook Islands, FSM, Fiji, Kiribati, Marshall Islands, Nauru, Palau, Samoa, Solomon Islands, Tonga and Vanuatu.

249 MISA 2010, Kiribati Family Health and Safety Study, p. 6.

250 UNICEF Pacific Child Protection Baseline Study 2009, p. 4.

251 Cook Islands, Fiji, Kiribati, Nauru, Niue, Samoa, Solomon Islands, Tokelau, Tonga, Tuvalu and Vanuatu.

Table 6.2: Violence and unintentional injury rates in 2011

Violence among students	Boys	Girls	Total
% of students in a physical fight one or more times in past 12 months	43.3	28.5	35.3
% of students seriously injured one or more times in past 12 months	64.2	53.2	58.3
% of students bullied on one or more days in past 30 days	42.1	32.2	36.8

Source: UNICEF EAPRO[252]

6.1.1.3. Sexual abuse, commercial sexual exploitation and trafficking in children

Childhood sexual abuse and commercial sexual exploitation of children are also of increasing concern in Kiribati. The 2010 Family Health and Support Study found that nearly one in five (19 per cent) of women aged 15–49 reported that they had experienced child sexual abuse before the age of 15.[253] This is slightly higher than the regional average of 17 per cent for the PICTS for which data are available.[254] In addition, approximately 20 per cent of women who reported that they had ever had sexual intercourse reported that their first sexual experience was either coerced or forced, and the younger the girl at fist sexual encounter, the more likely sex was forced. Girls are at greatest risk of sexual abuse by male family members, male acquaintances and strangers.[255] No similar information was available about sexual abuse of boys.

Sexual exploitation of girls continues to be a concern, with girls as young as 15 reportedly exploited in prostitution in local bars and hotels. Crew members of foreign fishing vessels account for much of the demand for children in the commercial sex sector. These girls generally receive financial support, food, alcohol, or goods in exchange for sexual services Some I-Kiribati—including family members of potential victims, older women, and hotel and bar workers—may facilitate the exploitation of girls in sex trafficking by providing a venue for prostitution.[256] A Rapid Assessment on Child Labour in Tarawa conducted by ILO in 2012 found that, out of the 61 children identified as being involved in child labour, 33 were involved in commercial sexual exploitation.[257]

6.1.1.4. Child labour

Although research is limited, there is evidence that children in Kiribati perform dangerous tasks in construction and street vending.[258] The ILO Rapid Assessment of Child Labour in Tarawa found that, in addition to the children engaged in commercial sexual exploitation, 28 children were

252 UNICEF EAPRO, 'Hidden in Plain Sight: A Statistical Analysis of Violence against Children', 2014, p. 117.

253 MISA 2010, Kiribati Family Health and Safety Study, p. 4.

254 Cook Islands, FSM, Fiji, Kiribati, Marshall Islands, Nauru, Palau, Samoa, Solomon Islands, Tonga and Vanuatu.

255 MISA 2010, Kiribati Family Health and Safety Study, p. 4.

256 US State Department. Trafficking in Persons Report, 2016, p.227.

257 ILO, http://www.ilo.org/suva/public-information/press-releases/WCMS_346774/lang--en/index.htm [02.12.17].

258 US Department of Labour, 2016 Findings on the Worst Forms of Child Labor: Kiribati https://www.dol.gov/agencies/ilab/resources/reports/child-labor/findings [02.12.17].

engaged in other forms of labour such as street vendors selling food and other items, mixing cements, boat building and construction.[259]

6.1.1.5. Child marriage

According to the SOWC 2016 dataset, marriage prevalence under the age of 15 in Kiribati is at 3 per cent and that under the age of 18 is at 20 per cent.[260] Customary law is reportedly more often applied in deciding questions relating to marriage, with cultural practices generally accepting of arranged marriages for children as young as 13.[261]

6.1.2. Community knowledge, attitudes and practices

Children in Kiribati are regarded as the 'pearl in the family', and are generally loved and cared for by not only their biological parents but also their extended families. These community caring practices provide an important social safety net for children. Traditional family and community structures remain strong in Kiribati. The *unamane,* male elders who represent the family or clan, and *maneaba* or community council, have significant influence in the community and continue to play an important role in local governance, peace and security.[262]

Corporal punishment is widely accepted in Kiribati. The disciplining of children through the use of physical force, humiliation and verbal abuse is viewed as a 'parent's right' and is often justified as rooted in cultural practices.[263] However, there are some indications that these attitudes are changing. Adult respondents in the Child Protection Baseline Study who said that they did not physically hurt children in their home provided several rights-based reasons for not doing so, including 'It is against child rights', indicating positive awareness and understanding of children's rights.[264] There is reportedly now greater awareness about the importance of exploring alternative options such as positive discipline, and the traditional perception that 'children should be seen and not heard' is now challenged through growing community awareness and understanding about the value and rights of children in society.[265]

6.1.3. Drivers of violence, abuse, neglect and exploitation of children

Reports have identified a number of social norms and community practices that impact on child protection in Kiribati. The key contributing factor to violence against children is the widely held

259 ILO, http://www.ilo.org/suva/public-information/press-releases/WCMS_346774/lang--en/index.htm [02.12.17].

260 Percentage of women 20–24 years old who were first married or in union before they were 15 years old and percentage of women 20–24 years old who were first married or in union before they were 18 years old.

261 IPU and WHO, 'Child, Early and Forced Marriage Legislation in 37 Asia-Pacific Countries', on http://www.ipu.org/pdf/publications/child-marriage-en.pdf [19.06.17].

262 MISA 2010, Kiribati Family Health and Safety Study, p. 36.

263 Ibid., p. 39.

264 UNICEF Pacific Child Protection Baseline Study 2009, pp. 119–120.

265 UNICEF Pacific. Child Protection Case Study: From Review to Reform, How Ground-Breaking Legislation is Promoting Child Protection in Kiribati, undated.

belief that it is an accepted cultural practice.[266] Through the normalization of violence within families, children learn from a young age that violence is accepted, thus perpetuating the cycle of violence.[267]

Gender norms and the low status of women and girls have also been identified as a factor contributing to family violence. Traditionally I-Kiribati society was patrilineal, and while the status of women is changing, women are still often considered subordinate to men and gender roles are still quite strictly defined.[268] High levels of physical and sexual partner violence in Kiribati are reportedly fuelled by dominant gendered social norms that make physical and sexual violence an acceptable or even deserved form of discipline for women who do not fulfil their prescribed gender roles.[269] Kiribati has the highest prevalence of girls justifying wife-beating out of 60 countries, at 77 per cent, compared with 65 per cent among boys.[270] Recent attempts to in pass an amendment to the Constitution to prohibit discrimination on the basis of sex reflects social norms about the role and value of women in society. [271]

The culture of silence around family violence, and sexual violence in particular, also contributes to the perpetuation of violence against children. Young girls who are raped are particularly unlikely to report the crime to the police due to the emphasis on female virginity before marriage.[272]

The number of children living away from their parents has also been cited as a causal factor for abuse and neglect, since children migrating from rural to urban areas are not cared for as closely as others.[273] A significant number of i-Kiribati children live away from their parents, with children most commonly moving from outer islands to South Tarawa for schooling or work and living with relatives.[274] The Child Protection Baseline Study found that 25 per cent of adult respondents had a biological child living outside their household, mainly with relative, and most did not have a good understanding of the potential risks involved.[275] Climate change has also contributed to significant levels of migration.[276] This removes children from the informal extended family and community care networks that might otherwise support them.

A key structural cause contributing to children's vulnerability to violence, abuse, neglect and exploitation are bottlenecks and barriers in the delivery of effective child and family welfare services, and in access to child-friendly justice (discussed below).

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266 MISA 2010, Kiribati Family Health and Safety Study, p. 38.

267 Ibid., p. 20.

268 ibid.

269 WHO, 'Measuring and Responding to Violence against Women in Kiribati'.

270 UNICEF EAPRO, 'Hidden in Plain Sight', p. 197.

271 UPR National Report, Kiribati 2014, para. 73.

272 MISA 2010, Kiribati Family Health and Safety Study, p. 40.

273 UNICEF, 'Child Poverty and Hardship in Kiribati', 2014, on https://www.unicef.org/pacificislands/Child_Poverty_Hardship_in_Kiribati...pdf [05.09.17].

274 Ibid.

275 UNICEF Pacific Child Protection Baseline Study 2009, p. 106.

276 UNESCAP, 'Climate Change and Migration in the Pacific', on http://www.unescap.org/sites/default/files/PCCMper%20cent20-per%20cent20per%20cent20Surveyper%20cent20Factper%20cent20Sheet.pdf [05.09.17].

6.2. The child protection system

The government of Kiribati has made significant progress in strengthening the national child protection system, however some gaps and challenges remain.

6.2.1. The legal and policy framework for child protection

Kiribati's legal framework for child protection has progressed considerably in the past few years with the introduction of a Children, Young People and Family Welfare Policy, new primary legislation on both child welfare and children in conflict with the law, as well as the National Approach to Eliminating Sexual and Gender Based Violence (ESGBV) in Kiribati: Policy and Action Plan 2011-2021. Children's right to care and protection has been addressed under a variety of national laws:

Key child protection laws

Child care and protection	Children, Young People and Family Welfare Policy; Children, Young People and Family Welfare Act 2012; The Family Peace Act 2014
Child custody and maintenance	Maintenance Ordinance; Custody of Children Act 1973
Child marriage	Marriage Amendment Act 2002
Birth registration	Births, Deaths and Marriages Registration Act 1966
Child labour	Employment and Industrial Relations Act 2016; Occupational Safety and Health Act 2015
Penalization of physical abuse, sexual abuse and sexual exploitation	Penal Code 1977
Child victims and witnesses in criminal proceedings	Evidence Act 2003; Criminal Procedure Code 1963
Violence in schools	Education Act 2013
Children in conflict with the law	Juvenile Justice Act 2015
Children with disabilities	None
Child protection in emergencies	Joint Implementation Plan for Climate Change and Disaster Risk Management 2014–2023

Kiribati laws also establishes a number of minimum ages designed to protect children from various forms of abuse and exploitation:

Legal definition of the child under Kiribati law

Definition of a child / young person under welfare law	18
Minimum age for marriage	18
Minimum age for employment	14
Minimum age for engaging in hazardous work	18
Age for consent to sexual activity under criminal laws	15
Minimum age of criminal responsibility	10
Maximum age for juvenile justice protections	18

6.2.1.1. Legal framework for child and family welfare services

Kiribati has developed a comprehensive Children, Young People and Family Welfare Policy to guide national efforts to strengthen the child protection system. The Policy emphasizes the importance of building on and strengthens traditional and community caring practices, whilst at the same time strengthening formal services to support children and their families.

The primarily legal framework for the delivery of child and family welfare services is the Children, Young People and Family Welfare Act 2012 (CYPFW Act). The Act outlines parents' responsibilities towards their children, acknowledges the state's obligation to support parents and protect children, and obligates the Ministry of Women, Youth and Social Affairs (MWYSA) to lead and coordinate prevention, early intervention and response services for children and their families, in collaboration with other government agencies, civil society and communities. The Act also outlines clear procedures for reporting, assessment and referral of concerns about a child's welfare. It emphasizes family strengthening, family preservation and consensus-based decision-making, with active participation of the child, his/her parents, extended family and community leaders in care and protection planning through 'family mediation'. Provision is also made for social welfare officers and police to intervene, on an emergency basis, to remove a child who is at risk of immediate harm, and, where necessary to apply to the court for a care and protection order. In addition, the Family Peace Act 2014 makes provision for protection orders to prohibit perpetrators of domestic violence from having contact with the victim, including a child.

6.2.1.2. Legal framework for justice for children

Kiribati's Penal Code 1977 criminalizes a range of offences against children, including assault and causing bodily harm, child stealing (child under 14), rape of a women or girl, abduction of a girl under 18 with intent to have sexual intercourse, indecent assault on a female (consent no defence under the age of 15), 'defilement' of a girl under 13 (regardless of consent), defilement' of a girl under 15 (regardless of consent, but with a significantly lower penalty), procuring a girl under 18, 'disposing' of and obtaining a child under 15 for immoral purposes, indecent practises between males, incest, failure to provide necessities, and cruelty to children under 15. The Measures to

Combat Terrorism and Transnational Organized Crime Act criminalizes human trafficking, including trafficking in children, but applies only to cross-border trafficking. Child pornography is penalized under the Communications Act 2013 which makes it an offence to produce, distribute, transmit or possess child pornography.

Kiribati Penal Code offences are framed in outdated language, do not provide equal protection to boys and girls, and the penalties for many offenses do not sufficiently reflect the grave nature of sexual abuse and exploitation of children. Section 226 of the Penal Code also permits corporal punishment by permitting parents, teachers and others with control over children to 'administer reasonable punishment'. In addition, the successful prosecution of crimes against children is hampered by the lack of comprehensive procedural protections to assist child victims and witness to give evidence. The Evidence Act 2003 authorizes the court to allow some children to give evidence through closed circuit television or from behind a screen, however this applies only to children under the age of 17, and only in relation to sexual offences.

The handling of children in conflict with the law is governed primarily by the Juvenile Justice Act 2015. The minimum age of criminal responsibility is 10, with a rebuttable presumption that children between the ages of 10 and 14 are incapable of committing a criminal offence unless it is 'proved that at the time of doing the act or omission he had capacity to know that he ought not to do the act or make the omission.'[277] Kiribati's minimum age is lower than the 'absolute minimum' age of 12 recommended by the UN Committee on the Rights of the Child.[278]

The Juvenile Justice Act 2015 includes a range of special procedural protections for children under the age of 18, including a requirement that the Juvenile Court hear children's cases separately and *in camera*, a presumption in favour of bail in all but serious cases, separation of children from adult detainees in police custody ad prison 'so far as is practicable', participation of the child's parent or guardian, requirement for the court to obtain a social background report prior to sentencing, provision of a range of non-custodial sentencing options, prohibition on imprisonment of children under 12, and a statement that children 14 to under 18 may not be given a prison sentence unless no other sentence would be 'suitable.' However, the Act lacks a comprehensive statement of guiding principles, provides limited guidance on arrest and investigation procedures (including limitations on use of force and restraints), does not make provision for pre-trial diversion or recognize informal justice processes, does not fully guarantee children's right to be separated from adult detainees, and does not address supervision, rehabilitation and reintegration support for children.

In addition to these laws, the Kiribati Police and Prison Service (KPPS) have issued Police Standard Operating Procedures on Child Protection and Handling Young People (October 2012) and Standard Operating Procedures on Diversion to provide police with more detailed guidance on handling cases involving children as offenders, victims and witnesses. A pocket guide for frontline police has also been developed to provide an easy checklists summary of child protection principles,

277 Penal Code, section 14.

278 Committee on the Rights of the Child General Comment No. 10, para.31.

investigations involving child victims, investigations involving young offenders, and investigating suspected child sexual abuse.[279]

6.2.2. Child protection structures, services and resourcing

At the core of any child protection system are the services that children and families receive to reduce vulnerability to violence, abuse, neglect and exploitation. These services should be designed to minimize the likelihood that children will suffer protection violations, help them to survive and recover from violence and exploitation, and ensure access to child-friendly justice.

6.2.2.1. Child and family welfare services

The lead agency responsible for child protection services in Kiribati is the Ministry of Women, Youth and Social Affairs (MWYSA). The Ministry's Social Affairs Department has 1 Principal Social Welfare Officer, 1 Senior Welfare Officer and 2 Social Welfare Officers (SWOs) based in the national capital, as well as one Assistant Social Welfare Officers (ASWOs) on each of the 22 islands. These officers have received training on child protection and their responsibilities under the CYPFW Act, and the Ministry has plans for further staff capacity building, with the support of UNICEF.[280]

The MWYSA supports a range of community-level child protection prevention programs, including promotion of key child protection concepts, raising awareness about the dangers of child abuse, reinforcing positive tradition and caring attitudes towards children, promoting positive parenting techniques, and raising awareness of the CYPFW Act.[281] Following the enactment of the CYPFW Act in 2013, the MWYSA also developed an implementation manual to support social workers and key agencies increase their understanding of the legislation and how it relates to their work. Training has been undertaken with Islands Councils and magistrates in South Tarawa and the outer islands.[282]

Within the first two years of the introduction of the CYPFW Act, rates of reporting of child abuse increased by 33 per cent, demonstrating an increased community understanding of the law and wider acceptance of the need to protect children.[283] Assessment, referral and response to reported child protection cases is guided mainly by SafeNet, a multi-agency case management system for handling of domestic violence and sexual abuse cases. SafeNet protocols and procedures link MWYSA's SWOs/ASWOs, the police, health workers and civil society service providers. It has reportedly improved inter-agency coordination, and referrals have been working well.[284] However, these procedures have been designed primarily for adult domestic violence victims, and do not

279 UNICEF Pacific and Carswell Consultancy. 2017. Evaluation of Capacity Development for Police, p. 76.

280 UNICEF Pacific, Interview with staff [29.11.17].

281 UNICEF Pacific. 2014. Child Protection Systems Governance Review. p. 27.

282 UNICEF Pacific. Child Protection Case Study: From Review to Reform, How Ground-Breaking Legislation is Promoting Child Protection in Kiribati, undated.

283 Ibid.

284 UNICEF Pacific and Carswell Consultancy. 2017. Evaluation of Capacity Development for Police, p. 73.

fully reflect the case management approach reflected in the CYPFW Act, which significantly strengthened the role of SWOs and ASWOs in responding to cases of child abuse and neglect. A 2014 UNICEF review noted that, despite the new formal requirements under the Act, most referrals still followed informal rules and long-standing agreements with faith-based organizations to shelter children and women requiring protection.[285]

Social welfare services to support children and their families remain quite limited. Counselling, legal advice and other support services are available through MWYSA staff and a range of NGOs and FBOs. The Kiribati Counselors Association (KCA) has approximately 60 members who have undertaken at least eight months of full-time training, most of whom are providing family counseling and school-based counseling services.[286] Alternative care for children who are without parental care, or who cannot for their own safety remain with their parents, is primarily provided through kinship care. There are limited alternative care options for children who are removed from their family but who cannot be placed with family members, and Kiribati does not yet have a formal foster care program.[287] The Women's Crises Centre provides temporary short-term shelter for victims of gender-based violence, including girls. [288]

There is a general lack of monitoring, accountability and quality control over CSOs providing services to children and their families, and the MWYSA has yet to establish the structures and mechanisms required to implement their new oversight responsibilities under the Act.[289] This acts as a barrier to ensure that vulnerable children receive consistent and quality support. The delivery of consistent child and family welfare services is also hindered by geographical challenges and the limited resources dedicated to the MWYSA and to social welfare services more generally.[290]

6.2.2.2. Access to child-friendly justice

Kiribati has made significant progress in promoting children's access to justice and improving the handling of child victims, witnesses and offenders. The Kiribati Police and prison Service (KPPS) has established a specialized Domestic Violence Unit that conducts community awareness activities and provides assistance to victims of domestic violence and sexual offences (adults and children), including ensuring appropriate referrals to a Social Welfare Officer.[291] In addition, the KPPS Community Policing Unit (CPU) conducts community awareness raising activities on child abuse prevention, promotes appropriate handling of children (as victims, witnesses, offenders) within the KPPS, promotes the use of diversion, and manages police referrals of juveniles to rehabilitation programmes.[292]

285 UNICEF Pacific. 2014. Child Protection Systems Governance Review, p. 24.

286 MISA 2010, Kiribati Family Health and Safety Study, p. 48.

287 UNICEF Pacific and Carswell Consultancy. 2017. Evaluation of Capacity Development for Police, p. 71.

288 MISA 2010, Kiribati Family Health and Safety Study, p. 48.

289 UNICEF Pacific. 2014. Child Protection Systems Governance Review, p. 46.

290 Ibid., p. 37.

291 UNICEF Pacific and Carswell Consultancy. 2017. Evaluation of Capacity Development for Police, p. 80.

292 Ibid., p. 77.

Community awareness activities have reportedly led to increased reporting of child abuse cases to the police.[293] However, children and their parents continue to face barriers to reporting, including children's fear of reprisals from the family, not being believed, being separated from their family, stigma for the family, and economic challenges if the perpetrator was the main 'breadwinner' in the family and was imprisoned. Many stakeholders also noted the challenges for children and family members to report abuse, particular in small communities where the repercussions for the victim and the family could be life-long.[294]

In order to improve the handling of children's cases, the KPPS Police Training Centre has developed a 5-day child protection training programme for police with technical assistance from UNICEF, which has been used for both in-service training and for training of new recruits. However, police officers in the outer islands tend to have less access to training than those on Tarawa.[295] A 2016 evaluation found that, whilst the SOPs and police training have contributed to improved police practices, a number of gaps and challenges remain. Children's experience with the police varied widely and depended on the knowledge, training, and attitude of the police they encountered. While many officers had a basic awareness of the procedures for child victims and offenders, some appeared to lack understanding and empathy. Procedures were not always consistently followed, for example, victims' privacy was not always respected, the 'No Drop' policy was not applied consistently and cases were not always properly investigated and followed-up.[296] Resourcing is a significant barrier for the KPPS, with police hampered by lack of functioning police vehicles and other materials. Many children and stakeholders complained that police response to incidents was very slow, and also highlighted concerns about lengthy investigations, lack of follow-up, poor investigation skills, and poor communication with victims about the progress of the case. The long court process was also cited as a frustration, with one stakeholder estimating that it could take over a year for a case to proceed through the court .[297]

KPPS handling of children in conflict with the law has also improved, though some challenges remain. Police have been actively diverting children at the pre-trial stage by issuing a formal caution, organizing a restorative community conference to develop a diversion plan, or by referring the child to the Alcohol Awareness and Family Rehabilitation (AAFR) and the MWYSA Youth Division Life Skills Training programme.[298] However, diversion is reportedly inconsistently implemented, and there are still incidents of children being detained in police cells with adults due to overcrowding and lack of appropriate facilities.[299]

A specialized Juvenile Court has been established in Tarawa to hear cases of children in conflict with the law and training on juvenile justice has been provided to magistrates and court clerks.[300]

293 Ibid., p. 83.
294 Ibid., p. 71.
295 Ibid. p. 76.
296 Ibid., p. 82
297 Ibid. pp. 70-71, p. 77.
298 Ibid., p. 80.
299 Ibid., p. 82.
300 UNICEF Pacific Child Protection Baseline Study 2009, p. 86.

Children have access to free legal aid through the People's Lawyer.[301] As part of the UPR Process, a submission from UNICEF noted that no children were held in prisons in South Tarawa, but that there were unconfirmed reports of boys being held in prison on Kiritimati Island.[302] According to the 2015 National Report to the UPR Process, though the Prison Ordinance 40 provides that juveniles be separated from the adult population, current resource constraints do not allow this.[303]

Informal justice mechanisms are commonly used in Kiribati to resolve offences involving child offenders and child victims.[304] This has the potential to provide a more community-based and restorative resolutions to minor offending by children. However, of concerns is the use of corporal punishment against children as part of some community resolutions.[305] The Child Protection Baseline Report also raised concerns that these practices discriminate against women and children and may not ensure the best interest of the child.[306]

6.2.2.3. Child protection in the health, education, labour and other allied sectors

Kiribati's education sector does not yet have a comprehensive policy on child protection in schools, and child protection issues have not been integrated into the Education Sector Strategic Plan 2012-2015. Corporal punishment is prohibited under the Education Act, but there are no reporting protocols or procedures outlining teachers' obligations to identify and refer cases of children who have been abused, neglected or exploited in their homes, school or community.[307] While some teachers receive child protection training within the Child Friendly School programme and through the counselling courses in the Kiribati Teachers College, there is no systemic provision of training on child protection.[308] The Eliminating Sexual and Gender Based Violence project is working with the Ministry of Education to include GBV in the schools' curriculum, for example, through discussion of healthy living to address family relationships and violence.[309]

Kiribati also does not have a clear policy or practical guidelines on addressing child protection issues through the health sector. The Health Sector Strategic Plan for 2012- 2015 includes some potentially relevant goals, but none of them are operationalized into programmes that would contribute to improved prevention, early intervention and response.[310] The MHMS reportedly has a Gender Based Violence Unit which is developing programs on GBV and coordinating training to health workers on how to receive and respond to abuse cases. Health staff provide medical treatment and conduct examinations of children who have been abused, and forensic medical

301 Van Welzenis, I., 'Country-Level Summaries of Diversion and Other Alternative Measures for Children in Conflict with the Law in East Asian and Pacific Island Countries', Internal UNICEF EAPRO Report, 2016, p. 117.

302 UN Stakeholders Information Submitted to UPR Process, Kiribati 2014, para. 32.

303 UPR National Report, Kiribati 2014, para. 121.

304 Van Welzenis, I., 'Country-Level Summaries', p. 120.

305 UNICEF Pacific Child Protection Baseline Study 2009, p. 3.

306 Ibid.

307 UNICEF Pacific. 2014. Child Protection Systems Governance Review, p. 20.

308 Ibid., p. 33.

309 Kiribati State Party Report to the UPR Process, para 64.

310 UNICEF Pacific. 2014. Child Protection Systems Governance Review, p. 32.

examination forms have been developed to record findings for both adults and children.[311] However, Kiribati lacks forensic capacity for DNA and other analysis.[312]

With respect to the labour sector, the Employment and Industrial Relations Act 2016 sets a minimum working age at 14 and a minimum age for hazardous work at 18.[313] The Act allows 'light work' from the age of 12, but does define light work or specify the activities, conditions and hours of work that are acceptable for children engaged in light work. The Occupational Safety and Health Act 2015 also prohibits hazardous occupations or activities for children, but as yet Kiribati has not identified by regulation the types of hazardous work prohibited for children. The Ministry of Labor and Human Resources Development is responsible for enforcing labor laws, including those related to child labor. With the support of the ILO Tackle project, some work has been done to raise awareness on child labour and to build government capacity to address child labour.[314]

6.2.3. Mechanisms for inter-agency coordination, information management and accountability

Kiribati has established a National Advisory Committee on Children (KNACC) to coordinate and monitor implementation of the CRC. It also has an inter-agency Child Protection Working group to lead policy design and implementation, and that played a central role in the development of the new Children, Young Persons and Family Welfare Policy and the CYPFW Act and Juvenile Justice Acts.[315] The Working Group is composed of Deputy Secretaries from relevant ministries, along with technical staff and NGO representatives, who meet on a monthly basis. It has reportedly played an effective role in ensuring coordination and oversight of policy design and coordination, and is linked to the Government's budgeting and reporting arrangements.[316]

Effective planning, policy development and monitoring of the child protection system is hampered by the lack of a centralized child protection information management system. The CYPFW Act explicitly requires the MWYSA to maintain an information management system on children and young people. However, this has not yet been implemented. Information relevant to child protection is fragmented across sectors which operate their own separate databases according to internal ministerial rules with no standardization of definitions or disaggregation criteria.[317] Data collection and collation in Kiribati represent a particular challenge because of the geography of the country and the lack of availability of internet services.[318]

311 Kiribati State Party Report to the UPR Process, para 67.

312 UNICEF Pacific and Carswell Consultancy. 2017. Evaluation of Capacity Development for Police, p. 71.

313 Sections 114 and 117.

314 US Department of Labor, 2016 Findings on the Worst Forms of Child Labor: Kiribati.

315 UNICEF Pacific. Child Protection Case Study: From Review to Reform, How Ground-Breaking Legislation is Promoting Child Protection in Kiribati

316 UNICEF Pacific. 2014. Child Protection Systems Governance Review, p. 46.

317 Ibid.

318 UNICEF Pacific. Child Protection Case Study: From Review to Reform, How Ground-Breaking Legislation is Promoting Child Protection in Kiribati.

6.3. Other child protection issues

6.3.1. Birth registration

Kiribati has made significant progress in improving rates of birth registration, having gone from one of the lowest rates in the Pacific[319] to an estimated birth registration rate of 94 per cent.[320] This improvement in registration has been attributed to a number of key developments, including: stationing a civil registry officer in the maternity ward at the Central Hospital in South Tarawa with the sole role of supporting birth registration by distributing forms and recording births a memorandum of understanding between MWYSA (Civil Registry Office) and the Ministry of Health and Medical Services, allowing registry staff to be stationed at the central hospital; and engaging in awareness-raising campaigns in communities, such that 'a high value is placed on the importance of birth registration in Kiribati.'[321] In a state whose population is dispersed across many islands, the increase in logistical feasibility and convenience and community buy-in have reportedly been instrumental in removing barriers to the realization of the right to birth registration.

6.3.2. Climate change and natural disasters

Like most PICTS, Kiribati s vulnerable to the impacts of climate change and natural disasters. In the event of a natural disaster such as typhoon or tsunami, children are the most vulnerable population. Effects of climate change like drought and high tides also harm vulnerable children.

Child protection has been factored into climate change and disaster risk management in Kiribati, including in the National Disaster Risk Management Plan 2012. The Plan had a strong focus on community-based response mechanisms, including plans for child protection. The new Joint Implementation Plan for Climate Change and Disaster Risk Management 2014–2023 similarly acknowledges that 'Climate change and disasters are felt first and most acutely by vulnerable and marginalized populations, including women, children, youth, people with disabilities, minorities, the elderly and the urban poor' and that violence against women and children 'can be exacerbated in times of disaster when normal social protection may be missing'.[322] Child protection in emergencies training has been provided to MWYSA staff and other key stakeholders at the national and sub-national level.

319 UNICEF, Australian Aid and EU, 'Child Protection Case Study. Partnerships Promoting High Birth Registration in Kiribati', undated, p. 2.

320 SWOC dataset.

321 UNICEF et al., 'Child Protection Case Study', p. 2.

322 P. 27.

7.

Social Protection

A comprehensive social protection system is essential to reduce the vulnerability of the most deprived persons – including children – to social risks. Social protection systems can strengthen the capacity of families and carers to care for their children and help remove barriers to accessing essential services, such as health care and education, and thereby help close inequality gaps. Social protection measures can also help cushion families against livelihood shocks, including unemployment, loss of a family member or a disaster, and can build resilience and productivity among the population.

According to UNICEF, social protection is 'the set of public and private policies and programmes aimed at preventing, reducing and eliminating *economic* and *social* vulnerabilities[323] to poverty and deprivation, and mitigating their effects'.[324] Social protection systems are essential to ensuring realization of the rights of children to social security (CRC Article 26) and a standard of living adequate for their physical, mental, spiritual, moral and social development (CRC Article 27). According to Article 27(2) of the CRC, State Parties are required to 'take appropriate measures to assist parents and others responsible for the child to implement this right [to an adequate standard of living] and shall in case of need provide material assistance and support programmes, particularly with regard to nutrition, clothing and housing'.

Effective social protection measures are also essential to achieving SDG 1: to eradicate extreme poverty (which is currently measured as people living on less than US$ 1.25 a day) for all people everywhere by 2030, and to reduce at least by half the proportion of men, women and children of all ages living in poverty in all its dimensions according to national definitions.

323 UNICEF distinguishes between the two as follows: 'Poverty reflects current assets or capabilities, while vulnerability is a more dynamic concept concerned with the factors that determine potential future poverty status. Vulnerability considers both an individual's current capabilities and the external factors that he/she faces, and how likely it is that this combination will lead to changes in his/her status.'

324 UNICEF Social Protection Strategic Framework, 2012, p. 24.

In order to achieve this, SDG 1.3 requires the implementation of 'nationally appropriate social protection systems and measures for all, including [social protection] floors'. A social protection floors consist of two main elements: essential services (access to WASH, health, education and social welfare); and social transfers (a basic set of essential social transfers in cash or in kind, paid to the poor and vulnerable).[325]

Key Social Protection-related SDGs

SDG	Target	Indicators
1.1	By 2030, eradicate extreme poverty for all people everywhere, currently measured as people living on less than US$ 1.90 a day	By 2030, eradicate extreme poverty for all people everywhere, currently measured as people living on less than US$ 1.90 a day
1.2	By 2030, reduce at least by half the proportion of men, women and children living in poverty in all its dimensions according to national definitions	Proportion of population living below the national poverty line, by sex and age
		Proportion of men, women and children of all ages living in poverty in all its dimensions according to national definitions
1.3	Implement nationally appropriate social protection systems and measures for all, including floors, and by 2030 achieve substantial coverage of the poor and the vulnerable	Proportion of population covered by social protection floors/systems, by sex, distinguishing children, unemployed persons, older persons, persons with disabilities, pregnant women, newborns, work-injury victims and the poor and the vulnerable
1.4	By 2030, ensure that all men and women, in particular the poor and the vulnerable, have equal rights to economic resources, as well as access to basic services, ownership and control over land and other forms of property, inheritance, natural resources, appropriate new technology and financial services, including microfinance	Proportion of population living in households with access to basic services
		Proportion of total adult population with secure tenure rights to land, with legally recognized documentation and who perceive their rights to land as secure, by sex and by type of tenure

Under UNICEF's Social Protection Strategic Framework, to achieve social protection it is necessary to develop an integrated and functional social protection system. This means developing **structures and mechanisms** to coordinate interventions and policies to effectively address multiple economic and social vulnerabilities across a range of sectors, such as education, health, nutrition, WASH and child protection.[326]

325 ILO and WHO, 'The Social Protection Floor: A Joint Crisis Initiative of the UN Chief Executive Board for Coordination on the Social Protection Floor', October 2009, on http://www.un.org/ga/second/64/socialprotection.pdf [14.08.17].

326 UNICEF Social Protection Strategic Framework, p. 31.

7.1. Profile of child and family poverty and vulnerability

As set out above, a significant proportion of Kiribati's population is living in poverty. While recent data are unavailable, the 2006 Household Income and Expenditure Survey (HIES) indicated that, while incidence of food poverty was quite low (5.3 per cent of the population was living below the food poverty line), incidence of basic needs poverty was reasonably high (21.8 per cent of the population was living below the basic needs poverty line).[327] Unfortunately, no HIES was carried out prior to 2006, so it is not possible to analyse trends over time. However, according to a UN survey carried out in 2009, 86 per cent of people were in a seriously more difficult financial situation in 2009 compared with 2008.[328] This indicates that Kiribati may not be progressing well against SDG target 2.1 (reduction by at least half the proportion of the population living in poverty according to national definitions).

In addition, a significant proportion of the population was found to be vulnerable to falling into poverty. According to analysis of the 2006 HIES, a further 5.6 per cent and 21.1 per cent of the population would fall into poverty with increases of the basic needs poverty line of 10 per cent and 20 per cent respectively.[329] This leaves a significant number of persons vulnerable to slipping into poverty when faced by shocks, such as unemployment, natural disasters or fluctuations in food and fuel prices. It has been estimated that a simultaneous shock to three basic commodities (rice, wheat and oil) would push a further 6 per cent of the population into poverty.[330]

Children appear to be more at risk of poverty in Kiribati. While one in six households are found to be living below the basic needs poverty line nationally, for households with children this increases to one in five.[331] Children living in households with older people were found to be poorest, with a basic needs poverty rate of 25 per cent.[332] The impacts of poverty are more significant for children, and there is growing evidence that children experience poverty more acutely than adults: the negative impacts on their development can have profound and irreversible effects into adulthood. It has also been suggested that the HIES underestimated the real economic stresses placed on children (and mothers). Even in households that have a level of expenditure that places them above the basic needs poverty line, the available cash may not necessarily benefit women and children but instead be utilized by the man/men in the household, leaving women and children to struggle.[333]

Like in most countries, national poverty averages in Kiribati mask inequalities within the country. The data demonstrate regional disparities in levels of poverty. As Figure 7.1 shows, the rate of persons living below the basic needs poverty line is highest in South Tarawa. However, food poverty rates are highest in Rest of Gilberts.

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327 KNSO and UNDP Pacific, 'Analysis of the 2006 Household Income and Expenditure Survey: A Report on the Estimation of Basic Needs Poverty Lines, and the Incidence And Characteristics of Poverty in Kiribati', 2010, p. 32.

328 UN, 2009, in AusAID, 'Poverty, Vulnerability and Social Protection: Kiribati Case Study', 2012, Pacific Social Protection Series, p. 16.

329 KNSO and UNDP Pacific, 'Analysis of the 2006 HIES', p. 32.

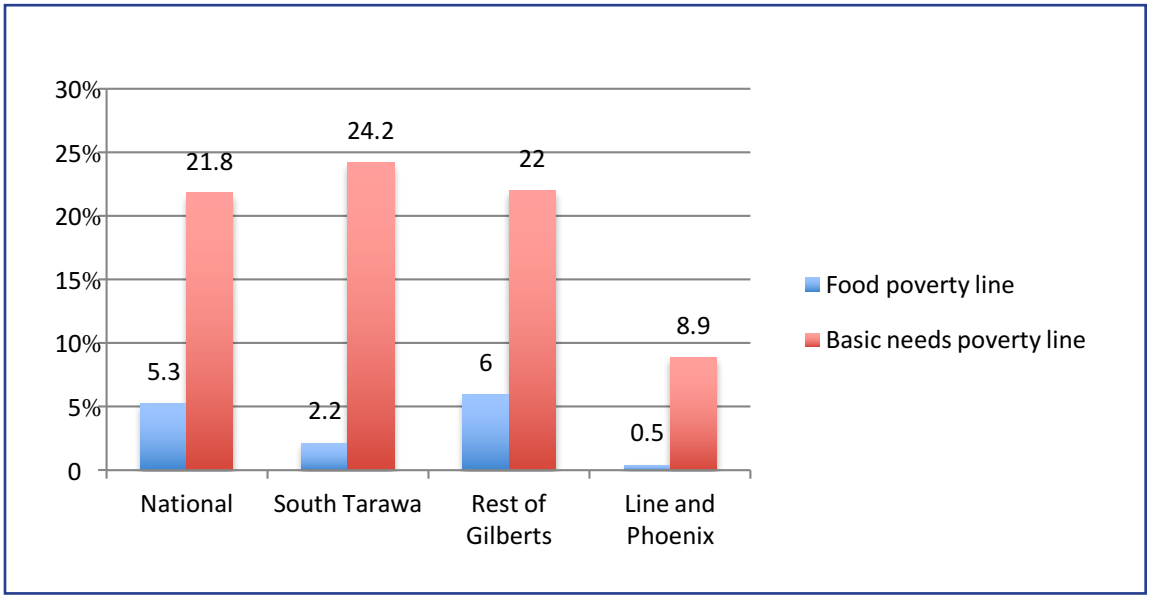
330 World Bank, 'Hardship and Vulnerability in the Pacific Island Countries', 2014, p. 67.

331 UNICEF, 'Child Poverty and Hardship in Kiribati', p. 35.

332 AusAID, 'Poverty, Vulnerability and Social Protection: Kiribati', p. 23.

333 ADB, 2009, in ibid.

Figure 7.1: Population living under food poverty and basic needs poverty line by region, 2006 (%)



Source: KNSO and UNDP Pacific, 'Analysis of the 2006 HIES', 2010

This indicates that poverty in Kiribati has an 'urban face'. According to a recent analysis of the HIES 2006 data, although South Tarawa is the capital and centre of employment, there are, nevertheless, 'many households whose expenditure cannot cover the basic-needs costs of a reasonable, minimum standard of living'.[334] In urban areas, high unemployment, large household sizes and inability to rely on subsistence farming as in rural areas drive many households into poverty.[335] This is consistent with consultations undertaken by ADB in 2007 that found people believed poverty to be worse in South Tarawa because of the greater need for cash.[336]

There are likely to be pockets of significant urban poverty and deprivation in informal 'squatter settlements' in South Tarawa. Like other PICTS, Kiribati has experienced an 'urban drift' of populations, in this case to South Tarawa, particularly of young men. This has led to high levels of unemployment and growing numbers living in squatter-type settlements (on land to which the residents have no legal title).[337] This has caused high rates of urbanization in South Tarawa, which has been characterized as 'one of the most over-crowded places on Earth', with infrastructure, facilities and natural resources over-burdened.[338] Conditions in squatter settlements across the Pacific are generally very bad, characterized by poor-quality, over-crowded housing without access to improved water sources, sanitation and other basic services. Poor conditions have negative impacts for children, including poor health and, relatedly, poor educational attainment.[339]

334 KNSO and UNDP Pacific, 'Analysis of the 2006 HIES'.

335 Republic of Kiribati (2010) in UNICEF, 'Child Poverty and Hardship in Kiribati'.

336 AusAID, 'Poverty, Vulnerability and Social Protection: Kiribati', p. 16.

337 KNSO and UNDP Pacific, 'Analysis of the 2006 HIES'.

338 World Bank, 'Systematic Country Diagnosis: Kiribati, Republic of Marshall Islands, Federated States of Micronesia, Palau, Independent State of Samoa, Kingdom of Tonga, Tuvalu and Republic of Vanuatu', p. 42.

339 World Bank, 'Hardship and Vulnerability in the Pacific Island Countries'.

This likely perpetuates a cycle of poverty, exclusion and deprivation for children living in these settlements.

The exception to the urban poverty trend is in the Southern Gilbert Group of Islands; here, rates of poverty appear to be high, accounting for a significant proportion of poverty in the 'Rest of Gilberts' group. Food poverty in the Southern Gilberts, according to the HIES, is as high as 11 per cent. The Southern Gilberts are very small and remote, with limited resources for food production. They are vulnerable to drought and periodic shipping and supply problems. They also have the highest proportion of older people and fewer working-age adults.[340] These factors can cause serious food security issues.[341] Basic needs poverty is also higher compared to the Northern and Central Gilbert Groups. This is characteristic of PICTS more generally: rural areas, particularly in more geographically isolated outer islands, tend to be poorer than more centrally located islands,[342] a trend compounded by lack of access to basic services.[343] According to a recent UNESCAP report, 'The greater concentration of economic activity in urban areas, as well as the greater provision of public services, contributes to this trend.'[344] Poverty rates are significantly lower in the Line Islands, 'reflecting a younger migrant population and greater national resources'.[345]

According to a multi-dimensional poverty assessment carried out recently by UNICEF using DHS data from 2009, poverty is associated with living in more rural, remote islands. A multi-dimensional approach recognizes that poverty is multi-faceted – broader than deprivation of income and characterized by a range of deprivations (education, health, housing, communications and access to information and income). According to this assessment, 89.1 per cent of children in the 'Rest of Gilberts' (rural) are severely deprived of one basic need and 62.3 per cent of two. In South Tarawa (Urban), 67.9 per cent of children are severely deprived of one basic need and 31.7 per cent of two.[346] The most common form of severe deprivation in both locations is shelter.

Poverty is associated with gender in Kiribati. Female-headed households are disproportionately represented in the lowest wealth quintiles. According to the 2006 HIES, while only one in five households is female-headed, around one in four in the lowest quintile in South Tarawa and the rural Gilberts is female-headed.[347] Poverty levels are particularly pronounced for children in female-headed households in the rural Gilberts, where a third of children live in female-headed households but, of these, 50 per cent are in the bottom three deciles.[348] The HIES found female-headed households were over-represented in the wealthiest quintile, but it has been noted that this is likely to have resulted from a flaw in the methodology, with households with husbands working as sea-farers counted as 'single' female-headed households.[349] Single women are

340 AusAID, 'Poverty, Vulnerability and Social Protection: Kiribati', p. 19.

341 KNSO and UNDP Pacific, 'Analysis of the 2006 HIES'.

342 UNDP, 'State of Human Development in the Pacific: A Report on Vulnerability and Exclusion at a Time of Rapid Change', p. 20.

343 AusAID, 'Poverty, Vulnerability and Social Protection in the Pacific: The Role of Social Transfers', 2012.

344 UNESCAP, 'State of Human Development in the Pacific'.

345 AusAID, 'Poverty, Vulnerability and Social Protection: Kiribati', p. 19.

346 UNICEF, 'Child Poverty and Hardship in Kiribati', p. 41.

347 AusAID, 'Poverty, Vulnerability and Social Protection: Kiribati', p. 21.

348 KNSO and UNDP Pacific, 'Analysis of the 2006 HIES'.

349 AusAID, 'Poverty, Vulnerability and Social Protection: Kiribati', p. 21.

reportedly becoming more vulnerable to living in poverty, as an increasing number of men are leaving their wives and traditional extended family support for single women is decreasing.[350] In addition, it is difficult for women to collect child maintenance, given the absence of effective family law systems in Kiribati.[351]

Poverty is also associated with educational level in Kiribati, with a strong correlation between poverty and vulnerability and level of education, according to the 2006 HIES. In the lowest three deciles, 57.8 per cent of the population has only primary education. Those who have completed secondary school or higher account for only 22 per cent of those in the lowest three deciles.[352]

Perhaps unsurprisingly, poverty rates are also significantly higher among households with unemployed members and those working in the informal sector. According to the 2006 HIES, 18.6 per cent of all households are without any member in employment and 5.7 per cent have only one employed member; however, these households represent 38 and 13.5 per cent of those in the bottom three deciles, respectively.[353]

However, access to formal employment is not a guarantee against poverty, particularly in South Tarawa, and the data point to a significant population of 'working poor' in Kiribati. According to the 2006 HIES, a quarter of households in the poorest three deciles are headed by someone who is employed; these are typically larger households with many children or older people.[354]

People living with a disability appear to be particularly vulnerable to poverty. While no data are available to test the association of disability with poverty (as disability is not included as a category in household surveys), those with a disability are very likely to be vulnerable to poverty, given the lack of educational and other opportunities accessible to them (see Chapter 5, above).

The causes of child and family poverty in Kiribati are complex, interconnected and open to fluctuation. As a small island economy, Kiribati faces many challenges confronting PICTS more generally, and the more particular challenges common to other island atoll states. These include 'its small size, remoteness, geographical fragmentation, a harsh natural environment with infertile soil, limited exploitable resources, and the need to create jobs and promote growth for an expanding population'.[355] The economy has a very limited export and production base, being limited to copra (coconut meat), seaweed and fishing. It is heavily reliant on foreign aid and vulnerable to external shocks, including climate change in particular (as discussed above). As a country that relies heavily on its marine resources to generate livelihoods, the impacts of climate change will be significant: tuna resources, in particular, are very dependent on climate and vulnerable to climate variability.[356] Given its high import dependence, the economy is vulnerable to commodity price fluctuations.[357]

350 ADB, 2009, in 'Poverty, Vulnerability and Social Protection: Kiribati', p. 21.

351 AusAID, 'Poverty, Vulnerability and Social Protection: Kiribati', p. 21.

352 KNSO and UNDP Pacific, 'Analysis of the 2006 HIES'.

353 Ibid., p. 37.

354 AusAID, 'Poverty, Vulnerability and Social Protection: Kiribati'.

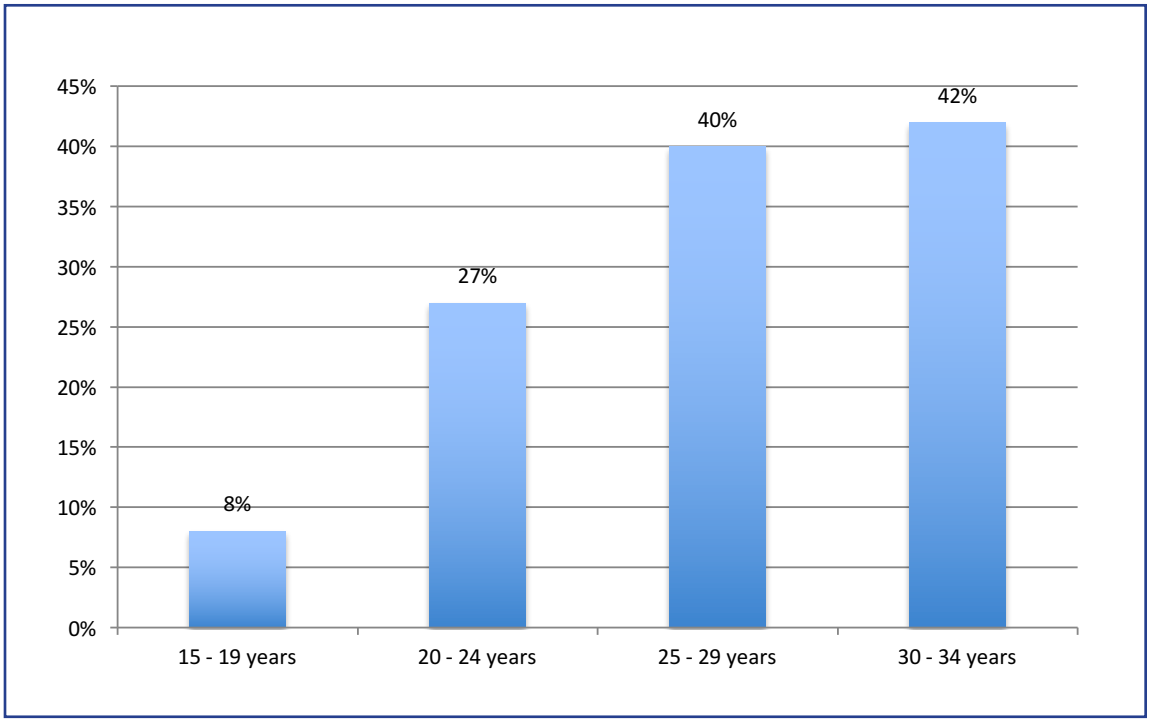
355 UNICEF, 'Child Poverty and Hardship in Kiribati', p. 29 .

356 Republic of Kiribati, 2010, in UNICEF, 'Child Poverty and Hardship in Kiribati'.

357 UNICEF, 'Child Poverty and Hardship in Kiribati', p. 29.

A limited economic base and exposure of the economy to shocks have led to a poverty of opportunity in PICTS, including Kiribati, which has a significant number of unemployed, particularly young people. Across the Pacific, economies are not able to generate sufficient jobs for the number of job-seekers. Also, the large number of young people with inadequate skills contributes to youth unemployment.[358] While it appears that there is a relatively low youth unemployment rate in Kiribati (6.7 per cent in 2005, according to ILO),[359] in effect it is much higher. For instance, it has been estimated that the unemployment rate is 64 per cent, when persons of working age who are involved in subsistence activities but would prefer wage labour are included.[360] Young people, in particular, lack access to the formal employment sector, as Figure 7.2 illustrates.

Figure 7.2: Percentage of persons in labour force who are in the formal sector, by age group



Source: Ministry of Finance and Economic Planning data 2007[361]

According to figures from 2009, around 2,000 young people enter the labour force each year but only 500 jobs are available in the public sector.[362] Meanwhile, insufficient opportunities, low educational attainment and lack of suitable skills effectively limit young people's opportunities

358 AusAID, 'Poverty, Vulnerability and Social Protection in the Pacific: The Role of Social Transfers', p. 4.

359 ILO, 'Pacific Island Countries', Youth Employment Brief, 2013, on www.youthmetro.org/uploads/4/7/6/5/47654969/youth_employment_policy_brief_pacific_islands_countries.pdf [05.09.17].

360 UNESCAP, 'Income Support Schemes in Pacific Island Countries: A Brief Overview', undated, p. 14.

361 In AusAID, 'Poverty, Vulnerability and Social Protection: Kiribati', p. 21.

362 ADB, 2009, in AusAID, 'Poverty, Vulnerability and Social Protection in the Pacific: The Role of Social Transfers'.

to subsistence production.[363] This has reportedly fuelled a range of social problems, including increased levels of alcohol consumption and involvement in gangs and criminal activity.[364]

Persons living below the poverty line are also more vulnerable to natural disasters. Subsistence farmers who depend on natural resources for their livelihoods are particularly affected.

7.2. Bottlenecks and barriers to ensuring an effective social protection system

Social protection encompasses many different types of systems and programmes, including social insurance (e.g. contributory schemes to provide security against risk, such as unemployment, illness, disability, etc.); social assistance (non-contributory measures such as regular cash transfers targeting vulnerable groups, such as persons living in poverty, persons with disabilities, the elderly, children); and social care (child protection prevention and response services, detailed in Chapter 6). There has been a growing acceptance in recent times that social security, in particular the provision of regular cash transfers to families living in and vulnerable to poverty, should be a key component of a social protection system.[365] Cash transfers provide households with additional income that enables them to invest in children's well-being and human development.[366]

The comprehensiveness and impact of Kiribati's 'formal' social protection system appears to be quite weak. ADB's Social Protection Indicator (formerly Index) (SPI) assesses social protection systems against a number of indicators to generate a ratio, which is expressed as a percentage of GDP per capita. The SPI for Kiribati was, in 2016, 1.1. This is below the Pacific regional average (including PNG) of 1.9, as set out in Figure 7.3.

The data indicate that the vast majority of social protection expenditure is for social assistance measures, as shown in Table 7.1. This contrasts with the trend in other PICTS, in which the majority of social protection expenditure is for social insurance (contributory) schemes.

Table 7.1: Social Protection Indicator by type of programme, 2012

Programme	Social Protection Indicator (%)
Overall	1.1
Social Assistance	1.0
Labour Market Programmes	0.2
Social Insurance	-

Source: Data from ADB, 'The Social Protection Indicator: The Pacific', 2016, p. 16

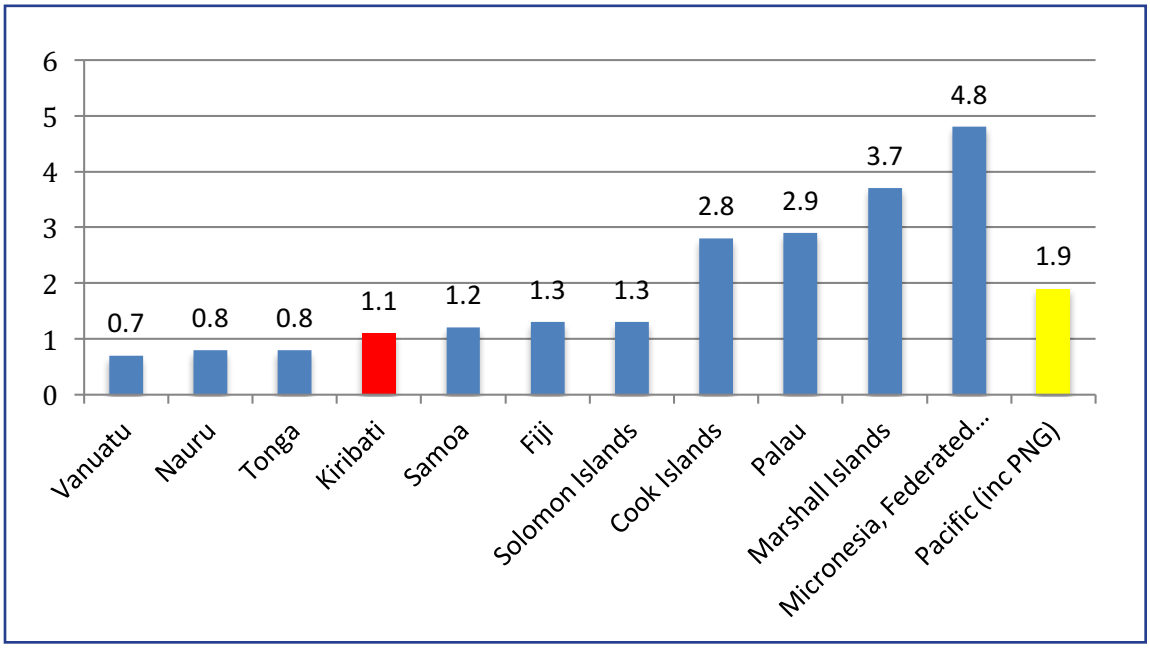
363 AusAID, 'Poverty, Vulnerability and Social Protection in the Pacific: The Role of Social Transfers', p. 4.

364 AusAID, 'Poverty, Vulnerability and Social Protection: Kiribati'.

365 UNICEF and MoWCPA, 'Child-Sensitive Social Protection in Fiji', 2015, p. 6.

366 UNICEF, Social Protection Strategic Framework, 2012.

Figure 7.3: Social Protection Indicator by country



Note: Please note that the Pacific-wide SPI aggregates include PNG and Timor-Leste but not Niue, Tokelau and Tuvalu.
Source: Data from ADB, 'The Social Protection Indicator: The Pacific', 2016, p. 16

In terms of social assistance measures, the Government provides a universal pension scheme, which guarantees an income for all persons over the age of 67 years in Kiribati. The scheme covers approximately 3,079 beneficiaries (as reported in 2012): 55 per cent of the older population.[367] Those aged 67–69 years receive a direct cash benefit of AU$ 40 per month and those aged over 70 years receive AU$ 50 a month. This is set at 80 per cent of an adult's monthly expenditure in the poorest quintile, and is considered an 'income supplement', meaning the benefit rate is less than the basic needs poverty line.[368] Nonetheless, data indicate that the scheme has a high take-up rate, and the amount compares favourably with similar schemes in other small states. It has also had a significant impact on poverty among households containing people over 70 years of age. In 2010, it reduced the poverty rate of these households by an estimated 19 per cent.[369]

There is no child benefit scheme in Kiribati, however, and social assistance measures targeted at other vulnerable populations are very limited, and focus on school fee schemes and the provision of cash payments to incapacitated parents of secondary school children.[370] It has also been found that the universal pension has had a positive impact on improving outcomes for children in households containing older persons. There is currently no disability benefit scheme in Kiribati: the only form of government support for children with disabilities is the payment of school fees for these children.[371]

367 AusAID, 'Poverty, Vulnerability and Social Protection: Kiribati'.
368 UNESCAP, 'Income Support Schemes in Pacific Island Countries: A Brief Overview', undated, p. 20.
369 AusAID, 'Poverty, Vulnerability and Social Protection: Kiribati'.
370 World Bank, 2006, in AusAID, 'Poverty, Vulnerability and Social Protection: Kiribati'.
371 AusAID, 'Poverty, Vulnerability and Social Protection: Kiribati'.

Social insurance is provided through a National Provident Fund and workers' compensation scheme. However, this is limited to formal sector workers, and thus excludes the majority of workers who operate in the informal economy – it is therefore not targeted to the poorest members of society. Contributory schemes involving formal sector workers also tend to have a gender bias, as the majority of formal sector workers are men.[372] Women face particular challenges accessing employment in the formal economy. While the labour force participation rate for young women compares favourably with that for young men (52.5 per cent for women 15–24 years and 52.9 per cent for men of this age group in 2005),[373] they have less access to paid employment. According to data from 2005, women make up only 38 per cent of the paid workforce. This reflects traditional gender norms in Kiribati, which relegate women to domestic roles within the home, where they are expected to 'assume a subordinate position'.[374]

Also, the SPI was calculated at zero, as there were reportedly no benefits paid under the social insurance scheme in 2012.[375] Fewer than 4 per cent of households received payments from the National Provident Fund, according to the 2006 HIES.[376]

Another component of social protection systems is activities to generate and improve access to employment opportunities among young people. Kiribati's SPI for its labour market programmes, while quite low, is one of the highest among PICTS. Kiribati is the only country in the region that distributes cash benefits to beneficiaries of labour market programmes. However, this takes the form of mobilization costs (i.e. airfares) for workers recruited under the New Zealand and Australian seasonal employment programmes, rather than, for example, programmes to generate opportunities and skills development for young people within Kiribati.[377] The government has also implemented projects in South Tarawa to assist young people in establishing businesses, through ILO. However, as of 2012, these projects covered only around 120 beneficiaries.[378]

The data indicate that the depth of social protection systems in Kiribati (the average benefits actual beneficiaries receive) is quite high, particularly in comparison with other PICTS, as Figure 7.5 shows.

The high rating for depth of benefits is attributed mainly to the generous payments paid to mobilize workers recruited under the New Zealand and Australian seasonal employment programme, as indicated in Table 7.2.

Also, Kiribati's depth indicator for social assistance programmes is quite high, reflecting 'the relative generosity of its senior citizens benefits programme'.[379]

372 UNESCAP, 'State of Human Development in the Pacific'.

373 ILO, 'Pacific Island Countries'.

374 AusAID, 'Poverty, Vulnerability and Social Protection: Kiribati'.

375 ADB, 'The Social Protection Indicator: Assessing Results for the Pacific', 2016, p. 16.

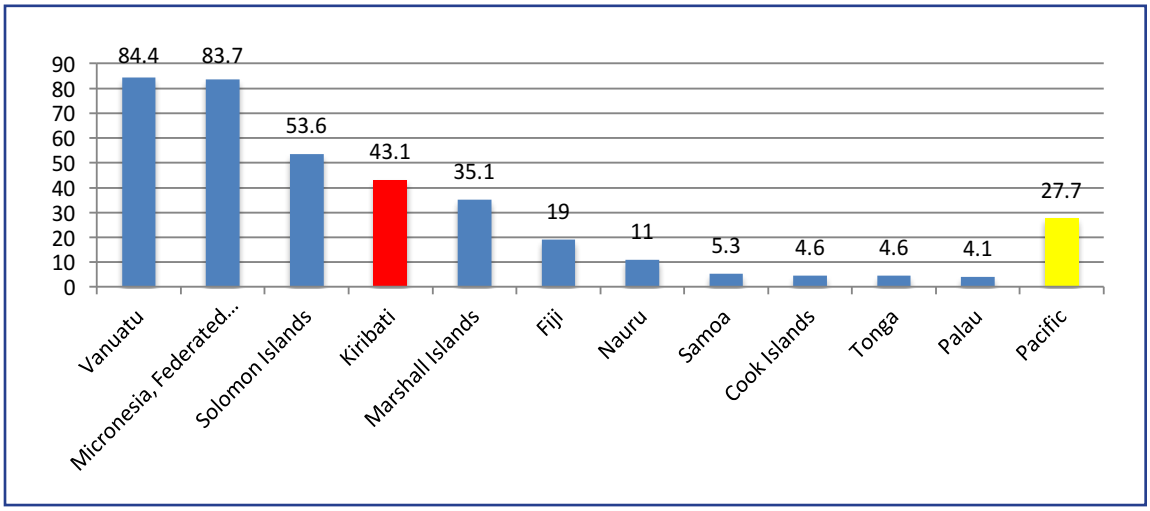
376 World Bank, 'Hardship and Vulnerability in the Pacific Island Countries'.

377 ADB, 'The Social Protection Indicator: The Pacific', 2016, p. 27.

378 AusAID, 'Poverty, Vulnerability and Social Protection: Kiribati'.

379 ADB, 'The Social Protection Indicator: The Pacific', 2016, p. 27

Figure 7.4: Depth of Social Protection Indicator, by country



Note: Please note that the Pacific-wide SPI aggregates include PNG and Timor-Leste but not Niue, Tokelau and Tuvalu.

Source: Data from ADB, 'The Social Protection Indicator: The Pacific', 2016, p. 16

Table 7.2: SPI depth indicator, by type of programme

Programme	SPIC depth indicator (% of per-capita GDP)
Overall	43.1
Labour Market	187.3
Social Assistance	37.2
Social Insurance	0.0

Source: Data from ADB, 'The Social Protection Indicator: The Pacific', 2016, p. 34

Breadth indicators represent the proportion of potential beneficiaries (those who could qualify for benefits) who actually receive social protection benefits. According to the ADB assessment, Kiribati receives a relatively low breadth indicator, as illustrated in Figure 7.5. This indicates that, while the amount of assistance provided to beneficiaries is relatively high, the number of beneficiaries receiving benefits is relatively low.

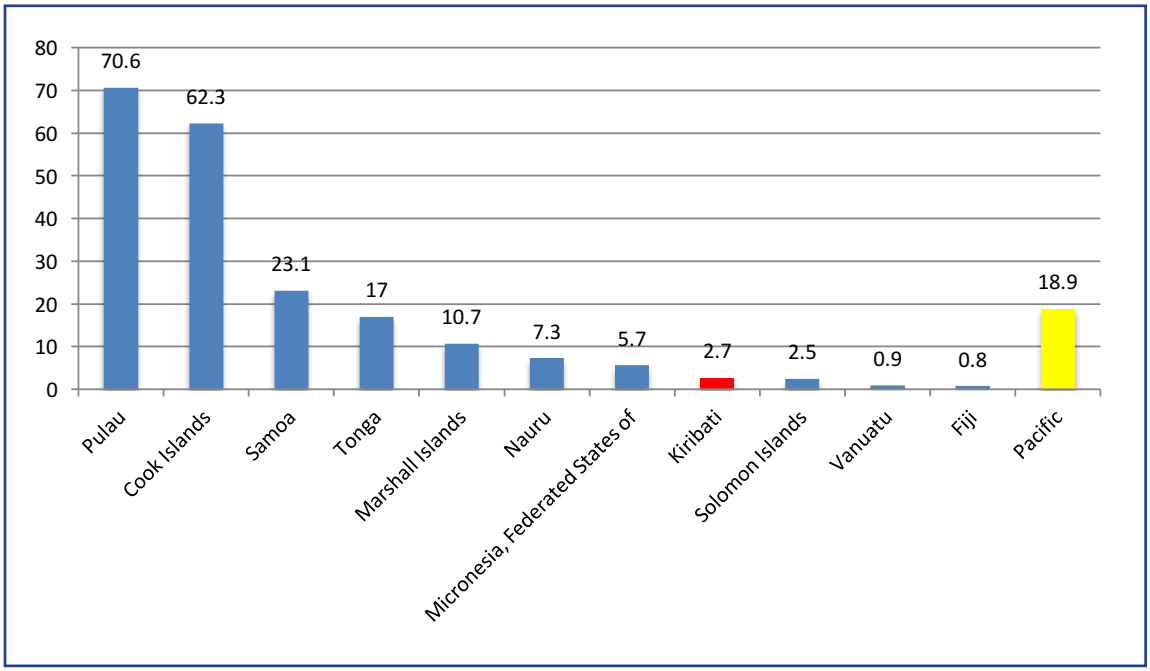
The breadth indicator is highest for social assistance programmes (2.6), compared with social insurance (0) and labour market programmes (0.1), Table 7.3. This indicates that only a very small proportion of the population benefits from the relatively generous level of payments under social assistance and labour market schemes.

Table 7.3: SPI breadth indicator, by type of programme

Programme	SPIC depth breadth (%)
Overall	2.7
Social Assistance	2.6
Labour Market	0.1
Social Insurance	0.0

Source: Data from ADB, 'The Social Protection Indicator: The Pacific', 2016, p. 37

Figure 7.5: Breadth of Social Protection Indicator, by country



Note: Please note that the Pacific-wide SPI aggregates include PNG and Timor-Leste but not Niue, Tokelau and Tuvalu.
Source: Data from ADB, 'The Social Protection Indicator: The Pacific', 2016, p. 16

Data for the Pacific also indicate that social protection schemes are not well targeted. When the SPI is disaggregated between the poor and the non-poor, the non-poor are found to be the main beneficiaries of social protection programmes (the aggregate SPI for the poor in PICTS is only 0.2 per cent of GDP per capita, while the SPI for the non-poor is 1.7 per cent of GDP per capita). This owes to the dominance of social insurance programmes.[380]

The targeting of social protection programmes also appears to have a gender dimension. Overall, the SPI for women in the Pacific is 0.8 per cent of GDP per capita compared with 1.1 per cent of

380 ADB, 'The Social Protection Indicator: The Pacific', 2016.

GDP per capital for men.[381] This is attributed to the differential access of women and men to social insurance measures.[382] As noted above, social insurance measures have a gender bias, as access is generally restricted formal sector workers, who are predominantly male.

It is also worth noting that Kiribati's largest form of social protection, in terms of government expenditure, is the copra fund subsidy. The subsidy guarantees a minimum purchase price for copra from the government of Kiribati. Copra producers receive this price when they bring copra in for weighing. The purpose of the scheme is to provide income protection to copra farmers, and to encourage people to remain on the outer islands. The scheme largely fulfills this function; however, it has also been criticized for discriminating against households with persons unable to perform farm work (e.g. the elderly and persons with disabilities).[383] It therefore does not effectively target the most vulnerable households. The fiscal cost of the scheme is also very high, accounting for between 5 and 7.5 per cent of recurrent government revenue in recent years.[384]

Other, non-state, forms of social protection exist in Kiribati and should be taken into account in development policies and systems on social protection. Informal extended family and community systems provide important safety nets and support. Kiribati's *bubuti* system has been key in providing those in need with informal social protection: extended family networks promote egalitarian values that encourage resource-sharing in communities to provide for those in need. However, while these systems still exist, 'Increasing poverty, urbanization, migration and cultural change are placing [them] under stress.'[385]

While Kiribati provides some formal social protection measures, which appear to be having a (limited) impact in terms of lifting people out of poverty, several operational barriers have been noted. The Elderly Fund is not underpinned by legislation; if the scheme were provided for in the law, it would make it difficult to reduce or modify it without broader consensus. Also, Kiribati lacks a separate, central agency mandated to work on social policy and the development of social protection services.[386]

Particularly in the context of diminishing traditional support systems, the absence of a comprehensive social protection system that effectively targets those who are most in need is a significant gap; lack of social assistance programmes that target vulnerable populations impairs the ability of the country to lift its people out of poverty and create improved conditions for economic growth.

381 Ibid. Please note the Pacific-wide SPI aggregates include PNG and Timor-Leste but not Niue, Tokelau and Tuvalu.

382 ADB, 'The Social Protection Indicator: The Pacific', 2016.

383 UNESCAP, 'Income Support Schemes in Pacific Island Countries: A Brief Overview', p. 20.

384 World Bank, 'Hardship and Vulnerability in the Pacific Island Countries', p. 67.

385 AusAID, 'Poverty, Vulnerability and Social Protection: Kiribati'.

386 Ibid.

8. Conclusions

In addition to the specific bottlenecks and barriers identified under each chapter above, the following key findings can be drawn from the wider situation analysis of women and children in Kiribati. Please note that these are not listed in any order of priority.

8.1. Climate change and disaster risks

Of all the Pacific Island nations, Kiribati is thought to be one of the most vulnerable to the impacts of climate change, as rising sea levels threaten the mere existence of its islands, none of which reaches more than 6 metres above sea level. A key finding of this report is that climate change and disaster risks have a considerable impact on all sectors in relation to the realization of children and women's rights.

- Climate change and extreme weather increase the threat of communicable and non-communicable diseases and exacerbate existing bottlenecks and barriers to **health** services by affecting access and supply routes to sources of health care as well as **WASH** infrastructures and practices. Natural disasters increase **food and nutrition insecurity**, while increasing the risk of food- and water-borne diseases.

- Disaster and climate risks affect access to and quality of **education** services through damage to schools, challenges in access and diverted resources.

- Climate change and extreme weather or other disasters also affect **child protection** concerns, by exacerbating the risk of violence against children, uprooting families and leaving children living in difficult and unsafe conditions.

- **Rising sea levels threaten the existence of Kiribati as a nation**. The government has begun adapting and responding to this threat, including through the promotion of a 'migration with dignity' approach, urging residents to move abroad, and its recent purchase of nearly 6,000 acres of land in neighbouring Fiji, as a potential refuge, and source of fresh-water and food supplies.

8.2. Financial and human resources

Kiribati continues to rely heavily on external development aid and a declining revenue from fishing licences, and the country is plagued by high unemployment rates. This leads to a lack of available resources across nearly all government departments and a resultant lack of financial resources for the delivery of services and systems for children, but it also seems to be linked to a lack of human resources (training and expertise) in several sectors.

- Lack of financial resources translates to lack of appropriate equipment and professionals, including in the **health** and **WASH** sectors in particular, but also in **justice** and **child protection**.

- The SitAn has revealed a lack of trained professionals in all sectors, including **health, WASH, education, child protection and justice**.

8.3. Geography

The geography of Kiribati plays a key role in the realization of the rights of women and children.

- Those living in rural and remote areas enjoy, on the whole, lesser outcomes and access to basic services than those who live in urban areas.

- Geography poses primary access challenges, to, for example, hospitals/health care centres, courts, police stations, schools and other facilities providing services to children and women.

- An increased drift from rural to urban areas is placing children at risk, and not only because urban settlements lack services and infrastructure. For example, children who relocate internally within Kiribati from rural to urban areas are removed from informal community-based protection mechanisms that might otherwise support them.

8.4. Equity

The analyses of WASH, health and education reveal discrepancies in relation to the enjoyment of rights between rural and urban areas.

- For example, the urban–rural divide in access to improved sanitation facilities is **one of the largest in the region**.
- Access to improved drinking water sources is also significantly more restricted in Kiribati's rural areas.
- Pupil–teacher ratios are more advantageous in urban areas compared with rural areas.

8.5. Gender

Socio-cultural norms and traditional perceptions around gender roles can act as barriers and bottlenecks to the realization of children and women's rights.

- Traditional gender roles support and facilitate the highest rates of **violence** against women and girls in the world, and the highest rate in the PIC region.
- Customary law is applicable to marriage and has no lower age limit, which means girls may be married at any age, opening them up to greater risk of domestic violence, early pregnancy and school drop-out.

8.6. Norms and attitudes

Cultural norms, attitudes and traditions were found to frequently act as barriers (but, in some cases, also as enablers) to the realization of children's rights in several sectors in Kiribati.

- The erosion of traditional community care, or the limitations of community care in urban areas, means children are more exposed to child protection concerns than before.
- At the same time, traditional attitudes that are permissive of violence and lack of community planning around child protection also expose children to risk.
- Traditional gender roles support and facilitate **violence** against women and girls, and marginalized groups, including **children with disabilities**.
- Traditional norms underlie key risk factors associated with negative health outcomes, such as the high smoking prevalence among Kiribati's youth population.

8.7. Poverty and vulnerability

The impacts of poverty are significant in Kiribati, and children and families are highly exposed to risk and economic shocks, particularly those caused by climate change and natural disasters.

- The absence of a comprehensive social protection system limits the ability of the government to lift vulnerable persons out of poverty and support economic growth.

- Lack of opportunities, for adolescents and young people in particular, perpetuate cycles of poverty and have led to unhealthy behaviours, such as drug and alcohol abuse and mental health issues.

8.8. Data availability

There are useful data sources in some sectors in Kiribati. However, this analysis has revealed several data gaps, and the absence of these data is, in itself, a key finding.

- There are no up-to-date estimates of child stunting and wasting rates in Kiribati, which represents a significant data gap.

- There is a lack of data around including about children with disabilities, other vulnerable groups and out-of-school-youth. Further, there is lack of data on specific types of child rights violations such as child labour and sexual exploitation.

- There are few data on disparities between different population groups, such as gender disparities or disparities between urban and rural areas.

Footnotes in tables

I UNISDR and GADRRRES, 'A Global Framework in Support of the Global Alliance for Disaster Risk Reduction and Resilience in the Education Sector and the Worldwide Initiative for Safe Schools', January 2017, on http://gadrrres.net/uploads/images/pages/CSS_Booklet_2017-updated.pdf [24.01.17].

II Table reproduced from ibid., p. 2.

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